STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366379	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eliza at Chagrin Falls	16695 Chillicothe Road Chagrin Falls, OH 44023

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and staff interview, the facility failed to appropriately label and date food for storage. This had the potential to affect 21 of 22 residents who received meals from the facility kitchen. The facility identified one resident (Resident #1) who received no food by mouth. The facility census was 22.Findings include: Observations on 01/20/26 at 9:52 A.M. with Dietary Manager #239 during the initial main kitchen tour revealed the following:In dry storage there was a bag of tortilla chips open to air and not labeled or dated.In the refrigerator there was an almost full pan of orange gelatin left uncovered, unlabeled and undated, a bag of diced carrots left open, unlabeled and undated, and a bag of cheddar cheese left open, unlabeled and undated.In the freezer there was a bag of French fries open to air not labeled and dated and a bag of fried chicken open to air, not labeled or dated.Interview at the time of the observation with Dietary Manager #239 verified the above findings during the initial kitchen tour.

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and review of facility policy, the facility failed to provide showers/bathing per resident preference and schedule. This affected six residents (#10, #11, #14, #25, #34 and #37) out of 22 residents reviewed for showers. The facility census was 22.Findings include:1. Review of the medical record for Resident #25 revealed an admission date of 06/15/24 with diagnoses of metabolic encephalopathy, acute cystitis (bladder infection), dementia, heart failure, anxiety disorder, delirium, and malignant neoplasm of trachea. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #25 had a Brief Interview for Mental Status (BIMS) score of 11 which indicated moderate cognitive decline. The resident required moderate assistance for all activities of daily living (ADL) including grooming, hygiene, and toileting needs. Resident #25 was dependent on staff for all mobility and transfer needs and utilized a wheelchair. The resident was always incontinent of bowel and bladder. Review of Resident #25's physician orders effective January 2026 revealed Resident #25 was to receive showers and skin checks twice weekly every Wednesday and Saturday per resident preference. Interview on 01/20/26 at 9:40 A.M. with Resident #25 revealed she had not received scheduled showers twice weekly per her preference. The resident stated it had been a while since she had a shower and would like them to restart. Resident #25 could not recall the last time she received a shower/bed bath. Interview with Certified Nursing Assistant (CNA) #208 on 01/22/25 at 7:25 A.M. revealed showers were scheduled twice weekly or more per resident preference. All showers were documented on a shower sheet for each resident and given to the Director of Nursing (DON) upon completion. Both the CNA and nurse sign off on all shower sheets and include documentation of skin checks for that resident. CNA #208 revealed if a resident refused a shower, the CNAs attempted again later that day and notified the nurse who provided re-education to the resident regarding the importance of showers/bed baths. CNA #208 stated that any refusals for showers/bed baths by a resident were documented in the progress notes and in the CNA tasks in the electronic medical record (EMR). Review of shower sheets for the last two months (December 2025 to January 2026) for Resident #25 revealed only two showers were documented, 12/31/25 and 01/07/26. Review of progress notes for Resident #25 revealed one documented shower refusal on 01/18/26. Review of CNA tasks in Resident #25's EMR revealed only one shower was documented on 12/26/25 from December 2025 to January 2026. Interview with the DON on 01/22/26 at 11:45 A.M. verified the missed showers for Resident #25 including the lack of shower/bathing documentation. 