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	07/07/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 3. Review of the medical record for Resident #28 revealed an admission date of 05/02/24 with diagnoses including diabetes mellitus, hypertension, anxiety, depression, bipolar disorder, and chronic kidney disease. Review of the minimum data set (MDS) assessment dated [DATE] revealed Resident #28 was cognitively intact and required substantial or maximum assistance for activities of daily living (ADLs). On 06/24/25 at 3:01 P.M., an observation of Resident #28's room revealed Resident #28 was laying in bed calling for help and her call light was observed on the floor and out of reach. An interview at the time of observation with Certified Nursing Assistant (CNA) #27 verified Resident #28's call light was on the floor and out of reach. On 06/25/25 at 10:40 A.M., an observation revealed Resident #28 was lying in bed and the call light was not in reach. The call signal light on top of the door was illumined, indicating the residents in the room requested assistance. Licensed Practical Nurse (LPN) #44 entered the room and asked Resident #28 what she needed. Resident #28 replied she needed her call light and wanted to get dressed. LPN #44 retrieved the call light and put it in reach of Resident #28. Resident #28's roommate stated she needed help and had put on the call light. On 06/25/25 at 10:42 A.M., an interview with LPN #44 verified Resident #28's call light was not reach. This deficiency represents non-compliance investigated under Master Complaint Number OH00165594. Based on observation, interview, record review and facility policy, the facility failed to ensure the resident's call light was within reach. This affected three Residents (#6, #28 and #122) out of six residents reviewed for call lights. The facility census was 63. Findings include: 1. Review of the medical record for Resident #6 revealed an admission date of 06/25/25 with diagnoses including acute respiratory failure, catatonic disorder, dysphagia, major depressive disorder, dependence on respiratory, multiple contractures, dependence on supplemental oxygen, and encephalopathy. (continued on next page)

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
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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13 with maximum full dependence on staff for all activities of daily living (ADLs) and hygiene needs. Resident #6 was unable to perform any self-care due to catatonic state and contractures and uses a pressure pad call light for assistance. Observation on 06/24/25 at 9:30 A.M. revealed pressure pad call light located on the floor and resident was unable to call for assistance. Interview on 06/24/25 at 9:32 A.M. with Certified Nursing Assistant (CNA) #52 verified pressure pad call light on floor. CNA #52 replaced call light next to contracted arm so resident could activate if needed. 2. Review of medical record for Resident #122 revealed an admission date of 06/19/25 with diagnoses including infection of skin and subcutaneous tissue, sepsis, staphylococcus and pseudomonas infections (highly resistant bacterial organisms which require extended antibiotics), morbid obesity, protein-calorie malnutrition, chronic kidney disease, and muscle weakness. Review of MDS dated [DATE] revealed Resident #122 was alert, oriented, appropriate and no behavioral concerns. MDS also revealed Resident #122 required maximum assistance for ADLs, mobility, and hygiene needs due to deconditioning and morbid obesity. Interview and observation on 06/25/25 at 9:11 A.M. revealed Resident #122 complained of having a wet gown and needed to be changed. Resident was unable to reach call light for assistance. Call light was observed to be wrapped around the side of the bed rail near head of bed and out of reach for resident. Interview on 06/25/25 at 9:13 A.M. with CNA #84 verified call light was out of reach for resident. Call light was repositioned and secured on bed within reach for resident. Review of facility policy titled Resident Communication and Call Light Policy revised on 02/24/2023 revealed when resident is in bed or confined to a chair, the call light will be within easy reach.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on record review, observation, and interview, the facility failed to honor resident preferences as ordered by the physician. This affected one resident (#19) out of two reviewed for choices. The facility census was 63. Findings include: Review of the medical record for Specified Resident #19 revealed an admission date of 10/22/24 with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, convulsions, hyperlipidemia, hypertension, depression, aphasia, muscle weakness, need for assistance with personal care, and difficulty in walking. Review of the quarterly Minimum Data Set (MDS) assessment, dated 04/18/25, revealed Resident #19 had severely impaired cognition. The assessment indicated Resident #19 required partial or moderate assistance for eating, oral hygiene, and personal hygiene; required substantial or maximum assistance for rolling left and right, sit to lying, and lying to sitting; and was totally dependent on staff for toileting hygiene, showering or bathing self, dressing, and chair/bed to chair transfer. Review of the optional state MDS assessment, dated 04/18/25, revealed Resident #19 required extensive assistance of two staff for bed mobility and total dependence of two staff for transfers. Review of the physician's orders for June 2025 identified orders for crush medications and split in divided amounts with pudding or yogurt only (ordered 12/28/24) and resident to be up before lunch and down after lunch as tolerated (ordered 04/02/25). Review of the progress note dated December 2024 through June 2025 revealed multiple documented instances of Resident #19 refusing his medications. Review of the progress note dated 12/08/24 at 12:12 P.M. revealed Resident #19 refused all morning medications crushed in applesauce because yogurt was unavailable. Review of the progress note dated 12/27/24 at 6:59 P.M. revealed medications were to be crushed and administered with pudding or yogurt. Review of the progress note dated 04/02/25 at 10:28 A.M. revealed Resident #19's representative was in agreement with getting the resident up before lunch and going down after lunch as long as Resident #19 agrees. Review of the progress note dated 04/12/25 at 4:59 A.M. revealed Resident #19 refused his medications and the resident indicated he would take them if the nurse put them in yogurt. On 06/23/25 at 12:45 P.M., an observation of Resident #19's room revealed he was sitting in bed feeding himself a hamburger. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/26/25 at 8:51 A.M., an interview with Licensed Practical Nurse (LPN) #45 revealed Resident #19's medications had been administered with applesauce that morning because the facility was out of yogurt. LPN #45 confirmed Resident #19's preference was for medications to be administered with yogurt instead of applesauce. On 06/26/25 at 9:03 A.M., an interview with Regional Dietary Manager #82 revealed there was yogurt available. Observation at the time of interview revealed a sufficient supply of yogurt in the walk-in refrigerator in the kitchen. On 06/26/25 at 9:05 A.M., an interview with the Director of Nursing (DON) confirmed Resident #19 preferred to take his medications with yogurt instead of applesauce. On 06/26/25 at 10:35 A.M., an interview with the DON confirmed Resident #19 had a physician's order to provide medications in pudding or yogurt only. The DON further revealed there was probably no yogurt in the second floor servery and LPN #45 did not go downstairs to look in the kitchen for yogurt. On 06/30/25 at 12:31 P.M., an observation of Resident #19 revealed he was in bed feeding himself a cheeseburger. On 06/30/25 at 12:40 