STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365828	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harvard Gardens Rehabilitation & Care Center	18810 Harvard Ave Cleveland, OH 44122

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 42011 Based on interview and record review, the facility failed to ensure resident concerns documented in the Resident Council Meeting Minutes for November and December 2024 were not altered or removed and failed to ensure concerns from the group meetings were acted upon. This affected Resident #2, #7, #16, #17, #19, #24, #30, #34, #42, #47, #51, #58, #61, #71, #72, #74, #76, #78, #95, #152, #155 and #160 who attended resident council meetings and/or expressed concerns related to call light response. This affected 21 of 96 facility residents and had the potential to affect all residents. Findings include: 1. Review of Resident Council minutes provided by the Administrator from 01/05/24 through 12/20/24 revealed Resident Council meetings were held monthly. Resident #7 was the Resident Council President from 01/05/24 through 12/20/24. Review of the Resident Council minutes provided by Former Activity Director (FAD) #650 revealed three copies dated 11/29/24. The first copy under new concerns for nursing revealed the concerns were call light and under call light was an additional concern: staying off the phone. Dietary concerns indicated meals needed to be on time. Review of the second identical form provided, dated 11/29/24, revealed under nursing concern there was white out visible covering staying off the phone and meals needed to be on time. The third form was a copy that was made after the white had been applied which made the form appear as though the concerns staying off the phone and meals needed to be on time never existed. Residents who attended the meeting included Resident #2, #7, #16, #19, #34, #42, #51, #58, #61, #71, #72, #74, #78, #95, and #152. Additionally, there were three similar forms dated 12/20/24 for Resident Council meeting minutes. The first form under nursing concerns revealed need more staff, call lights not answered, and aids and nursing need to stay off phones. The second copy had visible white out covering the concerns under nursing. There were tiny lines of some letters that were missed when the white out was applied. Under the third copy after the white out, the form appeared as though the nursing concerns never existed; although, the lines of the some of the letters that were missed when the white out was applied remained visible. Residents who attended the meeting included Resident #2, #7, #16, #19, #34, #42, #51, #58, #61, #71, #72, #74, #78, #95, and #152. Review of Resident Council minutes dated 01/05/24 completed by Former Activity Director (FAD) #641 revealed under nursing concerns documentation included call lights need to be answered quicker. (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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident Council minutes dated 02/08/24 completed by FAD #641 revealed under the minutes for old business, call lights were not addressed. There were no new nursing concerns documented. Review of Resident Council minutes dated 03/22/24 completed by FAD #641 revealed no concerns related to call lights. Review of Resident Council minutes dated 04/30/24 completed by FAD #641 revealed nursing concerns were given to Director of Nursing (DON). Review of Resident Council minutes dated 05/15/24 completed by FAD # 641 revealed DON made known of issues resolved. Review of Resident Council minutes dated 06/26/24 completed by FAD #641 revealed none under new nursing concerns. Review of Resident Council minutes dated 07/23/24 completed by FAD #641 revealed nursing concerns were given to DON and clinical team. Review of Resident Council minutes dated 08/29/24 completed by FAD #641 revealed nursing concerns included slow answering call lights; resident had to holler while staff just sitting. Review of Resident Council minutes dated 09/12/24 completed by FAD #641 revealed no concerns related to call lights were documented. Review of Resident Council minutes dated 10/22/24 completed by FAD #641 revealed the page for new concerns was missing. Review of Resident Council minutes dated 11/29/24 completed by FAD #650 revealed under new nursing concerns call light. Review of Resident Council minutes dated 12/20/24 completed by FAD #650 revealed under new nursing concerns the area to document was blank except for very small black lines. Review of Resident Council minutes dated 01/31/25 completed by Activity Assistant #651 revealed no concerns related to call lights. Phone interview on 02/10/25 at 7:50 P.M. with FAD #650 revealed residents at the facility had been complaining for a long time about call lights not getting answered, they were just being ignored. The DON addressed the concern about call lights in November (2024) but she did not do anything about them for months prior. FAD #650 stated, In December (2024) the Ohio Board of Nursing (OBN) came into the facility. The DON called me and asked me to make a copy of the Resident Council Minutes for them. I made the copies then gave them to the DON, she got mad and said you can't have the same complaint for two months in a row, referring to the call light complaint from the month prior, she was yelling at me in front of the Human Resources (HR), she said I guess I will have to take care of it, she then took white out and whited out the whole note for December then told me to go make copies of it, I kept the originals and gave them a copy. FAD #650 revealed she took the originals home with her. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 02/12/25 at 9:49 A.M. with Medical Records/HR #309 revealed FAD #650 resigned with the last day worked being 01/15/25 with no notice given. Review of the staff file for FAD #650 revealed a hire date of 08/01/24 as an activity assistant. On 11/04/24 FAD #650 was promoted to activities director. There were no concerns regarding FAD #650's performance and no documentation of the departure or the date of the departure. Medical Records/HR #309 revealed she just hadn't got to it yet but FAD #650 was sent home because she was turning in an expense receipt to be reimbursed for money she did not spend, FAD #650 texted the Administrator the next day and resigned. Medical Records/HR #309 revealed she never had a conversation/meeting with FAD #650 and the DON and never heard the DON yell at FAD #650. Interview on 02/12/25 at 10:08 A.M. with the DON revealed FAD #650 ran Resident Council meetings. The Resident Council meetings were reviewed in morning stand-up meetings. The DON revealed, The Activities Director would tell us if there were any concerns like if there were concerns with call lights or something. The DON revealed she never reviewed the Resident Council concerns with HR and she never discussed the minutes with FAD #650 other than during the morning meeting. Resident Council Minutes were never whited out, and she never discussed what should be put in the minutes. The DON said she never saw the forms for Resident Council minutes, they were only discussed in morning meetings. The three forms (the original, the whited out and the copied form after the white was applied) of Resident Council meeting minutes for December 2024 were reviewed with the DON. The DON said she never saw those forms; she never saw any resident council meeting minutes. The DON confirmed the OBN was at the facility in December 2024. The DON confirmed her cell phone number. Review of a phone text message provided by FAD #650 revealed on 01/02/25 at 8:12 A.M. the DON sent a phone text (the phone number matched the phone number the DON gave as her phone number) to FAD #650 which read, ODH is in the building, I need Resident Council now please, what time you get here. FAD #650 responded, On my way right now. Interview on 02/12/25 at 1:25 PM. with the Administrator revealed Resident Council minutes were reviewed as a group monthly. The three forms (the original, the whited out and the copied form after the white was applied) of Resident Council meeting minutes for December 2024 were reviewed with the Administrator. The Administrator revealed he had no knowledge of this, this was the first he heard of it. The Administrator revealed he remembered one time when the DON and FAD #650 were in the HR office, both yelling at each other. HR was present, it was a heated conversation. The Administrator verified yelling and revealed it was over the two departments not getting along. Interview during the Resident Council meeting held 02/13/25 at 11:13 A.M. with four residents (Resident Council President [Resident #7], Resident #30, Resident #47, and Resident #61) confirmed Resident Council meetings were held monthly. Residents #7, #47, and #61 revealed call light response times were still long and could take up to an hour or longer for staff to respond. An interview on 02/13/25 at 4:10 P.M. with the Administrator revealed the purpose of Resident Council Meetings was to hear the residents' concerns, address the concerns, and to review resident rights. 42734 (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Interviews on 02/10/25 and 02/11/25 at various times with Residents #2, # 7, #17, #24, #58, #61, #76, #152, #155 and #160 revealed concerns with call light response times. Some residents indicated the wait could be from one hour up to a whole shift. One resident stated the staff were sitting around not answering call lights. During the Resident Council meeting held on 02/13/25 at 11:04 A.M. with the President of Resident Council (Resident #7), Resident #30, Resident #47 and Resident #61 the residents said call lights had been mentioned at resident council several months in a row without improvement. They stated there were times when the call light was purposely hung on the wall or out of reach of the resident. Review of the concern logs revealed issues with call lights were mentioned on 06/13/24, 