

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 03/20/2025
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35768</p> <p>Based on record review, observation and interview, the facility failed to provide a dignified dining experience for residents who required assistance with feeding. This affected one (Resident #21) of five residents observed for dining.</p> <p>Findings Include:</p> <p>Review of medical record for Resident #21 noted an admitted [DATE]. Diagnoses included multiple sclerosis, contracture to right and left elbow, right and left knee, and contracture of muscle, unspecified thigh.</p> <p>Review of the comprehensive Minimum Data Set assessment, dated 01/06/25, revealed Resident #21 had intact cognition and was dependent for eating.</p> <p>Review of the plan of care dated 02/11/19 noted Resident #21 had performance deficit related to multiple sclerosis and required assistance with feeding. Interventions included to provide extensive assistance with eating.</p> <p>Observations on 03/17/25 at 8:51 A.M. revealed Certified Nursing Assistant (CNA) #331 standing at the foot of the bed which was against the wall reaching over to feed Resident #21.</p> <p>Interview during the observations with CNA #331 revealed she was standing as she was feeding Resident #21 because there was no room for a chair for her to sit in as she fed Resident #21.</p> <p>Interview on 03/18/25 at 9:32 A.M. with the Administrator revealed staff should be seated when feeding residents.</p> <p>Interview on 03/20/25 at 2:20 P.M. with the Administrator revealed the facility did not have a policy regarding providing a dignified dining experience for residents who were dependent for eating.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00163727.</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 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>36650</p> <p>Based on interviews and record review the facility failed to ensure resident concerns of missing items were addressed timely. This affected two of two residents reviewed for missing items (Resident #61 and #131). The facility census was 162.</p> <p>Findings Include:</p> <p>1. Interview on 03/17/25 at 12:15 P.M. with Resident #61 revealed his licenses, social security card and birth certificate that he kept in a locked drawer were missing; he did not suspect theft. He reported the missing items to staff but nothing happened.</p> <p>Interview on 03/19/25 at 11:40 A.M. with Social Worker #411 revealed she was told by Resident #61 several months ago that he was missing his driver's license, social security card and birth certificate that he kept in a locked drawer. Social Worker #411 stated she filled out a concern form and told Resident #61 she would help him to get the items replaced and he declined.</p> <p>Interview on 03/19/25 at 3:50 P.M. with the Administrator revealed she had no knowledge of Resident #61 reporting missing items. The Administrator revealed upon receiving reports of missing items, staff were to fill out a concern form and the form was to be given to her. The Administrator verified staff did not follow through with Resident #61's concerns regarding his missing items.</p> <p>Review of the grievance/concern log from January 2024 through March 2025 revealed no documentation of Resident #61's concern related to missing items.</p> <p>2. Interview on 03/18/25 at 9:29 A.M. with Resident #131 revealed she was missing two necklaces and she told Register Nurse (RN) #335. Resident #131 stated she lost the necklaces about eight months ago but did not report until a few months ago. Resident #131 had the prices for the necklaces which she gave to the staff. Resident #131 said they were waiting on the corporate office to replace the necklaces.</p> <p>Interview on 03/19/25 at 10:58 A.M. with RN #335 verified Resident #131 reported that she was missing two necklaces sometime before the new year. RN #335 explained Resident #131 had a very cluttered room and the necklaces could have been within the clutter. RN #335 said she filled out a concern form and had the pricing for the necklaces which she gave to the administrator. RN #335 told Resident #131 the pricing information would be sent to the corporate office. RN #335 did not know what happened after she gave the information to the administrator.</p> <p>Interview on 03/19/25 at 3:50 P.M. with the Administrator revealed she had no knowledge of Resident #131's missing items and there had been no follow up regarding Resident #131's missing items.</p> <p>Review of the grievance/concern log from January 2024 through March 2025 revealed no documentation of Resident #131's concern related to missing items.</p> <p>(continued on next page)</p>

