

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366263	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2025
NAME OF PROVIDER OR SUPPLIER Grace Brethren Village		STREET ADDRESS, CITY, STATE, ZIP CODE 1010 Taywood Road Englewood, OH 45322	

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 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48570</p> <p>Based on medical record review, resident interview, staff interview, and review of the facility policy, the facility failed to ensure resident code status was updated and correct in the medical electronic medical record. This affected one (Resident #26) of 15 sampled residents. The facility census was 39 residents.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #26 revealed an admitted [DATE] with diagnoses including congestive heart failure, chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, and multiple myeloma.</p> <p>Review of physician's orders for Resident #26 revealed an order dated 08/28/23 for the resident's code status to be Do Not Resuscitate Comfort Care Arrest (DNRCCA).</p> <p>Review of the care plan for Resident #26 dated 07/17/24 revealed the resident wished her code status to be DNRCCA and wanted her advanced directives wishes to be known to staff.</p> <p>Review of the progress note for Resident #26 dated 12/18/24 and timed at 9:40 A.M. revealed the resident's oxygen levels were low and the physician had recommended the resident be sent to the hospital for an evaluation. Resident #26 did not want to go the hospital because she feared being put on a ventilator. The physician recommended the facility talk to resident about changing her code status to DRNRCC and consulting with hospice.</p> <p>Review of the progress note for Resident #26 dated 12/18/24 and timed at 2:15 P.M. revealed the certified nurse practitioner was notified of resident condition and signed for the resident's code status to be changed to Do Not Resuscitate Comfort Care (DNRCC.)</p> <p>Review of the hard chart medical record for Resident #26 revealed it included a code status form for the resident to be a DNRCC dated 12/19/24 and signed by Family Nurse Practitioner (FNP) #63.</p> <p>Review of the Minimum Data Set (MDS) assessment for Resident #26 dated 12/29/24 revealed the resident was cognitively intact and required staff assistance with activities of daily living (ADLs.)</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 01/28/25 at 2:27 P.M. with Resident #26 confirmed she wished to continue as a DNRCC due to her diagnosis of multiple myeloma. Resident #26 was concerned if chest compressions were done, her bones would break.</p> <p>Interview on 01/28/25 at 3:07 P.M. with the Director of Nursing (DON) confirmed Resident #26's code status was changed to DNRCC on 12/19/24, and that the resident's code status order had not been updated from DNRCCA.</p> <p>Review of the facility policy titled Communication of Code Status dated October 2022 revealed the nurse who notates the physician's order for an advanced directive/code status is responsible for ensuring the code status is updated correctly in all sections of the resident's medical record including the hard chart, the electronic medical record, and the physician's orders.</p>		

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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48570</p> <p>Based on medical record review, resident interview, and staff interview, the facility failed to communicate the last covered day of skilled services to residents. This affected one (Resident #190) of three residents reviewed for beneficiary notices. The facility census was 39 residents.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #190 revealed an admitted [DATE] with diagnoses of aftercare following joint replacement surgery, hypertension, and dementia.</p> <p>Review of the Minimum Data Set (MDS) assessment for Resident #190 dated 01/17/25 revealed the resident had moderate cognitive impairment.</p> <p>Review of the progress note for Resident #190 dated 01/21/25 timed at 8:47 A.M. revealed the resident was alert, oriented, able to make her own decisions, and was a very social person.</p> <p>Review of the Notice of Medicare Non-Coverage (NOMNC) for Resident #190 dated 01/24/25 revealed the resident's last covered day (LCD) was 01/26/25. Admission Nurse (AN) #263 documented notification of the LCD to the resident's daughter by telephone on 01/24/25 at 4:30 P.M.</p> <p>Interview on 01/27/25 at 11:01 A.M. with Resident #190 confirmed concerns the facility did not provide her with a NOMNC nor did the facility communicate with her regarding her LCD of skilled services.</p> <p>Interview on 01/27/25 at 11:19 A.M. with AN #263 confirmed she did not provide a NOMNC to Resident #190 nor did she verbally communicate with the resident regarding the resident's LCD of skilled services. AN #263 confirmed the resident was alert and oriented.</p> <p>Review of progress note for Resident #190 dated 01/27/25 timed at 12:27 P.M. per AN #263 revealed the nurse met with the resident and apologized for not providing a copy of the NOMNC and verbal notification of the LCD to the resident. AN #263 then provided the resident with a copy of the NOMNC with a LCD of 01/26/25 and obtained the resident's signature.</p> <p>Interview on 01/30/25 at 3:00 P.M. with Chief Clinical Officer (CCO) #64 confirmed the facility did not have a policy for notification of NOMNCs.</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37447</p> <p>Based on medical record review, staff interview, and review of the facility policy, the facility failed to provide bed hold notices to residents or their representatives when residents were transferred to the hospital. This affected three (Residents #2, #11 and #26) of three residents reviewed for hospitalization s. The facility census was 39 residents.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #2 revealed an admitted [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction, hypertension, chronic kidney disease, vascular dementia, and epilepsy.