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	05/21/2026

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident record review, staff interviews, and facility policy review, the facility failed to provide a timely response to resident concerns. This affected one resident (#33) of three reviewed for resident's rights. The facility census was 96.Findings include: Review of the medical record for Resident #33 revealed she was admitted to the facility on [DATE] with diagnoses that included osteoarthritis of the left shoulder, type two diabetes mellitus, and dementia. Review of the care plan dated 03/21/25 revealed Resident #33 had a self-cere performance deficit with interventions to assist with ADLs.Review of the facility concern document dated 03/11/26 revealed Resident #33's representative reported Resident #33 was missing two pairs of pants, one black and whites stripped pair and one all white pair. Review of the document revealed Resident #33's missing items were not located in the laundry department, lost and found, and her room after a full sweep of the facility. Review of the concern document revealed a follow-up on 03/12/26 with a resolution that the facility would reimburse Resident #33 for two pairs of missing pants with receipt. Review of the receipt attached to the concern document revealed two pairs of men's active pants priced at $12.99 and $24.99.Review of the facility refund request details document dated 04/09/26 revealed a refund in the amount of $41.02 was to be paid to Resident #33 representative for two pairs of missing pants. Review of the facility document property refund dated 05/07/26 for miscellaneous payment request revealed the payment was still unpaid for Resident #33, approximately 57 days later after being made aware.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #33 had a Brief Interview for Mental Status (BIMS) score of 0 that indicated she had short- and long-term cognition deficits. Review of the MDS assessment revealed Resident #33 was impaired on one side upper extremity and required assistance from staff for activities of daily living (ADLs).Interview on 05/19/26 at 10:45 A.M. with the Director of Nursing (DON) revealed when residents and/or family informed them of missing items, it was documented on a concern form and then designated departments searched for the missing item. The DON revealed that once an item cannot be found, the concern form goes to the Administrator, and he puts in place a possible reimbursement or alternative solution. The DON revealed the residents and/or family would need to produce receipts to fulfill a reimbursement. The DON revealed she was aware of Resident #33 missing items but stated she notified us a while ago and should have already been reimbursed for that. The Administrator handles the reimbursement part. The DON confirmed and verified the above findings at the time of the interview. Interview on 05/19/26 at 11:28 A.M. with the Administrator revealed the facility had already reimbursed Resident #33's representative and that was the responsibility of the facility's corporate office. The Administrator revealed he had no control over how the corporate office handled reimbursement of funds for residents and families or how long it takes. Review of the facility documents related to Resident #33's representative concerns with the Administrator confirmed and verified the facility failed to provide timely resolution to Resident #33's representative and reimbursement still was not provided.This deficiency represents non-compliance investigated under Complaint Number 2705845.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed record review, hospital record review, review of facility fall investigations, facility policy review and interview, the facility failed to develop and implement a comprehensive, individualized and effective fall/safety plan of care to prevent repeated falls including falls with injury for Resident #97. This affected one resident (#97) of three residents reviewed for falls. The facility census was 96.Actual Harm occurred on 12/23/25 when Resident #97, who was at high risk for falls (with four falls between 12/17/25 and 12/22/25) and who had behaviors (agitation/restlessness) sustained a fall from bed resulting in a hematoma and visible injury to her right temple without evidence of comprehensive, individualized and effective interventions being in place to prevent the fall. Actual Harm continued on 01/11/26, when the facility failed to provide adequate and necessary supervision/intervention to prevent Resident #97 from sustaining an unwitnessed fall from her wheelchair resulting in an intracranial hemorrhage (brain bleed) and a seventh cervical (C7) superior facet and pedicle vertebral neck fracture. The resident was transferred to the hospital and did not return to the facility following this incident. Findings include: Review of the closed medical record for Resident #97 revealed the resident was admitted to the facility on [DATE] with diagnoses including non-traumatic subdural hemorrhage (bleeding in the space between the brain and the outermost protective membrane), non-traumatic intracranial hemorrhage (bleeding inside the skull), non-traumatic muscle wasting, and aphasia. Prior to admission to the facility, Resident #97 was hospitalized following a cerebrovascular accident (stroke) and fall at home. An