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy Grievance/Concern logs, dated 01/06/25 revealed all resident grievances and/or concerns would be recorded on the facility's resident grievance/concern log. The social service department was responsible for recording and maintaining the logs.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00162623 and OH00161502.</p>

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>39969</p> <p>Based on observation, interview, and review of the facility policy, the facility failed to ensure accurate portions were served according to the menu diet spread sheet. This affected 42 residents (#8, #24, #28, #33, #35, #37, #39, #41, #42, #44, #45, #55, #60, #81, #82, #83, #87, #92, #93, #95, #105, #112, #118, #120, #130, #132, #135, #143, #146, #149, #154, #155, #156, #157, #158, #160, #161, #162, #163, #164, #165, and #453). The facility census was 162.</p> <p>Findings Include:</p> <p>Observation of the lunch tray line meal service on 03/19/25 at 12:05 P.M. revealed a four ounce spoodle was used to serve the ham and beans and a three ounce spoodle was used to serve the fried potatoes.</p> <p>Review of the menu diet spread sheet revealed an eight ounce spoodle was supposed to be used for the ham and beans and a four ounce spoodle for the fried potatoes.</p> <p>Interview on 03/19/25 at 12:09 P.M. with Dietary Staff (DS) #339 verified the serving sizes served were not correct according to the menu diet spread sheet. DS #339 stated they had already served the early trays that included Residents #24, #28, #39, #42, #95, #120, and #132. DS #339 stated units [NAME] Point A and B were also served. This included residents #8, #33, #35, #37, #41, #44, #45, #55, #60, #81, #82, #83, #87, #92, #93, #105, #112, #118, #130, #135, #143, #146, #149, #154, #155, #156, #157, #158, #160, #161, #162, #163, #164, #165, and #453.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>51526</p> <p>Based on observation, staff interview, and review of facility policy, the facility failed to maintain a clean and sanitary kitchen. This had the potential to affect all residents except six residents (#26, #99, #104, #140, #158, and #305) who received nothing by mouth. Total census was 162.</p> <p>Findings Include:</p> <p>Observation during kitchen tour with Dietary Director #366 on 03/17/25 at 9:05 A.M. revealed a large broken beverage bottle and large container of strawberries with gray fuzzy growth located in the bottom of the extra refrigerator near the outside exit hallway to the kitchen. A large bag of salt and one cardboard box filled with graham cracker snacks were open to air and unlabeled located on the kitchen snack shelf. Additionally, two employee outside jackets were found together on the same kitchen snack shelf with food items. Three large floor bin containers located next to snack shelf were not closed and partially open to air. Each bin had a large amount of food debris and old crumbs located on the plastic bin cover. Bin #1 contained loose flour, Bin #2 contained loose dry oatmeal, and Bin #3 contained powdered thickener. The spice rack shelving by the mixer contained old food debris/crumbs and dried on liquid splatter. A blueberry muffin mix bag was also found opened, exposed to air, and undated on the middle shelf of the spice rack. In the large freezer unit, a large cardboard box of beyond burgers and two boxes of packaged donuts were found opened, exposed, and undated. One large box of graham cracker crumbs was found opened and undated in the dry storage area.</p> <p>Interview with Dietary Director #66 on 03/17/25 at 9:05 A.M. verified all findings during kitchen tour. Dietary Director #366 also stated staff should not have placed any personal items (outside jackets) with food items or in the actual kitchen area.</p> <p>Review of the diet type report dated 03/18/25 revealed six residents (#26, #99, #104, #140, #158, and #305) had physician orders to receive nothing by mouth.</p> <p>Review of facility policy titled Food Preparation and Storage (no date) revealed all kitchen surfaces and equipment would be cleaned and sanitized as appropriate and food items would be stored properly.