STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365746	A. BUILDING _____ B. WING _____	09/21/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BRENTWOOD HEALTH CARE CENTER	**907 AURORA RD SAGAMORE HILLS, OH 44067**

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** Based on observation, staff interview, and review of facility policy, the facility failed to ensure call lights were within reach for three (Residents #15, #16, and #18) of five residents reviewed for call light placement. The facility census was 66 residents. Findings include: 1. Review of the medical record revealed Resident #15 was admitted to the facility on [DATE] with the [DIAGNOSES REDACTED]. Review of the quarterly Minimum Data Set 3.0 assessment (MDS) dated revealed Resident #15 had impaired cognition and required extensive assistance of one staff member for bed mobility, dressing, toilet use, and personal hygiene. Review of the plan of care updated on 04/22/2020 Resident #15 was a potential injury risk due to decreased mobility, use of medications listed in fall risk assessment, visual impairment, impaired cognition, impaired balance. Interventions included keeping the call light within reach and staff would encourage resident to use it when assistance was needed. Observation on 09/16/2020 at 9:15 A.M. revealed Resident #15 was sitting up in the wheelchair with his over the bed table in front of him. There was one call light on the floor underneath his bed on his right side and the other call light was attached to his recliner behind him on the right-hand side. Resident #15 was unable to locate the call light when asked to push it. Interview on 09/16/2020 at 9:18 A.M. with STNA #19 verified Resident #15 could not reach his call light. She stated he is usually in his recliner however he was up in the wheelchair today because it was his shower day. 2. Review of the medical record revealed Resident #16 was admitted to the facility on [DATE] with the [DIAGNOSES REDACTED]. There was no MDS information available for this resident. Review of the plan of care dated 09/17/2020 revealed Resident #16 was a potential injury risk due to decreased mobility and difficulty with ambulation. Interventions included keeping the call light within reach and staff was to encourage the resident to use it when assistance was needed. Observation on 09/16/2020 at 9:05 A.M. revealed Resident #16 was in bed with the head of the bed rolled up watching television. Her call light was attached to the bottom part of the left side rail with the button part hanging down on the floor. The mattress was pushed up against the siderail so you could not see the call light. Resident #16 looked around and could not find her call light when asked to push the button. Interview on 09/16/2020 at 9:10 A.M. with Registered Nurse #50 verified the resident could not reach her call light. She stated they just took her breakfast tray out of the room and it must have slid down the siderail. 3. Review of the medical record revealed Resident #18 was admitted to the facility on [DATE] with the diagnose of right side [MEDICAL CONDITION], hypertensive [MEDICAL CONDITION], weakness, major [MEDICAL CONDITION], coronavirus, [MEDICAL CONDITION], and anxiety disorder. Review of the Quarterly MDS dated [DATE] revealed Resident #18 had impaired cognition and required extensive assistance with bed mobility, dressing, personal hygiene, and toilet use. Observation on 09/16/2020 at 9:25 A.M. revealed Resident #18 was sitting up in the wheelchair on the right side of the bed with the over the bed table in front of her. The call light was attached to the side rail on the other side of the bed. Interview on 09/16/2020 at 9:30 A.M. with Licensed Practical Nurse #2 verified the call light for Resident #18 was not within reach. This deficiency substantiates Master Compliant Number OH 484.
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, resident interview, staff interview, review of the call light policy, and review of call light audits, the facility failed to ensure call lights were answered in a timely manner for two (Residents #18 and #25) of three reviewed for call light response time. The facility census was 66 residents. Findings include: 1. Review of the medical record revealed Resident #25 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the quarterly Minimum Data Set 3.0 (MDS) assessment dated [DATE] revealed Resident #25 had intact cognition, required extensive assistance with two staff members for bed mobility, extensive assistance with one staff member for personal hygiene, and total assistance with transfers and toilet use. Interview on 09/15/2020 at 10:05 A.M. Resident #25 indicated the staff never answer her call light timely. She indicated it sometimes took the staff 30 to 45 minutes to answer her call light and sometimes they just came in the room and turned it off and went back out of the room without helping her. Review of call light times from the facility call light system revealed call light response times over 30 minutes on the following days: 07/22/20 at 4:37 A.M. was 44 minutes; 07/23/20 at 6:08 A.M. was 55 minutes; 07/26/20 at 3:58 A.M. was 50 minutes; 07/27/20 at 4:26 A.M. was 56 minutes; 07/31/20 at 3:03 A.M. was 32 minutes; 08/03/20 at 3:43 A.M. was one hour and six minutes; 08/04/20 at 7:27 A.M. was 40 minutes; 08/05/20 at 5:22 A.M. was 30 minutes; 08/06/20 at 5:30 A.M. was 48 minutes; 08/07/20 at 3;17 A.M. was 32 minutes; 08/07/20 at 6:20 A.M. was 30 minutes; 08/09/20 at 9:02 P.M. was 34 minutes; 08/10/20 at 4:45 A.M. was 49 minutes; 08/11/20 at 9:56 A.M. was 50 minutes; 08/13/20 at 6:20 P.M. was 33 minutes; 08/14/20 at 1:09 P.M. was 51 minutes; 08/15/20 at 4:27 A.M. was 1 hour and 22 minutes; 08/15/20 at 8:55 A.M. was 33 minutes; 08/18/20 at 3:03 P.M. was 38 minutes; 08/25/20 at 8:40 A.M. was 32 minutes; 09/01/20 at 6:26 A.M. was 35 minutes; 09/11/20 at 9:27 A.M. was 40 minutes; and 09/16/20 at 4:29 A.M. was 32 minutes. 2. Review of the medical record revealed Resident #18 was admitted to the facility on [DATE] with the [DIAGNOSES REDACTED]. Review of the quarterly MDS dated [DATE] revealed Resident #18 had impaired cognition and required extensive assistance with bed mobility, dressing, personal hygiene, and toilet use. Review of call light times from the facility call light system revealed call light response times over 30 minutes on the following days: 06/19/2020 at 1:30 P.M. was 46 minutes; 06/25/2020 at 6:11 P.M. was 35 minutes; 07/23/2020 at 11:55 A.M. was 36 minutes; 07/29/2020 at 8:06 A.M. was 49 minutes; 08/15/2020 at 1:33 P.M. was 32 minutes; and 08/30/2020 at 10:07 A.M. 45 minutes. Interview on 09/21/2020 at 12:27 P.M. with the Administrator revealed the expectation was for staff to answer the call light promptly, turn off the call light and provide the care needed. However, sometimes the staff could forget to turn off the call light before they started to provide care to the resident. He verified the call light times for Residents #25 and #18 were a little longer than we would expect the call lights to be. Review of the facility policy dated 02/01/15, Call Light, revealed the staff was to respond to patients requests and needs by answering the call light promptly, being courteous when entering the room, listening to the residents request and offer further assistance if needed. This deficiency substantiates Master Compliant Number OH 484.

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.