P.M., an interview with LPN #55 confirmed staff did not get Resident #19 out of bed before lunch. LPN #55 further stated she's not aware of staff ever getting Resident #19 out of bed before lunch in the entire time she had worked at the facility (eight months). LPN #55 verified she signed the MAR/TAR as completed for getting him out of bed despite staff not getting him out of bed on multiple days. LPN #55 also verified there were no documented refusals for Resident #19 getting out of bed. On 07/01/25 at 12:07 P.M., an observation of Resident #19's room revealed he was in bed and Social Services Designee (SSD) #13 was delivering his lunch to him in bed. On 07/01/25 at 12:10 P.M., an interview with SSD #13 confirmed Resident #19 was eating lunch in bed. On 07/02/25 at 12:34 P.M., an observation of Resident #19's room revealed he was in bed feeding himself a cheeseburger. On 07/02/25 at 2:13 P.M., an interview with LPN #44 confirmed Resident #19 had not been out of bed all day, verified she signed the MAR/TAR as completed for getting him out of bed despite staff not getting him out of bed, and LPN #44 said she signed it off as completed because she offered it. LPN #44 claimed Resident #19 refused to get out of bed and confirmed there was no documentation of the refusal. This deficiency represents non-compliance investigated under Master Complaint Number OH00165594.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure notice of transfer and bed hold notice was provided to the resident, and the discharge summary was completed. This affected six Residents #28, # 46, #55, #66 #118, and #119 of eight residents reviewed for hospitalization and discharge. Findings include: 1. Review of the medical record for Resident #28 revealed an admission date 05/02/24 with diagnoses including diabetes type II, puerperal vascular disease (PVR), hypertension, anxiety, depression, and bipolar. The record revealed Resident #28 was sent out to the hospital on [DATE].Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #28 had intact cognition and was dependent on staff for activities of daily living. Review of the Immediate Transfer/Discharge, a written discharge notice to the resident/representative dated 05/13/25 revealed that the welfare and needs of the resident cannot be met in the facility due to the urgent medical needs of the resident. There was no evidence that the resident/representative received the written discharge notice. Interview on 06/26/25 at 1:13 P.M. with Receptionist #9 stated when a resident is sent out to the hospital, the Immediate Transfer/Discharge Notice is added to the packet of information that goes with the resident to the hospital. Interview with the Administrator on 06/26/25 at 1:15 P.M. verified there was no way to ensure the residents received the written notice. The Administrator stated the facility had identified the transfer discharge notices as a part of Quality Assurance (QA) project. The Administrator stated she had instructed the receptionist to put a copy of the discharge transfer notice in with the hospital paperwork with every person who leaves 911. Interview on 06/26/25 at 1:32 P.M. with Resident #28 stated he had never seen the Immediate Transfer/Discharge form. 2. Review of the medical record for Resident #46 revealed an admission date 8/15/24 with diagnoses including chronic respiratory failure, quadriplegia, neuromuscular bladder, tracheostomy status. The record revealed Resident #46 was sent to the emergency room on [DATE], 05/16/25, and 05/24/25.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #46 had intact cognition and was dependent on staff for activities of daily living. Review of the Immediate Transfer/Discharge, the discharge notice to the resident/representative dated 04/10/25, 05/16/25, 05/24/25 revealed the welfare and needs of the resident cannot be met in the facility due to the urgent medical needs of the resident. There was no evidence that the resident/representative received the written notice. Interview on 06/26/25 at 1:13 P.M. with Receptionist #9 stated when a resident is sent out to the hospital the Immediate Transfer/Discharge Notice is added to packet of information that goes with the resident.Interview on 06/26/25 at 4:30 P.M. with Resident # 46 stated he had never seen the Immediate Transfer/Discharge form. Interview on 06/26/25 at 1:13 P.M. with Receptionist #9 stated when a resident is sent out to the hospital, the Immediate Transfer/Discharge Notice is added to the packet of information that goes with the resident to the hospital. Interview with the Administrator on 06/26/25 at 1:15 P.M. verified there was no way to ensure the residents received the written notice. The Administrator stated the facility had identified the transfer discharge notices as a part of Quality Assurance (QA) project. The Administrator stated she had instructed the receptionist to put a copy of the discharge transfer notice in with the hospital paperwork with every person who leaves 911. 3. Review of the medical record for Resident #66 revealed an admission date 04/09/25 with diagnoses including respiratory failure, cocaine use, chronic obstructive pulmonary disease (COPD), tracheostomy status a gastrostomy. The record revealed Resident #66 was sent to the emergency room on [DATE]. Further review of the discharge documentation revealed there was no evidence of a bed hold notice or Immediate Transfer/Discharge notice, the written notice to the representative provided on 04/11/25.Interview on 07/02/25 at 1:30 PM with the Administrator verified the Resident #66 did not receive a written notice of transfer or a bed hold notice. 4.Review of the medical record for Resident #119 revealed an admission date 04/09/25 with diagnoses including paroxysmal atrial fibrillation, cancer of the colon, respiratory failure, type II diabetes and ileostomy status. The Resident was discharges on 4/17/25. Further review of the medical record revealed there was no evidence of an Immediate Transfer/Discharge form, a written notice of discharge to the resident/representative. Interview on 07/02/25 at 9:30 A.M. with the Administrator verified there was no evidence of a written discharge notice issued to Resident #119. Review of the facility policy titled Resident discharge/transfer letter policy revised 12/09/24 stated the facility will complete discharge letter appropriately and according to all federal, state and local regulation. 6. Review of the medical record for Resident #55 revealed an admission date of 02/19/25 with diagnoses including cerebral infarction

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. Review of medical record for Resident #118 revealed an admission date of 02/13/25 with a diagnoses including acute and subacute endocarditis, methicillin resistant staph aureus (a highly resistant organism), anxiety, obesity, obstructive sleep apnea, hypertension, congestive heart failure, pacemaker, dysphagia, and muscle weakness. Review of Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15 which is indicative of the resident having full cognition. Resident #118 needed partial/moderate assistance with activities of daily living (ADLs) and hygiene needs. Resident used a wheelchair for mobility and was able to self-propel. Review of baseline care plan dated 02/14/25 revealed goals of safety, nutritional status, medication and activities. Review of medical record revealed no discharge summary or discharge planning process was completed by facility as required. Interview with Administrator on 06/30/25 at 1:57 P.M. verified that Resident #118 did not have a discharge summary completed at the facility per requirement.Review of facility policy titled, Resident Discharge/Transfer Letter Policy revised 12/09/24 revealed discharge notices must have the following components: 1. Reason for discharge 2. The effective date of transfer/discharge, 3. The location to which the resident is transferred/discharge.

