STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366343	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Royalton Post Acute	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)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to timely assist Resident #91 to get out of bed per his request and failed to provide foot pedals per request for Resident #83. This affected two residents (Resident #91 and #83) of three residents observed for timely accommodation of needs/requests. The facility census was 119.Findings include:1. Record review for Resident #91 revealed an admission date of 03/02/23. Diagnosis included dysphagia, polyneuropathy, and encounter for attention to gastrostomy. Review of the significant change Minimum Data Set (MDS) dated [DATE] revealed Resident #91 was moderately cognitively impaired. Resident #91 used a wheelchair for mobility, required substantial/maximal assistants for bed mobility, dependent for chair/bed to chair transfer, and personal hygiene. Review of the care plan dated 05/14/25 revealed Resident #91 had an activity of daily living self-care mobility functional ability performance deficit related to physical limitations, cognitive deficit, and cerebral infarction. Interventions included to assist with transfers with two assistants via Hoyer lift and wheelchair for mobility. Observation on 11/19/25 10:53 A. M. revealed Resident #91 was lying in bed. Resident #91 revealed he needed changed, and he wanted to get out of bed and revealed he asked his aide, but she never came back to help him up. Interview on 11/19/25 at 11:20 A.M. with Certified Nursing Assistant (CNA) #362 confirmed she was Resident #91 primary CNA. CNA #362 revealed Resident #91 was incontinent and changed earlier that day. CNA #362 stated, He asked me to get up, I just need to find his Broda chair, he asked me around 10:45 this morning but I had to go get someone else up. Observation on 11/19/25 at 11:37 A.M. revealed Resident #91 was still in bed. Resident #91 revealed he was not changed yet and requested surveyor to assist him. Resident #91 revealed he was also still waiting to get out of bed. Interview on 11/19/25 at 11:41 A.M. with CNA #394 revealed CNA #362 went on her lunch break. CNA #394 revealed she would assist to provide incontinence care for Resident #91. Interview on 11/19/25 at 1:39 P.M. with Resident #91 revealed he was still waiting to get out of bed. Interview on 11/19/25 at 1:43 P.M. with CNA #362 revealed she went in to assist Resident #91 about 15 min ago, he said he was sleepy. CNA #362 revealed she was going to get him up earlier, but she could not find a Broda chair to put him in and revealed she just found the chair. 2. Record review for Resident #83 revealed an admission date of 11/10/25, a discharge date of 11/15/25 and a readmission of 11/17/25. Diagnosis included spondylosis with radiculopathy lumbosacral region, muscle wasting and atrophy, incomplete lesion of L1 level of lumbar spinal cord subsequent encounter, post laminectomy syndrome, polyneuropathy, repeated falls, chronic pain, atherosclerotic heart disease, cervicalgia, foot drop right foot, presence of neurostimulator, muscle spasms, idiopathic chronic gout multiple sites, and transient cerebral ischemic attack. Review of the Minimum Data Set (MDS) dated [DATE] revealed Resident #83 was moderately cognitively impaired. Resident #83 had impairment to one side of the lower extremities, was dependent for putting on and taking off foot wear, partial moderate assist for sit to stand, and chair/bed to chair transfer. Resident #83 used a manual wheelchair and required supervision or touch assistance for mobility. Observation on 11/20/25 at 12:15 P.M. revealed Resident #83 was in a wheelchair being pulled backwards through the entrance of the facility doors and down the hall. Resident #83's feet were dragging on the floor. Observation revealed his elderly brother was pulling the wheelchair backwards, he ran into the wall nearly falling. Resident #83 screamed in fear. Admissions #243 approached. Interview with Resident #83 revealed he was returning from a doctor appointment. Resident #83 revealed his brother went with him and was returning him to the facility. Resident #83 revealed it was too hard to hold his legs in the air to go forward, it was too painful, and he did not have the strength, so his brother had to pull him backwards. Resident #83 expressed he was frustrated, he had asked several times for several days for foot pedals for the wheelchair, but no one had got them for him. Observation revealed Resident #83's brother then continued pulling Resident #83 down the hall backwards toward his room, staff never offered assistants. Interview on 11/20/25 at 2:21 P.M. with Physical Therapy Assistant (PTA) #322 revealed she worked with Resident #83 on ambulation for a while the previous day but Resident #83 was in too much pain in his legs, knees and back. PTA #322 revealed Resident #83 was self-limited due to pain and revealed he should not be pushed in the wheelchair with no foot pedals. Interview on 11/20/25 at 2:28 P.M. with Licensed Practical Nurse (LPN) Unit Manager (UM) #401 revealed Resident #83 did not get out of bed too often and stated, He can do more than he is willing to do, he is not doing it, he would rather everyone do it for him, back pain is normal for him; he recently had a pump put in his back. LPN UM #401 revealed when a resident was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366343	A. Building B. Wing	11/25/2025

