

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  366057	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/04/2024
NAME OF PROVIDER OR SUPPLIER  Middleburg Heights Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 19530 Bagley Road Middleburg Heights, OH 44130	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42730</p> <p>Based on record reviews, observations, resident interviews, staff interviews, and facility policy review, the facility failed to ensure residents were treated with dignity. This affected two (#20 and #55) of three residents reviewed for resident rights. The facility census was 64.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #20 revealed she admitted to the facility on [DATE] with diagnoses including orthopedic aftercare following surgical amputation and type II diabetes mellitus.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #20 was alert and oriented with cognition impairment. Resident #20 was dependent on staff for activities of daily living (ADLs).</p> <p>Observation and interview on 11/24/24 at 8:35 A.M. revealed Resident #20's call light was activated and Resident #20 was lying in bed wearing a gown with a foul odor coming from the room noticeably from the hallway. Resident #20 was observed covered in a brown-colored muddy consistency substance located on her bilateral lower extremities, stomach, chest, across her neck, under her chin and covered her gown and bed sheets. Resident #20 was observed yelling from her bed stating she had pressed her call light. She has been like this forever and felt nasty. Resident #21 stated there have been no staff in to check on her, her roommate was on the other side, and her door was wide open.</p> <p>Interview and observation on 11/24/24 at 8:37 A.M. with Registered Nurse (RN) #348, who was standing approximately 50 feet away from Resident #20's room, revealed he seen Resident #20 call light activated but he was not covering the hall on which she resided. RN #348 stated Resident #20 was the responsibility of the other assigned staff. RN #348 confirmed and verified Resident #20 was covered, in what he identified as feces and/or stool, and walked away stating I have to finish med pass.</p> <p>Interview on 11/24/24 at 8:39 A.M. with Certified Nursing Assistant (CNA) #334 revealed she was passing breakfast trays and did not smell Resident #20 as she passed trays, therefore she did not stop to answer her call light. CNA #334 revealed when she provided Resident #20 with her breakfast tray, she was clean and dry but could not identify how much time had passed since. CNA #334 verified Resident #20 was covered in feces and required assistance from staff for ADLs.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 11/25/24 at 4:23 P.M. with Licensed Practical Nurse (LPN) #332 stated Resident #20 was a total care for ADLs from staff, was incontinent of bowel and bladder, and required to be checked by staff often, aside from the typical two-hour interval checks.</p> <p>Review of the facility document titled Dignity dated 09/21/23 revealed the facility had a policy in place that each resident would be cared for in a manner that promoted and enhanced his or her sense of well-being, level of satisfaction with life, feeling of self-worth, and self-esteem. The facility would promptly respond to a resident's request for assistance.</p> <p>42011</p> <p>2. Record review for Resident #55 revealed an admitted [DATE]. Diagnosis included chronic obstructive pulmonary disease, unsteadiness on feet, and muscle weakness.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #55 was cognitively intact. Resident #55 used a walker for mobility and required set up or clean up assist for meals. Resident #55 was occasionally incontinent of urine and required partial moderate assistance for toileting, hygiene, and substantial/maximum assistants for personal hygiene.</p> <p>Observation on 11/24/24 at 8:56 A.M. revealed Resident #55 was sitting on the edge of his bed still wearing a t-shirt and brief. Resident #55's bedside table was in front of him. Resident #55's breakfast tray was on top of the bedside table. The food on the breakfast tray was consumed. Resident #55 confirmed he ate 100% of his breakfast. Resident #55 stated he was not doing well, he was soak and wet with urine running down his leg. Observation revealed Resident #55's brief was bulging. The sheet under Resident #55 was saturated with urine. There was a strong odor of urine surrounding Resident #55. Resident #55 could be seen by passing staff and visitors in the hall. Resident #55 stated, I have to wait until after breakfast to get changed. A liquid substance was puddled on the floor under Resident #55's brief.</p> <p>Interview on 11/24/24 at 8:59 A.M. with Certified Nursing Assistant (CNA) #337 revealed she just arrived at work two hours late, and everyone knows the staff can't change them until after the meal.</p> <p>Interview on 11/24/24 at 9:01 A.M. with CNA #429 stated Resident #55 told her he needed changed but they have to pass meals, there were several resident that have to wait. She stated she was instructed here if residents need changed or have to use bathroom, they have to wait until after the meal.</p> <p>Interview on 11/24/24 at 9:04 A.M. with CNA #353 stated the staff cannot assist residents to the bathroom or change them during meals or when passing trays. CNA #353 stated that was taught in school, they never do that, and the residents need to wait.</p> <p>Observation on 11/24/24 at 9:06 A.M. with CNA #429 confirmed Resident #55 could be seen sitting in his brief from the hall. CNA #429 confirmed Resident #55 had a foul urine odor, his brief was bulging, there was urine on the sheet, down the front of the sheet, and on the pad Resident #55 was sitting on.</p> <p>Interview on 11/26/24 at 10:27 A.M. with the Director of Nursing (DON) stated her expectations during meal time was if a resident needed changed or to use the bathroom, the CNA would stop passing trays and change the resident.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 11/26/24 at 10:32 A.M. with Regional Clinical Service Director #427 stated staff should provide incontinence care at the time the resident was incontinent and this was to treat the resident with dignity and not make them wait until after a meal.</p> <p>Interview on 11/26/24 at 10:47 A.M. with Resident #55 stated when he has to eat his meal when he was incontinent, it makes him feel bad, real bad, it happens way too often, and it was not right.</p> <p>Review of the facility document titled Dignity dated 09/21/23, revealed the facility had a policy in place that each resident would be cared for in a manner that promoted and enhanced his or her sense of well-being, level of satisfaction with life, feeling of self-worth, and self-esteem. The facility would promptly respond to a residents request for assistance and promote, maintain, and protect resident privacy, including bodily privacy during assistants with personal care and during treatment procedures.</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42730</p> <p>Based on record review, observations, resident interview, staff interview, and facility policy review, the facility failed to ensure residents were able to make choices pertaining to their personal preferences. This affected one (#268) of one resident reviewed for choices. The facility census was 64.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #268 revealed he was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease with acute exacerbation, dementia, and type II diabetes mellitus.</p> <p>Review of the Brief Interview for Mental Status (BIMS) assessment dated [DATE] revealed Resident #268 had a BIMS score of five which indicated he had severe cognition impairment.</p> <p>Review of the care plan dated 11/20/24 revealed Resident #268 had an activities of daily living (ADL) self-care performance deficit. Interventions included assisting the resident with ADLs.</p> <p>Observation and interview on 11/24/24 at 10:08 A.M. revealed Resident #268 was sitting in his wheelchair ambulating near the nurse's station located adjacent to the 400-hall. Resident #268 was observed yelling I want to be put back in bed. Resident #268 stated he had gotten up too early and he wanted to be put back in bed. Resident #268 stated staff told him he could not get back in bed until 11:00 A.M. because it was too early to lay back down.</p> <p>Observation and interview on 11/24/24 at 10:09 A.M. revealed Certified Nurse Assistant (CNA) #337 and #367 sitting at the nurse's station located adjacent to the 400-hall. CNAs #337 and #367 were observed reviewing staffing assignment sheets. CNA #337 stated Resident #268 had to wait to be put back in bed until staff figured out individual assignments and she could not provide a time in which it would occur. CNA #337 confirmed and verified Resident #268 was not able to be put back into bed at his request.</p> <p>Review of the facility document titled Dignity dated 09/21/23, revealed the facility had a policy in place that each resident would be cared for in a manner that promoted and enhanced his or her sense of well-being, level of satisfaction with life, feeling of self-worth, and self-esteem. The facility would honor choices and preferences. Residents would be allowed to choose when to sleep.</p>		

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<p>F 0569</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38091</p> <p>Based on record review and staff interview, the facility failed to ensure resident funds were conveyed timely upon resident discharge from the facility. This affected one (Resident #118) of one residents reviewed for funds conveyance. The facility census was 65.</p> <p>Findings include:</p> <p>Resident #118 was admitted to the facility on [DATE]. Resident #118 expired at the facility on [DATE].</p> <p>Review of the business records for Resident #118 revealed a check for Resident #118's personal funds balance remaining at the facility in the amount \$1,134.54 was dispensed on [DATE] to Resident #118's family.</p> <p>Interview on [DATE] at 3:15 P.M. with Business Manager #304 verified Resident #118's funds were conveyed outside of required timeframe (30 days).</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51067</p> <p>Based on medical record review, staff interview, and facility policy review, the facility failed to ensure advanced directives were accurate and recorded in the resident's medical record. This affected one (Resident #169) of one resident reviewed for advanced directives. The facility census was 64.</p> <p>Findings include:</p> <p>Medical record review revealed Resident #169 was admitted to the facility on [DATE]. Diagnoses included end stage renal disease, peripheral vascular disease, and type II diabetes mellitus. His Brief Interview for Mental Status (BIMS) score was 15 dated 10/22/24 revealed Resident #169 was cognitively intact.</p> <p>Review of Resident #169's medical record revealed no advanced directives noted in his care plan or located on the physicians' orders. In his electronic medical records, there were no advanced directives noted which would indicate he was to be a full code, which meant all life safety measures would be used to keep him alive, even in the event of cardiac arrest.</p> <p>Interview with Licensed Practical Nurse (LPN) #332 on 11/26/24 at 8:58 A.M. verified there were no advanced directives in Resident #169's medical record. LPN #332 confirmed in the event should the resident experience cardiac arrest, she would treat Resident #169 as a full code without having an order for any other code status.