

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366229	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2025
NAME OF PROVIDER OR SUPPLIER Parkside Villa		STREET ADDRESS, CITY, STATE, ZIP CODE 7040 Hepburn 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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42730</p> <p>Based on observation, record review, interview, and facility policy review, the facility failed to ensure call lights were within reach and accessible. This affected one resident (#4) of one resident reviewed for call light placement. The facility census was 142.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #4 revealed she was admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure, type 2 diabetes, and cellulitis of the right lower limb.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #4 was alert and oriented with cognition impairment, impaired on one side, and was dependent on staff for activities of daily living (ADLs).</p> <p>Review of the care plan dated 03/25/25 revealed Resident #4 was at risk for falls and had impaired mobility with interventions that included, but not limited to, call light accessible when in room.</p> <p>Observation on 04/22/25 at 3:00 P.M. revealed Licensed Practical Nurse (LPN) #858, Registered Nurse (RN) #879 and Certified Nurse Assistant (CNA) #881 seated at the nursing station located on the locked unit, Cypress.</p> <p>Observation and interview on 04/22/25 at 3:09 P.M. revealed Resident #4 yelling out for help. Resident #4 stated Help please, I want to get out of bed and dressed. Resident #4 was observed in bed with her gown on and call light not in reach. Resident #4's call light was located to her right side and hanging down to the floor. Resident #4 was observed trying to locate and reach her call light for staff assistance, but was unsuccessful. Resident #4 stated she did not know where her call light was and was trying to feel around and find it. Resident #4 stated she had been trying to find help for a while.</p> <p>Interview on 04/22/25 at 3:12 P.M. with LPN #858 revealed Resident #4 was alert to self and had a new diagnosis of dementia, unable to care for herself, and had difficulty with ADLs. LPN #858 revealed she had just arrived for her shift and was not sure who was assigned to Resident #4. LPN #858 revealed she was not aware of Resident #4 needing assistance and she would not being able to hear her yell out due to her room being so far away from the nurse's station.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366229	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2025
NAME OF PROVIDER OR SUPPLIER Parkside Villa		STREET ADDRESS, CITY, STATE, ZIP CODE 7040 Hepburn 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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 04/22/25 at 3:17 P.M. with LPN #858 revealed Resident #4 was laying in bed, yelling out for help, and attempting to reach call light. LPN #858 was observed asking Resident #4 if she needed assistance and Resident #4 stated she wanted to get dressed and out of bed. Resident #4 was also observed yelling at LPN #858 that she could find or reach her call light. LPN #858 picked up Resident #4 call light and stated the call light should be attached to your clothes, so that you could reach it and Resident #4 stated I know. LPN #858 confirmed and verified Resident #4 call light was out of reach.</p> <p>Review of the facility document titled Use of Call Light reviewed 01/06/25 revealed the facility had a policy in place that call lights were to always be placed within reach of the resident. Review of the documents revealed the facility did not implement the policy.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366229	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2025
NAME OF PROVIDER OR SUPPLIER Parkside Villa		STREET ADDRESS, CITY, STATE, ZIP CODE 7040 Hepburn 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 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35768</p> <p>Based on record review and interview the facility failed to ensure residents received restorative therapy as ordered. This affected one (Resident #138) of three residents reviewed for therapy. The facility census was 142.</p> <p>Findings include:</p> <p>Review of medical record for Resident #138 noted an admitted [DATE]. Diagnoses included chronic respiratory failure with hypoxia, acute kidney failure, encounter for attention to tracheostomy, and unspecified protein-calorie malnutrition.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment, dated 01/09/25, revealed the resident had impaired cognition. The resident was dependent for all activities of daily living.</p> <p>Review of plan of care dated 10/28/24 noted Resident #138 was at risk for impaired functional range of motion related to inability to move extremities independently. The plan of care included passive range of motion to bilateral to ankles and slow gentle pace holding at end range for 10 seconds. Additional instructions included to provide 10 repetitions for two to three sets over all joints including shoulder, elbow, wrists and digits. The plan of care stated to provide range of motion program (passive) six-seven days a week at least 15 minutes a day to upper and lower extremities.</p> <p>Review of physician order dated 04/04/25 noted Resident #138 was to receive passive range of motion to upper and lower extremities three to six times a week.</p> <p>Review of the facility task option for completing restorative therapy noted Resident #138 received therapy on 03/25/25, 04/10/25 04/14/25, 04/15/25, and 04/17/25.</p> <p>Interview on 04/23/25 at 12:09 P.M. with Certified Nurse Aide #991 stated residents were not receiving restorative therapy as scheduled because the restorative aides get pulled to work the floor all the time.</p> <p>Interview on 04/23/25 at 12:15 P.M., Registered Nurse (RN) #803 stated residents are scheduled to receive restorative therapy three to six times a week. RN #803 verified Resident #138 received therapy five times in a 30-day period due to lack of staffing in the restorative therapy department.</p> <p>Review of the facility policy titled Restorative Nursing Policy and Procedure, dated 01/06/25 noted each resident will be screened for restorative nursing upon admission, annually and quarterly. Licensed nursing personnel will supervise the restorative nursing programs.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00163918.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366229	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2025