2. Review of the medical record for Resident #10 revealed an admission date of 01/05/26 with diagnoses including quadriplegia, malignant neoplasm of the spinal cord, and muscle wasting. Review of January 2026 physician orders revealed Resident #10 had an order dated 01/07/26 to (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	schedule and complete skin checks twice weekly on bath/shower days in the morning every Wednesday and Sunday. Review of the care plan dated 01/05/26 revealed Resident #10 had an ADL functional performance deficit being dependent on staff for assistance. Interventions included for staff to provide assistance to maintain hygiene, adjust clothing, roll from lying on the back to left and right, transfers to bed to chair, and for dressing. Review of the five-day MDS assessment dated [DATE] revealed Resident #10 had intact cognition. He was dependent on staff assistance for showers/bathing, rolling left and right and transfers. Review of facility Shower Sheets revealed Resident #10 had a shower on 01/07/26 and on 01/18/26. The shower sheet dated 01/18/26 indicated Resident #10's wife assisted him with his shower. Interview on 01/20/26 at 11:48 A.M. with Resident #10 revealed he did not feel there was enough staff as he had been at the facility for three weeks and only had two showers. He was scheduled for and preferred to have a shower twice a week on Wednesday and Sunday. He had to have his wife come in and give him a shower on 01/17/26, since the facility had missed the previous two scheduled showers on 01/11/26 and 01/14/26. Staff had stated they were unable to give him a shower on those days as they did not have time. Interview on 01/22/26 at 9:30 A.M. with Agency CNA #231 revealed she came to the facility approximately six times a month and was unable to get all her scheduled showers/baths completed as there were too many assigned to be able to get done. Interview on 01/22/26 at 11:44 A.M. with Interim DON revealed Resident #10 was to receive a shower twice a week as scheduled as well as per his preference. She verified Resident #10 had received only two showers since admission on [DATE]. She also verified the shower sheet completed on 01/18/26 should have been dated 01/17/26 (Saturday) as she had assisted Resident #10 to his shower chair so Resident #10's wife could give him a shower. She verified Resident #10 did not receive a shower or bath from 01/08/26 to 01/16/26 (nine days) including on his scheduled shower days, 01/11/26 (Sunday) and 01/14/26 (Wednesday). She revealed there had been a problem with showers getting completed and had not found a solution yet. She stated she was going to go over the issue at the next staff meeting. 3. Review of the medical record for Resident #34 revealed an admission date of 01/13/26. On 01/22/26, the resident was sent to the hospital emergency room (ER). His diagnoses included malignant neoplasm to his prostate, diabetes, and hypertension. Review of January 2026 physician orders revealed Resident #34 had an order dated 01/16/26 to schedule and complete skin checks twice weekly on bath/showers days every night shift on Monday and Friday. Review of baseline care plan dated 01/15/26 revealed Resident #34 was cognitively intact and under the shower and bathing section he was not assessed for his ability. He required partial to moderate assistance with transfers. Review of facility Shower Sheets revealed one shower sheet since Resident #34's admission that was dated 01/16/26 at 9:00 P.M., completed by CNA #208. The sheet revealed he was offered a (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	shower and Resident #34 had refused as he stated he was tired. Interview at the time of the review with the Administrator verified the sheet was filled out on 01/22/26. Interview on 01/20/26 at 9:27 A.M. with Resident #34 and Resident #34's wife revealed the biggest concern they had with the facility was not receiving a bed bath since he was admitted to the facility. Resident #34 stated the staff had not washed him since he was admitted and he felt dirty. Interview on 01/21/26 at 3:07 P.M. with the Administrator verified there were no shower/bath sheets for Resident #34 from the date Resident #34 was admitted on [DATE] until 01/21/26 (nine days). Interview on 01/22/26 at 8:45 A.M. with the Administrator revealed he interviewed staff that had provided care for Resident #34 to find out why there were no shower/bath sheets and found CNA #208 had offered Resident #34 a shower/bed bath on 01/16/26 but he had refused. CNA #208 had not filled out a shower/bath sheet until today, 01/22/26. Interview on 01/22/26 at 9:30 A.M. with Agency CNA #231 revealed she came to the facility approximately six times a month and was unable to get all her showers/baths completed as scheduled as there were too many assigned to be able to get done. Interview on 01/22/26 at 11:44 A.M. with Interim DON revealed Resident #34 was scheduled to receive a shower and/or bath twice a week. The only shower/bath sheet was dated 01/16/26 (that was filled out on 01/22/26). She verified she had no documentation Resident #34 was offered or given a shower/bath from 01/17/26 to 01/22/26 (six days) including on 01/19/26, his scheduled shower/bath day. She stated there had been a problem with showers getting completed and had not found a solution yet. She was going to go over the issue at the next staff meeting. 