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations and interviews, the facility failed to provide meaningful resident-centered activities for Resident #57. This affected one (Resident #57) out of three residents reviewed for activities. The facility census was 63. Findings include: Review of the medical record for Resident #57 revealed an admission date of 01/09/25 with diagnoses of metabolic encephalopathy, moderate protein-calorie malnutrition, dysphagia, and type two diabetes mellitus. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #57 was cognitively impaired, rarely or never able to make needs known, and rarely or never understood communication. The assessment indicated that she was dependent upon two staff members to move in bed, take a shower or bath, and dependent on one staff member for dressing. Review of the current physician's orders revealed no pharmacological intervention for anxiety, agitation, or restlessness. Review of progress notes since admission revealed no evidence of anxiety or restlessness. Review of Resident #57's care plan revealed no evidence of anxiety, agitation, or restlessness addressed. Review of the activities care plan for Resident #57 revealed that she preferred activities that identify with her prior lifestyle. The identified goal was that Resident #57 would express satisfaction with daily routine and leisure activities. The identified interventions were to allow her to express her feelings and to interact with peers that have similar interests. Review of an activity assessment dated [DATE] for Resident #57 authored by Life Enrichment Director (LED) #4 revealed that Resident #57 interacted with team members during care and received a minimum of two visits per week from friends and family resulted in an assessment score of two. Per the facilities assessment a score of two required Resident #57 to receive two one-on-one visits per week. Review of the one-on-one activities visit documentation for Resident #57 provided by LED #4 with the following findings. 04/05/25 Resident #57 made eye contact, 04/19/25 Resident #57 refused, 04/26/25 Resident #57 refused, 05/03/25 Resident #57 made eye contact and verbal sounds, 05/17/25 Resident #57 refused, 05/21/25 Resident #57 made eye contact, verbal sounds and soft music was played, 05/31/25 Resident #57 refused, 06/07/25 Resident #57 refused, 06/21/25 Resident #57 refused, 06/21/25 Resident #57 made eye contact activities held her hand and applied lotion. No other documentation was provided. Visitation records were not signed to verify who provided these activities. During an observation on 06/23/25 at 10:30 A.M. Resident #57 was in bed lying on her left side, an enteral feeding pump was alarming, and the formula was not infusing. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 06/23/25 at 12:52 P.M. MDS Nurse #11 walked into Resident #57's room. The enteral feeding pump ceased beeping. MDS Nurse #11 verified that the pump was not infusing formula, that she restarted it and could not say how long the pump was beeping. During an observation 06/24/25 from 8:00 A.M. until 1:13 P.M. revealed Resident #57 lying on her left side without positioning device or pillows to relieve pressure or provide support. No staff members were observed entering Resident #57's room during this observation. An interview on 06/24/25 at 2:43 P.M. with Certified Nursing Assistant (CNA) #58 revealed that the CNAs check and change Resident #57 about every three hours or so. CNA #58 shared that Resident #57 required a Hoyer (mechanical) lift for transfer, but Resident #57 usually wasn't gotten out of bed. CNA #58 was unable to state why they did not get Resident #57 out of bed. An observation on 06/25/25 7:41 A.M. revealed Resident #57 lying on her back with legs bent at the knees without support for legs. Continued observations at 10:00 A.M., 12:30 P.M. and 4:03 P.M. revealed Resident # 57 to be in the same position. An interview on 06/26/25 at 7:52 A.M. LED #4 shared that residents who could not come to activities due to medical reasons or that preferred to stay in their rooms received one-on-one activities in their room. Some examples of one-on-one activities were puzzles, coloring pages, books, conversation, and playing music of the resident's choice. All residents were interviewed to find out what their preferred activities were, and a one-on-one visitation needs assessment was completed for residents that required one-on-one activities. Further shared that for Resident #57 it was more difficult to assess her preferences due to their lack of cognition and meaningful verbalization. We usually do one-on-one activities two to three times a week with her. For activity, we talk to her, she could nod or say yes/no responses. Lastly, she shared that the staff interacted with her while providing care, and she received visits from her husband. On 06/26/25 at 1:49 P.M. an interview with LED #4. verified that handwritten activity assessment that LED #4 provided was not dated or signed. LED #4 was unable to verify when the assessment was completed. Further verified that the handwritten assessment did not match the one in Matrix dated 04/04/25 and that the assessment in Matrix was the most accurate assessment. LED #4 shared that Resident #57 refused activities by frowning if they did not want to participate and was often asleep when activities staff approached them. LED #4 indicated that she did not think that being asleep was the same thing as refusal of the activity but could not verify if Resident #57 was reapproached while awake. An interview on 06/30/25 at10:36 A.M. with the Director of Nursing (DON) revealed that Resident #57 is a mechanical lift for transfers. The DON shared that this information was in Matrix for the CNAs to access. The DON verified that Resident #57 was not on bed rest. It was the expectation that she be dressed in street clothes and out of bed per the resident's wishes, but Resident #57 often did not want to be bothered. The DON further shared that Resident #57 got restless and could only be up in a chair for short periods of time before she became agitated. This deficiency represents non-compliance investigated under Complaint Number OH00165427.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, policy review, and review of the employee handbook, the facility failed to ensure staff performed transfers in a safe manner per physician's orders and re-assess fall risk after a fall occurred. This affected one resident (#19) out of four reviewed for accident hazards. The facility census was 63. Findings include: Review of the medical record for Resident #19 revealed an admission date of 10/22/24 with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, convulsions, hyperlipidemia, hypertension, depression, aphasia, muscle weakness, need for assistance with personal care, and difficulty in walking. Review of the physician's orders for Resident #19 identified an order for a mechanical lift for transfers (ordered 10/23/24). Review of the most recent fall risk assessment, dated 10/23/24, revealed Resident #19 had no falls within the previous six months, was completely paralyzed or completely immobilized, and had a score of 0.0 indicating low fall risk. Review of the progress note dated 12/17/24 at 1:38 P.M. revealed Resident #19's roommate notified staff that Resident #19 was on the floor. Resident #19 was found laying on his back to the side of his bed. Resident #19 had no indicators or complaints of pain, answered yes/no questions indicating he was trying to get out of bed, and denied hitting his head. The note dated 12/17/24 at 10:57 P.M. revealed Resident #19 returned to the facility. The note dated 12/19/24 at 