STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366355	A. Building B. Wing	11/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Singleton Health Care Center	1867 East 82nd Street Cleveland, OH 44103

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42730 Based on resident record review, resident interview, staff interview and facility policy review, the facility failed to ensure Resident #42 was treated with respect and dignity. This affected one resident (#42) of two residents reviewed for respect and dignity. The facility census was 48. Findings include: Review of the medical record for Resident #42 revealed she was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, dementia, schizophrenia, and schizoaffective disorder. Review of the care plan dated 02/14/22, revealed Resident #42 behaved in a problematic manner characterized by ineffective coping with paranoia and suspicious behaviors related to psychiatric illness. Interventions included reassuring safety and talking in a low pitch, calm voice to decrease and/or eliminate undesired behaviors and provide diversional activities. Review of the Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #42 had a Brief Interview for Mental Status (BIMS) score of three, indicating she had severe cognitive impairment. She was independent with some setup assistance with activities of daily living (ADL). Review of the MDS assessment revealed Resident #42 had a history of delusional thoughts. Observation on 11/13/24 at 3:44 P.M. revealed Resident #42 approached the locked secured door adjacent to the receptionist's desk and began knocking. Medical Secretary (MS) #562 got up from the seated position, opened the door in a forceful manner, and approached Resident #42 stating in a rude, blunt tone What do you want? Why are you knocking on the door that hard? Resident #42 was observed taking a step back from the door and asked MS #562 a question that was unclear. MS #562 revealed she did not know the answer to Resident #42's question, and Resident #42 turned and walked away. Interview on 11/13/24 at 3:45 P.M. with MS #562, while turning her eyes upward, revealed she did not always speak to residents in that manner, but Resident #42 was knocking on the door really hard. MS #562 confirmed and verified the interaction with Resident #42. Interview on 11/13/24 at 3:46 P.M. was attempted with Resident #42, but she declined to speak. Interview on 11/14/24 at 8:55 A.M. with Resident #42 revealed she was sometimes treated with respect and dignity. Resident #42 revealed MS #562 was sometimes mean and rude when she approached her. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility document titled Resident Rights and Dignity Policy, revised 2024, revealed the facility had a policy in place that residents would always be treated with courtesy and respect.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43063 Based on record review, interview and facility policy review, the facility failed to ensure Resident #200's baseline care plan was completed timely. This affected one resident (#200) of two residents reviewed for baseline care plans. The facility census was 48. Findings include: Review of the medical record for Resident #200 revealed an admitted [DATE] with diagnoses including diabetes mellitus and malignant neoplasm of pancreas (cancer). Resident #200 was discharged to the hospital on 10/10/24 and did not return to the facility. Review of the baseline care plan in the electronic health record dated 10/07/24 revealed it was blank and had not been completed. Interview on 11/14/24 at 9:48 A.M. with Licensed Practical Nurse (LPN) #569 revealed she assisted in completing the baseline care plans. She stated Resident #200 was admitted on [DATE] and was discharged on [DATE]. She stated she had initiated the baseline care plan, printed it out, and then began filling in the information by hand on the form with information provided through staff interviews and observations. She verified she had not completed the baseline care plan within 48 hours or entered it into the computer so nursing staff had it available. LPN #569 verified the baseline care plan should have been in the computer completed by 48 hours and reviewed with the resident and family. Review of the facility policy titled, Baseline Care Plan, dated 11/28/17, revealed the baseline care plan should be started on admission and completed within 48 consecutive hours of admission.