assessment included in the hospital discharge paperwork identified Resident #97 was at high risk for falls. Review of the facility's incident log dated 12/13/25 through 01/31/26 revealed Resident #97 sustained six falls at the facility on 12/17/25, 12/18/25, 12/21/25, 12/22/25, 12/23/25, and 01/11/26. Review of the care plan initiated on 12/15/25 revealed Resident #97 was at risk for activities of daily living (ADL) and mobility decline, utilized anticoagulants, and was at risk for falls related to altered balance and a history of falls. Interventions initiated on 12/15/25 included to keep call light and frequently used personal items within reach, obtain physical and occupational therapy consult as indicated and orient to new environment as indicated.Review of the plan of care revealed it was updated with new interventions on 12/18/25 to keep bed in low position with brakes locked, on 12/19/25 to provide diversionary activities during periods of restlessness and on 12/23/25 for a dump wheelchair and mattress to the floor while in bed, and move bed against the wall. An intervention included on the care plan to place Resident #97 behind the nurse's station during periods of restlessness to maintain safety was initiated on 01/12/26; however, the resident had been transferred to the hospital following a fall with injury on 01/11/26.Review of the therapy notes dated 12/15/25 through 01/10/26 revealed Precautions: falls and noted the resident was being treated by the physical and occupational therapy department. The therapy notes did not include what specific fall precautions were in place or necessary to address the resident's increased fall risk and ongoing falls sustained during this time period. The therapy notes did reflect Resident #97 was very distracted, agitated, required verbal cueing and maximal assist for activities of daily living (ADLs), had poor sitting balance due to weak core and/or trunk control throughout each session.Review of a fall investigation dated 12/17/25 at 10:35 P.M. revealed Resident #97 had a fall without injury. Resident #97 was observed lying in bed prior to her fall. Resident #97 was found sitting on the floor next to her bed and was unable to provide details of what happened. The investigation noted following the incident Resident #97's was assisted to her wheelchair and brought to the nursing station for one-on-one monitoring. Following the incident, a new intervention to keep bed in low position with brakes locked was added to the resident's plan of care. The position of the resident's bed at the time of the fall was not noted on the fall investigation.Review of the progress note dated 12/17/25 at 10:57 P.M. revealed Resident #97 was (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	observed sitting on the floor next to the bed. Resident #97 was assessed, denied pain or discomfort, and immediate care included assisting Resident #97 to her wheelchair and bringing her to the nurse's station. Review of the facility fall investigation and corresponding nursing progress note revealed no additional information as to the circumstances of the fall, any environmental factors associated with the fall, why the fall likely occurred, whether the resident's call light was in place/activated at the time of the fall, when the resident had last been seen by staff prior to the fall, and/or if the resident was having behaviors prior to the incident. Review of a fall investigation dated 12/18/25 at 5:40 P.M. revealed Resident #97 was sitting outside of the nurse's station and attempted to get out of her chair and fell to the floor before anyone was present. Resident #97 was assisted back into her chair by 2-person assist and placed behind the nurse's station for supervision. Following the incident, the facility implemented an intervention to provide diversional activities during periods of restlessness. Review of the progress note dated 12/18/25 at 6:08 P.M. revealed Resident #97 was sitting outside the nurse's station when she attempted to get up out of her chair and fell to the floor before anyone was present. Resident #97 was assisted back into her chair with two staff and placed behind the nurse's station for supervision. Resident #97 received new orders for Hydroxyzine (an antihistamine medication that also decreases symptoms of anxiety and tension) 25 milligram as needed every eight hours after physician notification.Review of the facility fall investigation and corresponding nursing progress note revealed no evidence the facility completed a root cause analysis of the fall. There was no evidence the resident had been provided necessary supervision in the presence of restlessness to prevent this fall. In addition, there was no evidence the need for and/or use of diversional activities was individualized to meet the resident's total care needs or that the facility provided guidance to staff as to what type of diversional activities should be used following the incident.Review of the progress note dated 12/21/25 at 3:45 P.M. revealed Resident #97 was sitting at the nurse's station in her wheelchair. Resident #97 was observed to keep making gestures of trying to get up but was readjusted in her chair by staff. Resident #97 then attempted to get up again and fell to her knees, rolled over, and laid out on the floor. Resident #97 stated she was scared once back into her chair. Resident #97's