STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365800	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heather Hill Care Communities	12340 Bass Lake Road Chardon, OH 44024

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49774 Based on record review, interview and facility policy review, the facility failed to ensure residents and/or resident representatives were able to participate in quarterly care plan conferences for Residents #10 and #62. This affected two residents (#10 and #62) of two resident records reviewed for participation in care planning. The facility census was 99. Findings include: 1. Review of Resident #62's medical record revealed an admitted [DATE]. Diagnoses included Alzheimer's disease with late onset, generalized anxiety disorder, major depressive disorder, and fracture of right ulna styloid process. Review of the annual Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #62 had a Brief Interview for Mental Status (BIMS) score of 00 meaning she was severely cognitively impaired. Resident #62 required partial to moderate assistance with toileting, transfers, and bed mobility, maximal assistance with dressing and personal hygiene. Review of the current care plan revealed Resident #62 was prone to behavior problems including yelling, screaming, and agitation and had a care plan in place which included intervening to protect the rights of others, diverting his attention, and monitoring medications for effectiveness. Review of the progress notes from May 2024 through November 2024 revealed Resident #62 had a care plan meeting 05/06/24 and did not have the next care plan meeting until 11/08/24. Interview on 01/14/25 at 3:25 P.M. with the Social Service Designee (SSD) #513 confirmed Resident #62 did not have a quarterly care plan meeting between 05/06/24 and 11/08/24. 2. Review of Resident #10's medical record revealed an admitted [DATE]. Diagnoses included paranoid schizophrenia, unspecified psychosis not due to a substance or known physiological condition, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, and major depressive disorder single episode, severe with psychotic features. (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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the annual MDS assessment dated [DATE], revealed Resident #10 had a BIMS score of 15 meaning she was cognitively intact; however, an attempted interview on 01/13/25 at 3:33 P.M. revealed she had impaired thought processes due to paranoid schizophrenia. Resident #10 required partial to moderate assistance with toileting showers, transfers, personal hygiene, lying to sitting, and sitting to stand. Resident #10 was compliant with all medications, including psychotropic medications, during the review period. Review of the current care plan revealed Resident #10 had a care plan in place for behavioral health needs and use of psychotropic medication. The care plan reflected interventions that targeted behaviors which resulted from disorganized and delusional thinking and false beliefs. Review of the Interdisciplinary Team (IDT) Plan of Care Review Summary dated 11/15/24 revealed an annual care plan meeting for Resident #10 was scheduled for that day with SSD #513. The IDT Plan of Care Review Summary noted only SSD #513 was in attendance and participated in the review of Resident #10's plan of care and did not include the resident or anyone else from the IDT. Interview on 01/14/25 at 3:25 P.M. with the SSD #513, confirmed the care plan meeting was a scheduled quarterly/annual and the conference was not held with the IDT, Resident #10, or the resident's representative. Review of the Care Planning-Resident Participation Policy, implemented 02/01/24, revealed it was the facility's policy to discuss the plan of care with the resident and/or representative at regularly scheduled care plan conferences and allow them to see the care plan initially, at routine intervals, and after significant changes.