</p> <p>Review of the Advanced Directives policy (revised June 2022) revealed the center's policy was to discuss with patients/residents their preferences for advanced directives. During the admission process, the patient/resident is given the chance to discuss their advanced directive preferences. The physician is notified of the resident's advanced directive wishes. The physician or designee completes updated code status paperwork/physician order as needed. All interactions with patient/ authorized representative regarding advanced directives will be communicated and documented in the patients' electronic medical record (EMR).</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42011</p> <p>Based on record review, staff interview, and review of the facility policy, the facility failed to ensure a baseline care plan was completed upon admission for a resident. This affected one (Resident #55) of six residents reviewed for baseline care plans. The facility census was 65.</p> <p>Findings include:</p> <p>Record review for Resident #55 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease and muscle weakness.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #55 was cognitively intact.</p> <p>There was no baseline care plan in Resident #55's medical record.</p> <p>Interview on 11/26/24 at 1:00 P.M. with Regional Clinical Service Director (RCSD) #427 verified Resident #55 did not have a baseline care plan completed in his medical record.</p> <p>Review of the facility policy titled Care Plan - Baseline dated 08/25/23 revealed it is the policy of the facility to develop a baseline plan of care to meet the resident's immediate health and safety needs for each resident within 48 hours of admission.</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide activities to meet all resident's needs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51067</p> <p>Based on record review, observations, volunteer interview, resident and family interview, and staff interview, the facility failed to provide the appropriate therapeutic activities as documented in the resident's care plan. This affected one (Resident #31) of one resident reviewed for activities. The facility census was 65.</p> <p>Findings include:</p> <p>Record review revealed Resident #31 was admitted to the facility on [DATE]. Her diagnoses included chronic kidney disease, major depression, anxiety, type II diabetes, and peripheral vascular disease. Her Brief Interview for Mental Status (BIMS) score was 15, dated 10/17/24, revealed Resident #31 was cognitively intact.</p> <p>Review of the care plan dated 12/12/23 revealed Resident #31 had an alteration in communication related to language barrier as she speaks no English, only Spanish. Her needs will be met by utilizing facility provided interpretation line, will be encouraged to engage in leisure preferences to promote socialization and provide physical and mental stimulation by being provided with a calendar of events monthly to inform resident/family, and staff of life enrichment programming, and Resident #31 will be provided with one-on-one programming.</p> <p>Observation and interview on 11/25/24 at 4:14 P.M. with Certified Nursing Assistant (CNA) #600 confirmed the activities calendar in Resident #31's room for the month of November 2024 was in English print.</p> <p>Interview and observation on 12/02/24 at 12:06 P.M. with Activities Director (AD) #300 stated volunteers visit with Resident #31 once weekly on Mondays, and there no other appropriate Spanish activities planned or carried out during the week for Resident #31. Housekeeping staff members provide bingo for one hour every other Sunday with a group of residents but there was no one-to-one interaction with Resident #31. AD #300 stated she attends care conferences of all residents, and she creates the monthly activity calendars.</p> <p>Interview and observation on 12/02/24 at 1:22 P.M. revealed there were two volunteers at Resident #31's bedside and were ending their visit with prayer. The two volunteers stated they visit with Resident #31 once weekly for 10 minutes and they agreed to translate with the resident. The volunteer stated Resident #31's remote control has been missing for approximately two weeks, and this was confirmed with Resident #31. Resident #31 stated she doesn't own a magnifying glass and prefers not to leave her room for activities.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Telephone interview on 12/02/24 at 1:31 P.M. with Resident #31's son and Resident #31 stated he agreed to assist with translation to the resident. The son confirmed the residents' television remote has been missing approximately one and a half weeks as that was the last time he visited and helped with staff to attempt to find remote control. He spoke with the nurse before he left regarding the television remote and nurse stated they would request a universal remote. Resident #31 stated she doesn't receive any daily visits from facility staff outside of the volunteers on Mondays. She received visits from staff only when providing ADL care. The son confirmed outside of volunteers and family he was not aware of any other emotional support being offered to the resident. Resident #31 stated a lady came into her room and attempted to leave a Spanish chronicle that she refused as she couldn't read it without a magnify glass.</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42011</p> <p>Based on observation, medical record review, hospital record review, review of the facility's fall investigation, resident interview, staff interview, and policy review, the facility failed to ensure Resident #34, who fell during staff care, was provided timely, adequate and necessary assessment/monitoring and care to treat a fracture and prevent discomfort and potentially additional injury. In addition, the facility failed to adequately and timely assess and report to the physician a change in Resident #41's eye condition to ensure timely and proper care was provided.</p> <p>Actual harm occurred on 10/17/24, when Resident #34 sustained a fall with injury during a physical therapy treatment that was not reported or immediately treated. At the time of the fall, Physical Therapy Assistant (PTA) #420 assisted Resident #34 back to a standing position, assured Resident #34 there was no serious injury, then assisted Resident #34 back to his chair. PTA #420 then obtained and placed an ice pack on the resident's injured left leg and encouraged Resident #34, who was in pain at that time, not to tell anyone about the fall or he (PTA #420) would be fired. PTA #420 failed to document or report the fall. An x-ray was ordered on 10/17/24 of the left leg due to swelling and complaints of pain but was not obtained until 10/18/24 at 3:20 P.M., after PTA #420 provided additional therapy services to the resident. The resident was subsequently diagnosed with a fractured leg which was not initially assessed until 10/19/24.</p> <p>This affected two residents (#34 and #41) of four residents reviewed for quality of care and treatment for change of condition. The facility census was 65.</p> <p>Findings include:</p> <p>1. Record review for Resident #34 revealed an admitted [DATE]. Diagnoses included abnormal coagulation profile, muscle weakness, unsteady on feet, fusion of spine, sacral and sacrococcygeal region, and acute embolism, thrombosis of deep veins of left upper extremity pyogenic arthritis and gout.</p> <p>Review of the Fall Risk - Evaluation dated 08/07/24 at 12:27 P.M., revealed Resident #34 was alert and oriented, had no falls in the last three months, had moderate/severe unsteadiness and required physical assistance.</p> <p>Review of the care plan dated 09/13/24 revealed Resident #34 was at risk for falls due to impaired balance/poor coordination and being unsteady on feet. Interventions included to provide assistance with transfer and ambulation as needed.</p> <p>Review of the progress note dated 10/14/24 at 4:09 A.M., completed by Registered Nurse (RN) Nurse Manager #349 revealed Resident #34 was skilled for pyogenic (painful infection caused by when a joint is invaded by an infectious agent) arthritis. Resident #34 received Physical Therapy (PT) due to unsteadiness on his feet. Resident #34 was alert and oriented times-four (person, place, time, and event). Resident #34 was pleasant and cooperative and had no complaints of pain or discomfort. Resident #34 required extensive assistance with activities of daily living (ADLs).</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Physical Therapy Treatment Encounter dated 10/17/24 electronically signed at 4:53 P.M. (untimed for the time of the actual treatment), by PTA #420, revealed the resident had precautions for fall risk. Therapy treatment was completed and documented. Response to treatment: Physical Therapy (PT) session completed with no concerns, or complications. Call light in reach upon exiting, and all infection control policies were followed per facility guidelines.</p> <p>Review of a nursing progress note dated 10/17/24 at 6:55 P.M., completed by Registered Nurse (RN) #350, documented Resident #34 complained of pain and swelling to the left (L) knee. The Certified Nurse Practitioner (CNP) was notified. Laboratory testing (Uric acid level) was ordered for A.M. as well as a two view L knee x-ray.</p> <p>Review of the Physical Therapy Treatment Encounter dated 10/18/24 electronically signed at 4:56 P.M. (untimed for the time of the actual treatment) by PTA #420, revealed precautions included fall risk. Therapy session completed and documented. Ice packs applied for 20 minutes duration on anterior aspect of left knee to reduce pain symptoms. Response to treatment: PT session completed with no concerns, or complications on this date. Call light left in reach of resident upon exiting, all infection control policies were followed per facility guidelines.</p> <p>Review of the progress noted for Resident #34 dated 10/18/24 at 7:57 P.M., completed by RN #350 revealed two view x-rays of the left knee completed. Results pending.</p> <p>Review of the progress note for Resident #34 dated 10/19/24 at 12:09 A.M., completed by Licensed Practical Nurse (LPN) #421 documented received call from (X-ray Company #422), fracture noted to the right (clarified left) proximal tibia. A new order was received to send (Resident #34) to the emergency room (ER).</p> <p>Review of the progress note for Resident #34 dated 10/19/24 at 12:17 A.M., completed by LPN #421 included informed (Resident #34) of abnormal x-ray result and that he needed to go to ER. Resident agreed and stated he would inform his wife.</p> <p>Review of the progress note for Resident #34 dated 10/19/24 at 12:56 A.M., completed by LPN #421 included 911 arrived at facility, Resident #34 was transferred to stretcher by 911. Resident stated to 911 I fell a few days ago in the doorway right here, my left leg hurts 9 out of 10. Emergent 911 verified to this nurse the right tibia had a fracture, this nurse reviewed x-ray report, and this x-ray was for right tibia.</p> <p>Review of the progress note for Resident #34 dated 10/19/24 at 12:57 A.M., completed by DON revealed a clarification: left tibia (fracture).</p> <p>Review of the progress note for Resident #34 dated 10/19/24 at 10:57 A.M., completed by LPN #332 documented Resident #34 returned to facility from Hospital #423. Resident #34 had a left tibial fracture. Resident #34 returned with a new script for Oxycodone five milligrams (mg) every six hours as needed for three days for pain. Resident #34 complained of pain to the left leg. Resident #34 was to keep the leg straight and elevated at all times.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Middleburg Heights Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  19530 Bagley Road Middleburg Heights, OH 44130	
