STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365355	A. BUILDING _____ B. WING _____	09/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MAYFIELD HEIGHTS HEALTHCARE.	6757 MAYFIELD RD 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 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility did not ensure bathing or showers were provided as scheduled for Resident #77 who was dependent on staff for care. This affected one resident, Resident #77 of three residents (Residents #76, #77 and #85) reviewed for bathing or showers. This had the potential to affect 41 residents identified as requiring assistance with bathing or showering (Resident #6, #12, #41, #63, #76, #77, #85, #102, #110, #111, #112, #113, #116, #117, #120, #121, #122, #123, #124, #128, #135, #136, #175, #176, #177, #178, #180, #181, #182, #183, #184, #185, #186, #187, #188, #189, #190, #195, #199, #765 and #767). The facility census was 78. Findings include: Review of the medical record for Resident #77 revealed a date of birth of 01/03/43 and admission into the facility on [DATE]. [DIAGNOSES REDACTED]. Review of the comprehensive medical assessment (MDS 3.0) and brief interview for mental status (BIMS) score, dated 08/06/20, revealed a score of 03 out of a possible 15 points and this indicated severely compromised cognition. Resident #77 was determined to need total assistance with bathing of one person. Review of the care plan developed for Resident #77 dated 02/19/20 revealed the resident required extensive assist of one person with bathing or showers. Review of the document, Blue Shower/Bath Schedule not dated, revealed Resident #77 had preferred a shower on Mondays and Thursdays during the 3:00 P.M. to 11:00 P.M. shift. Interview on 09/23/20 at 10:05 A.M. with Licensed Practical Nurse (LPN) #100 revealed it was stated the staff who provided the bathing care would have filled out a shower sheet with each event and documented the provision in the computer charting. Review of the documentation used in the computer charting system for the period from 08/24/20 through 09/23/20 revealed, Resident #77 had received physical help with bathing on Wednesday, 09/16/20 and Saturday, 09/19/20. No documentation was provided to evidence the provision of the showers as scheduled on the following dates: 08/26/20, 08/29,20, 09/02/20, 09/05/20, 09/09/20 and 09/12/20. Interview on 09/23/20 at 10:10 A.M. with the Director of Nursing and she verified the facility had no documented evidence of showers having been provided either with shower sheets or computer documentation. The nursing notes for Resident #77 did not speak to the provision of baths or showers being offered or given. This deficiency substantiates Complaint Numbers OH 633 and OH 500.
F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility did not ensure medications were administered to Resident #66 and Resident #54 as ordered. This affected two (Residents #66 and #54) of seven residents (Residents #35, #36, #37, #41, #54, #64 and #66) reviewed for medication administration. All 78 residents in the facility received medications. The census was 78 at the time of the survey. Findings include: 1. Review of the medical record for Resident #66 a date of birth listed as 01/13/62 and admission into the facility on [DATE]. [DIAGNOSES REDACTED]. Review of the comprehensive medical assessment (MDS 3.0) and brief interview for mental status (BIMS) score, dated 07/06/20, revealed a 15 of possible 15 points and this indicated an intact cognition. Review of the Medication Administration Record [REDACTED]. Medical record review for Resident #66 revealed lack of evidence medications were administered as ordered for the following physicians orders: On 07/10/19 the physician ordered [MEDICATION NAME] ([MEDICAL CONDITION]) 100 milligrams (mg) by mouth, three times a day. The MAR indicated [REDACTED].M. dose, 09/07/20 5:00 P.M. dose and 09/12/20 5:00 P.M. dose. On 09/19/20 both the 12:00 P.M. and 5:00 P.M. had missing documentation to evidence administration. On 01/25/19 the physician ordered [MEDICATION NAME] (an antipsychotic) 50 mg, one tablet by mouth, twice a day. The MAR indicated [REDACTED].M. dose and no evidence was presented for the 2:00 P.M. scheduled dose on 08/15/20, 08/16/20, 09/07/20 and 09/11/20. The morning