STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365746	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brentwood Health Care Center	907 Aurora Rd Sagamore Hills, OH 44067

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to accurately code the preadmission screen and resident review (PASRR) status on the Minimum Data Set (MDS) 3.0 assessment for Residents #43 and #82. This affected two (Residents #43 and #82) of three residents identified by the facility as having a level two mental illness and/or an intellectual disability. The facility census was 80.Findings include:1. Review of the medical record revealed Resident #43 was admitted to the facility on [DATE] with diagnoses that included bipolar disorder, schizophrenia and depression. Review of the level two PASRR assessment from the Ohio Department of Mental Health and Addiction Services (ODMHAS) (the state contracted PASRR agency for level two serious mental illness PASRR evaluations), dated 03/06/24, revealed Resident #43 had a level two mental illness.Review of section A of the most recent comprehensive MDS 3.0 assessment dated [DATE] revealed the facility answered no to the question Is the resident currently considered by the state level II pre admission screen and resident review (PASRR) process to have serious mental illness and/or intellectual disability (mental retardation in federal regulation) or a related condition?.2. Review of the medical record revealed Resident #82 was admitted to the facility on [DATE] with diagnoses that included cerebral palsy, epilepsy and anxiety disorder. Review of the level two PASRR assessment from the Ohio Department of Developmental Disabilities ([NAME]) (the state contracted PASRR agency for level two developmental disability PASRR assessments), dated 05/17/23, revealed Resident #82 had a level two developmental disability.Review of section A of the most recent comprehensive MDS 3.0 assessment dated [DATE] revealed the facility answered no to the question of Is the resident currently considered by the state level II pre admission screen and resident review (PASRR) process to have serious mental illness and/or intellectual disability (mental retardation in federal regulation) or a related condition?.Social Worker #461 verified the PASRR coding inaccuracies for Residents #43 and #82 in an interview on 07/23/25 at 3:00 P.M.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. (continued on next page)

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	365746	A. Building B. Wing	07/24/2025

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to ensure personal protective equipment (PPE) was worn for Enhanced Barrier Precaution (EBP) during medication administration via percutaneous endoscopic gastrostomy (PEG) tube for Resident #83. This affected one (Resident #83) five residents reviewed for medication administration had the potential to affect all residents on Registered Nurse (RN) #509's assignment, who had EBP's to include (Residents #3, #12, #35, and #36). The facility failed to ensure infection control was maintained during perineal care for Resident #94. This affected one resident (Resident #94) of three residents observed for perineal care and had the potential to affect all residents on Certified Nursing Assistant (CNA) #377's assignment to include (Residents #1, #13, #19, #38, #42, #43, #60, #62 and #68) and CNA #508's assignment to include (Residents #5, #29, #39, 44, #45, #73, #80, and #89). The facility census was 80.Findings include: 1. Review of the medical record for Resident #83 revealed an admission date of 07/31/24. Diagnoses included hemiplegia and hemiparesis following cerebral infarction, dysphagia, and encounter for attention to gastrostomy. Review of the care plan dated 05/10/25 revealed Resident #83 was at risk for dehydration related to use of tube feeding. Interventions included administer medications per physician orders, EBP due to tube feed, and head of bed at 30 degrees at all times. Review of the physician orders dated July 2025 revealed an order for Baclofen 5 milligram (mg) (muscle relaxer) via PEG-tube three times a day (TID) for muscle spasms and EBP due to tube feed every shift. Observation on 07/22/25 at 1:00 P.M. revealed RN #509 entered Resident #83's room, who was on EBP's for tube feeding, to administer medications via the PEG-tube site. RN #509 performed hand hygiene and donned gloves. RN #509 opened Resident #83's PEG-tube and flushed with 15 milliliter (ml) of water, followed by medication of Baclofen 5 mg mixed with 15 ml of water, followed by a 15 ml water flush. RN #509 closed the PEG-tube site, removed his gloves and performed hand hygiene before exiting Resident #509's room. RN #509 did not don a gown as required for EBP. Interview on 07/22/25 at 1:16 P.M. with RN #509 confirmed he did not wear the correct PPE to administer medications via PEG-tube. RN #509 reported he wasn't aware he had to wear PPE for tube feeding medication administration. RN #509 reported he did not know where the bin with PPE was located in Resident #83's room. Interview on 07/22/25 at 1:20 P. M. with the Director of Nursing (DON) confirmed EBP was to be in place and PPE worn for medications via PEG-tube feeding to include a gown. Observation on 07/22/25 at 1:20 P.M. with the DON in Resident #83's room revealed a plastic bin with PPE located in the corner of the room behind a Broda chair, with PRAFO boots (a foot and ankle orthotic) on top of it, and an oxygen tank in front of the bin drawers. Review of the facility policy, Enhanced Barrier Precautions, revised 03/29/24, revealed implement EBP's for the prevention of transmission of multidrug-resistant organisms (MRDO). The policy further stated make gowns and gloves available immediately near or outside of the resident's room. High-contact resident care activities include feeding tubes. 2. Review of the medical record for Resident #94 revealed an admission date of 05/12/25. Diagnoses included Alzheimer's Disease, dementia, and congestive heart failure. Review of the significant change Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #94 had severely impaired cognition and was dependent on staff for all needs. Observation on 07/23/25 at 8:17 A.M. of incontinence care for Resident #94 revealed CNAs #337 and #508 gathered supplies, explained the procedure, provided privacy, and donned gloves without performing hand hygiene first. CNA #508 placed two clean washcloths in the bottom of the sink and began to run water over them. CNA #508 then picked up one of the washcloths and added soap to it and then picked up the other washcloth and placed it on the counter and then placed the soap washcloth on top of it. CNA #508 then took a basin and placed water in it and then placed the two washcloths from the counter in the basin. CNA #508 began to perform perineal care. During perineal care when cleaning the buttocks, the washcloth had stool on it and CNA #508 got stool on her right gloved hand. CNA #508 continued to provide perineal care without removing the stool soiled glove, performing hand hygiene and donning new gloves. CNA #508 then grabbed a tube of barrier cream with the soiled glove and applied barrier cream to Interview on 07/23/25 at 8:39 A.M. with CNA #337 confirmed she did not perform hand hygiene before and after removing gloves. CNA #337 reported she did not know she had to wash hands before applying gloves and taking off gloves. Interview on 07/23/25 at 8:40 A.M. with CNA #508 confirmed she didn't wash hands before glove usage, placed two washcloths in bottom of sink, the placed the same two washcloths on the side of the sink, then got basin and placed the same two