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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the progress note for Resident #34 dated 10/19/24 at 1:39 P.M., completed by LPN #332, documented this nurse received in report today that the resident was sent out to hospital for leg pain. Resident #34 had stated that he had fallen while doing therapy. Resident #34 stated he was walking with the therapist when the therapist told him to stop because a piece had fallen off his chair and he had wanted to pick. Resident #34 stated when the therapist was doing this, resident's legs gave out and he fell. Resident #34 stated the therapist had picked him up off the floor and placed him into his wheelchair and gave him an ice pack. Resident #34 returned from Hospital #423 today 10/19/24 with a new diagnosis of left tibial fracture. Resident #34 had an immobilizer in place. Resident #34 was to keep left leg elevated as much as possible and needed to keep left leg as straight as possible.</p> <p>Review of the hospital discharge instructions from Hospital #423 with a visit date of 10/19/24 at 12:56 A.M., completed by Physician #424, documented the diagnosis was a nondisplaced fracture of proximal end of left tibia. (A tibial fracture is a break in the larger bone of your lower leg, this bone is also called the shin bone).</p> <p>Review of the Medication Administration Record (MAR) for Resident #34 revealed Oxycodone HCL five milligrams (mg) was administered on 10/19/24 at 1:00 P.M., for complaints of pain rated an eight on a scale of one to 10. The medication was documented as effective for pain. Further review of the MAR revealed Tylenol 325 mg two tablets were administered on 10/17/24 and 10/18/24 for complaints of pain rated a five, on 10/20/24 for pain rating of eight, and 10/21/24 for pain rating a nine.</p> <p>Review of the typed Facility Investigation form dated 10/21/24, (untimed), completed by Regional Director of Rehab Services #426, documented on Saturday, 10/19/24, the writer was made aware Resident #34 was sent out to the hospital on 10/19/24 and was found to have a tibia fracture. The DON reported (Resident #34) told her staff on 10/19/24 that he was working with PTA (#420) on Thursday, 10/17/24 and he fell during the therapy session. The patient (Resident #34) also told the nursing PTA #420 told him not to tell anyone about the fall. The Facility Investigation form included a phone interview with PTA #420, review of the progress notes including the x-ray results indicating a left proximal tibia fracture, statement from Certified Occupational Therapy Assistant (COTA) #428, Resident #34, and therapy notes. The last paragraph of the Facility Investigation completed by Regional Director of Rehab Services #426 dated 10/21/24, revealed this writer spoke to PTA #420 and informed him that his employment with the company was terminated effective immediately. Upon receipt of this information, PTA #420 confessed that the fall did happen with him and that he was scared to say anything because it was his first week there and he tried to give the resident ice packs. The form was hand signed by completed by Regional Director of Rehab Services #426 and dated 10/22/24.</p> <p>Review of the Modification of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #34 was cognitively intact. Resident #34 had impairment on one side of the upper extremity and impairments on both sides of the lower extremities. Resident #34 used a wheelchair for mobility. Resident #34 required partial/moderate assistance for bed mobility and substantial/maximum assistants for chair/bed-to-chair transfer. The ability to walk 10 feet in a room, corridor, or similar space was not attempted due to medical condition or safety concerns. Resident #34 did not receive scheduled pain medication, received as needed pain medication. Resident #34 had one fall with major injury since admission or prior assessment.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the physician orders from Hospital #423 Orthopedics follow up visit, dated 10/25/24, (untimed) revealed an order for knee immobilizer, at all times, non-weight bearing (NWB), follow up in one week for repeat x-rays, must remove the brace daily and cleanse skin to avoid breakdown.</p> <p>Interview and observation on 11/24/24 at 11:40 A.M. and 11/25/24 at 4:56 P.M., with Resident #34, revealed Resident #34 was sitting up in his wheelchair with his left leg elevated on the leg rest with a therapy band securing the leg to the leg rest. Resident #34 was wearing a knee immobilizer. Resident #34 stated his left tibia was fractured. Resident #34 stated he was working with therapy in his room when he fell , it was around 11:00 A.M., several weeks ago. Resident #34 stated, I was walking to the door with the therapist, I had a gait belt on and using the walker. Resident #34 confirmed the therapist was holding onto his gait belt while they were walking and revealed they heard something fall off the chair behind them. The therapist turned to look and saw it was the control knob from the chair. Resident #34 stated, The therapist told me to stop, I stopped, then I went down to my knees. Resident #34 revealed he fell as the therapist went to pick the object up from the floor. Resident #34 stated, Right after I fell , he stood me right up. I told him it hurt, it was a 10 out of 10 (pain scale), I told him that. He said I will put ice on it, you will be alright. He sat me in my chair, I told him I was hurting, he said don't worry, it ain't broken or you couldn't stand, he told me again please don't tell anybody or I will get in trouble. Resident #34 repeated, I did not tell anybody because I didn't want him to get into trouble because he asked me not to or he would get fired. Resident #34 revealed the next day the same therapist came back to work with him. The therapist put ice on his leg and kept moving his leg back and forth. Resident #34 stated, I told him it hurt, he kept moving it and telling me it will be ok. Resident #34 revealed he did tell (RN #350) that day about the fall with therapy and told her he did not want the therapist to get into trouble.</p> <p>Interview on 11/25/24 at 12:04 P.M., with Director of Rehabilitation (DOR) #425 and Regional Director of Therapy (RDOT) #426, revealed they were aware Resident #34 had a fall with a fracture that occurred while Resident #34 was receiving therapy services. RDOT #426 revealed on Saturday (10/19/24) in the morning, DOR #425 called him and told him. RDOT #426 instructed DOT #425 to call PTA #420. DOR #425 revealed she was made aware Resident #34 had a fracture, Saturday (10/19/24) in the morning. DOR #425 was told Resident #34 reported he fell during therapy and the therapist told him not to tell anyone. DOR #425 revealed she would also expect the therapist to report to nursing when a resident had a fall immediately then follow up with reporting to therapy. DOR #425 revealed when she spoke on the phone with PTA #420, he denied Resident #34 falling. RDOT #426 revealed the therapist does not document the time the therapy was received; the expectations are they finish therapy with residents, then document at the end of the day before going home. RDOT #426 revealed PTA #420 was suspended until further investigation. On Monday, 10/21/24, DOR #425 spoke with Resident #34, who confirmed what happened. RDOT #426 revealed he then called PTA #420 on 10/21/24 to terminate his employment. After termination, PTA #420 confirmed Resident #34 did have a fall during therapy on 10/17/24 and he did not say anything because he was scared for his job. PTA #420 stated Resident #34 was standing while PTA #420 was providing contact guard. Something fell off the wheelchair, when he took his hand off the gait belt to pick it up, Resident #34's legs gave out and he fell . RDOT #426 revealed PTA #420 admitted to telling Resident #34 not to tell anyone. DOR #425 confirmed if a resident had a suspected injury or change in condition, therapy would be held until the results of the change were determined.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 11/25/24 at 12:47 P.M., with Director of Nursing (DON) and Regional Clinical Service Director (RCSD), revealed the DON was notified on 10/19/24 by the night shift nurse that Resident #34 was sent to the hospital for a fracture. DON revealed the next morning, the day shift nurse reported Resident #34 told the Emergency Medical Squad (EMS) he had a fall with therapy. DON revealed the staff interviewed Resident #34, he was upset, he did not want the therapist to get into trouble. DON confirmed RN #350 was aware of the pain and swelling in the leg on 10/17/24. DON revealed she would have expected when a resident had a change in condition including unusual swelling and pain in an extremity, she would be notified by the staff at that time of the change. DON confirmed if the resident received therapy, the Therapy Director should have also been notified of the change in condition to prevent further potential injury. DON confirmed the x-ray result originally stated it was the right knee. Review of the x-ray result with DON confirmed an addendum was completed and concluded the proximal tibial fracture left. DON confirmed the x-ray was ordered on 10/17/24 documented at 6:55 P.M. and not completed until 10/18/24 at 3:20 P.M. and documented results received until 10/19/24 at 12:09 A.M. DON revealed she was unsure why the x-ray company did not complete the x-ray until the following afternoon but would look into it.</p> <p>Interview on 11/25/24 at 5:06 P.M., with RN #350 revealed she was an Interim Unit Manager. She assessed Resident #34 on 10/17/24 because he was complaining of pain in the left leg. During the assessment she also noted the leg was swollen. RN #350 revealed Resident #34 was lying in bed at the time, she asked if he did something to the leg and Resident #34 responded with, he was just having pain. RN #350 revealed she called the CNP who ordered a uric acid level due to his history of gout and ordered an x-ray. RN #350 revealed it was either on 10/17/24 in the evening or 10/18/24 in the morning, that Resident #34's wife told her about the fall with therapy. RN #350 stated, I do not normally inform therapy of changes in residents, not all residents receive therapy, so nursing does not normally notify therapy. RN #350 revealed she did not know why the x-ray took a whole day to come and revealed she did not call the x-ray company to confirm when they were coming.</p> <p>Review of the policy titled, Fall Management Guidelines, dated 12/13/23, documented a fall was defined as unintentionally coming to rest on the ground, floor or other level with or without injury to the resident. If a resident has just fallen or is observed on the floor without a witness to the event, evaluate for possible injuries to the head, neck, spine, and extremities prior to moving the resident. Obtain vital signs, evaluate for signs and symptoms or complaints of pain, complete range of motion with the resident, complete a head-to-toe skin assessment, if there is evidence of injury, provide appropriate first aid and/or obtain medical treatment immediately.</p> <p>Review of the policy titled, Change in Condition Notification, dated 08/09/23, revealed the policy of the facility was to notify the resident, his or her attending physician/practitioner, and the resident's designated representative of changes in the resident's medical/mental condition and or status. The nurse would notify the resident, his or her attending physician/practitioner, and the resident's designated representative when there was an accident or incident involving the resident which resulted in an injury and has the potential for requiring physician /practitioner intervention.</p> <p>2. Record review for Resident #41 revealed an admitted [DATE]. Diagnoses included dementia and presence of intraocular lens. On 07/08/24, Resident #41 started on hospice services. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #41 was severely cognitively impaired. Resident #41 was dependent on staff for personal hygiene.</p> <p>(continued on next page)</p>		

