STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366071	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT Alverna Home Inc	6765 State Road Parma, OH 44134

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident record reviews, staff interview, and facility policy review, the facility failed to ensure residents were treated with dignity during dining. This affected one resident (#30) of two reviewed for dignity. The facility census was 136.Findings include: 1.Review of the medical record for Resident #30 revealed she was admitted to the facility on [DATE] with diagnoses that included hemiplegia and hemiparesis, hypertension, and hyperlipemia.Review of Staff Assessment for Mental Status (SAMS) assessment revealed Resident #30 had a memory problem, had modified independence regarding task of daily life. Review of the SAMS assessment revealed Resident #30 was impaired on one side of the upper and lower extremities and was dependent on staff for activities of daily living (ADLs).Review of the care plan dated 02/08/22 revealed Resident #30 had a self-care performance deficit related to hemiplegia, aphasia, and muscle weakness and required the services and support of the facility with interventions that included set-up and clean-up assistance with eating and encouraged to engage in life of the facility and provide dining assistance.2.Review of the medical record for Resident #103 revealed she was admitted to the facility on [DATE] with diagnoses that included diverticulosis of the intestine, dementia, and impulse disorder. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #103 had a Brief Interview for Mental Status (BIMS) score of 4 that indicated cognition impairment. Review of the MDS assessment revealed Resident #103 required some assistance from staff for ADLs.Review of the care plan dated 04/02/26 revealed Resident #103 had a self-care and mobility performance deficit related to diverticulosis with interventions that included provide dining assistance as needed.Observation on 05/06/26 at 12:00 P.M. revealed Residents #30 and #103 seated at a table together in the third floor dining room. Resident #103 was observed receiving her lunch meal tray and begin to eat. Resident #30 sat without her lunch meal tray. Observation on 05/06/26 at 12:14 P.M. revealed random residents eating their lunch meal being served their lunch trays. Resident #30 continued to sit with Resident #103 without a lunch tray.Observation on 05/05/26 at 12:20 P.M. revealed all other residents eating in the dining room received their lunch tray and Resident #30 received her tray last. Observation revealed Resident #103 completed her lunch meal and left from the dining room.Interview on 05/06/26 at 12:21 P.M. with Certified Nurse Assistant (CNA) #548 confirmed and verified the above findings at the time of the interview.Review of the facility document titled Dignity dated 04/01/23, revealed the facility had a policy in place that each resident would be treated with respect and dignity as well as care in a manner and in an environment that maintains or enhances the resident's quality of life.

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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure Resident #139's new wound was identified and treated before developing a large size, becoming infected, and beginning to heal independent of facility action. This affected one of three residents reviewed for changes in status. The total census was 136. Findings include: Record review of Resident #139 revealed he was admitted [DATE] and discharged to home on [DATE]. His diagnoses included diabetes, venous insufficiency, and symbolic dysfunctions. His minimum data set assessment dated [DATE] revealed he had mild or no cognitive impairment and needed substantial or moderate assistance with toileting, bathing, and dressing the lower body. His admission assessment revealed he entered the facility with no edema and with wounds on his right and left toes and the top of his right foot. Records until 04/16/26 identified no evidence of any assessment, treatment, or acknowledgement of a wound to his right lateral leg.Record review of Resident #139 revealed a progress note dated 04/16/25 which said family was visiting and asked why his legs were swollen. The family also identified a healing wound to his right lateral leg. A skin/wound note the same day identified it as measuring 5 centimeters (cm) by 7 cm with a depth of 0.1 cm, with most areas scabbed over and a few with scant drainage. Progress notes the next day identified there was orange discoloration to the skin and antibiotics were ordered for infection of the wound. Review of his treatment record revealed dressings for the wound were ordered 04/17/26 and continued until discharge.Record review of Resident #139's wound assessment dated [DATE] revealed the wound was identified as an abrasion to the left lateral leg acquired in the facility measuring 5 cm by 7 cm by 0.1 cm. The wound bed was made of granulation tissue (a bumpy red or pink tissue associated with a wound already in the healing process, typically developing between three and seven days after the initial injury). Warmth and redness were noted as evidence of infection and the wound had light serosanguinous drainage. Pitting edema was noted around the wound. A freehand note identified the wound as being related to edema and cellulitis.Interview with Wound Nurse #613 on 05/07/26 at 9:07 A.M. revealed she recalled Resident #139 and said the left leg wound developed on an area hidden on the body by ace wraps. She said the wraps should have been taken off daily and changes in the skin should have been reported to her office. She confirmed resident #139's left leg wound was not identified until it was partway through the healing process, infected and edematous, and larger in size.This deficiency represents noncompliance investigated under Complaint Number 2587947.