STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366045	A. Building B. Wing	10/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jennings Hall	10204 Granger Road Garfield Heights, OH 44125

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview and facility policy review, the facility failed to ensure Resident #74 was treated with respect and dignity. This affected one resident (#74) out of three residents reviewed for respect and dignity. The facility census was 168. Findings include:Review of the medical record revealed Resident #74 was admitted to the facility on [DATE] with diagnoses including transient cerebral ischemic attack, heart failure, atrial fibrillation, hypertension, obstructive sleep apnea, peripheral autonomic neuropathy, anxiety disorder, abnormalities of gait and mobility, dysphagia, insomnia, muscle weakness, essential tremor, and foot drop. Review of the Minimum Data Set (MDS) 3.0 quarterly assessment revealed Resident #74 a Brief Interview of Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. Interview on 10/16/25 at 11:51 A.M. with Resident #74's responsible party revealed that during review of video camera footage placed in Resident 74's room, she observed staff telling Resident #74 she was fat. Resident #74's responsible party reported the incident to the facility's administration for further investigation. Observation on 10/21/25 at 11:20 A.M. of video submission dated 08/08/25 with the Administrator, the Chief Nursing Officer and Director of Nursing (DON) #303 revealed Care Partner (CP) #495 was alone in Resident #74's room and stated, Are you alright Big Mama? Interview on 10/21/25 at 11:55 A.M. with DON #303 revealed CP #495 was counseled in the past not to use derogatory terms when caring for Resident #74. Interview on 10/21/25 at 1:20 P.M., Resident #74 stated she felt sometimes staff could be mean to her. Interview on 10/21/25 at 1:23 P.M. with CP #495 revealed she made a statement to Resident #74 that she was thick but did not have an offensive intention. CP #495 stated DON #303 counseled her not to use terms that would offend a resident. Interview on 10/21/25 at 2:13 P.M. with DON #303 revealed CP #495 had used the term Big Mama to Resident #74, and Resident #74 felt offended with the term and felt disrespected. Review of a facility document dated 05/19/25 revealed CP #495 was disciplined and counseled not to use verbally abusive language to residents prior to the 08/08/25 incident. Review of the facility policy titled Residents' Rights, dated 06/12/18, revealed residents would be free from discrimination and reprisal from the facility in exercising their rights. This deficiency represents non-compliance investigated under Complaint Number 2642861.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not require residents to give up Medicare or Medicaid benefits, or pay privately as a condition of admission; and must tell residents what care they do not provide. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and review of the facility policy, the facility failed to ensure admission paperwork was signed as required. This affected one resident (#74) of three residents reviewed for admission. The facility census was 168. Findings include:Review of the medical record revealed Resident #74 was admitted to the facility on [DATE] with diagnoses including transient cerebral ischemic attack, heart failure, atrial fibrillation, hypertension, obstructive sleep apnea, peripheral autonomic neuropathy, anxiety disorder, abnormalities of gait and mobility, dysphagia, insomnia, muscle weakness, essential tremor, foot drop. Review of the Minimum Data Set (MDS) 3.0 quarterly assessment revealed Resident #74 had a Brief Interview of Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. Interview on 10/16/25 at 11:00 A.M. with Resident #74's responsible party revealed she was concerned because the facility had called her stating they did not have Resident #74's admission paperwork, and she was told she needed to fill out the admission paperwork again. Review of the admission packet provided by the Administrator on 10/20/25 for new admission residents, revealed the admission Agreement, assignment of benefits, authorization of representative, resident personal funds, suite hold and leave of absence, authorization for professional services, special financial Power of Attorney (POA), release of information to the facility and from the facility, information consent form, photo consent form, mail authorization form, contact information form, and organizational practices. The Administrator was unable to produce a signed copy of Resident #74's admission Agreement. On 10/20/25 at 9:37 A.M. an interview with the Administrator verified Resident #74's admission paperwork was not signed and should be completed at the time of admission. The Administrator stated when the facility performed audits of admission Agreements, they discovered Resident #74 did not have a signed admission Agreement. The facility had reached out to Resident #74's responsible party inquiring if she had a copy of the admission Agreement. The Administrator stated Resident #74's admission Agreement was not lost; it was not done. Interview on 10/20/25 at 4:04 P.M. with Resident #74's responsible party revealed the facility had contacted her to sign the facility admission Agreement because the facility admissions coordinator did not generate the document for her. Review of the facility's policy titled Admissions, dated 03/24/16, revealed and admission team met periodically as needed. Completed applications were reviewed to determine if the facility could properly serve the applicant. An application was deemed completed and ready for review by the admission team when it contained the completed admission application including completed financial disclosure, a completed pre-admission physical or medical transfer and copies of applicant's social security card, Medicare card and copies of all secondary medical insurance. This deficiency represents non-compliance investigated under Complaint Number 2642861.