STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365033	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CEDARWOOD PLAZA	12504 CEDAR ROAD CLEVELAND HEIGHTS, OH 44106

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 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure the accuracy of the assessments. This affected two (Residents #350 and #99) of 30 resident records reviewed for assessments. The facility census was 110 residents. Findings include: 1. Review of the record revealed Resident #350 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of fall investigations revealed Resident #350 had a fall on 10/01/2019, 10/19/2019, 11/14/2019, and 11/18/2019. Review of annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #350 had only one fall with no injury since admission/prior assessment. Interview with Licensed Practical Nurse #405 verified the annual MDS Section J for falls done on [DATE] was incorrect. 2. Review of the medical record revealed Resident #99 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The discharge MDS dated [DATE] revealed Resident #99 was coded as discharged to an acute hospital. Review of the progress notes on 12/21/2019 at 2:52 P.M. revealed the resident was discharged home with family. Review of the progress note on 12/20/2019 at 10:57 A.M. revealed Resident #99 was discharging to home with family/caregivers on 12/21/2019. Medications had been reconciled and clarified with the physician and Nurse Practitioner (NP) as needed. Social Services had medical equipment and home care services arranged. Staff were notified prescriptions were to be given upon discharge. Interview on 03/11/2020 at 2:57 P.M. with LPN #405 verified the discharge MDS, dated [DATE] was coded incorrectly.
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 observation, record review, and interview, the facility failed to ensure that interventions were put into place to prevent falls. This affected one (Resident #350) of four resident records reviewed for falls. The facility census was 110 residents Findings include: Review of the record revealed Resident #350 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of his care plan dated 10/22/2006 revealed Resident #350 was at risk for potential falls/injuries related to physical impairments, history of falls, impaired mobility, impaired balance, unsteady gait, cognitive impairment, poor safety awareness, and [MEDICAL CONDITION]. Review of his annual Minimum Data Set assessment dated [DATE] revealed he was severely cognitively impaired and required extensive assistance with one to two staff members for his activities of daily living. Review of unwitnessed fall report dated 11/14/2019 revealed Resident #350 had rolled from his low bed to the floor mat which was in place from previous falls. Review of the nurses note revealed that the resident could not explain how he ended up on the mat. No injuries were noted. The intervention of a therapy screen which was put into place following this fall revealed a therapy evaluation was completed on [DATE]. According to the therapy screen Resident #350 had no significant changes and was not put on therapy services. No additional interventions were put into place following this fall. Review of a subsequent fall dated [DATE] revealed Resident #350 had a fall in his room. Review of the nurses note revealed that the fall was unwitnessed, and the resident stated, I was trying to go to the bathroom. No injuries were noted. Review of the Nurse Practitioner notes revealed a visit had taken place on 12/18/2019 with no concerns. No additional interventions were put into place following this fall. Review of another fall dated 02/13/2020 revealed Resident #350 had fallen in his room. Review of the nurses note revealed that the fall was unwitnessed, and the resident stated, I was reaching the table. No injuries were noted. Review of the pharmacy review completed on 02/13/2020 revealed that Resident #350's medications were reviewed by the pharmacist with no recommendations made at that time. No additional interventions were put into place following this fall. Review of another fall dated 0[DATE] revealed Resident #350 had a fall in his room. Review of the nurses note revealed that the fall was unwitnessed, and the resident stated, I was trying to reach for my wheelchair to move it. Review of the fall investigation revealed that no additional interventions had been put into place, with a summary stating that the low bed and mat were effective. Observation made on 03/09/2020 at 12:30 P.M. revealed resident in his bed and the call light on the floor behind his bed, out of reach. Interview with State tested Nurses Aide #404 verified the call light was not in reach. Observation made on 0[DATE]20 at 10:09 A.M. revealed resident in his bed and the call light was on the floor beside his bed, out of reach. Interview with Licensed Practical Nurse #403 verified the call light was not in reach. An interview with the Director of Nursing (DON) on 03/11/2020 at 5:15 PM verified there were no additional long-term interventions put into place following these falls. The facility policy, Falls-Clinical Protocol, dated 11/13/2019 stated, Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls an to address risks of serious consequences of falling.
F 0756 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure pharmacy consultations were reviewed and addressed by the physician in a timely manner. This affected one (Resident #13) of five residents reviewed for unnecessary medications. The facility census was 110 residents. Findings include: Review of the record revealed Resident #13 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the consultant pharmacist interim reviews done on 06/14/2019 revealed the pharmacist recommendations to ensure the resident has an appropriate psychiatric [DIAGNOSES REDACTED]. Review of the physician response, dated 09/10/2019, stated that they agreed. In the comments the physician wrote to discontinue the [MEDICATION NAME], with no additional comments or notes explaining the reasoning. Review of the Medication Administration Record [REDACTED]. Interview on 0[DATE] at 11:49 A.M. with the Director of Nursing and Administrator verified that the pharmacist recommendations made on 06/14/2019 were not reviewed by the physician until 09/10/2019. Interview on 0[DATE] at 1:20 P.M. with Registered Nurse #402 verified that the pharmacy consultation done on 06/14/2019 was not addressed by the physician until 09/10/2019 and that their policy does not address a time limit for the physician to check the pharmacy recommendations.
F 0801 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.** **Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.**

