STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366266	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Enniscourt Nursing Care	13315 Detroit Ave Lakewood, OH 44107

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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the medical record review, review of the emergency medical services (EMS) run report, facility policy and procedure review and interview, the facility failed to report an allegation of neglect to the State agency. This affected one (Resident #45) of three residents reviewed for change in condition. The facility census was 42.Findings include:Review of the closed medical record revealed Resident #45 was admitted to the facility on [DATE] and expired in the facility on [DATE]. Diagnoses included acute on chronic congestive heart failure, atrial fibrillation, atherosclerotic coronary heart disease, hypertensive heart disease with heart failure, muscle weakness, and ischemic cardiomyopathy. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #45's memory was intact, and he had modified independence for cognitive skills for daily decision making. The assessment indicated the resident required supervision with eating, was dependent on staff for toileting hygiene, and required partial/moderate assistance with bed mobility and transfers. The baseline care plan was in progress. Review of the physician orders dated [DATE] revealed an order for aluminum and magnesium hydroxide suspension (often branded as Maalox or Mylanta) 200-200 milligrams (mg)/5 milliliters (ml) to give 10 ml every six hours as needed (PRN) for antacid. There were no physician orders for PRN medications for chest pain.Review of the progress notes revealed an electronic medication administration record (eMAR) note dated [DATE] at 12:28 A.M. revealed Registered Nurse (RN) #207 administered the PRN Maalox.Review of the eMAR noted dated [DATE] at 4:21 A.M. RN #207 indicated the PRN Maalox was effective.Review of the health status note dated [DATE] at 5:13 A.M. revealed Resident #45 was found by RN #207 lying in bed absent of vital signs. RN #207 called out for staff assistance and 911 was called, the head of the bed (HOB) was lowered, and cardiopulmonary resuscitation (CPR) was started immediately. Medics and police arrived at the bedside for assessment and provided all appropriate information. All parties were made aware.Further review of the closed medical record for Resident #45 revealed no documented evidence of an assessment or vital signs around the time the administration of the Maalox.Review of the EMS run report dated [DATE] revealed the call came in at 5:14 A.M., EMS was dispatched at 5:15 A.M. and EMS was at the resident at 5:21 A.M. Upon arrival, Resident #45 was found lying in bed. He was unresponsive and not breathing. Nursing staff on scene started performing CPR approximately five minutes prior to EMS arrival. Nursing staff stated that they came to check on Resident #45 and found him unresponsive and not breathing. Resident #45 had a wrist band on that stated he was a Full Code (if a person's heart stops beating or they stop breathing, medical staff will do everything possible to try to save their life). EMS noted to have checked multiple sites for a pulse such as radial and carotid and found the resident to be pulseless. Nursing staff claim to have checked on the resident at 4:00 A.M. Nursing staff claim that the resident had stated he was having chest pain earlier in the night. Resident #45 had rigor in his jaw and mottling throughout his body. Due to rigor mortis, mottling, and confirmed asystole in multiple leads, EMS (continued on next page)

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	contacted the physician at the local hospital who announced time of death at 5:28 A.M. Review of the device activity report dated [DATE] at 12:00 A.M. to [DATE] at 11:59 P.M. revealed Resident #45 was located in the television (TV) room which was set up as a private resident room. Resident #45 rang the call light on [DATE] at 11:07 P.M., 11:14 P.M., 11:28 P.M., 11:29 P.M. and on [DATE] at 12:14 A.M., 12:32 A.M., and at 12:48 A.M. Interview on [DATE] at 4:55 P.M., RN #207 stated she was part-time but had not been back to the facility since [DATE]. RN #207 stated the DON had called her and stated she needed to take her off the schedule and needed a statement regarding Resident #45. RN #207 stated she reached out to the DON with no response and had not heard anything since. RN #207 stated she could not recall exactly when, but the aide came to her and stated Resident #45 needed to see her due to having chest pain. RN #207 stated she