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Form Approved OMB
No. 0938-0391

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	06/24/2024

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

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44457 Based on interview, medical record review, and review of facility policy, the facility failed to ensure a restorative program was established for contracture management as recommended by therapy. This affected one (#110) of three residents reviewed for contracture management. The facility census was 178. Findings include: Review of the medical record for Resident #110 revealed diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, fibromyalgia, scoliosis, limitations of activities due to disability, and need for assistance with personal care. Review of physician's order dated 04/10/24 revealed apply left wrist brace at bedtime and remove in the morning for contracture prevention. Review of the Medicare Minimum Data Set (MDS) Admission assessment dated [DATE] revealed Resident #110 had severe cognitive impairment and was dependent on staff assistance for toilet hygiene, bathing, dressing, personal hygiene, and transfers. Review of the Nurse Practitioner Progress Note dated 04/25/24 revealed Resident #110 was a stroke patient and was admitted to facility for long term care. Review of the Occupational Therapy (OT) Evaluation and Plan of Treatment dated 05/16/24 revealed Resident #110 was started on therapy services for use of left resting hand splint and passive range of motion exercises. Resident #110 was noted to have left sided contractures of shoulder, elbow, wrist, hand, fingers, hip, foot, heel, knee, and ankle. Review of OT Discharge Summary dated 05/31/24 revealed Resident #110 was discharged from therapy services due to reaching the highest practicable level on skilled services. Discharge recommendations included restorative range of motion program and restorative splint/brace program. Resident #110's prognosis to maintain was identified as good with consistent staff follow-through. Further review of the medical record for Resident #110 revealed no evidence a restorative range of motion program had been established. (continued on next page)