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F 0684  Level of Harm - Actual harm  Residents Affected - Few	<p>Review of the physician orders for Resident #41 dated 02/11/21 revealed an order to use eye drops solution (Carboxymethylcellulose Sodium) instill one drop in both eyes every 12 hours as needed for dry eye. On 08/15/24, there was an order to wash the left eye with baby shampoo at bedtime for redness, discontinue when resolved.</p> <p>Review of the care plan dated 09/27/24 revealed Resident #41 had an eye infection both eyes. Interventions included to give therapeutic ointments, drops as ordered by physician, monitor/document/report to physician as needed (PRN) the following signs and symptoms: redness of the eye, pain, swelling, tearing of the eye, discharge, change in conjunctiva, and wash eye to remove crust and discharge PRN.</p> <p>Review of the progress notes for Resident #41 from 11/20/24 through 12/02/24 at 10:00 A.M. revealed no documentation regarding Resident #41's left eye.</p> <p>Observations on 11/24/24 at 8:45 A.M. revealed Resident #41 was sitting in the dining room. Resident #41's left eye was red, the lower eye lid was swollen, there was crusty yellow drainage on her upper and lower eye lashes, and yellow mucous drainage was stringing as Resident #41 opened and closed her eye. At 11:08 A.M., Resident #41 was sitting in the lounge. Resident #41's left eye continued to be red, the lower eye lid was swollen, there was crusty yellow drainage on her upper and lower eye lashes, and yellow mucous drainage was stringing as Resident #41 opened and closed her eye.</p> <p>Observation and interview on 12/02/24 at 10:11 A.M. revealed Resident #41 was sitting in a chair in her room. Registered Nurse (RN) Hospice Nurse #430 was present and preparing to leave. Observation of Resident #41's left eye and interview with RN Hospice Nurse #430 confirmed Resident #41's left eye continued to be red with a swollen lower eye lid and crusty yellow drainage on her lashes. RN Hospice Nurse #430 stated she didn't know Resident #41 well, as she was just filling in for the day (12/02/24).</p> <p>Interview on 12/02/24 at 10:12 A.M. with Licensed Practical Nurse (LPN) #328 stated Resident #41's eye was like that all the time.</p> <p>Interview and observation on 12/02/24 at 10:19 A.M. with Certified Nurse Practitioner (CNP) #431 revealed he was not told Resident #41's eye was red. CNP #431 stated Resident #41 had eye infections in the past but he did not visit her unless asked because Resident #41 currently received hospice services. Observation with CNP #431 of Resident #41's left eye revealed Resident #41 stated when asked by CNP #431 her left eye hurt a tiny bit. CNP #431 stated Resident #41's left lower eye lid was swollen, had red conjunctivitis, and she had a bacterial infection. CNP #431 stated he planned to treat the eye with tobramycin eye drops. CNP #431 stated he was not made aware of Resident #41's left eye swelling and drainage and stated the staff should have notified him.</p> <p>Interview on 12/02/24 at 10:44 A.M. with Regional Clinical Service Director #427 stated if a resident had a change in condition, the nurses were to notify the physician, family, and hospice, the primary physician was still to be notified even if a resident received hospice services.</p> <p>Review of the facility policy titled Change in Condition Notification dated 08/09/23 revealed it was the policy of the facility to notify the resident, his or her attending physician/practitioner, and the resident's designated representative of changes in the resident's medical/mental condition and or status.</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42011</p> <p>Based on observation, medical record review, hospital record review, review of the facility's fall investigation, review of witness statements, resident interview, staff interview, and policy review, the facility failed to ensure a Resident #34, who was at risk for falls, was provided necessary assistance to prevent an avoidable fall from occurring that resulted in major injury to the resident.</p> <p>Actual harm occurred on 10/17/24, during a physical therapy treatment, when Resident #34, sustained a fall with injury while ambulating with Physical Therapy Assistant (PTA) #420. At the time of the incident, PTA #420 let go of Resident #34's gait belt, (a safety belt used to prevent falls, by providing a handle for caregivers to hold onto to help residents regain balance if they start to fall) during the therapy session and turned away from Resident #34. The resident fell sustaining a fracture to the left leg.</p> <p>This affected one resident (#34) of four residents reviewed for falls/accidents. The facility census was 65.</p> <p>Findings include:</p> <p>Record review for Resident #34 revealed an admitted [DATE]. Diagnoses included abnormal coagulation profile, muscle weakness, unsteady on feet, fusion of spine, sacral and sacrococcygeal region, and acute embolism, thrombosis of deep veins of left upper extremity pyogenic arthritis and gout.</p> <p>Review of the Fall Risk - Evaluation dated 08/07/24 at 12:27 P.M., revealed Resident #34 was alert and oriented, had no falls in the last three months, had moderate/severe unsteadiness and required physical assistance.</p> <p>Review of the care plan dated 09/13/24 revealed Resident #34 was at risk for falls due to impaired balance/poor coordination and unsteady on feet. Interventions included to provide assistance with transfer and ambulation as needed.</p> <p>Review of the progress note dated 10/14/24 at 4:09 A.M., completed by Registered Nurse (RN) Nurse Manager #349 included Resident #34 was skilled for pyogenic (painful infection caused by when a joint is invaded by an infectious agent) arthritis. Resident #34 received Physical Therapy (PT) due to unsteadiness on his feet. Resident #34 was alert and oriented times-four (person, place, time, and event). Resident #34 was pleasant and cooperative and had no complaints of pain or discomfort. Resident #34 required extensive assistance with activities of daily living (ADLs).</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 the Physical Therapy Treatment Encounter dated 10/17/24 electronically signed at 4:53 P.M. (untimed for the time of the actual treatment), by PTA #420, revealed precautions included fall risk, left lower extremity (LLE) ankle foot orthosis (AFO), dialysis P.M.- five times a week, and slide board for transfers. PT transfer sit to /from stand times three trials with forward wheeled walker (FWW) via caregiver assist (CGA)/min A (minimum assistants), verbal /visual cues for positioning, technique, and facilitate anterior weight shifting, patient (pt) performed static standing times three trials for 2-3 minutes duration approximately each via CGA. Bilateral upper extremity (BUE) support, verbal cues for postural corrections, and to ensure pt. safety, pt. performed seated exercise to increase strength, endurance, and range of motion (ROM) to improve quality and safety with all functional mobility, verbal/visual cues for technique, and form, marches, long arch quad-extending (LAQs), ankle pumps, and hip abduction (abd)/adduction (add), 10x 2-3 minutes, pt. challenged and fatigued. Response to treatment: Physical Therapy (PT) session completed with no concerns, or complications. Call light in reach upon exiting, and all infection control policies were followed per facility guidelines.</p> <p>Review of the progress note dated 10/17/24 at 6:55 P.M., completed by Registered Nurse (RN) #350, documented Resident #34 complained of pain and swelling to the left (L) knee. The Certified Nurse Practitioner (CNP) was notified. Laboratory testing (uric acid level) was ordered for A.M. as well as a two view left knee x-ray.</p> <p>Review of the Physical Therapy Treatment Encounter dated 10/18/24 electronically signed at 4:56 P.M. (untimed for the time of the actual treatment) by PTA #420, revealed precautions included fall risk, LLE AFO, dialysis P.M. five times a week, slide board for transfers. PT performed seated therapeutic exercises (therex). RLE active range of motion (AROM), LLE active assist range of motion (AAROM) due to pain with movement. 10 times three verbal/visual cues for task instructions, technique, and form marches, LAQs, hip add, hip abd, ankle pumps, and ham curls against yellow tband (therapy band) with RLE only, pt. challenged, ice pack applied for 20 minutes duration on anterior aspect of left knee to reduce pain symptoms. Response to treatment: PT session completed with no concerns, or complications on this date. Call light left in reach of resident upon exiting, all infection control policies were followed per facility guidelines.</p> <p>Review of the progress noted for Resident #34 dated 10/18/24 at 7:57 P.M., completed by RN #350 revealed two view x-rays of the left knee completed. Results pending.</p> <p>Review of the progress note for Resident #34 dated 10/19/24 at 12:09 A.M., completed by Licensed Practical Nurse (LPN) #421 documented received call from (X-ray Company #422), fracture noted to the right (clarified left) proximal tibia. A new order was received to send (Resident #34) to the emergency room (ER).</p> <p>Review of the progress note for Resident #34 dated 10/19/24 at 12:17 A.M., completed by LPN #421 included informed (Resident #34) of abnormal x-ray result and that he needs to go to ER. Resident agreed and stated he would inform his wife.</p> <p>Review of the progress note for Resident #34 dated 10/19/24 at 12:56 A.M., completed by LPN #421 included 911 arrived at facility, (Resident #34) was transferred to stretcher by 911. Patient states to 911 I fell a few days ago in the doorway right here, my left leg hurts 9 out of 10. Emergent 911 verified to this nurse the right tibia had a fracture, this nurse reviewed x-ray report, and this x-ray was for right tibia.</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 the progress note for Resident #34 dated 10/19/24 at 12:57 A.M., completed by DON revealed a clarification: left tibia (fracture).</p> <p>Review of the progress note for Resident #34 dated 10/19/24 at 10:57 A.M., completed by LPN #332 documented Resident #34 returned to facility from Hospital #423. Resident #34 had a left tibial fracture. Resident #34 returned with a new script for Oxycodone five milligrams (mg) every six hours as needed for three days for pain. Resident #34 complained of pain to the left leg. Resident #34 was to keep the leg straight and elevated at all times.