

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366045	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/12/2024
NAME OF PROVIDER OR SUPPLIER Jennings Hall		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>26706</p> <p>Based on record review and interview, the facility failed to ensure comprehensive discharge assessments were completed at discharge. This affected two (Resident's #27 and #162) of 38 residents reviewed. The facility census was 169.</p> <p>Findings include</p> <p>1. Review of Resident #27's medical record revealed a 03/15/24 admitted with diagnoses including hyperlipidemia, dementia and malnutrition.</p> <p>Review of the Minimum Data Set (MDS) 3.0 Assessments revealed an Admission MDS was completed 03/28/24. There was no evidence of a subsequent MDS.</p> <p>Review of the nurse notes included the resident discharged home with family 04/16/24.</p> <p>Interview 09/12/24 at 10:05 A.M. with Licensed Practical Nurse (LPN) #659 verified the facility failed to submit a discharge MDS Assessment. LPN #659 included it was human error.</p> <p>On 09/12/24 at 4:07 P.M. the Administrator emailed the facility did not have a discharge MDS policy.</p> <p>2. Review of Resident #162's medical record revealed a 12/18/22 admission with diagnoses including renal insufficiency, dementia, and arthritis.</p> <p>Review of the MDS 3.0 Assessments revealed a Quarterly MDS was completed 04/04/24. There was no evidence of a subsequent MDS.</p> <p>Review of the nurse notes included the resident discharged home with family 04/16/24.</p> <p>Interview 09/12/24 at 10:05 A.M. with Licensed Practical Nurse (LPN) #659 verified the facility failed to submit a discharge MDS Assessment. LPN #659 included it was human error.</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 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37095</p> <p>Based on observation, record review, and interview, the facility failed to provide nutritional care and services consistent with Resident #88's assessed needs for eating meals to maintain nutritional status. This affected one resident (#88) of three residents reviewed for nutrition. The census was 169.</p> <p>Findings include:</p> <p>Record review of Resident #88 revealed she was admitted [DATE] and had diagnoses including glaucoma, unspecified visual loss, and unspecified protein-calorie malnutrition. An order dated 09/05/24 called for her to receive a divided dish with meals. Her dietician assessment dated [DATE] revealed she had symptoms of possible swallowing disorder including residual food in the mouth after meals and coughing or choking during meals.</p> <p>Record review of therapy documentation for Resident #88 revealed on 08/21/24 they trialed use of a divided dish to improve her independence with meals. A note on 08/21/24 revealed staff did not provide sufficient cueing for the resident, and a note on 09/02/24 revealed the resident's caregiver did not know she had vision difficulties. The resident demonstrated memory impairment. The divided plate was noted to have a positive impact on her ability to scoop food and locate food items. She was discharged from occupational therapy on 09/02/24 with a recommendation of supervision or touching assistance and a divided dish for all meals.</p> <p>Observation on 09/09/24 at 9:55 A.M. revealed Resident #88 was in bed eating breakfast. Her head was positioned at approximately a 30 degree incline and she had no fluids within reach. The breakfast was served on a normal plate. A sign behind her back noted she was on strict reflux precautions and was to be upright for all meals. Another sign labeled swallowing precautions noted she was to alternate liquids and solids when eating and sit up as close to 90 degrees as possible. She had some small coughing while eating.</p> <p>Interview with Resident #88 on 09/09/24 at 9:55 A.M. revealed she was waiting for something to drink. She said her head of bed should be higher when eating, and independently used the control to raise the head of the bed when the surveyor questioned if she was comfortable. She said it was sometimes hard to get enough to drink. She had poor eyesight and required setup assistance for eating. She denied knowledge of any need for assistive devices such as a divided plate. She did not recall anyone teaching her to sit up for meals or alternate food and liquids to assist swallowing.</p> <p>Observation on 09/09/24 at 10:04 A.M. revealed an aide entered the room and gave Resident #88 a small glass of juice. The resident drank the glass quickly over the course of the surveyor interview and asked the surveyor to get her more to drink.</p> <p>Interview with Registered Nurse #780 on 09/09/24 at 10:17 A.M. confirmed the above findings.</p> <p>Interview with Speech Therapist #793 on 09/10/24 at 10:37 A.M. revealed Resident #88 was referred to her service after weight loss. The resident was to be sitting up at least 45 degrees and ideally 90 degrees during meals. The resident needed setup assistance mostly due to vision problems.</p> <p>(continued on next page)</p>		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Dietician #724 on 09/10/24 at 2:42 P.M. revealed she was not involved in the decision to place Resident #88 on a divided dish. To her knowledge it was only put in place around 09/09/24, because she did not see the resident using a divided dish until recently.		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>45442</p> <p>Based on observation, interview and facility policy review, the facility failed to ensure food was prepared and served under sanitary conditions. This affected all 164 residents receiving meals from the kitchen, as the facility identified five residents (#10, #13, #38, #71 and #359) who did not consume meals by mouth. The facility census was 169.</p> <p>Findings include:</p> <p>Observation on 09/09/24 at 10:13 A.M. with Dietary Manager (DM) #642 during the initial kitchen tour revealed DM #642 had a full facial beard from ear to ear approximately one-inch long hair growth and was not wearing a beard net while working in the kitchen. DM #642 confirmed he was not wearing a beard net and should have been.</p> <p>Observation on 09/09/24 at 10:35 A.M. of DM #642 testing the level of quaternary sanitizer with a test strip for the three compartment sink revealed when he dipped the strip into the sanitizer water the strip did not change color. DM #642 confirmed the test strip did not change color so there was not an appropriate amount of sanitizer in the water to sanitize dishes. DM #642 was unable to provide evidence of the past month chemical testing logs.</p> <p>Observation on 09/10/24 at 3:56 P.M. of DM #642 revealed he continued to have a full facial beard approximately one inch in hair length and was not wearing a beard net while working in the kitchen. Dietary Manager #64 confirmed he did not have a beard net on.</p> <p>Observation on 09/11/24 at 12:35 P.M. of [NAME] #707 serving the resident lunch meal revealed he reached to get something out of the cabinet behind him using his gloved hand and then proceeded to use the same gloved hand to grab a handful of lettuce out of the lettuce container for a resident taco salad meal. Interview at the time of the observation with [NAME] #707 confirmed he used his gloved hand to open the cabinet door behind him to reach for an item out of the cabinet and then proceeded to grab lettuce for the resident meal and had not washed his hands or changed gloves in between time. [NAME] #707 confirmed he did not have a serving utensil for the lettuce and went back to the kitchen to get one. [NAME] #707 returned with the appropriate size serving spoon for the lettuce at 12:45 P.M. and meal service resumed.</p> <p>Interview on 09/11/24 at 1:05 P.M. with Dietitian #724 confirmed [NAME] #707 should have used a serving spoon to prevent any chance of sanitation concern and should not have used his hands.</p> <p>Review of the facility policy dated May 2018 called Culinary Services revealed culinary services will function according to the regulations established by the Ohio Department of Health.</p> <p>Interview on 09/12/24 at 1:12 P.M. with the Administrator confirmed the facility policy called; Culinary Services did not address specifics about hand washing procedures for the kitchen or when hair and beard nets were needed and stated they were unable to find a policy that addressed those concerns.</p>		