08/29/24 and 12/20/24. Interview on 02/12/25 at 10:08 A.M. with the Director of Nursing revealed she was aware of issues with call lights being on the Resident Council Minutes and Concern Logs. Two different versions of resident council minutes were reviewed. One version of Resident Council minutes revealed concerns with call lights on 01/15/24, 08/29/24, 11/29/24 and 12/20/24. On 01/15/24 the Resident Council minutes indicated call lights need to be answered quicker. On 08/29/24 the minutes indicated slow answering call lights, and a resident indicated they had to holler while staff sat. Another version of Resident Council Minutes dated 11/29/24 indicated call lights and staying off phone, and another version of minutes dated 12/20/24 indicated call lights not answered and aides and nursing need to stay off phones. This deficiency represents non-compliance investigated under Complaint Number OH00161616.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 39969 Based on record review and staff interview, the facility failed to ensure all required notices of potential financial obligation were given to residents prior to the discontinuation of skilled services while using their Medicare Part A benefit. This affected two residents (62 and #107) of three residents (#62, #106, and #107) reviewed for appropriate beneficiary notices. The facility census was 96. Findings include: 1. Review of the beneficiary notice worksheet provided by the facility during the annual survey revealed Resident #62 was discharged from skilled therapy services while using his Medicare Part A benefit on 09/03/24 and remained in the facility. Review of the notices provided to Resident #62 upon discontinuation of skilled services revealed a Notice of Medicare Non-coverage (NOMNC) signed by the resident representative on 09/10/24. There was no Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNFABN) provided as required. 2. Review of the beneficiary notice worksheet provided by the facility during the annual survey revealed Resident #107 was discharged from skilled therapy services while using his Medicare Part A benefit on 09/13/24 and remained in the facility. Review of the notices provided to Resident #107 upon discontinuation of skilled services revealed a Notice of Medicare Non-coverage (NOMNC) signed by the resident on 09/12/24. There was no Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNFABN) provided as required. Interviews on 02/11/25 at 5:31 P.M. and 5:43 P.M. with Social Worker (SW) #328 revealed the facility initiated the end of skilled services for both Residents #62 and #107 and came up with the last covered dates. SW #328 stated the notices were to be given at least 48 hours prior to the end of services. SW #328 verified the SNFABN was not given to Resident #62 and #107 and that NOMNCs were not given 48 hours prior to the end of services as required.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on interview, record review, and review of the facility policy, the facility failed to conduct a quarterly care plan meeting for one resident, Resident #2, of three residents reviewed for care plan meetings. The facility census was 96. Findings include: Medical record review for Resident #2 revealed an admitted [DATE]. Diagnoses included hemiplegia affecting left nondominant side, type two diabetes mellitus, and muscle weakness. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 was cognitively intact. Resident #2 had no impairment of the upper extremities, impairment on both sides of the lower extremities, and used a wheelchair for mobility. Review of Resident #2's medical record from 01/01/24 through 02/10/25 revealed no documentation of care plan meetings scheduled or held. Interview on 02/11/25 at 9:33 A.M. with Resident #2 revealed she was only invited to care plan meetings once a year. Interview on 02/12/25 at 1:22 P.M. with Licensed Social Worker (LSW) #328 confirmed there was no evidence Resident #2 had a care plan meeting in 2024. LSW #328 revealed she had been at the facility as the LSW since August 2024 but was never notified when Resident #2's care plan meeting was due to be held, so none were completed since she had been there. Review of the facility policy titled, Care Plans, Comprehensive, Person Centered dated December 2022 revealed the Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, developed and implemented a comprehensive, person centered care plan for each resident. The care plan interventions were derived from a thorough analysis of the information gathered as part of the comprehensive assessment. Each resident's comprehensive person centered care plan would be consistent with the resident's right to participate in the development and implementation of his or her plan of care. The IDT was to review and update the care plan when there was a significant change in the resident's condition; when a desired outcome had not been met; and at least quarterly, in conjunction with the required quarterly MDS assessment.