family and physician were notified.Review of the fall investigation dated 12/21/25 at 3:45 P.M. revealed Resident #97 had a witnessed fall without injury at the nurse's station. Review of the fall investigation revealed Resident #97 did not have a change in her behavior; however, it was noted Resident #97 was generally extremely confused and unable to understand her lack of ability to stand and walk. Resident #97 was placed back into her chair and given something to distract her and keep her from trying to get up (following the incident). The investigation included the resident was to be placed behind the nurse's station to maintain safety. The investigation also included the resident would have a dump (seat) to the wheelchair (which would place the back of the wheelchair seat lower than the front of the wheelchair creating a sloped, bucketed effect). Review of the nursing progress note and corresponding facility fall investigation revealed no evidence a root cause analysis was completed, no evidence effective interventions/diversional interventions were in place prior to the fall and/or evidence effective interventions were in place when staff identified the resident kept making gestures to try to get up to prevent the fall from occuring.Review of a fall investigation dated 12/22/25 at 11:00 A.M. revealed Resident #97 was found lying on the floor beside her bed after stating she was trying to walk to the restroom and lost balance. Resident #97's physician and family were notified of the unwitnessed fall.Review of the progress note dated 12/22/25 at 11:36 A.M. revealed Resident #97 was found lying on the floor beside her bed. Resident #97's family was present at bedside. Resident #97 stated I was trying to walk to the restroom and lost balance. The progress note revealed Resident #97 had an immediate intervention to keep call light in place.Review of the facility fall investigation and corresponding nursing progress note revealed no additional information as to what interventions were in place at the time of the fall, any additional circumstances related to the fall, any environmental factors associated with the fall, why the fall likely occurred, when the resident had last been seen by staff prior to the fall, and/or if the resident was having behaviors prior (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	to the incident. Review of a fall investigation dated 12/23/25 at 5:15 A.M. revealed Resident #97 had a fall with minor injury with a hematoma noted above her right eye and her nasogastric (NG) tube (a thin, flexible plastic catheter inserted through the nose, down the esophagus, and directly into the stomach) dislodged. The investigation included Resident #97 was last observed in her bed from 2:00 A.M. to 4:45 A.M., being checked every 15 to 30 minutes. After being checked on at 4:30 A.M., Resident #97 was found on the floor at the end of her bed. Resident #97 was assessed and assisted into her wheelchair. The investigation noted following the incident, Resident #97 was assisted by two staff back to her wheelchair, toileted, and placed in common area for monitoring. Resident #97 had ice applied to the hematoma and a message was left for the physician to return the call.Review of the progress note dated 12/23/25 at 2:10 P.M. revealed Resident #97 received new orders to discontinue Hydroxyzine and start Seroquel (an antipsychotic medication) 25 milligrams twice a day for agitation and restlessness. Resident #97's family was made aware. There was no additional information to explain why these changes were made at this time and/or to justify the use of the an atypical anti-psychotic medication for agitation/restlessness.Review of a progress note dated 12/23/25 at 10:09 P.M. (from the fall that occurred in the 4:00 A.M. hour) revealed Resident #97 was found on the floor on the left side of the bed on her right side with her NG tube pulled out. The note included Resident #97 was last seen and was provided with incontinence care at 4:30 A.M. Resident #97 was noted to have hematoma above her right eye. The progress note included Resident #97's call light was in reach, and the bed was in a low position. Resident #97 had ice applied to the hematoma and a message was left for her physician.Review of the facility fall investigation and nursing progress note revealed no root cause analysis of the fall was completed. In addition, there was no additional information as to any additional circumstances related to the fall, any environmental factors associated with the fall, why the fall likely occurred and/or if the resident was having any behaviors prior to the incident. Record review revealed no additional new fall/safety interviews were initiated to prevent falls from bed following this incident. Further review of Resident #97's progress notes revealed no indication of monitoring of the resident's hematoma, nor was the resident sent to the hospital for evaluation of a closed head injury sustained as a result of this fall.Review of the progress note dated 01/11/26 at 8:28 P.M. revealed Resident #97 was sitting across from the nurse's station in her wheelchair. The note included Licensed Practical Nurse (LPN) #241 had just sat down at the nurse's station a few minutes prior to chart, when she heard a loud noise. LPN #241 jumped up and observed Resident #97 lying on the floor on her left side. The note indicated LPN #241 