STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366458	A. Building B. Wing	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ahc of Landerhaven LLC	2108 Lander Road Mayfield Heights, OH 44124

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973 Based on interview, observation, record review, review of Self-Report Incident (SRI) review, and review of the facility policy revealed the facility did not ensure Resident #9 had a thorough comprehensive care plan with interventions regarding his refusals of care and/ or dementia care. This affected one resident (#9) out of nine resident care plans reviewed. The facility census was 22. Findings include: Review of the medical record for Resident #9 revealed an admitted [DATE] with diagnoses including dementia, acute respiratory failure, Parkinson's disease, congestive heart failure, and pressure ulcers to his sacral region, mid back, and right heel. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #9's Brief Interview for Mental Status (BIMS) score indicated he had moderate cognitive impairment as his BIMS score was a nine out of 15. He required substantial to moderate staff assist with dressing, bathing, and personal hygiene. He was dependent on staff assist with rolling left and right, toileting hygiene, and transfers. He was unable to ambulate. During the assessment period he rejected care one to three days of the seven-day assessment reference period. Review of the nursing note dated 08/03/24 at 4:17 A.M. and completed by Licensed Practical Nurse (LPN) #653 revealed Resident #9 refused skin assessment and morning medications. Review of SRI tracking number 250531 dated 08/07/24 revealed the Administrator filed an incident of neglect and mistreatment for Resident #9. The SRI revealed there was an allegation that Resident #9 was up in his wheelchair for an extended period as State tested Nursing Assistant (STNA) #624 had asked him a few times if he wanted to go to bed but he refused. The facility unsubstantiated the SRI but had revealed the facility would update the care plan to address Resident #9's refusals as he refused lab work, skin assessments, medications, and weights. Review of comprehensive care plan dated 08/13/24 revealed Resident #9 had identified the following refusals of treatment: all daily cares. Intervention listed on the care plan was treatments not to be provided: any daily cares that Resident #9 preferred not to participate in. There were no other care plans and/ or interventions regarding Resident #9's refusals of care and/ or dementia care. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and observation on 08/21/24 at 9:11 A.M. with Resident #9 revealed he was lying in bed and refused to be interviewed as he requested the surveyor leave his room as he did not want to talk, which was honored. Observation on 08/21/24 at 10:02 A.M. revealed STNA #618 came up to LPN #613 and reported Resident #9 was refusing to be turned as he was hitting out when she attempted to turn him. Interview on 08/21/24 at 10:50 A.M. with STNA #618 revealed Resident #9 refused activities of daily living (ADL) frequently including turning, personal hygiene, incontinence care, and transfers in and/out of bed. When she was asked what types of interventions were in place if he refused, she revealed the only thing was to continue to go into his room and offer/encourage him to participate. Observation on 08/21/24 at 11:30 A.M. revealed therapy, Occupational Therapy (OT) #650 and Occupational Therapy Assistant (OTA) #654, were in Resident #9's room attempting to encourage him to get up in his chair for lunch. Resident #9 yelled out refusing but after encouragement allowed staff to assist in getting him out of bed. Resident #9 then began to yell again once up in the wheelchair that he did not want his lunch despite alternatives offered. Resident #9 continued to yell out, but then started to drink his nutritional supplement when therapy reassured him that they would be back to assist him back to bed. Interview on 08/21/24 at 12:48 P.M. with Corporate Travel Registered Nurse (RN) #655 revealed Resident #9 refused wound care. Review of the nursing note dated 08/21/24 at 6:16 P.M. and completed by Corporate Travel RN #652 revealed Resident #9 refused all wound care treatments. Interview on 08/21/24 at 3:14 P.M. with OT #650 revealed a day at the beginning of August 2024 (she was unable to identify specific day) she had come in and staff had asked her for assistance as Resident #9 had been up in his wheelchair all day and night as he had refused to go to bed. She revealed she had a good rapport with Resident #9 and was able to encourage