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. 49774 Based on observation, interview, record review and policy review, the facility did not provide structured and routine activities on the memory care unit as scheduled. This affected all 27 residents (#1, #10, #11, #31, #32, #35, #37, #41, #42, #45, #54, #59, #62, #63, #74, #76, #77, #79, #83, #87, #90, #91, #92, #93, #99, #103, #108) that resided on the memory care unit. The facility census was 99. Findings include: Review of the activities calendar for January 2024 through November 2024 revealed no concerns with the scheduled activities; however, there was no activity calendar specific to the residents residing on the memory care unit. Review of the December 2024 activity calendar revealed on Tuesdays and Wednesdays only one activity was listed for the day between 10:30 A.M. and 11:00 A.M. and there were no activities after 3:00 PM on Saturdays. Review of the January 2025 activity calendar revealed there was no activity calendar specific to the residents residing on the memory care unit (unit G). The calendar reflected exercise took place on weekdays Monday through Friday at 11:00 A.M. On 01/16/25 and 01/30/25 exercise was the only activity listed on the calendar. On Tuesday and Wednesday 01/14/25, 01/15/25, 01/21/25, 01/22/25, 01/28/25, and 01/29/25 TBA (to be announced) listed on the calendar at 3:00 P.M. Religious services were scheduled for three Sundays, but on Sunday 01/26/25, the calendar listed self-directed activities with no specified time. Tuesday through Saturday there were no activities listed after 3:00 P.M. Observation on 01/13/25 at 10:02 A.M. revealed a dry erase board behind the nurse's station that listed the activity for the day before that stated Sunday, 01/12/25, ice cream social. The board did not list any other activities for that day. Observation on 01/13/25 at 10:13 A.M. revealed Resident #90 had an outdated activity calendar from December 2024 hung on the wall of his room. Observations on 01/13/25 at 11:00 A.M. and 3:33 P.M. revealed no activities were conducted on the memory care unit at the scheduled time. Observations on 01/14/25 at 3:08 P.M. revealed no activities were conducted on the memory care unit at the scheduled time. Observation on 01/15/25 at 11:09 A.M. revealed no activities were conducted on the memory care unit at the scheduled time. Interview on 01/13/15 at 9:49 A.M. with Resident #92 revealed there were rarely any activities on the memory care unit. Observation at the time of the interview revealed Resident #92 did not have an activity calendar posted. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 01/13/25 at 10:02 A.M. with Certified Nurse Assistant (CNA) #505, who worked on the memory care unit, revealed there were no activities for that day. She also stated, they don't push activities here and reported a band usually came on Thursdays. On 01/15/25 at 11:02 A.M. surveyor met with residents and Activity Director #604 during a resident council meeting where Resident Council President #16 expressed a desire to see more activity staff as there is only the Activity Director during the week and one activity assistant on the weekends. Interview on 01/15/25 at 11:07 A.M. with Licensed Practical Nurse (LPN) #540 revealed a coloring activity was held after lunch on 01/14/25. Interview on 01/15/25 at 12:27 P.M. with Activity Director (AD) #604 revealed there was only one activity staff daily which included herself on weekdays and an Activity Assistant #625 on Saturdays and Sundays. AD #604 further explained she did two activities in memory care (Unit G) and two activities upstairs and would do room visits in between activities when she had time. AD #604 would take activities to the memory care unit and the staff would work with them on activities if they had time; however, most of the residents on the memory care unit required one-on-one. She then reported that she invited residents to activities as she walked around and wrote that day's activity on the dry erase board. Review of the policy titled Activities with an implementation date of 02/01/24 revealed the program included facility-sponsored group, individual, and independent activities would be designed to meet the interests of each resident, as well as support their physical, mental, and psychosocial well-being.

