STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366158	A. BUILDING _____ B. WING _____	06/18/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE PAVILION REHABILITATION AND NURSING CENTER	13900 BENNETT ROAD NORTH ROYALTON, OH 44133

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 record review, interview and policy review, the facility failed to ensure thorough fall investigations. This affected one resident (Resident #33) of three residents (Residents #6, #11 and #33) reviewed for accidents. The facility census was 58. Findings include: Review of the medical record for Resident #33 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the comprehensive Minimum Data Set (MDS) 3.0 assessment, dated 05/22/20, revealed the resident had severely impaired cognition. The resident required total dependence with assistance of two staff for mobility and extensive assistance of two staff for transfers. Review of a Fall Risk Assessments dated 01/22/20, 03/08/20, 04/22/20 and 06/08/20 revealed the resident was at high risk for falls. Review of the nurse's notes dated 02/25/20 at 9:20 A.M. the nurse heard the alarm going off and found the resident sitting on the floor with her back to the bed. She was rubbing her left cheek which was red and slightly discolored. The resident stated she tried to get up and fell and hit her cheek. She was sent to the emergency room (ER) for a computed tomography (CT) scan. She was admitted to the hospital and returned on 03/02/20 with no new fall prevention interventions initiated. There was no documented evidence a thorough fall investigation was completed. Review of the Medicare 5-day MDS 3.0 assessment, dated 03/09/20, revealed the resident had severe cognitive impairment. The resident required extensive assistance of two staff for transfers and extensive assistance of one staff for ambulation. Review of the nurse's note dated 03/14/20 at 9:25 A.M. revealed the resident was found sitting on her buttocks on the floor in front of her wheelchair holding her head by housekeeping. There was no documented evidence that the wheelchair alarm was sounding, or non-skid socks were in use at the time of the fall. The resident was sent to the ER for evaluation. She returned to the facility, and new orders were received for a pull tab alarm to her chair at all times and a pressure bed alarm to her bed at all times. There was no documented evidence a thorough fall investigation was completed. Review of the nurse's notes dated 04/05/20 at 6:00 P.M. revealed the resident had an unwitnessed fall in the common area. There was no documented evidence the alarm was sounding, or non-skid socks were in place at the time of the fall. There was no documented evidence a thorough fall investigation was completed. Review of the nurse's note dated 04/10/20 at 2:33 P.M. revealed the nurse heard a loud boom, and the resident was found on the floor. When asked if she was in pain, the resident pointed to her head and right hip. 9-1-1 was called, and the resident was transferred to the ER. There was no documented evidence that the alarms were sounding or non-skid socks in were place at the time of the fall. The resident returned to the facility after being evaluated in the ER, and no new fall prevention interventions were implemented. There was no documented evidence a thorough fall investigation was completed. Review of the nurse's note dated 04/13/20 at 11:04 A.M. revealed the staff heard the bed alarm sounding and found the resident lying on the floor at the end of the bed with her head against the wall. The resident had a laceration to the back of her head with a small amount of blood and a hematoma. Non-skid socks were in place. The resident was sent to the ER and returned to the facility. No new fall prevention interventions were implemented. There was no documented evidence a thorough fall investigation was completed. Review of the nurse's note dated 04/13/20 at 6:28 P.M. revealed the nurse was in the dining room with the resident and turned to walk to the doorway when the nurse heard a loud noise and turned to observe the resident lying face first on the floor with a skin tear noted to her right forearm. The wheelchair was tilted forward, one brake was on, and a lap buddy (a pillow that snugs into the frame of the wheelchair and is meant to gently remind the occupant to ask for help before getting up) to and a foot buddy (a cushion to prevent the resident's feet from falling through the wheelchair leg rests)were in place. The resident did not have physician's orders [REDACTED]. There was no documented evidence that the wheelchair alarm was sounding, and no new fall prevention interventions were implemented. There was no documented evidence a thorough fall investigation was completed. Review of the nurse's note dated 04/22/20 at 6:00 A.M. revealed staff heard the alarm going off and found the resident on the floor mat with her head upright, back against the bed and legs extended on the floor. There was no documented evidence that the non-skid socks were in place. The staff re-educated the resident on using the call light. Review of the fall investigation report dated 04/24/20 at 7:47 A.M. revealed that Resident #33 had a fall. The report indicated what interventions were in place when the fall occurred. There were no new fall prevention interventions documented. Review of the quarterly MDS 3.0 assessment, dated 04/26/20, revealed severe cognitive impairment. The resident required extensive assistance of two staff for transfers and minimal assistance of one staff for ambulation. Review of the nurse's note dated 05/03/20 at 4:31 P.M. revealed the resident was observed on the floor next to the bed. She had gone over the bed bolsters (long narrow firm cushion placed on the sides of the mattress to prevent a fall from the bed) and landed on the floor mat. She had no documented physician's orders [REDACTED]. There