4. Review of the closed medical record for Resident #37 revealed an admission date of 08/01/25 and discharge to home on [DATE]. His diagnoses included fracture of right arm, hypertension, unsteadiness on feet, muscle weakness and history of falling. Review of August 2025 physician orders for Resident #37 revealed an order dated 08/01/25 to schedule and complete skin checks twice weekly on bath/shower days every nightshift on Tuesday and Saturday, and an order dated 08/19/25 to schedule and complete skin checks twice weekly on bath/shower days every dayshift on Tuesday and Saturday. Review of the five-day MDS assessment dated [DATE] revealed Resident #37 had impaired cognition. He required substantial to maximum staff assistance with lower body dressing and transfers. He was dependent on staff for rolling left and right in bed. The assessment indicated showers/bathing were not attempted due to medical condition and/or safety concerns. Review of facility Shower Sheets revealed Resident #37 had a bed bath on 08/12/25 and 08/26/25. Review of the care plan dated 08/16/25 revealed Resident #37 had an ADL functional performance deficit being dependent on staff for assistance. Interventions included for staff to provide assistance with hygiene, adjusting clothes, rolling left and right in bed, and substantial to maximum assistance with transfers. Interview on 01/22/26 at 9:30 A.M. with Agency CNA #231 revealed she came to the facility approximately six times a month and stated she was unable to get all her showers/baths completed (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	as scheduled as there were too many assigned to be able to get done. Interview on 01/22/26 at 11:44 A.M. with Interim DON revealed Resident #37 was scheduled to receive a shower and/or bath twice a week and there was no medical reason why Resident #37 could not at least receive a bed bath during his stay. She verified the facility only had two shower sheets for Resident #37 during his stay, on 08/12/25 and 08/26/25, and there was no evidence Resident #37 received a shower from 08/01/25 to 08/11/25 (11 days) and from 08/13/25 to 08/25/25 (13 days). She stated there had been a problem with showers getting completed and had not found a solution yet. She was going to go over the issue at the next staff meeting. 5. Review of the medical record for Resident #11 revealed an admission date of 08/23/24. Diagnoses included macular degeneration, Crohn's disease, osteoarthritis, and a history of falling. Review of the quarterly MDS assessment dated [DATE] revealed Resident #11 had intact cognition. The resident used a wheelchair for mobility and required partial/moderate assistance for showers/baths, sit to stand, and transfers. Review of physician orders effective January 2026 revealed Resident #11 was to receive showers and skin checks twice weekly on Wednesdays and Saturdays. Review of the shower sheets for the last two months (December 2025 to January 2026) revealed Resident #11 received a shower on 12/06/25 and 12/10/25. Thereafter, there was a ten-day gap before a shower was received on 12/20/25. The resident then had a shower on 12/24/25 and refused a shower on 12/27/25. Afterwards, the resident did not receive another shower until 01/10/26 which was 14 days from the previous shower. Ten days after that Resident #11 received a shower on 01/17/26. Interview on 01/20/26 at 11:32 A.M. with Resident #11 stated she didn't get her showers when she was supposed to. Interview on 01/21/26 at 3:07 P.M. with the Administrator verified there were no additional shower/bath sheets for Resident #11. Interview on 01/22/26 with CNA #208 revealed Resident #11 required total care, could assist and was able to stand and pivot. The resident did not refuse care. Interview on 01/22/26 at 9:30 A.M. with Agency (CNA) #231 revealed she came to the facility approximately six times a month and stated she was unable to get all her scheduled showers/baths completed as there were too many assigned to be able to get done. Interview on 01/22/26 at 11:44 A.M. with Interim DON revealed Resident #11 was to receive a shower twice a week as scheduled as well as per preference. She verified that those were all the shower sheets available for Resident #11. She stated there had been a problem with showers getting completed and had not found a solution yet. She was going to go over the issue at the next staff meeting. 