1:45 P.M. revealed Resident #19 returned to the facility following a transfer to the emergency room after experiencing a fall on 12/17/24. There was no documentation of a new fall risk assessment after Resident #19 sustained a fall on 12/17/24. Review of a video from the in-room camera dated 01/21/25 revealed Resident #19 was laying on the floor beside his bed. After the nurse assessed Resident #19 for injury, the video showed Certified Nursing Assistant (CNA) #60 and CNA #76 getting Resident #19 off the floor by lifting him under his arms. At no point was a mechanical lift used while transferring Resident #19 back into bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress note dated 01/21/25 at 9:30 P.M. revealed Resident #19 had a fall in his room, was assessed with no injuries identified, and the resident had no indicators or complaints of pain. The progress note dated 01/22/25 at 10:03 A.M. revealed the interdisciplinary team (IDT) reviewed Resident #19's fall from 01/21/25. Resident #19 was found on the floor in his room, was unable to state what he was attempting to do, had been in bed prior to the fall, and did not have any injuries after the fall. New interventions included low bed, bed against wall, mat to floor on open side of bed, and perimeter mattress to bed. The progress note dated 01/22/25 at 2:29 P.M. revealed Resident #19's representative was agreeable to the placement of a perimeter mattress. Resident #19's representative stated she did not want Resident #19's bed to be placed against the wall. The progress note dated 01/24/25 at 1:24 P.M. revealed the IDT reviewed the request from Resident #19's representative that the bed not be placed against the wall. There was no documentation of a new fall risk assessment after Resident #19 sustained a fall on 01/21/25. Review of the progress note dated 02/01/25 at 4:15 A.M. revealed Resident #19 was found sitting on the floor next to his bed, there was no apparent injury, and close observation would continue. Review of the IDT note dated 02/06/25 at 11:39 A.M. revealed Resident #19's fall was reviewed, the resident was unable to state what he was doing prior to the fall, no new safety devices were recommended by IDT, and therapy would assess for appropriateness of reacher in regards to ability to use. There was no documentation of a new fall risk assessment after Resident #19 sustained a fall on 02/01/25. Review of a video from the in-room camera dated 01/25/25 revealed CNA #46 and CNA #58 transferred Resident #19 from the bed to an electronic wheelchair utilizing a gait belt. At no point was a mechanical lift used while transferring Resident #19 into his wheelchair. Review of the quarterly Minimum Data Set (MDS) assessment, dated 04/18/25, revealed Resident #19 had severely impaired cognition. The assessment indicated Resident #19 required partial or moderate assistance for eating, oral hygiene, and personal hygiene; required substantial or maximum assistance for rolling left and right, sit to lying, and lying to sitting; and was totally dependent on staff for toileting hygiene, showering or bathing self, dressing, and chair/bed to chair transfer. The assessment indicated Resident #19 had one fall with no injury since the last assessment. Review of the optional state MDS assessment, dated 04/18/25, revealed Resident #19 required extensive assistance of two staff for bed mobility, total dependence of two staff for transfers, supervision with setup assist for eating, and total dependence of two staff for toilet use. Review of the physical therapy Discharge summary dated [DATE] revealed Resident #19 required a hoyer mechanical lift for transfers and was dependent on staff for basic mobility. Resident #19 was discharged from physical therapy due to progress ceased. Review of a video from the in-room camera dated 06/15/25 showed two staff members, Certified Nursing Assistant (CNA) #55 and CNA #58, in Resident #19's room during a hoyer mechanical lift transfer. While operating the hoyer mechanical lift to lift Resident #19 out of bed, CNA #55 grabbed her cell phone, propped the phone between her shoulder and her ear, and continued operating the hoyer mechanical lift while talking on the phone. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/25/25 at 3:38 P.M., review of the video dated 06/15/25 with the Administrator verified CNA #55 operated the hoyer mechanical lift to transfer Resident #19 while talking on her cell phone. On 06/26/25 at 10:45 A.M., review of the videos dated 01/21/25 and 01/25/25 with the Director of Nursing (DON) verified CNAs #46, #58, #60, and #76 all transferred Resident #19 without utilizing a hoyer mechanical lift. The DON further stated the facility did not have a specific policy or protocol detailing what to do after a fall occurs. On 06/26/25 at 10:50 A.M., an interview with the Administrator stated Resident #19's wife did not want Resident #19 to be transferred via mechanical lift. The Administrator verified Resident #19's care plan indicated the resident required a mechanical lift for transfers. The Administrator also reviewed and verified the contents of the videos from 01/21/25 and 01/25/25 at that time. On 06/26/25 at 12:20 P.M., an interview with the DON stated all staff were reporting to her that Resident #19's wife was insistent that staff not utilize a hoyer mechanical lift for transfers because Resident #19's wife wanted him transferred with a gait belt. The DON confirmed therapy had not cleared Resident #19 to be transferred with anything other than a hoyer mechanical lift. On 06/30/25 at 10:22 A.M., an interview with the DON confirmed Resident #19 did not have any new fall risk assessments after experiencing falls. The DON stated after a fall occurs, the IDT reviews the fall and a fall meeting occurs with therapy. The DON further stated no new fall risk assessment was completed that would give a new fall risk score. The DON also confirmed there was no mention of increased fall risk following the falls in January 2025 and February 2025. Review of the facility's employee handbook, dated 01/01/21, revealed the nature of the business of the facility did not allow for personal telephone calls during working hours. The unauthorized use of personal cellular phones or pagers while working in the facility was strictly prohibited and they may be confiscated until the end of the employee's shift. Review of the facility's policy titled Mechanical Lift Policy, dated 01/07/22, revealed a mechanical lift may be used for transferring residents that could not be safely transferred by themselves or with staff assistance. The resident's transfer status would be assessed on admission, quarterly, and as needed with any changes in the resident's transfer ability. Two staff person assist would be required for total body lifts. Any resident who could not be elevated from the floor utilizing contact guard or minimal assist would be lifted from the floor using a mechanical lift only. Review of the facility's policy titled Fall Prevention and Management Policy, dated 08/06/24, revealed residents would be assessed for fall risk on admission, quarterly, and as needed. All falls would be reviewed by the IDT, any new interventions would be implemented, and the care plan would be updated as necessary. The IDT review should include the results of the new fall risk assessment, discussion with the resident and/or any witnessing parties and to potential causal factors, review of the environment where the fall occurred, and discussion as to any new interventions which may help prevent further falls. This deficiency represents non-compliance investigated under Master Complaint Numbers OH00165594 and Complaint Number OH00165427.

