

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366343	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024
NAME OF PROVIDER OR SUPPLIER Legacy North Royalton		STREET ADDRESS, CITY, STATE, ZIP CODE 9055 West Sprague Road Parma, OH 44133	

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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43061</p> <p>Based on interview and record review the facility failed to ensure a comprehensive discharge care plan was in place for Resident #99. This affected one resident (Resident #99) out of three residents reviewed for comprehensive care plans. The facility census was 95.</p> <p>Findings include:</p> <p>Review of the closed medical record for the Resident #99 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnosis included but not limited to displaced intertrochanteric fracture of left femur, Parkinson's disease, aneurysm of the ascending aorta, chronic vascular disorder of intestine, right bundle-branch block, intracardiac thrombosis, history of falling, history of walking, muscle wasting and atrophy, and COVID-19.</p> <p>Review of the Admission Minimum Data Set (MDS) assessment, dated 07/25/24, revealed the resident had intact cognition. The resident was extensive assistance for bed mobility, substantial with maximal assistance for toileting hygiene, Review of behavior and mood revealed he had feelings of being down and trouble falling asleep. He had no behaviors.</p> <p>Review of the comprehensive care plan dated 07/19/24 revealed no care plan was in place for Resident #99's discharge.</p> <p>Interview on 08/27/24 at 7:49 A.M. with Licensed Social Worker (LSW) #167 verified there was no comprehensive discharge care plan in place for Resident #99.</p> <p>Review of facility policy, Care Planning-Interdisciplinary Team, revised 11/13/19, revealed the disciplinary team is responsible the development of an individualized comprehensive care plan for each resident and a comprehensive care plan for each resident is developed with in seven (7) days of completion of the resident assessment.</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43061</p> <p>Based on interview, closed medical record review, and facility policy review, the facility failed to ensure Resident #71, Resident #93, Resident #99 skin impairments were thoroughly assessed, monitored and treated timely. This affected three residents (#71, #93, and #99) out of three residents reviewed for skin impairments. The facility census was 95.</p> <p>Findings included:</p> <p>1. Review of the closed medical record for Resident #99 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnosis included but not limited to displaced intertrochanteric fracture of left femur, Parkinson's disease, aneurysm of the ascending aorta, chronic vascular disorder of intestine, right bundle-branch block, intracardiac thrombosis, history of falling, history of walking, muscle wasting and atrophy, and COVID-19.</p> <p>Review of the Admission Minimum Data Set (MDS) assessment, dated 07/25/24, revealed the resident had intact cognition.</p> <p>Review of Resident #99's hospital discharge paper work dated 07/18/24 at 11:27 A.M. revealed facility admission orders to have hip dressing in place for seven (7) days.</p> <p>Review of the Admission assessment dated [DATE] revealed under section 10, (skin) there was a picture/diagram of a person showing front and back side and numbered. The site was numbered #34 and left front thigh and type of skin impairment was identified to be a surgical incision. There were no further description of the incision and no further documentation regarding the surgical incision or the dressing required for the incision.</p> <p>Review of the physician orders for July 2024 revealed there was no admission order on 07/18/24 for Resident #99's dressing to left hip to remain in place for 7 days.</p> <p>Review of the care plan dated 07/19/24 revealed he receives anticoagulant drug therapy related to risk for developing a blood clot. Interventions included administer medications per physician order, assess for side effects including, bleeding abnormalities and monitor skin for bruises.</p> <p>Review of the Treatment Administration Records (TARS) dated 07/22/24 at 11:00 P.M. revealed the facility put in an order for Resident #99's left hip to keep dressing dry and intact for 7 days and to remove after 7 days.</p> <p>Review of the Weekly Skin Check form for Resident #99 dated 07/25/24, 08/01/24, and 08/08/24 revealed a picture/diagram of a person showing front and back side and on the front side the left thigh area was circled and on the back side the left elbow area was circled. There was no documentation as to what the area was or any further description of the skin areas. The form was signed by the nurse.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Weekly Skin Check form for Resident #99 dated 08/14/24 revealed a picture/diagram of a person showing front and back side and on the front side is circled the left thigh area and on the back side is circled the left elbow area. There was documentation on the left thigh front stating pre-existing. There was no further description of the circled areas. The form was signed by the nurse.</p> <p>Interview on 08/26/24 at 6:19 A.M. with Licensed Practical Nurse (LPN) #156 revealed weekly skin checks were to be completed by the nurse to include circling the area on the picture/diagram and documenting on the skin sheet the description and measurements of any skin impairments.</p> <p>Interview on 08/27/24 at 9:14 A.M. with Wound Registered Nurse (RN) #105 revealed there was no physician order put in place on 07/18/24 on admission for Resident #99 hip dressing change until 07/22/24 when she followed up with the resident and put the order in. Weekly skin checks were to be completed by the nurse to include circling the area on the picture/diagram and documenting on the skin sheet the description and measurements of any skin impairments</p> <p>Interview on 08/27/24 at 10:22 A.M. with Director of Nursing (DON) revealed skin assessments only had to list the locations by circling and no description of the skin area circled was required.