NAME OF PROVIDER OR SUPPLIER Parkside Villa		STREET ADDRESS, CITY, STATE, ZIP CODE 7040 Hepburn 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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42730</p> <p>Based on observation, resident record review, staff interviews, and facility policy review, the facility failed to ensure interventions were in place to prevent a fall. This affected one (#152) of three residents reviewed for falls. The facility census was 142.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #152 revealed she was admitted to the facility on [DATE] with diagnoses that included dementia, pressure ulcer of the left heel, and type 2 diabetes.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #152 was alert and oriented with cognition impairment and required assistance from staff for Activities of Daily Living (ADLs).</p> <p>Review of the physician orders dated 03/07/25 revealed an order for Resident #152 to reside on the secured unit to stabilize medical symptoms of psychiatric illness or dementia.</p> <p>Review of the care plan dated 03/10/25 revealed Resident #152 had a self-care mobility and functionality performance deficit and was a fall risk with interventions that included providing extensive assistance with transfers such as sit to stand, chair/bed to chair transfers, and supervision and/or touching during transfers.</p> <p>Review of the fall review assessment dated [DATE] revealed Resident #152 was high risk for falls, had problems with ambulation, required assistive devices for ambulation, and was unable to stand without physical assist. The fall review assessment noted Resident #152 was found on the floor.</p> <p>Review of the progress note dated 04/22/25 at 7:06 A.M. revealed Resident #152 was found on the bedroom floor, vital signs within normal limits, and can move all extremities. Resident #152 required staff assistance of one to lift off the floor.</p> <p>Review of the progress note dated 04/23/25 at 9:09 A.M. revealed Resident #152 was found on the floor in her room with risk factors including dementia, type 2 diabetes, and anxiety. Resident #152 currently resided on the memory care unit and neuro checks initiated. Review of the progress note revealed Resident #152 was assisted to her wheelchair and brought to the common area for closer observation.</p> <p>Observation on 04/22/25 at 6:35 A.M. revealed Resident #152 was observed on the floor between her bed and wheelchair. Resident #152 was yelling out for help. Maintenance Staff (MS) #913 was observed outside Resident #152 room, however, he did not acknowledge Resident #152 being on the floor and he did not alert staff. Observation revealed Licensed Practical Nurses (LPN) #738 and #731, Certified Nurse Assistant (CNA) #895, and Registered Nurse (RN) #879 were seated at the central nursing station, but unaware of Resident #152 yelling out for help. State Surveyor informed staff Resident #152 was on the floor yelling out for help. LPN #738, LPN #731, CNA #895, and RN #879 were observed entering Resident #152 room.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366229	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2025
NAME OF PROVIDER OR SUPPLIER Parkside Villa		STREET ADDRESS, CITY, STATE, ZIP CODE 7040 Hepburn 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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Interview on 04/22/25 at 6:43 A.M. with RN #879 revealed Resident #152 was a fall risk and required assistance from staff for ADLs including transfers. RN #879 revealed Resident #152 had behaviors that included attempting to self-transfer from the bed to her wheelchair. RN #879 revealed Resident #152 wheelchair should not be near her bed and was out of reach for that reason. RN #879 confirmed and verified Resident #152 wheelchair was at her bedside.</p> <p>Interview on 04/22/25 at 6:45 A.M. with CNA #895 revealed Resident #152 was always trying to get up and down and transfer to her wheelchair. CNA #895 revealed Resident #152 wheelchair was near her bed the last time she checked on her, but it should not have been. CNA #895 confirmed and verified Resident #152 wheelchair was at her bedside.</p> <p>Interview on 04/22/25 at 3:20 P.M. with LPN #858 revealed Resident #152 was able to ambulate throughout the unit once in her wheelchair. LPN #858 revealed Resident #152 transferred from her bed to her wheelchair unsupervised, however, she was not supposed to, due to being a fall risk. LPN #858 revealed Resident #152 was a one-person assist with supervision and her wheelchair should be out of reach, or at least at the end of the bed. LPN #858 confirmed and verified Resident #152 medical record revealed no documented fall interventions related to wheelchair not in reach or near bedside to prevent falls.</p> <p>Review of the facility document titled Falls reviewed 01/06/25 revealed the facility had a policy in place that residents would be assessed to identify history of falls and risk factors and document in the clinical record. Further review of the policy revealed the facility would implement interventions to prevent subsequent falls. Review of the document revealed the facility did not implement the policy.</p> <p>This deficiency represents noncompliance investigated under Complaint Number OH00164822.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366229	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2025
NAME OF PROVIDER OR SUPPLIER Parkside Villa		STREET ADDRESS, CITY, STATE, ZIP CODE 7040 Hepburn 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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42730</p> <p>Based on observations, resident record reviews, resident interviews, staff interviews, and facility policy review, the facility failed to ensure oxygen tubing labeled and changed routinely. This affected six (#84, #91, #114, #118, #160, #367) of six residents reviewed for respiratory services. The facility census was 142.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #114 revealed she was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes, chronic obstructive pulmonary disease, and dependence on supplemental oxygen.</p> <p>Review of the physician orders dated 03/27/25 revealed Resident #114 had an order in place for oxygen at 2-4 liters per minute via nasal canula every shift to keep pulse oximetry readings equal or greater than 92 percent.