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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 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and observations, the facility failed to ensure that colostomy care was provided as ordered and per resident's preference. This affected one resident (Resident #26) out of two residents reviewed for ostomy care. Findings include: Review of medical record revealed that Resident #26 was admitted on [DATE] with diagnosis of heart failure, weakness, polyneuropathy, and major depression. Review of the annual Minimum Data Set (MDS) dated [DATE] Resident #26 was alert and oriented without cognitive impairment. They were dependent upon staff for toilet hygiene, shower and bath, as well as personal hygiene. Resident #26 was always incontinent of bladder and had a colostomy for bowel movements. Review of physician's orders reveal an order dated 01/26/25 to empty the colostomy bag every shift. Report any changes noted such as changes is color of stool, amount of stool, or consistency of stool. Document emptying contents and any changes noted. Review of the comprehensive care plan updated 05/12/25 revealed that per resident's preference empty colostomy pouch, empty all stool, rinse well with water, make sure no stool is left inside the pouch. Reapply the pouch to the wafer. If it remained unclean, replace the pouch with a new one. Review of point of care history for Certified Nursing Assistant (CNA) documentation revealed instructions to the CNA, per Resident's preference, empty colostomy pouch, empty all stool, rinse well with water (make sure no stool left inside pouch) reapply pouch to wafer. If it remained unclean place a new pouch on. The documents provided indicated that the colostomy bag was emptied as follows: 05/27/25 The colostomy pouch was emptied on day shift but not night shift 05/28/25 The colostomy pouch was emptied on both shifts 05/29/25 The colostomy pouch was emptied on both shifts 05/30/25 No evidence that the colostomy pouch was emptied 05/31/25 No evidence that the colostomy pouch was emptied 06/01/25 No evidence that the colostomy pouch was emptied 06/02/25 The colostomy pouch was emptied on day shift but not on night shift 06/03/25 The colostomy pouch was emptied on both shifts 06/04/25 The colostomy pouch was emptied on day shift but not night shift (continued on next page)

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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 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	06/05/25 The colostomy pouch was emptied on night shift but not day shift 06/06/25 The colostomy pouch was emptied on night shift but no day shift 06/07/25 The colostomy pouch was emptied on day shift but not night shift 06/10/25 The colostomy pouch was emptied on both shifts 06/11/25 The colostomy pouch was emptied on day shift but not night shift 06/12/25 The colostomy pouch was emptied on day shift but not night shift 06/13/25 The colostomy pouch was emptied on both shifts 06/14/25 through 06/16/25 There was no evidence that the colostomy pouch had been emptied 06/17/25 The colostomy pouch was emptied on night shift but not day shift 06/18/25 There was no evidence that the colostomy pouch was emptied 06/19/25 The colostomy pouch was emptied on night shift but not on day shift 06/20/25 through 06/23/25 There was no evidence that the colostomy pouch was emptied 06/24/25 The colostomy pouch was emptied on night shift but not on day shift An interview on 06/23/25 at 9:30 A.M. with Resident #26 revealed hey had a colostomy bag that didn't get emptied or cleaned the way it was supposed to. Resident #26 further shared that if the colostomy pouch was not emptied often enough the pressure from gas and fecal matter kept the stoma from draining and that they became experienced nausea. They shared that when the pouch was emptied, the pouch should be taken off the wafer, rinsed and cleaned out. They stated that the CNAs often just open the bottom of the bag and don't clean the pouch out. An interview on 06/24/25 at 02:43 PM with CNA #58 revealed that they only emptied the colostomy pouch if a nurse told them to. CNA #58 reported that they just opened the bottom pouch and emptied it into another bag. Further they shared they received the usual training from the nurse about how to empty Resident #26 colostomy pouch. An observation on 06/25/25 at 03:33 P.M. of Resident #26 revealed their colostomy pouch to be puffed up with large amount of gas and more than half full of feces. Resident #26 revealed her pouch had not been emptied on night shift or day shift this day. An interview on 06/25/25 at 03:49 PM with Assistant Director of Nursing (ADON) #8 revealed Resident #26 was alert, oriented and a reliable source of information. ADON #8 verified that there was no evidence of CNA documentation for emptying the resident's colostomy bag for multiple days and shift and could not verify that the care was provided. This deficiency represents non-compliance investigated under Complaint Number OH00165230.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, policy review, and interview, the facility failed to provide evidence that enteral tube feedings were administered to prevent weight loss. This affected two residents (#57 and #60) out of three reviewed for tube feeding. The facility also failed to obtain weekly weights as ordered. This affected four residents (#11, #20, #57, and #60) out of six reviewed for nutrition. The facility also failed to provide adequate hydration to prevent dehydration. This affected one resident (#11) out of three reviewed for hydration. The facility census was 63.Actual harm occurred on 06/16/25 when Resident #60, who had severe cognitive impairment and required enteral tube feeding to meet nutritional needs, sustained a 20.6 pound weight loss (in 34 days) as a result of the facility's failure to accurately monitor and record tube feed intakes, obtain weekly weights as ordered, and adjust tube feeding rate timely to prevent further weight loss. On 05/01/25, Resident #60 weighed 207.2 pounds. On 05/07/25 and 05/13/25, Resident #60 weighed 207.0 pounds. On 05/22/25, Resident #60 weighed 197.8 pounds, which was a weight loss of 9.2 pounds (4.4%) in 9 days. On 06/16/25, Resident #60 weighed 186.4 pounds, which was a further weight loss of 11.4 pounds (5.8%) and there was no evidence that the facility had been monitoring Resident #60's weight between 05/22/25 and 06/16/25 or that adjustments had been made to the tube feeding order to prevent further weight loss. The weight