Resident #9 to lie down. Interview on 08/21/24 at 3:56 P.M. with Physical Therapy Assistant (PTA) #651 revealed there was a day at the beginning of August 2024 that Resident #9 had been up all day and night in his wheelchair as he refused to lie down. She revealed when she came in the morning after OT #605 and she were able to encourage Resident #9 to lie down and assisted him back into his bed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/22/24 at 11:24 A.M. with STNA #624 revealed approximately two weeks ago she worked 11:00 P.M. to 7:00 A.M. and when she came in Resident #9 was still up in his wheelchair. She revealed approximately 11:30 P.M. she went into his room and asked Resident #9 if he was ready to go to bed and he refused. She revealed approximately 12:30 A.M. she had gone back in his room, and he yelled at her and stated he was not getting in the bed. She revealed she had attempted again at 1:30 A.M. but he became aggressive stating, don't touch me, and he attempted to put his arm out to have STNA #624 back up from his personal space. She revealed he then began to yell to leave his room despite all attempts to encourage him to go to bed. She revealed since that was the third time she had attempted; she did not attempt any other times on her shift because he made it clear he was not going to bed and wanted to remain up in his chair. When asked if she was aware if there were any interventions in his care plan regarding how to address his refusals, she stated she was not. STNA #624 revealed she notified RN #638 of his refusals but was not aware if any other staff, including nurses, had attempted to encourage Resident #9 to get back into his bed. Interview on 08/22/24 at 12:55 P.M. with Administrator and Director of Nursing (DON) verified Resident #9's care plan was not thorough regarding what staff should do if Resident #9 was refusing care including if Resident #9 refused to go to bed for prolonged period. They verified he had pressure ulcers on his mid back and sacrum area. They verified the only thing in his care plan was they had identified Resident #9 refused treatments including all daily cares. They verified there was only one intervention listed on the care plan: treatments not to be provided: any daily cares that Resident #9 preferred not to participate in. There were no other care plans and/or interventions regarding Resident #9's refusals of care and/or dementia care. Observation on 08/23/24 at 10:20 A.M. of incontinence care and wound care completed by LPN #612 and STNA #605 revealed Resident #9 yelled out refusing care to be completed. LPN #612 and STNA #605 explained and educated on the importance of the incontinence care and treatments, but he continued to refuse. STNA #605 then stated that Resident #9 had been a lawyer and was asking him to describe the funniest case he had. Resident #9 proceeded to talk about his profession and consented to have incontinence care and wound care completed. Interview on 08/26/24 at 10:09 A.M. with RN #638 revealed approximately two weeks ago she had worked night shift 12:00 A.M. to 8:00 A.M. not as the floor nurse but to assist with paperwork. She revealed the dayshift staff had come in and questioned why Resident #9 was up in his chair, and at that time, STNA #624 stated that she had asked him multiple times to go to bed and he refused. RN #638 revealed that was the first time she was aware that he had refused all night to lie down as STNA #624 had not reported it to her previously. RN #638 had asked Agency LPN #900 if she was aware and all she stated was she had seen Resident #9 up in his wheelchair in no distress but did not seem to know anything else regarding him being up in his chair all night. Review of the facility policy labeled, Comprehensive Care Plan, dated July 25, 2023, revealed the facility would develop a comprehensive person-centered care plan based on the patients' strengths and preferences. The facility can help the individual exercise the right of choice effectively by discussing condition, treatment options including related risks and benefits and expected outcomes. The policy revealed if the resident declines specific interventions the facility must address the individuals concerns and offer relevant alternatives. The policy revealed a variety of interventions should be used to meet the individuals needs and patients' rights based on many factors. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents non-compliance investigated under Master Complaint Number OH00156758 and Compliant Numbers OH00156670, OH00156639, and OH00156596.