first looked at Resident #45's physician's orders in the computer and saw orders for Maalox but nothing PRN for chest pain. RN #207 stated she then went to see the resident and asked how he was feeling and asked if he was having chest pain or indigestion and discomfort. RN #207 stated Resident #45 told her he was having indigestion, and she gave him the PRN Maalox. She recalled when she entered the resident's room, he was trying to get up and go to the bathroom. She stated that she took his blood pressure, and it was elevated. She then helped Resident #45 settle back into bed and retook his blood pressure, and it was normal. She stated she did not document the assessment or vital signs in the medical record. RN #207 stated the next time she walked by Resident #45 he was fine and was sleeping. She stated that she knew he was sleeping because she saw his chest rise and fall. RN #207 stated she did not recall what time that was. She stated she knew the aide had taken the resident to the bathroom, and she did not hear anything else in the evening. When she was about to do medication pass, she walked past Resident #45's room and saw him lying in bed but tilted to the side. She stated he didn't look right, which prompted her to go to his room. She asked the aide to get everyone to help, and she called 911. She put 911 on speaker and began CPR on Resident #45 until EMS arrived. EMS announced that Resident #45 was deceased . She stated that she felt like she should have checked on Resident #45 more frequently but felt everything was okay since the aide did not say anything else to her.Interview on [DATE] at 7:13 P.M., CNA #208 stated she had worked a double shift on [DATE], came in at 3:00 P.M. but was not assigned Resident #45 until 11:00 P.M. Initially Resident #45 complained that he had not had a bowel movement since he was in the hospital and felt he needed to go. He was too weak to sit on bedside commode, so she got him on a bed pan. Resident #45 sat on the bed pan for a while and nothing happened, so she took him off. Approximately 20 minutes later, he rang and asked for the bed pan again. Resident #45 was alert and oriented and able to make his needs known. The second time she put him on bed pan, he had a large bowel movement. CNA #208 stated she got him cleaned up and reported to the nurse that Resident #45 had a large bowel movement. Approximately 20 minutes later, Resident #45 rang the call light and told her he was having chest pain, and she told RN #207. The nurse did not get up right away, and she did not see her get up and go to Resident #45's room. She had gone to care for another resident. Approximately 20 minutes went by, and Resident #45 rang his call light again. CNA #208 stated she went to see what the resident needed, and he again complained about chest pain. CNA #208 stated the resident appeared to be in distress, and she told RN #207. She didn't know if RN #207 had been in since she had told her the first time, but when she told the nurse again, the nurse told her that she had given him Maalox, and he needed to give it time to work. CNA #208 stated Resident #45 stayed on his call light approximately every 20 minutes and stated between her and the other two aides, CNA #136 and #153, they answered and he repeatedly complained of chest pain. She stated at one point, he told her he was feeling chest tightness. CNA #208 stated she did not tell the nurse chest tightness; she told (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	her chest pain and thought it was all the same because they usually send residents out to the hospital with complaints of chest pain. She repositioned the resident in bed when he rang and only told the nurse twice of his complaints of chest pain, but she knew the other two CNA told the nurse as well. CNA #208 stated Resident #45 rang his call light up until between 2:20 A.M. and 2:30 A.M. on [DATE], and that was the last time she went into his room. She stated when she had repositioned him in bed and he seemed to be more comfortable. CNA #208 stated after that she checked in on him between 3:30 A.M. and 3:45 A.M. and she assumed he was sleeping because he was still in the same position that she had last repositioned him between 2:20 A.M. and 2:30 A.M. At approximately 4:00 A.M. she started to do her rounds, and the nurse started to pass medications. When the nurse found Resident #45 unresponsive, she called her. Resident #45 was slumped over in bed. When the first shift nurse came in, she asked what happened and she told her. CNA #208 stated she was off the next night and when she returned Friday, [DATE], at around 3:00 P.M. the nurse