

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366335	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/16/2024
NAME OF PROVIDER OR SUPPLIER Snf-the Villa at Marymount		STREET ADDRESS, CITY, STATE, ZIP CODE 5200 Marymount Village Drive Garfield Heights, OH 44125	
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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37097 THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NONCOMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on medical record review, review of facility Self-Reported Incidents (SRIs), review of facility investigation documents, resident interview, staff interview, and review of the facility policy, the facility failed to ensure residents were free from abuse. This affected one (Resident #10) of three residents reviewed for abuse. The facility census was 88 residents. Findings include: Review of the medical record for Resident #10 revealed an admitted [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction. diabetes with diabetic neuropathy, and repeated falls. Review of the Minimum Data Set (MDS) assessment for Resident #10 dated 11/05/24 revealed the resident had intact cognition. Review of the SRI and facility investigation for Resident #10 dated 11/19/24 revealed Resident #10 made an allegation of abuse to the Director of Nursing (DON) regarding Certified Nursing Assistant (CNA) #427. Resident #10 reported when CNA #427 came into her room the aide was upset that she had to change the resident. Resident #10 alleged CNA #427 pushed her toward the wall and hit the resident in the head. Resident #10 stated she had not reported the incident to anyone at the time, and she waited until the morning and called her daughter. Further review of the SRI revealed the facility substantiated abuse had occurred and CNA #427 was terminated. Review of a written statement regarding Resident #10 dated 11/19/24 revealed Licensed Practical Nurse (LPN) # 302 brought CNA#427 to Resident #10's room and the resident identified the CNA as the person who hit her. Review of the written statement regarding Resident #10 dated 11/19/24 revealed CNA #427 denied ever pushing, hitting, or yelling at Resident #10. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/12/24 at 9:58 A.M. with Resident #10 confirmed the staff treated her well except for an aide that had yelled at her and hit her. Resident #10 confirmed the facility staff told her the aide was fired and there had been no problems since then. Interview on 12/12/24 at 12:04 P.M. with the DON and the Administrator confirmed the facility had substantiated abuse had occurred per CNA #427 towards Resident #10. The CNA was terminated and the facility implemented corrective action following the incident. Review of the facility policy titled Abuse undated revealed residents would be protected from abuse while they were in the facility and no abuse or harm of any type towards a resident would be tolerated. The deficient practice was corrected on 11/19/24 when the facility implemented the following corrective actions: On 11/19/24 CNA #427 was suspended. On 11/19/24 Resident #10 was interviewed. On 11/19/24 the DON notified Resident #10's family of the resident's allegation of abuse per CNA #427. On 11/19/24 the DON/designee interviewed all residents on the unit who were cognitively intact with no concerns related to the allegation. On 11/19/24 the DON/designee completed full skin assessments on all residents on the unit who were unable to be interviewed with no concerns identified. On 11/19/24 the DON educated all the staff in building on the Abuse policy and reporting. Staff who were not on duty were educated by phone, those that were unable to be reached were educated prior to the next shift. All newly hired staff will be educated on the abuse process during orientation. On 11/19/24 CNA #427 was terminated. On 11/19/24 the Administrator notified Resident #10 and the resident's family of the outcome of the abuse investigation and that CNA #427 was no longer employed with the facility. This deficiency represents noncompliance investigated under Complaint Number OH00160124.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30809 Based on medical record review, observation, staff interview, and review of the facility policy the facility failed to ensure a medication administration error rate of less than five percent (%.) This affected two (Resident #12 and Resident #85) of four residents observed during medication administration. The medication error rate was eight % with 37 medication opportunities and three errors. The facility census was 88 residents. Findings include: 1. Review of the medical record for Resident #12 revealed an admitted [DATE] with diagnoses including gastroparesis, gastroesophageal reflux disease, urinary retention, chronic pain syndrome, chronic kidney disease, depression, high blood pressure. Review of the December 2024 physician's orders for Resident #12 revealed an order for multivitamin one tablet by mouth daily. Observation of medication administration on 12/11/24 at 8:19 A.M. for Resident #12 per Licensed Practical Nurse (LPN) #287 revealed the nurse administered a multivitamin tablet with minerals to the resident. Interview on 12/11/24 at 11:05 A.M. with LPN #287 confirmed she administered a multivitamin tablet which contained minerals to Resident #12 instead of multivitamin tablet without minerals per the physician's order. 