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #114 was alert and oriented, required assistance from staff for activities of daily living (ADLs), had shortness of breath or trouble breathing when lying flat, and required oxygen.</p> <p>Review of the care plan dated 04/18/25 revealed Resident #114 was dependent on supplemental oxygen.</p> <p>Observation and interview on 04/21/25 at 10:10 A.M, revealed Resident #114 was laying in bed with her nasal canula on with no dated tubing. Resident #114 revealed she was unsure of the last time it was changed, and it was never dated.</p> <p>2. Review of the medical record for Resident #84 revealed she was admitted to the facility on [DATE] with diagnoses that included polyneuropathy, respiratory failure, and dependence on supplemental oxygen.</p> <p>Review of the physician orders dated 01/10/25 revealed an order for oxygen at 4 liters via nasal canula every shift and 2 liters every 4 hours for shortness of breath.</p> <p>Review of the MDS assessment dated [DATE] revealed Resident #84 was alert and oriented to person, place, and time, was dependent on staff for ADLs and required oxygen.</p> <p>Review of the care plan dated 03/25/25 revealed Resident #84 required oxygen.</p> <p>Observation and interview on 04/21/25 at 10:10 A.M, revealed Resident #84 was currently out of the room with her oxygen tubing still attached to the concentrator. Resident #84 oxygen tubing was undated.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366229	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2025
NAME OF PROVIDER OR SUPPLIER Parkside Villa		STREET ADDRESS, CITY, STATE, ZIP CODE 7040 Hepburn 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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Interview and observation on 04/21/25 at 10:32 A.M. with Certified Nurse Assistant (CNA) #717 revealed the nurses were responsible for changing and dating oxygen tubing. CNA #717 confirmed and verified the oxygen tubing belonging to Resident #114 and #84 was not dated and she could not verify the last time it was changed.</p> <p>Interview on 04/21/25 at 10:51 A.M. with Resident #84 revealed she had just returned from dialysis. Resident #84 revealed her oxygen tubing was not dated and not changed.</p> <p>Interview on 04/22/25 at 3:32 P.M. with Licensed Practical Nurse (LPN) #906 revealed the respiratory department were responsible for changing tubing and the nurses were responsible for dating the tubing. LPN #906 revealed all oxygen tubing were to be changed once a week. LPN #906 revealed it was the facility policy to change and date oxygen tubing weekly. LPN #906 was unable to confirm when the oxygen tubing for Resident #114 and #84 was changed.</p> <p>38523</p> <p>3. Review of the medical record for Resident #91 revealed an admitted [DATE] and readmitted [DATE] and a discharge date of [DATE] and diagnoses including unspecified atrial fibrillation, acute and chronic respiratory failure with hypoxia, end stage renal disease, dependence on renal dialysis, lung transplant, acute pulmonary edema, dependence on respirator ventilator, encounter for attention to tracheostomy, atelectasis, long-term (current) use of inhaled steroids, dependence on supplemental oxygen, personal history of COVID-19, personal history of nicotine dependence, personal history of other diseases of the respiratory system and personal history of pneumonia (recurrent).</p> <p>Review of Resident #91's orders dated 04/07/25 revealed oxygen at two liters (L) via nasal canula (NC) every four hours as needed for shortness of breath. The order specified may titrate to keep pulse oximetry equal or greater than 92%.</p> <p>Observation on 04/22/25 at 8:53 A.M. revealed Resident #91's oxygen tubing was not dated.</p> <p>Interview on 04/22/25 at 8:53 A.M. with Respiratory Therapist (RT) #816 verified Resident #91's oxygen tubing was not dated.</p> <p>4. Review of the medical record for Resident #118 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD), chronic respiratory failure with hypoxia and long-term (current) use of inhaled steroids.</p> <p>Review of Resident #118's orders dated 04/21/25 revealed orders for oxygen at 4L via NC, keep head of bed elevated, as tolerated, due to shortness of breath while lying flat related to COPD and change tubing and rinse concentrator filter weekly, every night shift on Thursdays for routine care.</p> <p>Observation on 04/22/25 at 3:10 P.M. revealed Resident #118's oxygen tubing was not dated.</p> <p>Interview on 04/21/25 at 3:10 P.M. with LPN #735 verified Resident #118's oxygen tubing was not dated.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366229	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2025
NAME OF PROVIDER OR SUPPLIER Parkside Villa		STREET ADDRESS, CITY, STATE, ZIP CODE 7040 Hepburn 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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>5. Review of the medical record for Resident #160 revealed an admitted [DATE]. Diagnoses included acute and chronic respiratory failure unspecified whether with hypoxia or hypercapnia, dependence on supplemental oxygen and personal history of pneumonia (recurrent).</p> <p>Review of Resident #160's orders dated 03/24/25 revealed an order for oxygen at 3L per minute via NC. Resident #160 also had an order to change oxygen tubing and concentrator filter weekly every night shift every Thursday for routine care.</p> <p>Observation on 04/21/25 at 10:30 A.M. revealed Resident #160's oxygen tubing was not dated.</p> <p>Interview on 04/21/25 at 2:59 P.M. Certified Nursing Assistant (CNA) #875 verified Resident #160's oxygen tubing was not dated.</p> <p>6. Review of the medical record for Resident #367 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included pulmonary hypertension, peripheral vascular disease and venous insufficiency (chronic and peripheral).</p> <p>Review of Resident #367's orders dated 04/16/25 revealed orders for oxygen at 3L per minute via NC and change oxygen tubing and concentrator filter weekly every night shift every Thursday for routine care.</p> <p>Observation on 04/21/25 at 10:30 A.M. revealed Resident #367's oxygen tubing was not dated.</p> <p>Interview on 04/21/25 at 10:30 A.M. CNA #979 verified Resident #367's oxygen tubing was not dated.</p> <p>Review of the facility document titled Oxygen Administration reviewed 01/06/25 revealed the facility had a policy in place that equipment utilized to administer oxygen, including tubing, was to be changed and dated. Review of the document revealed the facility did not implement the policy.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366229	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2025
