STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366441	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seven Hills Health & Rehab Center	819 Rockside Road Seven Hills, OH 44131

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35768 Based on observation, record review and interview, the facility failed to ensure a medication error rate of less than 5% (percent). A total of 24 medications were observed with two errors for a medication error rate of 8. 33%. This finding affected two (Resident #39 and #41) of three residents observed for medication administration. Findings include: 1. Review of medical record for Resident #39 revealed an admitted [DATE]. Diagnoses included type two diabetes with diabetic neuropathy, unspecified, major depressive disorder, recurrent and bipolar disorder. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had intact cognition. Review of physician order dated 01/24/24 revealed orders for Novolin 70-30 via flexpen, administer 45 units one time a day. Observation on 10/03/24 8:43 A.M. revealed Licensed Practical Nurse (LPN) #836 administered 45 units of Novolin to Resident #39. LPN #836 retrieved the injector pen, sanitized the tip, twisted the injector needle and turned to the dosage dial to 45 units before injecting the insulin. LPN #836 did not prime the insulin pen. Interview during observation with LPN #836 revealed they did not know they were supposed to prime the insulin pen before administering insulin. 2. Review of medical record for Resident #41 revealed an admitted [DATE]. Diagnoses included type two diabetes with foot ulcer. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had intact cognition. Review of physician order dated 09/25/24 revealed orders for insulin Glargine-yfgn, administer 14 units one time a day. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366441	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seven Hills Health & Rehab Center	819 Rockside Road Seven Hills, OH 44131

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 10/03/24 8:11 A.M. revealed LPN #840 administered 14 units of Glargine to Resident #41. LPN #840 retrieved the injector pen, sanitized the tip, twisted on the injector needle and turned to the dosage dial to 14 units before injecting the insulin. LPN #840 did not prime the insulin pen. Interview during observation with LPN #836 revealed they were not aware of the need to prime the insulin pen. Review of the facility policy titled, Using Insulin Pen Delivery Systems, dated 2023 indicated to attach new safety pen needle, hold upright and prime the pen to remove air bubbles and to ensure the needle is open and working properly, dial to prescribed dosage, and inject fully by depressing push button.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366441	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seven Hills Health & Rehab Center	819 Rockside Road Seven Hills, OH 44131

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35768 Based on record review, observations and interviews the facility failed to ensure insulin was dated, labeled, and discarded properly. This affected six residents (#11, #12, #16, #30, #41 and Resident #53) of 12 residents reviewed for insulin storage. Findings include: Review of medical record for Resident #11 revealed an admitted [DATE]. Diagnosis included type two diabetes. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment for Resident #11 dated 08/14/24 revealed the resident had impaired cognition. Review of medical record for Resident #12 revealed an admitted [DATE]. Diagnosis included type two diabetes. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment for Resident #12, dated 09/26/24 revealed the resident had intact cognition. Resident #12 was ordered insulin. Review of medical record for Resident #16 revealed an admitted [DATE]. Diagnosis included type two diabetes. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment for Resident #16 dated 09/30/24 revealed the resident had intact cognition. Resident #16 was ordered insulin. Review of medical record for Resident #30 revealed an admitted [DATE]. Diagnoses included type two diabetes, alcoholic cirrhosis of the liver and bipolar disorder. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment for Resident #30 dated 08/07/24 revealed the resident had intact cognition. Resident #30 was ordered insulin. Review of medical record for Resident #41 revealed an admitted [DATE]. Diagnosis included type two diabetes. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment for Resident #41 dated 07/30/24 revealed the resident had intact cognition. Resident #41 was ordered insulin. Review of medical record for Resident #53 revealed an admitted [DATE]. Diagnosis included type two diabetes and hypoglycemia unspecified. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment for Resident #53 dated 08/02/24 revealed the resident had impaired cognition. Resident #53 was ordered insulin. Observation of a medication cart on 10/03/24 at 8:30 A.M. revealed insulin injector pens with no date or name documented. Observations included one injector pen with no name or date, an injector pen of Aspart for Resident #11 dated 08/18/24, two injector pens of Lispro for Resident #12 not dated, and an injector pen of Lispro for Resident #41 that was not dated. Interview during observation with Licensed Practical Nurse (LPN) #840 verified the findings and stated all insulin must be labeled with names and dates. LPN #840 revealed insulin should be discarded after 28 days of the open date. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366441	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seven Hills Health & Rehab Center	819 Rockside Road Seven Hills, OH 44131

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations of a medication cart on 10/03/24 at 8:50 A.M. revealed insulin injector pens with no date or name documented. Observations included one injector pen with no name or date, an injector pen Lispro for Resident #16 not dated, an injector pen of Lispro and B insulin for Resident #30 not dated, and an injector pen of Glargine for Resident #53 not dated. Interview during observations with LPN #836 verified the findings and stated all insulin must be labeled with names and dates when opened. Review of the facility policy titled Pharmacy Services and Procedure Manual, dated 2022 noted staff should document the date opened on the label of medications with shortened expiration dates including insulin's and irrigation solutions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366441	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seven Hills Health & Rehab Center	819 Rockside Road Seven Hills, OH 44131

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35768 Based on record review, observation, interview and policy review the facility failed to maintain infection control standards when administering medications. This affected one (Resident #30) of three residents reviewed for infection control during medication administration. Findings include: Review of medical record for Resident #30 revealed an admitted [DATE]. Diagnoses included type two diabetes, alcoholic cirrhosis of the liver and bipolar disorder. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment for Resident #1 dated 08/07/24 revealed the resident had intact cognition. Observations on 10/02/24 at 7:55 A.M. revealed Licensed Practical Nurse (LPN) #836 administering medications for Resident #30. LPN #836 placed nine medications into her bare hand before placing them in the medication cup. Interview during the observation with LPN #836 revealed she should not have put the medication in my hand, they should go in the cup. Review of the facility policy titled, Pharmacy Services and Procedure Manual, dated 2022 revealed staff should not touch the medication when opening a bottle or unit dose package.