

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  366428	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/31/2024
NAME OF PROVIDER OR SUPPLIER  O'Neill Healthcare Fairview Park		STREET ADDRESS, CITY, STATE, ZIP CODE 20770 Lorain Road Fairview Park, OH 44126	

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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>39973</p> <p>THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.</p> <p>Based on interview, review of employee personnel files, review of employee handbook and review of abuse policy revealed the facility did not ensure residents were free from potential neglect when staff were sleeping while on duty. This had the potential on 08/05/24 to affect 16 Residents: #1, #4, #9, #10, #13, #18, #20, #22, #28, #29, #36, #44, #58, #76, #85, and #99 when Licensed Practical Nurse (LPN) #608 was assigned to on the south hall was found sleeping. This also had the potential on 09/04/24 to affect 22 Residents: #1, #4, #9, #10, #13, #18, #20, #22, #28, #29, #36, #42, #44, #58, #66, #71, #76, #85, #90, #99, #106, and #107 when LPNs #604 and #613 were assigned to on the south hall were found sleeping. The facility census was 105.</p> <p>Findings included:</p> <p>1. Review of personnel file for LPN #608 revealed a hire date of 07/02/24 and she received new hire orientation on 07/02/24 which included the handbook regarding the following actions by an employee would be considered gross misconduct and would result in immediate termination that included sleeping while on duty.</p> <p>Review of Daily Schedule for 08/05/24 revealed LPN #608 was assigned to the south hall from 7:00 P.M. to 7:30 A.M. She was assigned the following 16 Residents: #1, #4, #9, #10, #13, #18, #20, #22, #28, #29, #36, #44, #58, #76, #85, and #99.</p> <p>Review of witness statement dated 08/06/24 and completed by LPN #610 revealed she went to lunch and when she came back LPN #608 was sleeping. She revealed she was intentionally noisy, and LPN #608 awoke.</p> <p>Review of witness statement dated 08/07/24 and completed Director of Nursing (DON) revealed she called LPN #608, and LPN #608 verified on 08/05/24 she had nodded off.</p> <p>Review of Termination Report dated 08/12/24 revealed LPN #608 was terminated due to sleeping while on duty. The report was signed by the Administrator, and Human Resource (HR) #614 on 08/12/24. LPN #608 did not sign the termination.</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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Interview on 10/30/24 at 4:13 P.M. with Former Certified Nursing Assistant (CNA) #609 revealed on 08/05/24 she saw LPN #608 sleeping multiple times throughout the shift on 08/05/24. She revealed she would sleep approximately ten to twenty minutes each time as she would wake up and then dose back off.</p> <p>Interview on 10/30/24 at 4:20 P.M. with LPN #610 revealed LPN #608 was sleeping at the nurse's station in front of the computer with her head on the table. She revealed she had her eyes closed and that she startled her when she woke LPN #608 up by making noise.</p> <p>2. Review of personnel file for LPN #613 revealed a hire date of 04/03/23 and she received new hire orientation on 04/03/23 which included the handbook regarding the following actions by an employee would be considered gross misconduct and would result in immediate termination that included sleeping while on duty.</p> <p>Review of personnel file for LPN #604 revealed a hire date of 11/15/23 as she worked first shift as a CNA until she became licensed as an LPN on 07/26/24. Her first day of training as a nurse was on 09/04/24 from 7:00 P.M. to 7:30 A.M. She received new hire orientation on 11/15/23 which included the handbook regarding the following actions by an employee would be considered gross misconduct and would result in immediate termination that included sleeping while on duty.</p> <p>Review of Daily Schedule for 09/04/24 revealed LPN #613 was training LPN #604 to the south hall from 7:00 P.M. to 7:30 A.M. They were assigned the following 22 Residents: #1, #4, #9, #10, #13, #18, #20, #22, #28, #29, #36, #42, #44, #58, #66, #71, #76, #85, #90, #99, #106, and #107.</p> <p>Review of Termination Report dated 09/05/24 revealed LPN #604 was terminated due to sleeping while on duty. The report was signed by the Administrator, DON and HR #614 on 09/05/24. LPN #604 did not sign the termination.