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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** 39973 Based on observation, interview, record review and review of the facility policy, the facility did not ensure Resident #102 was offered to rinse his mouth after administration of steroidal (anti-inflammatory) based respiratory inhaler. This affected one resident (#102) out of one resident observed for respiratory inhaler use. This had the potential to affect eight residents (#2, #6, #19, #20, #33, #65, #82 and #102) identified by the facility with orders for respiratory inhalers. The facility census was 99. Findings include: Review of the medical record for Resident #102 revealed an admitted [DATE] with diagnoses including hypertension, allergic rhinitis, and congestive heart failure. Review of the care plan dated 11/18/24 revealed Resident #102 had altered health maintenance related to progressive physical and mental status including congestive heart failure. Interventions included administering medications as ordered and monitoring for signs of distress including respiratory symptoms. There was nothing in the care plan regarding rinsing the resident's mouth after inhaler use. Review of the January 2025 physician's orders revealed Resident #102 had the following order: Pulmicort Flexhaler (corticosteroid respiratory inhaler) inhalation aerosol powder breath activated 108 microgram (mcg) one inhalation orally two times a day. There was nothing in the order regarding rinsing the resident's mouth after inhalation. Observation on 01/14/25 at 9:04 A.M. revealed Registered Nurse (RN) #553 administered Pulmicort Flexhaler one inhalation to Resident #102. After administration, he was not encouraged to rinse his mouth out. Interview on 01/14/25 at 9:10 A.M. with RN #553 verified she had not offered Resident #102 to rinse his mouth after administration of his inhaler as she had never heard of that as a prevention for the formation of a fungal infection of the mouth. She revealed that the facility would just treat with Nystatin (anti-fungal medication used to treat fungal infections) instead if a resident developed a fungal infection. Interview with 01/15/25 at 1:03 P.M. with Regional RN #630 verified each time a steroidal inhaler was administered, the nurse was to offer the resident to rinse his mouth to prevent the development of a fungal infection. Interview on 01/14/25 at 10:42 A.M. with Pharmacist #700 contracted by the facility verified after administration of a steroidal based inhaler, it was recommended to encourage a resident to rinse their mouth to prevent the development of a fungal infection. Review of the undated package insert guidelines labeled, Pulmicort Flexhaler (Budesonide) revealed after administration of the inhaler, the guidance was to rinse the resident's mouth with water and spit to prevent infection in the mouth. (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 Administration of Metered-Dose Inhaler, dated 02/01/24, revealed the facility was to administer medications as prescribed and in accordance with professional standards. If the inhaler was a corticosteroid the nurse was to allow the resident to rinse and gargle with water to remove the medication from the back of the throat.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51072 Based on observations, record reviews, interviews and reviews of the facility policy revealed the facility did not ensure the Physician's Order and the Care Plan for the use of oxygen were in place for Resident #94. This affected one resident #94 out of four. This had the potential to affect 14 Resident's(#3, #14, #17, #20, #27, #44, #46, #48, #51, #65, #68, #70, #71, #100) that was identified by the facility utilizing oxygen. Findings Include: Review of medical record for Resident #94 revealed an admitted [DATE] and his diagnoses included chronic kidney disease, vascular dementia without behavioral or psychotic disturbance, heart failure, fluid overload, primary hypertension, and atrial fibrillation. Review of Quarterly Minimum Data Set (MDS) 3.0 dated 12/16/24 revealed that in Section O - Special Treatments, Procedures and Programs, Letter C1 Oxygen Therapy was marked that resident was not receiving oxygen therapy. Review of undated comprehensive care plan revealed Resident #94's care plan did show the focus, goals and interventions for oxygen use. Review of January, 2025 Physician orders revealed no order for oxygen for Resident #94 Observation on 01/13/25 at 09:54 A.M. revealed Resident #94 sitting on the edge of his bed and to the left of the resident, next to his bed was an oxygen concentrator. It was running at 2.5 liters, which was connected via nasal cannula which was on the floor not attached to the resident and not labeled. Interview on 01/13/25 at 9:54 A.M. with Resident #94 stated he removed the nasal cannula sometimes because it is irritating. Interview on 01/13/25 at 09:58 A.M. with Registered Nurse (RN) #584 and verified that the oxygen tubing was not labeled and on the floor. RN #584 stated that it is the policy to label and date oxygen tubing. She revealed the procedure for changing the tubing was to be changed every 72 hours. Observation on 01/13/25 at 11:05 A.M. revealed Resident #94 with new oxygen tubing and he continued to have oxygen at 2.5 liters per nasal cannula that was labeled, dated and verified with RN #584. Interview on 01/14/25 at 9:45 A.M. with Regional RN #630, Assistant Director of Nursing (ADON) #599 and the Administrator. And verified there were no physicians order for oxygen for Resident #94 Interview on 01/15/25 at 02:00 P.M. with MDS Coordinator #576 verified that the Care Plan for Resident #94 had not been updated with the focus, goal and interventions for oxygen. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy labeled, Oxygen Administration dated 02/01/24 revealed under the policy Explanation and Compliance Guidelines that Oxygen was administered under orders of a physician, except in case of an emergency. Staff shall document the initial and ongoing assessment of the resident's condition warranting oxygen and the response to oxygen therapy. The resident Care Plan shall identify the interventions for oxygen therapy based on the resident's assessment and orders.