</p> <p>Review of the progress note for Resident #34 dated 10/19/24 at 1:39 P.M., completed by LPN #332, documented this nurse received in report today that resident was sent out to hospital for leg pain. Resident #34 had stated that he had fallen while doing therapy. Resident #34 stated that he was walking with the therapist when the therapist told him to stop because a piece had fallen off his chair and he had wanted to pick. Resident #34 stated that when the therapist was doing this, resident's legs gave out and he fell . Resident #34 stated the therapist had picked him up off the floor and placed him into his wheelchair and gave him an icepack. Resident #34 returned from (Hospital #423) today 10/19/24 with a new diagnosis of left tibial fracture. Resident #34 had an immobilizer in place. Resident #34 was to keep left leg elevated as much as possible and needed to keep left leg as straight as possible.</p> <p>Review of the hospital discharge instructions from Hospital #423 with a visit date of 10/19/24 at 12:56 A.M., completed by Physician #424, documented the diagnosis was a nondisplaced fracture of proximal end of left tibia. (A tibial fracture is a break in the larger bone of your lower leg, this bone is also called the shin bone).</p> <p>Review of the Modification of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #34 was cognitively intact. Resident #34 had impairment on one side of the upper extremity and impairments on both sides of the lower extremities. Resident #34 used a wheelchair for mobility. Resident #34 required partial/moderate assistance for bed mobility and substantial/maximum assistants for chair/bed-to-chair transfer. The ability to walk 10 feet in a room, corridor, or similar space was not attempted due to medical condition or safety concerns. Resident #34 did not receive scheduled pain medication, received as needed pain medication. Resident #34 had one fall with major injury since admission or prior assessment.</p> <p>Review of the typed Facility Investigation form dated 10/21/24, (untimed), completed by Regional Director of Rehab Services #426, documented on Saturday, 10/19/24, the writer was made aware Resident #34 was sent out to the hospital on 10/19/24 and was found to have a tibia fracture. The DON reported (Resident #34) told her staff on 10/19/24 that he was working with PTA (#420) on Thursday, 10/17/24 and he fell during the therapy session. The patient (Resident #34) also told the nursing that (PTA #420) told him not to tell anyone about the fall. The Facility Investigation form included a phone interview with PTA #420, review of the progress notes including the x-ray results indicating a left proximal tibia fracture, statement from Certified Occupational Therapy Assistant (COTA) #428, Resident #34, and therapy notes. The last paragraph of the Facility Investigation completed by Regional Director of Rehab Services #426 dated 10/21/24, revealed this writer spoke to (PTA #420) and informed him that his employment with the company was terminated effective immediately. Upon receipt of this information, (PTA #420) confessed that the fall did happen with him and that he was scared to say anything because it was his first week there and he tried to give the patient ice packs. The form was hand signed by completed by Regional Director of Rehab Services #426 and dated 10/22/24.</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 the handwritten witness statement dated 10/21/24, untimed completed by COTA #428 revealed Resident #34 stated on Saturday, 10/19/24, that PTA #420 was walking with him in his room without a gait belt on when patient fell on his knees injuring himself. Patient stated the control knob on the power wheelchair fell on the floor and PTA #420 went to find the knob for the wheelchair to follow behind the patient. Patient stated that PTA told him not to tell anyone he fell . Patient (Resident #34) was given an ice pack by PTA (#420) for leg after fall to relieve pain. The statement included, (Resident #34) asked me to keep the incident quiet. Patient is extremely distraught due to the big setback.</p> <p>Review of the typed statement dated 10/21/24, untimed completed by Director of Rehabilitation #425 revealed the writer asked PTA #420 what happened to Resident #34 on 10/17/24 during his treatment. PTA #420 states, He told me he hurt his knee and banged it on something. PTA #420 told the patient, We can hold off on walking and I will bring you a couple ice packs throughout the day to help with the knee pain. Patient (Resident #34) was agreeable and continued with session that day. On 10/18/24, the writer asked PTA #420 what happened following the complaint of pain on Thursday during the Friday treatment. PTA #420 stated that a male State tested Nursing Assistant (STNA) from dialysis assisted (PTA #420) in transferring patient from dialysis chair to power chair, PTA #420 noticed no instability throughout the transfer. Patient (Resident #34) reported pain following the transfer but was able to continue on, with therapeutic exercises with ice pack provided by PTA #420. The writer asked PTA #420 if he had a gait belt on during the treatment, PTA #420 stated, I always have a gait belt on any patient I see. PTA #420 stated the patient never reported a fall to him on Thursday or Friday.</p> <p>Review of the physician orders from Hospital #423 Orthopedics follow up visit, dated 10/25/24, (untimed) revealed an order for knee immobilizer, at all times, non-weight bearing (NWB), follow up in one week for repeat x-rays, must remove the brace daily and cleanse skin to avoid breakdown.</p> <p>Interview and observation on 11/24/24 at 11:40 A.M. and 11/25/24 at 4:56 P.M., with Resident #34, revealed Resident #34 was sitting up in his wheelchair with his left leg elevated on the leg rest with a therapy band securing the leg to the leg rest. Resident #34 was wearing his knee immobilizer. Resident #34 stated his left tibia was fractured. Resident #34 stated he was working with therapy in his room when he fell , it was around 11:00 A.M., several weeks ago. Resident #34 stated, I was walking to the door with the therapist, I had a gait belt on and using the walker. Resident #34 confirmed the therapist was holding onto his gait belt while they were walking and revealed they heard something fall off the chair behind them. The therapist turned to look and saw it was the control knob from the chair. Resident #34 stated, The therapist told me to stop, I stopped, then I went down to my knees. Resident #34 revealed he fell as the therapist went to pick the object up from the floor. Resident #34 stated, Right after I fell , he stood me right up. I told him it hurt, it was a 10 out of 10 (pain scale), I told him that. He said I will put ice on it, you will be alright. He sat me in my chair, I told him I was hurting, he said don't worry, it ain't broken or you couldn't stand, he told me again please don't tell anybody or I will get in trouble. Resident #34 repeated, I did not tell anybody because I didn't want him to get into trouble because he asked me not to or he would get fired. Resident #34 revealed the next day the same therapist came back to work with him. The therapist put ice on his leg and kept moving his leg back and forth. Resident #34 stated, I told him it hurt, he kept moving it and telling me it will be ok. Resident #34 revealed he did tell (RN #350) that day about the fall with therapy and told her he did not want the therapist to get into trouble.</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 11/25/24 at 12:04 P.M., with Director of Rehabilitation (DOR) #425 and Regional Director of Therapy (RDOT) #426, revealed they were aware Resident #34 had a fall with a fracture that occurred while Resident #34 was receiving therapy services. RDOT #426 revealed on Saturday (10/19/24) in the morning, DOR #425 called him and told him. RDOT #426 instructed DOT #425 to call PTA #420. DOR #425 revealed she was made aware Resident #34 had a fracture, Saturday (10/19/24) in the morning. DOR #425 was told Resident #34 reported he fell during therapy and the therapist told him not to tell anyone. DOR #425 revealed when she looked into it, she saw the note indicating Resident #34 was having leg pain Thursday and Friday. DOR #425 revealed no one in nursing told therapy, Resident #34 was having leg pain or an x-ray prior to Saturday and she would expect to know anytime anyone receiving therapy services was having swelling, pain or an x-ray. DOR #425 revealed she would also expect the therapist to report to nursing when a resident had a fall immediately then follow up with reporting to therapy. DOR #425 revealed when she spoke on the phone with PTA #420, he denied Resident #34 falling. RDOT #426 revealed the therapist does not document the time the therapy was received; the expectations are they finish therapy with residents, then document at the end of the day before going home. RDOT #426 revealed PTA #420 was suspended until further investigation. On Monday, 10/21/24, DOR #425 spoke with Resident #34, who confirmed what happened. RDOT #426 revealed he then called PTA #420 on 10/21/24 to terminate his employment. After termination, PTA #420 confirmed Resident #34 did have a fall during therapy on 10/17/24 and he did not say anything because he was scared for his job. PTA #420 stated Resident #34 was standing while PTA #420 was providing contact guard. Something fell off the wheelchair, when he took his hand off the gait belt to pick it up, Resident #34's legs gave out and he fell. RDOT #426 revealed PTA #420 admitted to telling Resident #34 not to tell anyone. DOR #425 confirmed if a resident had a suspected injury or change in condition, therapy would be held until the results of the change were determined.</p> <p>Interview on 11/25/24 at 12:47 P.M., with Director of Nursing (DON) and Regional Clinical Service Director (RCSD), revealed the DON was notified on 10/19/24 by the night shift nurse that Resident #34 was sent to the hospital for a fracture. DON revealed the next morning, the day shift nurse reported Resident #34 told the Emergency Medical Squad (EMS) he had a fall with therapy. DON revealed the staff interviewed Resident #34, he was upset, he did not want the therapist to get into trouble. DON confirmed RN #350 was aware of the pain and swelling in the leg on 10/17/24. DON revealed she would have expected when a resident had a change in condition including unusual swelling and pain in an extremity, she would be notified by the staff at that time of the change. DON confirmed if the resident received therapy, the Therapy Director should have also been notified of the change in condition to prevent further potential injury. DON confirmed the x-ray result originally stated it was the right knee. Review of the x-ray result with DON confirmed an addendum was completed and concluded the proximal tibial fracture left. DON confirmed the x-ray was ordered on 10/17/24 documented at 6:55 P.M. and not completed until 10/18/24 at 3:20 P.M. and documented results received until 10/19/24 at 12:09 A.M. DON revealed she was unsure why the x-ray company did not complete the x-ray until the following afternoon but would look into it.</p> <p>(continued on next page)</p>		