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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 - Minimal harm or potential for 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** 51067 Based on record review, interviews and facility policy review, the facility failed to ensure fall prevention interventions were documented on the Kardex, failed to ensure an accurate falls risk assessment, and failed to do post fall assessments for 72 hours according to the facility policy for Resident #34. In addition, the facility failed to ensure safety of Resident #200 during care. This affected two residents (#34 and #200) of two residents reviewed for accidents. The facility census was 48. Findings include: 1. Review of the medical record revealed Resident #34 was admitted to the facility on [DATE] with diagnoses including epilepsy, hypertension, bradycardia, conversion disorder with seizures, cognitive communication deficit, dementia with behaviors, schizophrenia, cardiomyopathy, congestive heart failure, and vitamin B12 deficiency. Review of Resident #34's medication orders for July 2024 through September 2024 revealed orders for Norvasc, Losartan Potassium, Metoprolol Succinate ER (antihypertensives), Torsemide, hydralazine HCL, Furosemide, spironolactone (diuretics) and Depakote ER and Keppra (anti-seizure medications). Review of the fall incident description dated 09/29/24 at 6:07 P.M. revealed Resident #34 was in his room with a Certified Nurse Aide (CNA) present, and he tripped over a book bag that was kept underneath his bed. Resident #34 was observed on floor on all fours and was assessed by the nurse and had no injuries. He was educated to educated to keep the walkway free of clutter. Review of medical record dated 09/29/24 to 10/01/24 revealed the facility failed to assess Resident #34 every shift post fall for 72 hours according to their policy. Review of the Medication Administration Record (MAR) for September 2024 revealed Resident #34 had been receiving the antihypertensives, antiseizure and diuretic medications as ordered. Review of the fall risk assessment dated [DATE] for Resident #34 revealed under section G. Medications, the resident took only one to two of the following medications in the last seven days: anesthetics, antihistamines, antiseizure, antihypertensives, benzodiazepines, cathartics, diuretics, hypoglycemics, narcotics, psychoactives, sedatives/hypnotics. Further review revealed under section H. Predisposing diseases included CVA, Parkinson's disease, seizures, arthritis, loss of limb, arthritis, osteoporosis, fractures, multiple sclerosis, vertigo and hypotension, and the assessment indicated Resident #34 had none of the predisposing diseases. Review of the plan of care, dated 10/07/24, revealed Resident #34 had a risk for falls related to seizure disorder. An intervention included to ensure the floor was free of clutter. Review of Resident #34's current Kardex revealed the intervention dated 10/07/24 to ensure the resident's floor remained free of clutter had not been added. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Nursing (DON) on 11/13/24 at 1:35 P.M. confirmed the new fall intervention dated 10/07/24 ensure floor remain free of clutter was not on the Kardex. Interview with CNA #524 on 11/14/24 at 9:28 A.M. revealed that she refers to the Kardex or will ask the nurse regarding any changes or updates to a resident's care. Interview with Minimum Data Set 3.0 (MDS) Licensed Practical Nurse (LPN) #569 on 11/13/24 at 1:42 P.M. confirmed incorrect documentation was identified on the falls risk assessment dated [DATE] based on the record review pertaining to the medications and predisposing diseases. Interview with the Director of Nursing (DON) on 11/13/24 at 2:53 P.M. confirmed that nursing documentation was not completed on every shift for 72 hours per [NAME] Health Care Post Fall Protocol, dated 12/01/2016. Review of the facility policy titled, [NAME] Health Care Post Fall Protocol, dated 12/01/16, revealed the MDS Coordinator would complete a fall risk assessment after the fall and add new interventions to the resident's fall risk care plan. 43063 2. Review of the medical record for Resident #200 revealed an admitted [DATE] with diagnoses including diabetes mellitus and malignant neoplasm of pancreas (cancer). Resident #200 was discharged to the hospital on 10/10/24 and did not return to the facility. Review of the nursing admission observation dated 10/05/24 revealed Resident #200 needed a mechanical Hoyer lift for transfers. He was dependent on staff for personal hygiene, including bed baths. Review of the fall risk assessment dated [DATE] stated Resident #200 was at risk for falls as he was disoriented and had decreased muscle coordination with jerking movements. It was noted that Resident #200 did not have any falls in the past three months. Review of the baseline care plan in the electronic health record dated 10/07/24 revealed it was blank and had not been completed. Review of the nursing progress note dated 10/07/24 at 6:32 A.M. for Resident #200 revealed he fell at approximately 5:45 A.M. during care. Resident #200 was rolled on his side by the aide during bathing and the resident fell out of bed. The resident had no injuries from the fall. Review of the fall investigation dated 10/07/24 stated Resident #200 fell out of bed when Certified Nursing Assistant (CNA) #523 rolled him onto his side during care. Resident #200 rolled off the bed and onto the floor. The statement from CNA #523 verified he had rolled the resident onto his side, and the resident had rolled off the bed onto the floor. Review of the verbal warning by the DON to CNA #523 dated 10/09/24 revealed he was disciplined and educated for giving