were no new fall prevention interventions implemented. There was no documented evidence a thorough fall investigation was completed. Review of the nurse's note dated 05/07/20 at 1:54 A.M. revealed the resident was medicated with [MEDICATION NAME] (narcotic pain medication). The nurse stated Resident #33 was in bed with the bed in the lowest position, mat on the floor and bed alarm on the bed. The nurse proceeded to go to another resident's room to administer medications and heard a loud noise coming from Resident #33's room. She ran into the room and observed the resident lying on the mat on the floor on her right side with blood on her hands. She had bruising noted to the middle of her forehead with two medium sized open areas. She was transferred to the ER. There was no documented evidence a thorough fall investigation was completed. Review of the hospital notes dated 05/07/20 revealed that she was diagnosed with [REDACTED]. Review of the medical record revealed the resident returned to the facility on [DATE]. Review of the physician's orders [REDACTED]. Light weighted blanket for anxiety was ordered on [DATE]. Review of the nurse's note dated 06/08/20 at 8:34 P.M. revealed the resident had fallen out of her wheelchair before the state tested nurse aide (STNA) could get to her. The resident was bleeding from the nose and transferred to the ER by ambulance. There was no documented evidence that the wheelchair alarm was sounding. Review of the nurse's note dated 06/09/20 at 5:45 A.M. revealed Resident #33 returned to the hospital at 5:15 A.M. Review of the hospital notes dated 06/09/20 revealed that Resident #33 was seen for nasal fracture. Review of the physician's orders [REDACTED]. Interview on 06/15/20 at 9:04 A.M. with Director of Nursing (DON) revealed he was hired in May and does not know much about the falls prior to 05/11/20. Resident #33's on 05/12/20 had an intervention of a weighted blanket and alarm. Medications were changed on 05/19/20 and a GeneSight test (a test to analyze how your genes may respond to and metabolized antidepressants). He verified that there was no documentation of what interventions were in place and no new interventions documented at the time the falls prior to him being hired on 05/11/20, and there was no documented evidence the alarm was sounding at the time of the fall on 06/08/20. The DON stated Resident #33 had interventions in place all the time. The lap buddy was reinstated on 06/09/20 after a trial period without it. The trial period started 06/08/20. Review of facility policy titled Falls and Fall Risk, Managing, dated 12/2007, revealed the facility did not implement the policy regarding the allegation. The policy states staff will monitor and document each resident's response to interventions intended to reduce falling or the risk of falling. If resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change interventions. The staff and/or physician will document the basis for conclusions that specify irreversible risk factors exist that continue to present a risk for falling or injury due to falls. This deficiency

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

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	366158	A. BUILDING _____ B. WING _____	06/18/2020

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THE PAVILION REHABILITATION AND NURSING CENTER	13900 BENNETT ROAD NORTH ROYALTON, OH 44133

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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 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) substantiates Complaint Number OH 335.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and policy review, the facility failed to ensure care plans were revised for Resident #33 in the areas of falls. This affected one resident (Resident #33) of three residents (Residents #6, #11 and #33) reviewed for accidents. The facility census was 58. Findings include: Review of the medical record for Resident #33 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the comprehensive Minimum Data Set (MDS) 3.0 assessment, dated 05/22/20, revealed the resident had severely impaired cognition. The resident required total dependence with assistance of two staff for mobility and extensive assistance with two staff for transfers. Review of a Fall Risk Assessments dated 01/22/20, 03/08/20, 04/22/20, and 06/08/20 revealed the resident was at high risk for falls. Review of the physician's orders [REDACTED]. Light weighted blanket for anxiety was ordered on [DATE]. Review of the physician's orders [REDACTED]. Review of the Resident #33's fall care plan dated 06/09/20 revealed that Resident #33 was at risk for falls. Intervention included ensure non-skid footwear, bed in lowest position, call light within reach, lap buddy reinstated after discontinuing trial, consult for medication review, and light weighted blanket to reduce anxiety. The bed and chair alarms, floor mat and bed bolsters were not documented on the plan of care. Interview on 6/17/20 at 1:55 P.M. with MDS Nurse #113 revealed care plans are updated quarterly, upon readmission, significant change and after a fall meeting. Fall meetings are held the day after a fall. MDS Nurse #113 stated that he does not keep notes and probably missed some interventions. Review of facility policy titled Falls and Fall Risk, Managing, dated 12/2007, revealed the facility did not implement the policy regarding the allegation. The policy states staff will monitor and document each resident's response to interventions intended to reduce falling or the risk of falling. If resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change interventions. The staff and/or physician will document the basis for conclusions that specify irreversible risk factors exist that continue to present a risk for falling or injury due to falls. This deficiency substantiates Complaint Number OH 335.