on duty told her what she said sounded concerning and asked her to tell the DON. CNA #208 stated she talked to the DON and was told that if she was unsure about something or had concerns, she could call her. CNA #208 stated she did not write a statement and stated she felt like she should have done more. CNA #208 stated the Administrator was usually in the building up until 3:00 A.M. to 4:00 A.M. but she left early, and that she may have told her, but may not have because she thought the RN knew something she didn't. CNA #208 stated Resident #45 looked so uncomfortable, like he was in distress, and he said more than once he had chest pain.Interview on [DATE] at 12:30 P.M. with the Administrator revealed the Administrator stated she knew what CNA #208's story was. The Administrator stated CNA #208 stated Resident #45 had complained of having discomfort in his chest and went to tell the nurse and the nurse didn't seem concerned. The Administrator stated CNA #208 told everyone that the nurse didn't do anything regarding Resident #45's complaints. The Administrator stated she didn't report it to the State agency because when CNA #208 first came to them she was saying the nurse was lazy and not doing anything; it did not seem to be truly a concern. Interview on [DATE] at 12:30 P.M. the DON stated it was the very next day when CNA #208 came to her and reported that the nurse didn't do anything regarding Resident #45's complaints. The DON stated she didn't report it to the State agency. The DON stated she could not remember what exactly CNA #208 said, but the resident was complaining to her about pressure and discomfort. Interview on [DATE] at 1:08 P.M., CNA #135 stated she was not working in the hall that Resident #45 resided on, but the aide that was assigned to him had to be stationed outside another resident's room. CNA #136 stated Resident #45 was in the TV room and rang his call light often that night. CNA #153 stated she knew Resident #45 rang his call light frequently because they have pagers, and when a call light rings, it goes to all their pagers. CNA #136 stated she only answered his call light once, and he complained of chest tightening. She did not recall the time, but it was before 4:00 A.M. She told RN #207 and went back to her assigned area. CNA #136 stated RN #207 did tell her that she had given Resident #45 something and he needed to let it kick in. CNA #136 stated whatever the nurse gave Resident #45 was not working. CNA #136 stated sometime after 4:30 A.M., CNA #208 ran to her and said Resident #45 was gone. CNA #136 stated she went to the assisted living to get the nurse and when she came back to the skilled side, CNA #208 and RN #207 were in Resident #45's room. CNA #136 stated that she and RN #207 switched off on doing CPR, and she believed the assisted living nurse called 911 and the Administrator. CNA #136 stated EMS arrived around 5:00 A.M. CNA #136 stated she heard RN #207 tell the assisted living nurse that Resident #45 had complained of chest burning, but that was not true. CNA #136 stated Resident #136 said it was chest pain, and he had his hand on his chest. Resident #45 looked like he was in distress like he was having heart attack or stroke, and the nurse (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had no sense of urgency.Interview on [DATE] at 1:25 P.M. with CNA #153 via telephone revealed she had walked past Resident #45's room and he was yelling out. She and CNA #136 went into Resident #45's room and he wanted water and stated his chest was feeling tight. She and CNA #136 went to tell the nurse, but she could not recall what time that was, and that was her only interaction with Resident #45. CNA #153 stated she helped clean up after he passed away. CNA #153 stated Resident #45 rang his call light, and she also heard him yelling out.Review of the undated facility policy Abuse, Mistreatment, Neglect, Exploitation, & Misappropriation of Resident Property, revealed all incidents and allegations of Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Resident Property and all injuries of unknown source must be reported immediately to the Administrator or designee. Allegations involving neglect, exploitation, misappropriation of Resident Property and injuries of unknown source will be reported to ODH (Ohio Department of Health) immediately, but in no event later than 24 hours from the time the incident/allegation was made known to the staff member. Once the Administrator and ODH are notified, an investigation of the allegation violation will be conducted. This deficiency represents non-compliance investigated under Complaint Number 2723415.