care to a bed bound resident and leaving him in an unsafe position resulting in a fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/14/24 at 9:41 A.M. with the DON verified CNA #523 was providing care to Resident #200 on the morning of 10/07/24 and rolled him onto his side, and the resident rolled out of bed onto the floor in between the wall and the bed. She stated CNA #523 was educated and provided a verbal warning because he did not ensure the positioning of the bed against the wall and did not have two staff members while providing care. She verified she was unsure if Resident #200 needed the assistance of two staff members during bed mobility or bathing due to the baseline care plan not being completed timely. Interview on 11/14/24 at 9:48 A.M. with LPN #569 revealed she assisted in completing the baseline care plan for Resident #200. She stated Resident #200 was admitted on [DATE] and was discharged on [DATE]. She stated she had initiated the baseline care plan, printed it out, and then began filling in the information through staff interviews and observations. She verified she had not completed the baseline care plan within 48 hours or placed it in the computer so that nursing staff had it available. LPN #569 verified the baseline care plan should have been completed and entered into the computer within 48 hours of admission and reviewed with the resident and family. She also verified there were no interventions to assist in preventing falls for Resident #200. Attempted interviews on 11/14/24 at 10:59 A.M. and 2:15 P.M. with CNA #523 were unsuccessful. Voicemail messages were left and were not returned. Review of the facility policy titled, Baseline Care Plan, dated 11/28/17, revealed the baseline care plan should be started on admission and completed within 48 consecutive hours of admission.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45441 Based on record review and interview, the facility failed to ensure pharmacy recommendations were followed up on for Resident #1. This affected one resident (Residents #1) of five residents reviewed for unnecessary medications. The facility census was 48. Findings include: Review of the medical record for Resident #1 revealed an admitted [DATE] with diagnoses including arthritis, schizophrenia and insomnia. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #1 was cognitively intact. She required set up assistance for eating and oral hygiene and substantial or maximum assistance for dressing, toileting, showering and personal hygiene. Review of the Medication Administration Record (MAR) for July 2024 revealed an order for Haldol (an antipsychotic medication) 0.5 milligrams (mg) intramuscularly (IM) every six hours as needed (prn). The order began on 07/22/24 and was discontinued on 08/29/24. Review of the document titled Note to Attending Physician/Prescriber dated 07/18/24 revealed pharmacist #570 requested Medical Director (MD) #571 to consider adding an end date of 08/05/24 to Haldol IM 0.5 mg. There was no evidence MD #572 addressed the recommendation. Interview on 11/14/24 at 10:36 A.M. with the Director of Nursing confirmed the recommendation by Pharmacist #570 for Resident #1 dated 07/18/24 was not addressed by MD #572 regarding the end date of 08/05/24 for the Haldol. Review of the facility policy titled Medication Monitoring dated 06/21/17 revealed residents who received psychotropic medications would receive gradual dose reductions unless clinically contraindicated.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51067 Based on interview and record review, the facility failed to ensure fall risk assessments were documented accurately for Resident #34 who was at risk of falls. This affected one resident (Resident #34) of three residents reviewed for falls. The facility census was 48. Findings include: Review of the medical record revealed Resident #34 was admitted to the facility on [DATE] with diagnoses including epilepsy, hypertension, bradycardia, conversion disorder with seizures, cognitive communication deficit, dementia with behaviors, schizophrenia, cardiomyopathy, congestive heart failure, and vitamin B12 deficiency. Review of Resident #34's medication orders for July 2024 through September 2024 revealed orders for Norvasc, Losartan Potassium, Metoprolol Succinate ER (antihypertensives), Torsemide, hydralazine HCL, Furosemide, spironolactone (diuretics) and Depakote ER and Keppra (anti-seizure medications). Review of the fall risk assessments dated 07/05/24 and 10/02/24 for Resident #34 revealed under section G. Medications, the resident took only one to two of the following medications in the last seven days: anesthetics, antihistamines, antiseizure, antihypertensives, benzodiazepines, cathartics, diuretics, hypoglycemics, narcotics, psychoactives, sedatives/hypnotics. Review of the Medication Administration Record (MAR) for September 2024 revealed Resident #34 had been receiving the antihypertensives, antiseizure and diuretic medications as ordered. Further review of the fall risk assessments dated 07/05/24 and 10/02/24 revealed under section H. Predisposing diseases included CVA, Parkinson's disease, seizures, arthritis, loss of limb, arthritis, osteoporosis, fractures, multiple sclerosis, vertigo and hypotension, and the assessment indicated Resident #34 had none of the predisposing diseases. Interview with Minimum Data Set (MDS) Licensed Practical Nurse (LPN) #569 on 11/13/24 at 1:42 P.M. confirmed that incorrect documentation was identified on the falls risk assessments dated 10/2/24 and 07/05/24. LPN #569 confirmed that each of the assessments had identical documentation that was incorrect based on the record review pertaining to the medications and predisposing diseases.