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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 - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and review of the facility policy, the facility failed to notify the physician timely and monitor the resident for adverse effects after a medication error occurred. This affected one resident (Resident #44) of three residents reviewed for medication errors. The facility census was 119.Findings include:Record review for Resident #44 revealed an admission date of 11/03/21. Diagnosis included type two diabetes mellitus (DM) with diabetic neuropathy, long term use of insulin and Alzheimer's disease. Review of the Annual Minimum Data Set (MDS) dated [DATE] revealed Resident #44 was unable to complete the Brief Interview for Mental Status, had short- and long-term memory problems and had severely impaired cognitive skills. Resident #44 had diabetes mellitus and received insulin injections daily. Review of the physician orders for Resident #44 revealed on 02/14/25 Resident #44 was to receive Lantus Solostar subcutaneous solution pen injector 100 units per milliliter (ml), inject 20 units subcutaneous in the evening for DM.Record review of the Investigation Report dated 02/15/25 untimed with a date of incident of 02/14/25 completed by Director of Nursing (DON) revealed: On 02/14/25 Resident (#44) did not receive 7:00 P.M. insulin. On 02/14/25 Nurse (Licensed Practical Nurse (LPN) #213) reports she was passing medication to (Resident #44) when family requested that her comforter be changed. Nurse (LPN #213) reported that she assisted with family request and continued to pass medications. Nurse (LPN #213) reports she did not realize that she did not administer (Resident #44's) insulin until the next day when she received a call from the Unit Manager (UM) (#371). UM (#371) reports she was notified by the daughter of the resident. Review of Resident #44's medical record revealed no evidence the resident was monitored for adverse effects of missing insulin. Review of the care plan dated 03/21/25 revealed Resident #44 had a diagnosis of diabetes and was at risk for complications manifested by hyperglycemia, hypoglycemia, neuropathy, peripheral vascular disease and skin breakdown. Interventions included to administer medications per the physician orders.Review of the Investigation report dated 10/28/25 untimed completed by DON with date of incident 10/17/25 revealed on 10/17/25 (Resident #44) had a missed dose of insulin. Review of the timeline of events revealed LPN (#267) stated she was unable to take care of (Resident #44) due to (Resident #44's) daughter request. LPN #213 agreed to care for (Resident #44). (LPN #213) was also reminded to administer the insulin. (Resident #44) missed afternoon insulin and her bedtime medications. This was verified by recording review, medical record review and witness statements.Review of the physician orders and Medication Administration Record (MAR) for Resident #44 for 10/17/25 revealed Resident #44 missed the following medications and accucheck:1. Cetirizine HCL oral tablet 10 milligrams (mg) give one tablet by mouth for allergies to be administered at 5:00 P.M.2. Lantus Solorstar sq solution pen injector 100 units per ml, inject 20 units sq in the evening for DM to be administered at 5:00 P.M.3. Accucheck without coverage two times a day for DM, notify on call if blood sugar over 250 to be assessed at 7:00 P.M.4. Gabapentin capsule 100 mg give one capsule by mouth for neuropathy to be administered at 4:00 P.M.5. Glycolax powder give 17 grams by mouth for constipation to be administered at 7:00 P.M.6. Metoprolol Tartrate 25 mg give one tablet by mouth for hypertension to be administered at 4:00 P.M.7. Tylenol extra strength oral tablet 500 mg give 1000 mg by mouth for pain to be administered at 5:00 P.M.8. Pepcid oral tablet 20 mg give one tablet by mouth two times a day for gastro esophageal reflux disorder (GERD) to be administered at 6:00 P.M.9. Simethicone oral tablet 80 mg give one tablet by mouth for gas to be administered at 5:00 P.M.10. Sucralfate suspension one gram per 10 ml, give 10 ml by mouth for gastric protection to be administered at 5:00 P.M.Review of Resident #44's medical record revealed no evidence the resident's physician was notified of the medication errors on 10/17/25 or was monitored for adverse effects of missing the medications.Interview on 11/25/25 at 12:18 P.M. with Director of Nursing (DON) verified the medication errors that occurred for Resident #44 on 02/14/25 and 10/17/25. DON revealed that when there was a medication error, the resident should be monitored daily for 72 hours following the error. DON reviewed the medical record and confirmed on 02/14/25 and 10/17/25 Resident #44 was not monitored daily for 72 hours for effects related to the missed doses of medications and the physician was not notified timely of the medication errors that occurred 10/17/25.Review of the facility policy titled, Adverse Consequences and Medication Errors dated February 2023 revealed a medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician orders, manufacturer specifications, or accepted professional standard and principals of the professional providing services. Example of medication errors include omission (a drug is ordered but not