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety 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 closed medical record review, interview, review of the emergency medical services (EMS) run report, and facility policy review, the facility failed to provide timely, necessary and adequate care and services following an acute change in condition. Resident #45 had a recent hospitalization and a significant cardiac history including cardiac coronary disease, history of a heart attack, atrial fibrillation, and congestive heart failure. The facility failed to ensure changes in the resident's medical condition were adequately assessed, failed to have documented evidence of notification to the physician and that adequate care and services were implemented for Resident #45 when the resident had repeatedly complained of chest pain and tightness. This resulted in Immediate Jeopardy with subsequent death beginning on [DATE] when Resident #45's repeated complaints of chest pain and tightness were not adequately addressed. This affected one (Resident #45) of three residents reviewed for change in condition. The facility census was 42. On [DATE] at 4:27 P.M. the Administrator, Director of Regulatory Compliance Nurse (DRCN) #123, and Director of Nursing (DON) were notified Immediate Jeopardy began on [DATE] when staff identified Resident #45 exhibited a change in condition which included repeated complaints of chest pain and tightness on [DATE] between 11:00 P.M. and early morning of [DATE]. On [DATE] at 5:22 A.M. per the EMS report, upon their arrival Resident #45 was unresponsive and not breathing, had rigor mortis in his jaw, had mottling (refers to a patchy, lace-like, or marbled discoloration of the skin, typically appearing reddish-blue or purple, signifying decreased circulation) and was pronounced dead at 5:28 A.M. The EMS report also indicated the nursing staff reported the resident had complained of chest pain earlier in the night. The Immediate Jeopardy was removed on [DATE] when the facility implemented the following actions: RN #207 has not worked since the time of the incident, [DATE]. On [DATE] the change in condition policy was reviewed on Thursday, [DATE], by the DON and Administrator before staff were educated on it. No changes were made. On [DATE], the DON reviewed the last two weeks of records of all residents in the facility for changes in condition and to ensure that they were properly reported and addressed. No issues were identified. On [DATE], the DON ran a report for all residents with cardiac diagnoses and reviewed for any need for reassessment or recent change in condition. No concerns were identified. On [DATE] and [DATE], the DON in-serviced all certified nursing assistants (CNA) on the need to immediately notify the nurse if there is a change in condition or emergency and on the facility protocol for obtaining assistance during an emergency situation, including what to do if a nurse is unavailable or not responding. CNAs were instructed to escalate up the chain to the charge nurse or DON if a nurse is unavailable or not responding. Nine CNAs have been in-serviced at this time. Any CNA not in-serviced on [DATE] will not be permitted to work until in-servicing is completed. On [DATE] and [DATE], the DON in-serviced all licensed nurses on the facility policies and procedures related to change in condition, appropriate assessments and documentation of the same, timely notification to physician of change in condition and how to respond to emergency situations. 11 nurses have been in-serviced at this time. Any licensed nurses who are not in-serviced by [DATE] will not be permitted to work until in-servicing is completed. On [DATE], an ad hoc QAPI meeting was held with the Medical Director #300, Administrator, DON, RN #123, RN #121, and RN #118 to discuss the incident, follow-up measures and action plan and to review any relevant policies. No policy updates were needed. On [DATE], the DON and designees will begin monitoring all shift reports and nurse's notes daily to ensure all changes in condition are timely reported to the physician and appropriately addressed. The audits will be conducted daily for two weeks and then three times a week for six weeks. The QA Committee will monitor the results of the audits will and follow-up (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	as needed.Although the Immediate Jeopardy was removed on [DATE] the deficiency remains at a Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility is still in the process of implementing their corrective action plan and monitoring to ensure on-going compliance.Findings include:Review of the closed medical record revealed Resident #45 was admitted to the facility on [DATE]. Resident #45 expired in the facility on [DATE]. Diagnoses included acute on chronic congestive heart failure, atrial fibrillation, atherosclerotic coronary heart disease, hypertensive heart disease with heart failure, muscle weakness, and ischemic cardiomyopathy. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #45's memory was intact, and he had modified independence for cognitive skills for daily decision making. The resident required supervision with eating, was dependent on staff for toileting hygiene and required partial/moderate assistance with bed mobility and transfers. The baseline care plan was in progress. Review of the physician orders dated [DATE] revealed an order for aluminum and magnesium hydroxide suspension (often branded as Maalox or Mylanta) 200-200 milligrams (mg)/5 milliliters (ml) to give 10 ml every six hours as needed (PRN) for antacid. There were no physician orders for PRN medications for chest pain.Review of the progress notes revealed an electronic medication administration record (eMAR) note dated [DATE] at 12:28 A.M. revealed Registered Nurse (RN) #207 administered the PRN Maalox.Review of the medical record revealed no documented evidence of an assessment or vital signs for Resident #45 around the time the administration of the Maalox and no documentation related to chest pain.Review of the device activity report revealed Resident #45 rang the call light on [DATE] at 11:07 P.M., 11:14 P.M., 11:28 P.M., 11:29 P.M. and on [DATE] at 12:14 A.M., 12:32 A.M., and at 12:48 A.M. Review of the eMAR noted dated [DATE] at 4:21 A.M. RN #207 indicated the PRN Maalox was effective. Review of the health status note dated [DATE] at 5:13 A.M. revealed Resident #45 was found by RN #207 lying in bed absent of vital signs. RN #207 called out for staff assistance and 911 was called and cardiopulmonary resuscitation (CPR) was started immediately. Medics and police arrived at the bedside for assessment and provided all appropriate information. All parties were made aware.Review of the EMS run report dated [DATE] revealed the call came in at 5:14 A.M., EMS was dispatched at 5:15 A.M. and EMS was with Resident #45 at 5:21 A.M. Upon arrival, Resident #45 was found lying in bed. He was unresponsive and not breathing. Nursing staff on scene started performing CPR approximately five minutes prior to EMS arrival. Nursing staff stated that they came to check on Resident #45 and found him unresponsive and not breathing. Resident #45 had a wrist band on that stated he was a Full Code (if a person's heart stops beating or they stop breathing, medical staff will do everything possible to try to save their life). EMS checked multiple sites for a pulse such as radial and carotid and found the resident to be pulseless. Nursing staff claim to have checked on the resident at 4:00 A.M. Nursing staff claim that the resident had stated he was having chest pain earlier in the night. Resident #45 had rigor in his jaw and mottling throughout his body. Due to rigor mortis, mottling, and confirmed asystole in multiple leads, EMS contacted the physician at the local hospital who announced time of death at 5:28 A.M. During an interview on [DATE] at 4:55 P.M., RN #207 stated she was part-time but had not been back to the facility since [DATE]. RN #207 stated the DON had called her and stated she needed to take her off the schedule and needed a statement regarding Resident #45. RN #207 stated she reached out to the DON with no response and had not heard anything since. RN #207 stated she could not recall exactly when, but the aide came to her and stated Resident #45 needed to see her due to having chest pain. RN #207 stated she first looked at Resident #45's physician's orders in the computer and saw orders for Maalox but nothing PRN for chest pain. RN #207 stated she then went to see the resident and asked how he was feeling and asked if he was having chest (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	pain or indigestion and discomfort. RN #207 stated Resident #45 told her he was having indigestion, and she gave him the PRN Maalox. She recalled when she entered the resident's room, he was trying to get up and go to the bathroom. She stated that she took his blood pressure, and it was elevated. She then helped Resident #45 settle back into bed and retook his blood pressure, and it was normal. She stated she did not document the assessment or vital signs in the medical record. RN #207 stated the next time she walked by Resident #45 he was fine and was sleeping. She stated that she knew he was sleeping because she saw his chest rise and fall. RN #207 stated she did not recall what time that was. She stated she knew the aide had taken the resident to the bathroom, and she did not hear anything else in the evening. When she was about to do medication pass, she walked past Resident #45's room and saw him lying in bed but tilted to the side. She stated he didn't look right, which prompted her to go to his room. She asked the aide to get everyone to help, and she called 911. She put 911 on speaker and began CPR on Resident #45 until EMS arrived. EMS announced that Resident #45 was deceased . She stated that she felt like she should have checked on Resident #45 more frequently but felt everything was okay since the aide did not say anything else to her.During an interview on [DATE] at 7:13 P.M., CNA #208 stated she had worked a double shift on [DATE], came in at 3:00 P.M. but was not assigned Resident #45 until 11:00 P.M. Initially Resident #45 complained that he had not had a bowel movement since he was in the hospital