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365033	A. BUILDING _____ B. WING _____	**03/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CEDARWOOD PLAZA	**12504 CEDAR ROAD CLEVELAND HEIGHTS, OH 44106**

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 0801 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 1) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to employ a qualified dietitian. This affected all 110 facility residents. Findings include: Review of the record of Resident #74 revealed she was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The resident's quarterly Minimum Data Set (MDS) assessment dated [DATE], and most recent significant change MDS dated [DATE], both revealed the resident was cognitively impaired and was dependent on staff for eating and her other activities of daily living. The resident also had impaired skin areas. Review of the care plan for nutrition dated 08/29/2008, and updated through 05/19/2020, revealed the resident was at risk due to her medical diagnoses. Interventions included encouraging oral and fluid intake, provide supplements per dietitian recommendation and physician order, and monitor for signs of dehydration. Review of a dietitian note dated 12/11/2019 revealed the resident has sustained a significant weight loss for one month and the last six months. The note indicated the resident's weight had been relatively stable in the prior 5 months and that her weight could fluctuate due to diuretic use. Review of a nutrition note dated [DATE] revealed a quarterly assessment indicating the resident was on a regular diet with regular texture and received a snack in the evening. The note indicated the resident's food preferences were updated. An order was written by Dietitian #401, dated [DATE], which recommended adding Boost VHC (very high calorie) twice daily. It was not cosigned by a physician and was not transcribed to the resident's orders. Interview on 03/09/2020 at 10:01 A.M. with Dietitian #401 revealed she was the facility's full-time dietitian and worked Monday through Friday. Interview on 03/11/2020 at 1:40 P.M. with Dietitian #401 revealed she was a dietary technician and was the author of all the nutrition notes regarding Resident #74. Interview on 03/11/2020 at 2:02 P.M. with Dietitian #401 and the Administrator revealed Dietitian #401 was not a licensed or registered dietitian. Dietitian #401 said she was scheduled to take the exam in order to become a registered dietitian at the end of March 2020. The Administrator said the Corporate Dietitian was licensed and registered and visited the facility weekly. Dietitian #401 said the corporate dietitian would check in on her and coordinate with the kitchen during these visits. Interview on 0[DATE] at 10:50 A.M. with the Administrator revealed Dietitian #401 completed all the facility residents' nutrition assessments and care plans. The Administrator verified Dietitian #401 did not meet the requirements for a qualified dietitian, but said the corporate dietitian provided oversight. However, the facility was unable to provide any documented evidence of what the corporate dietitian completed while at the facility that would demonstrate oversight of the nutrition assessments and care plans completed for all of the facility residents by Dietitian #401. Review of the list of key personnel provided by the facility listed Dietitian #401 as the facility dietitian.