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51526</p> <p>Based on observation, record review, staff interviews, and facility policy, the facility failed to ensure Resident #112 was placed on contact isolation precautions per the physician orders. This affected one resident (#112) out of four residents reviewed for isolation precautions and had the potential to affect all residents in facility. Total census was 162.</p> <p>Findings Include:</p> <p>Review of the medical record for Resident #112 revealed an admitted [DATE] with diagnoses including paraplegia, protein calorie malnutrition, multiple pressure ulcers stage four, ureterostomy, neuromuscular dysfunction of bladder, and anxiety disorder.</p> <p>Observation on 03/18/25 at 4:30 P.M. revealed door signage of enhanced barrier precautions (EBP) in place for Resident #112.</p> <p>Review of medical record revealed an order for isolation was entered on 12/12/24 for contact precautions. Resident #112 was identified as a carrier for Acinetobacter baumannii (a highly resistant organism to antibiotics that can cause hospital-acquired infections as well as community infections in nursing homes).</p> <p>Interview on 03/18/25 at 4:40 P.M. with Assistant Director of Nursing (ADON) #335 verified the isolation order was contact precautions and not EBP.</p> <p>Review of facility policy titled Isolation Precautions (dated 11/30/2023) revealed In addition to Standard Precautions, use Contact Precautions for residents known or suspected to be infected with microorganisms than can be easily transmitted by direct or indirect contact, such as handling environmental surfaces or resident-care items. In some instances, residents colonized with these organisms may also require Contact Precautions</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>35768</p> <p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>Based on observations and interview the facility failed to maintain clean and sanitary resident rooms and failed to ensure the outdoor courtyard used for smoking was not littered with cigarette butts. This affected 10 of 162 residents (Residents #9, #38, #49, #52, #53, #61, #111, #112, #164, #306). Facility census was 162.</p> <p>Findings include:</p> <p>39969</p> <p>1. Observation of Resident #9's room on 03/18/25 at 8:57 A.M. revealed a moderate amount of a dried tannish, substance splattered on the tube feeding pole, on the dresser next to bed, the floor, on the wall up to the ceiling behind the bed, the floor mat, and on the privacy curtain. Interview at the time of the observation with Resident #9 revealed last week an aide did something and the tube feeding formula bag burst and splattered everywhere.</p> <p>Observation of Resident #9's room on 03/18/25 at 9:04 A.M. with Registered Nurse (RN) #307 verified the dried formula as described above. RN #307 stated the splattered formula looked old, like it happened last week.</p> <p>36650</p> <p>2. Observation on 03/17/25 at 9:33 A.M. revealed nine residents (Resident #38, #49, #52, #53, #61, #111, #112, #164 and #306 out in the courtyard smoking. Further observations revealed over 50 cigarette butts on the ground in the grass, flower beds, in cracks outside sidewalks and under trees.</p> <p>Interview on 03/17/25 at 9:40 A.M. with Housekeeper #416 verified the cigarette butts on the ground. Housekeeper #416 said cigarette butts should be put in the appropriate receptacle.</p> <p>Interview on 03/17/25 at 9:45 A.M. with Maintenance Director #415 revealed residents threw cigarette butts on the ground even though there were plenty of receptacles in the smoking area.</p> <p>3. Observation of Resident #61's room on 03/17/25 at 11:25 A.M. revealed dried blood smeared on the floor that appeared to be from the wound on the bottom of Resident #61's foot.</p> <p>Interview on 03/17/25 at 11:27 A.M. with Resident #61 revealed housekeeping did not come into his room to clean every day.</p> <p>Observation of Resident #61's room on 03/18/25 at 4:00 P.M. revealed the floor was dirty and still had spots of smeared blood on the floor. Interview with Resident #61 revealed he did not think housekeeping had cleaned his room recently.</p> <p>Interview on 03/18/25 at 4:05 P.M. with Licensed Practical Nurse (LPN) #317 confirmed Resident#61's floor was not clean and there was dried blood on the floor.</p> <p>(continued on next page)</p>

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 03/20/25 at 9:07 A.M. with Housekeeper #459 revealed resident rooms were to be cleaned daily which included sweeping and mopping the floors.</p>		