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident record review, resident interviews, staff interviews, and facility policy review, the facility failed to ensure restorative programs were implemented. This affected three residents (#24, #31, #130) of three reviewed for restorative services. The facility census was 136.Findings include: 1.Review of the medical record for Resident #24 revealed she was admitted to the facility on [DATE] with diagnoses that included multiple sclerosis (MS), contractures of the muscles, multiple sites, and scoliosis.Review of the physician orders dated 03/26/25 revealed an order for Passive Range of Motion (PROM) Bilateral Upper Extremities (BUE) and Active Assisted Range of Motion (AAROM) Bilateral Lower Extremities (BLE) 3-6 times per week in 15-minute sessions.Review of the physician orders dated 07/02/25 revealed an order for Resident #24 to wear bilateral dynamic Ankle-Foot Orthosis (AFO) splints BLE for contracture management to be worn for up to 2 hours during the day and only to be completed with therapy or restorative Certified Nurse Assistants (CNAs).Review of the physician orders dated 07/29/25 revealed an order for splint and/or brace bilateral ankle dynamic AFO brace 3-6 times weekly in 15-minutes sessions.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #24 had a Brief Interview for Mental Status (BIMS) score of 15 that indicated she was alert and oriented to person, place, and time. Review of the MDS assessment revealed Resident #24 was impaired on both sides, upper and lower extremities, and was dependent on staff for activities of daily living (ADLs).Review of the care plan dated 02/10/26 revealed Resident #24 had an ADL self-care performance deficit related to MS, impaired mobility, lack of coordination and weakness and contractures of the muscles with interventions that included, but not limited to, restorative ADL training 15-minute sessions 3-6 times per week, use of mechanical lift for transfers and 2 person care for ADLs.Review of the physical therapy (PT) Discharge summary dated [DATE] revealed Resident #24 had an established restorative program in place following her discharge from PT that consisted of ROM stretching and splinting.Review of the restorative splint and/or brace, ROM BUE, and PROM BLE program participation log dated 04/06/26 through 05/05/26 revealed Resident #24 received restorative services 8 times within 30 days. Review of the participation log revealed Resident #24 did not receive restorative services 3-6 times per week as ordered and care planned.2. Review of the medical record for Resident #31 revealed she was admitted to the facility on [DATE] with diagnoses that included dementia, mild protein-calorie malnutrition, and dysphagia.Review of the physician orders revealed an order dated 08/27/24 for restorative nursing ambulation of 30-50 feet using wheeled walker with contact guard assist in 15-minute sessions 3-6 times per week.Review of the physician orders dated 09/05/24 revealed an order for restorative nursing AROM BUE 15-minute sessions 3-6 times per week.Review of the physician orders dated 05/12/25 revealed an order for AROm BLE 15-minute sessions 3-6 times per week. Review of the care plan dated 01/20/26 revealed Resident #31 was at risk for falls related to weakness, poor safety awareness with interventions that included restorative program for ambulation and AROM BUE 15-minute sessions 3-6 times per week.Review of the MDS assessment dated [DATE] revealed Resident #31 had a BIMS score of 4 that indicated she was alert and oriented with cognition impairment. Review of the MDS assessment revealed Resident #31 was dependent on staff for ADLs. Review of the restorative walking, ROM AROM BLE, and ROM BUE program participation log dated 04/06/26 through 05/05/26 revealed Resident #31 received restorative services 11 times within 30 days. Review of the participation log revealed Resident #31 did not receive restorative services 3-6 times per week as ordered and care planned.3. Review of the medical record for Resident #130 revealed she was admitted to the facility on [DATE] with diagnoses that included dementia. Solitary pulmonary nodule, and hypertension.Review of the physician orders dated 02/22/24 revealed orders for restorative ambulation and toileting for 15-minte sessions 3-6 times per week.Review of the MDS (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment dated [DATE] revealed Resident #130 had a BIMS score of 15 that indicated she was alert and oriented to person, place and time. Review of the MDS assessment revealed Resident #130 was dependent