</p> <p>Review of Termination Report dated 09/05/24 revealed LPN #613 was terminated due to failing or refusing to cooperate fully with a facility investigation or inspection. The report was signed by the Administrator, and HR #614 on 09/05/24. LPN #613 did not sign the termination.</p> <p>Review of witness statement dated 09/05/24 and completed by LPN #604 revealed she did not recall falling asleep on 09/04/24. She stated she did watch a movie during down time.</p> <p>Review of witness statement dated 09/05/24 and completed by LPN #613 revealed on 09/04/24 she was sitting in the social area facing the window on the unit and was not sleeping on the job.</p> <p>Review of witness statement dated 09/05/24 and completed by LPN #605 revealed on 09/04/24 she noticed LPN #604 and LPN #613 sleeping from 3:00 A.M. till 4:45 A.M. in the dining room.</p> <p>Review of witness statement date 09/05/24 and completed by CNA #607 revealed she seen two nurses, LPN #604 and LPN #613, both sleeping.</p> <p>Review of witness statement dated 09/05/24 completed by CNA #606 revealed two nurses, LPN #604 and LPN #613, were sleeping.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of witness statement dated 09/05/24 and completed by CNA #615 revealed on 09/04/24 she seen two nurses, LPN #604 and LPN #613, sleeping in the dining room.</p> <p>Interview on 10/30/24 at 4:16 P.M. with CNA #606 revealed she witnessed both, LPN #604 and 613, sleeping while on duty. She revealed one was sleeping by the window in a chair leaning to one side and her head down but not on the table. She revealed the other was by the piano sitting next to the wall with her eyes closed. She revealed she did not know which nurse was where but that both were sleeping at the same time.</p> <p>Interview on 10/30/24 at 4:47 P.M. with Administrator and DON verified on 08/05/24 LPN #608 was observed to be sleeping while on duty by more than one staff member. LPN #608 was terminated for sleeping on duty. They verified on 09/05/24 LPN #613 was training LPN #604 and both were observed sleeping while on duty by more than one staff member. They verified LPN #604 and LPN #613 were both terminated.</p> <p>Interview on 10/31/24 at 10:02 A.M. with HR #615 revealed any new hire she goes over line by line regarding the employee handbook including sleeping on duty which would result in immediate termination.</p> <p>Review of undated employee handbook revealed the following actions by an employee would be considered gross misconduct and would result in immediate termination that included sleeping while on duty.</p> <p>Review of facility policy labeled, Abuse, Neglect, Involuntary Seclusion, Misappropriation Prevention dated October 2017 revealed all residents would be free from abuse and neglect. Neglect was defined as failure of the facility, its employees or service providers to provide goods and services to a resident that were necessary to avoid physical harm, pain, mental anguish or emotional distress.</p> <p>The deficient practice was corrected on 09/05/24 when the facility implemented the following corrective actions:</p> <p>On 08/12/24 LPN #608 was terminated due to sleeping while on duty.</p> <p>On 09/05/24 LPN #613 was terminated due to failing or refusing to cooperate fully with a facility investigation or inspection regarding her sleeping while on duty.</p> <p>On 09/05/24 LPN #604 was terminated due to sleeping while on duty.</p> <p>On 09/05/24 during employee orientation HR #614 continued to educate all new employees regarding the employee handbook regarding the following actions by an employee would be considered gross misconduct and would result in immediate termination that included sleeping while on duty.</p> <p>On 09/05/24 with the awareness and termination of staff sleeping the DON had been coming in a few times a week at times as early as 2:00 A.M. and rounded on the units to ensure staff were not sleeping. No staff were observed to be sleeping.</p> <p>On 09/05/24 all staff were in serviced by the Administrator that sleeping on duty was not tolerated and would result in immediate termination and staff were in serviced on the abuse policy.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 10/08/24 all staff were in serviced again by the Administrator, DON, and HR #614 that sleeping on duty was not tolerated and would result in immediate termination</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00158747.</p>