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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** 42011 Based on observation, interview, and record review, the facility failed to ensure Resident #2 received range of motion and a palm guard or carrot after receiving therapy services for a left hand contracture. This affected one resident (Resident #2) of one resident reviewed for contractures. The facility census was 96. Findings include: Medical record review for Resident #2 revealed an admitted [DATE]. Diagnosis included hemiplegia affecting left nondominant side. Review of the care plan revised 07/25/24 revealed Resident #2 needed assistance for activities of daily living related to left hand contracture, and impaired mobility. Interventions included left hand carrot orthosis six to eight hours per day as tolerated. An additional care plan for Resident #2 updated 11/07/24 revealed Resident #2 had a contracture post cerebrovascular accident (CVA) to her left hand. Interventions included range of motion as tolerated to the site. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 was cognitively intact. Resident #2 had no impairment to the upper extremity and impairment on both sides of the lower extremity. Resident #2 used a wheelchair for mobility, required set up or clean up assistance with meals, was dependent for bathing and dressing, and required substantial/maximal assist for personal hygiene. Observation and interview between 02/11/25 at 9:39 A.M. and 02/13/25 at 10:02 A.M. with Resident #2 revealed Resident #2's left hand/fingers (all fingers) were contracted with the nails pressing on the palm. Resident #2 revealed she was unable to open the fingers without assistance and she use to wear a splint. The splint was lost about four months ago and since then she had not worn anything in her palm. Resident #2 revealed prior to receiving the splint, she wore a palm guard. The palm guard was taken away after receiving the splint and it was never brought back. Resident #2 revealed the nurses or nursing assistants never completed range of motion (ROM) to her left hand. The only time ROM was completed was when she received therapy services. Interview on 02/12/25 at 2:07 P.M. with Licensed Practical Nurse (LPN) #528 confirmed she was Resident #2's primary care nurse. LPN #528 confirmed Resident #2 use to wear a splint, but LPN #528 had not seen it in a long time and did not know what happened to the splint. LPN #528 confirmed Resident #2 did not have a palm guard and revealed she did not know if any staff did ROM to the left hand. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/13/25 at 9:31 A.M. with Director of Therapy #501 revealed Resident #2 was on case load several times. Last year while on therapy from 01/26/24 through 05/22/24, therapy had a vendor come out and a left hand splint was made for Resident #2. The splint was trialed in therapy, Resident #2 had moments she did not want to wear the splint but she did wear it at times in therapy. When therapy discharged Resident #2 no orders were written for the splint use because she was not consistent with wearing the splint. No orders were written for ROM because, The staff automatically do that. They do not have a restorative program at the facility so we don't write the orders. Director of Therapy #501 confirmed a palm protector was recommended after therapy was completed but an order was not written for that because, She use to have a palm protector prior to therapy. Director of Therapy #501 revealed she was not sure what happened to the splint for Resident #2, she may have had it after therapy. Interview on 02/13/25 at 12:45 P.M. with the Director of Nursing confirmed the staff did not do routine ROM, if there was no order for Resident #2, they would not have known to do ROM. Interview on 02/13/25 at 1:11 P.M. with Certified Nursing Assistant (CNA) #643 confirmed she was Resident #2's assigned CNA. CNA #643 revealed she did not open Resident #2's fingers or exercise them.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on observation, interview, and record review, the facility failed to ensure the hydration needs of Resident #156 were met when water flushes were not administered via a percutaneous endoscopic gastrostomy (PEG) tube per the physician orders. This affected one of one resident reviewed for tube feedings, Resident #156. The facility census was 96. Findings include: Medical record review for Resident #156 revealed an admitted [DATE]. Diagnosis included malignant neoplasm of oropharynx. Review of the progress notes dated 02/03/25 timed 10:25 P.M. authored by Licensed Practical Nurse (LPN) #640 revealed Resident #156 was alert and oriented to person, place, and month. Resident #156 received tube feeding via PEG tube. Resident #156 received nothing by mouth (NPO). Review of Resident #156's physician orders revealed an order dated 02/04/25 for enteral feed every four hours flush with 120 milliliters (ml) water every four hours. An order dated 02/05/25 indicated enteral feed every shift of Isosource HN 60 ml continuously. Observation of Resident #156's tube feeding pump on 02/12/25 at 2:44 P.M. revealed the tube feeding was set at 60 ml an hour continuous and the water flushes were set to infuse at 30 ml every four hours, not 120 ml every four hours as ordered. Observation on 02/12/25 at 2:47 P.M. with Licensed Practical Nurse Unit Manager (LPN UM) #426 verified Resident #156's tube feeding pump was set to deliver a water flush of 30 ml every four hours. LPN UM #426 reviewed the order and verified the flush should be set at 120 ml water every four hours. Interview on 02/12/25 at 2:51 P.M. with LPN #438 verified she was Resident #156's primary care