

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365753	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/23/2024
NAME OF PROVIDER OR SUPPLIER Royal Oak Nursing & Rehab Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 6973 Pearl Rd Middleburg Heights, OH 44130	
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)		
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32650</p> <p>Based on interview, medical record review, and policy review, the facility failed to notify the resident's emergency contact regarding a change in condition. This affected one resident (Resident #100) of three residents reviewed for a change in condition. The facility census was 69.</p> <p>Findings Include:</p> <p>Medical record review revealed Resident #100 was admitted to the facility on [DATE] for skilled therapy after having a hip replacement. Resident #100 was discharged home on 10/16/24. Admitting diagnoses include diabetes, high blood pressure, heart disease, congestive heart failure, and osteoporosis.</p> <p>Review of the physician's orders for Resident #100 revealed the resident was taking Eliquis (an anticoagulant) 5 milligrams (mg) twice a day for blood clot prevention.</p> <p>Review of the admission Minimum Data Set (MDS) 3.0 comprehensive assessment for Resident #100, dated 10/14/24, revealed the resident was cognitively intact, was in need of supervision for toileting, and was receiving speech therapy, occupational therapy, and physical therapy.</p> <p>Review of the progress note dated 10/06/24 timed at 7:37 A.M. for Resident #100 revealed Registered Nurse (RN) #449 heard the resident yelling for help. RN #449 found the resident lying on her stomach on the floor with her walker under her legs. After assessing the resident, RN #449 assisted Resident #100 into the recliner. Resident #100 had a large hematoma on the left side of her forehead. The resident's call light was in place at the time of the fall. Resident #100 said she tripped on her oxygen tubing and fell. The nurse practitioner (NP) was notified and ordered the resident be evaluated in the emergency room (ER) and to have a Computed Tomography (CT) scan of her head. The Assistant Director of Nursing (ADON) was also notified of the fall and the transfer to the ER for an evaluation. There was no documentation regarding Resident #100's daughter being notified of the fall or of the transfer to the ER for evaluation.</p> <p>(continued on next page)</p>		

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
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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the progress note dated 10/06/24 timed at 5:10 P.M. revealed Resident #100 returned from the ER. Her CT scan was negative, her blood sugar was high at 498, and the resident had three plus pitting edema to both of her legs. Licensed Practical Nurse (LPN) #414 educated the resident about keeping her legs elevated due to the edema, if she needed to get up to use her call light and ask for assistance, and administered Humalog (a type of insulin) 4 units subcutaneously as well as the sliding scale order for Humalog. LPN #414 placed a call to the resident's daughter at 5:39 P.M. and left a voicemail message regarding Resident #100.</p> <p>Interview with Human Resources Director #427 on 10/21/24 at 11:20 A.M. revealed Resident #100's daughter called the facility on 10/07/24 to report a concern that she was not notified of her mother's fall or transfer to the ER for evaluation. The daughter said the nurse she spoke with on the phone the evening of 10/06/24 was rude. The concern was investigated by the Director of Nursing (DON).</p> <p>Interview with the DON on 10/23/24 at 4:00 P.M. confirmed the facility should have notified Resident #100's emergency contact of the resident's fall and transfer to the ER.</p> <p>Review of the facility's Notification of Change policy, last reviewed on 06/01/24, revealed the responsible party/emergency contact should be notified regarding any accident that results in an injury or has the potential to require physician intervention.</p> <p>This deficiency represents noncompliance investigated under Complaint Number OH00158694.</p>		