on staff for ADLs.Review of the care plan dated 03/29/26 revealed Resident #130 required staff assistance with ADL care related to dementia, history of fractures, and difficulty in walking with interventions that included restorative nursing for ambulation and ADL training for toileting 15-minute sessions 3-6 times per week.Review of the restorative toileting training and walking program participation log dated 04/06/26 through 05/05/26 revealed Resident #130 received restorative services 11 times within 30 days. Review of the participation log revealed Resident #130 did not receive restorative services 3-6 times per week as ordered and care planned.Interview on 05/05/26 at 10:34 A.M. with Rehabilitation Aide (RA) #463 revealed she was a restorative aide but had a floor assignment instead due to staffing levels. RA #463 revealed she was scheduled to do restorative services every day but was pulled to the floor quite a bit. RA #463 revealed another staff member had to go home for a family emergency therefore, she was assigned to assist as a CNA. RA #463 revealed she gets pulled to the floor a lot more often lately. RA #463 confirmed and verified the above findings at the time of the interview.Interview on 05/05/26 at 10:51 A.M. with Licensed Practical Nurse (LPN) #625 revealed there were specific staff that addressed and were assigned to complete restorative services. LPN #625 revealed restorative staff completed walking, stretching, toileting, feeding, and other exercises assigned to individual programs for residents. LPN #625 revealed sometimes the restorative aides get pulled from their assignment to assist with ADLs as floor staff and the restorative programs were put off until another time. LPN #625 confirmed and verified the above findings at the time of the interview.Interview on 05/05/26 at 1:48 P.M. with CNA #927 revealed RA #745 was assigned to do restorative programs for designated residents. CNA #927 revealed RA #745 was assigned to restorative exercises but was pulled to complete ADLs as a floor CNA. CNA #927 revealed Resident #24 required restorative services and was unable to receive services at the time. CNA #927 revealed Resident #24 always asked if she would receive services each day, but she could not provide an answer because depending on the day and the number of staff available, restorative services would not get done. CNA #927 confirmed and verified the above findings at the time of the interview.Interview on 05/05/26 at 1:57 P.M. with Registered Nurse (RN) #519 revealed there was one restorative aide assigned to each floor. RN #519 revealed the one restorative aide assigned to the 3rd floor was pulled to the memory care unit due to not having enough staff to cover the unit. RN #519 revealed RA #745 was assigned to complete restorative services for the third floor unit and due to her no longer assigned as restorative aide, residents residing on the unit would not get services. RN #519 confirmed and verified the above findings at the time of the interview.Interview on 05/05/26 at 2:00 P.M. with RA #745 revealed residents who were assigned to restorative programs typically were seen by the therapy department first and then added to restorative as a maintenance program. RA #745 revealed RAs were unable to document services unless they completed at least 15-minute sessions with residents. RA #745 revealed she was assigned to the 3rd floor and sometimes she was pulled to work as CNA to help assist with meals and/or feeding, answering call lights, or complete full shifts if a staff member called off, went home early, or did not show up. RA #745 revealed she was pulled a lot to work as a floor CNA and were unable to complete restorative programs as required, needed, or requested. CNA #745 revealed Resident #24 was really tight and really needed restorative services and she always felt bad when she couldn't get to her. RA #745 revealed she did not consistently provide restorative services to Resident #24, #31, and #130. RA #745 confirmed and verified the above findings at the time of the interview.Interview on 05/06/26 at 9:15 A.M. with Resident #24 revealed she was supposed to receive restorative services multiple times per week, but she was getting very little exercise due to the facility not having enough floor staff and needing to pull the restorative staff to assist with resident ADL care. Resident #24 revealed she required restorative services to decrease pain and to slow the process of her MS symptoms. Interview on 05/06/26 at 2:00 P.M. with Director of Therapy (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(DOT) #471 revealed after residents completed therapy, the therapy department created restorative programs for the nursing department to complete as a continuation of therapy for maintenance. DOT #471 revealed Residents's#24, #31, and #130 were on restorative programs due to medical diagnoses to decrease and/or prevent decline. DOT #471 revealed there were not enough RAs due to them getting pulled to the floor all the time and not being able to keep up with the restorative programs. DOT #471 revealed residents and families called complaining that they were not getting the restorative services or were only getting services once a week. DOT #471 confirmed and