</p> <p>Review of the Minimum Data Set (MDS) assessment for Resident #2 dated 01/15/25 revealed the resident was moderately cognitively impaired and required staff assistance with activities of daily living (ADLs.)</p> <p>Review of a progress note for Resident #2 dated 12/28/24 revealed the resident was sent to the hospital for evaluation and treatment.</p> <p>Review of the medical record for Resident #2 revealed it did not include a bed hold notice for the resident's transfer to the hospital on 12/28/24.</p> <p>25908</p> <p>2. Review of the medical record for Resident #11 revealed an admitted d of 05/24/24 with diagnoses including cerebral vascular disease, anxiety, and dementia.</p> <p>Review of the progress note for Resident #11 dated 08/06/24 revealed the resident was transferred to the hospital after a fall.</p> <p>Review of the MDS for Resident #11 dated 01/22/24 revealed the resident was severely cognitively impaired.</p> <p>Review of the medical record for Resident #11 revealed it did not include a bed hold notice for the resident's hospital transfer on 08/06/24.</p> <p>48570</p> <p>3. Review of the medical record for Resident #26 revealed an admitted [DATE] with diagnoses including congestive heart failure, chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, and multiple myeloma.</p> <p>Review of the progress note for Resident #26 dated 12/18/24 revealed the resident was sent to the hospital for evaluation and treatment of respiratory distress.</p> <p>(continued on next page)</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the MDS for Resident #26 dated 12/29/24 the revealed the resident was cognitively intact and required staff assistance with ADLs.</p> <p>Review of the medical record for Resident #26 revealed it did not include a bed hold notice for the resident's transfer to the hospital on 12/18/24.</p> <p>Interview on 01/29/25 at 4:53 P.M. with Chief Clinical Officer (CCO) #64 confirmed the facility had not provided bed hold notices to Residents #2, #11, and #26 nor to the residents' representatives upon resident transfer to the hospital.</p> <p>Review of the facility policy titled Bed Hold Notice Upon Transfer policy dated October 2024 revealed at the time of transfer for hospitalization the facility would provide to the resident and/or their representative written notice specifying the duration of the bed hold policy and information explaining the return to the next available bed.</p> <p>Review of the facility policy titled Transfer and discharge date d October 2024 revealed the facility would provide a notice of the facility's bed hold policy to the resident and the resident's representative upon resident transfer to the hospital.</p>

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<p>F 0661</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37447</p> <p>Based on medical record review and staff interview the facility failed to complete a resident discharge summary including a recapitalization of the stay, a final summary of status and a post discharge plan. This affected one (Resident #39) of one residents reviewed for discharge. The facility census was 39 residents.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #39 revealed an admitted [DATE] with diagnoses including chronic kidney disease, sick sinus syndrome, hypertension, osteoarthritis, and traumatic subdural hemorrhage with a discharge date of [DATE].</p> <p>Review of the Minimum Data Set (MDS) assessment for Resident #39 dated 12/01/24 revealed the resident was severely cognitively impaired and required staff assistance with activities of daily living (ADLs).</p> <p>Review of the discharge MDS assessment for Resident #39 dated 12/03/24 revealed the resident discharged home.</p> <p>Review of the medical record for Resident #39 revealed it did not include a discharge summary.</p> <p>Interview on 01/30/25 at 11:15 A.M. with Licensed Practical Nurse (LPN) #74) confirmed the facility had not completed a discharge summary for Resident #39 who had discharged to home on 12/03/24.</p> <p>Review of the facility policy titled Transfer and discharge date d October 2024 revealed members of the interdisciplinary team (IDT) should complete relevant sections of the discharge summary that included a recapitulation of the resident's stay that included diagnoses, course of illness and treatment and therapy, pertinent labs and consultation results, as well as a final summary of the resident's status. The discharge summary should also include reconciliation of all pre-discharge medications with the resident's post-discharge medications and a post discharge plan of care.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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** 25908</p> <p>Based on medical record review, observation, staff interview, and review of the facility policy, the facility failed to ensure residents had adequate supervision and use of appropriate assistive devices to prevent falls. This affected three (Residents #4, #11, and #21) of five residents reviewed for falls. The facility also failed to thoroughly investigate resident falls and implement interventions to prevent further falls. This affected one (Resident #34) of five residents reviewed for falls. The facility census was 39 residents.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #4 revealed an admitted [DATE] with diagnoses including Parkinson's disease, vascular dementia, psychosis and anxiety.</p> <p>Review of the fall assessment for Resident #4 dated 01/19/25 revealed the resident at high risk for falls.</p> <p>Review of the care plan for Resident #4 dated 01/19/25 revealed the resident was at risk for falls and interventions included to not leave the resident alone in common areas.</p> <p>Review of the Minimum Data Set (MDS) assessment for Resident #4 dated 01/22/25 revealed the resident was severely cognitively impaired and required maximum staff assistance with ambulation.