and afternoon opportunities for administration were not evidenced on 09/19/20. On 02/21/18 the physician ordered [MEDICATION NAME] (anticonvulsant) 900 mg to be administered by mouth, three times a day. The Medication Administration Record [REDACTED].M. morning doses and the 9:00 P.M. scheduled evening doses. The MAR failed to evidence the evening dose on 08/16/20 and 08/28/20 having been administered. On 12/01/18 the physician ordered [MEDICATION NAME] (for gastric reflux) 20 mg by mouth, each morning. The MAR failed to evidence administration on 08/09/20 and 09/18/20. On 12/21/18 the physician ordered aspirin, 81 mg chewable administered by mouth each day. The MAR failed to evidence administration on 08/11/20. On 12/01/18 the physician ordered [MEDICATION NAME]-[MEDICATION NAME] (for [MEDICAL CONDITION]) 160-4.5 micrograms (mcg), two puffs to be inhaled twice a day. The MAR failed to evidence administration on 08/05/20 and 09/11/20 for the scheduled 9:00 A.M. administration and no evidence was present for the scheduled 5:00 P.M. opportunity on 08/06/20, 09/06/20, 09/09/20 and 09/11/20. On 02/11/20 the physician ordered [MEDICATION NAME] HCL (antianxiety) 10 mg by mouth, three times a day. The MAR failed to evidence administrations for the 1:00 P.M. scheduled dose on 09/11/20 and 09/19/20 and the 5:00 P.M. scheduled doses on 09/09/20 and 09/11/20. On 12/01/18 the physician ordered [MEDICATION NAME] (antihypertensive) 24 hour extended release, 180 mg by mouth, each day. The MAR failed to evidence the 9:00 A.M. administration on 08/11/20 and 08/28/20. On 12/01/28 the physician ordered [MEDICATION NAME] (for enlarged prostate) 5 mg by mouth, each day. The MAR failed to evidence the 9:00 A.M. scheduled administration on 08/25/20. On 12/18/18 the physician ordered [MEDICATION NAME] HCL ([MEDICATION NAME]) 50 mg three times a day by mouth. The MAR failed to evidence administration for the 8:00 A.M. scheduled dose on 08/11/20, the 1:00 P.M. scheduled dose and the 5:00 P.M. scheduled dose on 09/09/20. On 12/01/18 the physician ordered [MEDICATION NAME] (for hypertension and heart failure) 10 mg by mouth, each day. The MAR failed to evidence administration of this medication on 08/11/20 for the scheduled 9:00 A.M. dose. On 12/21/18 the physician ordered Senna (laxative) 8.6 mg tablet twice a day. The MAR failed to evidence administration for the scheduled 9:00 A.M. dose on 08/19/20 and the scheduled 9:00 P.M. dose on 08/07/20, 08/16/20 and 09/09/20. On 12/01/18 the physician ordered [MEDICATION NAME] Respimat ([MEDICAL CONDITION]) 2.5 mcg, two puffs inhaled, once a day. The MAR failed to evidence the administration on 09/11/20. On 12/01/18 the physician ordered lacosamide (anticonvulsant) 100 mg tablet by mouth, every 12 hours. The MAR failed to evidence the administration of the 9:00 A.M. scheduled dose on 08/06/20, 08/07/20, 08/10/20, 08/11/20 and 08/28/20 and the scheduled dose on 08/07/20, 08/12/20 and 08/16/20. On 12/01/18 the physician ordered [MEDICATION NAME] (antipsychotic) 7.5 mg at bedtime. The MAR failed to evidence administration on 08/16/20 and 09/20/20. On 12/01/18 the physician ordered tamsulosin (for enlarged prostate) HCL, 0.4 mg at bedtime. The MAR failed to evidence administration on 08/07/20, 08/16/20, 08/16/20 and 09/09/20. On 12/01/18 the physician ordered trazadone (antidepressant) 200 mg at bedtime. The MAR failed to evidence administration on 08/07/20, 08/16/20 and 09/09/20. Review of the nursing notes for Resident #66 failed to evidence any documentation related to the missing medications and all the designated spaces on the MAR indicated [REDACTED]. On 09/22/20 at 12:45 P.M. an interview was completed with Resident #66 who was alert with an intact cognition. Resident #66 was asked if the staff had failed to administer medications according to the MAR. Resident #66 stated he had never refused medications and if it was not documented then he sometimes did not get his medications. He could not specifically identify each date. 2. Medical record review for Resident #54 revealed a date of birth 12/02/63 and admission into the facility on [DATE] with the latest

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
MAYFIELD HEIGHTS HEALTHCARE.	6757 MAYFIELD RD 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.