6. Review of the medical record for Resident #14 revealed an admission date of 01/02/26. Diagnoses included displaced intertrochanteric fracture, diabetes, congestive heart failure, and a history of falling, (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the five-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #14 had intact cognition. The resident was one-person physical assistance with showers/bathing. Review of physician orders effective January 2026 revealed Resident #14 was to have showers and skin checks twice weekly on Mondays and Thursdays. Review of the shower sheets from admission for Resident #14 revealed the resident received a bed bath on 01/20/26. There were no other shower sheets. Interview on 01/20/26 at 1:50 P.M. with Resident #14 stated she didn't get enough showers. Interview on 01/21/26 at 3:07 P.M. with the Administrator verified there were no additional shower/bath sheets for Resident #14. Interview on 01/22/26 at 9:30 A.M. with Agency (CNA) #231 revealed she came to the facility approximately six times a month and stated she was unable to get all her scheduled showers/baths completed as there were too many assigned to be able to get done. Interview on 01/22/26 at 11:44 A.M. with Interim DON revealed Resident #14 was to receive a shower twice a week as scheduled as well as per preference. She verified that those were all the shower sheets available for Resident #14. She stated there had been a problem with showers getting completed and had not found a solution yet. She was going to go over the issue at the next staff meeting. Review of facility policy labeled, Hygiene, Bathing, and Showering Policy, revised 2023 revealed the facility provided assistance with personal hygiene, bathing, and showering to maintain residents' comfort, dignity, health, and quality of life. Hygiene and bathing services were provided in accordance with the residents' needs and preferences. This deficiency represents non-compliance investigated under Complaint Number 2599654.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, review of Centers for Medicare & Medicaid Services memorandum and review of facility policy, the facility failed to ensure enhanced barrier precautions (EBP) were in place or implemented when indicated and the facility failed to ensure the catheter valve/port on Resident #33's indwelling catheter (a flexible tube used to drain urine from the bladder) drainage bag (a bag that collects urine) was not on the floor. This affected four Residents (#1, #14, #33, #36) out of ten residents reviewed for EBP and/or catheter use. This had the potential to affect 14 residents (#1, #6, #10, #12, #14, #19, #21, #22, #25, #27, #28, #33, #34 and #36) identified with EBP and seven residents (#6, #10, #14, #19, #22, #25 and #33) identified by the facility with urinary catheters. Findings include: 1. Review of the medical record for Resident #36 revealed an admission date of 01/14/26 and his diagnoses included aftercare following surgery of genitourinary system, acute cystitis and malignant neoplasm of the bladder. Review of the undated Baseline Care Plan for Resident #36 revealed Resident #36 had bilateral nephrostomy tubes (a thin catheter that drains urine directly from the kidney). There was nothing on his care plan regarding EBP to be utilized. Review of January 2026 physician orders for Resident #36 revealed an order dated 01/17/26 for EBP including gown and glove during high contact resident care activities due to bilateral nephrostomy tubes. Observation on 01/21/26 at 7:58 A.M. revealed an aide came and reported to Agency Registered Nurse (RN) #238 that Resident #36 had blood in his right nephrostomy tube and bag. Agency RN #238 went to check Resident #36's nephrotomy tube and upon entrance to his room there was no signage indicating Resident #36 was on EBP. Agency RN #238 proceeded to apply gloves but no gown as she bent over Resident #36 and assessed including turning him to his side. During her assessment Agency RN #238's uniform came in direct contact with Resident #36. Agency RN #238 contacted Physician Assistant (PA) #235 of the blood in his nephrostomy tube. Interview on 01/21/26 at 8:05 A.M. with Interim Director of Nursing (DON) who was walking by Resident #36's room verified there was no signage that indicated Resident #36 was on EBP. She verified Resident #36 was to be on EBP due to his bilateral nephrostomy tubes. Observation on 01/21/26 at 8:12 A.M. revealed Agency RN #238 re-entered Resident #36's room as PA #235 asked her to get a set of vitals. PA #235 was in his room with gloves on