

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365757	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/31/2024
NAME OF PROVIDER OR SUPPLIER  Broadview Multi Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39333</p> <p>Based on record review, review of a facility self-reported incident (SRI), review of facility investigation, review of facility policy, and staff interview, the facility failed to prevent the misappropriation of Resident #130's prescribed narcotics. This affected one resident (#130) of three residents reviewed for misappropriation. The facility census was 153.</p> <p>Findings include:</p> <p>Medical record review revealed Resident #130 was admitted to the facility on [DATE] with diagnoses to include but not limited to diabetes mellitus, bipolar disorder, anxiety disorder, and chronic pain. Review of the quarterly Minimum Data Set (MDS) assessment, dated 10/04/24, revealed Resident #130 had moderately impaired cognition, was on a pain regimen, and was dependent for activities of daily living.</p> <p>Review of Resident #130's plan of care dated 04/26/16 with a revision on 06/01/17 revealed Resident #130 was at risk for pain/discomfort related to a history of stroke, chronic colitis, chronic pain, and right hip pain. Interventions included but were not limited to acknowledge presence of pain, administer pain medications as ordered, monitor and document for side effects of pain regimen, encourage non-medical interventions to control pain and decrease use of analgesic therapy.</p> <p>Review of the pharmacy packing slip dated 09/30/24 revealed that a total of 116 pills of oxycodone-acetaminophen 5-325 milligram (mg) (opioid analgesic) were delivered to the facility for Resident #130 and signed off by License Practical Nurse (LPN) #524.</p> <p>Review of the October 2024 physician orders revealed Resident #130 was ordered oxycodone-acetaminophen (opioid analgesic) tablet 10-325 milligrams (mg) to be given every six hours for chronic pain.</p> <p>Review of Resident #130's Medication Administration Record (MAR) from 10/01/24 through 10/28/24 revealed on 10/15/24, Resident #130 did not have any Percocet (oxycodone/acetaminophen) that could be administered and staff were waiting for the medication to arrive.</p> <p>Review of the medication administration note dated 10/15/24 timed 2:59 A.M. revealed Percocet oral tablet 10-325 mg was not given because medication was not available.</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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the medication administration note dated 10/16/24 timed 1:21 A.M. revealed Percocet oral tablet 10-325 mg was given from the stock in the Pyxis machine (an automated medication dispensing system).</p> <p>Review of the medication administration note dated 10/16/24 at 6:23 A.M. revealed Percocet oral tablet 10-325 mg was not given related to no authorization to pull the medication.</p> <p>Review of the nurse practitioner (NP) note dated 10/16/24 timed 8:23 A.M. revealed Resident #130's chief complaint was pain. The NP asked Resident #130 if she would like to switch to a different pain medication and Resident #130 declined because the Percocet controlled her pain every six hours. The NP ordered Percocet 5-325 mg to be pulled from the Pyxis times four tablets for two doses.</p> <p>Review of the nurses note dated 10/17/24 timed 2:52 A.M. revealed the nurse called the pharmacy to follow up with Resident #130's narcotic pain medication. The pharmacy stated that the medication would be delivered around 11 :00 A.M. and nurse would be able to pull medication from the Pyxis machine.</p> <p>Review of the facility's SRI initiated 10/18/24 revealed that Resident #130's sister called and had concerns about the timeliness of Resident #130's medication. An addendum to the SRI was added after the conclusion was drawn that there were some potential inconsistencies with the narcotic log related to Resident #130's order for Percocet 10-325 mg. The Administrator began a secondary investigation utilizing Quality Assurance Performance Improvement (QAPI).</p> <p>An interview on 10/30/24 at 10:30 A.M. with the Administrator revealed that staff called the pharmacy to obtain a refill for Resident #130's Percocet, at the time they were notified it was too early, and they would need to obtain a new prescription. An investigation was initiated and during the investigation, it was discovered that a full card of Resident #130's Percocet and the narcotic sheet were missing. The nurses were not counting all the medication cards containing Percocet, but the current in use card. The nurses did not realize a full card of Percocet was missing until there was no longer any Percocet available for administration. All the nurses were drug tested for opioids except one who refused (Registered Nurse [RN] #600). All the nurses tested negative for opioids. RN #600 refused to take a test stating she took Suboxone (used to treat opioid dependence), so she would come up positive. The administrator explained that if she was on a prescribed medication, it would not be an issue. RN #600 stated that she got the Suboxone from a friend and resigned immediately.</p> <p>A telephone interview on 10/30/24 at 1:30 P.M. with RN #600 revealed she did not know about the missing Percocet and immediately after ended the phone call.</p> <p>Review of the facility policy dated 11/30/23 titled, Abuse, Mistreatment, Neglect, Exploitation, and Misappropriation of Resident Property, revealed misappropriation was the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without resident's consent.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00159092.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>39333</p> <p>Based on record review, observations, and interviews, the facility did not ensure food was served at palatable temperatures. This had the potential to affect 151 residents that received meals from the facility. Three residents (Resident #12, #48, and #116) out of 154 residents received nothing by mouth. The facility census was 154.</p> <p>Findings include:</p> <p>Interviews during the complaint investigation on 10/29/24, 10/30/24 and 10/31/24 during various hours from 7:45 A.M. through 4:00 P.M. with Residents #32, #119, #121, and #130 revealed that the food was cold and/or not palatable.</p> <p>Observation of tray line on 10/29/24 from 11:50 A.M. through 1:06 P.M. revealed food was above 165 degrees Fahrenheit (F) on the tray line. The food truck left the kitchen at 1:06 P.M. and arrived at the unit at 1:07 P.M.</p> <p>When the last tray on the truck was delivered on 10/29/24 at 1:15 P.M., the test tray was removed from the food cart and placed on a table where food temperatures were taken. The Corn flake crusted pork was 109 degrees Fahrenheit (F), and the cabbage was 116 degrees F. Registered Dietary Technician #409 stated that the food should have been hotter. The taste test revealed that the food was tepid.</p> <p>The facility provided a document indicating three residents (Resident #12, #48, and #116) received nothing by mouth.</p> <p>The facility was not able to provide a policy regarding what food temperatures should be during service.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00159092.</p>