loss continued and on 06/19/25 the resident was assessed to sustain an additional weight loss of 7.0 pounds (3.8%) with a recorded weight of 179.4 pounds. Resident #60 sustained a severe weight loss of 13.4% since admission (in 51 days). Findings include: 1. Review of the medical record for Resident #60 revealed an admission date of 04/30/25 with diagnoses including aspiration pneumonia, lung cancer, cerebral infarction, dysphagia, laryngeal cancer, aphasia, and dysarthria. Review of the medical nutritional therapy assessment, dated 05/02/25, revealed Resident #60 received nothing by mouth (NPO) and required a feeding tube to meet nutritional needs. The assessment indicated Resident #60 required 2184 to 2589 calories, 81 to 97 grams of protein, and 2427 to 2832 milliliters (ml) of fluid daily. The nutritional goals included no unplanned significant weight changes, tube feeding formula and flushes as ordered, and weekly weights for four weeks. Review of the nutrition care plan, initiated 05/05/25, revealed Resident #60 was at increased nutritional risk related to gastric tube use, lung and laryngeal cancer, pneumonia, cerebral infarction, dysphagia, hemiplegia, overweight, requiring enteral feedings for nutrition and hydration, and malnutrition. Interventions included but were not limited to: check tube placement prior to medication or tube feeding administration (05/05/25), monitor for complications such as diarrhea, gastric distention, aspiration, and report complications to the physician (05/05/25), monitor labs per orders (05/05/25), monitor need for increased nutritional interventions related to diagnoses, tube feeding, medications, and other listed problems (05/05/25), monitor for signs and symptoms of dehydration such as poor skin turgor, cracked lips, thirst, fever, and abnormal labs (05/05/25), monitor weight per protocol (05/05/25), provide diet as ordered (05/05/25), provide tube feeding as ordered (05/05/25), provide tube feeding and medication flushes as ordered (05/05/25), and report 5% weight loss or gain to the physician and Registered Dietitian (RD) (05/05/25). The nutrition care plan was last reviewed and revised on 05/05/25 at 2:02 P.M. by RD #83. Review of the admission Minimum Data Set (MDS) assessment, dated 05/06/25, revealed Resident #60 had severe cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 00. The assessment also indicated Resident #60 received 51% or more of daily calories from tube feeding and 501 milliliters (ml) or more of daily fluid from tube feeding.Review of the physician's orders for Resident #60 identified orders for NPO (ordered 04/30/25), weekly weights for four weeks (ordered 04/30/25, discontinued 06/03/25), bolus enteral feedings of Isosource to infuse 360ml every six hours via enteral tube, flush with 30ml of water after the bolus feed, and record amounts (ordered 04/30/25, discontinued 05/01/25), bolus enteral feedings of Isosource 1.5 to infuse 360ml every six hours via enteral tube for a total of 1440ml of formula providing 2160 calories, flush with 30ml of water after the bolus feed, and record amounts (ordered 05/01/25, discontinued 05/02/25), bolus enteral feedings of Isosource 1.5 to infuse 400ml every six hours via enteral tube for a total of 1600ml of formula providing 2400 calories, flush with 30ml of water after the bolus feed, and record amounts (ordered 05/02/25, discontinued 06/19/25), and bolus enteral feedings of Isosource 1.5 to infuse 500ml every six hours via enteral tube for a total of 2000ml of formula providing 3000 calories, flush with 30ml of water after the bolus feed, and record amounts (ordered 06/19/25). Physician's orders for routine tube feeding flushes were separate from the enteral formula orders and were as follows: free water flushing

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F 0692 Level of Harm - Actual harm Residents Affected - Few	2. Review of the medical record for Resident #57 (R #57) revealed an admission date of 01/09/25 with diagnoses of metabolic encephalopathy, moderate protein-calorie malnutrition, dysphagia, and type two diabetes mellitus.Review of the quarterly minimum data set (MDS) assessment dated [DATE] revealed R #57 was cognitively impaired, rarely or never able to make needs known, and rarely or never understood communication. The assessment indicated that she was dependent upon two staff members to move in bed, take a shower or bath, and dependent on one staff member for dressing. Review of the physician's orders revealed no pharmacological intervention for anxiety, agitation or restlessness, and no as needed medication for bowel regime. Further review of the physician's orders for June 2025 for R #57 identified orders for Diabetisource AC at 60 milliliters (ml) per hour for 22 hours to provide 1320ml formula and 1584 calories daily (ordered 03/17/25, discontinued 06/30/25), and Diabetisource AC at 65 ml per hour for 22 hours to provide 1,430ml formula and 1,716 calories daily (order dated 06/30/25).Review of medical nutritional therapy assessment, authored by Registered Dietitian (RD) #83 and dated 04/03/25, revealed R #57 received nothing by mouth (NPO) and required a feeding tube to meet nutritional needs. The assessment indicated the ordered enteral feeding would provide 1,584 calories, 79 milligrams (mg) of protein, 1,077 milliliters (ml) of free fluids plus flushes to total 1,977 ml daily. The estimated nutritional needs portion of the assessment was blank and there were no nutritional needs specified. The nutritional goals included tolerance to enteral feedings, no signs or symptoms of dehydration, and no significant weight changes. Review of lab results dated 05/08/25 revealed a basic metabolic panel (BMP) and a complete blood count (CBC) was obtained with results essentially within expected range for diagnosis and no new orders were obtained. Review of the lab results dated 06/05/25 revealed a BMP, CBC and hemoglobin A1C were obtained, and all results were within expected range and no new orders were written. There was no evidence that a Pre-Albumin level was obtained.Review of weights for R #57 revealed a weight loss of 4.8% within 30days. The documented weights were as follows: 152.0 pounds on 05/06/25, 154.2 pounds on 06/09/25, and 146.8 pounds on 06/26/25.Review of the Medication Administration Record (MAR) for R #57 for June 2025 revealed the following: On 06/09/25, 300ml of Diabetisource AC was administered, which provided a daily total of 360 calories (a deficit of 1224 calories from what was ordered).On 06/11/25, 300ml of Diabetisource AC