STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365757	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broadview Multi Care Center	5520 Broadview Rd Parma, OH 44134

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013 Based on observation, interview, record review and review of the facility policy the facility failed to ensure Resident #22 was assisted into bed timely after returning from an appointment. This affected one resident (Resident #22) and had the potential to affect eleven residents (Resident's #5, #22, #45, #69, #71, #76, #78, #87, #103, #143, #167 residing on the nursing unit who required a mechanical lift for transfers. The facility census was 175. Findings include: Review of Resident #22's medical record revealed an admitted [DATE] and diagnoses included hydronephrosis with renal and ureteral calculous obstruction, type two diabetes mellitus with diabetic neuropathy, muscle weakness, and difficulty in walking. Review of Resident #22's care plan dated 10/03/23 included Resident #22 had an ADL (Activity of Daily Living) self-care deficit related to weakness, impaired mobility. Resident #22 would improve current functional status related to ADL's. Interventions included to provide total assist with transfer (chair to bed to chair transfer, shower transfer), use a mechanical lift transfer with two assist, monitor for fatigue and provide rest periods as needed. Review of Resident #22's Quarterly Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #22 was cognitively intact. Resident #22 was frequently incontinent of urine and occasionally incontinent of bowel. Resident #22 was dependent for toileting hygiene and bathing and required substantial to maximal assistance with dressing. Resident #22 was dependent for transfers and used a wheelchair. Review of Resident #22's physician orders revised 03/20/24 revealed mechanical lift for all transfers at all times with assist of two. (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
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 04/23/24 at 3:30 P.M. of Registered Nurse (RN) #497 and State tested Nursing Assistant (STNA) #312 revealed they were standing in the hall of the Rosepointe B nursing unit outside of Resident #22's room, having a conversation, and Resident #22's call light was on. STNA #312 stated she just arrived for work at 3:30 P.M. and was assigned to Rosepointe B nursing unit for the 3:00 P.M. until 11:00 P.M. shift., and STNA #335 was also assigned to the unit, but she did not know where STNA #335 was. RN #497 stated she thought STNA #335 was on her lunch break. Further observation revealed STNA #312 entered Resident #22's room and answered his call light. Resident #22 was sitting in a wheelchair by his bed and indicated he would like to go to bed. STNA #312 walked out of the room and told RN #497 Resident #22 requested to be assisted into bed, RN #497 stated okay and walked into the nurses station. RN #497 did not come back and assist STNA #312 to help Resident #22 into bed. STNA #312 told the surveyor she could not put Resident #22 into bed by herself because he required a mechanical lift. Observation on 04/23/24 at 3:45 P.M. of Resident #22's call light revealed it was on, and no staff were visible on the unit. Interview on 04/23/24 at 3:50 P.M. with Resident #22 revealed he had been waiting awhile to go to bed, had been rushed at lunch and unable to finish his meal because transportation was at the facility to pick him up for an appointment. Resident #22 stated he hoped his lunch was available because he was hungry. Resident #22 indicated he returned from his appointment slightly after 3:00 P.M., he was not able to walk to get into bed by himself, he activated his call light when he returned around 3:00 P.M., and was waiting for someone to put him to bed. Resident #22 stated he told the staff he wanted to go to bed when he returned at 3:00 P.M. , it was now 3:50 P.M. and he was still waiting. Observation on 04/23/24 at 3:52 P.M. revealed STNA's #312 and #335 entered Resident #22's room with a mechanical lift and assisted him into bed. STNA #312 left the room with the mechanical lift and STNA #335 provided Resident #22's incontinence care without assistance. Further observation revealed Resident #22's incontinence brief was soaked with urine, and STNA #335 stated Resident #22 was gone a long time for his appointment she was not surprised the brief was saturated with urine. Interview on 04/23/24 at 4:05 P.M. with STNA #335 revealed there were not enough STNA's assigned to Rosepointe B, and when there were only two STNA's they worked nonstop to provide care for the residents. STNA #335 stated Resident's #76 and #101 were very challenging and the STNA's had to keep an eye on them and babysit plus take care of all the other residents on the nursing unit. STNA #335 indicated she made sure the residents were taken care of before she took her lunch break, and usually went around 3:00 P. M., but then there was no one to back her up. Interview on 04/23/24 at 5:03 P.M. with STNA #345 revealed she was called and asked if she could work today starting at 3:00 P.M. and she arrived to Rosepointe B around 3:15 P.M. STNA #345 stated when she arrived to the nursing unit she immediately went in a room of a resident with a call light on and provided care. Review of the facility policy titled Ohio Resident Rights and Facility Responsibilities included it was the facility's policy to abide by all resident rights, and to communicate these right to residents and their designated representatives in a language that they can understand. The rights of a resident of a home shall include, but were not limited to the right to have all reasonable requests and inquiries responded to promptly. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents non-compliance investigated under Complaint Number OH00152723.