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	366343	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (continued on next page)

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	366343	A. Building B. Wing	11/25/2025

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and review of the facility policy, the facility failed to ensure Resident #14 received timely assistance to maintain continence. This affected one resident (Resident #14) of three residents observed for incontinence care. The facility census was 119.Findings include:Record review for Resident #14 revealed an admission date of 02/25/22. Diagnosis included Parkinson's disease and muscle wasting.Review of the quarterly Minimum Data Set (MDS) dated [DATE] for Resident #14 revealed a Brief Interview of Mental Status (BIMS) score of 12 (moderately cognitively impaired). Resident #14 was frequently incontinent of bowel and bladder, used a wheelchair for mobility, required partial/moderate assistants for toileting transfer and toileting hygiene. Review of the care plan dated 04/07/25 revealed Resident #14 had an activity of daily living (ADL) self-care performance deficit related to physical limitations. Interventions included Resident #14 required extensive assistance of one person for toileting. Observation on 11/19/25 at 11:17 A.M. revealed Resident #14 was sitting up in a wheelchair in the Activities room. Observation on 11/19/25 at 11:33 A.M. revealed Activities Aide #247 was pushing Resident #14's wheelchair towards her room from the Activities room. Activities Aide #250 was walking next to Activities Aide #247. Observation revealed Resident #14 requested to use the bathroom revealing she had to urinate. Activities Aide #250 instructed Activities Aide #247 that Resident #14 would have to wait at the nurses' station stating, We can't take her to her room, or she will try to go to the bathroom by herself. Observation revealed Activities Aid #247 sat Resident #14 across from the nurses' station then both Activities Aides #247 and #250 turned and walked up the hall away from Resident #214. Observation revealed neither Activity Aide notified any staff that Resident #14 requested to use the bathroom to urinate. Continued observation on 11/19/25 from 11:33 A.M. to 12:09 P.M. revealed no staff assisted Resident #14 to the bathroom. Resident #14 continued sitting across from the nurse's station. Interview on 11/19/25 at 11:52 A.M. with Certified Nursing Assistant (CNA) #394 and #399 revealed there was not enough staff to timely assist residents to the bathroom or with incontinent care timely, especially during the mealtimes residents would have to wait. Observation revealed at 12:09 P.M. Activities Director #246 approached Resident #14 and pushed her wheelchair to the Recreational Therapy room, served her lunch tray to her then left the room. Interview with Resident #14 verified no one took her to the bathroom and Resident #14 revealed she still needed to go. Interview on 11/19/25 at 12:11 P.M. with Certified Nursing Assistant (CNA) #394 confirmed she was Resident #14's primary CNA. CNA #394 confirmed that no one told her Resident #14 needed to use the bathroom to urinate. Observation with CNA #394 confirmed Resident #14 was sitting in the Recreational Therapy room by herself eating her lunch. Activities Director #246 entered the room and revealed she put Resident #14 there because they were going to have an activity after lunch. Activities Director #246 revealed she would sit with Resident #14 while she ate her meal. CNA #394 thanked Activities Director #246 and walked away without offering to take Resident #14 to the bathroom. Resident #14 then again revealed to Activities Director #246 that she needed to use the bathroom to urinate. Activities Director #246 did not leave to get assist for Resident #14 to use the bathroom. Interview on 11/19/25 at 12:20 P.M. with Activities Aides #247 and #250 revealed Activity Aid #250 was training Activity Aid #247. Both Activities Aides #247 and #250 verified neither notified any staff Resident #14 needed to use the bathroom when they sat her across from the nurses station at approximately 11:33 A.M.; Activity Aid #250 revealed, We cannot take her to her room, or she will try to go by herself, we did not see staff so we left, no one was notified. Observation on 11/19/25 at 12:30 revealed Resident #14 was still sitting in the Recreational Therapy room by herself. Resident #14 confirmed she was still waiting to use the bathroom. Observation on 11/19/25 at 12:50 P.M. revealed Resident #14 was sitting in the doorway of her room. Resident #14 verified her CNA just finished assisting her to the bathroom. Resident #14 revealed, If my bladder is full, it does hurt and I have to go a little in my pants when I can't hold no more. Resident #14 revealed it happens some days when they are too busy to take her. Interview on 11/19/25 at 12:51 P.M. with Licensed Practical Nurse (LPN) #267 confirmed she was Resident #14's primary nurse and revealed, (Resident #14) is continent of urine if we take her. Interview on 11/19/25 at 12:54 P.M. with CNA #394 revealed she took Resident #14 to the bathroom about 10 minutes ago. CNA #394 revealed Resident #14's brief was wet with urine, but she also urinated in the toilet too. CNA #394 revealed Resident #14 was usually continent of urine but sometimes also incontinent and revealed Resident #14 was last assisted to the bathroom right before breakfast (approximately 8:00 A.M.). Interview