was administered, which provided a daily total of 360 calories (a deficit of 1224 calories from what was ordered).On 06/12/25, 300ml of Diabetisource AC was administered, which provided a daily total of 360 calories (a deficit of 1224 calories from what was ordered).On 06/14/25, 750ml of Diabetisource AC was administered, which provided a daily total of 900 calories (a deficit of 684 calories from what was ordered). On 06/15/25, 810ml of Diabetisource AC was administered, which provided a daily total of 972 calories (a deficit of 612 calories from what was ordered).On 06/16/25, 300ml of Diabetisource AC was administered, which provided a daily total of 360 calories (a deficit of 1224 calories from what was ordered).On 06/17/25, 810ml of Diabetisource AC was administered, which provided a daily total of 972 calories (a deficit of 612 calories from what was ordered).On 06/18/25, 810ml of Diabetisource AC was administered, which provided a daily total of 972 calories (a deficit of 612 calories from what was ordered).On 06/19/25, 300ml of Diabetisource AC was administered, which provided a daily total of 360 calories (a deficit of 1224 calories from what was ordered).On 06/21/25, 300ml of Diabetisource AC was administered, which provided a daily total of 360 calories (a deficit of 1224 calories from what was ordered).On 06/22/25, 300ml of Diabetisource AC was administered, which provided a daily total of 360 calories (a deficit of 1224 calories from what was ordered).On 06/23/25, 300ml of Diabetisource AC was administered, which provided a daily total of 360 calories (a deficit of 1224 calories from what was ordered).On 06/24/25, 870ml of Diabetisource AC was administered, which provided a daily total of 1044 calories (a deficit of 540 calories from what was ordered). On 06/25/25, 300ml of Diabetisource AC was administered, which provided a daily total of 360 calories (a deficit of 1224 calories from what was ordered).On 06/26/25, 300ml of Diabetisource AC was administered, which provided a daily total of 360 calories (a deficit of 1224 calories from what was ordered).On 06/27/25, 870ml of Diabetisource AC was administered, which provided a daily total of 1044 calories (a deficit of 540 calories from what was ordered).On 06/28/25, 1260ml of Diabetisource AC was administered, which provided a daily total of 1512 calories (a deficit of 72 calories from what was ordered).On 06/29/25, 660ml of Diabetisource AC was administered, which provided a daily total of 792 calories (a deficit of 792 calories from what was ordered) Review of bowel tracking records for R #57 from 06/20/25 through 06/29/25

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, interview, and facility policy review, the facility failed to ensure pain medications were administered timely to ensure effective pain management. This affected one resident (#120) out of eight residents reviewed for medication administration. The facility census was 63. Findings include: Review of medical record for Resident #120 revealed an admission date of 04/15/25 with diagnoses including pathological fractures, malignant neoplasm's of bone, malignant neoplasm of bladder, protein-calorie malnutrition, urostomy, and need for assistance with personal care. Review of Resident #120's Minimum Data Sheet (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 15 indicating intact cognition. Resident #120 required moderate assistance for upper body activities of daily living (ADLs) and maximum assistance for lower body and mobility needs. Resident #120 also needed maximum assistance for toileting and hygiene needs. Review of care plan dated 05/01/25 revealed Resident #120 had chronic pain related to cancer and fractures. Interventions included the administration of pain medications per physician order and evaluate the effectiveness. Review of Resident #120's physician orders dated 04/15/25 revealed Morphine Extended Release 15 milligrams was ordered to be a scheduled medication administered twice daily from 7:00 A.M. to 11:00 A.M. and from 7:00 P.M. to 11:00 P.M., not as needed. Review of Resident #120's Medication Administration Record (MAR) revealed the resident did not receive any scheduled morphine doses on 04/15/25 or 04/16/25 in the morning as required. Resident #120 received one dose of Acetaminophen 325 milligrams on 04/16/25 at 6:58 A.M. for a pain score of four and a follow-up pain assessment of four with no relief. Further review of the MAR noted Resident #120 received the first dose of scheduled Morphine on 04/16/25 during the evening between 7:00 P.M. and 11:00 P.M. Further review of Resident #120's medical record revealed no documented evidence of new interventions for pain management while Resident #120 was awaiting his Morphine ER medication and while the Acetaminophen medication was ineffective. Interview with Licensed Practical Nurse (LPN) #19 on 06/24/25 at 1:45 A.M. verified the pharmacy delivers twice daily. She stated the facility also kept a variety of frequently used medications and antibiotics in stock to use if resident medications were unavailable. Those were kept in the medication storage room. Interview with LPN #23 on 06/24/25 at 2:00 P.M. revealed if there was a stat order, the pharmacy could make an emergency drop of the medication. If something was not available, the Omnicare Pharmacist would reach out to other sites for availability or notify physician of possible replacement. Interview with LPN #23 on 06/24/25 at 2:35 P.M. verified that pharmacy dropped off medications twice daily, once at 5:00 P.M. and another during the night. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Nursing (DON) on 06/30/25 at 10:20 A.M. verified the missing medication in the MAR and further verified that Resident #120 did not receive his scheduled pain medication as ordered. Review of facility policy titled, Pain Management Policy revised on 01/08/25 revealed the facility will assess for pain and/or potential for pain in order for the resident to reach and maintain his/her highest practicable level of physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care. Review of facility policy titled Pharmacy: Delivery and Receipt of Routine Deliveries revised on 08/01/24 revealed if an item ordered by the facility is not received, the facility staff should check for a pharmacy communication slip indicating the reason a medication was not delivered. Facility should also contact pharmacy and document any delivery discrepancies. This deficiency represents noncompliance investigated under Complaint Numbers OH00163252 and OH00165427.