verified the above findings at the time of the interview.Interview on 05/06/26 at 3:22 P.M. with Staffing Coordinator (SC) #900 revealed if the facility was short on floor staff, the RAs were pulled from their restorative programs to assist throughout the facility as CNAs. SC #900 revealed having appropriate floor staff to assist throughout the facility for ADLs was a priority and coverage was more important than restorative programs. SC #900 confirmed and verified the above findings at the time of the interview.Interview on 05/06/26 at 9:48 A.M. with Resident #130 revealed RA #745 was assigned to complete restorative exercises with her but that was only when she wasn't pulled to be an CNA for the day. Resident #130 revealed she needed to walk with RA #745 to help keep her in shape and without pain. Resident #130 revealed she did not get restorative services as ordered.Review of the medical records for Residents #24, #31, and #130 revealed the facility removed RAs from their assigned restorative roles and utilized them as CNAs due to ongoing low staffing levels. As a result, residents who were identified to receive restorative nursing services did not consistently receive those services as ordered and care planned which had the potential for risk and decline in functional abilities.Review of the facility document titled Restorative Nursing dated 09/01/23, revealed the facility had a policy in place to provide maintenance and restorative services designed to maintain or improve a resident's abilities to the highest practicable level. Review of the policy revealed designated staff would be trained on basic and maintenance care that included maintaining proper positioning and body alignment, turning and repositioning, and exercising through passive or active range of motion and/or splint or brace assistance. Further review revealed resident's plan would include type of activities to be performed and frequency. Review of the facility document revealed the facility did not implement the policy.This deficiency represents non-compliance investigated under Master Complaint Number 2724206 and Complaint Number 2701574.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident record review, resident interview, staff interviews, and facility policy review, the facility failed to provide care and services to prevent a fall during a mechanical lift transfer. This affected one resident (#24) of three reviewed for falls. The facility census was 136.Findings include: Review of the medical record for Resident #24 revealed she was admitted to the facility on [DATE] with diagnoses that included multiple sclerosis (MS), contractures of the muscles, multiple sites, and scoliosis.Review of Resident #24's physician orders dated 01/23/25 revealed an order for two person care for ADLs.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #24 had a Brief Interview for Mental Status (BIMS) score of 15 that indicated she was alert and oriented to person, place, and time. Review of the MDS assessment revealed Resident #24 was impaired on both sides, upper and lower extremities, and was dependent on staff for activities of daily living (ADLs).Review of the care plan dated 02/10/26 revealed Resident #24 was at risk for falls and had and ADL self-care performance deficit related to MS, impaired mobility, lack of coordination and weakness and contractures of the muscles with interventions that included, but not limited to, follow fall protocol, educate staff on safety measures, use of mechanical lift for transfers and 2 person care for ADLs.Review of the incident log dated 03/05/26 through 05/05/26 revealed Resident #24 had a fall during staff assist incident dated 03/18/26 at 10:15 A.M.Review of the fall investigation revealed Resident #24 had a fall during staff assist on 03/18/26 at 10:15 A.M. Certified Nursing Assistant's (CNAs) #548 and #927 were transferring Resident #24 into her wheelchair when she slid out of the mechanical lift onto the floor with her head resting on the base of the mechanical lift. Resident #24 revealed she hit her head on the mechanical lift leg, denied pain and was transported to the hospital.Witness statement from CNA #548, dated 03/18/26, revealed she was positioned at Resident' #24 feet holding and guiding her legs, and CNA #927, who was positioned at the head of Resident #24 and guiding the mechanical lift, went to get her up, took her from over the bed and noticed she was slipping out of the mechanical lift. CNA #548 revealed Resident #24 was then lowered to the ground, and all hooks were in place before moving her.Witness statement from CNA #927, dated 03/18/26, revealed she was assisting CNA #548 get Resident #24 up for an appointment and when they moved her from the bed, noticed Resident #24 was slipping. CNA #927 reveled CNA #548 had Resident #24 legs as she lowered the mechanical lift while holding up under Resident #24. CNA #927 revealed all hooks were in place before moving her.Further review of the fall investigation revealed CNA #927 received competency training related to mechanical lift on 03/24/26 as a result of Resident #24 fall.Review of the incident note dated 03/18/26 at 11:01 A.M. revealed while CNAs #548 and #927 were using the mechanical lift to transfer Resident #24 from