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F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) re-entry on 08/30/18. [DIAGNOSES REDACTED]. Review of the comprehensive medical assessment (MDS 3.0) and brief interview for mental status (BIMS) score, dated 08/06/20, revealed a 15 of possible 15 points and this indicated an intact cognition. Medical record review for Resident #54 revealed lack of evidence medications were administered as ordered for the following physicians orders: On 11/29/18 the physician ordered [MEDICATION NAME] (for muscle spasms) 20 mg, every eight hours. Review of the MAR indicated [REDACTED].M. administration on 08/07/20, 08/08/20, 08/29/20, 09/01/20, 09/07/20 and 09/12/20. No evidence was documented for the scheduled 2:00 P.M. administration on 08/18/20, 08/23/20, 08/29/20 and 09/19/20. No evidence was present for the scheduled 10:00 P.M. administration on 08/01/20, 08/20/20, 08/25/20, 08/27/20 and 09/15/20. On 11/29/20 the physician ordered aspirin EC, 81 mg by mouth, twice a day. The MAR failed to evidence administration for the scheduled 8:00 A.M. dose on 08/29/20 and the scheduled 8:00 P.M. evening dose on 08/01/20, 08/19/20, 08/20/20, 08/25/20 and 09/15/20. No evidence was present for the scheduled 8:00 P.M. administration on 08/01/20, 08/19/20, 08/20/20 and 08/25/20. On 11/29/20 the physician ordered dalfampridine (for MS) ER, 10 mg by mouth, twice a day. The MAR failed to evidence administration for the scheduled 8:00 A.M. dose on 08/23/20, 08/29/20 and for the scheduled 8:00 P.M. dose on 08/12/20, 08/13/20, 08/19/20, 08/20/20, 08/25/20 and 09/15/20. On 11/29/18 the physician ordered glatiramer (for MS) 20 mg injected subcutaneously each day at the scheduled time of 8:00 A.M. The MAR failed to evidence the administration of this medication on 08/02/20 and on 08/29/20. On 11/29/18 the physician ordered calcium [MEDICATION NAME] with vitamin D3 (supplement) two tablets by mouth, twice a day, at the scheduled time of 8:00 A.M. and 4:00 P.M. The MAR failed to evidence the scheduled 8:00 A.M. administration of this medication on 08/29/20 and on the scheduled 4:00 P.M. opportunity on 08/18/20, 08/19/20, 08/20/20, 08/22/20, 08/23/20, 08/29/20 and 09/10/20. On 07/16/19 the physician ordered [MEDICATION NAME] (for hypertenion and chest pain) five mg tablet by mouth, each day. The MAR failed to provide documentation for the administration opportunity on 08/02/20, 08/13/20, 08/23/20, 08/29/20 and 09/05/20. On 11/29/20 the physician ordered [MEDICATION NAME] HCL (antianxiety) 10 mg tablet by mouth three times a day. The MAR indicated [REDACTED].M. dose on 08/13/20, 08/23/20 and 08/29/20. No evidence was presented for the scheduled 1:00 P.M. opportunity on 08/19/20, 08/20/20, 08/23/20, 08/29/20 and 09/11/20. The scheduled 5:00 P.M. opportunities had no evidence of administration on 08/01/20, 08/02/20, 08/03/20, 08/18/20, 08/19/20, 08/20/20 and 08/26/20. On 11/29/20 the physician ordered potassium CL ER (supplement) 10 milliequivalents (meq) by mouth each day. The MAR failed to evidence administration on 08/07/20, 08/13/20, 08/29/20, 09/05/20 and 09/19/20. On 11/29/20 the physician had ordered Senna, two - 8.6 mg tablets by mouth, each day. The MAR failed to evidence administration on 08/01/20, 08/16/20, 08/18/20, 08/19/20, 08/20/20, 08/22/20 and 09/17/20. On 11/29/20 the physician ordered [MEDICATION NAME] HCL (antidepressant and for nerve pain) 10 mg tablet, four tablets for a total of 40 mg at bedtime. The facility failed to evidence administration on 08/01/20, 08/10/20, 08/11/20, 08/12/20, 08/15/20, 08/18/20, 08/19/20, 08/20/20, 08/22/20, 08/24/20, 08/25/20, 08/27/20, 09/14/20, 09/15/20, 09/16/20 and 09/17/20. On 11/29/20 the physician ordered [MEDICATION NAME] (anticonvulsant) 300 mg by mouth, four times a day. The MAR failed to evidence administration for the 12:00 A.M. dose on 08/01/20, 08/06/20, 08/21/20, 08/24/20, 09/01/20 and 09/01/20. No evidence was presented for the 6:00 A.M. administration opportunity on 08/01/20, 08/04/20, 08/08/2008/21/20, 08/24/20, 08/25/20, 08/29/20, 09/01/20, 09/07/20, 09/08/20 and 09/09/20. No evidence was present for the 12:00 P.M. administration opportunity on 