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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 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** 42013 Based on interview, record review and review of facility policy the facility failed to ensure Resident #176's physician orders were followed for treatments to her left above the knee amputation stump. This affected one resident (Resident #176) out of three residents reviewed for treatments. The facility census was 175. Findings include: Review of Resident #176's medical record revealed an admitted [DATE] and diagnoses included encounter for orthopedic aftercare following surgical amputation, dehiscence of amputation stump, acquired absence of left leg above knee, and encounter for surgical aftercare following surgery on the skin and subcutaneous tissue. Resident #176 was discharged from the facility on 04/08/24. Review of Resident #176's hospital After Visit Summary discharge instructions revealed she had a hospital admission from 03/14/24 through 03/22/24. Resident #176's principal diagnosis was incision and drainage abscess, thigh or knee region. Resident #176 had an amputation stump infection. Treatment, wound care included the physician ordered a special dressing or packing to the wound. When a wound was deep, or when it tunneled under the skin, packing the wound could help it heal. The packing material absorbed any drainage from the wound , which helped the tissues heal from the inside out. Without packing, the wound might close at the top without healing at the deeper areas of the wound. This could then possibly trap fluid and bacteria in the deeper areas leading to the wound to not heal and, or infection. Further review of the discharge instructions revealed Resident #176 had a left leg, full thickness surgical wound with brown and yellow slough along the incision at first evaluation. The plan was to perform wet to dry dressing twice daily with wound packing. Continue wound packing until wound heals and the wound was unable to be packed. Fill the entire wound but do not overstuff. To perform the dressing change, lift the patient's leg up towards her abdomen. Remove the old dressing, cleanse wound with wound cleanser and pat dry. Gently fill wound with Kerlix moistened with Vashe (Vashe Wound Solution is a wound cleanser containing Pure Hypochlorous Acid: a vital molecule produced by the human body ' s own immune system when fighting harmful bacteria and infection, The use of Vashe with collagenase results in more efficient wound bed preparation and debridement versus saline with collagenase) leaving a tail outside the wound for easy removal. Lay Vashe moistened Kerlix on the wound (along the incision and the posterior leg). Cover with ABD's, wrap with Kerlix and secure with an ACE wrap. Change twice daily and as needed based on drainage. Review of Resident #176's progress notes dated 03/22/24 at 9:45 P.M. included Resident #176 was admitted on [DATE] at 6:30 P.M. Resident #176 had no apparent short term or long term memory problems, answered questions readily and her motivation was good. Resident #176 required two person assistance for bed mobility and transfers. Review of Resident #176's physician orders dated 03/23/24 at 12:45 A.M. revealed to cleanse wound with NS (normal saline) or skin cleanser and pat dry with two nonsterile two by two's, apply wet to dry F/B (followed by) ABD (abdominal) pad, Kerlix wrap and ACE wrap, monitor for signs and symptoms of pain with dressing change, medicate with pain medication as needed and, or notify the physician if pain is present, location was left lower amputation site. Two times a day and as needed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review revealed there were no orders to gently fill wound with Kerlix moistened with Vashe (Vashe Wound Solution is a wound cleanser containing Pure Hypochlorous Acid: a vital molecule produced by the human body ' s own immune system when fighting harmful bacteria and infection, The use of Vashe with collagenase results in more efficient wound bed preparation and debridement versus saline with collagenase) leaving a tail outside the wound for easy removal. Lay Vashe moistened Kerlix on the wound (along the incision and the posterior leg). Review of Resident #176's physician orders from 03/22/24 through 04/08/24 did not reveal orders to use normal saline instead of Vashe for treatment. Review of Resident #176's Treatment Administration Record (TAR) dated 03/23/24 through 04/08/24 revealed cleanse wound with NS or skin cleanser and pat dry with two nonsterile two by two's, apply went to dry followed by ABD pad, Kerlix wrap and ace wrap. monitor for signs and symptoms of pain with dressing change, medicate with pain medication as needed and, or notify physician if pain was present for left lower amputation site. Further review of Resident #176's TAR did not reveal instructions to gently fill wound with Kerlix moistened with Vashe leaving a tail outside the wound for easy removal. Lay Vashe moistened Kerlix on the wound (along the incision and the posterior leg). Review of Resident #176's care plan dated 03/25/24 included Resident #176 had the potential for alteration in skin integrity related to impaired mobility, incontinence, L AKA (left above the knee amputation) wound dehiscence and infection and other diagnoses. Resident #176 would not develop skin breakdown through the review date. Interventions included to administer treatments as ordered and monitor for effectiveness. Interview on 04/24/24 at 4:56 P.M. with Certified Wound Nurse/Licensed Practical Nurse (CWN/LPN) #360 revealed Resident #176's wound treatment orders were put in Resident #176's electronic medical record by the nurse and she reviewed the orders to make sure they were correct and easy to follow. CWN/LPN #360 confirmed Resident #176's physician orders and TAR did not have orders to pack the wound with Vashe moistened Kerlix, and stated specific orders from the discharge instructions were not needed because nurses would know the wound needed to be packed, and if a dressing was ordered wet to dry the nurses knew to pack the area. CWN/LPN #360 stated wet to dry was for an open area and was not put on the skin. CWN/LPN #360 stated Resident #176 was not seen by a physician or wound nurse practitioner at the facility because she was followed by her orthopedic surgeon, and it was too confusing if more than one physician were involved. Interview on 04/25/24 at 8:27 A.M. with the Director of Nursing (DON) revealed the facility used normal saline as the wound cleanser. The DON confirmed Resident #176 had Vashe ordered for the treatment of her left above the knee amputation site, but normal saline was used instead. The DON stated she was familiar with Vashe, but it was standard in long term care to use normal saline and pack the Kerlix in the wound loosely. The DON confirmed the physician was not contacted to obtain new orders to use saline instead of Vashe. Interview on 04/25/24 at 8:59 A.M. with Registered Nurse (RN) #446 revealed she completed Resident #176's dressing change to her amputation site at least one time and it was a really bad wet to dry dressing change. RN #446 stated she used the small bottles of saline to moisten the packing, she knew what Vashe was and did not remember if she used Vashe as a wash for Resident #176's treatment. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Ohio Resident Rights and Facility Responsibilities included it was the facility's policy to abide by all resident rights, and to communicate these rights to residents and their designated representatives in a language that they could understand. The resident had the right upon admission and thereafter to adequate and appropriate medical treatment and nursing care and to other ancillary services that comprise necessary and appropriate care consistent with the program for which the resident was contracted. This deficiency represents non-compliance investigated under Complaint Number OH00152608 and is an example of continued non-compliance from the survey dated 04/01/24.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013 Based on observation, interview, record review and review of facility policy, the facility failed to ensure Resident #47's urine culture result report was reported timely to the physician, and failed to ensure Resident #10 and Resident #47 received appropriate incontinence care timely. This affected two residents (Resident #10 and #47) out of three reviewed for incontinence. The facility census was 175. Findings include: 1. Review of Resident #47's medical record revealed an admitted [DATE] and diagnoses included chronic respiratory failure with hypoxia, metabolic encephalopathy, and acute pancreatitis without necrosis or infection. Review of Resident #47's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #47 was cognitively intact. Resident #47 was always incontinent of urine and bowel. Review of Resident #47's progress notes dated 04/10/24 through 04/24/24 did not reveal evidence Resident #47 requested two incontinence briefs or an incontinence brief and a liner, or the risks of wearing two incontinence briefs, or a brief and a liner were discussed with her. Review of Resident #47's care plan revised 04/11/24 included Resident #47 had an ADL self care performance deficit related to limited mobility, impaired balance and other diagnoses. Resident #47 would improve current functional status related to ADL's (Activity of Daily Living's). Interventions included to provide total assistance with bed mobility, mechanical lift for transfers with two assist, Resident #47 was totally dependent for toileting hygiene and to provide incontinence care after each episode of incontinence. Review of Resident #47's progress notes dated 04/10/24 at 10:01 P.M. revealed Resident #47 was admitted to the facility on [DATE] at 8:40 P.M. and included Resident #47 had a 14 F (french, size) foley (indwelling) catheter which was placed on 04/09/24 while she was admitted to the hospital. Review of Resident #47's progress notes dated 04/11/24 at 9:22 A.M. written by Resident #47's Nurse Practitioner included Resident #47 was post acute hospitalization for pancreatitis, UTI (urinary tract infection), and acute kidney injury (AKI). Resident #47's records state she was sent to the hospital on 03/19/24 and found to have acute pancreatitis with pseudocyst, UTI, cellulitis and AKI. Review of Resident #47's progress notes dated 04/15/24 at 8:40 P.M. revealed Resident #47's foley catheter was changed per request from Resident #47's Nurse Practitioner, and urine to be sent out in the morning of 04/16/24. A new foley catheter, size 16 F was inserted. Further review revealed Resident #47's catheter was discontinued per order on 04/16/24 at 9:17 A.M. Review of Resident #47's physician orders dated 04/15/24 at 7:19 P.M. revealed send a urine for urinalysis and culture and sensitivity. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #47's urine culture revealed it was collected on 04/16/24 and reported on 04/20/24. The report indicated Resident #47 had morganella morgani, an organism known to possess inducible beta-lactamase, suggest clinical observation for the development of resistance after using cephalosporins or extended spectrum penicillins. Further review revealed neither doxycycline or Keflex was on the list of antibiotics which were effective against the organism morganella morgani. Review of Resident #47's progress notes dated 04/16/24 through 04/24/24 did not reveal evidence Resident #47's Physician or Nurse Practioner were notiifed of Resident #47's urinalysis and culture and sensitivity results. Review of Resident #47's physician orders dated 04/18/24 revealed Doxycycline Hyclate oral tablet 100 mg, give 100 mg by mouth two times a day for lymphedema. Observation on 04/24/24 at 7:58 A.M. of Resident #47 revealed she was lying in bed with the head of the bed elevated. Resident #47 stated her incontinence brief was not changed since last night around 9:00 P.M. Resident #47 stated she put her call light on about 8:00 P.M. because she had a bowel movement and no one answered the light until around 9:00 P.M. Resident #47 stated she did not like laying in a dirty brief. Resident #47 stated the STNA's did not come in her room during the night to check on her or ask if she needed her incontinence brief changed, and she wished the STNA's had changed her on the night shift. Resident #47 indicated she liked to have her incontinence brief changed timely because she had a urinary tract infection recently and she wanted to be careful so she did not develop another one. Resident #47 stated she was scheduled to receive a shower around 10:00 A.M. and the STNA's would change her incontinence brief then. Observation on 04/24/24 at 10:10 A.M. of Resident #47 revealed State tested Nursing Assistant (STNA) #469 was preparing to give her a shower. There was a strong odor of urine in the room. STNA #469 stated Resident #47's incontinence brief did not always get changed at night. Resident #47 stated she had a urinary tract infection recently and wanted to be careful she did not develop another one. STNA's #377 and #459 entered Resident #47's room to help transfer her using the mechanical lift from her bed to the shower bed. Before Resident #47 was transferred incontinence care was provided and observation revealed Resident #47 was wearing two incontinence briefs which were saturated with urine and had a moderate to large formed brownish bowel movement. Resident #47 stated she did not ask to wear two incontinence briefs and did not know why she had two on. Resident #47 stated sometimes she wore a liner and an incontinence brief. Observation of Resident #47's perineal area and buttocks revealed they were reddened. Review of Resident #47's care plan revealed an intervention of Resident #47 preferred to wear brief with liner at times and would add additional brief if liner not available was added on 04/24/24 by Clinical Services Manager #509 after the surveyor observation on 04/24/24 that Resident #47 was wearing two incontinence briefs. Review of Resident #47's progress notes dated 04/24/24 at 11:54 A.M. included lab results reported to physician and new orders were received. Reclarified with physician UA (urinalysis) results. Would stop Doxy (doxycycline, antibiotic as the resident was on for lymphedema) on 04/24/24 and start Cipro (Ciprofloxacin, antibiotic) 500 milligram (mg) twice a day as culture was not sensitive to current antibiotic (Doxycycline Hyclate) or Keflex (antibiotic, Cephalosporin) which Resident #47 completed on 04/23/24. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #47's physician orders dated 04/24/24 at 12:12 P.M. revealed orders Ciprofloxacin HCL (hydrochloride) tablet 500 mg, give one tablet by mouth two times a day for infection for seven days. Interview on 04/24/24 at 1:48 P.M. with Staff Development Coordinator (SDC) #505 revealed on 04/15/24 she provided a staff inservice and education titled incontinence care, urinary catheters, double briefing. SDC #505 stated she provided education on the correct procedure for incontinence care. SDC #505 indicated she educated staff that residents should wear one brief unless it was care planned that their preference was two briefs, and if a resident preferred two incontinence briefs the nurse needed to be notified and it should be documented in the progress notes that the resident preferred two incontinence briefs and the risks of wearing two incontinence briefs should be documented. SDC #505 stated the more briefs a resident wore increased the chances of developing a decubitus ulcer. SDC #505 stated if a resident preferred an incontinence brief with a liner it should be care planned, and there should be documentation in the progress notes regarding resident preferred to wear an incontinence brief and a liner and the risks of wearing both should be documented. SDC #505 stated she educated staff on importance of checking on residents every two hours and to knock on door and ask the residents if they need to use the bathroom or bedpan or change their incontinence brief if it was soiled. SDC #505 stated the night shift STNA's should be checking on residents every two hours. SDC #505 stated she heard the day shift STNA's say night shift did not change residents timely. Interview on 04/24/24 at 1:04 P.M. with Unit Manager (UM) #489 revealed when asked about Resident #47's urinalysis and culture and sensitivity collected on 04/16/24 and reported on 04/20/24, UM #489 stated the doctor did not catch on that the antibiotic the resident was on was not effective. UM #489 was not sure if Physician #506 or Nurse Practitioner (NP) #507 viewed the results. Interview on 04/24/24 at 1:17 P.M. of Physician #506 revealed she was not aware until today (04/24/24) that Resident #47 had a urinalysis and culture and sensitivity ordered. Physician #506 did not know who ordered Resident #47's urinalysis and culture and sensitivity, checked Resident #47's orders and found out it was ordered by NP #507. Interview on 04/24/24 at 5:12 P.M. with NP #507 revealed she ordered Resident #47's urinalysis and culture and sensitivity because she had a foley catheter and had a UTI while in the hospital. NP #507 stated Resident #47 was on Keflex (antibiotic) and doxycycline (antibiotic) and she did not see the urine results which were reported on 04/20/24 until the facility staff called her today (04/24/24). NP #507 stated Physician #506 was also called today (04/24/24) with the results. NP #507 stated not getting the correct antibiotic could cause the infection to worsen but when she last saw Resident #47 she was reading, watching television, was not lethargic and did not have a fever. NP #507 stated she had a lot of residents to see and it was the facility's job to get Resident #47's urine culture results and report it to her or Physician #506. NP #507 stated she was not notified of Resident #47 urine culture and sensitivity results until today and both UM #489 and the Director of Nursing called her with the results, and the antibiotic order was changed from Doxycycline to Ciprofloxacin. Review of the facility policy titled Ohio Resident Rights and Facility Responsibilities included it was the facility's policy to abide by all resident rights, and to communicate these rights to residents and their designated representatives in a language that they could understand. The resident had the right upon admission and thereafter to adequate and appropriate medical treatment and nursing care and to other ancillary services that comprise necessary and appropriate care consistent with the program for which the resident was contracted. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident #10's medical record revealed an admitted [DATE] and diagnoses included multiple sclerosis, unspecified protein-calorie malnutrition, and weakness. Review of Resident #10's care plan revised 08/25/22 included Resident #10 had bladder incontinence , activity intolerance, and impaired mobility and no control. Resident #10 would remain free from skin breakdown due to incontinence and brief use through the review date. Interventions included to check for wetness before and after meals, at bedtime at during rounds during the night, to check Resident #10 for incontinence and if she was incontinent to remove wet, soiled clothing and briefs, provide incontinence care and apply protective barrier after each incontinent episode. There was no evidence of a care plan or interventions for an incontinence brief and a liner. Review of Resident #10's Quarterly MDS 3.0 assessment dated [DATE] revealed Resident #10 had moderate cognitive impairment. Resident #10 was always incontinent of urine and bowel. Resident #10 was dependent for toileting hygiene, personal hygiene, bathing and dressing. Review of Resident #10's progress notes from 03/25/24 through 04/24/24 did not reveal evidence Resident #10 requested an incontinence brief with a liner, or that the risks of wearing an incontinence brief and liner were explained to her. Observation on 04/24/24 at 9:02 A.M. of STNA #469 and #459 preparing to provide Resident #10's incontinence care revealed Resident #10 stated she was changed last night but could not remember the time. STNA #469 stated this was an ongoing problem, and often when she came to work residents were soaking wet and were not changed all night. STNA #469 proceeded to provide Resident #10's incontinence care and when Resident #10's incontinence brief was removed a liner could also be seen, and both were wet. STNA #469 stated she was not sure why Resident #10 had a liner and Resident #10 stated she did not request to wear an incontinence brief and a liner. Interview on 04/24/24 at 1:48 P.M. of Staff Development Coordinator (SDC) #505 revealed on 04/15/24 she provided a staff inservice and education titled incontinence care, urinary catheters, double briefing. SDC #505 stated she provided education on the correct procedure for incontinence care. SDC #505 indicated she educated staff that residents should wear one brief unless it was care planned that their preference was two briefs, and if a resident preferred two incontinence briefs the nurse needed to be notified and it should be documented in the progress notes that the resident preferred two incontinence briefs and the risks of wearing two incontinence briefs should be documented. SDC #505 stated the more briefs a resident wore increased the chances of developing a decubitus ulcer. SDC #505 stated if a resident preferred an incontinence brief with a liner it should be care planned, and there should be documentation in the progress notes regarding resident preferred to wear an incontinence brief and a liner and the risks of wearing both should be documented. SDC #505 stated she educated staff on importance of checking on residents every two hours and to knock on door and ask the residents if they need to use the bathroom or bedpan or change their incontinence brief if it was soiled. SDC #505 stated the night shift STNA's should be checking on residents every two hours. SDC #505 stated she heard the day shift STNA's say night shift did not change residents timely. (continued on next page)