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F 0689  Level of Harm - Actual harm  Residents Affected - Few	<p>Interview on 11/25/24 at 5:06 P.M., with RN #350 revealed she was an Interim Unit Manager. She assessed Resident #34 on 10/17/24 because he was complaining of pain in the left leg. During the assessment she also noted the leg was swollen. RN #350 revealed Resident #34 was lying in bed at the time, she asked if he did something to the leg and Resident #34 responded with, he was just having pain. RN #350 revealed she called the CNP who ordered a uric acid level due to his history of gout and ordered an x-ray. RN #350 revealed it was either on 10/17/24 in the evening or 10/18/24 in the morning, that Resident #34's wife told her about the fall with therapy. RN #350 stated, I do not normally inform therapy of changes in residents, not all residents receive therapy, so nursing does not normally notify therapy. RN #350 revealed she did not know why the x-ray took a whole day to come and revealed she did not call the x-ray company to confirm when they were coming.</p> <p>Review of the policy titled, Fall Management Guidelines, dated 12/13/23, documented a fall was defined as unintentionally coming to rest on the ground, floor or other level with or without injury to the resident. If a resident has just fallen or is observed on the floor without a witness to the event, evaluate for possible injuries to the head, neck, spine, and extremities prior to moving the resident. Obtain vital signs, evaluate for signs and symptoms or complaints of pain, complete range of motion with the resident, complete a head-to-toe skin assessment, if there is evidence of injury, provide appropriate first aid and/or obtain medical treatment immediately.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42730</p> <p>Based on record reviews, observations, resident interviews, staff interviews, and facility policy review, the facility failed to ensure residents were provided incontinence care in a timely manner. This affected two residents (#20 and #55) of three reviewed for incontinent care. The facility census was 64.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #20 revealed she admitted to the facility on [DATE] with diagnoses including orthopedic aftercare following surgical amputation and type II diabetes mellitus.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #20 was alert and oriented with cognition impairment. Resident #20 was dependent on staff for activities of daily living (ADLs).</p> <p>Review of the care plan dated 09/02/24 revealed Resident #20 had an alteration in elimination related debility, general weakness, diarrhea, and had an ADL self-care performance deficit related to amputation. Interventions included assisting with toileting and hygiene needs as needed, incontinence care per facility protocol, and to be kept clean, dry and odor free.</p> <p>Review of the physician orders dated 11/22/24 revealed Resident #20 had an order in place to check for bowel movement every shift.</p> <p>Observation and interview on 11/24/24 at 8:35 A.M. revealed Resident #20's call light was activated and Resident #20 was lying in bed wearing a gown with a foul odor coming from the room noticeably from the hallway. Resident #20 was observed covered in a brown-colored muddy consistency substance located on her bilateral lower extremities, stomach, chest, across her neck, under her chin and covered her gown and bed sheets. Resident #20 was observed yelling from her bed stating she had pressed her call light. She has been like this forever and felt nasty. Resident #21 stated there have been no staff in to check on her.</p> <p>Interview and observation on 11/24/24 at 8:37 A.M. with Registered Nurse (RN) #348, who was standing approximately 50 feet away from Resident #20's room, revealed he seen Resident #20 call light activated but he was not covering the hall on which she resided. RN #348 stated Resident #20 was the responsibility of the other assigned staff. RN #348 confirmed and verified Resident #20 was covered, in what he identified as feces and/or stool, and walked away stating I have to finish med pass.</p> <p>Interview on 11/24/24 at 8:39 A.M. with Certified Nursing Assistant (CNA) #334 revealed she was passing breakfast trays and did not smell Resident #20 as she passed trays, therefore she did not stop to answer her call light. CNA #334 revealed when she provided Resident #20 with her breakfast tray, she was clean and dry but could not identify how much time had passed since. CNA #334 verified Resident #20 was covered in feces and required assistance from staff for ADLs.</p> <p>(continued on next page)</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 11/25/24 at 4:23 P.M. with Licensed Practical Nurse (LPN) #332 stated Resident #20 was a total care for ADLs from staff, was incontinent of bowel and bladder, and required to be checked by staff often, aside from the typical two-hour interval checks.</p> <p>42011</p> <p>2. Record review for Resident #55 revealed an admitted [DATE]. Diagnosis included chronic obstructive pulmonary disease, unsteadiness on feet, and muscle weakness.</p> <p>Review of the quarterly Minimum Dat Set (MDS) assessment dated [DATE] revealed Resident #55 was cognitively intact. Resident #55 used a walker for mobility and required set up or clean up assist for meals. Resident #55 was occasionally incontinent of urine and required partial moderate assistance for toileting, hygiene, and substantial/maximum assistants for personal hygiene.</p> <p>Review of the care plan revealed Resident #55 had an alteration in elimination related to debility and generalized weakness. Interventions included to assist with toileting and hygiene needs as needed. Incontinence care per facility protocol.</p> <p>Observation on 11/24/24 at 8:56 A.M. revealed Resident #55 was sitting on the edge of his bed still wearing a t-shirt and brief. Resident #55's bedside table was in front of him. Resident #55's breakfast tray was on top of the bedside table. The food on the breakfast tray was consumed. Resident #55 confirmed he ate 100% of his breakfast. Resident #55 stated he was not doing well, he was soak and wet with urine running down his leg. Observation revealed Resident #55's brief was bulging. The sheet under Resident #55 was saturated with urine. There was a strong odor of urine surrounding Resident #55. Resident #55 could be seen by passing staff and visitors in the hall. Resident #55 stated, I have to wait until after breakfast to get changed. A liquid substance was puddled on the floor under Resident #55's brief.</p> <p>Interview on 11/24/24 at 8:59 A.M. with Certified Nursing Assistant (CNA) #337 revealed she just arrived at work two hours late, and everyone knows the staff can't change them until after the meal.</p> <p>Interview on 11/24/24 at 9:01 A.M. with CNA #429 stated Resident #55 told her he needed changed but they have to pass meals, there were several resident that have to wait. She stated she was instructed here if residents need changed or have to use bathroom, they have to wait until after the meal.</p> <p>Interview on 11/24/24 at 9:04 A.M. with CNA #353 stated the staff cannot assist residents to the bathroom or change them during meals or when passing trays. CNA #353 stated that was taught in school, they never do that, and the residents need to wait.</p> <p>Observation on 11/24/24 at 9:06 A.M. with CNA #429 confirmed Resident #55 could be seen sitting in his brief from the hall. CNA #429 confirmed Resident #55 had a foul urine odor, his brief was bulging, there was urine on the sheet, down the front of the sheet, and on the pad Resident #55 was sitting on.</p> <p>Interview on 11/26/24 at 10:27 A.M. with the Director of Nursing (DON) stated her expectations during meal time was if a resident needed changed or to use the bathroom, the CNA would stop passing trays and change the resident.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 11/26/24 at 10:47 A.M. with Resident #55 stated when he has to eat his meal when he was incontinent, it makes him feel bad, real bad, it happens way too often, and it was not right.</p> <p>Review of the facility document titled Incontinence Care- Urinary and Fecal dated 04/22/24, revealed the facility had a policy in place to provide guidelines for cleansing the perineum and buttocks after an incontinent episode or with daily care. The facility would provide residents who were incontinent of bowel and bladder care assistance as needed based on resident request and/or check and change, or as per resident preference or need.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42730</b></p> <p>Based on record reviews, observations, resident interviews, staff interviews, and policy review, the facility failed to ensure oxygen tubing was changed per physician orders and failed to ensure there was a physician order in place to administer oxygen to a resident. This affected two (#19 and #43) of two residents reviewed for respiratory care. The facility identified fifteen residents (#1, #4, #7, #18, #19, #24, #38, #41, #43, #44, #51, #53, #54, #57, and #218) who utilized oxygen. The facility census was 64.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #19 revealed an admitted [DATE] with diagnoses including shortness of breath, obstructive sleep apnea, and chronic obstructive pulmonary disease (COPD).</p> <p>Review of the quarterly, Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #19 was alert and oriented to person, place, and time.</p> <p>Review of the care plan dated 08/26/24 revealed Resident #19 had shortness of breath related to COPD. Interventions included providing oxygen delivery via nasal cannula and/or mask continuously.</p> <p>Review of the physician orders dated 08/29/24 revealed an order to change oxygen tubing every week and as needed. The physician orders dated 11/19/24 revealed an order for oxygen delivery at two to five liters continuously every shift via nasal cannula.</p> <p>Interview and observation on 11/24/24 at 9:53 A.M. revealed Resident #19 sitting in his room on the edge of the bed. Resident #19 stated he utilized oxygen daily and the facility staff never changed his oxygen tubing. Observation at the time of the interview revealed a blue colored oxygen concentrator with oxygen tubing dated 11/04/24, approximately 21 days ago.</p> <p>Interview and observation on 11/24/24 at 10:14 A.M. with Licensed Practical Nurse (LPN) #341 revealed oxygen tubing was to be changed weekly every Sunday on night shift. LPN #341 stated Resident #19 utilized oxygen daily and had orders in his medical record. LPN #341 confirmed Resident #19's oxygen tubing was dated 11/04/24.</p> <p>2. Review of the medical record for Resident #43 revealed an admitted [DATE] with diagnoses including end stage renal disease and acute and chronic respiratory failure. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #43 had cognition impairment. Resident #43 was dependent on staff for activities of daily living (ADLs).</p> <p>Review of the progress note dated 07/08/24 at 6:13 P.M. revealed Resident #43 was admitted to the facility from Southwest General Hospital on three liters of oxygen continuously.</p> <p>Review of the care plan dated 08/23/24 revealed Resident #43 had an altered respiratory status and difficulty breathing related to acute and chronic respiratory failure. Interventions included monitoring, documenting and reporting breathing patterns to physician and administer medications as ordered. The care plan had no indications of oxygen use.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the current and past physician orders revealed no orders for oxygen or oxygen tubing in Resident #43's medical record.