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview and facility policy review, the facility failed to ensure staff provided Resident #74 with the appropriate level of assistance to ensure a safe transfer and bed mobility. This affected one resident (#74) of three residents reviewed or transfers and bed mobility and had the potential to affect 60 residents (#15, #109, #95, #66, #82, #157, #78, #165, #162, #153, #87, #154, #124, #123, #143, #53, #42, #116, #27, #29, #49, #69, #125, #32, #93, #47, #25, #110, #104, #155, #89, #108, #99, #40, #112, #51, #14, #16, #57, #37, #71, #128, #76, #34, #120, #161, #156, #13, #60, #94, #115, #113, #126, #160, #15, #115, #113, #126, #160, and #24) identified by the facility as dependent on staff for transfers from bed to chair and 20 residents (#66, #82, #122, #153, #157, #165, #51, #104, #156, #15, #63, #113, #115, #126, #160, #32, #125, #150, #27, and #80) residents identified by the facility as dependent on staff to roll left and right in bed. The facility census was 168. Findings include:Review of the medical record revealed Resident #74 was admitted to the facility on [DATE] with diagnoses including transient cerebral ischemic attack, heart failure, atrial fibrillation, hypertension, peripheral autonomic neuropathy, anxiety disorder, abnormalities of gait and mobility, dysphagia, insomnia, muscle weakness, tremor, and foot drop. Review of the care plan initiated on 05/15/25 revealed Resident #74 was at risk for falls related to deconditioning, gait and balance problems and tremors. Goals included Resident #74 would be free from falls, Resident #74 would be free from minor injury, and Resident #74 would not sustain serious injury. Interventions included anticipating the needs of Resident #74, Resident #74 needed prompt response to all requests for assistance, encouraging Resident #74 to participate in activities that promote exercise for physical strengthening and improved mobility, and physical therapy (PT) to evaluate and treat as ordered and as needed. Review of the health status note dated 06/07/25 at 10:50 A.M. written by Registered Nurse (RN) #308 revealed Resident #74 stated her arm was extended too far in the Hoyer (mechanical) lift last night. The care partner stated Resident #74's arm was not extended, and Resident #74 complained of pain to that left arm. RN #308 assessed Resident #74's skin, and if the pain did not get better, RN #308 would call the doctor. Review of the health status note dated 06/08/25 at 8:38 A.M. written by RN #308 revealed Resident #74 stated her shoulder hurt. RN #308 reported the pain to the nurse practitioner (NP). Review of the PT discharge summary electronically signed on 06/09/25 at 4:11 P.M., revealed the dates of service were 05/13/25 to 06/09/25. Resident #74's highest practical level was achieved. Resident #74 was baseline dependent on staff to roll from lying back to left and right and PT did not attempt to assist using log rolling techniques due to medical conditions or safety concerns. Resident #74's discharge mobility consisted of dependent on staff for chair to bed or chair transfers. PT recommendation consisted of mechanical sling lift bed to wheelchair transfers. Review of the physician visit note dated 06/12/25 written by NP #583 revealed Resident #74 was seen as a follow up for left shoulder pain. Pain was present in the left humerus. Resident #74 stated she was in pain since they Hoyered her. Pain was present for the last five days. There was no improvement with pain. The incident occurred more than two days ago, and the left shoulder was affected. The pain severity of five on a zero to ten pain scale, ten being the worst pain. The pain was moderate and had been intermittent since the injury. Resident #74 had no other injuries or history of shoulder surgery. The plan was a left humerus x-ray per order. Review of physician visit note dated 06/13/25 at 1:30 P.M. written by NP #583, revealed an x-ray was completed and unremarkable. The results were reviewed with Resident #74 and her daughter. A lidocaine patch (pain relieving patch) was ordered, and Resident #74 was given Tylenol (analgesic) for pain. Review of the occupational therapy (OT) discharge summary electronically signed on 06/26/25 at 9:22 A.M., revealed the dates of service were 05/12/25 to 06/19/25. Resident #74's goal was met on 06/19/25 to increase ability to tolerate ceiling lift transfers with no complaints of pain or discomfort. Resident #74's baseline was trialed with various slings to increase comfort during transfers. The discharge summary revealed Resident #74 tolerated a full sling during transfers. Review of the health status note dated 08/08/25 at 1:53 P.M. written by RN #308 revealed Resident #74 reported she was smashed on the left side of the face while being turned in bed this morning. The care partner reported her glasses touched Resident #74's face, but Resident #74 now stated it felt like she was hit with a bowling ball in the face. No redness or bruising were noted. Reported to the Director of Nursing (DON) and NP. The NP assessed Resident #74 resulting in no new skin issues. (There was only one staff member in the room at the time of the incident). Review of the physician visit note dated 08/08/25 at 10:27 P.M. written by NP #583 revealed Resident #74

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and interview, the facility failed to ensure medications were secured until consumed by residents. This affected one resident (#87) of 25 residents (#28, #42, #52, #53, #56, #64, #75, #84, #87, #114, #116, #117, #122, #124, #127, #132, #139, #142, #146, #153, #154, #162, #165, #166, and #167) residing on the Main Level [NAME] Unit. The facility census was 168. Findings include:Review of the medical record for Resident #87 revealed an admission date of 12/12/24 with diagnoses including type two diabetes mellitus, primary generalized osteoarthritis, and chronic diastolic heart failure. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #87 had intact cognition. Interview on 10/16/25 at 9:11 A.M. noted Resident #87 sitting at a table in the dining room. Interview with the resident revealed no concerns; however, further observations revealed a medication cup sitting on the table filled with 19 medications. No medications were controlled medications. Interview on 10/16/25 at 9:13 A.M., the Director of Nursing (DON) observed the medication cup filled with medications. The DON then stated, this is wrong to have the medications sitting on the table without staff. The facility was unable to provide a policy related to ensuring medications were consumed by residents. This deficiency represents non-compliance investigated under Complaint Number 2642861.