F 0689 **Level of harm** - 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, interview and policy review, the facility to ensure fall prevention interventions were in place as ordered by the physician and failed to implement new fall prevention measures after multiple falls for one resident (Resident #33). Actual harm occurred on 05/07/20 when Resident #33 fell out of bed resulting in rib fractures and scalp lacerations and 06/08/20 when physician ordered fall prevention interventions were not in place, and Resident #33 fell resulting in the resident being sent to the emergency room for a nasal fracture. This affected one resident (Resident #33) of three residents (Residents #6, #11 and #33) reviewed for accidents. The facility census was 58. Findings include: Review of the medical record for Resident #33 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of a Fall Risk assessment dated [DATE] revealed the resident was at high risk for falls. Review of the Resident #33's fall care plan dated 01/24/20 revealed Resident #33 was at risk for falls. Intervention included ensure non-skid footwear. Review of the admission Minimum Data Set (MDS) 3,0 assessment dated [DATE] revealed the resident had severe cognitive impairment. She was non-ambulatory and required extensive assistance of two staff for bed mobility. Review of the physician's orders [REDACTED]. Review of the nurse's notes dated 02/25/20 at 9:20 A.M. revealed the nurse heard the alarm going off and found the resident sitting on the floor with her back to the bed. She was rubbing her left cheek which was red and slightly discolored. The resident stated she tried to get up and fell and hit her cheek. She was sent to the emergency room (ER) for a computed tomography (CT) scan. She was admitted to the hospital and returned on 03/02/20 with no new fall prevention interventions initiated. There was no documented evidence a thorough fall investigation was completed. Review of the Fall Risk assessment dated [DATE] revealed the resident was at high risk for falls. Review of the Medicare 5-day MDS 3.0 assessment, dated 03/09/20, revealed the resident had severe cognitive impairment. The resident required extensive assistance of two staff for transfers and extensive assistance of one staff for ambulation. Review of the nurse's note dated 03/14/20 at 9:25 A.M. revealed the resident was found sitting on her buttocks on the floor in front of her wheelchair holding her head by housekeeping. There was no documented evidence that the wheelchair alarm was sounding or non-skid socks in use at the time of the fall. The resident was sent to the ER for evaluation. She returned to the facility and new orders were received for a pull tab alarm to her chair at all times and a pressure bed alarm to her bed at all times. Review of the nurse's notes dated 04/05/20 at 6:00 P.M. revealed the resident had an unwitnessed fall in the common area. There was no documented evidence that the alarm was sounding, or non-skid socks were in place at the time of the fall. No new fall prevention interventions were implemented. There was no documented evidence a thorough fall investigation was completed. Review of the nurse's note dated 04/10/20 at 2:33 P.M. revealed the nurse heard a loud boom, and the resident was found on the floor. When asked if she was in pain, the resident pointed to her head and right hip. 9-1-1 was called, and the resident was transferred to the ER. There was no documented evidence that the alarms were sounding or non-skid socks in were place at the time of the fall. The resident returned to the facility after being evaluated in the ER, and no new fall prevention interventions were implemented. There was no documented evidence a thorough fall investigation was completed. Review of the nurse's note dated 04/13/20 at 11:04 A.M. revealed the staff heard the bed alarm sounding and found the resident lying on the floor at the end of the bed with her head against the wall. The resident had a laceration to the back of her head with a small amount of blood and a hematoma. Non-skid socks were in place. The resident was sent to the ER and returned to the facility. No new fall prevention interventions were implemented. There was no documented evidence a thorough fall investigation was completed. Review of the nurse's note dated 04/13/20 at 6:28 P.M. revealed the nurse was in the dining room with the resident and turned to walk to the doorway when the nurse heard a loud noise and turned to observe the resident lying face first on the floor with a skin tear noted to her right forearm. The wheelchair was tilted forward, one brake was on, and a lap buddy (a pillow that snugs into the