STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365691	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mentor Hills Post Acute	8200 Mentor Hills Drive Mentor, OH 44060

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0774 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Help the resident with transportation to and from laboratory services outside of the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and facility policy review, the facility failed to ensure transportation to and from a planned physician appointment for Resident #94. This affected one (Resident #94) of three residents reviewed for transportation assistance. The facility census was 95. Findings include: Review of the medical record revealed Resident #94 was admitted to the facility on [DATE]. Medical diagnoses included malignant neoplasm of right lung, malignant neoplasm of lower right lung, cerebrovascular disease, hypertension, vertigo, hyperlipidemia, anxiety, major depression, gastro esophageal reflux, and abnormal gait. Review of facility document dated 03/25/25, revealed Resident #94 was to have an appointment on 05/02/25 for a CT (computed tomography) of the chest, abdomen, pelvis and a Radiation Oncology appointment to establish a new patient. In addition, on 05/08/25 Resident #94 was to have an appointment with Hematology and Oncology to establish Resident #94 and infusion therapy. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #94's cognition was intact. Supervision was needed to transfer from bed to chair. Resident #94 did not have pain at present and life expectancy was not less than six months. Resident #94 received chemotherapy. Review of the care plan dated 04/19/25 revealed Resident #94 was at risk for complications related to the administration of chemotherapy. Interventions included encouraging fluids, following up with oncologist/hematologist, administering medication as ordered and monitoring for signs of activity intolerance such as fatigue, shortness of breath, pallor or cyanosis, vertigo, weakness. Review of facility document title Appointment Information dated 05/08/25 revealed Resident #94 was scheduled for a Hematology and Oncology visit for small cell right Atezolizumab (immunotherapy) infusion; but Resident #94 was documented as not seen. Review of facility Appointment Calendar dated May 2025, revealed Resident #94 was scheduled on 05/02/25 for an appointment with transportation, but no appointments were scheduled on 05/08/25. Review of Resident Grievance Form, dated 05/13/25, revealed Resident #94 had a concern regarding a missed appointment. Investigation findings revealed the appointment was missed due to transportation error. The resolution revealed the appointment was rescheduled. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365691	A. Building B. Wing	06/05/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0774 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/04/25 at 2:00 P.M. with the Administrator revealed the Unit Manager was on vacation during the week of 05/08/25, therefore transportation was not scheduled for Resident #94's appointment. The Administrator verified Resident #94 missed the 05/08/25 infusion appointment. The interview on 06/04/25 at 3:00 P.M. with Unit Manager (UM) #309 revealed she was responsible for setting up residents outside appointments and transportation. UM #309 verified Resident #94 missed an infusion appointment in May 2025 because she did not see the appointment come through. Interview on 06/04/25 at 3:15 P.M. with the Social Worker # 301 revealed the nursing staff scheduled transportation for residents to outside appointments and verified Resident #94 missed her infusion appointment. An interview on 06/05/25 at 10:43 A.M. with UM #308 revealed the Unit Managers reviewed orders in the medical records and followed up with transportation for appointments. UM #308 stated she assumed UM #309 had taken care of all appointments prior to her vacation. Interview on 06/05/25 at 12:02 P.M. with the Director of Nursing (DON) verified Resident #94's family filed a grievance on 05/13/25 because Resident #94 missed the 05/08/25 appointment. The DON stated the appointment was missed and transportation was not set up because UM #309 was on vacation that week. The DON verified no physician order was placed in the electronic medical record for 05/08/25 and verified the transportation calendar did not have an appointment for Resident #94 on 05/08/25, and the facility was notified on 03/25/25 regarding the CT of chest, abdomen, pelvis and Radiation Oncology physician appointment on 05/02/25 and the Hematology and Oncology physician appointment with infusion scheduled for 05/08/25. Review of the undated facility policy Transportation, Social Services revealed the facility would help arrange transportation for residents as needed. This deficiency represents non-compliance investigated under Complaint Number OH00165684.