2. Review of the medical record for Resident #85 revealed an admitted [DATE] with diagnoses including multiple sclerosis, depression, anxiety, high blood pressure, and atherosclerotic heart disease. Review of the December 2024 physician's orders for Resident #85 revealed orders for the following medications to be administered at 9:00 A.M. along with the resident's other medications: apply triamcinolone acetonide external cream to the neck topically, Biotene dry mouth moisturizing mouth/throat solution, administer one spray for dry mouth. Observation on 12/11/24 at 8:58 A.M. of medication administration for Resident #85 per LPN #294 revealed the nurse administered Resident #85's oral medications but had not administered triamcinolone cream or Biotene spray. Interview on 12/11/24 at 8:58 A.M. with LPN #294 confirmed she had not administered Resident #85's triamcinolone cream or Biotene spray as ordered. Review of the facility policy titled Medication Administration revealed medications are to be administered as prescribed and in accordance with good nursing principles and practices. This deficiency represents noncompliance investigated under Complaint Number OH00159325.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30809 Based on medical record review, observation, staff interview, and review of the facility policy, the facility failed to ensure medications were not left unattended at the resident bedside. This affected two (Residents #56 and #85) of four residents observed for medication administration. The facility census was 88 residents. Findings include: 1. Review of the medical record for Resident #56 revealed an admitted [DATE] with diagnoses including stroke with left sided paralysis, inguinal hernia, high blood pressure, heart failure, osteoarthritis, and Alzheimer's dementia. Review of the December 2024 physician's orders for Resident #56 revealed an order dated 12/01/24 for Miralax 17 grams, dissolve in four ounces of liquid once daily. Observation on 12/11/24 at 8:50 A.M. of medication administration for Resident #56 per Licensed Practical Nurse (LPN)#307 revealed the nurse left the resident's Miralax dose dissolved in liquid at the resident's bedside, instructed the resident to make sure to consume the medication, and then exited the room. Interview on 12/11/24 at 8:51 A.M. with LPN #307 confirmed she did not ensure Resident #56 consumed the Miralax dose. LPN #307 stated it would take too long if she had to watch all the residents consume all of their medications. 2. Review of the medical record for Resident #85 revealed an admitted [DATE] with diagnoses including multiple sclerosis, depression, anxiety, high blood pressure, and atherosclerotic heart disease. Review of the December 2024 physician's orders for Resident #85 revealed an order for the resident to swish with Peridex oral solution mouth wash at 9:00 A.M. Observation on 12/11/24 at 8:58 A.M. of medication administration for Resident #85 per LPN #294 revealed the nurse left Resident #56's 9:00 A.M. dose of Peridex mouthwash on the resident's bedside and exited the room. Interview on 12/11/24 at 8:58 A.M. with LPN #294 confirmed she had left Resident #85's Peridex oral solution ordered at 9:00 A.M. at the resident's bedside and the nurse had not ensured the order was carried out. Review of the facility policy titled Medication Administration revealed the nurse should always observe the resident after administration to ensure that the dose was completely ingested.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30809 Based on medical record review, observation, staff interview, and review of the facility policy, the facility failed to ensure staff performed proper hand hygiene during medication administration. This affected three (Residents #12, #17, and #37) of four residents observed for medication administration. The facility census was 88 residents. Findings include: 1. Review of the medical record for Resident #12 revealed an admitted [DATE] with diagnoses including gastroparesis, gastroesophageal reflux disease, urinary retention, chronic pain syndrome, chronic kidney disease, depression, high blood pressure. Observation on 12/11/24 at 8:19 A.M. of medication administration for Resident #12 per Licensed Practical Nurse (LPN) #287 revealed the nurse did not perform hand hygiene prior to taking the resident's medications from the cart and administering the medications to the resident. Interview on 12/11/24 at 8:20 A.M. with LPN #287 confirmed she had not performed hand hygiene prior to taking Resident #12's medications from the cart and administering them to the resident. 2. Review of the medical record for Resident #17 revealed the resident was admitted with diagnoses including multifocal leukoencephalopathy, hyperlipidemia, vascular dementia, gastroenteritis, colitis, uterovaginal prolapse, syncope with collapse, hydronephrosis, and chronic kidney disease. Observation on 12/11/24 at 8:21 A.M. of medication administration for Resident #17 per LPN #426 revealed the nurse did not perform hand hygiene prior to taking the resident's medications from the cart and administering the medications to the resident. Interview on 12/11/24 at 8:22 A.M. with LPN #426 confirmed she had not performed hand hygiene prior to taking Resident #17's medications from the cart and administering them to the resident. 3. Review of the medical record for Resident #37 revealed an admitted [DATE] with diagnoses including high blood pressure, hypokalemia, malnutrition, heart arrhythmia, cerebral vascular disease, and dysphagia. Observation on 12/11/24 at 8:35 A.M. of medication administration for Resident #37 per LPN #307 revealed the nurse donned a pair of disposable gloves without performing hand hygiene, prepared the medications, and administered them to the residents. Interview on 12/11/24 at 8:36 A.M. with LPN #307 confirmed she had not performed hand hygiene prior to donning gloves, taking Resident #37's medications from the cart and administering them to the resident. Review of the facility policy for medication administration revealed the nurse should adhere to good hand hygiene, which included washing hands thoroughly before beginning a medication pass, prior to handling any medication, and after coming into direction contact with a resident.		