</p> <p>Review of Resident #43 electronic medical record revealed a photo of Resident #43 with oxygen in place being administered via nasal cannula.</p> <p>Review of Resident #43's oxygen saturation level summary revealed Resident #43 received oxygen via nasal cannula on the following dates: 07/08/24 through 07/11/24, 07/16/24 through 07/20/24, 07/25/24 through 07/26/24, 07/29/24 through 07/30/24, 08/02/24, 08/08/24 through 08/11/24, 08/14/24, 08/24/24 through 08/25/24, 08/28/24, 09/06/24, 09/09/24, 09/12/24, 09/14/24 through 09/20/24, 09/26/24, 10/02/24, 10/04/24 through 10/05/24, 10/08/24 through 10/12/24, 10/14/24, 10/20/24, 10/23/24 through 10/25/24, 10/27/24, 10/31/24 through 11/01/24, 11/04/24, 11/07/24 through 11/11/24, 11/14/24 through 11/15/24, 11/18/24, and 11/22/24.</p> <p>Interview and observation on 11/24/24 at 10:16 A.M. with Licensed Practical Nurse (LPN) #341 confirmed Resident #43 utilized oxygen but could not recall her physician orders. LPN #341 verified there was oxygen tubing dated 11/04/24 with the oxygen concentrator actively running.</p> <p>Interview on 11/25/24 at 4:23 P.M. with LPN #332 confirmed Resident #43 utilized oxygen as needed but could not locate an oxygen order in her medical record or care plan. LPN #332 confirmed there was no care plan, no physician orders, and there was documented oxygen saturation levels in Resident #43's medical record.</p> <p>Interview on 12/02/24 at 12:20 P.M. with the Director of Nursing (DON) stated Resident #43 admitted to the facility with oxygen in place. The DON reviewed Resident #43's current and past orders and could not locate an order for oxygen. The DON confirmed Resident #43 received oxygen since July 2024 without orders in place.</p> <p>Review of the facility document titled Oxygen Safety Policy dated 08/02/10, revealed the facility had a policy in place to promote safety precautions during oxygen administration that included oxygen administered by way of an oxygen mask or nasal cannula and oxygen cylinders were to be turned off when not in use.</p>		

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NAME OF PROVIDER OR SUPPLIER  Middleburg Heights Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  19530 Bagley Road Middleburg Heights, OH 44130	
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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42730</p> <p>Based on observations, resident interviews, staff interviews, and review of the facility assessment and staff schedules, the facility failed to ensure adequate and sufficient staff levels to meet the needs of the residents. This had the potential to affect all residents residing in the facility. The facility census was 64.</p> <p>Findings include:</p> <p>Observation on 11/24/24 from 8:00 A.M. to 9:00 A.M. during tour of the facility, revealed a daily staffing sheet dated 11/23/24 for the 11:00 P.M. to 7:00 A.M. shift that indicated there were three nurses and five Certified Nursing Assistant (CNAs) to cover the night shift. Observation during the tour of the facility revealed there were only two CNAs in the facility for a census of 64.</p> <p>Interview on 11/24/24 at 8:25 A.M. with Licensed Practical Nurse (LPN) #325 stated she had one CNA to assist her for the first shift.</p> <p>Interview on 11/24/24 at 8:27 A.M. with LPN #343 stated there were only two CNAs in the facility, and it was not enough to meet the needs of the residents.</p> <p>Interview and observation on 11/24/24 at 8:28 A.M. revealed Resident #55's call light activated. Resident #55 was observed laying in bed with his brief exposed. Resident #55 stated his brief was urine soaked, he needed to be changed, and he had been waiting 10 minutes for staff to answer his call light.</p> <p>Observation and interview on 11/24/24 at 8:35 A.M. revealed Resident #20 call light activated with her observed lying in bed wearing a gown with a foul odor coming from the room noticeably from the hallway. Resident #20 was observed covered in a brown-colored muddy consistency substance located on her bilateral lower extremities, stomach, chest, across her neck, under her chin and covered her gown and bed sheets. Resident #20 was observed yelling out statements from her bed stating she had pressed her call light. She has been like this forever. She feels nasty. No one came to see her. She was sitting there forever.</p> <p>Interview on 11/24/24 at 8:36 A.M. with Registered Nurse (RN) #348 revealed he covered the night shift and was waiting for his relief. RN #348 revealed there were currently only two CNAs working but there were supposed to be four to five CNAs per the schedule. RN #348 stated two CNAs called off for their night shift.</p> <p>Interview and observation on 11/24/24 at 8:43 A.M. revealed Resident #55 call light turned off. Resident #55 was observed sitting on the edge of his bed and stated, I still need some help. Resident #55 stated his brief was still soiled and the CNA, assigned to his hall, told him he had to wait until after he finished his breakfast to be changed. Resident #55's brief appeared wet with a liquid substance dripping onto the floor underneath his feet.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview on 11/24/24 at 10:04 A.M. with Resident #269 stated there were not enough staff to meet his needs, and his call light sometimes took up to an hour for a response.</p> <p>Observation and interview on 11/24/24 at 10:08 A.M. revealed Resident #268 sitting in his wheelchair ambulating near the nurse's station located adjacent to the 400-hall. Resident #268 was observed yelling I want to be put back in bed. Resident #268 stated he had gotten up too early and he wanted to be put back in bed. Resident #268 revealed staff told him he could not get back in bed until 11:00 A.M. because it was too early to lay back down. At 10:09 A.M., CNA #337 and #367 were sitting at the nurse's station located adjacent to the 400-hall. CNAs #337 and #367 were observed reviewing staffing assignment sheets. CNA #337 stated Resident #268 had to wait to be put back in bed until staff figured out individual assignments and she could not provide a time in which it would occur. CNA #337 confirmed Resident #268 was not able to be put back into bed at his request. CNAs #337 and #367 stated there were currently only two CNAs when the first shift started. Nurses and CNAs worked 12-hour shifts, but task went unfinished.</p> <p>Reconciliation with the staff schedules, the daily staffing sheets, observed floor staff, and census and acuity levels, revealed the facility did not accurately staff the facility to meet the needs of the residents residing in the facility.</p> <p>Review of the facility assessment dated [DATE] revealed staffing was based on the resident population and acuity. The facility would ensure at least four licensed nurses and at least six CNAs would be scheduled for coverage on each shift.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36650</p> <p>Based on review of facility policy, record review, staff interview, and review of Self-Reported Incidents (SRI) and witness statements, the facility failed to maintain accurate account of all controlled drugs. This affected five residents (Resident #27, #29, #47, #48 and #60) reviewed for reconciliation of narcotics. The facility census was 65.</p> <p>Findings include:</p> <p>Review of the SRI control number 253924 dated 11/11/24 revealed Licensed Practical Nurse (LPN) #322 told management that when she was signing out narcotics, she noticed her signature had been forged by sign out of Resident #47 and #48 narcotics that she did not give, and her signature was also used as the second signature for wasting medications with LPN #323. The investigation revealed the dates surrounding these allegations ranged from 11/06/24 through 11/11/24. Throughout the investigation of these allegations, additional allegations were reported. LPN #333 reported that someone had forged his signature on a narcotic sheet, falsely indicating that he had wasted two Oxycodone (narcotic) tablets. Notably, the suspended nurse (LPN #323) had worked the shift after him as well. A third nurse (LPN #332) came forward and reported that her signature had also been forged next to the suspended nurse's name, suggesting they had wasted several narcotics together. She asserted that the signature was not hers and confirmed she had never wasted any medications with the nurse in question. A fourth nurse (LPN #324) came forward and reported that her signature was forged next to the suspended nurse's name, indicating she had wasted Oxycodone with her. This nurse also denied ever wasting medications with LPN #323.</p> <p>Review of the witness statement from LPN #323 dated 11/12/24 revealed LPN #323 denied knowledge about other signatures for other nurses on the narcotic sheets. LPN #323 stated she gave medication according to narcotic sheets and the computer and when residents requested pain medications. LPN #323 denied knowledge of wrong signatures being done.</p> <p>1. Review of the medical record for Resident #27 revealed an admitted [DATE]. Review of the narcotic sheet for Resident #27 for Oxycodone five milligrams (mg) revealed on 11/09/24 at 1:20 A.M., LPN #333 signed out one tablet, on 11/09/24 at 3:30 P.M., one tablet was signed out by LPN #332, and on 11/10/24 at 7:00 A.M., one tablet was signed out by LPN #322. After each LPN's signature, LPN #323's signature followed.</p> <p>Review of the nursing witness statements revealed on 11/12/24, LPN #322 looked at the narcotic book on 100-hall and there were two signatures that did not match on 11/10/24. LPN #322 stated she never wasted any narcotics with LPN #323. On 11/14/24, LPN #332 stated her signature had been forged and denied wasting Resident #27's Oxycodone five mg on 11/09/24 at 3:30 P.M. with LPN #323. LPN #333 stated on 11/09/24 at 1:20 A.M., he did not sign out Resident #27's Oxycodone five mg. On 11/14/24, LPN #332 stated the signature for 11/09/24 at 3:30 P.M. was not her signature. On 11/14/24, LPN #322 denied the signature on 11/10/24 at 7:00 A.M. for two Oxycodone five mg was not her signature and she never gave Resident #27's Oxycodone at that time.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 11/26/24 at 2:25 P.M. with LPN #332 stated narcotics have to have two nurses to destroy a narcotic. LPN #332 stated her signature was forged for Resident #27. LPN #332 denied wasting any narcotics for Resident #27 and that when you sign out a narcotic it is to be documented on the narcotic sheet and in the resident's electronic record.</p> <p>2. Review of the medical record for Resident #29 revealed an admitted [DATE]. Review of the narcotic sheet for Hydrocodone/APAP (opioid) tablet 7.5-325 mg take one tablet by mouth twice a day as needed for pain revealed on 10/17/24 at 9:00 P.M. and on 10/18/24 at 7:00 A.M., they were signed out by LPN #322. The signature on 10/18/24 at 7:00 A.M., did not match any of LPN #322's other signatures. LPN #323 signature followed LPN #322.</p> <p>Review of the witness statement dated 11/14/24 reveled LPN #322 denied she signed out Hydrocodone/APAP 7.5/325 mg tablet on 10/17/24 at 9:00 P.M. and on 10/18/24 at 7:00 A.M.</p> <p>3. Review of the medical record for Resident #47 revealed an admitted [DATE]. Review of the narcotic count sheet for Resident #47 for Oxycodone/APAP 5-325 mg take one tablet by mouth every six hours as needed revealed on 11/01/24, Resident #47 received five doses of Oxycodone/APAP 5- 325 mg and was only to receive four tablets a day. On 11/15/24 at 10:30 A.M., 11/16/24 at 9:44 A.M. and 11/16/24 at 3:30 P.M., they were signed out by LPN #324. LPN #323 signature followed LPN #324.