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973 Based on interview, record review, and review of the facility policy the facility did not ensure medical records were maintained in an accurate manner including treatments were documented per the treatment administration record (TAR) as ordered. This affected three residents (#9, #14, and #23) out of nine medical records reviewed for accuracy. The facility census was 22. Findings include: 1. Review of the medical record for Resident #9 revealed an admitted [DATE] with diagnoses including dementia, acute respiratory failure, Parkinson's disease, congestive heart failure, and pressure ulcers to his sacral region, mid back, and right heel. Review of the undated care plan for Resident #9 revealed he had actual impaired skin integrity related to pressure injuries to his left heel, back, and coccyx and an arterial ulcer to his left toe. Interventions included an air mattress to the bed, encourage and assist to reposition at least every two hours, and treatments as ordered. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #9's Brief Interview for Mental Status (BIMS) score indicated he had moderate cognitive impairment as his BIMS score was a nine out of 15. He required substantial to moderate staff assist with dressing, bathing, and personal hygiene. He was dependent on staff assist with rolling left and right, toileting hygiene, and transfers. He was unable to ambulate. During the assessment period he rejected care one to three days of the seven-day assessment reference period. Review of the July and August 2024 physician order's revealed Resident #9 had a physician order dated 07/11/24 to 08/02/24 to cleanse his mid back wound with normal saline, pat dry, apply hydrofera blue (sponge like wound dressing to assist in holding drainage) (cut to fit) slightly moistened with normal saline and apply foam dressing Monday, Wednesday, and Friday and as needed. Review of the July 2024 TAR revealed Resident #9's treatment to his mid back was documented as completed on 07/12/24 and on 07/31/24. The TAR revealed an X on all the other days from 07/11/24 to 07/31/24 and had no documentation the treatment was completed. Interview on 08/26/24 at 10:30 A.M. with the Director of Nursing (DON) verified Resident #9 was to have the dressing completed to his mid back Monday, Wednesday, and Friday but on 07/15/24, 07/17/24, 07/19/24, 07/22/24, 07/24/24, 07/26/24, and 07/29/24 there was no documentation this was completed as there was only an X on the TAR. 2. Review of the closed medical record for Resident #23 revealed an admitted [DATE], and she was discharged on [DATE]. Her diagnoses included displaced fracture of the left tibia, non-pressure chronic ulcer to her left heel and midfoot, diabetes with peripheral angiopathy (small blood vessels were damaged and burst open), and hypertension. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the July and August 2024 physician orders revealed Resident #23 had an order dated 07/04/24 to pack her left foot with gauze dressing of betadine (antiseptic), cover with an abdominal (ABD) pad and wrap with Kerlix gauze and an Ace bandage daily and an order dated 07/30/24 to have a wound vac to unspecified location and to change three times a week (Monday, Wednesday, and Friday). There was no physician order for a wet to dry dressing to be applied as indicated in the nursing notes dated 08/06/24. Review of the admission MDS assessment dated [DATE] revealed Resident #23 had intact cognition. Review of the care plan dated 07/14/24 revealed Resident #23 had actual impaired skin integrity related to chronic ulcer to left heel. Interventions included left leg boot when in bed, treatment as ordered, and measure wound areas at least weekly. Review of the physician progress note dated 07/29/24 completed by Podiatrist #655 revealed Resident #23 had left plantar heel wound and he ordered to continue treatment of betadine-soaked dressing, cover with an ABD pad, and wrap with Kling (Kerlix gauze) and Ace wrap. The progress note noted to order a wound vac and apply at 125 millimeter of mercury (mmHg) continuous suction and change every two to three days. Review of the August 2024 TAR revealed Resident #23 had an order for a wound vac to unspecified location and to change three times a week (Monday, Wednesday, and Friday): on 08/02/24 and 08/05/24 the TAR was blank indicating no documentation that the treatment was completed. The TAR also continued to have the treatment to pack her left foot with gauze dressing of betadine, cover with an ABD pad and wrap with Kerlix gauze and an Ace bandage daily. There was no documentation this was completed on 08/01/24, as it was blank. There was