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	366441	A. Building B. Wing	07/07/2025

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interviews, review of resident council meeting minutes, review of dining council minutes, the facility failed to ensure palatable meals were being provided. This affected three residents (Resident #11, #30 and #45) and had the potential to affect 56 residents receiving food from the kitchen (except Residents # 6, #44, #51, #55, #57, #60, and #218 whom the facility identified as nothing by mouth). The facility census was 63. Findings include: Review of the food committee meeting minutes dated 01/21/25 revealed the following concerns: -an unidentified resident stated the Salisbury steak was bad -residents are asking for more juice options to be added to the juice cart at meals. Review of the food committee meeting minutes dated 02/25/25 revealed the following concerns: -rice is cooked too long and hard to chew -residents requested fresh fruit with meals -residents requested no more vegetable lasagna -residents reported getting sour milk with meals -residents reported kitchen not making enough food and are told they are not allowed to request more -Resident #50 stated on 02/22/25's lunch tray they only got spinach and bread with no meat -Residents requested if the dining room can be served first so their food is still hot when they are served Review of the 03/18/25 resident council meeting minutes revealed to see attached dining concerns, but the facility was unable to provide evidence of the food committee minutes for 03/18/25. Review of the 04/22/25 food committee meeting minutes revealed the following concerns: -the resident wanted things added to the food to make it taste better not just Stouffer's food -dietary staff need to read meal tickets better to ensure accuracy Review of the 05/20/25 food committee meeting minutes revealed the following concerns: -snacks are left at the nurses' desk, but when residents request a snack there are none left -Resident #37 reported not getting his double portions as requested (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 06/23/25 at 11:48 A.M. with Resident #11 revealed sometimes she gets foods she dislikes even though she has requested not to receive them. Observation on 06/25/25 at 11:40 A.M. with [NAME] #26 revealed the following temperatures: stuffed peppers 176 Fahrenheit (F), ground beef tips 170 F, pureed beef roast 183 F, beef patty 182 F, pureed cauliflower 168 F, cauliflower 185 F, mashed potatoes 175 F, gravy 185 F, burgers 185 F, chicken noodle soup 185 F, chicken breast 167 F, and noodles 180 F, and pureed bread 172 F. Lunch tray service began at 11:55 P.M. in the first floor serving station and finished at 12:18 P.M. The tray serving cart was delivered to first floor rooms starting at 12:20 P.M. The lunch tray pass finished at 12:31 P. M. The lunch test tray was completed with Regional Dietary Manager #82 and Dietitian #83 at 12:32 P.M. Temperatures of the test tray were as follows: Stuffed pepper 139 F, mashed potatoes 116 F, mixed vegetables 113 F, milk 49 F, and coffee 140 F. Interview following the temperatures with Dietitian #83 revealed the mashed potatoes and mixed vegetables were warmish but could be warmer for preference. Interview on 06/25/25 at 2:26 P.M. with Resident #30 revealed lunch was okay today but is frequently cold and has reported it previously. Interview on 06/25/25 at 2:29 P.M. with Resident #45 revealed she frequently receives cold meals and just doesn't eat them. Review of the 08/28/19 revised facility policy called; Food Temperatures Policy revealed hot foods should be palatable at the time of delivery. This deficiency represents non-compliance investigated under Complaint Number OH00165427.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of shower documentation and interviews, the facility failed to ensure accurate and complete bathing documentation was completed as required for four residents (Residents #5, #19, #33 and #57) of four residents reviewed for activities of daily living. The facility census was 63. Findings include:1. Review of the medical record for Resident #5 revealed an admission date of 12/09/16. Diagnoses included but were not limited to schizophrenia, anxiety disorder, obsessive compulsive disorder and osteoarthritis. Review of the 03/31/25 Minimum Data Set (MDS) 3.0 for Resident #5 revealed intact cognition and was dependent upon staff for bathing. Review of Resident 5's care plan dated 02/26/24 revealed she is dependent upon staff for bathing. Review of the shower sheets from 04/03/25, 4/07/25, 04/10/25, 04/14/25, 04/17/25, 04/20/25, 04/25/25, 05/06/25, 05/09/25, 05/13/25, 05/15/25, 05/20/25, 05/23/25, 05/27/25, 06/06/25, 06/10/25, and 06/17/25 revealed no evidence the nurse reviewed the shower sheet and no signature. Shower sheets that had documented refusals on 04/07/25, 04/14/25, 04/17/25, 04/20/25, 05/06/25, 05/15/25, and 05/27/25 revealed no evidence of a nursing progress note documenting the refusal or reattempts to offer bathing.Review of the facility provided shower sheet for Resident #5 received on 6/24/25 at 4:06 P.M. dated 06/24/25 revealed a bed bath was given and no nurse signature was found. Review of the facility shower schedule revealed Resident #5's scheduled shower days were Tuesday and Friday on the day shift. Interview on 06/24/25 at 4:34 P.M. with Assistant Director of Nursing (ADON) #8 revealed there is a shower book on each unit with the shower schedule. If a resident refuses, the aide is supposed to tell the nurse, and the nurse is to go to the resident and ask the reason for the refusal and document it in the nursing progress notes. The aide is supposed to give the completed shower sheet to the nurse, and the nurse is to review and sign the shower sheet. The ADON confirmed the above shower sheets provided by the facility were not signed by the nurse and the refusals listed above were not documented in the nursing progress notes. Interview on 06/24/25 at 5:00 P.M. with Resident #5 confirmed no one had offered her a bed bath and had only provided incontinence care. Interview on 06/24/25 at 5:16 P.M. with Certified Nurse Aide (CNA) #80 revealed Resident #5 was scheduled for a shower today but had not had the chance to bathe her due to busyness. CNA #80 confirmed the shower sheets was filled out at the beginning of shift in the morning because she always completes her showers. CNA #80 confirmed she had completed a shower sheet for Resident #5 at the beginning of her shift but had not bathed her and confirmed since she had not bathed her, she was unable to accurately confirm the completed skin check questions. Review of the 09/09/22 revised facility policy called Resident Bath/Showering/Scheduling Policy revealed each resident will be asked about bathing preferences upon admission (type of bath, preferred days and times). Each resident will be scheduled to receive a minimum of two times per week. When the bath or shower is complete, the nursing assistant will document the activity on the shower sheet in the electronic record. The nurse will address any findings in the clinical record and appropriate interventions will be initiated. If the bath/shower cannot be given or the resident refuses, the nursing assistant will promptly report the refusal to the charge nurse. The nurse in charge will speak with the resident who refuses to ascertain why and determine if alternative arrangements can be made. If the resident continues to refuse, the charge nurse will document the resident's refusal in the medical record.Review of the facility form called Bath/Shower sheet revealed the licensed nurse and nursing assistant are to review the shower sheet together. Charge nurse will address the concerns before submitting the form to the Director of Nursing. 2. Review of the medical record for Resident #33 admitted on [DATE] with diagnosis of diabetes mellitus type 2, and obstructive reflux uropathy. Review of Resident #33's MDS admission assessment dated [DATE] revealed Resident #33 was alert and oriented without cognitive impairment and was dependent upon staff for ADLs. Resident #33 was noted to have an indwelling urinary catheter and was continent of bowel. Review of Resident #33's shower sheets for April 2025 through June 2025 revealed the resident received showers on 04/05/25, 04/16/25, 05/07/25, 05/24/25, 05/28/25, 05/31/25, 06/04/25. 06/14/25, 06/18/25, 06/21/25. 06/25/25, 06/27/25, and on two additional dates for which the dates are illegible on the shower sheets. No other evidence was provided of showers being given for Resident #33.An interview on 06/26/25 at 2:25 P.M. with ADON #8 revealed that the facility did not have all the documentation for Resident #33's showers for the months of April, 2025, May 2025, and June 2025. ADON #8 confirmed she had requested unnamed staff members to complete and sign shower sheets for the missing dates where there is no record of a shower being given. 3. Review of the medical record for