

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365870	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/01/2024
NAME OF PROVIDER OR SUPPLIER Judson Park		STREET ADDRESS, CITY, STATE, ZIP CODE 2181 Ambleside Rd Cleveland, OH 44106	

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 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35768</p> <p>Based on record review and interview the facility failed to provide written information to the resident or resident representative regarding the facility bed hold policy upon discharge to hospital. This affected one (Resident #27) of three residents reviewed who required a bed hold notice.</p> <p>Findings include:</p> <p>Review of medical record for Resident #27 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included restlessness and agitation, chronic kidney disease, Alzheimer's disease, and delirium due to known physiological condition.</p> <p>Review of the comprehensive Minimum Data Set (MDS) assessment, dated 09/02/24, revealed Resident #27 had impaired cognition.</p> <p>Review of the nurse progress note dated 09/02/24 timed at 8:30 P.M. revealed Resident #27's son, who was at the facility after a fall, requested staff to contact emergency services because of Resident #27's increased pain levels and long wait time for x-rays. At 8:45 P.M. emergency services arrived at the facility to transport Resident #27 to the hospital.</p> <p>Review of the nurse progress note dated 09/03/24 timed at 1:57 A.M. revealed Resident #27 was admitted to the hospital with a left femur fracture.</p> <p>Interview on 09/30/24 at 11:20 A.M., with Admission Director (AD) #105 revealed each resident who was discharged to the hospital from the facility received a packet which included information regarding bed holds. Review of a packet which AD #105 indicated each resident received upon discharge confirmed the packet included the required bed hold notice information. AD #105 could not confirm that Resident #27 or the resident's representative received a packet which would have included the bed hold information.</p> <p>Interview with Resident #27's son on 10/07/24 at 9:46 A.M. revealed he did not receive a bed hold notice or discharge packet when his mother discharged emergently to the hospital after a fall on 09/02/24. However, on 09/03/24 he contacted the facility and requested a bed hold based on the information he read in admission agreement which was signed by himself and the facility representative. Resident #27's son said he wanted to ensure his mother had a place to go upon her discharge from the hospital. His mother's payer source was Medicare.</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 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>This deficiency represents non-compliance investigated under Complaint Number OH00157559.</p>		

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<p>F 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35768</p> <p>Based on record review, policy review, and interview the facility failed to allow a resident to return to the facility after discharge to hospital for a change in condition. This affected one (Resident #27) of three residents reviewed who had been transferred to the hospital.</p> <p>Findings include:</p> <p>Review of medical record for Resident #27 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included restlessness and agitation, chronic kidney disease, Alzheimer's disease, and delirium due to known physiological condition.</p> <p>Review of the comprehensive Minimum Data Set (MDS) assessment, dated 09/02/24, revealed Resident #27 had impaired cognition.</p> <p>Review of the nurse progress note dated 09/02/24 timed at 8:30 P.M. revealed Resident #27's son, who was at the facility after a fall requested staff to contact emergency services because of Resident #27's increased pain levels and long wait time for x-rays. At 8:45 P.M. emergency services arrived at the facility to transport Resident #27 to the hospital.</p> <p>Review of the nurse progress note dated 09/03/24 timed at 1:57 A.M. revealed Resident #27 was admitted to the hospital with a left femur fracture.</p> <p>Interview on 09/30/24 at 11:20 A.M., with Admission Director (AD) #105 revealed Resident #27 was not readmitted to the facility because the census was 30 (capacity 36) and the facility held/reserved beds for any potential admission from their sister facilities. AD #105 contacted her supervisor who directed her to refuse the readmission. AD #105 stated the facility policy did not reflect the procedure for reserving beds because the procedure/process was internal. AD #105 said the family of Resident #27 contacted the facility within 24 hours to request a bed-hold.