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39333</p> <p>Based on observation, interview, and record review, the facility failed to provide residents with their preferences during meals. This affected two residents (#13 and #66) out of three residents (#13, #66, and #91) reviewed for diets and weight loss. The facility census was 154.</p> <p>Findings include:</p> <p>1. Medical record review for Resident #13 revealed the resident was admitted to the facility on [DATE] with a readmitted [DATE] and diagnoses including diabetes mellitus, chronic kidney disease and major depressive disorder. Review of the quarterly Minimum Data Set (MDS) assessment, dated 08/03/24, revealed the resident had intact cognition and required set up only for eating.</p> <p>Review of the October 2024 physician orders revealed that Resident #3 was ordered a regular diet with no restrictions and double portions of protein.</p> <p>Review of Resident #13's diet ticket revealed that he wanted triple portions of protein.</p> <p>Review of Resident #13's care plan dated 01/30/23 with a revision date of 01/31/24 revealed Resident #13 had altered nutritional status due to diagnoses. Interventions included but were not limited to honoring food preferences.</p> <p>Observation on 10/29/24 at 12:27 P.M. revealed Resident #13's tray was put into the food cart with a single portion of the alternate meat. Resident #13's diet ticket indicated triple portions of protein. Upon request, Dietary Aide (DA) #540 removed the ray from the food cart and Registered Dietary Technician #409 verified the prepared meal tray included one portion of protein, not three.</p> <p>2. Medical record for Resident #66 revealed the resident was admitted to the facility on [DATE] with diagnoses including heart disease, dementia, and major depressive disorder. Review of the comprehensive Minimum Data Set (MDS) assessment, dated 10/18/24, revealed the resident was rarely understood and was dependent for eating.</p> <p>Review of the October 2024 physician orders revealed that Resident #66 was ordered a regular diet, regular texture, and regular consistency of liquids.</p> <p>Review of Resident #66's diet ticket revealed that the resident wanted ice cream and eight ounces of whole milk to drink.</p> <p>Review of the nutritional assessment for Resident #66 dated 10/17/24 timed 1:45 P.M. revealed Resident #66 received a nutritional supplement, whole milk with meals, and pudding or ice cream with lunch and dinner for additional calories.</p> <p>Review of Resident #66's care plan with a revision date of 10/17/24 revealed Resident #66 had altered nutritional status due to diagnoses. Interventions included but were not limited to honoring food preferences and nutrient dense food items added to trays.</p> <p>(continued on next page)</p>

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 10/29/24 at 12:11 P.M. revealed Resident #66's tray was put into the food cart without the eight ounces of whole milk and ice cream that was on the ticket. Upon request, Dietary Aide (DA) #540 removed the tray from the food cart, and DA #448 verified the tray to be delivered to Resident #66 did not include whole milk or ice cream. DA #448 said there was no whole milk or ice cream available, but the resident was supposed to receive the items with her lunch meal.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00159092.</p>		