bed to wheelchair, one strap became unhooked and Resident #24 slid out of the sling headfirst and hit her head on the mechanical leg and landed on the floor. CNA notified Licensed Practical Nurse (LPN) #625 of the fall. Upon entering the room Resident #24 was on the floor lying on her back, with her head resting on the base of the mechanical lift. Resident #24 was assessed and vital signs were taken with no pian or injury noted. Resident #24 was taken to a local hospital per request. Mechanical lift was assessed for any damage or tears with none noted and in good condition.Review of the 72-hour post fall monitoring note dated 03/18/26 at 11:13 A.M. revealed Resident #24 denied any pain at the time of the fall and remained at baseline.Review of the alert note dated 03/18/26 at 2:37 P.M. revealed per the local hospital, Resident #24's diagnostic imaging and x-rays were negative, and Resident #24 would be returning to the facility with a pick-up time of 4:00 P.M.Review of the hospital discharge instructions dated 03/18/26 revealed Resident #24 had a diagnosis of an accidental fall, acute head injury, cervical strain, and contusion of the left shoulder. Review of the discharge paperwork revealed Resident #24 received x-rays of the left shoulder with no fractures or dislocation noted and imaging of the cervical (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	spine, brain and head with no hemorrhage, infarction or abnormalities related to trauma.Review of the Occupational Therapy (OT) evaluation and plan of treatment dated 03/30/26 revealed Resident #24 was referred for services due to a recent fall from the mechanical left from bed to wheelchair resulting in Resident #24 striking her head and left shoulder.Interview on 05/06/26 at 9:15 A.M. with Resident #24 revealed she fell out of the mechanical lift while being transferred due to two CNA's chatting with each other and not paying attention. Resident #24 revealed the mechanical lift strap was not in place and before she had a chance to say anything, she fell backwards and hit her head and left shoulder on the leg of the mechanical lift. Resident #24 revealed 911 was called she was rushed to the hospital and although she had no injuries, she had a lot of pain and contusion of the shoulder.Interview on 05/05/26 at 1:48 P.M. with CNA #927 revealed she was helping transfer Resident #24 on the day she had a fall from the mechanical lift. CNA #927 revealed one the straps became undone and caused Resident #24 to slip out of the mechanical lift and onto the floor. CNA #927 revealed she was unsure how the strap became undone and was educated and retrained following the incident. CNA #927 confirmed and verified the above findings at the time of the interview.Interview on 05/07/26 at 10:00 A.M. with LPN #625 revealed she was the nurse on duty at the time of Resident #24 fall. LPN #625 revealed Resident #24 was preparing to go to the dentist at the time of her fall when two CNA's (#548 and #927) were transferring her via the mechanical lift, when she slipped out due to the strap becoming undone, and fell to the floor. LPN #625 revealed when she arrived at the room, Resident #24 was lying on the floor with her head on the base of the mechanical lift. LPN #625 revealed Resident #24 was assessed with no injuries noted and neuro checks put in place. LPN #625 revealed Resident #24 was subsequently sent to a local hospital for evaluation. LPN #625 revealed Resident #24 was monitored and provided a lidocaine patch upon her return for shoulder pain. LPN #625 revealed Resident #24 was sent to the hospital for evaluation following the fall and although she returned to the facility with no acute injury identified, Resident #24 continued to complain of left shoulder pain. LPN #625 confirmed and verified Resident #24 fall demonstrated failure to ensure she was transferred safely during use of the mechanical lift, placing her at risk for injury during transfer assistance. LPN #625 confirmed and verified the above findings at the time of the interview.Interview on 05/07/26 at 2:02 P.M. with the Director of Nursing (DON) revealed Resident #24 had a fall from the mechanical lift during a staff transfer and as a result the mechanical lift was taken out of service. The DON revealed the mechanical lift had no problem with the mechanisms and Resident #24 didn't drop to the floor but was lowered when staff noticed she was slipping. The DON revealed the maintenance department inspected the mechanical lift and had no issues. The DON stated, maybe the staff put the hooks on wrong. The DON confirmed and verified the above findings at the time of the interview.Review of the facility document titled Mechanical Lift Transfer undated, revealed the facility had a policy in place that designated residents would be assisted to transfer by mechanical lift for the safety and comfort for both residents and staff members. Review of the policy revealed staff were to use two employees, follow the manufacturer's instructions, assemble equipment, and position equipment for smooth transfer. Review of the facility document revealed the facility did not implement the policy.Review of the facility document titled Fall Prevention & Management Policy reviewed 10/23/24, revealed the facility had a policy in place to educate, manage risk factors, and implement appropriate interventions to reduce the risk of falls. Review of the facility document revealed the facility did not implement the policy.This deficiency represents non-compliance investigated under Complaint Number 2615273.