immediately ran to Resident #97, picked her up off the ground underneath her arms, and alerted another (unnamed) LPN to help assist Resident #97 into her wheelchair. LPN #241 began brushing Resident #97 hair out of her face, when she noticed a large hematoma to the left side of the resident's forehead. Resident #97 was conscious and an ice pack was placed on the hematoma. Resident #97 was assessed and the on-call physician was made aware and gave a new order to send Resident #97 to a local emergency room (ER). Resident #97's daughter was notified of the fall, findings, and ER transfer. Emergency Medical Services (EMS) arrived and were made aware of the fall, hematoma, and vital signs and transported Resident #97 to a local hospital. Resident #97's daughter came into the facility following the incident and shouted at staff stating, It's your guy's fault.Review of a fall investigation dated 01/11/26 revealed Resident #97 sustained a fall with a major injury. Review of the fall investigation revealed Resident #97 was last seen by Certified Nurse Assistant (CNA) #359 at 7:25 P.M. and appeared confused and trying to self-ambulate. At the time of the fall, Resident #97 was sitting across from the nurse's station in her wheelchair, when LPN #241 heard a loud noise after sitting down to chart. LPN #241 jumped up and observed Resident #97 lying on the floor on her left side and immediately ran to pick her up off the ground under her arms and alerted another (unnamed) LPN to assist Resident #97 back into her wheelchair. After brushing hair out of her face, Resident #97 was noted to have a large hematoma to the left side of her forehead. Immediately following the incident, Resident #97 was placed on one-on-one supervision until EMS arrived. Resident #97 was admitted to (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	a local hospital for trauma related to a fall.Review of the nursing progress note and facility investigation revealed no evidence comprehensive, individualized and effective fall/safety interventions, including adequate and necessary supervision were in place prior to this fall incident. Review of an encounter summary dated 01/11/26 revealed Resident #97 was admitted to a local hospital with diagnoses that included, but were not limited to, traumatic intracerebral hemorrhage with loss of consciousness, fall, acute pain due to trauma, C7 cervical fracture, and hospice care. The encounter note referenced a referral to an inpatient hospice care facility. The resident subsequently passed away in the hospital.Record review revealed Resident #97 was admitted to the facility (on 12/13/25) with a history of falls and known high fall risk requiring increased supervision and appropriate interventions. Resident #97 sustained six falls in less than 30 days following admission without evidence of a comprehensive, individualized and effective fall management program which included ongoing preventative measures to be implemented for her safety. Furthermore, Resident #97's fifth fall resulted in a head injury that she was not transferred to the hospital or sent for further medical evaluation for. Resident #97 then sustained an additional fall (sixth), that resulted in a C7 fracture and brain bleed, hospice admission, and subsequently passed away approximately 10 days after transferring to the hospital following the fall.Interview on 05/12/26 at 10:22 A.M. with Registered Nurse (RN) #357 revealed residents who had an unwitnessed fall were to be assessed, checked for range of motion, assisted back in bed, and then the falls investigated to determine the cause of the fall. RN #357 revealed following a fall, residents' families and physicians were notified, neurological checks were put in place, and interventions were to be implemented. RN #357 revealed residents with head injuries, including hematomas, were to be sent out to the hospital for further evaluation.Interview on 05/12/26 at 10:28 A.M. with RN #303 revealed unwitnessed falls required head-to-toe assessments, obtaining vital signs, checking for injuries, implementing neurological checks, notification to the physician and families, and if a resident hit their head, they were sent to the hospital for evaluation.Interview on 05/12/26 at 10:45 A.M. with the Director of Nursing (DON) revealed residents who sustained an unwitnessed fall, depending on who was present or discovered the fall, would notify the nurse immediately to assess the scene. The DON revealed staff would attempt to figure out why the fall occurred and if there were no apparent injuries, they would check range of motion and pick the resident up off the floor. The DON revealed if the fall resulted in injury or suspected head injury, the resident was to be left in place and vitals assessed with a call made to EMS for evaluation. The DON revealed if a resident had blunt head trauma, the facility would send them out via 911. The DON revealed any injury to the head required assessment, vital signs, neurological checks, and more than likely a visit to the ER. The DON stated Resident #97's case was a sad case. The resident had been driving before she was admitted to the facility after having some sort of aneurysm or stroke where she became debilitated. The DON revealed Resident #97's cognition was not there, she had poor safety awareness, and the DON stated the resident's falls were difficult to manage. The