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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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/18/24 at 2:09 P.M. with Therapy Director #463 revealed Resident #110 was on therapy services for splinting and range of motion exercises. Therapy Director #463 indicated Resident #110's daughter was educated during therapy sessions on range of motion exercises. Therapy Director #463 indicated Resident #110's daughter was at the facility all the time and was doing the exercises. Follow up interview on 06/18/24 at 3:35 P.M. with Therapy Director #463 confirmed there was no restorative program for range of motion established for Resident #110. Interview on 06/20/24 at 11:59 A.M. with Restorative Licensed Practical Nurse (LPN) #348 revealed she had not received a restorative program from therapy for Resident #110; however, Resident #110 was appropriate for a program. Restorative LPN #348 indicated she was unsure why it was expected Resident #110's daughter would complete the exercises. Restorative LPN #348 was not aware of the recommendations on the OT discharge summary for a range of motion program and restorative splint/brace program. The Director of Nursing (DON), who was present during interview, indicated it did not make sense that Resident #110's daughter was responsible for maintaining the range of motion program for Resident #110 while admitted at the facility. Review of facility policy Restorative Nursing Policy and Procedure dated 11/30/23 revealed each resident would be screened for restorative nursing upon admission, readmission, annually, quarterly, and with significant changes. Restorative programs could be determined as a continuation of care following therapy services. This deficiency represents non-compliance investigated under Complaint number OH00154470 and OH00154244.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 42733 Based on observation, interview and record review the facility failed to ensure adequate and timely incontinence care. This affected two (#53 and #89) of four residents observed for incontinence care. The facility also failed to ensure adequate urinary catheter care. This affected two (#9 and #65) of two residents observed for urinary catheter care. The facility census was 178. Findings include: 1. Review of Resident #9's medical records revealed an admitted [DATE]. Diagnoses included neuromuscular bladder and stoke with left sided weakness. Review of Resident #9's Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #9 had intact cognition, was incontinent of bowel, and had a urinary catheter. Review of Resident #9's care plan dated 05/09/24 revealed Resident #9 was at risk for infection related to urinary catheter. Interventions included cleanse suprapubic catheter (catheter placed in the abdomen used to drain urine from the bladder) site with normal saline, apply mesalt (a dressing for discharging wounds) and a drain sponge secured with tape daily. Interview on 06/17/24 at 10:20 A.M. with Licensed Practical Nurse (LPN) #335 confirmed Resident #9 had a urinary catheter. Observation of Resident #9 with LPN #335 revealed a split gauze dressing around the insertion site of the suprapubic catheter was saturated with urine and the skin around the insertion site was reddened. Interview with LPN #335 confirmed the soiled dressing and reddened area. LPN #335 did not know when catheter care had last been completed. Interview with Resident #9 at time of observation revealed catheter care had not been performed for several days. 2. Review of Resident #53''s medical records revealed an admitted [DATE]. Diagnoses included chronic kidney disease and muscle weakness. Review of Resident #53''s care plan dated 03/25/24 revealed Resident #53 was incontinent of bowel and bladder. Interventions included provide incontinence care as needed. Review of Resident #53's MDS assessment dated [DATE] revealed Resident #53 had impaired cognition, required substantial assistance with toileting and was incontinent of bowel and bladder. Observation on 06/20/24 at 9:28 A.M. revealed a strong pungent odor from Resident #53. Observation of incontinence care at 9:31 A.M. with State tested Nurse Aide (STNA) #397 for Resident #53 revealed Resident #53 had a large amount of foul smelling liquid stool in his groin area. STNA #397 confirmed the observation and stated it appeared as if Resident #53 had not received proper and adequate cleaning during incontinence care. Resident #53 was not interviewable. 3. Review of Resident #65's medical records revealed an admitted [DATE]. Diagnoses included spinal cord injury, paraplegia muscle weakness and need for personal care assistance. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the care plan dated 05/17/24 revealed Resident #65 was at risk for infection related to suprapubic catheter. Interventions included provide catheter care per physician orders. Review of Resident #65's MDS assessment dated [DATE] revealed Resident #65 had intact cognition. Resident #65 had a suprapubic catheter and a colostomy. Review of Resident #65's current physician orders for June 2024 revealed provide catheter care every shift. Observation of Resident #65 on 06/17/24 at 10:01 A.M. with STNA #421 revealed Resident #65 had a suprapubic catheter. Further observation revealed a split gauze around the insertion site that was soiled with dried blood and was sticking to Resident #65's abdomen. The skin around the insertion site was reddened. Interview with Resident #65 at time of observation revealed staff rarely performed catheter care. Interview with STNA #421 at time of observation revealed she had not performed catheter care and was unable to state when it had last been completed. 4. Review of Resident #89's medical records revealed an admitted [DATE]. Diagnoses included stroke with right sided weakness and acute kidney injury. Review of Resident #89's MDS assessment dated [DATE] revealed Resident #89 was rarely understood and was incontinent of bowel and bladder. Review of Resident #89's care plan dated 06/07/24 revealed Resident #89 was incontinent of bowel and bladder. Interventions included check resident for incontinence and provide care as needed. Interview on 06/17/24 at 6:44 A.M. with Resident #89 revealed he was soiled and had last been changed before bed the previous evening. Observation of incontinence care on 06/17/24 at 6:50 A.M. for Resident #89 with STNA #458 revealed Resident #89 was incontinent of a large amount of urine and liquid stool that had saturated through the mattress pad and onto the bed. Interview with STNA #458 at time of observation revealed there had been multiple assignment changes and she was unsure who was assigned to care for Resident #89. This deficiency represents non-compliance investigated under Complaint Number OH00154470.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42733 Based on observation, interview and record review the facility failed to ensure proper infection control techniques were used for residents on isolation precautions. This affected one (#146) of three residents observed for isolation precautions. The facility census was 178. Findings include: Review of Resident #146's medical records revealed an admitted [DATE]. Diagnoses included stoke with right sided weakness, need for personal care assistance and cognitive deficits. Review of Resident #146's care plan dated 06/05/24 revealed Resident #146 was incontinent of bowel and bladder. Interventions included check resident for incontinence and provide care as needed. Review of Resident #146's Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #146 had impaired cognition. Resident #146 was incontinent of bowel and bladder. Review of Resident #146's progress note dated 06/19/24 revealed a stool sample was obtained to test for Clostridioides difficile (C-diff), a bacterial infection. Review of the progress note dated 06/20/24 revealed contact isolation precautions were initiated due to C-diff results were pending. Observation on 06/20/24 at 7:28 A.M. revealed isolation supplies and signs posted for contact precautions for Resident #146's room indicating use of gown, gloves and mask. Observation at 8:00 A.M. revealed a staff member entered Resident #146's room without donning personal protective equipment (PPE). Continued observation revealed Licensed Practical Nurse (LPN) #319 was in Resident #146's room and stated she was going to provide Resident #146 with incontinence care. LPN #319 stated she referred to answer any questions after she completed Resident #146's care. At 8:12 A.M. LPN #319 exited Resident #146's room and interview with LPN #319 confirmed the isolation supplies and signs posted outside the resident's room indicated Resident #146 was on contact precautions. LPN #319 stated she was unaware of why Resident #146 was on contact precautions and she confirmed she had not worn PPE while performing incontinence care. Review of facility policy Isolation Precautions revised 11/30/23 revealed a resident could be placed in Isolation Precautions without a physician orders. Residents with suspected C-diff infections were to be placed in contact precautions and inform staff members of the need of isolation precautions. This deficiency represents non-compliance investigated under Complaint Number OH00154470.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 42733 Based on observation and interview the facility failed to provide a clean and sanitary environment. This affected five (#89, #110, #115, #134 and #180) residents and had the potential to affect all residents residing in the facility. The facility census was 178. Findings include: Observation on 06/17/24 at 6:38 A.M. revealed several dirty, moldy towels underneath an ice machine with puddles of water under the machine. Further observation revealed the floors around the ice machine were dirty with various debris. This was confirmed at time of observation with Licensed Practical Nurse (LPN) #465. Interview with LPN #465 at the time of the observation revealed she was aware of concerns related to housekeeping, especially on the weekends. On 06/17/24 at 6:44 A.M. a strong foul odor was noted outside of Resident #115's room. The origin of the odor was not determined; however, observation revealed a food tray on a wheelchair outside of Resident #134's room from the previous meal service. The floors in this area were dirty with various types of debris on them. The observations and odor were verified with LPN #465 at time of observation. Observation on 06/17/24 at 6:58 A.M. revealed Resident #89's tube feeding pole and oxygen concentrator had a large amount of dried tube feeding formula on them. This observation was confirmed with State tested Nursing Assistant (STNA) #458. Interview on 06/17/24 at 7:24 A.M. with Resident #180 revealed her room was not cleaned daily. Resident #180 stated her room was last cleaned approximately two weeks ago. Observation revealed the floors were dirty and there was various food debris on the floor. Interview on 06/17/24 at 10:55 A.M. with Housekeeper #466 revealed she was aware of concerns related to housekeeping. Housekeeper #466 had started her employment at the facility about a month ago. The previous housekeeper was terminated due to not performing his cleaning duties. Housekeeper #466 stated she had been trying to get things clean since she started. Housekeeper #466 worked every other weekend and stated she observed dirty rooms when she returned to work after being off for the weekend. Observation on 06/18/24 at 7:09 A.M. revealed two meal trays on a sink in Resident #110's room from the previous meal. This observation was confirmed with Registered Nurse (RN) #374 who stated the previous shift should have removed the meal trays after dinner. This deficiency represents non-compliance investigated under Complaint Number OH00154244.