NAME OF PROVIDER OR SUPPLIER Parkside Villa		STREET ADDRESS, CITY, STATE, ZIP CODE 7040 Hepburn 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 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42730</p> <p>Based on resident record review, resident interview, staff interviews, dialysis staff interviews, and facility policy review, the facility failed to ensure residents requiring dialysis attended scheduled appointments. This affected one (#84) of one resident reviewed for dialysis. The facility identified 13 total residents who received dialysis treatments. The facility census was 142.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #84 revealed she was admitted to the facility on [DATE] with diagnoses that included polyneuropathy, respiratory failure, dependence on dialysis, and hypertensive heart and chronic kidney disease.</p> <p>Review of the MDS assessment dated [DATE] revealed Resident #84 was alert and oriented to person, place, and time, was dependent on staff for ADLs and required dialysis.</p> <p>Review of the physician order dated 01/15/25 revealed an order to complete dialysis communication form before dialysis and send with patient to dialysis one time a day every Monday, Wednesday, and Friday.</p> <p>Review of the care plan dated 03/25/25 revealed Resident #84 had renal failure related to end stage renal disease, required hemodialysis on Monday, Wednesday, and Fridays.</p> <p>Review of the progress notes dated 03/12/25 revealed no indication that Resident #84 received dialysis.</p> <p>Review of the paper chart for Resident #84 revealed no pre- and post- dialysis treatment forms dated for 03/12/25.</p> <p>Review of the physician order dated 04/09/25 revealed an order for dialysis Monday, Wednesday, and Friday at to be performed at the facility's in-house dialysis unit with a chair time of 6:45 A.M. Transportation arrangements were to be performed by staff once a day every Monday, Wednesday, and Friday.</p> <p>Observation on 04/21/25 at 10:10 A.M. revealed Resident #84 was at dialysis, which was located on the 2nd floor of the facility. Resident #84 room was also located on the 2nd floor of the facility.</p> <p>Observation and interview on 04/21/25 at 10:41 A.M. with Resident #84 revealed she was seated at the nursing station in her wheelchair and had just returned from dialysis. Resident #84 revealed dialysis was located onsite in the facility right down the hall from her room. Resident #84 revealed her main concern with the facility was staffing. Resident #84 revealed the facility never had enough staff to meet her needs. Resident #84 revealed she was unable to attend dialysis on 03/12/25 due to not having enough staff in the building to get her out of bed and transport her down the hall to her dialysis appointment.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366229	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2025
NAME OF PROVIDER OR SUPPLIER Parkside Villa		STREET ADDRESS, CITY, STATE, ZIP CODE 7040 Hepburn 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 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 04/22/25 at 3:32 P.M. with Licensed Practical Nurse (LPN) #906 revealed Resident #84 went to dialysis three times a week on Monday, Wednesday and Fridays. LPN #906 revealed the facility utilized a form that both facility staff and dialysis staff completed for pre- and post- dialysis treatments. LPN #906 revealed the night shift was responsible for completing the form, provided it to dialysis staff, and after completion placed in the hard chart. LPN #906 revealed staffing had been a little challenging lately. LPN #906 revealed staff completing the form must sign and date it before placing it in the chart. LPN #906 revealed the night shift was responsible for getting Resident #84 out of bed and transported to dialysis.</p> <p>Interview on 04/23/25 at 9:38 A.M. with Dialysis Registered Nurse (DRN) #500 revealed Resident #84 was on dialysis and was to attend every Monday, Wednesday, and Friday. DRN #500 revealed she was very familiar with Resident #84 and distinctly remembered her not attending dialysis on 03/12/25 due to not having enough staff. DRN #500 revealed the Certified Nurse Assistant (CNA) assigned to Resident #48 stated she was not going to get Resident #84 up for her dialysis appointment due to having a migraine. DRN #500 revealed she attempted multiple times to get staff to bring Resident #84 to dialysis because it was a very big deal, but staff did not comply. DRN #500 revealed Resident #84 chair time was 6:45 A.M.</p> <p>Review of the Dialysis patient note dated 03/12/25 at 9:02 A.M. revealed per facility staff, Resident #84 was unable to be transported on time due to facility staff stating she had a migraine and was unable to get Resident #84 into her chair. Dialysis staff questioned if any other facility staff would be able to get Resident #84 to her treatment but was informed there wasn't anyone else to complete the transport. Review of the patient note revealed facility staff stated Resident #84 would not be able to attend dialysis until after 1st shift arrived. Dialysis staff attempted to check with facility staff for 45 minutes after first shift arrived and Resident #84 could not attend due to transportation issues.</p> <p>Interview on 04/23/25 at 9:43 A.M. with DRN #500 revealed Resident #84 appointment time was at 6:45 A.M. DRN #500 confirmed and verified Resident #84 did not attend dialysis on 03/12/25 due to not having enough staff.</p> <p>Interview on 04/23/25 at 3:30 P.M. with the Director of Nursing (DON) revealed she was unaware of Resident #84 missing any dialysis appointments. DON provided Resident #84 Medication and Treatment Administration Record (MAR/TAR) that indicated Resident #84 attended dialysis on 03/12/25. DON reviewed Resident #84 MAR/TAR and confirmed and verified LPN #842 signed and dated that Resident #84 attended dialysis, when in fact she did not. DON confirmed and verified, after review of the dialysis patient note, Resident #84 did not attend dialysis appointment due to staff not getting her up.</p> <p>Follow-up interview on 04/23/25 at 4:13 P.M. with the DON revealed LPN #842 was the nurse on duty and she reported she was not aware of any residents missing their scheduled dialysis appointments. DON provided unsigned dialysis sheets located in Resident #84 paper chart that were already reviewed, confirmed, and verified prior by the state surveyor and DRN #500 as invalid. DON was unable to identify the CNA on duty at the time of Resident #84 missed appointment. DON confirmed and verified the above findings during the interview.</p> <p>Interview on 04/23/25 at 4:30 P.M. was attempted with LPN #842 but was unsuccessful.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366229	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2025