DON revealed Resident #97 was a frequent faller and had to be sent out (to the hospital) after her last fall in the facility (January 2026). The DON revealed she was not aware of what happened to Resident #97 after her fall on 01/11/26, despite facility documentation (hospital encounter) which stated Resident #97's outcome after discharge. Interviews on 05/12/26 at 4:33 P.M. and on 05/113/26 at 11:32 A.M. with the DON confirmed neither Resident #97's physician (Medical Doctor (MD) #360), or facility staff sent Resident #97 to the hospital after her 5th fall on 12/23/25 that resulted in a visible head injury, a hematoma to the forehead. The DON verified Resident #97's fall interventions were not effective due to the resident being agitated and needing to be within close distance of staff. The DON revealed staff nurses would bring Resident #97 to the nurse's station multiple times or provided one-on-one due to her being agitated or restless.Interview on 05/13/26 at 1:49 P.M. with LPN #241 revealed when residents had an unwitnessed fall, staff were to make sure they were safe, vital signs were assessed, the resident would be checked for injuries, and the family and physician would be notified. LPN #241 revealed if a resident hit their head during a fall, whether (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	there was bleeding or not, a resident was to be sent out 911 for evaluation. LPN #241 revealed she did not work with Resident #97 a lot, but she was working at the time of her fall on 01/11/26. LPN #241 revealed Resident #97 had just finished visiting her family when they left and placed her in front of the nurse's station. LPN #241 revealed Resident #97 was seated in her wheelchair as CNAs were getting ready to put her to bed, when she turned around to sit down to chart and heard a loud noise. LPN #241 revealed she jumped up and observed Resident #97 on the floor, ran to her and picked her up off the floor with the help of CNA #359, who no longer works at the facility. LPN #241 revealed the resident's neurological assessment was not right and a call was placed to send Resident #97 out to the hospital for evaluation. LPN #241 revealed Resident #97 was to be in the common area if not in bed, had orders for a mattress on the floor in case she rolled out of bed, and was to be at the nurse's station for monitoring. LPN #241 revealed Resident #97 could not walk on her own and if she tried to get up, she was going to hit the floor. LPN #241 revealed Resident #97 sustained a hematoma to her forehead immediately after her fall.Interview on 05/13/26 at 4:27 P.M. with the DON revealed residents who were impulsive required one-on-one supervision and falls were generally reviewed in facility team meetings. The DON revealed Resident #97 was restless at times, but she did not know if she was always restless. The DON revealed Resident #97 was to be toileted, given diversional activities, and left at the nurse's station for close monitoring.Interview on 05/13/26 at 5:03 P.M. with Director of Rehab (DOR) #273 revealed Resident #97 was very impulsive and admitted to the facility in bad shape. DOR #273 revealed Resident #97 was unable to ambulate on her own, needed hands on her at all times, needed a lot of help, had poor judgment, and was a high fall risk with severe deficits. DOR #273 revealed Resident #97 had an intervention put in place of dumping the wheelchair seat, (the rehab department made the recommendation) and the maintenance department was to modify the equipment based on the recommendation. DOR #273 revealed Resident #97 had a dump wheelchair implemented between 12/21/25 to 12/24/25, but the maintenance department would have to confirm if the modification was actually completed. Interview on 05/13/26 at 5:16 P.M. with Director of Maintenance (DOM) #264 revealed his department was responsible for implementing the dump wheelchairs by request of the rehab department. DOM #264 revealed sometimes staff put in electronic work orders or told him verbally of a dump wheelchair request. During the interview, DOM #264 was unable to confirm or verify if Resident #97 had a dump wheelchair in place during her stay.Interview on 05/14/26 at 8:53 A.M. with Resident #97's family member revealed upon Resident #97's admission to the facility, the family reported to facility staff that the resident was not safe on her own and was at very high fall risk. Resident #97's family member shared Resident #97 constantly tried to get out of bed and chair and was extremely restless and needed consistent monitoring. Resident #97's family member indicated following the resident's fall on 01/11/26, the resident was admitted to hospice and passed away. Resident #97's family member stated family had requested some type of special wheelchair for the resident's safety, but none was ever implemented. Resident #97's family member revealed Resident #97 had a fall around Christmas (12/23/25) and when family arrived to the facility, Resident #97 was bruised really bad and the facility refused to send her to the hospital. Resident #97's family member stated the family took the resident to the hospital to get evaluated and were informed by hospital staff the resident had sustained a brain injury. (Review of the resident's medical record could not confirm the resident's family member took the resident to the hospital or that she was diagnosed with a