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366343	A. Building B. Wing	11/25/2025

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure #78 received the ordered amount of tube feeding daily. This affected one resident (Resident #78) of three residents reviewed for tube feeding management. The facility census was 119.Findings include:Record review for Resident #78 revealed an admission date of 08/01/25. Diagnosis included dysphagia following cerebral infarction, hemiplegia and hemiparesis, and aphasia. Review of the admission MDS dated [DATE] revealed Resident #78 was severely cognitively impaired. Resident #78 was dependent for activities of daily living including bed mobility and transfers. Resident #78 had no or unknown weight loss and weight was 188. Review of the physician orders dated 08/01/25 revealed Resident #78 was NPO. Additional orders dated 08/28/25 for Resident #78 revealed an order for enteral feed order every shift for nutrition Peptamen 1.5 continuous: Give formula at 75 cc an hour flush 300 cc every six hours ok to use Jevity 1.5 if Peptamen unavailable.Review of the care plan for Resident #78 dated 08/05/25 revealed Resident #78 had a peg tube and was at risk for enteral nutrition complications related to aspiration pneumonia, clogged tubing, excessive residual, infection, nausea or vomiting, and tubing and displacement. Interventions included to monitor weight per protocol.Review of the weight log for Resident #78 revealed on 09/04/25 Resident #78 weighed 192.3 pounds. On 10/07/25 Resident #78 weighed 192.4 pounds. On 11/07/25 Resident #78 weighed 188.6 pounds. Observation on 11/19/25 at 2:23 P.M. revealed Resident #78 was in bed with his eyes closed. Observation revealed Resident #78's tube feeding pump was beeping and revealed, clog in line downstream. The containing of tube feeding was Jevity 1.5 dated as initiated on 11/19/25 at 12:50 A.M. at 75 cc an hour. The container was a 1000 ml container. Observation revealed there was 370 ml remaining in the container and the tube feeding was not flowing.Observation on 11/19/25 at 3:09 P.M. and 4:30 P.M. revealed Resident #78' tube feeding pump was beeping, not infusing and read, clog in line downstream.Observation on 11/19/25 at 4:31 P.M. with LPN #268 confirmed Resident #78's tube feeding was not infusing. LPN #268 confirmed the tube feeding pump was beeping and revealed, clog in line downstream. The containing of tube feeding was Jevity 1.5 dated as initiated on 11/19/25 at 12:50 A.M. at 75 cc an hour. The container was a 1000 ml container. Observation confirmed there was 370 ml remaining in the container. LPN #268 revealed she started her shift at 3:00 P.M., had not visited with Resident #78 yet and was not told his tube feeding had not been infusing. The tube feeding should have been completed at approximately 1:00 P.M. LPN #268 confirmed Resident #78 did not receive the ordered amount of nutrition.This deficiency represents non-compliance investigated under Complaint Number 2661500.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366343	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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. (continued on next page)

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	366343	A. Building B. Wing	11/25/2025