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	365757	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broadview Multi Care Center	5520 Broadview Rd Parma, OH 44134

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Ohio Resident Rights and Facility Responsibilities included it was the facility's policy to abide by all resident rights, and to communicate these rights to residents and their designated representatives in a language that they could understand. The resident had the right upon admission and thereafter to adequate and appropriate medical treatment and nursing care and to other ancillary services that comprise necessary and appropriate care consistent with the program for which the resident was contracted. This deficiency represents non-compliance investigated under Complaint Number OH00153182 and is an example of continued non-compliance from the survey dated 04/01/24.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013 Based on observation, interview, and record review, the facility failed to ensure sufficient staffing to timely transfer residents who required two person Hoyer lift assistance. This affected Resident #22 and had the potential to affect all eleven residents (Resident's #5, #22, #45, #69, #71, #76, #78, #87, #103, #143, #167) residing on the nursing unit who required a mechanical lift for transfers. Findings include: Review of Resident #22's medical record revealed an admitted [DATE] and diagnoses included hydronephrosis with renal and ureteral calculous obstruction, type two diabetes mellitus with diabetic neuropathy, muscle weakness, and difficulty in walking. Review of Resident #22's care plan dated 10/03/23 included Resident #22 had an ADL (Activity of Daily Living) self-care deficit related to weakness, impaired mobility. Resident #22 would improve current functional status related to ADL's. Interventions included to provide total assist with transfer (chair to bed to chair transfer, shower transfer), use a mechanical lift transfer with two assist, monitor for fatigue and provide rest periods as needed. Review of Resident #22's Quarterly Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #22 was cognitively intact. Resident #22 was frequently incontinent of urine and occasionally incontinent of bowel. Resident #22 was dependent for toileting hygiene and bathing and required substantial to maximal assistance with dressing. Resident #22 was dependent for transfers and used a wheelchair. Review of Resident #22's physician orders revised 03/20/24 revealed mechanical lift for all transfers at all times with assist of two. Observation on 04/23/24 at 3:30 P.M. of Registered Nurse (RN) #497 and State tested Nursing Assistant (STNA) #312 revealed they were standing in the hall of the Rosepointe B nursing unit outside of Resident #22's room, having a conversation, and Resident #22's call light was on. STNA #312 stated she just arrived for work at 3:30 P.M. and was assigned to Rosepointe B nursing unit for the 3:00 P.M. until 11:00 P.M. shift., and STNA #335 was also assigned to the unit, but she did not know where STNA #335 was. RN #497 stated she thought STNA #335 was on her lunch break. Further observation revealed STNA #312 entered Resident #22's room and answered his call light. Resident #22 was sitting in a wheelchair by his bed and indicated he would like to go to bed. STNA #312 walked out of the room and told RN #497 Resident #22 requested to be assisted into bed, RN #497 stated okay and walked into the nurses station. RN #497 did not come back and assist STNA #312 to help Resident #22 into bed. STNA #312 told the surveyor she could not put Resident #22 into bed by herself because he required a mechanical lift. Observation on 04/23/24 at 3:45 P.M. of Resident #22's call light revealed it was on, and no staff were visible on the unit. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 04/23/24 at 3:50 P.M. of Resident #22 revealed he had been waiting awhile to go to bed, had been rushed at lunch and unable to finish his meal because transportation was at the facility to pick him up for an appointment. Resident #22 stated he hoped his lunch was available because he was hungry. Resident #22 indicated he returned from his appointment slightly after 3:00 P.M., he was not able to walk to get into bed by himself, he activated his call light when he returned around 3:00 P.M., and was waiting for someone to put him to bed. Resident #22 stated he told the staff he wanted to go to bed when he returned at 3:00 P.M. , it was now 3:50 P.M. and he was still waiting. Observation on 04/23/24 at 3:52 P.M. revealed STNA's #312 and #335 entered Resident #22's room with a mechanical lift and assisted him into bed. STNA #312 left the room with the mechanical lift and STNA #335 provided Resident #22's incontinence care without assistance. Further observation revealed Resident #22's incontinence brief was soaked with urine, and STNA #335 stated Resident #22 was gone a long time for his appointment she was not surprised the brief was saturated with urine. Interview on 04/23/24 at 4:05 P.M. of STNA #335 revealed there were not enough STNA's assigned to Rosepointe B, and when there were only two STNA's they worked nonstop to provide care for the residents. STNA #335 stated Resident's #76 and #101 were very challenging and the STNA's had to keep an eye on them and babysit plus take care of all the other residents on the nursing unit. STNA #335 indicated she made sure the residents were taken care of before she took her lunch break, and usually went around 3:00 P. M., but then there was no one to back her up. Interview on 04/23/24 at 5:03 P.M. of STNA #345 revealed she was called and asked if she could work today starting at 3:00 P.M. and she arrived to Rosepointe B around 3:15 P.M. STNA #345 stated when she arrived to the nursing unit she immediately went in a room of a resident with a call light on and provided care. Review of the list of residents requiring a mechanical lift revealed eleven residents (Resident's #5, #22, #45, #69, #71, #76, #78, #87, #103, #143, #167) residing on the Rosepointe B nursing unit required a mechanical lift for transfers. Review of the facility policy titled Ohio Resident Rights and Facility Responsibilities included it was the facility's policy to abide by all resident rights, and to communicate these right to residents and their designated representatives in a language that they can understand. The rights of a resident of a home shall include, but were not limited to the right to have all reasonable requests and inquiries responded to promptly. This deficiency represents non-compliance investigated under Complaint Number OH00152723.