but no gown and evaluated Resident #36 including leaning over Resident #36 as she conducted a head-to-toe assessment. During PA #235's assessment her white lab coat came in direct contact with Resident #36. Agency RN #238 then obtained his blood pressure, heart rate, and oxygen saturation without gloves and/or a gown in place. Interview on 01/21/26 at 8:20 A.M. with PA #235 verified Resident #36 was on EBP. She stated she was not even thinking and went in and assessed Resident #36. She verified she did not utilize a gown. Interview on 01/21/26 at 10:00 A.M. with Agency RN #238 revealed she was from agency and did not see a sign indicating Resident #36 was on EBP. She verified she did not wear a gown as she assessed Resident #36 and when she took Resident #36's vitals she did not have gloves and/or a gown on. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 01/21/26 at 12:06 P.M. with Interim DON verified Agency RN #238 and PA #235 should have worn EBP including gloves and gown during Resident #36's assessment and taking vitals as they were in direct contact. 2. Review of the medical record for Resident #33 revealed an admission date of 01/19/26 and his diagnoses included benign prostatic hyperplasia (enlargement of the prostate causing urinary issues) with lower urinary tract symptoms, chronic kidney disease, and diabetes. Review of January 2026 physician orders revealed Resident #33 had an order for an indwelling urinary catheter and catheter care to be provided every shift. There was no order for EBP. He also had an order for cephalexin (antibiotic) 500 milligrams (mg) one capsule by mouth every six hours for four days as he had a urinary tract infection (UTI). Review of the care plan dated 01/20/26 revealed Resident #33 required EBP as he was at risk for developing a MRDO (multidrug resistant organism) infection as he had a wound. Interventions included posting signage on the door or wall outside of the resident room indicating precautions and required personal protective equipment of gown and gloves. Observation on 01/20/26 at 9:16 A.M. revealed Resident #33 was lying in a low bed with his indwelling urinary catheter drainage bag on the side of his bed with part of the bag laying on the floor. The valve/port to the drainage bag was in direct contact with the floor as the drainage bag was not in a dignity pouch. Interview on 01/20/26 at 9:18 A.M. with Licensed Practical Nurse (LPN) #222 verified Resident #33's indwelling urinary catheter drainage bag valve/port was in direct contact with the floor and part of the bag was also lying on the floor. She also verified there was no signage on the outside of Resident #33's door indicating he was on EBP. She verified he should be on EBP as he had an indwelling urinary catheter and wounds. She also verified he had a current UTI and was on antibiotic therapy. Review of the Baseline Care Plan dated 01/21/26 revealed Resident #33 had an indwelling urinary catheter and was dependent on staff for his toileting hygiene. There was nothing in the baseline care plan regarding care of his urinary catheter including keeping the drainage bag especially the valve/port off the floor and EBP. Interview on 01/21/26 at 12:06 P.M. with Interim DON verified Resident #33's indwelling catheter bag should not be on the floor and Resident #33 did not have an order for EBP. She verified he should have had a physician order for EBP as he had wounds and an indwelling urinary catheter. She revealed when a resident was admitted at times there was a delay in getting the signage up and a physician order for EBP. She revealed it was not on the admitting nurse checklist to implement and that she had planned to add that so at times the signage did not get hung or the physician order obtained until she came in and reviewed the admission. She verified it could be a day or two after a resident was admitted until she was on duty to hang up the sign and obtain a physician order for EBP. 3. Review of the medical record for Resident #1 revealed an admission date of 12/31/25 and his diagnoses included acute and chronic respiratory failure, hypertension, malignant neoplasm of tongue and presence of gastrostomy tube (g-tube) (a tube inserted through the abdomen into the stomach to provide nutrition, fluids, and/ or medications). Review of January 2026 physician orders revealed Resident #1 had an order for EBP including (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wearing gown and gloves during high-contact resident care activities due to presence of a g-tube. Review of the care plan dated 01/02/26 revealed Resident #1 required EBP as