and felt he needed to go. He was too weak to sit on bedside commode, so she got him on a bed pan. Resident #45 sat on the bed pan for a while and nothing happened, so she took him off. Approximately 20 minutes later, he rang and asked for the bed pan again. Resident #45 was alert and oriented and able to make his needs known. The second time she put him on bed pan, he had a large bowel movement. CNA #208 stated she got him cleaned up and reported to the nurse that Resident #45 had a large bowel movement. Approximately 20 minutes later, Resident #45 rang the call light and told her he was having chest pain, and she told RN #207. The nurse did not get up right away, and she did not see her get up and go to Resident #45's room. She had gone to care for another resident. Approximately 20 minutes went by, and Resident #45 rang his call light again. CNA #208 stated she went to see what the resident needed, and he again complained about chest pain. CNA #208 stated the resident appeared to be in distress, and she told RN #207. She didn't know if RN #207 had been in since she had told her the first time, but when she told the nurse again, the nurse told her that she had given him Maalox, and he needed to give it time to work. CNA #208 stated Resident #45 stayed on his call light approximately every 20 minutes and stated between her and the other two aides, CNA #136 and #153, they answered and he repeatedly complained of chest pain. She stated at one point, he told her he was feeling chest tightness. CNA #208 stated she did not tell the nurse chest tightness; she told her chest pain and thought it was all the same because they usually send residents out to the hospital with complaints of chest pain. She repositioned the resident in bed when he rang and only told the nurse twice of his complaints of chest pain, but she knew the other two CNA told the nurse as well. CNA #208 stated Resident #45 rang his call light up until between 2:20 A.M. and 2:30 A.M. on [DATE], and that was the last time she went into his room. She stated when she had repositioned him in bed and he seemed to be more comfortable. CNA #208 stated after that she checked in on him between 3:30 A.M. and 3:45 A.M. and she assumed he was sleeping because he was still in the same position that she had last repositioned him between 2:20 A.M. and 2:30 A.M. At approximately 4:00 A.M. she started to do her rounds, and the nurse started to pass medications. When the nurse found Resident #45 unresponsive, she called her. Resident #45 was slumped over in bed. When the first shift nurse came in, she asked what happened and she told her. CNA #208 stated she was off the next night and when she returned Friday, [DATE], at around 3:00 P.M. the nurse on duty told (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	her what she said sounded concerning and asked her to tell the DON. CNA #208 stated she talked to the DON and was told that if she was unsure about something or had concerns, she could call her. CNA #208 stated she did not write a statement and stated she felt like she should have done more. CNA #208 stated the Administrator was usually in the building up until 3:00 A.M. to 4:00 A.M. but she left early, and that she may have told her, but may not have because she thought the RN knew something she didn't. CNA #208 stated Resident #45 looked so uncomfortable, like he was in distress, and he said more than once he had chest pain. During an interview on [DATE] at 12:30 P.M., the Administrator stated Resident #45 was in the TV room and this was his fifth stay at the facility. The Administrator stated the resident was more debilitated this time than he had been during prior stays. She stated she usually worked late into night shift and left sometime around 2:00 A.M. to 2:30 A.M. on [DATE]. The Administrator stated nobody said anything to her prior to her leaving. She was aware of what CNA #208's story was. The Administrator stated earlier in the day she knew Resident #45 used his call light and sometimes he called out because he needed to have a bowel movement. The Administrator stated CNA #208 was on duty and informed Resident #45's aide at that time that he needed to go to the bathroom. The Administrator stated Resident #45 was very weak, and his aide at the time needed help getting the resident up on the bedside commode. After 11:00 P.M., CNA #208 was assigned to Resident #45. The Administrator stated CNA #208 stated Resident #45 had complained of having discomfort in his chest and went to tell the nurse, and the nurse didn't seem concerned. She was in her office, and if he had been calling out, she would have heard him. The Administrator stated she understood the resident had chest discomfort and knew he had a large bowel movement. Resident #45 had to do a lot of pushing and felt better after. The Administrator stated Resident #45 was alert and oriented and he would have said he wanted to go to the hospital. During an interview on [DATE] at 12:30 P.M., the DON stated RN #207 called her on [DATE] around 5:00 A.M. and said Resident #45 was complaining of indigestion and pressure in his chest. The DON stated RN #207 stated she had repositioned