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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** 39973 Based on observation, interview, record review and review of the facility policy, the facility did not ensure medications were administered utilizing proper infection control standards including not touching medications with ungloved hands and hand hygiene between residents. This affected two residents (Resident #69 and #102) out of five residents reviewed for medication administration. The facility census was 99. Findings included: 1. Review of the medical record for Resident #69 revealed an admitted [DATE] with diagnoses including chronic kidney failure, pulmonary embolism, and protein-calorie malnutrition. 2. Review of medical record for Resident #102 revealed an admitted [DATE] with diagnoses including hypertension, allergic rhinitis, and congestive heart failure. Observation on 01/14/25 at 8:37 A.M. revealed Resident Nurse (RN) #553 was preparing Resident #102's medications, and the following infection control issues were identified: RN #533 reached into the ascorbic acid (vitamin C) bottle with her ungloved fingers to obtain two 500 milligram (mg) tablets and then placed the two tables in the plastic medication cup. RN #533 poured one aspirin 81 mg chewable tablet into her ungloved hand and then placed it in the plastic medication cup. RN #533 took the potassium chloride extended release10 milliequivalent (mEq) tablet and broke the tablet in half with her ungloved hands and placed it in the plastic medication cup. RN #533 took the propranolol (medication for hypertension) 60 mg tablet out of the packet and laid it onto the medication cart. She then picked up the tablet off the medication cart with her ungloved hand and placed it in the plastic medication cup. RN #533 took the Risperdal 0.5 mg (anti-psychotic medication) out of the packet and laid it onto the medication cart. She then picked up the tablet off the medication cart with her ungloved hand and placed it in the plastic medication cup. RN #533 took the torsemide (diuretics used for congestive heart failure) 20 mg three tablets and laid them onto the medication cart. She then picked up the tablet off the medication cart and placed it in the plastic medication cup. Observation on 01/14/25 at 8:50 A.M. revealed RN #533 then proceeded into Resident #102's room obtained his blood pressure, temperature, and oxygen saturation. She then proceeded to administer Resident #102's medications as prepared. She then proceeded out of his room and did not perform hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 01/14/25 at 8:59 A.M. revealed RN #533 proceeded then to prepare Resident #69's medication (still without performing hand hygiene). She prepared Eliquis (blood thinner medication) 5 mg tablet and went into Resident #69's room and administered the medication. Interview on 01/14/25 at 9:10 A.M. with RN #533 verified she did reach into the containers with her ungloved hand to obtain medications, pour medications out of the container into her ungloved hand, break medication in half with her ungloved hand and place medications out of the packet onto the medication cart and pick up with her ungloved hand. She stated, what else we supposed to do as she revealed she came from the hospital and that was what they do there and did not know she could not do that at this facility. She revealed she thought she did use hand sanitizer between the administration of Resident #102 and Resident #69's medications. Interview on 01/15/25 at 1:03 P.M. with Regional RN #630 verified nurses should perform hand hygiene between each resident they administer medications to. She also verified that a nurse should not touch the medication with her ungloved hands including reaching into medication bottles, pouring medications into her hand out of medication bottle, breaking medication in half and picking medications up off the medication cart. Review of the facility policy labeled, Medications Administration, dated 02/10/24, revealed medications were to be administered in accordance with professional standards to prevent contamination or infection. The policy revealed after administration of medication the nurse was to wash hands. There was nothing in the policy regarding not touching medications with bare hands.