</p> <p>Review of the witness statement from LPN #324 dated 11/11/24 revealed she was counting with nurse from night shift and realized her signature had been copied from 11/06/24. It was two Oxycodone and a Norco for another resident. LPN #324 denied the signature on 11/05/24 at 10:30 A.M., on 11/06/24 at 9:44 A.M. and on 11/06/24 at 3:50 P.M. was not her signature.</p> <p>4. Review of the medical record for Resident #48 revealed an admitted [DATE]. Review of the narcotic sheet for Resident #48 revealed Hydrocodone/APAP 7.5-325 mg take one tablet by mouth twice a day revealed on 11/06/24 at 9:07 A.M. and at 2:01 P.M. LPN #324's signature was there indicating she signed out for them. LPN #323 signature followed LPN #324.</p> <p>Review of the witness statement for LPN #332 dated 11/14/24 denied the signature on 11/06/24 at 2:01 P.M. was her signature for Resident #48's Hydrocodone 7.5/235 mg.</p> <p>5. Review of the medical record for Resident #60 revealed an admission 12/04/24. Review of Resident #60's narcotic sheet for Oxycodone five mg tablet take one tablet by mouth every eight hours as needed revealed on 11/09/24 at 7:00 A.M., two pills were signed out by LPN #333 and LPN #323 worked the shift after him.</p> <p>Review of the narcotic sheet and MAR for November 2024 revealed on the narcotic sheet on 11/09/24, Resident #60 received Oxycodone five mg tablets two tablets at 7:00 A.M., one tablet at 7:16 A.M., 1:19 P.M. , and 7:20 P.M. The MAR for November 2024 revealed Resident #60 did not receive any Oxycodone on 11/09/24.</p> <p>Review on the witness statement by LPN #333 dated 11/12/24 revealed he did not waste Resident #60's two Oxycodone with LPN #323 on 11/09/24. LPN #333 stated his signature had been forged and denied giving Resident #60 an Oxycodone on 11/09/24 at 1:20 A.M.</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the Controlled Medication guidelines policy revised dated 03/20/24 revealed the licensed nurse will validate the physician's order on the medication administration record matches. A physical inventory of all controlled medications is completed by two licensed nurses and is documented on the shift-to-shift form.</p> <p>Review of the facility policy titled Medication Administration, dated 08/07/23 revealed the licensed nurse is responsible for validating documentation for all medications is complete for any medications administered during the shift.</p> <p>This deficiency represents non-compliance investigated under Control Number OH00159967.</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>51067</p> <p>Based on observations, resident interviews, review of the job descriptions for the Administrator and Director of Nursing (DON), review of facility policy, and review of the employee handbook, the facility failed to ensure staff did not have personal conversations, which included being on their phones, playing loud music from their phones, wearing ear buds or other Bluetooth accessories while in resident rooms or in resident care areas of the facility. This affected ten residents (#168, #169 and the eight residents who attended the resident council meeting) reviewed for administration.</p> <p>Findings include:</p> <p>Observation on 11/24/24 at 8:24 A.M. of the 400 hallways near the dialysis room revealed a cellular phone lying on the desk at the nurses' station playing loud music.</p> <p>Interview with Resident #168 on 11/24/24 at 9:01 A.M. revealed that agency staff was no help, doesn't answer call light timely, always on their phones, and will have you waiting for hours to only come into the room and turn the call light off.</p> <p>Interview with Resident #169 on 11/24/24 at 10:16 A.M. revealed it was hard to get help from the Certified Nursing Assistant (CNA) when he uses his call bell it can take up to 30 minutes for someone to answer his call light. Resident #169 stated he has had to use various objects in his room to make noise to get someone to come in for help. An example he gave was banging his urinal onto his bedside table. Resident #169 stated he had his girlfriend go out into the hallway for help and has observed all staff on their phones.</p> <p>Interview with eight residents, which included the President and [NAME] President, during Resident Council (RC) meeting on 12/02/24 at 10:09 A.M. revealed the residents expressed great concern with cell phone usage. They reported the cell phone usage was in resident rooms, common areas, and in the dining room, and the loud noise of music from staff phones. These concerns have been brought up at numerous RC meetings.</p> <p>Review of the job description for the Administrator, dated 01/01/12, revealed the Administrator reported to the Chief Operating Officer (COO). The direct report of the Administrator included the DON. The Administrator is responsible for planning, organizing, directing and managing the skilled nursing facility operations to ensure Resident quality of life and care and maintain compliance with all local state and federal laws and regulations.</p> <p>Review of the job description for the DON, dated 01/01/12, revealed the DON reported to the Administrator. The direct report of the DON includes nurses and CNAs. The DON is responsible for managing, directing, and supervising the nursing department to ensure Residents are receiving the appropriate care and are enabled to obtain their optimum level of functioning. To ensure staff has the equipment and knowledge to perform their duties within their scope of practice and that they always know what is expected of them.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the Employee Handbook revealed personal communication devices are not used during work times unless authorized for company business.</p> <p>Review of the Electronic Communication Policy, undated, revealed any personal calls are to be made during non-work time.</p>		

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36650</p> <p>Based on staff interview, record review, review of the Self-Reported Incident (SRI), and review of facility policy, the facility failed to ensure the coordination of care to the resident by the hospice staff. This affected one (Resident #2) of one resident reviewed for hospice services. The facility census was 65.</p> <p>Findings include:</p> <p>Record review for Resident #2 revealed an admitted [DATE]. Diagnoses included nontraumatic intracerebral hemorrhage in brain stem, aphasia, legal blindness, muscle weakness, vascular dementia, and hemiplegia and hemiparesis following cerebral infarction of the left non-dominant side.</p> <p>Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #2 was severely cognitively impaired. Resident #2 had impairment on one side of the upper and lower extremities, used a wheelchair for mobility, was dependent on staff for showers and transfers. Resident #2 required the use of a mechanical lift for transfers. Resident was on hospice.</p> <p>Review of the transfer plan of care dated 08/22/23 revealed Resident #2 required a two-person assist with a mechanical lift for transfers.</p> <p>Review of the hospice note dated 10/15/24 by Certified Nursing Assistant (CNA) #382 revealed a partial bed bath range of motion, and companionship was provided to Resident #2 and did not have any pain.</p> <p>Review of the SRI control number 253101 dated 10/18/24 revealed Resident #2 was receiving hospice care. Hospice CNA #382 did not employ the mechanical lift and instead lifted the resident manually from her bed to her Broda chair during bathing on 10/15/24. Resident #2 sustained bruising to her inner right thigh. The facility's investigation did not include a statement from Hospice CNA #382 and there was no evidence there was any training and/or follow up with Hospice CNA #382 after the facility completed their investigation.</p> <p>Interview on 12/02/24 at 4:39 P.M. with Licensed Practical Nurse (LPN) #341 (Unit Manager) stated it was documented on the 10/15/24 that the hospice aide, CNA #382 gave the Resident #2 a partial bed bath. The resident was up in the chair and the hospice aide laid her back down on her own. The facility aide offered to help spot her with the transfer because she was a Hoyer, the hospice CNA #382 responded she didn't transfer her with a Hoyer, and she does it by herself all the time. LPN #341 verified CNA #382 did not follow Resident #2's plan of care and transferred her with one assist and did not use a mechanical lift.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00160339.</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>38091</p> <p>Based on observation and staff interview, the facility to ensure a clean, safe and well-maintained environment for the residents. This had the potential to affect all 64 residents residing in the facility.</p> <p>Findings include:</p> <p>1. Environmental tour of the facility with Maintenance Director (MD) #344 on 11/25/24 between 7:30 A.M. and 8:00 A.M. revealed the following that was verified at the time of discovery.</p> <p>1a. The cover to the baseboard heater in Resident #220's room was bent.</p> <p>1b. The wall behind the bed in Resident #34's room was significantly scuffed with noticeable areas of paint chipping off the wall.</p> <p>1c. The privacy curtains in Residents #9, #27, #38, and #55's room had noticeable stains on them.</p> <p>1d. The fall mats utilized by Residents #13 and #268 were significantly torn, tattered and dirty.</p> <p>1e. The room occupied by Residents #37 and #41 had a large crack in the toilet seat.</p> <p>1f. The activities room had a two-foot-long crack in the flooring.</p> <p>1g. The room occupied by Resident #11 had caulking around the toilet that was coming up and the toilet was not secured to the floor.</p> <p>1h. The window blinds in Residents #29 and #268's room was brown in color with a thick layer of dust and other dirt.</p> <p>1i. The wall in the room occupied Residents #2 and #6 had significant damage with a noticeable hole in it. MD #999 stated during the observation you could put your whole fist through the hole in the wall.</p> <p>1j. The baseboard cover to the heater in Resident #24 and #61's room was off.</p> <p>1k. The wheelchair utilized by Resident #13 had large chunks of dried food and spills on the frame, armrest and legs and the left armrest was torn, tethered and stained.</p> <p>1l. Multiple light fixtures in the hallways throughout the facility had dead insects inside them.</p> <p>1m. The handrails throughout the facility had noticeable areas of rough chipped areas that created a hazard for residents who use the handrails for balance.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  366057	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/04/2024
NAME OF PROVIDER OR SUPPLIER  Middleburg Heights Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  19530 Bagley Road Middleburg Heights, OH 44130	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>2. Observation of the laundry area on 11/26/24 between 2:00 P.M. and 2:11 P.M. revealed in the back of the laundry areas was a large filter on the inside of the dryer. The filter was noted to be approximately 80% covered in lint and required force to be removed.</p> <p>Interview on 11/26/24 at 2:12 P.M. with Housekeeper (HSKP) #315 verified the condition of the filter in the laundry area.</p>		