he was at risk for developing a MRDO (multidrug resistant organism) infection as he had a wound and an indwelling medical device (g-tube). Interventions included posting signage on the door or wall outside of the resident room indicating precautions, personal protective equipment (PPE) of gown and gloves, and providing education to the resident, visitors and caregivers. Review of the five-day Minimum Data Set (MDS) dated [DATE] revealed Resident #1 had intact cognition and had a g-tube. Observation on 01/21/26 at 9:17 A.M. revealed LPN #222 applied gloves and gown prior to entering Resident #1's room to administer his medications through his g-tube. Resident #1 and Resident #1's wife, who was present in the room immediately questioned LPN #222 why the nurse had a gown on. LPN #222 explained that Resident #1 was on EBP due to his g-tube and staff needed to wear gloves and gown when in direct contact with Resident #1. Resident #1 and Resident #1's wife became upset stating he had been at the facility several weeks and never had seen any staff including LPN #222 wear a gown during the administration of his g-tube medications and/or other direct care needs. LPN #222 shrugged her shoulders when Resident #1 and Resident #1's wife questioned again why it was the first time staff had worn a gown. Interview on 01/21/26 at 9:29 A.M. with Resident #1's wife revealed she was upset as she was at the facility every day and had seen Resident #1 multiple times receive his medications through his g-tube and the nurse had never had a gown on until today, 01/21/26. Interview on 01/21/26 at 12:06 P.M. with Interim DON verified Resident #1 was on EBP as he had a g-tube and that staff were to wear a gown and gloves especially during high contact care activities including the administration of medications through his g-tube. 4. Review of the medical record for Resident #14 revealed an admission date of 01/02/26. Diagnoses included displaced intertrochanteric fracture, diabetes, congestive heart failure, and a history of falling. Review of the five-day Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition and required one-person physical assistance with showers/bathing. Review of January 2026 physician orders for Resident #14 revealed an order for Enhanced Barrier Precautions: gown and glove use during high-contact resident care activities due to a surgical wound. Review of the care plan dated 01/18/26 revealed Resident #14 required EBP for being at risk for developing a MRDO (multidrug resistant organism) infection because of a wound. Interventions included posting signage on the door or wall outside of the resident room indicating precautions and required personal protective equipment of gown and gloves. Observation on 01/21/26 at 7:56 A.M. of Resident #14 revealed the resident in bed asleep. There was signage on the door indicating Enhanced Barrier Precautions (EBP) and there was no Personal Protective Equipment (PPE) on or near the door to the resident's room. Interview on 01/21/26 at 8:02 A.M. with LPN #222 confirmed PPE for EBP was not in place. (continued on next page)

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	366379	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eliza at Chagrin Falls	16695 Chillicothe Road Chagrin Falls, OH 44023

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility policy labeled, Indwelling Catheter Justification and Removal, dated 2023 revealed there was nothing in the policy regarding ensuring the catheter drainage bag was not on the floor. Review of the memorandum, QSO-24-08-NH, entitled Enhanced Barrier Precautions in Nursing Homes, dated 03/20/24, by the Centers for Medicare & Medicaid Services, Department of Health & Human Services revealed enhanced barrier precautions are indicated for residents with wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. The effective date for implementation of enhanced barrier precautions under the guidelines was 04/01/24. Review of the undated facility policy labeled, Enhanced Barrier Precautions (EBP), revealed the purpose of the policy was to prevent the spread of MDRO and other transmissible pathogens through consistent application of EBP. Facilities were to implement EBP for residents who are colonized or infected with MDRO, are at risk for MDRO including ventilator-dependent residents, residents with indwelling medical devices and residents with wounds. EBP expands standard precautions by requiring a gown and gloves during high-contact resident care activities. The policy revealed a standardized sign would be posted outside the resident room indicating EBP required.