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013 Based on observation, interview, record review and review of the facility policy the facility failed to ensure sufficient staffing to meet the behavioral health needs of the residents. This affected Resident's #76 and #101 and had the potential to affect all 31 residents residing on their nursing unit. The census was 175. Findings include: 1. Review of Resident #101's medical record revealed an admitted [DATE] and diagnoses included vascular dementia, hemplegia (paralysis) and hemiparesis (weakness) following cerebral infarction affecting left non-dominant side, and schizophrenia. Resident #101 resided on Rosepointe B unit. Review of Resident #101's care plan revised 04/09/24 included Resident #101 demonstrated socially inappropriate behaviors, verbally inappropriate towards staff, observed Resident #101 placing self on floor, crawling on floor, and was hard to redirect. Resident #101's dignity would be honored AEB (as evidenced by) Resident #101's needs would be honored daily by next review date. Interventions included assess for causes of behavior and alter environment as needed, to escort Resident #101 to a private area if unable to divert Resident #101's attention, and provide diversional activities as appropriate. Review of Resident #101's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #101's Brief Interview for Mental Status was not completed due to Resident #101 was rarely or never understood. Resident #101 was frequently incontinent of urine and always incontinent of bowel. Resident #101 was dependent for bathing, toileting and personal hygiene and bathing. Resident #101 required substantial to maximal assistance for dressing. Review of Resident #101's progress notes dated 04/20/24 at 5:29 P.M. included an unidentified nurse was leaving another resident room when the supervisor stated Resident #101 attempted to stand in the common area, was asked to sit down, then sat and flopped hard in the chair causing the chair to tilt backwards while Resident #101 was sitting in it. Resident #101 appeared to be in no pain with no injuries, vital signs were within normal limits, and he was assisted off the floor by two staff members. Review of the facility nursing assignment sheets dated 04/20/24 revealed on second shift (3:00 to 11:00 P.M.) two STNA's (STNA's #399 and #504) were assigned to the Rosepointe B nursing unit. RN #352 and LPN #364 were were the two nurses assigned to Rosepointe B from 3:00 P.M. until 7:00 P.M. Review of the facility incident log dated 04/20/24 at 5:50 P.M. revealed Resident #101 had a fall. Review of Resident #101's progress notes dated 04/20/24 at 5:50 P.M. revealed Resident #101 was transferred to the local hospital due to fall per physician orders. Resident #101 returned from the hospital at 10:10 P.M. with no new orders. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility nursing assignment sheets dated 04/22/24 from 7:00 A.M. until 3:00 P.M. revealed two STNA's (STNA's #327 and #356) were assigned to Rosepointe B. Registered Nurse (RN) #347 and RN #474, and Hospitality Aide # 447 were assigned to Rosepoint B. Interview on 04/22/24 at 8:26 A.M. with RN #347 revealed she was scheduled to work on Rosepointe B, and today she was the supervisor and also had an assignment. RN #347 stated when she was the supervisor she did not always have an assignment in addition to being the supervisor, but sometimes if there was a call off she took an assignment. RN #347 indicated when she was the supervisor and also had an assignment it was very hard for her to get everything done she needed to do. RN #347 stated if she was called away from her assignment to handle an issue her work sat for her until she came back, and she often stayed late to finish work, expecially charting and sometimes treatments. RN #347 stated she worried about staffing today because Rosepointe B had 31 residents and only two STNA's, four or five residents had dementia and psychiatric issues and it was hard for the STNA's to get all their work done. RN #347 stated a resident asked her for orange juice and there was no STNA around to get it, and another resident asked her for cookies, and there was no STNA to get the cookies either, RN #347 indicated she ran to get the orange juice and cookies, but then her meds did not get passed. Interview on 04/22/24 at 1:29 P.M. with State tested Nursing Assistant (STNA) #356 revealed today (04/22/24) she was assigned to Rosepointe B which was the unit Resident #101 resided on. STNA #356 stated only two aides were assigned to Rosepointe B, there were 31 residents and they required alot of assistance with their care. STNA #356 stated there were multiple residents residing on the unit who required a mechanical lift. STNA #356 stated she often did not have enough time to complete her charting in the electronic record, and things like transfers using a mechanical lift, incontinence care and showers did not always get done timely. Interview on 04/22/24 at 1:41 P.M. of State tested Nursing Assistant (STNA) #327 revealed she always worked on Rosepointe B which was the nursing unit Resident #101 resided on. STNA #327 stated today (04/22/24) from 7:00 A.M. until 3:00 P.M. two STNA's were assigned to care for 31 residents on Rosepointe B, and each STNA had sixteen residents to take care of. STNA #327 stated they did the best they could, but two STNA's were not enough to care for the residents, because many of the residents were dependent on staff for their care and there were quite a few residents who needed a mechanical lift for transfers. STNA #327 indicated Resident's #76 and #101 required almost constant supervision because they had behaviors and took alot of time, she had both residents in her assignment, and it wasn't fair to the other residents. STNA #327 stated sometimes there was a third STNA scheduled on Rosepointe B, but they were usually told to go home around 11:00 A.M and they were full time STNA's. STNA #327 stated there was no time for her to take a break because she wanted to make sure the residents were cared for. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 04/22/24 at 1:51 P.M. with STNA #327 of Resident #101 revealed Resident #101 was lying in bed without an incontinence brief, had taken the sheets off the bed and was lying on a bare mattress. STNA #327 stated Resident #101 took his incontinence brief off, clothes off, and sheets off the bed multiple times during the day, she was in the room constantly, he had behaviors, and it was not fair to the other residents. STNA #327 stated she changed Resident #101's incontinence brief and put clean sheets on his bed 20 minutes ago. Observation revealed STNA #327 could not find a clean fitted sheet in Resident #101's cupboard and walked out of his room to find one. When STNA #327 walked out of Resident #101's room she noticed a call light was on at the very end of a long hall of resident rooms. STNA #327 stated STNA #356 was at lunch and a call light was on, and she would need to answer the call light before finishing Resident #101's care. STNA #327 was about half way down the hall on her way to answer the call light when Registered Nurse (RN) #474 told STNA #327 she would answer the call light. STNA #327 found a fitted sheet and walked back into Resident #101's room to finish his care. Observation revealed Resident #101 sitting on the side of the bed with no incontinence brief or pants on and long dry red scabs could be seen on his bilateral lower legs. STNA #327 indicated Resident #101 picked his legs, crawled on the