08/02/20, 08/29/20 or the 6:00 P.M. administration opportunity on 08/01/20, 08/18/20, 08/19/20 and 08/20/20. Review of the nursing notes for Resident #54 failed to evidence any documentation related to the missing medications and all the designated spaces on the MAR indicated [REDACTED]. During an interview on 09/22/20 at 2:50 P.M. with the Director of Nursing, it was verified each nurse administering medications would have been required to document the administration, refusal or other outcome within the documented space on the medication administration record. Discussion as to the findings being the result of missed opportunities to pass medications or failure to document the administration was completed and the DON stated it could be a result of both failures to pass medications and lack of accurate documentation. These findings were verified with the DON at the time of the interview. Review of the document, Administering Medications, revised December 2012, stated under section 18, if a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the Medication Administration Record [REDACTED]. Section 19 revealed the individual administering the medication must initial the resident's MAR indicated [REDACTED]. This deficiency substantiates Complaint Numbers OH 041, OH 666, OH 964 and OH 754.
F 0777 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure the diagnostic X-ray tests, for Resident #8 were delivered to the physician as ordered in a timely manner. This affected one resident, Resident #8, of three residents (Residents #37, #19 and #8) reviewed for diagnostic tests. The facility census was 78. Findings include: Medical record review revealed Resident #8 was admitted to the facility on [DATE] and discharged from the facility on 09/04/20 to home. The primary [DIAGNOSES REDACTED]. Additional [DIAGNOSES REDACTED]. Review of the comprehensive assessment (MDS 3.0) dated 07/27/20 revealed the brief interview for mental status (BIMS) score was 15 of a possible 15 and this indicated an intact cognition for Resident #8. Review of the nursing notes upon admission, 07/23/20 revealed Resident #41 was admitted due to a [MEDICAL CONDITION] humerus and the left arm was in a brace to help prevent movement. Review of the physician order, dated 07/29/20, revealed the staff was to obtain an X-ray of the left humerus, two views. An appointment for a follow up service was ordered for 08/07/20 and to be conducted virtually. The order stated the X-ray films were to be delivered prior to the appointment, to the hospital with the suite number 300 identified. Diagnostics note dated 07/29/20 at 2:44 P.M. revealed a two-view X-ray of the left humerus was ordered for 08/05/20. The CD would be copied and needed to be taken over to the orthopedic surgeon's office located across the street with the address documented. A general progress note, dated 08/05/20 revealed the technician arrived to perform the X-ray at approximately 8:20 A.M. A health status note dated 08/06/20 at 3:03 P.M. revealed the results of X-ray of the left humerus show a mildly displaced and 10 millimeters separated spiral fracture mid-humeral shaft presently and there was no new bone/callus identified. The medical doctor and daughter were notified. Resident #8 had a phone appointment with the orthopedic surgeon on 08/07/20 to discuss the results of the X-ray. Review of the physician order [REDACTED]. Instructions to not remove the brace were attached. The order further stated the X-ray films or disk to remain at the facility and given to the Director of Nursing (DON). Review of a health status note dated 08/07/20 at 5:56 P.M. revealed the orthopedic surgeon's office staff had called to have an X-ray of the left humerus repeated on Tuesday, 08/11/20. The brace was not to be removed during the X-ray. The X-ray disk or films were to be given to the DON for delivery to the orthopedic surgeon's office. A general progress note dated 08/11/20 at 2:48 P.M. revealed the resident's X-ray result was returned to facility and findings included a mildly displaced and 10 mm separated spiral fracture mid humeral shaft. There was no new bone/callus identified. The proximal and distal humeral shafts were