STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366111	A. Building B. Wing	04/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Falling Water Healthcare Center	18840 Falling Water Strongsville, OH 44136

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37096 Based on medical record review, observation, staff interview, and review of the facility policy, the facility failed to maintain a medication error rate of less than five percent (%). The medication error was 12.00% due to three observed medication errors for 25 medication administration opportunities. This affected two (Residents #9 and #42) of four residents observed for medication administration. The facility census was 94 residents. Findings include: 1. Review of the medical record for Resident #9 revealed an admitted [DATE] with diagnoses including dysphagia, hemiplegia, aphasia, anxiety disorder and reflux disease. Review of the comprehensive Minimum Data Set (MDS) assessment for Resident #9 dated [DATE] revealed the resident had impaired cognition and required staff assistance with bed mobility, transfers, and personal hygiene. Review of the [DATE] physician's orders for Resident #9 revealed the resident had an order for Aspirin 81 milligram (mg) enteric coated, delayed release tablet by mouth daily. Observation on [DATE] at 8:32 A.M. revealed Licensed Practical Nurse (LPN) #204 prepared Resident #9's morning medications which included a chewable Aspirin 81 mg tablet. The aspirin tablet was administered whole, and the resident swallowed the tablet with water. Interview on [DATE] at 8:44 A.M. with LPN #204 confirmed she administered a chewable aspirin tablet to Resident #9, but the resident's order was for an enteric coated, delayed release tablet. 2. Review of the medical record for Resident #42 revealed an admitted [DATE] with diagnoses including bipolar disorder, depression, chronic obstructive pulmonary disease, and coronary artery disease. Review of the comprehensive MDS assessment for Resident #42 dated [DATE] revealed the resident had impaired cognition and required staff assistance with bed mobility, transfers, and personal hygiene. (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: 366111	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2024
NAME OF PROVIDER OR SUPPLIER Falling Water Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 18840 Falling Water Strongsville, OH 44136	

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the [DATE] physician's orders for Resident #42 revealed an order for Mucinex 600 mg by mouth every 12 hours and an order to give an iron tablet extend release by mouth every morning and evening for iron deficiency. The order did not indicate how many mg of iron was needed. Observation on [DATE] at 9:00 A.M. revealed LPN #250 administered Resident #42's morning medications including a Mucinex 600 mg with an expiration date of ,d+[DATE] and an iron 50 mg extended-release tablet to the resident. Interview on [DATE] at 9:07 A.M. with LPN #250 confirmed she did not check Resident #42's Mucinex for an expiration date and the dose she administered to the resident was expired. LPN #250 further confirmed Resident #42's iron order did not include a dose, and she administered iron 50 mg extended release because it was the only extended iron tablet available. Interview on [DATE] at 9:09 A.M. with LPN #210, Clinical Manager, confirmed the order for Resident #42's iron had no dose listed. Review of the facility policy titled Medication Administration revealed the policy was to provide resident centered care that met the psychosocial, physical and emotional needs and concerns of the resident. This deficiency represents noncompliance investigated under Complaint Number OH00151491.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366111	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2024
NAME OF PROVIDER OR SUPPLIER Falling Water Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 18840 Falling Water Strongsville, OH 44136	

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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 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** 37096 Based on medical record review, staff interview, review of the emergency medical service report (EMS), and review of the facility policy, the facility failed to ensure the resident medical record included accurate documentation. This affected one (Resident #95) of three residents whose records were reviewed for medical record documentation. The facility census was 94 residents. Finding include: Review of the medical record for Resident #95 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included cerebral infarction, a stroke, chronic kidney disease. Review of the Minimum Data Set (MDS) assessment for Resident #95 dated 02/18/24 revealed the resident had moderately impaired cognition and was dependent on staff assistance with transfers and used a wheelchair. Review of the progress note for Resident #95 dated 03/14/24 timed at 2:21 P.M. revealed the resident left for an eye appointment. Review of the progress note for Resident #95 dated 03/15/24 timed at 04:04 A.M. revealed the nurse called the emergency room for an update on the resident. Review of the EMS report for Resident #95 dated 3/14/23 timed at 5:04 P.M. revealed the resident was in the back of the facility van and started sliding out of her wheelchair. The resident complained of chest pain and stated she felt weak and sick. Further review of the report revealed the resident was taken off the van, put on a stretcher, and transported via ambulance to the emergency room . Interview on 04/04/24 at 3:15 P.M. with Transporter #233 confirmed upon return trip back from an appointment Resident #95 started to slide out of her chair. The transporter stopped the van, called 911, and positioned himself against the resident's knees to prevent the resident from sliding out of her chair. The resident was transported by EMS to the emergency room . Review of the progress notes for Resident #95 dated 03/14/24 through 03/15/24 revealed the notes did not include documentation regarding the incident described by Transporter #233 in which the resident started to slide out of her chair and was transported to the hospital via EMS. Interview on 04/15/24 at 3:03 P.M. with the Director of Nursing (DON) confirmed Resident #95's medical record did include documentation regarding the incident described by Transporter #233 in which the resident started to slide out of her chair and was transported to the hospital via EMS. Review of the policy titled Clinical Documentation Standards undated revealed nurses should follow the basic standard of practice for documentation which included providing a timely and accurate account of resident information in the medical record.