floor, would not leave clothes on and was generally a lot of work. STNA #327 proceeded to provide incontinence care while Resident #101 squirmed around the bed, and when she was finished, before she had a chance to put Resident #101's brief on he urinated on the clean incontinence brief and fitted sheet. STNA #327 had to leave the room to find another fitted sheet and incontinence brief, brought them to the room, proceeded to provide incontinence care a second time and was able to put Resident #101's brief on him, and to put the fitted sheet on the bed. When asked, STNA #327 stated the nurses tried to help the aides with resident care, but they were busy too. STNA #327 pointed to Resident #101's shirt and said that was his third shirt today. STNA #327 finished Resident #101's care and as she walked out of Resident #101's room at 2:17 P.M. he immediately started trying to take his shirt and incontinence brief off. Observation on 04/22/24 at 2:17 P.M. revealed Resident #173's call light was on and STNA #327 walked in her room to answer the call light and came out of the room two minutes later. Observation on 04/22/24 at 2:19 P.M. of Resident #76 with STNA #327 revealed Resident #76 was lying in his bed, taking his incontinence brief off and his fingers had feces on them. STNA #327 stated she just changed him before she talked to the surveyor at around 1:50 P.M. and she would need to clean him up and change him again now. STNA #327 left the room to find a fitted sheet and something to clean Resident #76's fingers, she returned with Registered Nurse (RN) #474 to assist her because STNA #356 was on her lunch break. As RN #474 and STNA #327 came back to Resident #76's room a call light started alarming and RN #474 left the room to answer it. STNA #327 waited for RN #474 to return. RN #474 returned to the room and STNA #327 proceeded to provide incontinence care with RN #474's assistance. RN #474 stated Resident #76 was constantly taking his incontinence brief and clothing off and digging in his rectum with his fingers, he consumed his feces, and she was going to get a psych consult. Observation of Resident #76's fingers revealed they were covered in feces, his bed was wet with urine, and the incontinence brief he had taken off and thrown on the bed was dry with no urine in it. RN #474 stated this was the fourth time today she cleaned feces off his hands, and it took two staff to change him every time. RN #474 indicated Resident #76 required alot of supervision. STNA #327 and RN #474 finished Resident #76's incontinence care and left his room at 2:45 P.M. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 04/22/24 at 2:45 P.M. of Resident #101 with STNA #327 revealed he had taken his incontinence brief off and had removed his fitted sheet from the bed, and was sitting on the side of the bed with no incontinence brief or pants on. STNA #327 stated she did not go to lunch today, and rarely went to lunch because she was constantly in Resident #76 and #101's room along with trying to care for the other 14 residents in her assignment. STNA #327 entered Resident #101's room, provided incontinence care and found a fitted sheet for his bed. Observation on 04/22/24 at 4:07 P.M. of Registered Nurse (RN) #474 revealed she was supposed to leave at 3:00 P.M. but stayed to catch up on some stuff like taking physician orders off the charts, documenting in resident records, checking resident labwork before she went home. RN #474 stated RN #347 left the floor for a quick break because she came to work at 7:00 A.M. and was too busy during the day to take a break. RN #474 indicated RN #347 worked until 7:00 P.M. and was assigned to relieve her when she returned from her break. RN #474 stated she also was too busy to take a break since came in at 7:00 A.M., she did not eat the lunch she packed, and only left the floor for about 15 minutes to get a drink. RN #474 stated she had to help the STNA's with resident care because if she didn't they would not be able to get the care done, but when she helped she didn't get her work done, and that was why she was still at the facility. RN #474 stated it was important to make sure the residents were cared for. Review of Resident #101's progress notes dated 04/22/24 at 4:11 P.M. revealed Resident #101 took off his (incontinence) brief multiple times this shift. Resident #101 was dressed in a brief and a new gown. Observation on 04/22/24 at 4:28 P.M. of RN's #347 and #474 revealed they were sitting at the nurses station. RN's #347 and #474 stated they usually did not take a lunch break because if they did then they could not get their work done. RN #347 stated they would not be able to complete things like charting, taking physician orders off the charts, and checking labwork. RN's #347 and #474 stated they often were not able to complete their resident charting because they wanted to make sure residents were cared for first. RN #347 stated sometimes treatments did not completed during her shift and she stayed to finish treatments before she went home. Review of Resident #101's progress notes dated 04/22/24 at 6:51 P.M. included Resident #101 was sitting in the common area and was fed his dinner. The STNA left the area to collect trays and another staff member found him on his hands and knees next to his chair. Resident #101 was assisted to his chair and taken into the nurses station to sit with the nurse. Interview on 04/24/24 at 4:00 P.M. with the Director of Nursing (DON) revealed Nursing Scheduler #320 did not determine staffing for the facility, but was directed by the DON and the Administrator. The DON stated there was a morning meeting every day at 8:30 A.M. and both the DON and the Administrator determined the number of STNA's and nurses needed on each nursing unit. The DON stated on 04/22/24 the determination was two STNA's were needed on the Rosepointe B nursing unit, and there were two Registered Nurse's assigned to the unit too. The DON indicated the facility always met the staffing requirements. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 04/25/24 at 9:24 A.M. of STNA #504 revealed she was working on 04/20/24 and was assigned to Rosepointe B when Resident #101 had a fall and was sent to the hospital. STNA #504 stated there were two STNA's assigned to Rosepointe B on 04/20/24, she was on a break and when she returned to the unit from her break she found out Resident #101 had a fall. STNA #504 stated Resident #101 was constantly moving, he gets out of bed, he talks to himself, he was blind, he takes his clothes and incontinence brief off, and goes to the bathroom on the floor. STNA #504 indicated Resident #101 spoke Spanish, but would switch to English if staff could not communicate with him in Spanish. STNA #504 indicated when there were only two STNA's assigned to the Rosepointe B nursing unit it was hard to keep track of everything, all the residents were needy, and the STNA's could be changing a resident and Resident #101 would be crawling in the hall, or climbing on a table in the common area. STNA #504 stated Resident #101 could be combative at times, and he would come out of his room with no clothing or an incontinence brief on. On the day he fell STNA #504 stated Resident #101 was in the common area and pushed himself backwards while sitting in a chair and hit his head. STNA #504 stated she did not witness Resident #101's fall because she was on a break and STNA #399 did not witness the fall because she was in a resident room providing care. STNA #504 indicated Licensed Practical Nurse (LPN) #364 was supervising Rosepointe B and also had an assignment, and she was in the nursing station. RN #352 was in the hall passing resident medications, and LPN #364 heard Resident #101 fall from where she was sitting in the nursing station. Interview on 04/25/24 at 10:26 A.M. with Licensed Practical Nurse (LPN) #419 revealed she was very familiar with Resident #101, he usually was not combative, but the last time she worked with him he was combative, cursing, and crawled out of bed and into another resident room. LPN #419 stated she had him in the nurses station with her and gave him a drink and that calmed him down, but he needed to have a close eye on him, and he had no sense of what he was doing. LPN #419 stated she had to complete a risk management for Resident #101 because he crawled out of bed and was kind of kneeling half in the bed, and this happened around 10:30 P.M. LPN #419 indicated there were two STNA's assigned to Rosepointe B on that evening shift. 