NAME OF PROVIDER OR SUPPLIER Parkside Villa		STREET ADDRESS, CITY, STATE, ZIP CODE 7040 Hepburn 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 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Dialysis agreement dated 04/01/21, revealed the facility had the sole responsibility for transporting dialysis patients to and from the dialysis treatment den within the nursing facility at the scheduled times. Review of the Dialysis agreement revealed if a patient was more than 30 minutes late for an appointment or missed an appointment due to lack of transportation, Davita staff would determine if it was safe to treat at that time or required to reschedule due to safety concerns.</p> <p>This deficiency represents noncompliance investigated under Complaint Number OH00163704.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366229	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2025
NAME OF PROVIDER OR SUPPLIER Parkside Villa		STREET ADDRESS, CITY, STATE, ZIP CODE 7040 Hepburn 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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42730</p> <p>Based on observations, resident record review, resident interviews, and staff interviews. The facility failed to ensure adequate staff levels to meet the needs of the residents. This affected three (#4, #79, #104) of three residents reviewed and had the potential to affect all residents residing in the facility. The facility census was 142.</p> <p>Findings include:</p> <p>1. Interview on 04/21/25 at 9:55 A.M. with Resident #148 revealed there weren't enough staff in the building and call lights went unanswered.</p> <p>Interview on 04/21/25 at 10:04 A.M. with Resident #72 revealed there were not enough staff, especially aides, and call light wait times were long.</p> <p>Interview on 04/21/25 at 10:12 A.M. with Resident #35 revealed staff did not show up for work and she had to wait long periods of time to get up out of bed.</p> <p>Interview on 04/21/25 at 10:23 A.M. with Resident #74 revealed the facility was short on aides.</p> <p>Interview on 04/21/25 at 10:41 A.M. with Resident #84 revealed the facility was always short on staff.</p> <p>Interview on 04/21/25 at 10:46 A.M. with Certified Nurse Assistant #CNA) #953 revealed there were not enough aides. CNA #953 revealed there were only two aides covering the secured unit and it wasn't enough for the census and acuity level.</p> <p>Interview on 04/21/25 at 10:51 A.M. with Licensed Practical Nurse (LPN) #939 revealed there were not enough staff to manage the census and acuity levels. LPN #939 revealed there were multiple residents that required hooyer lift, hands-on feedings, showers, and frequent check and changes and monitoring.</p> <p>2. Review of the medical record for Resident #4 revealed she was admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure, type 2 diabetes, and cellulitis of the right lower limb.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #4 was alert and oriented with cognition impairment, impaired on one side, and was dependent on staff for Activities of Daily Living (ADLs).</p> <p>Review of the care plan dated 03/25/25 revealed Resident #4 was at risk for falls and had impaired mobility with interventions that included, but not limited to, call light accessible when in room.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366229	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2025
NAME OF PROVIDER OR SUPPLIER Parkside Villa		STREET ADDRESS, CITY, STATE, ZIP CODE 7040 Hepburn 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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Observation and interview on 04/22/25 at 3:09 P.M. revealed Resident #4 yelling out for help. Resident #4 stated Help please, I want to get out of bed and dressed. Resident #4 was observed in bed with her gown on and call light not in reach. Resident #4 call light was located to her right side and hanging down to the floor. Resident #4 was observed trying to locate and reach her call light for staff assistance, but it was unsuccessful. Resident #4 stated she did not know where her call light was and was trying to feel around and find it. Resident #4 stated she had been trying to find help for a while.</p> <p>Interview on 04/22/25 at 3:12 P.M. with LPN #858 revealed Resident #4 was alert to self and had a new diagnosis of dementia, unable to care for herself, and had difficulty with ADLs. LPN #858 revealed she had just arrived for her shift and was not sure who was assigned to Resident #4. LPN #858 revealed she was not aware of Resident #4 needing assistance and she would not be able to hear her yell out due to her room being so far away from the nurse's station.</p> <p>Observation on 04/22/25 at 3:17 P.M. with LPN #858 revealed Resident #4 was laying in bed, yelling out for help, and attempting to reach call light. LPN #858 was observed asking Resident #4 if she needed assistance and Resident #4 stated she wanted to get dressed and out of bed. Resident #4 was also observed yelling at LPN #858 that she could not find or reach her call light. LPN #858 picked up Resident #4 call light and stated the call light should be attached to your clothes, so that you could reach it and Resident #4 stated I know. LPN #858 confirmed and verified Resident #4 call light was out of reach.</p> <p>Interview on 04/22/25 at 3:19 P.M. with Registered Nurse (RN) #879 revealed the CNA assigned to Resident #4 had left at 3:00 P.M. and there weren't any coverage for her at this time. RN #879 revealed without staff coverage or Resident #4 call light within reach, no one would have known she required assistance. RN #879 revealed she preferred to be dressed and out of bed. RN #879 confirmed and verified lack of staffing.</p> <p>3. Review of medical record for Resident #79 noted an admitted [DATE]. Diagnoses included malignant neoplasm of endometrium and genital organs, morbid obesity, and foot drop of left foot.