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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. Based on observation, interview, record review and review of facility policy, the facility failed to appropriately cover an indwelling urinary catheter drainage bag with a dignity/privacy pouch. This affected one resident (#33) out of three residents reviewed for urinary catheters and had the potential to affect seven residents (#6, #10, #14, #19, #22, #25 and #33) identified by the facility with urinary catheters. The facility census was 22.Findings include: Review of the medical record for Resident #33 revealed an admission date of 01/19/26 and his diagnoses included benign prostatic hyperplasia (enlargement of the prostate causing urinary issues) with lower urinary tract symptoms, chronic kidney disease, and diabetes. Review of January 2026 physician orders revealed Resident #33 had an order for an indwelling urinary catheter and catheter care was to be provided every shift. Observation on 01/20/26 at 9:16 A.M. revealed Resident #33 was lying in a bed with his indwelling urinary catheter drainage bag on the side of his bed with part of the bag laying on the floor. From the hallway, yellow urine of approximately 100 cubic centimeters (cc) was seen as there was no dignity/privacy pouch covering the catheter drainage bag. Interview on 01/20/26 at 9:16 A.M. with Resident #33 revealed he was pleasantly confused regarding the privacy of his catheter. Interview on 01/20/26 at 9:18 A.M. with Licensed Practical Nurse (LPN) #222 verified Resident #33's indwelling urinary catheter drainage bag was not covered with a dignity/privacy pouch and from the hallway, urine was seen inside his drainage bag. Review of Baseline Care Plan dated 01/21/26 revealed Resident #33 had an indwelling catheter and was dependent on staff for his toileting hygiene. There was nothing in the care plan about providing a dignity pouch to cover his urinary catheter drainage bag.Review of facility policy labeled, Resident Rights, dated 11/28/16 revealed all residents had the right to be treated with dignity and respect. There was nothing in the policy regarding ensuring privacy/dignity in relation to covering an indwelling catheter drainage bag. This deficiency represents non-compliance investigated under Complaint Number 2599654.

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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, interview, record review, and review of facility policy, the facility failed to ensure residents were free of significant medication errors. This affected two residents (#1 and #25) out of five residents reviewed for medication administration. The facility census was 22.Findings include:1. Review of the medical record for Resident #25 revealed an admission date of 06/15/24 with diagnoses of metabolic encephalopathy, acute cystitis (bladder infection), dementia, heart failure, anxiety disorder, delirium, and malignant neoplasm of trachea. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 11 which indicated moderate cognitive decline. Resident #25 required moderate assistance for all activities of daily living including grooming, hygiene, and toileting needs, and was dependent on staff for mobility and transfers utilizing a wheelchair. Review of the care plan dated 12/26/25 revealed Resident #25 had congestive heart failure Interventions included to administer cardiac medications as ordered and to monitor any signs and symptoms of congestive heart failure including orthopnea (difficulty breathing while lying down), weakness and/or fatigue, increased heart rate, lethargy (drowsiness) and disorientation. Review of physician orders revealed Resident #25 had an order dated 12/29/25 for amlodipine besylate 5 milligrams (mg) once daily for hypertension with a parameter to hold the medication for systolic blood pressure (SBP) less than 130. Review of the Medication Administration Record (MAR) for December 2025 and January 2026 revealed Resident #25 was erroneously administered amlodipine on multiple days when the ordered parameters indicated the medication was to be held. Resident #25 received amlodipine on 01/05/26 with a SBP of 116, on 01/07/26 with a SBP of 127, on 01/08/26 with a SBP of 122, on 01/10/26 with a SBP of 121, on 01/11/26 with a SBP of 113, on 01/12/26 with a SBP of 104, on 01/17/26 with a SBP of 108, and on 01/18/26 with a SBP of 118. Interview on 01/21/25 at 5:15 P.M. with Director of Nursing (DON) verified the multiple significant medication errors and stated nursing staff should not have administered the amlodipine as the blood pressure levels were outside of the parameters to be given. 