</p> <p>Observation on 01/28/25 at 10:19 A.M. revealed Resident #4 was sitting in his wheelchair in the dining room with no staff present.</p> <p>Interview on 01/28/25 at 10:20 A.M. with Licensed Practical Nurse (LPN) #271 confirmed Resident #4 had been left alone without supervision in the dining room and the resident should not be left alone due to his frequent falls.</p> <p>2. Review of the medical record for Resident #11 revealed an admitted [DATE] with diagnoses including cerebral vascular disease, anxiety, and dementia.</p> <p>Review of the fall risk assessment for Resident #11 dated 11/12/24 revealed the resident was at high risk for falls.</p> <p>Review of the care plan for Resident #11 dated 11/14/24 revealed the resident was at risk for falls with an intervention to ensure the resident had on proper footwear, either shoes and socks or nonskid socks.</p> <p>Review of the MDS assessment for Resident #11 dated 01/22/25 revealed the resident was severely cognitively impaired and required maximum assistance with standing.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observations of Resident #11 throughout the morning of 01/29/25 revealed the resident was anxious and at times trying to stand without assistance. Resident #11 was wearing regular socks, instead of shoes and socks or non-skid socks as per the resident's care plan.</p> <p>Interview on 01/29/25 at 2:25 P.M. with LPN #27 confirmed Resident #11 was wearing regular socks but should be wearing shoes and socks or nonskid socks due to the resident's high risk for falls.</p> <p>37447</p> <p>4. Review of the medical record for Resident #34 revealed an admitted [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction, hypertension, metabolic encephalopathy, malignant neoplasm of bladder, anxiety disorder, major depressive disorder, and epilepsy.</p> <p>Review of the MDS assessment for Resident #34 dated 11/25/24 revealed the resident was moderately cognitively impaired and required staff assistance with activities of daily living (ADLs).</p> <p>Review of the care plan for Resident #34 dated 01/26/25 revealed the resident was at risk for falls due to impaired cognition and safety awareness, impaired mobility, and poor balance and weakness secondary to a recent stroke with left hemiplegia. Interventions included the following: fall mats, bed in low position, bolster mattress, frequent safety checks.</p> <p>Review of the progress note for Resident #34 dated 12/27/24 revealed the resident raised his bed to the high position. The nurse went in and put the bed lower to floor and repositioned the resident in bed. Five minutes later Resident #34 was yelling out he needed help. When the nurse entered the room the resident was found on the floor and it was noted the resident had raised his bed back up to the high position.</p> <p>Review of the fall investigation for Resident #34 dated 12/27/24 revealed the nurse observed the resident had raised his bed to the high position and she lowered it. A few minutes later Resident #34 called out, and he had raised the bed back up to a high position and had fallen out. The resident was sent to the hospital for an evaluation because he hit his head and was on a blood thinner, Eliquis. Resident #34 was admitted to the hospital after a scan of the resident's head showed a small right sided hematoma. The investigation did not include any interventions or measures to be implemented in order to prevent further falls.</p> <p>Interview on 01/30/25 at 12:21 P.M. with the DON confirmed a new intervention had not been implemented nor added to the care plan for Resident #34 following the resident's fall on 12/27/24.</p> <p>Review of the facility policy titled Incidents and Accidents revised October 2022 revealed the facility should assure appropriate and immediate interventions were implemented and corrective action taken to prevent further occurrences.</p> <p>48570</p> <p>3. Review of the medical record for Resident #21 revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disease, type two diabetes mellitus, and malignant neoplasm of the brain.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the MDS assessment for Resident #21 dated 12/21/24 revealed the resident was cognitively intact and required substantial staff assistance for bed mobility and transfers and was dependent on staff for wheel chair mobility.</p> <p>Review of the care plan for Resident #21 dated 03/18/23 revealed the resident was at risk for falls related to poor safety awareness and generalized weakness. Interventions included staff should assist the resident with ambulation and transfers using therapy recommendations. The resident's care plan was updated on 12/25/24 to include the intervention of use of a gait belt for all resident transfers.</p> <p>Review of the progress note for Resident #21 dated 12/25/24 timed at 8:16 A.M. revealed the aide reported lowering the resident down to the floor in front of the recliner in the resident room while assisting with transferring the resident. The aide stated Resident #21's knees got wobbly when assisting the resident to stand and pivot from the wheelchair to the recliner.</p> <p>Interview on 01/30/25 at 12:34 P.M. with the Director of Nursing (DON) confirmed the intervention added to Resident #21's care plan on 12/25/24 to ensure gait belt use with all transfers was not an appropriate intervention since that was supposed to be the standard practice for all residents who need assistance with transfers and ambulation. The facility policy was to use a gait belt with residents that could not independently ambulate or transfer. Interview confirmed the aide had not used a gait belt when assisting with the transfer for Resident #21 on 12/25/24 which resulted in a fall for the resident.</p> <p>Review of the facility policy titled Use of Gait Belt dated January 2018 revealed the facility staff should use gait belts with residents that could not independently ambulate or transfer for the purpose of safety.</p>		