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment, dated 03/12/25, revealed the resident had intact cognition. The resident required moderate assistance for activities of daily living.</p> <p>Review of plan of care dated 03/20/25 noted Resident #79 had impaired mobility and required assistance with activities of daily living. Interventions included the use of mechanical lift, and extensive assistance with toilet use.</p> <p>Interview on 04/22/25 at 10:36 A.M., Resident #79 was observed lying in bed. Resident #79 stated she wanted to be out of bed by 9:00 A.M. every day, but staff were unable to assist her in a timely manner due to lack of staffing.</p> <p>Interview on 04/22/25 at 10:43 A.M., Certified Nurse Assistant (CNA) #979 stated the facility was short staffed all the time causing longer wait times for care and getting residents out of bed in a timely manner.</p> <p>4. Review of medical record for Resident #104 noted an admitted [DATE]. Diagnoses included anxiety disorder, depression, and muscle weakness.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366229	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2025
NAME OF PROVIDER OR SUPPLIER Parkside Villa		STREET ADDRESS, CITY, STATE, ZIP CODE 7040 Hepburn 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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of the quarterly Minimum Data Set (MDS) assessment, dated 03/07/25, revealed the resident had intact cognition. The resident required maximum assistance for activities of daily living.</p> <p>Review of plan of care dated 05/02/24 noted Resident #104 had activity of daily living self-care performance deficit related to activity intolerance, fatigue, impaired imbalance, and limited mobility. Interventions included to provide extensive assistance while in bed, for mobility and transfers.</p> <p>Interview on 04/22/25 at 10:44 A.M., Resident #104 was observed lying in bed. Resident #104 stated he wanted to be out of bed by 10:00 A.M. every morning. Additional interview and observation at 2:50 P.M. noted Resident #104 still lying in bed. Resident #104 stated he asked staff around 10:00 A.M. that morning.</p> <p>Interview on 04/22/25 at 3:00 P.M., Certified Nurse Assistant (CNA) #991 stated Resident #104 had been asking to get out of bed all day, but confirmed no staff had assisted him.</p> <p>This deficiency represents noncompliance investigated under Master Complaint Number OH00165209 and Complaint Numbers OH00164386, OH00164301, OH00163918, OH00163704, OH00163225, OH00162452, OH00162142, and OH00161942.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366229	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2025
NAME OF PROVIDER OR SUPPLIER Parkside Villa		STREET ADDRESS, CITY, STATE, ZIP CODE 7040 Hepburn 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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>38523</p> <p>Based on observation, staff interview, and facility policy review, the facility failed to ensure medications were stored in a safe, secured and proper manner. This had the potential to affect 101 residents who were identified by the facility to be independently mobile. The census was 142.</p> <p>Findings include:</p> <p>Observation on 04/22/25 at 1:00 P.M. revealed the staff development room was full of unreturned resident prescription medications. There were seven large boxes filled with cards of medications, and a table full of prescription medication cards for residents who had discharged . Additional medications were stacked on the floor of the room. There were three large purple bags of medications that were ready to be returned. There were creams, injectables, breathing treatments, cards (blister packs) and cards of unused pills, tablets, and capsules. There were at least 200 separate medications that were unsecured in the room.</p> <p>On 04/22/25 at 1:00 P.M. the Maintenance Supervisor verified the room was unlocked and a whole lot of medications were stored in the Staff Development room.</p> <p>On 04/22/25 at 1:09 P.M. the Director of Nursing verified the room containing discharged residents' medications should have been locked. She also stated all the medications in that room were going to be returned to the pharmacy for resident credit. The medications were collected weekly and eventually returned to pharmacy.</p> <p>Review of the facility policy, Medication Storage in the Facility, dated 11/21 revealed the facility will ensure medication and biological's were stored safely, securely nor properly following manufacturer's recommendations or those of the supplier. The medication supply was to be accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366229	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2025
NAME OF PROVIDER OR SUPPLIER Parkside Villa		STREET ADDRESS, CITY, STATE, ZIP CODE 7040 Hepburn 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 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely, quality laboratory services/tests to meet the needs of residents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45442</p> <p>Based on interview, closed medical record review and review of laboratory testing results, the facility failed to ensure physician ordered testing was completed timely as required. This affected one (Resident #147) of three reviewed for timely completion of physician orders. This had the potential to affect all 142 residents residing at the facility.</p> <p>Findings include:</p> <p>Review of the closed medical record for Resident #147 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included but were not limited to anoxic brain damage, type II diabetes mellitus with chronic kidney disease, dependence on renal dialysis, anemia, unspecified protein-calorie malnutrition, and gastrostomy.</p> <p>Review of Resident #147's care plan initiated on 12/06/24 indicated bowel incontinence related to impaired mobility, loss of sphincter control, and physical limitations. Interventions were to record bowel movement, note size and consistency. Report any abnormalities to the charge nurse. Resident #147 was also noted to require total assistance for toileting and required a mechanical lift for toileting and transfers.</p> <p>Review of the 01/02/25 Nurse Practitioner note revealed Resident #147 was being seen for hypotension, anemia and hypoglycemia. Resident #147 was noted to still have low blood pressures and was noted to have received intravenous fluids (IVF) for hypotension with suspected hemodilution from IVF. Laboratory testing to evaluate for occult stool (blood in the stool) was ordered.