2. Review of Resident #76's medical record revealed an admitted [DATE] and diagnoses included nontraumatic intracerebral hemorrhage, vascular dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, and adjustment disorder. Resident #76 resided on Rosepointe B unit. Review of Resident #76's Admission MDS 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status was not conducted due to Resident #76 was rarely or never understood. Resident #76 was frequently incontinent of urine and always incontinent of bowel. Resident #76 was dependent for toileting hygiene, personal hygiene, and bathing. Resident #76 needed substantial to maximal assistance with dressing. Review of Resident #76's care plan dated 03/19/24 included Resident #76 had impaired cognition function and impaired thought processes related to cognitive and communication lossess. Resident #76 responds to his name. Resident #76 would improve current level of cognitive function through the review date. Interventions included to monitor, document and report to the physician any changes incognitive function, specifically changes in decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, and level of consciousness, mental status. Further review did not reveal evidence Resident #76 had a care plan for behaviors including putting his hands in his incontincence brief and consuming feces. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365757	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broadview Multi Care Center	5520 Broadview Rd Parma, OH 44134

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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 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the list of residents requiring a mechanical lift revealed eleven residents (Resident's #5, #22, #45, #69, #71, #76, #78, #87, #103, #143, #167) residing on the Rosepointe B nursing unit required a mechanical lift for transfers. Review of the facility incident log revealed Resident #76 had a fall on 04/14/24 at 11:07 A.M. Review of the facility nursing staff assignment sheets dated 04/14/24 revealed two STNA's (STNA's #461 and #508) were assigned to work first shift (7:00 A.M. to 3:00 P.M.) on the Rosepointe B nursing unit where Resident's #76 resided. Further review revealed RN's #342 and 497 and Hospitality Aide #322 were also assigned to Rosepointe B. Review of Resident #76's progress notes dated 04/14/24 at 11:13 A.M. included Resident #76 was observed by an unidentified STNA lying on the floor next to his bed, his bed was in the low position, vital signs were checked, were within normal limits, and Resident #76 had no apparent injury. The Nurse Practitioner was notified and orders given to send Resident #76 to the Emergency Department for a CT (computerized tomography) scan via a transport service. Resident #76 was on Plavix (anticoagulant). Resident #76 was unable to provide a statement, was nonverbal, and tried to get out of bed without assistance. Review of Resident #76's progress notes dated 04/14/24 at 6:28 P.M. included the nurse spoke with the emergency room physician and Resident #76 was admitted to the hospital for a possible small cranial bleed. Review of Resident #76's progress notes dated 04/19/24 at 5:20 P.M. included Resident #76 was readmitted to the facility from the hospital. Observation on 04/22/24 at 2:19 P.M. of Resident #76 with STNA #327 revealed Resident #76 was lying in his bed, taking his incontinence brief off and his fingers had feces on them. STNA #327 stated she just changed him before she talked to the surveyor at around 1:50 P.M. and she would need to clean him up and change him again now. STNA #327 left the room to find a fitted sheet and something to clean Resident #76's fingers, she returned with Registered Nurse (RN) #474 to assist her because STNA #356 was still at lunch. As RN #474 and STNA #327 came back to Resident #76's room a call light started alarming and RN #474 left the room to answer it. STNA #327 waited for RN #474 to return. RN #474 returned to the room and STNA #327 proceeded to provide incontinence care with RN #474's assistance. RN #474 stated Resident #76 was constantly taking his incontinence brief and clothing off and digging in his rectum with his fingers, he consumed the feces on his fingers, and she was going to get a psych consult. Observation of Resident #76's fingers revealed they were covered in feces, his bed was wet with urine, and the incontinence brief he had taken off and thrown on the bed was dry with no urine in it. RN #474 stated this was the fourth time today she cleaned feces off his hands, and it took two staff to change him every time. RN #474 indicated Resident #76 required alot of supervision. STNA #327 and RN #474 finished Resident #76's incontinence care and left his room at 2:45 P.M. Interview on 04/22/24 at 3:43 P.M. with Resident #5 (Resident #76's roommate) revealed it was very uncomfortable to be Resident #76's roommate and says this happens all the time. Resident #5 stated he did not request a room change or complain to the Administrator or Director of Nursing (DON) because he did not want to cause problems. Resident #5 stated it could take awhile for his call light to be answered, the average wait time was 15 to 20 minutes, and longer if the facility was short on help. Resident #5 stated it took longer for call lights to be answered at shift change. (continued on next page)

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	365757	A. Building B. Wing	04/25/2024

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 04/25/24 at 8:15 A.M. with RN #342 revealed he was working on 04/14/24 when Resident #76 had a fall and was sent to the local hospital Emergency Department. RN #342 stated an unidentified STNA found Resident #76 lying on the ground by his bed, his head was touching the floor, and notified him. RN #342 indicated he reported the fall to the Nurse Practitioner, Resident #76 was taking an anticoagulant, and the Nurse Practitoner gave an order to send Resident #76 to the hospital for evaluation. RN #342 stated thank god I followed up because the hospital found a small brain bleed, and Resident #76 was admitted to the hospital for a few days. RN #342 stated he could not remember what aides were working that day, but Resident #76 was a challenging resident, had behaviors and required a lot of attention. Interview on 04/25/24 at 9:09 A.M. with RN #446 revealed Resident's #76 and #101 were a handful, and when only two STNA's were assigned to Rosepointe B it could be hard to keep track of them. This deficiency represents non-compliance investigated under Complaint Number OH00152723.