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. Based on resident interviews, staff interviews, facility documents and policy review, the facility failed to ensure residents were served a variety of meal choices. This had the potential to affect all residents residing in the facility except three Residents (#29, #54 and #125) who were identified by the facility as not receiving food by mouth (NPO) or from the kitchen. The facility census was 136.Findings include: Interview on 05/06/26 at 9:15 A.M. with Resident #24 revealed the food choices were always the same and rotated throughout each week. Resident #24 revealed she was served a lot of pasta and potatoes and little variations of alternatives. Resident #24 revealed the food quality had gone downhill over the last few months.Review of the weekly menu dated 05/03/26 through 05/09/26 revealed 5 out of 7 breakfast meals, 5 out of 7 lunch meals, and 4 out of 7 dinner meals, within the same week served a variation of potatoes. Review of the menu revealed the following:On 05/03/26 the breakfast meal consisted of breakfast potatoes, the lunch meal potato soup, and the dinner meal potato soup and sweet potatoes fries.On 05/04/26 the breakfast meal consisted of hashbrown patties, the lunch meal mash potatoes and gravy, and the dinner meal had herbed red potatoes.On 05/05/26 the lunch meal consisted of rosemary scalloped potatoes, and the dinner meal mashed potatoes.On 05/06/26 the breakfast meal consisted of tater tots, the lunch meal baked potatoes, and the dinner meal dill potatoes.On 05/07/26 the breakfast meal consisted of hashbrown patties.On 05/09/26 the breakfast meal consisted of corned beef hash and the lunch meal consisted of candied yams.Interview on 05/06/26 at 3:22 P.M. with Dietary Technician (DT) #829 revealed residents often complained about eating the same food items. DT #829 revealed kitchen staff just followed the menus provided and the dietary director was responsible for switching things around. DT #829 chuckled as he reviewed the number of different variations of potatoes that appeared on the menu multiple times throughout the week. DT #829 during review of the menus confirmed and verified the above findings at the time of the interview.This deficiency represents non-compliance investigated under Master Complaint Number 2724206.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366071	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT Alverna Home Inc	6765 State Road Parma, OH 44134

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident record review, staff interview, and facility policy review, the facility failed to ensure resident meal preferences were honored. This affected one resident (#109) of one reviewed for preferences. The facility census was 136.Findings include: Review of the medical record for Resident #109 revealed he was admitted to the facility on [DATE] with diagnoses that included cerebral infarction, hemiplegia and hemiparesis affecting right dominant side, and hypertension.Review of the physician orders dated 03/05/25 revealed an order for Resident #109 to receive double portions for all meals with extra gravy.Review of the physician orders dated 04/03/25 revealed an order for general diet, regular texture and thin liquids.Review of the care plan dated 04/29/25 revealed Resident #109 had variable food intakes with need for supplementation with interventions that included honor food preferences.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #109 had a brief Interview for Mental Status (BIMS) score of 12 that indicated he was alert and oriented to person, place, and time. Review of the MDS assessment revealed Resident #109 was impaired on one side and required some assistance from staff for activities of daily living (ADLs).Observation on 05/06/26 at 11:50 A.M. with Dietary Aide (DA) #941 of the lunch tray line revealed Resident #109's lunch meal was being plated. Certified Nurse Assistant (CNA) #548, as Resident #109 meal tray reached completion stated, Resident #109 gets two potatoes, and you only gave him one. DA #941, in response stated, I'm only giving him one because I don't know if we have enough. DA #941 revealed he was aware that Resident #109 were to be served double portions at all his meals, but he wasn't going to give him two potatoes when interviewed by the surveyor. Observation revealed Resident #109 lunch meal tray had one potato placed on his plate. DA #941 confirmed and verified the above findings at the time of the observation and interview.Review of the lunch meal ticket dated 05/06/26 revealed Resident #109 had a general diet with regular textures and thin liquids. Resident #109 lunch consisted of pasta fagioli soup, 2 baked potatoes, carrots, caramel marshmallow brownies, and honey garlic chicken thighs. Review of the meal ticket revealed Resident #109 was to receive double portions and to be served all his meals in the dining room.Observation on 05/06/26 at 12:18 P.M. revealed DA #941 providing Resident #109 a second potato after surveyor intervention. Review of the facility document titled Resident Services dated 05/01/28, revealed the facility had a policy in place that resident's rights and decisions would be honored and respected.