</p> <p>Interview with Resident #27's son on 10/07/24 at 9:46 A.M. revealed he did not receive a bed hold notice when his mother discharged emergently to the hospital after a fall on 09/02/24. However, on 09/03/24 he contacted the facility and requested a bed hold based on the information regarding bed holds located in the signed admission agreement. The complainant wanted to ensure his mother had a place to go upon her discharge from the hospital. He was told they could not hold a bed for his mother. His mother's payer source was Medicare Advantage. Resident #27 was discharged from the hospital on 09/15/24 and admitted to another area nursing home.</p> <p>Review of the facility Bed Hold and Return to Facility Policy and Procedure, dated 2016 revealed the following.</p> <ol style="list-style-type: none"> 1. Medicare as the primary payer source- unlimited days with payment of daily room rate. 2. Medicaid as primary payer source- 30 days. <p>(continued on next page)</p>		

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<p>F 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3. Private pay as the primary payer source- unlimited days with payment of daily room rate.</p> <p>Facility will readmit or allow the opportunity for return to facility when:</p> <ol style="list-style-type: none"> 1. Residents to return to facility after hospitalization or therapeutic leave if their needs were met by the facility. 2. The resident required the services provided by the facility. 3. If the resident was eligible for Medicare or Medicaid skilled nursing facility services. <p>This deficiency represents non-compliance investigated under Complaint Number OH00157559.</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35768</p> <p>Based on record review, interview, and policy review, the facility failed to ensure adequate supervision and individualized care planned interventions to prevent/reduce risk of falls and injury. This affected one resident (#27) of three residents reviewed who were at risk for falls.</p> <p>Actual harm occurred on 09/02/24 when Resident #27, who was identified as a high risk for falls, was found on the floor, unable to move her left leg and in severe pain. Resident #27 was sent to the hospital for evaluation and treatment where she was diagnosed with a fractured hip. Prior to the incident, Resident #27's scheduled sitter did not show up and the family nor the contacted company that provided the sitter were notified so arrangements for a replacement could be made. In addition, there was no evidence facility fall interventions were in place at the time of the resident's fall. While unsupervised in her room, Resident #27 got up from a wheelchair and walked out to the corridor where she fell .</p> <p>Findings include:</p> <p>Review of medical record for Resident #27 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included restlessness and agitation, chronic kidney disease, Alzheimer's disease, and delirium due to known physiological condition.</p> <p>Review of the facility Fall Risk assessment dated [DATE] revealed Resident #27 was disoriented to person, place, and time daily. Resident #27 was bed bound and required use of assistive devices including wheelchair, walker, furniture, and or cane. Resident #27 scored a 17 on the assessment indicating a high risk for falls.</p> <p>Review of the paper initial/interim plan of care dated 08/27/24 revealed Resident #27 was at risk for falls. Interventions included keep call light signal within reach, keep bed in lowest position and locked and ensure proper footwear, non-skid with proper soles.</p> <p>Review of the plan of care located in the electronic medical record dated 08/27/24 revealed Resident #27 was at risk for falls. The care plan did not include any interventions to prevent falls or to protect the resident from injury.</p> <p>Review of a nurse progress note dated 08/26/24 timed 10:40 P.M. revealed Resident #27 did not walk; a walking goal was not clinically indicated.</p> <p>Review of a nurse progress note dated 08/27/24 timed 12:07 A.M. revealed Resident #27 was always disoriented to person, place, and time.</p> <p>Review of a nurse progress note dated 08/28/24 timed 3:08 P.M. revealed Resident #27 had a fall on 08/27/24. The progress note indicated that a fall mat and alarm were in place. The progress note provided no information regarding the time, place or specifics of the fall. Further review of the medical record revealed no evidence of a post fall assessment, monitoring, or a fall investigation related to the 08/27/24 fall.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of an activity participation progress note dated 08/29/24 timed 2:53 P.M. revealed Resident #27 indicated she was bed bound and could not walk.