</p> <p>Review of the physician order dated 01/03/25 timed at 12:42 P.M. revealed an order for Resident #147 to perform Hemoccult (to test for blood in the stool) with next bowel movement. Notify the physician or certified nurse practitioner when completed. To be completed every shift. Discontinue when complete. Order was discontinued on 01/19/25.</p> <p>Review of the 01/04/25 nursing med pass note timed at 12:04 P.M. noted for Resident #147 revealed a medication pass note to perform hemoccult with next bowel movement. Notify the physician when completed. Discontinue when complete. No bowel movement was noted.</p> <p>Review of the 01/04/25 nursing med pass note timed at 10:07 P.M. for Resident #147's occult stool gave no indication if occult stool was obtained.</p> <p>Review of the 01/05/25 nursing med pass note timed at 2:39 A.M. for Resident #147's occult stool indicated occult stool not applicable.</p> <p>Review of the 01/05/25 nursing med pass note timed at 2:50 P.M. for Resident #147's occult stool indicated no bowel movement.</p> <p>Review of the 01/06/25 nursing med pass note timed at 7:01 A.M. for Resident #147's occult stool indicated no bowel movement.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366229	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2025
NAME OF PROVIDER OR SUPPLIER Parkside Villa		STREET ADDRESS, CITY, STATE, ZIP CODE 7040 Hepburn 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 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the 01/06/25 Nurse Practitioner note timed at 1:00 P.M. for Resident #147 revealed a follow up visit related to hypotension and anemia. No noted results for occult stools.</p> <p>Review of the 01/07/25 nursing med pass note timed at 5:45 A.M. for Resident #147's occult stool gave no indication of whether sample was obtained.</p> <p>Review of the 01/07/25 Nurse Practitioner note for Resident timed a 1:02 P.M. revealed follow up for request of percutaneous endoscopic gastrostomy (PEG) removal. No result was available for the result of the occult stool sample.</p> <p>Review of the 01/08/25 nursing med pass note timed at 5:24 A.M. for Resident #147's occult stool gave no indication if sample was obtained.</p> <p>Review of the 01/08/25 Nurse Practitioner note timed at 9:00 A.M. for Resident #147 revealed a follow up visit for dysphagia and removal of feeding tube. No noted results for occult stools.</p> <p>Review of the 01/08/25 nursing med pass note timed at 8:40 A.M. for Resident #147 indicated no bowel movement.</p> <p>Review of the 01/09/25 nursing med pas note timed at 9:56 P.M. for Resident #147's occult stool order gave no indication of whether a sample was obtained.</p> <p>Review of the 01/10/25 nursing med pass note timed at 8:37 P.M. for Resident #147's occult stool order gave no indication whether a sample was obtained.</p> <p>Review of the 01/11/25 nursing med pass note timed at 5:50 A.M. for Resident #147's occult stool order stated no bowel movement during shift.</p> <p>Review of the 01/11/25 nursing med pass note timed at 12:45 P.M. for Resident #147's occult stool order revealed no bowel movement during shift.</p> <p>Review of the 01/11/25 nursing med pass noted timed at 7:22 P.M. for Resident #147's occult stool order revealed no bowel movement during shift.</p> <p>Review of the 01/13/25 nursing med pass note timed at 10:36 P.M. for Resident #147's occult stool order gave no indication if a sample was obtained.</p> <p>Review of the 01/15/25 nursing med pass note timed at 3:06 A.M. for Resident #147's occult stool order indicated no bowel movement during shift.</p> <p>Review of the 01/17/25 nursing med pass note timed at 3:44 A.M. for Resident #147's occult stool order gave no indication if a sample was obtained.</p> <p>Review of the January 2025 Medication Administration Record (MAR) for Resident #147 revealed following the 01/03/25 order for a Hemoccult stool sample there were nine shifts where no response was recorded, 20 shifts that indicated not applicable, 15 shifts indicating other and a negative result recorded on the 01/18/25 day shift.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366229	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2025
NAME OF PROVIDER OR SUPPLIER Parkside Villa		STREET ADDRESS, CITY, STATE, ZIP CODE 7040 Hepburn 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 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the 01/21/25 Nurse Practitioner note timed at 3:11 P.M. for Resident #147 revealed a follow up for weakness and deep vein thrombosis (DVT). No noted results were indicated for occult stools.</p> <p>Review of the 01/23/25 Nurse Practitioner noted timed at 2:24 P.M. for Resident #147 revealed lab results reviewed were within normal limits.</p> <p>Review of the Minimum Data Set (MDS) 3.0 quarterly assessment dated [DATE] revealed Resident #147 had intact cognition, was noted to be incontinent of bowel and bladder, used a wheelchair, and required maximum assistance of two staff for toileting hygiene.</p> <p>Interview on 04/29/25 at 8:35 A.M. with Registered Nurse (RN) #927 confirmed she was unable to provide evidence of an occult stool test being obtained or resulted for Resident #147 until 01/18/25 which was indicated as negative on the MAR. RN #927 was also unable to provide evidence of when the physician was notified of the results. RN #927 confirmed a 01/18/25 occult stool result was not timely for the 01/03/25 physician order.</p> <p>Interview on 04/29/25 at 8:41 A.M. with Nurse Practitioner (NP) #510 revealed she saw Resident #147 on 01/03/25 and had stopped her hypertension medications and had ordered an occult stool sample to be obtained related to potential anemia. NP #510 confirmed a timely result would be within 24 hours of obtaining an occult stool and confirmed a result on 01/18/25 was not considered timely.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366229	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2025