frame of the wheelchair and is meant to gently remind the occupant to ask for help before getting up) and a foot buddy (a cushion to prevent the resident's feet from falling through the wheelchair leg rests)were in place. The resident did not have physician's orders [REDACTED]. There was no documented evidence that the wheelchair alarm was sounding, and no new fall prevention interventions were implemented. There was no documented evidence a thorough fall investigation was completed. Review of the nurse's note dated 04/22/20 at 6:00 A.M. revealed staff heard the alarm going off and found the resident on the floor mat with head upright, back against the bed and legs extended on the floor. There was no documented evidence that the non-skid socks were in place. The staff re-educated the resident on using the call light despite her severe cognitive impairment. No further fall prevention interventions were implemented. There was no documented evidence a thorough fall investigation was completed. Review of the Fall Risk assessment dated [DATE] revealed the resident was at high risk for falls. Review of the quarterly MDS 3.0 assessment, dated 04/26/20, revealed severe cognitive impairment. The resident required extensive assistance of two staff for transfers and minimal assistance of one staff for ambulation. Review of the nurse's note dated 05/03/20 at 4:31 P.M. revealed the resident was observed on the floor next to the bed. She had gone over the bed bolsters (long narrow firm cushion placed on the sides of the mattress to prevent a fall from the bed) and landed on the floor mat. She had no documented physician's orders [REDACTED]. There were no new fall prevention interventions implemented. There was no documented evidence a thorough fall investigation was completed. Review of the nurse's note dated 05/07/20 at 1:54 A.M. revealed the resident was medicated with [MEDICATION NAME] (narcotic pain medication). The nurse stated she was in bed with the bed in the lowest position, mat on the floor and bed alarm on the bed. The nurse proceeded to go to another resident's room to administer medications and heard a loud noise coming from Resident #33's room. She ran into the room and observed the resident lying on the mat on the floor on her right side with blood on her hands. She had bruising noted to the middle of her forehead with two medium sized open areas. She was transferred to the ER. Review of the hospital notes dated 05/07/20 revealed that she was diagnosed with [REDACTED]. Review of Resident #33's physician's orders [REDACTED]. physician's orders [REDACTED]. Review of the nurse's note dated 06/08/20 at 8:34 P.M. revealed the resident had fallen out of her wheelchair before the state tested nurse aide (STNA) could get to her. The resident was bleeding from the nose and

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) transferred to the ER by ambulance. There was no documented evidence that the wheelchair alarm was sounding. The resident returned to the facility with a fractured nose. Review of the Fall Risk assessment dated [DATE] revealed the resident was at high risk for falls. Review of the hospital notes dated 06/09/20 revealed that Resident #33 was seen for nasal fracture. Review of the physician's orders [REDACTED]. Review of the fall investigation dated 06/09/20 at 8:29 A.M. revealed that Resident #33 had a fall and sent out to emergency room as an immediate intervention for evaluation and treatment. Lap buddy was reinstated as intervention after a discontinued trial period. No other current interventions were mentioned. Interview on 06/15/20 at 9:04 A.M. with Director of Nursing (DON) revealed he was hired in May and does not have first-hand knowledge of falls prior to 05/11/20 (DON's date of hire). The DON verified, regarding all Resident #33's falls from 02/25/20 through 06/09/20 there was no evidence ordered interventions were in place at the time of the falls. He also verified the lack of a thorough investigation for each fall and no new interventions were initiated to prevent further falls. Review of facility policy titled Falls and Fall Risk, managing, dated 12/2007, revealed the facility did not implement the policy regarding the allegation. The policy states staff will monitor and document each resident's response to interventions intended to reduce falling or the risk of falling. If resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change interventions. The staff and/or physician will document the basis for conclusions that specify irreversible risk factors exist that continue to present a risk for falling or injury due to falls. This deficiency substantiates Complaint Number OH 335.