</p> <p>Review of the comprehensive Minimum Data Set (MDS) assessment, dated 09/02/24, revealed Resident #27 had impaired cognition. Behaviors identified on the MDS assessment included verbal and physical aggressiveness toward staff.</p> <p>Review of nurse progress note dated 09/02/24 timed 8:30 P.M. revealed Resident #27's son, who was at the facility after a fall requested that staff contact emergency services due to Resident #27's increased pain levels and long wait time for x-rays.</p> <p>Review of the nurse progress note dated 09/02/24 timed 8:45 P.M. revealed emergency services arrived at the facility. There was no information regarding the fall, injury, pain, or assessment of the resident.</p> <p>Review of nurse progress note dated 09/03/24 timed 1:57 A.M. revealed Resident #27 was admitted to the hospital with a left femur fracture.</p> <p>Review of the facility's undated and untimed fall incident report revealed on 09/02/24 Resident #27 was found on the floor in the hallway. Resident #27 complained of severe pain in left hip. Resident #27 was unable to straighten left leg due to severe pain. Predisposing physiological factors included gait imbalance and impaired memory. Resident #27 was ambulating without assistance. The family and physician were notified on 09/02/24 at 7:32 P.M.</p> <p>Interview on 09/29/24 at 8:35 A.M. with Registered Nurse (RN) #103 revealed she was not sure if Resident #27 had any alarms in place during her stay at the facility. RN #103 stated typically residents at risk for falls had bed and chair alarms, staff kept the bed at its lowest level and beds were placed with one side against the wall if possible.</p> <p>Interview on 09/30/24 at 10:52 A.M. with Resident #27's physician revealed she received a call from staff notifying her Resident #27 had a fall. The physician stated that Resident #27 had no rotation in her leg, could put weight on the leg and did not want to go the hospital.</p> <p>Follow up interview on 09/29/24 at 11:15 A.M. with RN #103 revealed she found Resident #27 on the floor in the hallway just outside the resident's room around 7:00 P.M. RN #103 assessed Resident #27 who indicated her left hip was hurting and she could not move the leg. RN #103 stated it took three staff members to transfer Resident #27 from the floor to her wheelchair and then to her bed. RN #103 contacted the physician who ordered x-rays. RN #103 said a sitter the family hired to stay with Resident #27 was not working at the time of the fall. RN #103 did not know why the sitter was not working or why staff did not contact the family to report the scheduled sitter did not show for the assigned shift. RN #103 did not recall an alarm sounding when she found Resident #27 on the floor. RN #103 did not send Resident #27 to the hospital immediately because the physician wanted x-rays prior to sending the resident to the hospital. Resident #27 could not bear weight on the left leg. Resident #27 was sent to the hospital upon the son's request.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 09/30/24 at 12:12 P.M. with the Director of Nursing (DON) and Resident Care Coordinator (RCC) #106 confirmed there were no progress notes regarding Resident #27's falls on 08/27/24 and 09/02/24. They indicated the facility had not completed a fall investigation related to the 08/27/24 fall to determine the root cause which could have potentially prevent another fall. They verified the electronic plan of care dated 08/27/24 indicated Resident #27 was at risk for falls but did not include interventions to prevent falls or protect the resident from injury if a fall occurred. RCC #106 stated Resident #27 had an alarm on her wheelchair and bed and a fall mat next to the bed but verified there was no documentation to support they were implemented. RCC #106 indicated a sitter for Resident #27 had been at the facility (on 09/02/24) and then left. The DON and RCC #106 did not know why the sitter left the facility or why the family was not informed of the sitter leaving. Upon the sitter leaving Resident #27's supervision by facility staff was not increased.</p> <p>Interview on 09/30/24 at 2:25 P.M. with agency State tested Nurse Assistant (STNA) #107 revealed she worked 2:30 P.M. to 11:00 P.M. on 09/02/24 the day Resident #27 fell . STNA #107 stated Resident #27 had no sitter while STNA #107 was working which was the 2:00 P.M. to 11:00 P.M. shift. STNA #107 stated when the family arrived after being notified of the fall they asked where the sitter was. STNA #107 stated Resident #27 had a bed alarm only, there was no alarm on the wheelchair. STNA #107 explained a sitter for another resident observed Resident #27 stand up from wheelchair and walk into the hallway by herself. Resident #27 was in excruciating pain and screamed out every time staff tried to move her. The physician wrote an order for x-rays which did not happen because of the long wait time. The family requested for staff to send Resident #27 to the hospital. Resident #27 left for the hospital at approximately 8:30 P.M.