STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366101	A. BUILDING _____ B. WING _____	**08/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ELIZA BRYANT CENTER	**7201 WADE PARK CLEVELAND, OH 44103**

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 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review and interview, the facility failed to implement their abuse, neglect and injuries of unknown origin policy. This affected one (Resident #1) of three residents (Resident #1, Resident #2 and Resident #3) reviewed for abuse, neglect, and injuries of unknown origin concerning injuries of unknown origin. The facility census was 98. Findings include: Review of the medical record for Resident #1 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the admission Minimum Data Set (MDS) assessment, dated 07/22/20 revealed the resident had intact cognition. The resident required extensive two-person assist for bed mobility, transfers, dressing and toilet use. The extensive assistance of one-person was needed for locomotion on unit, eating and personal hygiene. Walking did not occur. Review of the nurse progress notes revealed on 08/01/20 at 8:13 A.M. Resident #1 asked the nurse if she could go to the hospital. The resident stated, I can't breathe well, and I don't feel good, I'm going to call 911 if you don't send me. The nurse tried to reach the residents physician but didn't get an immediate answer. Resident #1 called 911 while nurse was not present and was taken to the hospital. Review of the nurse progress notes from 07/30/20 through 08/05/20 revealed no notes regarding Resident #1's hospital admission or the hospital admitting [DIAGNOSES REDACTED].M. with the Director of Nursing, DON, revealed Resident #1 had been there just over two weeks. The resident had come in from a hospital with COVID-19. The DON was aware Resident #1 had been admitted back to the hospital with COVID-19 and pneumonia. The DON did not mention any other diagnosis. Interview on 08/06/20 at 10:58 AM with the DON revealed Registered Nurse (RN) #101 called the hospital back and got verbal confirmation that the resident was admitted and given the diagnosis. On 08/06/20 at 12:41 P.M. a signed statement from RN #101 revealed on 08/03/20 at approximately 8:30 A.M. RN #101 called the hospital and spoke with the nurse on duty in reference to Resident #1 regarding if the resident had been admitted and the resident's admitting [DIAGNOSES REDACTED]. There was no related Self-Reported Incident (SRI) or investigation available regarding the periprosthetic [MEDICAL CONDITION], which was an injury of unknown origin. Interview on 08/06/20 at 3:58 P.M. the DON verified no SRI had been started or reported to the Ohio Department of Health (ODH). The facility policy titled, Resident Abuse, Neglect Prohibition. Exploitation and Injury of Unknown Origin/ Misappropriation Preface and Definitions., dated 08/07/19, revealed the written policy included the following key components: Screening of potential new hires; training of employees; prevention; identification of possible incidents or allegations which need investigation; investigation of incidents and allegations; protection of residents during investigations; reporting of incidents, investigations and the facility response to the results of their investigations. According to the policy, upon discovery of a violation the nurse/nursing supervisor must report it immediately (Immediate: as soon as possible, not to exceed 24 hours after discovery) to the Administrator and the DON. All alleged violations must be reported immediately. An immediate investigation will be initiated. The Administrator and/or DON shall guide staff for reporting the allegation to the Centers of Medicare and Medicaid Services (CMS) and complete the Ohio Department of Health online reporting form immediately. The following deficiency is based on incidental findings discovered during the course of this complaint investigation.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review and interview, the facility failed to notify the State Agency of an injury of unknown origin. This affected one Resident (#1) of three residents (Resident #1, Resident #2 and Resident #3) reviewed for abuse, neglect, and injuries of unknown origin concerning injuries of unknown origin. The facility census was 98. Findings include: Review of the medical record for Resident #1 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the admission Minimum Data Set (MDS) assessment, dated 07/22/20 revealed the resident had intact cognition. The resident required extensive two-person assist for bed mobility, transfers, dressing and toilet use. The extensive assistance of one-person was needed for locomotion on unit, eating and personal hygiene. Walking did not occur. Review of the nurse progress notes revealed on 08/01/20 at 8:13 A.M. Resident #1 asked the nurse if she could go to the hospital. The resident stated, I can't breathe well, and I don't feel good, I'm going to call 911 if you don't send me. The nurse tried to reach the residents physician but didn't get an immediate answer. Resident #1 called 911 while nurse was not present and was taken to the hospital. Review of the nurse progress notes from 07/30/20 through 08/05/20 revealed no notes regarding Resident #1's hospital admission or the hospital admitting [DIAGNOSES REDACTED].M. with the Director of Nursing, DON, revealed Resident #1 had been here just over two weeks. The resident had come in from a hospital with COVID-19. The DON was aware Resident #1 had been admitted back to the hospital with COVID-19 and pneumonia. The DON did not mention any other diagnosis. Interview on 08/06/20 at 10:58 AM with the DON revealed Registered Nurse (RN) #101 had called the hospital back and got verbal confirmation that the resident was admitted and diagnosis. On 08/06/20 at 12:41 PM a signed statement from RN #101 