NAME OF PROVIDER OR SUPPLIER Parkside Villa		STREET ADDRESS, CITY, STATE, ZIP CODE 7040 Hepburn 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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45442</p> <p>Based on observation, interview, review of the facility policy and review of facility temperature monitoring logs, the facility failed to ensure unit refrigerators temperature monitoring logs were completed as required. This had the potential to affect all 115 residents receiving food from the facility kitchen. The facility identified twelve residents who received nothing by mouth (NPO). The facility census was 142.</p> <p>Findings include:</p> <p>Observation and interview on 04/24/25 at 3:00 P.M. with Registered Dietitian (RD) #852 of the facility unit refrigerators used for outside foods brought in for residents revealed no temperature monitoring logs were on the facility refrigerators. RD #852 stated the temperatures are to be taken for each unit refrigerator twice daily and are kept at the nurses' stations. Upon searching each nurse's station, it was revealed the temperature monitoring log for the Cypress unit refrigerator and freezer were only completed from 04/01/25 through 04/04/25, 04/07/25 and 04/08/25. Observation of the temperatures log for Juniper unit revealed it was only completed from 04/01/25 to 04/08/25. Observation of the Woods unit temperature log was only completed from 04/01/25 through 04/16/25. Observation of the temperature log for Redwood revealed no temperatures were recorded for 04/01/25 through 04/23/25. Observation of the personal refrigerator and freezer for room [ROOM NUMBER] revealed no temperatures recorded for the month of April, the personal refrigerator and freezer for room [ROOM NUMBER] revealed temperatures were only recorded for 04/01/25 through 04/08/25, and the personal refrigerator and freezer in room [ROOM NUMBER] revealed temperatures were recorded for 04/01/25 through 04/04/25, 04/07/25 and 04/08/25. At the time of the observations, RD #852 confirmed the unit refrigerator and freezer temperature monitoring logs were not completed as required at the time of the observation.</p> <p>Review of the 02/2023 revised facility policy called; Food Storage: Cold Foods revealed a written record of daily temperatures will be recorded.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366229	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2025
NAME OF PROVIDER OR SUPPLIER Parkside Villa		STREET ADDRESS, CITY, STATE, ZIP CODE 7040 Hepburn 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 0926</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have policies on smoking.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35768</p> <p>Based on record review, interview and review of the facility policy the facility failed to effectively implement the facility smoking policy. This affected one (Resident #108) of one resident reviewed for smoking. The facility census was 142.</p> <p>Findings include:</p> <p>Review of medical record for Resident #108 noted an admitted [DATE]. Diagnoses included respiratory failure, unspecified whether with hypoxia or hypercapnia, metabolic encephalopathy, delusional disorder, and visual hallucinations.</p> <p>Review of Social Services smoking assessment dated [DATE] noted Resident #108 exhibited knowledge of facility smoking rules and policies, does not smoke in designated areas only, does not know correct smoke time, does know where smoking materials are to be properly stored/kept. Resident #108 could use a lighter safely, could hold smoking materials safely, could extinguish smoking materials, and does not demonstrate compliance with facility smoking rules. Resident #108 was safe to smoke independently/unsupervised.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment, dated 01/09/25, revealed the resident had intact cognition. The resident was dependent for all activities of daily living.</p> <p>Review of Social Services progress note dated 04/21/25 noted Resident #108 was displaying unsafe smoking practices and is refusing to smoke off campus. Resident #108 received re-education related to smoking policy and safe smoking practices. Resident #108 stated she would think about it.</p> <p>Review of plan of care dated 04/22/25 noted Resident #108 had the potential for tobacco use related injuries of infection control issues related to cognitive impairment, impulse control, and poor safety awareness. Interventions included to review smoking policy with Resident #108 if non-compliant with the smoking policy and ensure that family is aware that they are not to give Resident #108 cigarettes or lighters.</p> <p>Observations on 04/23/25 at 3:00 P.M. noted Resident #108 in her wheelchair sitting outside next to the facility. The survey team observed Resident #108 pull out a pack of cigarettes and lighter from her purse, and light a cigarette. The survey team informed Maintenance Director #905 who was in the conference room with the survey team. Maintenance Director #906 went outside to educate Resident #108.</p> <p>Observations on 04/23/25 at 3:30 P.M. noted Resident #108 located on her unit, Resident #108 was asked by Registered Nurse (RN) #772 to remove smoking materials from her purse. Resident #108 then went into the dining room and started to mess with her purse. Resident #108 observed the state surveyor and went her room and closed the door stating she needed to make a call. Continued observations noted Social Worker (SW) #834 was called to the unit to speak with Resident #108 about smoking materials. SW#834 asked Resident #108 for the smoking materials, Resident #108 denied having any materials.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366229	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2025
NAME OF PROVIDER OR SUPPLIER Parkside Villa		STREET ADDRESS, CITY, STATE, ZIP CODE 7040 Hepburn 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 0926</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 04/24/25 at 10:55 A.M., SW #834 stated the facility smoking assessments were supposed to be completed annually and quarterly. SW #834 verified that an initial assessment was completed when Resident #108 was admitted and then on 04/21/25 when Resident #108 was observed smoking on facility grounds.</p> <p>Review of the policy Non-Smoking Policy dated 01/06/25 revealed the facility is a non-smoking facility and informs all prospective residents and/or their responsible party of the non-smoking policy prior to admission. The procedure included residents and/or their responsible party are informed of the non-smoking policy prior to admission, the facility's smoking policy will be posted in the facility, and the admissions coordinator will maintain a current list of area facilities that can accommodate residents who smoke and will direct prospective residents to these facilities as needed.</p>		