STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365305	A. Building B. Wing	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willoughby Post Acute	37603 Euclid Ave Willoughby, OH 44094

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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0697 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed record review, policy review and interview, the facility failed to provide adequate and timely pain assessment and interventions following a fall with acute injury. This affected one resident (#148) of three residents reviewed for pain. The facility census was 146. Actual Harm occurred on 09/25/25 when Resident #148 was diagnosed with displaced fractures of the left lower leg bones (tibia and fibula) from a fall that had occurred on 09/24/25. Resident #148, who was admitted to the facility on [DATE] for respite care with hospice services was not adequately assessed or provided timely pain interventions following the fall on 09/24/25. During the morning of 09/25/25 it was noted Resident #148 had been up all night the previous night screaming, crying loudly and being aggressive. Resident #148's pain escalated throughout the day on 09/25/25 until an x-ray was ordered. On 09/25/25 at 7:04 P.M. (almost 24 hours after the fall) the radiology report identified the resident's fractures, and the resident was then transferred to the hospital for treatment. The resident did not return to the facility. Findings include: Review of the closed medical record for Resident #148 revealed an admission date of 09/24/25 and discharge date of 09/25/25. Resident #148 had diagnoses including senile degeneration of the brain, vascular dementia, diabetes, anxiety disorder, and unspecified fall-subsequent encounter. Review of the admission Summary note dated 09/24/25 at 12:20 P.M. revealed Resident #148 was admitted for respite care. The family dropped off the resident. The resident was confused but easy to redirect and able to voice his needs. The resident received hospice care, and self-propelled around the second floor in his wheelchair. Medications were verified by the physician. There was no evidence of a pain assessment being completed at the time of admission. Review of the physician orders for Resident #148 revealed an order dated 09/24/25 at 7:45 P.M. for Lorazepam (Ativan) 0.5 milligrams (mg) by mouth every four hours as needed for anxiety or restlessness, and Morphine Sulfate (concentrate), an opioid analgesic used to treat moderate to severe pain (100 mg per 5 milliliters (ml)) give 0.5 ml by mouth every four hours as needed for pain or shortness of breath. On 09/25/25 at 9:30 A.M. there was an order for Lidocaine Pain Relief External Patch 4% to the lower back and ribs once daily for pain. Review of a nurse's note dated 09/24/25 at 8:14 P.M. by Licensed Practical Nurse (LPN) #201 revealed Resident #148 was sitting on the floor of the internet cafe at about 7:30 P.M. The note included vital signs were within normal limits. Skin check and range of motion (ROM) were performed, and the note revealed the resident had no apparent injuries noted. The resident was transferred to his wheelchair. The resident's doctor, ex-wife, and unit manager were notified. There was no evidence of a pain assessment being completed or of hospice being notified of the incident. Review of a nurse's note dated 09/25/25 at 6:44 A.M. by Registered Nurse (RN) #204 revealed Resident #148 was up all-night screaming, crying loudly and was aggressive. The resident was not directable and continued to cry out and moan. Resident #148 complained of knee pain. The resident continued to remove his indwelling urinary catheter from his drainage bag leaving urine on the floor beside the bed. The resident would not keep his gown on, and his gown and bed linens were changed three times. There was no evidence of hospice being notified of the resident's condition throughout the night. Review of the Hospice Visit Summary dated 09/25/25 from 11:16 A.M. to 12:32 P.M. revealed an unidentified hospice aide and nurse visited Resident #148 and upon arrival at the facility the resident was heard screaming down the hallway. The resident was seen in bed covered with urine, so they got him up into a chair, and changed him and the bed, during which Resident #148 screamed in pain again. The resident's left knee was swollen, bruised and red. The resident was unable to bear weight to left hip or straighten his left knee. The facility's Director of Nursing (DON) and Unit Manager (UM) #206 entered the room and stated they did not know the resident was hurt but had reports which indicated Resident #148 fell the previous day with no injuries and neurological checks within normal limits. The summary revealed this was the first hospice was informed of the fall that had occurred on the previous day. The hospice physician was notified and gave an order for an x-ray. The facility was notified of the new order and was obtaining it. The resident's power of attorney (POA) was in agreement, and the facility was to contact hospice with the x-ray results. Review of a nurse's note dated 09/25/25 at 3:12 P.M. by RN #211 revealed an unidentified hospice nurse notified the facility of Resident #148 having swelling to the left knee and it was red and warm to the touch. The resident was medicated with Morphine as ordered and it had positive effects. Additionally, an x-ray was ordered of the left ankle. The resident's mother was updated about the new order. Review of the medication administration record for September 2025 revealed no medication was documented as offered, refused or received to