STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365753	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royal Oak Nursing & Rehab Ctr	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **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 Resident #43's wound treatment was performed as ordered by the physician. This affected one resident (#43) out of three residents reviewed for wound care. The facility census was 77.Findings include:A review of Resident #43's clinical record revealed an admission date of 07/14/25 with diagnoses including high blood pressure, heart arrhythmias, heart failure with a cardiac pacemaker, hypothyroidism, osteoarthritis, atherosclerotic heart disease, and high cholesterol.A review of Resident #43's wound assessment dated [DATE] indicated the left shin wound measured 0.80 centimeters (cm) long by 2.40 cm wide by 0.1 cm deep. The wound was draining a slight amount of serosanguinous fluid with attached wound edges and intact surrounding tissue. The wound was classified as a skin tear.A review of Resident #43's physician orders revealed an order dated 08/02/25 to perform the left shin wound treatment every Tuesday, Thursday and Saturday. Cleanse the left shin with normal saline, apply xeroform and cover with border gauze every night shift every Tuesday, Thursday, and Saturday.An observation on 08/06/25 at 12:44 P.M. of Resident #43's wound treatment with Licensed Practical Nurse (LPN) #808 revealed the wound treatment located on Resident #43's shin was dated 08/03/25 with the initials of the nurse who had completed the wound treatment. LPN #808 verified the wound treatment had not been changed as ordered on 08/05/25. Review of the facility's policy and procedure titled Wound Treatment Management dated 12/01/2021 indicated the policy was to promote wound healing of various types of wounds, it was the policy of the facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. Wound treatments would be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change.This deficiency represents non-compliance investigated under Complaint Number 1289786 (OH00166311).

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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(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 - Few	Provide and implement an infection prevention and control program. (continued on next page)

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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 - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, and facility policy review, the facility failed to ensure enhanced barrier precautions (EBP) were implemented during Resident #22's incontinence and wound care care and Resident #43's wound care. This affected two residents (#22 and #43) of three residents reviewed for EBP. The facility identified 16 residents who required EBP. The facility census was 77.Findings include: 1. A review of Resident #22's clinical record revealed an admission date of 02/11/25 with diagnoses including fracture of the right patella and upper end of humerus, atherosclerotic heart disease, pulmonary hypertension, morbid obesity, anxiety, gastroesophageal reflux disease, high blood pressure, diverticulosis, cardiomegaly, kidney stones with hypertensive kidney failure, benign prostatic hyperplasia, encephalopathy, and obstructive reflex uropathy.A review of Resident #22's physician's orders revealed an order dated 03/11/25 for gloves and gown to be worn when providing dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, and wound care. Resident #22 had an additional order dated 07/24/25 which stated to cleanse the right buttock with normal saline, apply hydrogel and calcium alginate to the wound and cover the wound with a foam dressing once a day on the night shift.A review of Resident #22's wound assessment dated [DATE] revealed a left buttock wound measured 1 centimeter (cm) long by 2 cm wide by 0.1 cm deep. The wound was draining a moderate amount of serosanguinous fluid with dry red skin surrounding the wound edges. There were no changes in the wound treatment, and the wound was improving.An observation on 08/06/25 at 10:30 A.M. of Licensed Practical Nurse (LPN) #808 perform Resident #22's wound care revealed a failure to implement the enhanced barrier precautions (EBP) to prevent cross contamination of germs during the task. LPN #808 entered Resident #22's room and donned a pair of disposable gloves, but did not don a gown. LPN #808 proceeded to assist with turning Resident #22 to perform his wound care. When Resident #22 was turned on to his side he was incontinent with a large soft bowel movement and LPN #808 performed the incontinence care. LPN #808 then proceeded to apply the physician ordered wound treatment to Resident #22's right buttock cheek. After cleaning Resident #22's perineal area and performing the wound care Resident #22's draw sheet was soiled with blood and feces. Resident #22 was turned side to side and the draw sheet was removed and LPN #808 placed the soiled draw sheet directly on the floor.An interview with LPN #808 on 08/06/25 at 12:31 P.M. verified the above findings and was unsure what the facility's policy was for handling soiled linens to prevent cross contamination of germs. LPN #808 agreed there was no signage on Resident #22's door to indicate EBP should be implemented and there was no personal protective equipment placed outside Resident #22's door. LPN #808 agreed he should have worn a gown during Resident #22's incontinence and wound care.2. A review of Resident #43's clinical record revealed an admission date of 07/14/25 with diagnoses including high blood pressure, heart arrhythmias, heart failure with a cardiac pacemaker, hypothyroidism, osteoarthritis, atherosclerotic heart disease, and high cholesterol.A review of Resident #43's physician orders revealed an order dated 08/02/25 to perform the left shin wound treatment every Tuesday, Thursday and Saturday. Cleanse the left shin with normal saline, apply xeroform and cover with border gauze every night shift every Tuesday, Thursday, and Saturday.An interview with Resident #43 on 08/06/25 at 12:30 P.M. revealed the staff did not wear a gown when assisting her with wound care and other direct care needs, including her bath and personal hygiene tasks.An observation on 08/06/25 at 12:44 P.M. with LPN #808 verified there was no signage outside of Resident #43's room to indicate EBP should be implemented and there was no personal protective equipment located outside of Resident #22's room door.Review of the facility policy and procedure titled Enhanced Barrier Precautions revised on 07/13/22 revealed it was the policy of the facility to implement enhanced barrier precautions for preventing transmission of novel or targeted multidrug-resistant organisms. Enhanced barrier precautions referred to the use of gowns and gloves for certain residents during specific high-contact resident care activities that have been found to increase risk for transmission of multidrug-resistant organisms. Clear signage will be posted on the door or wall outside of the resident room indicating the type of precautions, required personal protective equipment (PPE), and the high-contact resident care activities that require the use of gown and gloves. An order for enhanced barrier precautions will be obtained for residents with wounds and/or indwelling medical devices (e. g., central line, urinary catheter, feeding tube, tracheostomy/ventilator) regardless of multidrug-resistant organisms colonization status. High-contact resident care activities included dressing, bathing, transferring