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North Royalton Post Acute	9055 West Sprague Road Parma, OH 44133

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure a medication error rate of less than 5%. A total of 31 medications were administered with two errors for a medication error rate of 6.45%. This affected two residents (Resident #26 and Resident #79) of five residents observed for medication administration. 1.Record review for Resident #26 revealed an admission date of 02/09/23. Diagnosis included Type one diabetes mellitus (DM) with diabetic neuropathy and hypertensive chronic kidney disease with stage one through stage four chronic kidney disease. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #26 was cognitively intact. Resident #26 had DM and required insulin injections. Review of the care plan dated 03/13/25 revealed Resident #26 had a diagnosis of diabetes and was at risk for complications manifested by hyperglycemia (high blood sugar), hypoglycemia (low blood sugar), skin breakdown and neuropathy. Interventions included administering medications per order. Review of the physician orders for Resident #26 dated 09/20/25 revealed an order for Novolog flexpen subcutaneous (sq) solution pen injector 100 units per milliliter (ml) inject seven units one time a day for DM, hold if blood sugar less than 120. Observation on 11/20/25 at 8:45 A.M. of medication administration revealed Licensed Practical Nurse (LPN) Unit Manager (UM) #401 assessed Resident #26's blood sugar. LPN UM #401 then removed Resident #26's Novolog insulin pen from the medication cart and placed a new needle on the insulin pen. LPN UM #401 then dialed the insulin pen to seven. Observation revealed LPN UM #401 did not prime the insulin pen. LPN UM #401 then administered the insulin to Resident #26 then returned to the medication cart. LPN UM #401 confirmed she did not prime Resident #26's insulin pen prior to dialing the seven units and administering the insulin. LPN UM #401 revealed she did not need to prime insulin pens.2. Record review for Resident #79 revealed an admission date of 02/11/21. Diagnosis included DM with unspecified diabetic retinopathy, chronic kidney disease, and diabetic polyneuropathy. Review of the quarterly MDS dated [DATE] revealed Resident #79 was cognitively intact. Resident #79 required assistants with activities of daily living, had a diagnosis of DM and received insulin injections. Review of the care plan dated 04/02/25 revealed Resident #79 had a diagnosis of diabetes and was at risk for complications manifested by hyperglycemia (blood sugar too high) and hypoglycemia (blood sugar too low). Interventions included to administer medications as ordered. Review of the physician orders for Resident #79 dated 10/31/25 revealed an order for Lantus Solostar solution pen injector 100 units per ml inject 20 units sq one time a day for DM. Observation on 11/20/25 at 9:10 A.M. of medication administration revealed LPN #310 removed Resident #79's Lantus Solostar solution pen injector from the medication cart and placed a new needle on the insulin pen. LPN #310 then dialed the insulin pen to 20. Observation revealed LPN #310 did not prime the insulin pen. LPN #310 then administered the insulin to Resident #79 then returned to the medication cart. LPN #310 confirmed she did not prime the insulin pen and revealed she only primes the insulin pens if she sees air bubbles. Interview on 11/20/25 at 11:08 A.M. with Director of Nursing (DON) confirmed insulin pens require the pen to be primed after placing the needle on and prior to dialing the ordered dose of insulin. DON confirmed both nurses, LPN UM #401 and LPN #310 worked at different times throughout the facility with all residents residing in the facility. Review of the insulin pen pamphlet information provided by DON titled, To use an insulin pen undated revealed Step one: Prepare the pen. Twist a new needle onto the pen. A new needle is required for every injection. Prime the pen: Dial two units on the dose selector. Point the needle up and gently tap the pen to move air bubbles to the top. Press the injection button and watch for a drop of insulin to appear on the needle tip. If you don't see a drop, repeat the priming process. Dial the correct dose prescribed by the Dr.; The instructions included to the administer the insulin per the physician orders. Review of the facility policy titled, Administering Medications revised April 2019 revealed medications are administered in a safe and timely manner, and as prescribed. The deficiency represents non-compliance investigated under Complaint Number 1348044 and 1348045.