the resident in bed and gave him Mylanta (Maalox). RN #207 informed her around the time of her medication pass that Resident #45 had passed away. The DON asked RN #207 if she took vital signs, and RN #207 told her that she took vital signs and said they were fine, but she did not document them in the medical record. The DON stated that RN #207 had only documented the resident's temperature. The DON stated when there was a change in condition it was individual based on the situation, and Resident #45 was alert and oriented, and able to make his needs known. At that time the resident wanted to try the Mylanta (Maalox), and it was effective and that would be something she would have done as well with no further distress. The DON stated decisions would be based on nursing judgement, and the difference would be if the resident was not alert or oriented then they would likely send them out. The DON stated it was the very next day when CNA #208 came to her and reported that the nurse didn't do anything regarding Resident #45's complaints. During an interview on [DATE] at 1:08 P.M., CNA #135 stated she was not working in the hall that Resident #45 resided on, but the aide that was assigned to him had to be stationed outside another resident's room. CNA #136 stated Resident #45 was in the TV room and rang his call light often that night. CNA #153 stated she knew Resident #45 rang his call light frequently because they have pagers, and when a call light rings, it goes to all their pagers. CNA #136 stated she only answered his call light once, and he complained of chest tightening. She did not recall the time, but it was before 4:00 A.M. She told RN #207 and went back to her assigned area. CNA #136 stated RN #207 did tell her that she had given Resident #45 something and he needed to let it kick in. CNA #136 stated whatever the nurse gave Resident #45 was not working. CNA #136 stated sometime after 4:30 A.M., CNA #208 ran to her and said Resident #45 was gone. CNA #136 stated she went to (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366266	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Enniscourt Nursing Care	13315 Detroit Ave Lakewood, OH 44107

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the assisted living to get the nurse and when she came back to the skilled side, CNA #208 and RN #207 were in Resident #45's room. CNA #136 stated that she and RN #207 switched off on doing CPR, and she believed the assisted living nurse called 911 and the Administrator. CNA #136 stated EMS arrived around 5:00 A.M. CNA #136 stated she heard RN #207 tell the assisted living nurse that Resident #45 had complained of chest burning, but that was not true. CNA #136 stated Resident #136 said it was chest pain, and he had his hand on his chest. Resident #45 looked like he was in distress like he was having heart attack or stroke, and the nurse had no sense of urgency.During an interview on [DATE] at 1:25 P.M. with CNA #153 via telephone revealed she had walked past Resident #45's room and he was yelling out. She and CNA #136 went into Resident #45's room and he wanted water and stated his chest was feeling tight. She and CNA #136 went to tell the nurse, but she could not recall what time that was, and that was her only interaction with Resident #45. CNA #153 stated she helped clean up after he passed away. CNA #153 stated Resident #45 rang his call light, and she also heard him yelling out. Review of the policy titled Acute Condition Changes-Clinical Protocol, undated, revealed under the section titled Assessment and Recognition revealed the physician will help identify individuals with a significant risk for having acute changes of condition during their stay. In addition, the nurse shall assess and document/report the following baseline information: vital signs, neurological status, current level of pain, and any recent changes in pain level, level of consciousness, cognitive and emotional status, resident's age and sex, onset, duration, severity, recent labs, history of psychiatric disturbances, mental illness, depression, etc., all active diagnoses; and all current medications. Direct care staff, including nursing assistants, will be trained in recognizing subtle but significant changes in the residents and how to communicate these changes to the nurse. Under the section of the policy titled Treatment/Management revealed the physician will help identify and authorize appropriate treatments. The physician and staff will identify relevant resident/patient wishes, including advanced directives and physician orders for life sustaining treatment (POLST) orders related to life-sustaining treatments. If it is decided, after sufficient review, that care or observation cannot reasonably be provided in the facility, the physician will authorize transfer to an acute hospital, emergency room, or another appropriate setting. Under the section titled Monitoring and Follow-Up the staff will monitor and document the resident/patient's progress and responses to treatment, and the physician will adjust treatment accordingly.This deficiency represents non-compliance investigated under Complaint Number 2723415.