unremarkable. Humeral head was maintained, with in the glenoid fossa. Compared with the last study of 08/05/20, the left humerus was without change. Interviews were completed on 9/21/20 1:30 P.M. congruently with the Administrator, DON, and corporate registered nurse (RN) #200 present. During the interview, the DON stated there had been a hiccup with the transfer of the X-ray film or CD to the orthopedic surgeon office located across the street. It was stated the X-ray had been completed as ordered but not delivered across the street to the orthopedic surgeon office prior to the scheduled appointment on 08/07/20. It was standard for the DON or a staff member to deliver the films by walking the X-rays to the orthopedic surgeon's office located across the street. The DON confirmed the X-rays had been completed on 08/05/20 but they had failed to deliver the film or the CD to the orthopedic surgeon's office. The DON further stated the physician had ordered a redo of the X-ray and DON personally took it over. The DON stated the reason for the failure to transfer the X-ray films for Resident #41 was due to communication changes. The finding of the failure to transfer X-rays to the surgeon as ordered was verified with the Administrator, DON and RN #200 at the time of the interview. This deficiency substantiates Complaint Number OH 908.
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** Based on record review and interviews, the facility did not ensure Resident #66 and Resident #54 had a complete and

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F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) accurate medical record. This affected two residents, Resident #66 and #54 of seven residents (Resident #35, #36, #37, #41, #54, #64 and #66) reviewed for medication administration and associated documentation. The facility census was 78. Findings include: Review of the medical record for Resident #66 revealed a date of birth listed 01/13/62 and admission into the facility on [DATE]. [DIAGNOSES REDACTED]. Review of the comprehensive medical assessment (MDS 3.0) and brief interview for mental status (BIMS) score, dated 07/06/20, revealed a 15 of possible 15 points and this indicated an intact cognition. Observations completed during the survey period revealed the nursing staff used paper charting to document the resident's medication pass. Folders or logs with the resident's medication orders and medication administration records were used daily to document the outcomes of medication administration opportunities. Review of the medication administration record (MAR), 08/01/20 through 09/21/20 revealed non-compliance related to documentation of medication administration and the outcome of scheduled medication administration opportunities on the MAR. On 07/10/19 the physician ordered [MEDICATION NAME] ([MEDICAL CONDITION]) 100 milligrams (mg) by mouth, three times a day. The MAR revealed no documentation on to indicate this medication had been given on 08/20/20 12:00 P.M. dose, 09/07/20 5:00 P.M. dose and 09/12/20 5:00 P.M. dose. On 09/19/20 both the 12:00 P.M. and 5:00 P.M. had missing documentation to evidence administration. On 01/25/19 the physician ordered [MEDICATION NAME] (an antipsychotic) 50 mg, one tablet by mouth, twice a day. The MAR revealed no documentation to indicate this medication had been given on 08/09/20, 08/11/20, 08/12/20 and 08/14/20 for the scheduled at 8:00 A.M. dose and no evidence was presented for the 2:00 P.M. scheduled dose on 08/15/20, 08/16/20, 09/07/20 and 09/11/20. The morning and afternoon opportunities for administration were not evidenced on 09/19/20. On 02/21/18 the physician ordered [MEDICATION NAME] (anticonvulsant) 900 mg to be administered by mouth, three times a day. The medication administration record revealed no documentation on the MAR to indicate this medication had been given on 08/11/20, 08/12/20, 09/08/20 and 09/09/20 for the scheduled 8:00 A.M. morning doses and the 9:00 P.M. scheduled evening doses. The MAR failed to evidence the evening dose on 08/16/20 and 08/28/20 having been administered. On 12/01/18 the physician ordered [MEDICATION NAME] (for gastric reflux) 20 mg by mouth, each