

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365926	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/06/2024
NAME OF PROVIDER OR SUPPLIER Normandy Manor of Rocky River		STREET ADDRESS, CITY, STATE, ZIP CODE 22709 Lake Rd Rocky River, OH 44116	

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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42730</p> <p>Based on observations, resident record review, resident and family interviews, staff interviews, facility policy review, call light audit review, resident council meeting minutes review, and concern log review, the facility failed to ensure call lights were in reach for two residents (#31, #62) and also failed to ensure call lights were answered in a timely manner for eighteen residents (#6, #17, #20, #24, #27, #60, #61, #65, #68, #72, #89, #92, #94, #101, #110, #127, #133, #136). This had the potential to affect all residents residing in the facility. The facility census was 136.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #65 revealed she was admitted to the facility on [DATE] with diagnoses including sepsis, hyperlipidemia, and atherosclerotic heart disease.</p> <p>Review of the physician orders revealed an order to encourage Resident #65 to reposition dated 10/04/24 and an order dated 10/08/24 for hooyer lift transfers at all times.</p> <p>Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #65 had a memory problem, was moderately impaired regarding task of daily life with inattention that was present but fluctuated and was dependent on staff for care.</p> <p>Review of the care plan dated 10/04/24 revealed Resident #65 was at risk for falls and had a self-care performance deficit related to limited mobility and pain. Interventions included ensure the call light was within reach, assist with transfers, require hands-on assistance including holding, lifting, and supporting trunk and limbs, and transfers of two staff with mechanical hooyer lift.</p> <p>Interview on 11/04/24 at 8:34 A.M. with Resident #109 revealed her call light response time were always too long. Resident #109 revealed staff would enter her room after she activated the call light, turn it off, and not return until later. Resident #109 revealed she always waited over 15 minutes. Resident #109 revealed there were never enough staff to cover staff breaks. Resident #109 revealed after activating her call light, staff didn't return until at least 45 minutes later.</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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation and interview on 11/04/24 at 2:31 P.M. revealed Resident #65 was sitting in her tilt-in-space wheelchair, slouched down, leaning on her right side. Resident #65 revealed she was uncomfortable, sliding down in her wheelchair, and was feeling sick. Resident #65's daughter, who was in the room, pacing back and forth looking out the door for staff, revealed Resident #65's call light was activated 30 minutes ago. Resident #65's daughter revealed Certified Nursing Assistant (CNA) #889 came in the room, turned off the call light, and stated she would return to assist Resident #65 into bed. Resident #65's daughter revealed the resident was not feeling well, was uncomfortable in the wheelchair, and wanted to be placed in bed. Resident #65's daughter reactivated the call light.</p> <p>Observation on 11/04/24 at 2:40 P.M. revealed CNA #889 entered Resident #65's room and turned off the call light and left the room.</p> <p>Interview on 11/04/24 at 2:42 P.M. with CNA #889 revealed Resident #65's call light was turned on twice and she turned it off both times and would return when able to assist the resident. CNA #889 confirmed, verified, and acknowledged Resident #65 wanted to be placed in bed and was not feeling well.</p> <p>Observation on 11/04/24 at 2:45 P.M. revealed CNA #889 walked by Resident #65's room without providing assistance.</p> <p>Interview on 11/04/24 at 2:50 P.M. with Registered Nurse (RN) #648 revealed Resident #65's call light was activated approximately 40 minutes ago due to her not feeling well. RN #648 revealed she provided Resident #65 with Zofran at that time. RN #648 revealed Resident #65 was a two-person hoier lift and utilized a tilt-in-space wheelchair. RN #648 revealed Resident #65 always slid down in her wheelchair and would lean towards one side. RN #648 revealed she would alert the CNA to put her in bed. RN #648 confirmed and verified Resident #65 wasn't feeling well, wanted to be placed in bed, and was positioned uncomfortably in her wheelchair.</p> <p>Observation on 11/04/24 at 2:58 P.M. revealed CNA #889 arrived to Resident #65's room with a hoier lift and left it at the entrance to the door. CNA #889 was observed walking down the hall.