nurse. LPN #438 revealed she did not see Resident #156's feeding pump was set to deliver 30 ml of water every four hours. LPN #438 said she had not looked at the pump all day, she did not need to. LPN #438 verified the water flushes Resident #156 received went by what was programmed into the feeding pump. LPN #438 revealed the pump was set at the same settings a week ago when she worked. At 2:57 P.M. the Director of Nursing (DON) approached and asked what the problem was. LPN #438 explained Resident #156's feeding pump was set wrong, it was set to flush water at 30 ml every four hours instead of 120 ml every four hours. LPN #438 confirmed she signed the Medication Administration Record (MAR) indicating Resident #156 received 120 ml every four hours without looking at the pump to verify that was what the resident received. The DON stated, It don't matter, she gets enough, they give water with meds so I will fix the machine. Review of the MAR for Resident #156 revealed routine medications were administered at 6:00 A.M., upon rising, at dinner and 7:00 P.M. (four times a day routinely). There was no documentation of water flushes given during medication administration. The MAR included the order for enteral feed every four hours, flush with 120 ml water every four hours. Further review of the MAR revealed medications were not administered every four hours. The MAR indicated LPN #438 worked day shift on 02/05/25.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 39969 Based on record review and interview the facility failed to ensure pharmacy recommendations were addressed. This affected one resident (#86) of five residents (#53, #69, #84, #86, and #156) reviewed for unnecessary medications. The facility census was 96. Findings include: Review of the medical record for Resident #86 revealed and admitted d of 03/16/24. Diagnoses included vascular dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, depression, and major depressive disorder, recurrent and moderate. Review of the physician orders for February 2025 revealed active orders for quetiapine fumarate (antipsychotic) oral tablet 25 milligrams (mg). Give two tablets by mouth two times a day related to vascular dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Review of the Pharmacist's Recommendation to Prescriber forms dated 04/04/24 and 01/15/25 revealed a request to clarify/document the approved diagnosis to justify use of quetiapine and update order in the electronic medical record (EMR) and listed 12 diagnoses. A circle was noted around number four to indicate: mood disorders (including mania, bipolar disorder, depression with psychotic features, and treatment refractory major depression) on both forms dated 04/04/24 and 01/15/25. Under prescriber's response was written agree and the forms were signed and dated on 04/09/24 and 01/10/25 respectively. Interview on 02/12/25 at 1:01 P.M. with the Director of Nursing (DON) verified the above. The DON stated when she saw the second pharmacy recommendation come in she thought the diagnosis was correct. The DON did not realize the diagnosis for the quetiapine 25 mg was for vascular dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Upon request, the facility did not provide a policy related to addressing pharmacy recommendations.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 42011 Based on observation, interview and review of the facility policy, the facility failed to assure expired medications were removed from the medications used for resident consumption. This had the potential to affect all 96 residents residing at the facility. Findings include: Observation on 02/10/25 at 6:30 P.M. with Licensed Practical Nurse (LPN) #416 of the South Medication Storage Room revealed a container of promethazone hydrochloride tablets 50 milligrams (mg) with an expiration date of 10/24/24, bisocodyl suppositories (six of 12 remaining) with an expiration date of January 2025, an additional box of bisocodyl suppositories (eight of 12 remaining) with an expiration date of January 2025, a Trulicity pen with the expiration date of 01/17/25, a humulog insulin pen with an expiration date of 12/20/24, deep sea nasal spray with an expiration date of January 2025, and two bottles of omeprazole 20 mg with an expiration date of January 2025. LPN #416 verified the expired medications and confirmed they were stored with medications used for residents. Observation on 02/13/25 at 12:23 P.M. with LPN #436 of the second floor Medication Storage Room revealed four bottles of omeprazole 20 mg tablets with an expiration date of January 2025, two bottles of aspirin 325 mg with an expiration date of September 2024, two bottles of vitamin D3 125 micrograms (mcg) with an expiration date of December 2024. LPN #436 verified the expired medications and confirmed they were stored with medications used for residents. Observation on 02/13/25 at 12:35 P.M. with LPN #436 of the C106 medication cart revealed a partially used bottle of vitamin B12 100 mcg with an expiration date of April 2024, a partially used vial of clear eyes eye drops expired January 2025. LPN #436 verified the expired medications and confirmed they were stored with medications used for residents. Observation on 02/13/25 at 12:40 P.M. with LPN #436 of the C104 medication cart revealed a partially used bottle of vitamin B12 100 mcg with an expiration date of January 2025. LPN #436 verified the expired medication and confirmed the medication was stored with medications used for residents. Review of the facility policy titled, Storage of Medications revised April 2019 revealed discontinued, outdated, or deteriorated drugs or biologicals were to be returned to the dispensing pharmacy or destroyed.