morning. The MAR failed to evidence administration on 08/09/20 and 09/18/20. On 12/21/18 the physician ordered aspirin, 81 mg chewable administered by mouth each day. The MAR failed to evidence administration on 08/11/20. On 12/01/18 the physician ordered [MEDICATION NAME]-[MEDICATION NAME] (for [MEDICAL CONDITION]) 160-4.5 micrograms (mcg), two puffs to be inhaled twice a day. The MAR failed to evidence administration on 08/05/20 and 09/11/20 for the scheduled 9:00 A.M. administration and no evidence was present for the scheduled 5:00 P.M. opportunity on 08/06/20, 09/06/20, 09/09/20 and 09/11/20. On 02/11/20 the physician ordered [MEDICATION NAME] HCL (antianxiety) 10 mg by mouth, three times a day. The MAR failed to evidence administrations for the 1:00 P.M. scheduled dose on 09/11/20 and 09/19/20 and the 5:00 P.M. scheduled doses on 09/09/20 and 09/11/20. On 12/01/18 the physician ordered [MEDICATION NAME] (antihypertensive) 24 hour extended release, 180 mg by mouth, each day. The MAR failed to evidence the 9:00 A.M. administration on 08/11/20 and 08/28/20. On 12/01/28 the physician ordered [MEDICATION NAME] (for enlarged prostate) 5 mg by mouth, each day. The MAR failed to evidence the 9:00 A.M. scheduled administration on 08/25/20. On 12/18/18 the physician ordered [MEDICATION NAME] HCL ([MEDICATION NAME]) 50 mg three times a day by mouth. The MAR failed to evidence administration for the 8:00 A.M. scheduled dose on 08/11/20, the 1:00 P.M. scheduled dose and the 5:00 P.M. scheduled dose on 09/09/20. On 12/01/18 the physician ordered [MEDICATION NAME] (for hypertension and heart failure) 10 mg by mouth, each day. The MAR failed to evidence administration of this medication on 08/11/20 for the scheduled 9:00 A.M. dose. On 12/21/18 the physician ordered Senna (laxative) 8.6 mg tablet twice a day. The MAR failed to evidence administration for the scheduled 9:00 A.M. dose on 08/19/20 and the scheduled 9:00 P.M. dose on 08/07/20, 08/16/20 and 09/09/20. On 12/01/18 the physician ordered [MEDICATION NAME] Respimat ([MEDICAL CONDITION]) 2.5 mcg, two puffs inhaled, once a day. The MAR failed to evidence the administration on 09/11/20. On 12/01/18 the physician ordered lacosamide (anticonvulsant) 100 mg tablet by mouth, every 12 hours. The MAR failed to evidence the administration of the 9:00 A.M. scheduled dose on 08/06/20, 08/07/20, 08/10/20, 08/11/20 and 08/28/20 and the scheduled dose on 08/07/20, 08/12/20 and 08/16/20. On 12/01/18 the physician ordered [MEDICATION NAME] (antipsychotic) 7.5 mg at bedtime. The MAR failed to evidence administration on 08/16/20 and 09/20/20. On 12/01/18 the physician ordered tamsulosin (for enlarged prostate) HCL, 0.4 mg at bedtime. The MAR failed to evidence administration on 08/07/20, 08/16/20, 08/16/20 and 09/09/20. On 12/01/18 the physician ordered trazadone (antidepressant) 200 mg at bedtime. The MAR failed to evidence administration on 08/07/20, 08/16/20 and 09/09/20. Review of the nursing notes for Resident #66 failed to evidence any documentation related to the missing medications and all the designated spaces on the MAR were left blank for the identified dates above. Review of the nursing notes for Resident #66 failed to evidence any related documentation for the dates the MAR failed to evidence the outcome of the medication pass. These designated spaces on the MAR were left blank for the dates specified above. 2. Medical record review for Resident #54 revealed a date of birth 12/02/63 and admission into the facility on [DATE], latest re-entry on 08/30/18. [DIAGNOSES REDACTED]. Review of the comprehensive medical assessment (MDS 3.0) and brief interview for mental status (BIMS) score, dated 08/06/20, revealed a 15 of possible 15 points and this indicated an intact cognition. Review of the MAR, 08/01/20 through 09/21/20 revealed non-compliance related to medication administration and the outcome of scheduled medication administration opportunities on the MAR. On 11/29/18 the physician ordered [MEDICATION NAME] (for muscle spasms) 20 mg, every eight hours. Review of the MAR revealed no documentation present to evidence the scheduled 6:00 A.M. administration on 08/07/20, 08/08/20, 08/29/20, 