</p> <p>Observation on 11/04/24 at 3:00 P.M. revealed CNA #889 and RN #648 returned to Resident #65's room and entered the room. RN #648 was observed exiting the room and continued to pass medications. Resident #65 was still observed to be sitting in her wheelchair with the transfer to bed incomplete.</p> <p>Observation on 11/04/24 at 3:02 P.M. revealed CNA #726 and #889 arrived at Resident #65 room to complete the hoier transfer after approximately 1 hour of feeling sick and positioned uncomfortably in her wheelchair. CNA #726 and #889 confirmed and verified they arrived to complete the transfer at this time.</p> <p>Review of the call light audit report dated 11/01/24 through 11/03/24, provided by the Director of Nursing (DON) on 11/04/24 at 9:30 A.M. and confirmed and verified as accurate, revealed the following:</p> <p>The call light belonging to Resident #72 was activated on 11/01/24 at 8:31 P.M. and wasn't answered until 20 minutes later.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The call light belonging to Resident #110 was activated on 11/01/24 at 9:48 P.M. and wasn't answered until 25 minutes later and activated again on 11/03/24 at 4:11 A.M. and wasn't answered until 26 minutes later.</p> <p>The call light belonging to Resident #24 was activated on 11/01/24 at 9:53 P.M. and wasn't answered until 20 minutes later and activated again on 11/02/24 at 3:04 A.M. and wasn't answered until 39 minutes later.</p> <p>The call light belonging to Resident #17 was activated on 11/01/24 at 10:10 P.M. and wasn't answered until 22 minutes later and activated again on 11/02/24 at 6:54 P.M. and wasn't answered until 27 minutes later.</p> <p>The call light belonging to Resident #60 was activated on 11/02/24 at 7:17 A.M. and wasn't answered until 29 minutes later and activated again on 11/02/24 at 10:15 A.M. and wasn't answered until 22 minutes later and activated again on 11/02/24 at 10:59 A.M. and wasn't answered until 28 minutes later and activated again on 11/02/24 at 8:39 P.M. and wasn't answered until 25 minutes later.</p> <p>The call light belonging to Resident #92 was activated on 11/02/24 at 8:29 A.M. and wasn't answered until 23 minutes later and activated again on 11/02/24 at 10:46 P.M. and wasn't answered until 34 minutes later.</p> <p>The call light belonging to Resident #133 was activated on 11/02/24 at 8:32 A.M. and wasn't answered until 22 minutes later.</p> <p>The call light belonging to Resident #27 was activated on 11/02/24 at 9:29 A.M. and wasn't answered until 26 minutes later.</p> <p>The call light belonging to Resident #6 was activated on 11/02/24 at 9:56 A.M. and wasn't answered until 24 minutes later.</p> <p>The call light belonging to Resident #89 was activated on 11/02/24 at 10:01 A.M. and wasn't answered until 22 minutes later.</p> <p>The call light belonging to Resident #61 was activated on 11/02/24 at 10:06 A.M. and wasn't answered until 35 minutes later.</p> <p>The call light belonging to Resident #136 was activated on 11/02/24 at 11:28 A.M. and wasn't answered until 23 minutes later and activated again on 11/02/24 at 1:42 P.M. and wasn't answered until 21 minutes later.</p> <p>The call light belonging to Resident #68 was activated on 11/02/24 at 2:44 P.M. and wasn't answered until 21 minutes later.</p> <p>The call light belonging to Resident #20 was activated on 11/02/24 at 6:52 P.M. and wasn't answered until 28 minutes later.</p> <p>The call light belonging to Resident #127 was activated on 11/02/24 at 9:34 P.M. and wasn't answered until 23 minutes later.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The call light belonging to Resident #94 was activated on 11/02/24 at 11:29 P.M. and wasn't answered until 21 minutes later and activated again on 11/03/24 at 3:03 A.M. and wasn't answered until 33 minutes later and activated again on 11/03/24 at 3:39 A.M. and wasn't answered until 23 minutes later.</p> <p>The call light belonging to Resident #101 was activated on 11/02/24 at 11:29 P.M. and wasn't answered until 21 minutes later and activated again on 11/03/24 at 3:05 A.M. and wasn't answered until 28 minutes later.</p> <p>2. Review of the medical record for Resident #62 revealed she was admitted to the facility on [DATE] with diagnoses including atrial fibrillation, dementia, and anemia.</p> <p>Review of the physician orders revealed an order for tilt-in-space wheelchair dated 06/05/23 and two-person transfer at all times dated 06/17/24.</p> <p>Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #62 had a Brief Interview for Mental Status (BIMS) score of 9 that indicated she was alert and oriented with cognition impairment and dependent on care from staff.