revealed on 08/03/20 at approximately 8:30 A.M. RN #101 had called the hospital and spoke with the nurse on duty in reference to Resident #1 regarding if the resident had been admitted and the resident's admitting [DIAGNOSES REDACTED]. There was no related Self-Reported Incident (SRI) or investigation available regarding the periprosthetic [MEDICAL CONDITION], which was an injury of unknown origin. Interview on 08/06/20 at 3:58 P.M. the DON verified no SRI had been started or reported to the Ohio Department of Health (ODH). The facility policy titled, Resident Abuse, Neglect Prohibition. Exploitation and Injury of Unknown Origin/ Misappropriation Preface and Definitions., dated 08/07/19, revealed the written policy included the following key components: Screening of potential new hires; training of employees; prevention; identification of possible incidents or allegations which need investigation; investigation of incidents and allegations; protection of residents during investigations; reporting of incidents, investigations and the facility response to the results of their investigations. According to the policy, upon discovery of a violation the nurse/nursing supervisor must report it immediately (Immediate: as soon as possible, not to exceed 24 hours after discovery) to the Administrator and the DON. All alleged violations must be reported immediately. An immediate investigation will be initiated. The Administrator and/or DON shall guide staff for reporting the allegation to the Centers of Medicare and Medicaid Services (CMS) and complete the Ohio Department of Health online reporting form immediately. The following deficiency is based on incidental findings discovered during the course of this complaint investigation.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review and interview, the facility failed to investigate an injury of unknown origin. This affected one Resident (#1) of three residents (Resident #1, Resident #2 and Resident #3) reviewed for abuse, neglect, and injuries of unknown origin concerning injuries of unknown origin. The facility census was 98. Findings include: Review of the medical record for Resident #1 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the admission

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.

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ELIZA BRYANT CENTER	7201 WADE PARK CLEVELAND, OH 44103

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) Minimum Data Set (MDS) assessment, dated 07/22/20 revealed the resident had intact cognition. The resident required extensive two-person assist for bed mobility, transfers, dressing and toilet use. The extensive assistance of one-person was needed for locomotion on unit, eating and personal hygiene. Walking did not occur. Review of the nurse progress notes revealed on 08/01/20 at 8:13 A.M. Resident #1 asked the nurse if she could go to the hospital. The resident stated, I can't breathe well, and I don't feel good, I'm going to call 911 if you don't send me. The nurse tried to reach the residents physician but didn't get an immediate answer. Resident #1 called 911 while nurse was not present and was taken to the hospital. Review of the nurse progress notes from 07/30/20 through 08/05/20 revealed no notes regarding Resident #1's hospital admission or the hospital admitting [DIAGNOSES REDACTED].M. with the Director of Nursing, DON, revealed Resident #1 had been here just over two weeks. The resident had come in from a hospital with COVID-19. The DON was aware Resident #1 had been admitted back to the hospital with COVID-19 and pneumonia. The DON did not mention any other diagnosis. Interview on 08/06/20 at 10:58 AM with the DON revealed Registered Nurse (RN) #101 had called the hospital back and got verbal confirmation that the resident was admitted and diagnosis. On 08/06/20 at 12:41 PM a signed statement from RN #101 revealed on 08/03/20 at approximately 8:30 A.M. RN #101 had called the hospital and spoke with the nurse on duty in reference to Resident #1 regarding if the resident had been admitted and the resident's admitting [DIAGNOSES REDACTED]. There was no related Self-Reported Incident (SRI) or investigation available regarding the periprosthetic [MEDICAL CONDITION], which was an injury of unknown origin. Interview on 08/06/20 at 3:58 P.M. the DON verified no SRI had been started or reported to the Ohio Department of Health (ODH). The facility policy titled, Resident Abuse, Neglect Prohibition. Exploitation and Injury of Unknown Origin/ Misappropriation Preface and Definitions., dated 08/07/19, revealed the written policy included the following key components: Screening of potential new hires; training of employees; prevention; identification of possible incidents or allegations which need investigation; investigation of incidents and allegations; protection of residents during investigations; reporting of incidents, investigations and the facility response to the results of their investigations. According to the policy, upon discovery of a violation the nurse/nursing supervisor must report it immediately (Immediate: as soon as possible, not to exceed 24 hours after discovery) to the Administrator and the DON. All alleged violations must be reported immediately. An immediate investigation will be initiated. The Administrator and/or DON shall guide staff for reporting the allegation to the Centers of Medicare and Medicaid Services (CMS) and complete the Ohio Department of Health online reporting form immediately. The following deficiency is based on incidental findings discovered during the course of this complaint investigation.