09/01/20, 09/07/20 and 09/12/20. No evidence was documented for the scheduled 2:00 P.M. administration on 08/18/20, 08/23/20, 08/29/20 and 09/19/20. No evidence was present for the scheduled 10:00 P.M. administration on 08/01/20, 08/20/20, 08/25/20, 08/27/20 and 09/15/20. On 11/29/20 the physician ordered aspirin EC, 81 mg by mouth, twice a day. The MAR failed to evidence administration for the scheduled 8:00 A.M. dose on 08/29/20 and the scheduled 8:00 P.M. evening dose on 08/01/20, 08/19/20, 08/20/20, 08/25/20 and 09/15/20. No evidence was present for the scheduled 8:00 P.M. administration on 08/01/20, 08/19/20, 08/20/20 and 08/25/20. On 11/29/20 the physician ordered dalfampridine (for MS) ER, 10 mg by mouth, twice a day. The MAR failed to evidence administration for the scheduled 8:00 A.M. dose on 08/23/20, 08/29/20 and for the scheduled 8:00 P.M. dose on 08/12/20, 08/13/20, 08/19/20, 08/20/20, 08/25/20 and 09/15/20. On 11/29/18 the physician ordered glatiramer (for MS) 20 mg injected subcutaneously each day at the scheduled time of 8:00 A.M. The MAR failed to evidence the administration of this medication on 08/02/20 and on 08/29/20. On 11/29/18 the physician ordered calcium [MEDICATION NAME] with vitamin D3 (supplement) two tablets by mouth, twice a day, at the scheduled time of 8:00 A.M. and 4:00 P.M. The MAR failed to evidence the scheduled 8:00 A.M. administration of this medication on 08/29/20 and on the scheduled 4:00 P.M. opportunity on 08/18/20, 08/19/20, 08/20/20, 08/22/20, 08/23/20, 08/29/20 and 09/10/20. On 07/16/19 the physician ordered [MEDICATION NAME] (for hypertenion and chest pain) five mg tablet by mouth, each day. The MAR failed to provide documentation for the administration opportunity on 08/02/20, 08/13/20, 08/23/20, 08/29/20 and 09/05/20. On 11/29/20 the physician ordered [MEDICATION NAME] HCL (antianxiety) 10 mg tablet by mouth three times a day. The MAR did not contain documentation to evidence administration for the scheduled 9:00 A.M. dose on 08/13/20, 08/23/20 and 08/29/20. No evidence was presented for the scheduled 1:00 P.M. opportunity on 08/19/20, 08/20/20, 08/23/20, 08/29/20 and 09/11/20. The scheduled 5:00 P.M. opportunities had no evidence of administration on 08/01/20, 08/02/20, 08/03/20, 08/18/20, 08/19/20, 08/20/20 and 08/26/20. On 11/29/20 the physician ordered potassium CL ER (supplement) 10 milliequivalents (meq) by mouth each day. The MAR failed to evidence administration on 08/07/20, 08/13/20, 08/29/20, 09/05/20 and 09/19/20. On 11/29/20 the physician had ordered Senna, two - 8.6 mg tablets by mouth, each day. The MAR failed to evidence administration on 08/01/20, 08/16/20, 08/18/20, 08/19/20, 08/20/20, 08/22/20 and 09/17/20. On 11/29/20 the physician ordered [MEDICATION NAME] HCL (antidepressant and for nerve pain) 10 mg tablet, four tablets for a total of 40 mg at bedtime. The facility failed to evidence administration on 08/01/20, 08/10/20, 08/11/20, 08/12/20, 08/15/20, 08/18/20, 08/19/20, 08/20/20, 08/22/20, 08/24/20, 08/25/20, 08/27/20, 09/14/20, 09/15/20, 09/16/20 and 09/17/20. On 11/29/20 the physician ordered [MEDICATION NAME] (anticonvulsant) 300 mg by mouth, four times a day. The MAR failed to evidence administration for the 12:00 A.M. dose on 08/01/20, 08/06/20, 08/21/20, 08/24/20, 09/01/20 and 09/01/20. No evidence was presented for the 6:00 A.M. administration opportunity on 08/01/20, 08/04/20, 08/08/2008/21/20, 08/24/20, 08/25/20, 08/29/20, 09/01/20, 09/07/20, 09/08/20 and 09/09/20. No evidence was present for the 12:00 P.M. administration opportunity on 08/02/20, 08/29/20 or the 6:00 P.M. administration opportunity on 08/01/20, 08/18/20, 08/19/20 and 08/20/20. Review of the nursing notes for Resident #54 failed to evidence any related documentation for the dates the MAR failed to evidence the outcome of the medication pass. These designated spaces on the MAR were left blank for the dates specified above. Observations completed during the survey period revealed the nursing staff used paper charting to document resident's medication pass. Folders or logs with the resident's medication orders and medication administration records were used daily to document the outcomes of medication administration opportunities. Interview with Registered Nurse (RN) #901 was completed on 09/22/20 at 7:20 A.M. and verified all nurses were required to document each resident's medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365355	A. BUILDING _____ B. WING _____	09/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MAYFIELD HEIGHTS HEALTHCARE.	