brain bleed during this time period).Interview on 05/14/26 at 12:29 P.M. with LPN #358 revealed Resident #97 was confined to her bed and wheelchair and was to be placed at the nurse's station for safety due to being a high fall risk. LPN #358 revealed Resident #97 was very impulsive, had very poor trunk support, was nonverbal, and was kept in the common area for monitoring. LPN #358 revealed Resident #97 was not sent out to the hospital for the fall on 12/23/25 which resulted in a head injury and/or trauma even though LPN #358 stated residents who have falls resulting in them hitting their head were to be sent out to hospital for evaluation. LPN #358 revealed Resident #97 was sent out to the hospital for a fall one time and that was the fall that occurred on (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	01/11/26 when she did not return to the facility.Interview on 05/14/26 at 1:48 P.M. with MD #360 revealed Resident #97 was a high fall risk resident who was very confused. MD #360 revealed Resident #97 would attempt to get out of bed and wheelchair all the time. MD #360 revealed Resident #97 was to be kept at the nurse's station all the time to keep an eye on her, but her last fall was a big fall, and she didn't return to the facility after being sent to the hospital. MD #360 revealed that anytime a resident had a fall and hits their head, they need to be sent to the hospital for evaluation, especially residents who can't verbalize what happened during the fall or state if they hit their head or not. MD #360 also revealed if visible head trauma was noted, residents were sent to the hospital for evaluation. MD #360 revealed the facility staff informed her of all of Resident #97's falls, but she did not recall a fall with a hematoma on 12/23/25.Interview on 05/13/25 at 5:00 P.M. with the DON confirmed and verified following the fall that resulted in a head injury on 12/23/25, Resident #97 was not transferred to the hospital or provided a timely emergency medical evaluation despite evidence of injury and her known history of repeated falls. The DON verified the above findings at the time of the interview. During the onsite survey, no additional information was provided by the facility related to Resident #97's falls and/or the concerns noted above related to the lack of comprehensive, individualized and effective fall management program to prevent six falls including falls with major injury within 30 days of the resident's admission.Review of the facility document titled Fall Risk Assessment revised March 2018, revealed the facility had a policy in place to review falls and establish a resident-centered falls prevention plan based on relevant assessment information. Review of the document revealed the facility did not implement the policy.Review of the facility document titled Assessing Falls and Their Causes revised March 2018, revealed the facility had a policy in place that after a fall, if there were evidence of an injury, provide appropriate first aid and/or obtain medical treatment immediately. Review of the document revealed the facility did not implement the policy.This deficiency represents non-compliance investigated under Complaint Number 2715885.

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	366343	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Royalton Post Acute	9055 West Sprague Road Parma, OH 44133

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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 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, observation, and facility policy review, the facility failed to ensure urinary catheter care was provided according to professional standards of practice, and failed to ensure urinary catheter and colostomy care were provided and in a timely manner to Resident #49. This affected one resident (#49) of three residents reviewed for bowel and bladder care. The facility census was 96. Findings include: Review of the medical record revealed Resident #49 was admitted to the facility on [DATE] with diagnoses including cerebral infarction, epilepsy, type 2 diabetes, chronic kidney disease, dysfunction of the bladder and Bell's Palsy.Review of Resident of the care plan dated 03/16/26 revealed the resident was at risk for complications with urinary system related to neurogenic bladder and a suprapubic catheter. The Resident was at risk of complication with gastrointestinal system due to a colotomy. The resident was care planned for enhanced barrier precaution (EBP) during high contact activities due to presence of suprapubic catheter and colostomy, Intervention included to ensure items for EBP are in place gloves, gowns, alcohol bases hand sanitizer, signage and trash receptacles. Utilize personal protective equipment (PPE) during high contact resident care activities.Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had impaired cognition and was dependent on staff for toileting. The resident had indwelling catheter and bowel continence was recorded as not rated. Review of the physician orders for May 2026 revealed an order for colostomy care every shift and suprapubic catheter care every shift and as needed. Review of the Treatment Administration Record (TAR) for March revealed catheter care was not documented as provided on 03/20/26, 03/26/26, 03/27/26, 03/28/26, 03/29/26, and 03/31/26 on day shift. Continued review of the TAR revealed colostomy care was not documented as provided on 03/20/26, 03/26/26, 03/27/26, 03/28/26, 03/29/26, and 03/31/26 on day shift.Review of the TAR for April 2026 revealed catheter care was not documented as provided on 04/03/36, 04/06/26, 04/09/26, 04/10/26, 04/20/26, 04/24/26/ and 04/30/26. Continued review of the TAR revealed colostomy care was not documented as provided on 04/03/36, 04/06/26, 04/09/26, 04/10/26, 04/20/26, 04/24/26/ and 04/30/26.Review of the TAR for May 2025 revealed catheter care was not documented as provided on 05/01/26 on night shift and on 05/04/26 and 05/10/26 on day shift. Continued review of the TAR revealed colostomy care was not recorded as provided on the night shift of 05/01/26 and on day shift on 05/04/26 and 05/10/26.Observation on 05/12/26 at 11:56 A.M. revealed Licensed Practical Nurse (LPN) #239 perform urinary catheter care for Resident #49. Upon entering the room, signate was observed on the door that read contact precautions everyone must: clean their hands before room entry and discard gloves before room exit. Put on a gown before room entry and discard gloves before exit. LPN #239 was in the room gathering supplies for care. LPN #239 was observed wearing gloves but no gown. LPN #239 removed Resident #49's brief and cleaned around the catheter site and on each side of the catheter. LPN #239 did not clean the down the catheter. LPN #239 changed gloves, rinsed and dried around the catheter, then applied a brief.Interview on 05/12/26 at 12:09 P.M. with LPN #239 following the observation revealed LPN #239 stated she was unaware she had to wear a gown while providing catheter care. LPN #239 verified she did not clean the catheter because she did not want to dislodge the catheter. LPN #239 stated she was a new nurse and had not performed catheter care since nursing school.Interview on 05/12/25 at 3:13 P.M. with Registered Nurse (RN) #351, the Unit Manager, revealed RN #351 stated she would expect the nurses to clean the catheter during care.Interview on 05/13/26 at 11:00 A.M. with the Director of Nursing (DON) verified the catheter care and colostomy care was not documented on the above dates. The DON stated she would have to talk to the nurses to find out why care was not documented on those dates.Further observation on 05/14/26 at 10:55 A.M. with the DON of Resident #49's colostomy bag revealed it had come loose. There was loose stool over Resident #49's abdomen. (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview at the time of observation with Resident #49 revealed she had been waiting two hours for someone to clean her up and put on a new [colostomy] bag. Interview at this time with the DON stated she would get the nurse and aide to clean up the resident and change the colostomy bag. Interview on 05/14/26 at 2:30 P.M. with Certified Nursing Assistant (CNA) #325 stated she was assigned to Resident #49. CNA #325 checked on Resident #49 between 7:00 A.M. and 7:30 A.M. at the beginning of her shift and did not get back to her until 11:00 A.M. when she was told by the nurse to provide care to Resident #49. Interview on 05/14/26 at 2:35 P.M. with LPN #251 stated she was the assigned nurse to Resident #49. LPN #251 stated she was unaware that Resident 49's colostomy bag had come loose until the DON told her to change the bag and that was prior to lunch.Review of the facility's policy titled Suprapubic Catheter Care undated revealed the policy stated to clean area around catheter with soap and water, clean any crusted material from the catheter at the insertion site. Do not pull on the catheter or advance the catheter into the bladder. Rinse and dry the area well. The policy did not address to clean down the catheter.Review of the facility policy titled Charting and Documentation dated July 2017 revealed the following information was to be documented in the resident medical record: objective observations, medications administered, treatments or services performed, change in condition, events, incidents or accidents involving the resident, and progress toward or changes in the care plan goals and objectives.This deficiency represents non-compliance investigated under Complaint Numbers 2966927 and 2705845.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, and facility policy review, the facility failed to ensure Resident #33 was free from significant medications errors. This affected one Resident (#33) of three reviewed for medication administration. The facility census was 96. Findings include: Record review revealed Resident#33 was admitted to the facility on [DATE] with diagnoses including osteoarthritis, dementia, type two diabetes mellitus, dysphagia, and peripheral vascular disease. Review of Resident #33's active physician orders revealed the resident had orders for Lantus Solostar (a long acting insulin) inject five units subcutaneously twice day, Zyrtec (an antihistamine commonly used to treat allergy symptoms) 10 milligram (mg) daily, Gabapentin (an anticonvulsant commonly used to treat neuropathy pain) 100 mg twice daily, Miralax (a laxative) 17 grams once daily, Metoprolol Tartrate (an antihypertensive) 25 mg twice daily, Pepcid (an antacid) 20 mg twice daily, Simethicone 80 mg, give 1.5 tablets three times daily for gastric protection, Tylenol 1000 mg twice daily for pain, and Fluticasone Propionate (a nasal spray used for allergies) 50 micrograms (mcg) per actuation, give one spray in each nostril daily. Review of the Medication Administration Record (MAR) for December 2025 revealed on 12/14/25, Resident #33's evening medications, including insulin, were recorded as refused by the resident. On 12/24/25, evening medications (including Zyrtec, Gabapentin, Miralax, Metoprolol Tartrate, Pepcid, Tylenol, Simethicone, and Lantus insulin) were not documented as administered. On 12/25/25, Resident #33's morning medications (including Lantus insulin, Flonase, Gabapentin, Metoprolol Tartrate, Miralax, Tylenol, and Simethicone) were not documented as administered. On 12/30/25, Resident #33's evening medications (including Zyrtec, Gabapentin, Miralax, Metoprolol Tartrate, Pepcid, Tylenol, Simethicone, and Lantus insulin) were not documented as administered. Review of the progress notes revealed on 12/14/25 there was no documentation the physician was notified regarding the resident's refusal of medications and Lantus insulin. There was no progress note for 12/24/25, 12/25/25, and 12/30/25 regarding why scheduled insulin and medications were not administered or to indicate the physician had been notified. Continued review of the progress notes revealed a note dated 12/29/25 at 10:58 A.M. stated the physician notified of allegation from 12/14/25 that the resident did not receive scheduled insulin.Review of the MAR for March 2026 revealed on 03/24/26 the morning medications were not documented as administered including Lantus, Flonase, Gabapentin, Metoprolol Tartrate, Miralax, Tylenol, and Simethicone.Review of the progress notes revealed on 03/24/26 there was no notification to the physician regarding refusal of medications and Lantus insulin.Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively impaired and was dependent on activities of daily living. The resident was recorded to have received insulin.Interview on 05/14/26 at 9:45 A.M. with the Registered Nurse (RN) #357 verified that there was no documentation that Resident #33 received scheduled medications including insulin on the dates above in December 2025 and in March 2026. RN #357 verified that the physician was not notified of the missed medications and insulin in December 2025 or March 2026. Review of the facility policy titled Charting and Documentation dated July 2017 all services provided to the resident, progress toward the care plan goals, or any changes int her resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record.Review of the facility policy titled Medication Administration dated 06/29/2017 revealed after administration, return to the medication cart and document medication administration with initials on the MAR immediately after administering medication to each resident. The policy further noted that if the insulin dose cannot be administered at the designated time or interval, notify the prescriber as appropriate. The policy noted insulin should be immediately documented on the MAR after administration to avoid duplicate administration by another nurse. This deficiency represents non-compliance investigated under Complaint Numbers 2966927 and 2705845.

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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** Based on observation, interview, and facility policy review, the facility failed to properly disinfect glucometers after resident use. This affected one Resident (#33) of three residents reviewed for infection control and had the potential to affect six additional residents (#2, #20, #33, #51, #61, and #90) on the nurse's assignment that received blood glucose checks. The facility census was 96.Findings include: Record review revealed Resident#33 was admitted to the facility on [DATE] with diagnoses including osteoarthritis, dementia, type 2 diabetes, dysphagia, peripheral and vascular disease. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively impaired and was dependent on activities of daily living. The resident received insulin.Review of the physician orders for May 2026 revealed an order for Lantus Solostar pen injector inject 5 units subcutaneously two times a day. If Libre (a blood glucose sensor) was unavailable a blood glucose device could be used [to check the resident's blood glucose level].Observation on 05/11/2026 at 8:30 A.M. of medication administration with Licensed Practical (LPN) #257 for Resident #33 revealed LPN #257 prepared to obtain Resident #33's blood glucose level and insulin administration. Continued observation revealed LPN #257 took the glucometer out of the medication cart along with supplies and entered Resident #33's room. LPN #257 washed her hands, donned gloves, wiped the resident's index finger with an alcohol pad, pricked the finger with a lancet, and applied a blood sample to the glucometer test strip to obtain a blood sugar reading of 140. LPN #257 removed her gloves, washed her hands, walked back to medication cart, cleaned the glucometer with an alcohol pad and placed the glucometer back in the medication cart.Interview 05/11/26 at 9:30 A.M. with LPN #257 revealed the process for cleaning the glucometer was to use alcohol wipes. LPN #257 verified she always cleans the glucometer with alcohol pads. Review of the facility policy titled Blood Glucose Testing undated stated to disinfect the glucometer with bleach wipes, allow drying for three to five minutes per manufacturer's instructions.