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	365828	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harvard Gardens Rehabilitation & Care Center	18810 Harvard Ave Cleveland, OH 44122

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on observation, interview, record review, review of the manufacturer instructions, and review of the facility policy, the facility failed to maintain appropriate infection control practices when obtaining blood glucose levels via a glucometer. This affected three (Residents #83, #156 and #52) of three residents observed for blood sugar assessments via glucometer and had the potential to affect an additional 19 residents, Resident #2, #4, #7, #8, #11, #19, #24, #27, #28, #34, #36, #41, #61, #66, #72, #73, #105, #153, and #154 who were identified by the facility as receiving blood sugar checks via glucometer. In addition the facility failed to have a complete water management plan in place. This had the potential to affect all residents. The facility census was 96. Findings include: 1. Medical record review for Resident #83 revealed an admitted [DATE]. Diagnosis included diabetes mellitus due to underlying condition with diabetic amyotrophy. Review of the care plan dated 01/07/25 revealed Resident #83 had an impaired metabolic status related to diabetes. Interventions included to monitor Resident #83's glucose levels per physician orders. Review of the physician orders for Resident #83 dated 01/07/25 revealed orders to notify physician if blood sugar less than 70 or greater than 400 and to document response four times a day related to diabetes mellitus. Review of the Admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #83 was moderately cognitively impaired and required assistance with activities of daily living. Observation on 02/11/25 at 11:35 A.M. revealed Licensed Practical Nurse (LPN) #416 assessing Resident #83's blood sugar. LPN #416 picked up the glucometer that was stored on top of the medication cart (LPN #416 did not clean the glucometer) and went to Resident #83's room and completed a fingerstick blood sugar with Resident #83. LPN #416 then returned the glucometer to the medication cart. LPN #416 did not wash her hands prior to leaving Resident #83's room. LPN #416 then wiped the front and back of the glucometer with an alcohol wipe for less than four seconds and placed the glucometer in the top drawer of the medication cart. LPN #416 verified she did not wash her hands prior to leaving Resident #83's room and confirmed she cleaned the glucometer with an alcohol wipe. LPN #416 indicated there was one glucometer per medication cart which was used for all residents who required a fingerstick blood sugar. 2. Medical record review for Resident #156 revealed an admitted [DATE]. Diagnosis included type two diabetes mellitus. Review of the progress note dated 02/03/25 timed 10:25 P.M. authored by LPN #640 revealed Resident #156 was alert and oriented and required assistance with activities of daily living. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the care plan dated 02/05/25 revealed Resident #156 had an impaired metabolic status related to diabetes. Interventions included to monitor Resident #156's glucose levels per physician orders. Review of the physician orders revealed Resident #156 did not have orders for a blood sugar assessment. Observation on 02/12/25 at 11:48 A.M. revealed LPN #438 removed the glucometer from the top drawer of the medication cart. LPN #438 did not clean the glucometer. LPN #438 entered Resident #156's room and assessed Resident #156's blood sugar via fingerstick using the glucometer. LPN #438 then left Resident #156's room and did not wash her hands prior to leaving the room. LPN #438 returned to the medication cart and washed her hands after being reminded by the Director of Nursing (DON). Unit Manager #426 then reminded LPN #438 to clean the glucometer with Sani wipes. LPN #438 then wiped the glucometer off with a Sani wipe and sat it on top of the medication cart. Unit Manager #426 instructed LPN #438 to clean the glucometer again and set it on a paper towel. Observation with Unit Manager #426 revealed LPN #438 wiped the front and back of the glucometer with a Sani wipe for less than three seconds. LPN #438 then laid the glucometer on a dry paper towel. 