6757 MAYFIELD RD 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 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) pass in the MAR and the outcome of the opportunity to administer the medication. Interview with RN #900 was completed on 09/24/20 at 2:10 P.M. and verified all nurses were required to document each resident's medication pass in the MAR and the outcome of the opportunity to administer the medication. During interview on 09/22/20 at 2:50 P.M. with the Director of Nursing (DON) it was verified each nurse administering medications would have been required to document the administration, refusal or other outcome within the documented space on the medication administration record. This was standard nursing practice. Discussion as to the findings being the result of missed opportunities to pass medications or failure to document the administration was completed and the DON stated it could be a result of both failures to pass medications and lack of accurate documentation. These findings were verified with the DON at the time of the interview. Review of the document, Administering Medications, revised December 2012, stated under section 18, if a drug was withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall have initial and circle the medication administration record (MAR) space provided for that drug and dose. Section 19 revealed the individual administering the medication must initial the resident's MAR on the appropriate line after giving each medication and before administering the next ones. This deficiency substantiates Complaint Numbers OH 041, OH 666, OH 964 and OH 754.
F 0908 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Keep all essential equipment working safely.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and review of maintenance records the facility failed to ensure oxygen concentrators used to supply oxygen to Resident #100 and Resident #101 had been inspected annually for service as required. This affected two (Residents #100 and #101) of three residents (Residents #100, #101 and #102) reviewed for oxygen concentrator maintenance. This deficiency had the potential to affect 11 residents identified as requiring the use of an oxygen concentrator, (Residents #100, #101, #102, #110, #111, #112, #113, #114, #115, #116 and #117). The facility census was 78. Findings include: 1. Medical record review for Resident #100 revealed a birth date of [DATE] and an admission on [DATE]. [DIAGNOSES REDACTED]. an order for [REDACTED].M. Resident #100 was observed with an oxygen concentrator (a machine used to make oxygen from room air at the bedside) that delivered oxygen to the resident. The service sticker on the front of the machine stated the next service was due on [DATE]. No evidence was located on the machine to show the concentrator had an annual service. 2. Medical record review for Resident #101 revealed a birth date of [DATE] and admission on [DATE]. [DIAGNOSES REDACTED]. an order for [REDACTED].M. Resident #101 was observed with an oxygen concentrator and the maintenance service sticker on the front of the machine stated the next service was due on [DATE]. No evidence was located on the machine to show the concentrator had had an annual service. During the observation, Resident #102 stated the filter had looked dirty and the observed filter was covered in dust. During interview with the Administrator and Director of Nursing on [DATE] at 5:30 P.M. it was stated the facility could not produce evidence of the annual inspection for the oxygen concentrators. At the time of the interview the Administrator stated all the oxygen concentrator units should have been serviced prior to the date stated on the expired maintenance sticker and should have been serviced annually. This deficiency substantiates Complaint Number OH 964.