</p> <p>Review of the care plan dated 10/25/24 revealed Resident #62 had a self-care performance deficit related to limited mobility, limited balance, fatigue, and was at risk of falls. Interventions included tilt-in-space wheelchair, assist of two staff, and ensure the call light was within reach for prompt response.</p> <p>Observation and interview on 11/04/24 at 2:34 P.M. revealed Resident #62 call light was laying on the floor behind her wheelchair. Resident #62 revealed she needed the CNA assigned to her for help. Resident #62 revealed she could not reach her call light.</p> <p>Observation and interview on 11/04/24 at 2:35 P.M. with CNA #889 revealed Resident #62's call light was out of reach. CNA #889 was observed picking up the call light and stated to Resident #62 Your call light was out of reach; you wouldn't be able to reach it. CNA #889 confirmed and verified the findings.</p> <p>3. Review of the medical record for Resident #31 revealed she was admitted to the facility on [DATE] with diagnoses including portal vein thrombosis, essential hypertension, and hyperlipidemia.</p> <p>Review of the physician orders revealed Resident #31 had an order dated 06/03/24 for transfer assist of two staff with hoyer.</p> <p>Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #31 had a memory problem, dependent on staff for care, and was severely impaired regarding task of daily life.</p> <p>Review of the care plan dated 09/26/24 for Resident #31 revealed an activities of daily living (ADL) self-care performance deficit related to limited mobility, deconditioning and was at risk for falls. Interventions included ensuring the call light was within reach, hands-on assistance and the use of a mechanical hoyer lift with two staff.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 11/04/24 at 3:44 P.M. revealed Resident #31 was observed from the hall, laying in bed. The call light was wrapped around the bedrail and was hanging low to the floor and out of reach.</p> <p>Observation and interview on 11/04/24 at 3:44 P.M. with Licensed Practical Nurse (LPN) #710 revealed Resident #31 required assistance from staff for all care and call light was to remain in reach at all times. LPN #710 revealed Resident #31 was unable to engage in conversation and staff were to complete rounds to ensure safety. LPN #710 confirmed and verified Resident #31 call light was not within reach.</p> <p>Review of the resident council meeting minutes dated 08/21/24 revealed an identified concern by Resident #86 related to long call lights on the weekends.</p> <p>Review of the concern log dated 09/30/24 revealed an identified concern by Resident #17 related to call lights.</p> <p>Review of the facility document titled Call Lights: Accessibility and Timely Response reviewed 04/01/22, revealed the facility had a policy in place to ensure the facility was adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Review of the policy revealed call lights would be directly relayed to a staff member or centralized location to ensure an appropriate response and staff would ensure the call light was within reach of resident and secured, as needed. Further review of the policy revealed a procedure was in place that required staff to answer a call light, turn off the signal and respond accordingly, and if assistance was needed, keep the call light on until help arrived.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00158808 and Complaint Number OH00158488.</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34297</p> <p>Based on record review and interview, the facility failed to timely notify Resident #146's physician or nurse practitioner (NP) regarding the resident's decreased oral intake. This affected one resident (#146) of three residents reviewed for notification of change. The facility census was 136.</p> <p>Findings include:</p> <p>Review of Resident #146's medical record revealed the resident was admitted on [DATE] and discharged on [DATE] with diagnoses including cerebral infarction, unspecified dementia, hypothyroidism and major depressive disorder.</p> <p>Review of Resident #146's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited severe cognitive impairment; the resident had not had a weight loss or weight gain.</p> <p>Review of Resident #146's weight tracking form revealed on 05/02/24 the resident weighed 147.8 pounds in a wheelchair and on 09/05/24 the resident weighed 148 pounds in a wheelchair.</p> <p>Review of Resident #146's physician orders revealed an order dated 04/24/24 (discontinued 05/20/24) for a no concentrated carbohydrates diet, mechanical soft texture with a thin liquid consistency.