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	366343	A. Building B. Wing	11/25/2025

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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. (continued on next page)

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	366343	A. Building B. Wing	11/25/2025

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North Royalton Post Acute	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and review of the facility policy, the facility failed to maintain infection control practices for one Resident #91 during incontinence care and wound care. This affected one resident (Resident #91) of three residents observed for infection control. The facility census was 119. Findings include: Record review for Resident #91 revealed an admission date of 03/02/23. Diagnosis included dysphagia, polyneuropathy, and encounter for attention to gastrostomy. Review of the significant change Minimum Data Set (MDS) dated [DATE] revealed Resident #91 was moderately cognitively impaired. Resident #91 used a wheelchair for mobility, required substantial/maximal assistants for bed mobility, dependent for chair/bed to chair transfer, and personal hygiene. Resident #91 had a feeding tube and received an antibiotic. Review of the care plan dated 11/03/25 revealed Resident #91 was at risk for complications related to peg site infection. Interventions included infection control prevention practices and to monitor for signs and symptoms of worsening infection. Review of the care plan dated 11/06/25 revealed Resident #91 had impaired skin integrity as evidence by skin tear/abrasion to the left lateral calf and was at high risk for further breakdown and or slow delayed healing. Interventions included to administer treatments as ordered and monitor for effectiveness and notify the physician if signs and symptoms of infection occur. Review of the care plan dated 05/14/25 for Resident #91 revealed Enhanced Barrier Precautions: Resident requires EBP during high contact resident care activities due to the presence of indwelling device (e.g. central lines, feeding tubes) not known to be infected or colonized with any MDRO. Interventions included to utilize PPE (gown and gloves; face shield as indicated) during high contact resident care activities (e.g. dressing, bathing/showering, transferring, hygiene, linen changes, brief changes, toileting assistant, device care, wound care). Review of the physician orders for Resident #91 for November 2025 revealed orders to: 1. Cleanse peg tube insertion site with soap and water, pat dry, apply Bactroban topically, cover with a dry sterile dressing twice a day. 2. Enhanced Barrier Precautions: Use gown and gloves for high-contact resident care including dressing, bathing, showering, transfers, hygiene care, changing linens, changing briefs, assisting with toileting, dressing changes, and care of any device (trach, central line, tube feeding, catheter). every shift for reducing the chance of spreading infection. Observation on 11/19/25 at 11:41 A.M. of incontinence care provided by Certified Nursing Assistant (CNA) #394 and #399 for Resident #91 revealed Resident #91 was lying in bed. CNA #394 and #399 entered the room, applied gloves and began repositioning Resident #91 in bed. Resident #91 had a large bowel movement. Resident #91's right leg was pressed against CNA #399's clothing while holding him to the side while CNA #394 was cleaning his backside. Neither CNA #394 nor #399 applied an isolation gown during the care. Interview on 11/19/25 at 11:52 A.M. revealed CNA #394 revealed they only need to apply an isolation gown if the resident had a foley catheter. CNA #399 revealed she was not aware they were supposed to apply a gown to provide care. Observation on 11/23/25 at 9:37 A.M. of Licensed Practical Nurse (LPN) #261 provide wound care to Resident #91's peg tube insertion site revealed LPN #261 removed the intact undated dressing at Resident #91's peg tube insertion site. The dressing had a moderate amount of thick brown drainage. The inside edges of the dressing was covered with black drainage. The peg tube site was deep red and excoriated approximately three inches surrounding the insertion site. LPN #261 applied clean gloves then cleaned the insertion site with soap and water, applied antibiotic ointment to the sterile drain sponge (using the same gloves she cleaned the soiled wound with), then applied the sterile drain sponge over the insertion site. Observation revealed LPN #261 never washed her hands or used hand sanitizer after cleaning the peg tube insertion site and before applying the sterile dressing. LPN #261 confirmed she did not wash her hands or use hand sanitizer after cleaning the soiled peg tube site area and confirmed she wore the same soiled gloves used to clean the site to apply the sterile dressing. Interview on 11/23/25 at 10:47 A.M. with Director of Nursing (DON) confirmed LPN #261 should have washed her hands with soap and water or used hand sanitizer after cleansing Resident #91's peg tube site and before applying the sterile dressing. DON confirmed the physician order was for a dry sterile dressing twice a day and according to the order, sterile technique should have been used to apply a sterile dressing. DON confirmed sterile techniques were never used (including sterile gloves) to provide the treatments to the peg tube site. DON revealed the order should not have been sterile due to wound care for peg tube sites were usually not a sterile technique but clean technique should have still been used. DON also confirmed that an isolation gown should be worn at all