

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/26/2024
NAME OF PROVIDER OR SUPPLIER Oaks of Brecksville		STREET ADDRESS, CITY, STATE, ZIP CODE 8757 Brecksville Road Brecksville, OH 44141	

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)
<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35768</p> <p>Based on observation, medical record review, staff interview, and review of a facility policy, the facility failed to maintain resident care equipment in a clean and sanitary condition. This affected three (#4, #75, and #76) of three residents reviewed for environment. The census was 73.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #4 revealed an admitted [DATE]. Diagnoses included heart failure, chronic kidney disease, anxiety disorder, depression, and dysphagia.</p> <p>Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] for Resident #4 revealed the resident had an intact cognition. Resident #4 required set and clean up assistance with eating. Resident #4 was dependent for all other activities of daily living.</p> <p>Observation during medication administration on 08/26/24 at 8:00 A.M. revealed Resident #4's power wheelchair was dirty. The right arm rest and controller were leaning over the side of the chair. The arm rest had dried food debris caked (approximately six inches in diameter) on the padding located on the top of the arm rest and on the frame/bracket below the arm rest. There was also dried food debris caked on the right front wheel and frame of the wheelchair.</p> <p>Interview on 08/26/24 at 8:05 A.M., with State tested Nurse Aide (STNA) #100 verified the observation of Resident #4's power wheelchair and stated Resident #4 had behaviors including throwing food on floor and on the wheelchair. STNA #100 stated staff must clean Resident #4's wheelchair after every meal. STNA #100 also stated staff place a bag over the right arm rest to prevent food from getting on the chair.</p> <p>Review of the facility policy titled, Cleaning and Disinfecting of Resident Care Equipment, dated 2024, lacked information directing staff on how and why to clean/sanitize resident wheelchairs.</p> <p>38091</p> <p>2. Review of Resident #75's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease, type two diabetes, and atrial fibrillation.</p> <p>(continued on next page)</p>

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)		
<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the most recent MDS 3.0 assessment dated [DATE] revealed Resident #75 was cognitively intact and required hands on assistance of one staff person for completing activities of daily living.</p> <p>Review of the care plan dated 07/10/24 revealed Resident #75 was at risk for falls related to a right leg amputation with interventions that included a fall mat to the floor to the side of the bed.</p> <p>3. Review of Resident #76's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included brain aneurysm, dementia, epilepsy, and bipolar disorder.</p> <p>Review of the most recent MDS 3.0 assessment dated [DATE] revealed Resident #76 was moderately cognitively impaired and required hands on assistance for completing her activities of daily living.</p> <p>Review of the care plan dated 03/25/24 revealed Resident #76 was at risk for falls due to impaired cognition and impaired mobility. Review of the care plan interventions revealed a intervention for a mat to floor next to the bed.</p> <p>Observation on 08/26/24 at approximately 11:00 A.M. revealed both Resident #75 and Resident #76's mats used for fall interventions were not clean with various areas of brown and other colored substance on each of the mats. Additionally, Resident #75's mat had significant tears in the exterior. The Administrator verified the conditions of Resident #75 and Resident #76's mats in an interview on 08/26/24 at 11:00 A.M.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00156493.</p>		