STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366377	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tranquility of Richmond Heights	562 Richmond Road Richmond Heights, OH 44143

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32650 Based on staff interview, resident interview, record review, and policy review, the facility failed to ensure two (#32 and #7) of three residents reviewed for admission, transfers, or discharges, were notified of past due payments resulting in a 30 day discharge notice and failed to ensure the reasons for the transfers or discharge was documented in the medical record. The facility census was 49. Findings Include: 1.Resident #32 was admitted to the facility on [DATE] with diagnoses including infection and inflammatory reaction with removal of internal fixation device of a left hip replacement, post traumatic stress disorder, high blood pressure, diabetes, depression, and generalized anxiety disorder. Review of the physician's orders for Resident #32 revealed an order dated 09/04/24 from Medical Doctor (MD) #400 indicating he certified that there is a medical necessity for this patient/resident to be in this skilled nursing facility. I have informed the resident of diagnoses, treatment and care plan. I have read, reviewed and agree with the resident's plan of care. Orders are verified and approved as by my signature, as physician, on the last page. Review of the comprehensive quarterly [NAME] Data Set (MDS) 3.0 assessment, dated 09/11/24, revealed Resident #32 was cognitively intact, exhibited no adverse behaviors, was dependent on staff for toileting, showering, dressing, and personal hygiene. The resident had almost constant pain which did not interfere with sleep or daily activities. Review of the medical record for Resident #32 revealed no documentation regarding the facility issuing a 30 day discharge notice for lack of payment. There was no documentation the facility had discussed with the resident at any time that she owed the facility money for her care and treatment. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident #32 on 10/03/24 at 10:40 A.M. confirmed she had been issued a 30 day notice on 09/18/24. She had resided in the facility for a little over a year and had no desire to transfer to another facility. The resident stated she had never been told she owed the facility for nonpayment of her care until the facility gave her the discharge letter on 09/18/24. Resident #32 said she contacted her insurance company and they told her the facility had not submitted the necessary documentation for review to determine if the care she was receiving was necessary. The resident had not been updated about the pending discharge since receiving the discharge notice other than the Administrator was working on finding a way for the resident to remain in the facility. Resident #32 confirmed she had filed an appeal regarding the discharge notice but had not heard anything about a hearing being scheduled. Interview with the Ombudsman on 10/03/24 at 11:06 A.M. revealed he had been notified that a 30 day discharge notice had been issued for Resident #32 and that a hearing had been set to hear the resident's appeal. Telephone interview with the Administrator and the Director of Operations (DOO) on 10/03/24 at 2:22 P.M. revealed the facility did not realize Resident #32's insurance company was not paying the resident's bills. The Admininstrator believed Resident #32's bills stopped being paid when the company took over ownership in December 2023. The residents using this insurance had been previously granted long term care authorization but after taking over the approvals were discontinued. The Administrator was currently working on approval being granted for the resident to stay. The Administrator revealed that he had just been informed of the hearing date for Resident #32's appeal of the discharge notice. The Administrator confirmed he should have documented in the medical record that the 30 day notice had been issued and the reason for the discharge notice. The DOO reminded the Administrator there must be documentation completed when a 30 day discharge notice was issued. Interview with the Director of Nursing (DON) on 10/03/24 revealed she was sure Resident #32 was aware she owed money to the facility so the receipt of a discharge notice should not be a surprise. The DON said she knew Resident #32 from a previous facility and the resident was an expert manipulator and liar and she would say anything to get what wanted. 2. Resident #7 was admitted to the facility on [DATE] with diagnoses including diabetes, bilateral below the knee amputations, major depression, and generalized anxiety disorder. Review of the physician's orders for Resident #7 revealed an order dated 10/27/23 from Medical Doctor (MD) #400 indicating he certified that there is a medical necessity for this patient/resident to be in this skilled nursing facility. I have informed the resident of diagnoses, treatment and care plan. I have read, reviewed and agree with the resident's plan of care. Orders are verified and approved as by my signature, as physician, on the last page. Review of the annual comprehensive MDS 3.0 assessment revealed Resident #7 was cognitively intact. The resident was independent for all activities of daily living. She was not receiving therapy at the time of the assessment. Review of the medical record revealed no documentation regarding the facility issuing a 30 day discharge notice for lack of payment for Resident #7. There was no documentation the facility had discussed with the resident that she owed the facility money for her care and treatment. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident #7 on 10/03/24 at 1:58 P.M. revealed she was issued a 30 day discharge notice on 09/18/24 because the facility needed some sort of a discharge. The resident confirmed she had not been aware she owed the facility money for her care and treatment until she received the discharge notice. The resident said she hoped to transfer to the facility's assisted living unit. Resident #7 said she was not aware she could appeal the discharge notice as they never told her that was an option. The resident said she provided all of her own care except for medications and food. She purchased all of her own supplies because she wanted them handy if the facility ran out of them. The resident said she did not know how she went from being a long term resident to suddenly not being one. Interview with the Ombudsman on 10/03/24 at 11:06 A.M. revealed he had been notified that a 30 day discharge notice had been issued for Resident #7. Review of the facility's Transfer and Discharge (including AMA) policy, last reviewed/revised on 04/04/24, revealed a facility-initiated transfer or discharge which the resident objected to or did not originate through a resident's verbal or written request, and/or was not in alignment with the resident's stated goals for care and preferences. A discharge notice could be issued if the resident had failed, after reasonable and appropriate notice, to pay or have paid under Medicare or Medicaid for his/her stay at the facility. Nonpayment applied if the resident did not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denied the claim and the resident refused to pay for his or her stay. The policy also indicated that supporting documentation would include evidence of the resident's or the resident's representative verbal or written notice of intent to leave the facility, a discharge plan, and documented discussions with resident and/or the resident's representative. This deficiency represents non-compliance investigated under Complaint number OH00158120.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32650 Based on interview, record review, and policy review, the facility failed to ensure Resident #100 received assistance as needed and failed to recognize a change in Resident #100's condition. This affected one (#100) of six residents reviewed for the provision of care and services. The facility census was 49. Findings Include: Resident #100 was admitted to the facility on [DATE] with diagnoses including breast cancer to the left breast, dementia without behavioral disturbance, multiple sclerosis, high blood pressure, left mastectomy, and psychotic disorder with delusions. Review of the quarterly comprehensive Minimum Data Set (MDS) 3.0 assessment, dated [DATE] revealed Resident #100 was moderately cognitively impaired, needed set up for eating, and supervision for toileting and bathing. Review of the progress notes revealed on [DATE] timed 2:06 P.M. revealed Resident #100 had an appointment scheduled for 10:00 A.M. but was unable to make it due to the resident being incontinent of a large amount of stool. It took a long time to clean the resident up so the resident's daughter contacted the doctor's office and was able to reschedule the appointment to 2:00 P.M. Review of the progress noted dated [DATE] at 7:35 A.M. revealed Licensed Practical Nurse (LPN) #421 called the resident's daughter at home and asked where her mother was as she had not returned to the facility. The daughter told LPN #421 that her mother was not doing well, that she had been admitted to the hospital and she would not be returning to the facility. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident #100's daughter on [DATE] at 2:17 P.M. revealed on [DATE] the daughter arrived at the facility to take her mother (Resident #100) for a full body scan. She felt her mother was a bit off. She had been finding meal trays in her mother's room with uneaten food and drinks that had not been consumed. No one from the facility notified the family that Resident #10 had decreased eating and drinking. The daughter asked the nurses if they could test her urine when she returned to the facility as she thought her mother might have a urinary tract infection. On [DATE] Resident #100's sister (the daughter's aunt) arrived at the facility to take Resident #100 to her first radiation treatment. Her mother had been incontinent of stool and staff refused to provide incontinence care because the resident was listed as self-sufficient for toileting. The resident's sister gathered the necessary supplies and proceeded to clean Resident #100 without staff assistance. The appointment for radiation treatment was rescheduled for 2:00 P.M. that day. The resident's sister left with Resident #100 at 1:30 P.M. Resident #10 was not able to have her radiation treatment because when the radiologist assessed Resident #10 she was immediately sent to the emergency room (ER) due to being very lethargic, her inability to stand, and difficulty waking her up. The daughter did not notify the facility her mother had been admitted due to dissatisfaction with the care her mother received at the facility. No one contacted the family about the whereabouts of her mother until LPN #421 called her on [DATE] at 7:35 A.M. The daughter informed LPN #421 her mother would not be returning to the facility. The daughter said her mother was admitted to the hospital where they discovered her mother's cancer had metastasized everywhere. She was discharged from the hospital to the daughter's house and died at the daughter's home on [DATE]. Interview with the Director of Nursing (DON) on [DATE] at 4:30 P.M. revealed she was positive either the daughter or the hospital called the facility to inform them of Resident #100's admission to the hospital on [DATE]. The DON confirmed there was no documentation from when the resident left the faciity on [DATE] at 1:30 P.M. until LPN #421 contacted Resident #100's daughter on [DATE] at 7:35 A.M. to find out where the resident was. The DON said LPN #422, who was assigned to Resident #100 on [DATE], was a new graduate nurse and the DON had since educated her regarding when a family requested assistance it should be provided. The DON agreed Resident #100 had a drastic change in condition in a very short period. Documentation of the meal percentages Resident #100 ate during the week before her discharge and Resident #100's care Kardex (a summary of the care needed for each resident and how many people were needed to provide it) were requested and not provided. The DON said the information could not be obtained from the electronic medical record after 30 days. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Telephone interview with Resident #100's sister on [DATE] at 3:05 P.M. revealed she arrived at the facility at 9:15 A.M. on [DATE] to take her sister to her first radiation treatment. When she arrived Resident #100 was still in bed and was not dressed to leave. The sister assisted Resident #100 up and realized the resident had been incontinent of a large amount of stool. She assisted the resident back to bed and went to request help. The sister saw LPN #422 and requested assistance getting her sister cleaned up. LPN #422 said she would notify the aides. LPN #422 returned to the room and told the sister Resident #100 was self-sufficient with toileting so the resident would have to clean herself up. The sister realized they would not be able to make their 10:00 A.M. appointment and called the resident's daughter to update her. The resident's sister then proceeded to clean up her sister by herself. Resident #100's daughter was able to reschedule the radiation treatment for 2:00 P.M. The resident and her sister left for the appointment at 1:30 P.M. Resident #100 had to be transported via a wheelchair because she could barely stand which was a drastic change for the resident as she usually walked everywhere. When they arrived at the radiation treatment appointment Resident #100 did not receive her treatment because the physician sent Resident #100 immediately to the emergency room (ER) for evaluation. Resident #100 was subsequently admitted to the hospital. During interview with the DON on [DATE] at 2:35 P.M. the DON said the facility was aware Resident #100 had been admitted to the hospital. The DON said the hospital notified the facility the resident had been admitted , not the family. This deficiency represents non-compliance investigated under Complaint number OH00157364.

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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 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** 32650 Based on interview, record review, and policy review, the facility failed to ensure appropriate and accurate medical record documentation for one (#100) of six residents reviewed for change in condition. The facility census was 49. Findings Include: Resident #100 was admitted to the facility on [DATE] with diagnoses including breast cancer to the left breast, dementia without behavioral disturbance, multiple sclerosis, high blood pressure, left mastectomy, and psychotic disorder with delusions. Review of the quarterly comprehensive Minimum Data Set (MDS) 3.0 assessment, dated 08/06/24 revealed the Resident #100 was moderately cognitively impaired and needed supervision for all care. Review of the progress note dated 08/22/24 timed 2:06 P.M. revealed Resident #100 had an appointment scheduled for 10:00 A.M. but was unable to make the appointment because the resident had been incontinent of a large amount of stool and it took a long time to clean the resident up. The resident's daughter contacted the doctor's office and was able to reschedule the appointment to 2:00 P.M. The resident left the facility at 1:30 P.M. The next documented note was dated 08/23/24 timed 7:35 A.M. indicating Licensed Practical Nurse (LPN) #421 called the resident's daughter at home and asked where her mother was as she had not returned to the facility. The daughter told LPN #421 that her mother was not doing well, that she had been admitted to the hospital and she would not be returning to the facility. Review of August 2024 Medication Administration (MAR) for Resident #100 revealed LPN #421 marked Resident #100's 6:00 A.M. medications as given. The medications included protonix (used to treat gastric reflux) 40 milligrams (mg) orally, buspirone (an antianxiety medication) orally, and oxycodone (a narcotic pain medication) 5 mg orally. Interview with the Director of Nursing (DON) on 10/02/24 at 2:10 P.M. revealed she did not remember who notified the facility about Resident #100 being admitted to the hospital. She said her regional nurse told her not to document when a resident is admitted to hospital. The DON said she did not know why LPN #421 would document the protonix, buspirone, and oxycodone as given when the resident was in the hospital. Interview with the DON on 10/02/24 at 4:30 P.M. revealed she was positive either the daughter or the hospital called the facility to inform them of Resident's 100 admission on 08/22/23. The DON confirmed there was no documentation from when the resident left the faciity on [DATE] at 1:30 P.M. until LPN #421 contacted Resident #100's daughter on 08/23/24 at 7:35 A.M. The DON reiterated the regional nurse said not to document anything about admissions in the medical record. A copy of the facility's documentation policy was requested and the DON said they did not have one; what needed to be documented was covered in specific procedure policies. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DON on 10/03/24 at 2:35 P.M. revealed the facility was aware Resident #100 had been admitted to the hospital following the radiation appointment on 08/22/24. The DON said the hospital notified the facility the resident had been admitted , not the family. The DON indicated although there was no documentation the facility knew where the resident was. This deficiency represents non-compliance investigated under Complaint number OH00157364.