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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** Based on record review and interview the facility failed to ensure an accurate and complete medical record was maintained for Resident # 1 related to a hospital admission and hospital diagnoses. This affected one (Resident #1) of three residents (Resident #1, Resident #2 and Resident #3) reviewed for abuse, neglect, and injuries of unknown origin concerning injuries of unknown origin. The facility census was 98. Findings include: Review of the medical record for Resident #1 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the admission Minimum Data Set (MDS) assessment, dated 07/22/20 revealed the resident had intact cognition. The resident required extensive two-person assist for bed mobility, transfers, dressing and toilet use. The extensive assistance of one-person was needed for locomotion on unit, eating and personal hygiene. Walking did not occur. Review of the nurse progress notes revealed on 08/01/20 at 8:13 A.M. Resident #1 asked the nurse if she could go to the hospital. The resident stated, I can't breathe well, and I don't feel good, I'm going to call 911 if you don't send me. The nurse tried to reach the residents physician but didn't get an immediate answer. Resident #1 called 911 while nurse was not present and was taken to the hospital. Review of the nurse progress notes from 07/30/20 through 08/05/20 revealed no notes regarding Resident #1's hospital admission or the hospital admitting [DIAGNOSES REDACTED].M. with the Director of Nursing, DON, revealed Resident #1 had been here just over two weeks. The resident had come in from a hospital with COVID-19. The DON was aware Resident #1 had been admitted back to the hospital with COVID-19 and pneumonia. The DON did not mention any other diagnosis. Interview on 08/06/20 at 10:58 AM with the DON revealed Registered Nurse (RN) #101 had called the hospital back and got verbal confirmation that the resident was admitted and diagnosis. The information was not in the electronic medical record at the time of the interview. On 08/06/20 at 12:41 PM a signed statement from RN #101 revealed on 08/03/20 at approximately 8:30 A.M. RN #101 called the hospital and spoke with the nurse on duty in reference to Resident #1 regarding if the resident had been admitted and the resident's admitting [DIAGNOSES REDACTED]. Interview on 08/06/20 at 3:58 P.M. the DON verified there was not information in the medical record regarding the regarding Resident #1's hospital admission and admitting diagnoses. On 08/06/20 at 12:41 PM a signed statement from RN #101 revealed on 08/03/20 at approximately 8:30 A.M. RN #101 had called the hospital and spoke with the nurse on duty in reference to Resident #1 regarding if the resident had been admitted and the resident's admitting [DIAGNOSES REDACTED]. Interview on 08/06/20 at 3:58 P.M. the DON verified there was not a nursing note in the medical record regarding the regarding Resident #1's hospital admission and admitting diagnoses. The information was not in the electronic medical record at the time of the interview. On 08/06/20 at 12:41 PM a signed statement from RN #101 revealed on 08/03/20 at approximately 8:30 A.M. RN #101 had called the hospital and spoke with the nurse on duty in reference to Resident #1 regarding if the resident had been admitted and the resident's admitting [DIAGNOSES REDACTED]. Interview on 08/06/20 at 3:58 P.M. the DON verified there was not a nursing note in the medical record regarding the regarding Resident #1's hospital admission and admitting diagnoses. The information was not in the electronic medical record at the time of the interview. The following deficiency is based on incidental findings discovered during the course of this complaint investigation.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to implement effective infection control practices to ensure adequate daily screening of residents during the Coronavirus pandemic. This affected two (Resident #2 and Resident #3) of three residents (Resident #1, Resident #2 and Resident #3) reviewed for infection control and had the potential to affect the 97 residents who were not on the COVID unit or any new admissions who had not been tested for Coronavirus. Resident #1 was on the COVID unit. Facility census was 98. Findings Include: 1. Review of the medical record for Resident #2 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the quarterly Minimum Data Set (MDS) assessment, 07/01/20, revealed the resident had intact cognition and required supervisions for bed mobility, transfers, locomotion, dressing, toilet use and personal hygiene. Review of the resident's vitals from 07/15/20 through 08/04/20 revealed the resident's temperature was assessed daily. Review of Resident #2's assessments, Medication Administration Record [REDACTED]. 2. Review of the medical record for Resident #3 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the quarterly Minimum Data Set (MDS) assessment, dated 05/01/20, revealed the resident had intact cognition. Resident #3 required extensive assistance of two for bed mobility, transfers, dressing and toilet use. The resident needed the extensive assistance of one for personal hygiene and was totally dependent on one person for locomotion. Review of Resident #3's vitals from 07/15/20 through 08/04/20 revealed the resident's temperature was assessed daily. Review of Resident #3's assessments, Medication Administration Record [REDACTED].M. with the Director of Nursing (DON) revealed the facility monitored the temperatures of all residents daily. Residents admitted with a positive COVID-19 test were monitored for signs and symptoms using a COVID assessment. New resident who had not had a COVID-19 test were put in precautions and monitored for signs and symptoms using the same assessment. Interview on 08/06/20 at 3:58 P.M. with the DON verified facility did not document signs and or symptoms unless the residents were on the COVID unit or were new residents in precautions. The following deficiency is based on incidental findings discovered during the course of this complaint investigation.