</p> <p>Interview on 09/30/24 at 3:54 P.M. with Unit Supervisor (US) #108 revealed she was informed of Resident #27's fall at 7:00 P.M. The x-ray technician did not arrive at the facility until after Resident #27 left the facility. Resident #27 left the facility around 8:30 P.M.</p> <p>Interview on 09/30/24 at 4:10 P.M. with the DON revealed Resident #27 should have had an alarm on her wheelchair.</p> <p>Interview on 10/01/24 at 11:23 A.M. with the director of the company responsible for providing sitters for residents at the facility revealed the sitter for Resident #27 flat out lied to the company indicating she/he was at the facility providing services for Resident #27 at the time of the fall. The director stated if the facility would have contacted the company when the sitter did not show the sitter would have been replaced. The director stated it was an unfortunate situation.</p> <p>Review of the facility's visitor/contractor sign in log revealed the sitter assigned to work with Resident #27 did not sign into the facility on [DATE].</p> <p>Review of the facility Falls Policy, dated 2020 indicated all residents would be assessed for fall risk. Interventions would be incorporated into the plan of care utilizing the Fall Assessment Follow-up Tool as guidance for interventions.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00157559.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35768</p> <p>Based on record review and interview the facility failed to ensure the medical record contained an accurate representation of the resident's actual experience. This affected one (Resident #27) of three residents reviewed for falls.</p> <p>Findings include:</p> <p>Review of medical record for Resident #27 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included restlessness and agitation, chronic kidney disease, Alzheimer's disease, and delirium due to known physiological condition.</p> <p>Review of the comprehensive Minimum Data Set (MDS) assessment, dated 09/02/24, revealed Resident #27 had impaired cognition. Behaviors identified on the MDS included verbal and physical aggressiveness toward staff.</p> <p>Review of the plan of care dated 08/27/24 revealed Resident #27 was at risk for falls.</p> <p>Review of a nurse progress note dated 08/28/24 timed 3:08 P.M. revealed Resident #27 had a fall on 08/27/24. The progress note indicated that a fall mat and alarm were in place. The progress note provided no information regarding the time, place or specifics of the fall. Further review of the medical record revealed no evidence of a post fall assessment, monitoring, or a fall investigation related to the 08/27/24 fall.</p> <p>Review of nurse progress note dated 09/02/24 timed 8:30 P.M. revealed Resident #27's son, who was at the facility after a fall requested that staff contact emergency services due to Resident #27's increased pain levels and long wait time for x-rays.</p> <p>Review of the nurse progress note dated 09/02/24 timed 8:45 P.M. revealed emergency services arrived at the facility. There was no information regarding the fall, injury, pain, or assessment of the resident.</p> <p>Review of nurse progress note dated 09/03/24 timed 1:57 A.M. revealed Resident #27 was admitted to the hospital with a left femur fracture.</p> <p>Interview on 09/30/24 at 10:52 A.M. with Resident #27's physician revealed she received a call from staff notifying her Resident #27 had a fall. The physician stated that Resident #27 had no rotation in her leg, could not put weight on the leg and did not want to go to the hospital.</p> <p>Interview on 09/29/24 at 11:15 A.M. with Registered Nurse (RN) #103 revealed she found Resident #27 on the floor in the hallway just outside the resident's room around 7:00 P.M. RN #103 assessed Resident #27 who indicated her left hip was hurting and she could not move the leg. RN #103 stated it took three staff members to transfer Resident #27 from the floor to her wheelchair and then to her bed. RN #103 contacted the physician who ordered x-rays. Resident #27 could not bear weight on the left leg. Resident #27 was sent to the hospital upon the son's request.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 09/30/24 at 12:12 P.M. with the Director of Nursing (DON) and Resident Care Coordinator (RCC) #106 confirmed there were no progress notes regarding Resident #27's falls on 08/27/24 and 09/02/24.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00157559.</p>		