</p> <p>Interview on 08/27/24 at 10:42 A.M. with LPN #148 revealed weekly skin checks were to be completed by the nurse to include circling the area on the picture/diagram and documenting on the skin sheet the description and measurements.</p> <p>Interview on 08/27/24 at 1:24 P.M. with LPN #178 revealed weekly skin checks were to be completed by a stat tested nursing assistance (STNA) circling on the skin sheet/shower sheet and nursing then documenting any skin issues in the computer to include description and measurement.</p> <p>Review of facility policy, Skin Management, revised 11/30/23, revealed a resident identified with skin breakdown will have a documented skin assessment weekly, wound description including measurements will be documented in point click care (computer system) and treatments as ordered.</p> <p>2. Review of the closed medical record for the Resident #71 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnosis included but not limited to encounter orthopedic aftercare, ankylosis spondylitis unspecified sites in spine, collapsed vertebra, and unspecified subsequent encounter for fracture with routine healing.</p> <p>Review of the Medicare 5-day Minimum Data Set (MDS) assessment, dated 08/14/24 , revealed the resident had intact cognition.</p> <p>Review of the Admission assessment dated [DATE] revealed under section 10, (skin) there was a picture/diagram of a person showing front and back side and numbered. The site stated other (specify) lower back and type surgical incision. There were no measurements and no further documentation regarding the surgical incision or the dressing.</p> <p>Review of the Weekly Skin Check form for Resident #71 dated 08/14/21 revealed a picture/diagram of a person showing front and back side and on the back side was circled with no description of the skin area circled. There was no documentation as to what the area was or any further description or measurements. The form was signed by the nurse.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Weekly Skin Check form for Resident #71 dated 08/21/21 revealed a picture/diagram of a person showing front and back side and on the back side was circled with the word surgical: wrote on form. There was no further documentation as to what the area was or any further description or measurements of the area. The form was signed by the nurse.</p> <p>Interview on 08/26/24 at 6:19 A.M. with LPN #156 revealed weekly skin checks were to be completed by the nurse to include circling the area on the picture/diagram and documenting on the skin sheet the description and measurements of any skin impairments.</p> <p>Interview on 08/27/24 at 9:14 A.M. with Wound RN #105 revealed revealed weekly skin checks were to be completed by the nurse to include circling the area on the picture/diagram and documenting on the skin sheet the description and measurements of any skin impairments.</p> <p>Interview on 08/27/24 at 10:22 A.M. with DON revealed skin assessments only had to list the locations by circling and no description of the skin area circled was required.</p> <p>Review of facility policy, Skin Management, revised 11/30/23, revealed a resident identified skin breakdown will have a documented skin assessment weekly, wound description including measurements will be documented in point click care (computer system) and treatments as ordered.</p> <p>3. Review of the closed medical record for Resident #93 revealed an admitted ,d+[DATE]/24 and a discharge date of [DATE]. Diagnosis included but not limited to vertebrogenic low back pain, and sacrum, subsequent encounter for fracture with routine healing.</p> <p>Review of the Admission Medicare 5-day assessment dated [DATE] revealed Resident #93 had intact cognition.</p> <p>Review of the Admission assessment dated [DATE] revealed under section 10, (skin) there was a picture/diagram of a person showing front and back side and numbered and the section was blank.</p> <p>Review of the Weekly Skin Check form for Resident #93 dated 08/13/24 and 08/22/24 revealed a picture/diagram of a person showing front and back side and on the front side there was a circle on right elbow, a circle of left elbow and circle above left elbow. There was no description or measurements of the skin area circled. The form was signed by the nurse.</p> <p>Review of the Weekly Skin Check form for Resident #93 dated 08/24/24 revealed a picture/diagram of a person showing front and back side and on the front side a circle on right elbow, left elbow and above left elbow. There is writing on the document stating bruising. There was no description or measurements of the bruising. The form was signed by the nurse.</p> <p>Interview on 08/26/24 at 6:19 A.M. with LPN #156 revealed weekly skin checks were to be completed by the nurse to include circling the area on the picture/diagram and documenting on the skin sheet the description and measurements of any skin impairments.</p> <p>Interview on 08/27/24 at 9:14 A.M. with Wound RN #105 revealed revealed weekly skin checks were to be completed by the nurse to include circling the area on the picture/diagram and documenting on the skin sheet the description and measurements of any skin impairments.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 08/27/24 at 10:22 A.M. with DON revealed skin assessments only had to list the locations by circling the skin impaired area and no description of the skin area circled was required.</p> <p>Review of facility policy, Skin Management, revised 11/30/23, revealed a resident identified skin breakdown will have a documented skin assessment weekly, wound description including measurements will be documented in point click care (computer system) and treatments as ordered.</p>