</p> <p>Review of Resident #146's Documentation Survey Report (nurse aide tracking form) from 09/01/24 to 09/20/24 revealed 45 entries were documented and the resident consumed 25% of eleven meals, 50% of ten meals, 75% of fifteen meals, 100% of no meals and refused nine meals. The documentation on the report form indicated on 09/16/24 the resident refused the breakfast, lunch and dinner meal and on 09/17/24 the resident refused the breakfast meal for a total of four meals at 25% or less consumed. The documentation from 09/16/24 for breakfast, lunch and dinner and 09/17/24 for breakfast revealed the resident refused fluids.</p> <p>Review of Resident #146's physician orders revealed an order dated 05/20/24 (discontinued 09/26/24) for a no concentrated carbohydrates diet, regular texture, thin liquids consistency.</p> <p>Review of Resident #146's Functional Abilities and Goals assessment dated [DATE] revealed the resident had no impairment on the upper extremity (shoulder, elbow, wrist, hand) and required setup or clean-up assistance to use suitable utensils to bring food and/or liquids to the mouth and swallow food and/or liquid once the meal was placed in front of the resident.</p> <p>Review of Resident #146's Nutrition Assessment form dated 08/17/24 revealed the resident was on a no concentrated sweets regular thin liquids diet and the snacking preference was cookies. The resident was independent with eating.</p> <p>Review of Resident #146's physician orders revealed an order dated 09/16/24 (discontinued 09/20/24) for a no concentrated carbohydrates diet, mechanical soft texture with a thin liquid consistency.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #146's progress note dated 09/16/24 at 9:39 A.M. revealed the resident consumed soft foods effectively and the resident's diet was downgraded to mechanical soft and ground meats.</p> <p>Review of Resident #146's progress note dated 09/16/24 at 2:04 P.M. revealed the resident consumed 25% of breakfast and lunch and consumed a total of 480 ml (milliliters) of fluids with breakfast and lunch.</p> <p>Review of Resident #146's progress note dated 09/16/24 at 2:06 P.M. revealed to continue to encourage the resident's fluid intake.</p> <p>Review of Resident #146's progress note dated 09/16/24 at 6:21 P.M. revealed the resident consumed two bowls of fruit and 360 ml of water.</p> <p>Resident #146's medical record and progress notes did not have documentation for the breakfast meal on 09/17/24 except the resident refused the meal and fluids.</p> <p>Review of Resident #146's progress notes did not reveal evidence the physician/NP were notified of Resident #146's decreased oral intake which included 25% for the breakfast, lunch and dinner meals on 09/16/24 with a total of 840 ml of fluids (for all three meals) and no fluids or food consumed for the breakfast meal on 09/17/24 as evidenced by the documentation in the medical record.</p> <p>Review of Resident #146's Multidisciplinary Care Conference form dated 09/17/24 at 3:30 P.M. (with the resident's nephew by phone) revealed the facility was working on the resident's hands to get them less tight using a splint for the lower tightness and the resident was now a feed for all meals. A conversation was held discussing hospice services.</p> <p>Review of Resident #146's medical record and progress note dated 09/19/24 at 6:27 P.M. revealed the resident did not eat her dinner and refused to open her mouth. Staff would continue to monitor.</p> <p>Review of Resident #146's speech therapy (ST) Discharge Summary form dated 09/19/24 revealed the resident was discharged from ST due to hospitalization . The form indicated instruction was provided to the resident and primary caregivers in cognitive-communicative strategies and functional memory techniques in order to facilitate improved functional abilities, increase safety and decrease need for assistance and prevent decline from current level of skill performance with carryover demonstrated.</p> <p>Review of Resident #146's physician orders revealed an order dated 09/20/24 for a pureed food diet with regular thin liquids.</p> <p>Interview on 1/05/24 at 9:26 A.M. with NP #897 revealed she was notified of Resident #146's change in condition on 09/19/24. She confirmed she was in the building on 09/17/24 and staff did not notify her of concerns in Resident #146's care.</p> <p>Interview on 11/06/24 at 11:43 A.M. with the Administrator confirmed the documentation revealed Resident #146 refused the breakfast meal on 09/17/24. The Administrator indicated she had only refused one meal in sequence but consumed 25% of the breakfast, lunch and dinner on 09/16/24 for a total of four meals at 25% or less consumed.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 11/06/24 at 11:56 P.M. with the Administrator and Director of Nursing (DON) confirmed Resident #146's son was aware of the resident's poor appetite. The Administrator and DON indicated the resident had consumed 840 ml fluids between 09/16/24 for breakfast, lunch and dinner and 09/17/24 for the breakfast meal and stated the NP was made aware of the resident's poor appetite on 09/19/24.