nothing on the TAR regarding documentation that a wet to dry dressing was applied to Resident #23's right heel as indicated in the nurse's notes on 08/06/24. Review of the nursing note dated 08/02/24 at 8:19 P.M. and completed by Registered Nurse (RN) #656 revealed the wound vac was applied to Resident #23's left foot, and she tolerated it well. Review of the nursing note dated 08/06/24 at 11:52 A.M. and completed by RN #657 revealed Resident #23 stated the wound vac was turned off because the nurse prior had changed it incorrectly. The note revealed Resident #23 had spoken to the physician and he stated that the wound vac could come off. RN #657 asked if she could turn it on and she stated no, and she wanted it removed. RN #657 educated the resident that the wound vac was the order, and that it was considered a refusal, but Resident #23 stated that it was her right and she wanted the wound vac removed. RN #657 applied a wet to dry dressing. (There was no order for the wet to dry in the physician orders and it was not on the TAR) Interview on 08/26/24 at 2:27 P.M. with the DON revealed when Podiatrist #655 ordered the wound vac to Resident #23's left heel, the other treatment (pack her left foot with gauze dressing with betadine, cover with an ABD pad and wrap with Kerlix gauze and an Ace bandage daily) should have been discontinued. She verified the TAR for Resident #23's wound vac was blank on 08/02/24 and 08/05/24. She also verified the order should have identified the location of where the wound vac should have been applied: left planter heel. She verified in the nursing notes dated 08/06/24 at 11:52 A.M. and completed by RN #657 indicated she applied a wet to dry dressing to Resident #23's left planter heel, but there was no physician's order, and it was not documented on the TAR. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of medical record for Resident #14 revealed an admitted [DATE] with diagnoses including displaced intertrochanteric fracture of right femur, diabetes, and pressure ulcer to right buttock. Review of the July and August 2024 physician order's revealed Resident #14 had an order from 07/12/24 to 08/07/24 to cleanse her right buttock with normal saline, pat dry, apply MediHoney (an antibacterial/ anti-inflammatory wound gel), and cover with a foam dressing twice a day. Review of the July 2024 TAR revealed Resident #14's treatment to her right buttock was not documented as completed: 07/13/24 (7:00 A.M. to 7:00 P.M.), 07/18/24 (7:00 P.M. to 7:00 A.M.), and 07/19/24 (7:00 A.M. to 7:00 P.M.). Review of the admission MDS assessment dated [DATE] revealed Resident #14 had impaired cognition. She was at risk for developing pressure ulcers and had one Stage two (partial thickness loss of dermis presenting as a shallow open ulcer with a red, pink wound bed, without slough, may also present as an intact or open/ruptured serum filled blister) pressure ulcer present on admission. Review of the care plan dated 07/26/24 revealed Resident #14 had actual impaired skin integrity. Interventions included encourage and assist to reposition at least every two hours, pressure reducing cushion to wheelchair, and treatment per current orders. Review of the August 2024 TAR revealed Resident #14's treatment to her right buttock was not documented as completed: 08/01/24 (7:00 A.M. to 7:00 P.M.), 08/05/24 (7:00 P.M. to 7:00 A.M.), and 08/06/24 (7:00 A.M. to 7:00 P.M.). Interview on 08/22/24 at 8:39 A.M. with Resident #14 revealed she had no concerns regarding her treatment to her right buttock not being completed as ordered. Interview on 08/26/24 at 10:30 A.M. with the DON verified Resident #14's TAR had no documented evidence the right buttock treatment was completed on 08/01/24 (7:00 A.M. to 7:00 P.M.), 08/05/24 (7:00 P.M. to 7:00 A.M.), and 08/06/24 (7:00 A.M. to 7:00 P.M.) as the TAR was blank. Review of the facility policy labeled; Clean Dressing Change, dated 2023, revealed it is the policy of the facility to provide wound care in a manner to decrease potential for infection and/ or cross contamination. The policy revealed physician orders would specify type of dressing and frequency of changes. The policy did not have anything in regard to ensuring treatments were documented as ordered after the completion of the dressing change. Review of the facility policy labeled; Charting Requirements, last updated 06/25/24, revealed treatment nurses would be responsible for charting on each treatment they completed including condition of site. This deficiency represents non-compliance investigated under Master Complaint Number OH00156758 and Complaint Numbers OH00156639 and OH00156596.