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, resident interviews, staff interviews, and facility policy review, the facility failed to ensure meals were served in a timely manner to ensure proper temperature and failed to ensure hairnets were worn to ensure proper sanitation. This had the potential to affect all residents residing in the facility except three Residents (#29, #54 and #125) who were identified by the facility as not receiving food by mouth (NPO) or from the kitchen. The facility census was 136.Findings include: Interview on 05/05/26 at 1:48 P.M. with Certified Nurse Assistant (CNA) #927 revealed residents in the facility complained about cold and nasty food all the time. CNA #927 revealed staff had to call the kitchen all the time with resident complaints.Interview on 05/06/26 at 9:15 A.M. with Resident #24 revealed the food was never hot and it always arrived late. Resident #24 revealed the food quality had gone downhill over the last few months.Interview on 05/06/26 at 12:11 P.M. with Resident #109 revealed the food was always cold and he requested to have his tray warmed up or served first. Resident #109 revealed he preferred to eat in the dining room to ensure he received his meals first.Observation and interview on 05/06/26 at 11:40 A.M. with Dietary Technician (DT) #829 located in the kitchen revealed the facility served the dining rooms first and then room trays went last. Observation revealed the third floor cart was sent to the dining room at approximately 11:43 A.M.Observation on 05/06/26 at 11:50 A.M. with Dietary Aide (DA) #941 of the temperatures of the lunch meal revealed pasta with meat sauce was 157 degrees Fahrenheit (F), carrots were 170 degrees F, honey garlic chicken was 124 degrees F, baked potatoes was 174 degrees F, soup was 168 degrees F, the pureed mashed potatoes were 168 degrees F, and hamburger 160 degrees F.Observation and interview on 05/06/26 at 12:22 P.M. revealed Resident Care Assistant (RCA) #418 entered into the third floor kitchen without a hairnet and/or hair covering and entered the refrigerator. RCA #418 revealed she did not know she couldn't enter the kitchen without a hairnet because it was not the main kitchen. RCA #418 confirmed and verified the above findings at the time of the interview.Observation and interview on 05/06/26 at 12:53 P.M. of the lunch meal service with DA #941 revealed multiple plated hot food items sitting uncovered on the steam table and not being actively assembled onto trays or transported for service. The food remained on the steam table without staff intervention. DA #941 stated I'm not waiting on anything or additional items and indicated there was no specific reason for the delay in tray assembly or delivery when interviewed.Temperatures of the food items were taken on the steam table prior to service and again on a test tray at the time of meal delivery. The following temperature decreases were noted: the baked potato decreased from 174 to 147 degrees F, pasta with meat decreased from 157 to 143 degrees F, soup decreased from 168 to 134 degrees F, and the carrots decreased from 170 to 124 degrees degrees F. The carrots and soup were below the required hot holding temperature of 135 degrees F after serving the lunch meal, and the chicken measured below acceptable hot holding temperature at 134 degrees F prior to meal tray pass, indicating significant heat loss prior to service. Multiple food items were also observed to be lukewarm at the time of service.The test tray observation on 05/06/26 at 1:01 P.M. with DT #829 revealed the facility failed to maintain proper time and temperature control of hot foods and failed to ensure prompt service with potential to increase the risk that food entered the temperature danger zone and was not served at safe and palatable temperatures. DT #829 confirmed and verified the above findings at the time of the interview and observation.Review of the food committee minutes and resident council minutes dated February, March, and April 2026 revealed on 02/12/26, hot plates were tested and were currently being utilized for all meals. The minutes dated 03/12/26 revealed the pallets in the kitchen were new would make the food stay hot longer and the minutes dated 04/16/26 revealed residents reported the food was warmer. Review of the minutes revealed residents consistently voiced concerns regarding the temperature of their meals.Review of the facility document titled Personal Hygiene dated 10/25/22, (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	revealed the facility had a policy in place that personal hygiene was an essential part of food safety and preventing the spread of bacteria that included, but not limited to, hair restraints. Review of the policy revealed hair must be appropriately restrained by using a hair net that competed covered all hair in any food production area.This deficiency represents non-compliance investigated under Master Complaint Number 2724206 and Complaint Numbers 2661047 and 2609451.