</p> <p>Interview on 11/06/24 at 12:22 P.M. with the Administrator indicated on 9/17/24 occupational therapy (OT) worked with the resident.</p> <p>Interviews on 11/06/24 at 12:29 P.M. with OT #899 and Physical Therapy Assist (PTA)/Rehab Director #900 confirmed OT #899 assisted Resident #146 with the lunch meal on 09/17/24 and she had consumed approximately 25% to 50% of her meal. She stated the resident was a maximum assist with meals and she did have increased pocketing and needed more cues for swallowing.</p> <p>Review of the Notification of Changes policy revised 09/30/22 revealed the purpose of the policy was to ensure the facility promptly informed the resident, consults the resident's physician; and notifies the resident's representative of a change requiring notification.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00158595.</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>42730</p> <p>Based on record review, staff interviews and review of the employee handbook, the facility failed to ensure staff did not neglect resident care due to staff sleeping while on duty. This had the potential to affect all twenty-two residents (#3, #12, #14, #15, #20, #34, #43, #46, #51, #53, #55, #57, #64, #70, #79, #116, #119, #123, #124, #128, #131, #134) residing on the 500-Hall and had the potential to affect all twenty-three residents (#8, #9, #16, #17, #26, #31, #39, #47, #58, #59, #68, #72, #80, #85, #86, #88, #97, #103, #106, #117, #125, #127, #133,) residing on the 800-Hall. The facility census was 136.</p> <p>Findings include:</p> <p>Review of the resident council meeting minutes dated 09/25/24 revealed an identified concern by Resident #17 regarding staff sleeping outside of his room with blankets. Resident #17 resided on the 800-Hall.</p> <p>Review of the facility Employee Handbook effective 05/01/16 revealed the facility had in place requirements of its staff to promote efficiency, productivity, and cooperation. Review of the handbook, page 28 and 29, revealed prohibited actions that would result in disciplinary actions up to and including termination of employment, including sleeping on duty.</p> <p>Review of email correspondence on 11/06/24 at 10:24 A.M. from the Administrator revealed a termination form dated 11/05/24 for Certified Nursing Assistant (CNA) #844 indicating she was terminated after receiving three previous disciplinary actions related to work performance. Review of the termination form revealed CNA #844 was noted to be sleeping on her hallway during the 11/04/24 shift and witnessed by the charge nurse.</p> <p>Interview on 11/04/24 at 8:34 A.M. with Resident #109 revealed staff slept during the night shift and even in their cars. Resident #109 revealed staff informed her that they went to their cars to sleep and would set their alarms to 6:00 A.M. to ensure they entered the building prior to shift change. Resident #109 revealed due to staff sleeping, she went without care for up to an hour at times.</p> <p>Interview on 11/05/24 at 6:04 A.M. with Licensed Practical Nurse (LPN) #806 revealed there were four CNA and one nurse for the 500-Hall and 800-Hall. LPN #806 revealed she caught CNA #722 asleep on the 800-Hall in a chair. LPN #806 verified the finding and appeared upset and stated, I don't work under these circumstance or conditions and all staff need to be prepared to handle their business. LPN #806 revealed she would alert the administration staff of her concerns.</p> <p>Observation and interview on 11/05/24 at 6:08 A.M. with CNA #722 revealed she was aware of the facility policy regarding sleeping on duty as it was listed in the employee handbook. When asked if she was caught sleeping by LPN #806, CNA #722 rolled her eyes in an upward direction indicating annoyance. CNA #722 stated she did not go to sleep on duty.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365926	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/06/2024
NAME OF PROVIDER OR SUPPLIER Normandy Manor of Rocky River		STREET ADDRESS, CITY, STATE, ZIP CODE 22709 Lake Rd Rocky River, OH 44116	
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of the facility document titled Abuse, Neglect and Exploitation reviewed 10/01/22, revealed the facility had a policy in place to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent neglect. Review of the policy revealed neglect included but not limited to failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Review of the document revealed the facility did not implement policy.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00158488.</p>		