3. Medical record review for Resident #52 revealed an admitted [DATE]. Diagnosis included type two diabetes mellitus. Review of the care plan dated 12/12/24 revealed Resident #52 had an impaired metabolic status related to diabetes. Interventions included to monitor glucose levels per physician orders. Review of the physician orders for Resident #52 dated 12/13/24 revealed insulin lispro injection solution inject as per sliding scale subcutaneously three times a day for blood sugar related to diabetes mellitus. Review of the Admission MDS assessment dated [DATE] revealed Resident #52 was cognitively intact and required assistance with activities of daily living. Observation on 02/12/25 at 11:59 A.M. revealed LPN #438 picked up the same glucometer used for Resident #156 from the medication cart. LPN #438 then entered Resident #52's room and assessed Resident #52's blood sugar via the glucometer. LPN #438 then returned to the medication cart, wiped the front only of the glucometer with a Sani wipe for less than three seconds and sat the glucometer on a dry paper towel. LPN #438 confirmed there was one glucometer per medication cart which was used for all residents requiring a blood sugar via glucometer. Review of the cleaning directions on the container of Sani wipes with LPN #438 and Unit Manager #426 on 02/12/25 at 12:11 P.M. revealed for nonporous surfaces, using a Sani wipe, wet the nonporous surface, allow to remain visibly wet for four minutes and air dry. Review of the facility policy titled, Glucometer/Point of Care Blood Testing and Disinfection Procedure revised 12/27/23 revealed whether shared or assigned to a singular resident, blood testing meters were to be disinfected between each use (before use the clinician should assume the meter was dirty and disinfect before use) according to the manufacturer instruction and infection prevention guidelines. Maintain visible wetness of meter for required kill time according to the germicidal disinfectant instructions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility policy titled, Hand Hygiene dated October 2024 revealed the facility considered hand hygiene the primary means to prevent the spread of infections. Use an alcohol based hand rub or soap and water before and after direct contact with residents. 42734 4. Review of the facility's water management plan provided by the Administrator revealed it was a 25-page guide for implementing the facility plan. It had no specific information about the facility. Review of test results dated 07/23/24 revealed the facility tested for Legionella and the results were negative. Review of test logs for the last 12 months including the construction area revealed maintenance was running water weekly from the water taps in the construction area. Interview on 02/12/25 at 10:00 A.M. with Regional Maintenance (RM) #621 revealed he was looking for the facility's water management plan. He stated the company was working with the Ohio Department of Health and a third party specialist on water management plans for each of their buildings. A water management plan was not provided after requesting one several times. During a subsequent interview with RM #621 on 02/12/25 at 1:15 P.M. logs for testing hot water and the logs for monitoring the rooms under construction were provided. RM #621 also provided a floor plan with red splotches marking up the floor plan. RM #621 verbally described the water flow but the water flow was not apparent by viewing the floor plan. Interview on 02/13/25 at 12:30 P.M. with the Administrator revealed they did not have a water management plan or a waterflow diagram. Review of the facility policy titled Legionella Water Management Program, dated as reviewed in 2024 revealed the facility would have a water management program overseen be the water management team, the water management program would include a detailed description and diagram of the water system in the facility.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39969 Based on observation, record review, and interview, the facility failed to ensure call lights were easily accessible and consistently in good working order. This affected five residents (#6, #7, #154, #155, and #156) of five residents reviewed for call lights. Findings include: 1. Review of the medical record for Resident #6 revealed an admitted [DATE]. Diagnoses included osteoarthritis, paranoid schizophrenia, anxiety disorder, and presence of cardiac pacemaker. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #6 had intact cognition and required supervision or touching assistance with chair/bed to chair transfer, partial or moderate assistance with toilet transfer, and used a wheelchair. Interview on 02/11/25 at 11:37 A.M. with Resident #6 revealed he pressed his call light and was waiting for staff to assist him to bed. Resident #6 stated he had been waiting for 15 minutes and no one had responded. Resident #6 stated this happened a lot. Observation at the time of the interview revealed the light was not lit on the call light panel near his bed and observation of the light outside of his room above the door revealed it was not lit either. Resident #6 pressed the call light again and the lights did not illuminate. During observation on 02/11/25 at 11:40 A.M. with Certified Nurse Aide (CNA) #512 Resident #6 pressed his call light and again the lights above the panel and outside above the door did not illuminate. Interview at this time with CNA #512 verified the light on the panel and outside of the door were not illuminated. CNA #512 pressed the call light button again, and it did not come on. CNA #512 stated she would let maintenance know and that she was not aware of any prior concerns related to the functioning of Resident #6's call light. 42011 2. Medical record review for Resident #7 revealed an admitted [DATE]. Diagnoses included left artificial knee joint, osteoarthritis right knee, and lack of coordination. Review of the Annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #7 was cognitively intact. Resident #7 required set or or clean up assistance with toilet hygiene. Observation on 02/11/25 at 9:58 A.M. revealed Resident #7 was sitting up in her wheelchair. Resident #7's call light was lying on the floor behind the nightstand. Resident #7 verified she was unable to reach her call light. Observation and interview on 02/11/25 at 9:59 A.M. with MDS Coordinator #521 confirmed Resident #7's call light was lying on the floor behind the nightstand and confirmed Resident #7 would not be able to reach her call light. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/13/25 at 11:13 A.M. during Resident Council Meeting Resident #7 (Resident Council President) revealed the staff would hang her call light on the wall or place it somewhere she could not reach it. 3. Record review for Resident #154 revealed an admitted [DATE]. Diagnoses included chronic kidney disease and osteomyelitis. Review of the progress note dated 01/28/25 timed 6:07 P.M. authored by Licensed Practical Nurse (LPN) #642 revealed Resident #154 was alert and oriented. Observation on 02/11/25 at 11:58 A.M. revealed Resident #154 was sitting up in her wheel chair. Resident #154's call light was observed lying on the floor behind her. Resident #154 confirmed she was unable to reach her call light. Observation and interview on 02/11/25 at 12:00 P.M. with LPN #426 confirmed Resident #154's call light was lying on the floor behind her. LPN #426 confirmed Resident #154 would not be able to reach the call light. 4. Medical record review for Resident #156 revealed an admitted [DATE]. Diagnoses included malignant neoplasm of oropharynx and type two diabetes mellitus. Review of the progress noted dated 02/03/25 timed 10:25 P.M. authored by Licensed Practical Nurse (LPN) #640 revealed Resident #156 was alert and oriented. Resident #156 was continent of urine and bowel but required assistance for transfers and activities of daily living. Interview on 02/11/25 at 10:31 A.M. with Resident #156 revealed her call light had not worked consistently since she was admitted to the facility. Resident #156 revealed the staff knew about it and she would have to wait until someone came in her room to get assistance because she had no way to call for assistance. At the time of the interview Resident #156 pushed her call button and the light did not come on. Resident #156 then pushed her call light two additional times and the light did not come on. The surveyor pushed the call button and the light did not come on. Observation with the Director of Nursing (DON) on 02/11/25 at 10:41 A.M. revealed when the DON pushed Resident #156's call button it came on. Interview with Resident #156 in the presence of the DON revealed staff did not answer her call light timely, at times she went to sleep and woke up and staff still had not responded. 5. Medical record review for Resident #155 revealed an admitted [DATE]. Diagnosis included osteoarthritis. Review of the progress note dated 01/31/25 timed 3:49 P.M. authored by LPN #640 revealed Resident #155 was alert and oriented. Resident #155 was admitted to the facility with a diagnosis of a left total knee replacement. Resident #155 was a fall risk and required assistance with activities of daily living. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 02/11/25 at 10:35 A.M. with Resident #155 revealed she was Resident #156's room mate. Resident #155 said the staff did not answer her call light timely. Observation revealed Resident #155 pushed her call light button two different times and the call light did not come on. This defiency represents non-compliance investigated under Complaint Number OH00161616.