2. Review of the medical record for Resident #1 revealed an admission date of 12/31/25 and diagnoses included dysphagia (difficulty swallowing), acute and chronic respiratory failure with hypoxia (low levels of oxygen in body tissues), malignant neoplasm of the tongue, and gastrostomy status (g-tube) (a tube inserted through the abdomen into the stomach to provide nutrition, fluids, and/or medications). Review of December 2025 and January 2026 physician orders revealed Resident #1 had the following orders: aspirin 81 mg chewable tablet per g-tube due to heart disease, atorvastatin calcium (cholesterol medication) 40 mg tablet per g-tube in the morning, and brensocatib 25 mg tablet per g-tube in the morning due to bronchiectasis (a lung condition that causes cough, sputum production with recurrent lung infections). He had an order dated 12/31/25 that medications may be crushed as appropriate and placed in a food item or given with liquid. There was no order indicating the medications could be crushed together and administered through his g-tube. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the care plan dated 01/06/26 revealed Resident #1 had a nutritional problem related to dysphagia, hypertension, chronic kidney disease, underweight and enteral nutrition related to nothing by mouth status (NPO). Interventions included providing enteral nutrition and flushes as ordered, and the dietician to evaluate. There was nothing in the care plan regarding administration of medications including crushing it through the g-tube. Review of the five-day MDS assessment dated [DATE] revealed Resident #1 had intact cognition and had a g-tube. Review of the care plan dated 01/19/26 revealed Resident #1 required tube feeding. Interventions included he needed the head of bed elevated 45 degrees during the tube feed, to check the tube placement and gastric contents per facility policy, provide care to the tube site as ordered, and to monitor, document and report any abnormal signs and symptoms. There was nothing in the care plan regarding the administration of medications including crushing it through the g-tube. Observation on 01/21/26 at 9:17 A.M. revealed Licensed Practical Nurse (LPN) #222 prepared the following medications at the medication cart: aspirin 81mg chewable tablet, atorvastatin calcium 40 mg tablet, and brensocatib 25mg tablet. She then took all the medications and crushed the medications together. She proceeded to enter Resident #1's room and after checking for placement and flushing Resident #1's g-tube with water, administered all the combined crushed medications. She administered a water flush after the combined crushed medications. Interview on 01/21/26 at 10:04 A.M. with LPN #222 verified she crushed the following medications together: aspirin 81mg chewable tablet, atorvastatin calcium 40 mg tablet, and brensocatib 25 mg tablet and then administered it through Resident #1's g-tube. She verified Resident #1 did not have an order to crush all his medications together and administer all at once. She stated she always had crushed the medications together and did not know they needed to be crushed separately unless there was a physician order. She was not aware of whether a physician and/or pharmacist had reviewed if the above medications were safe to crush together and if there was a potential for an interaction if they were crushed and administered together. Interview on 01/21/25 at 10:32 A.M. with Consultant Pharmacist #500 revealed she had not reviewed Resident #1's medications to ensure they were able to be crushed together and administered safely through his g-tube especially the brensocatib since it was a new medication that she was not familiar with. She revealed she would have to research if it was safe. Interview on 01/21/26 at 12:09 P.M. with Interim Director of Nursing (DON) revealed the nurse should not have crushed the medications together and administered the medications through Resident #1's g-tube. She verified there was no evidence that the physician and/or pharmacist had reviewed Resident #1's medications to ensure it was safe to crush the medications together and whether there were known drug interactions if they were crushed together. Review of the facility policy labeled, Enteral Feeding, dated 2023 revealed the purpose of the policy was to provide adequate nutrition and hydration. Prior to flushing, and administration of medication per feeding tube the nurse needed to ensure proper placement. There was nothing in the policy regarding crushing of medications. Review of the facility policy labeled, Medication Administration Policy, dated 2023 revealed all medications would be administered safely, accurately, and in accordance with the resident's plan of (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care and prescribed orders. Medication administration standards revealed the licensed nurse shall follow the rights of medication administration including right resident, right medication, right dose, right route, right time, right documentation, right reason and right response. There was nothing in the policy regarding crushing medications including through a g-tube.