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	12/19/2024

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 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** 34297 THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENCE OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY Based on observation, record review and interview, the facility failed to provide adequate care and services to prevent a second degree burn on the Resident #68's right hand. Actual Harm occurred on 12/03/24 when Resident #68 sustained a second degree burn to her right dorsal hand after spilling hot noodle soup onto her right hand. The soup had been heated in a microwave by nursing staff at an unknown hot temperature and then handed to the resident who was standing in the area. This affected one resident (#68) of three residents reviewed for accidents/hazards. Findings include: Review of Resident #68's medical record revealed the resident was admitted on [DATE] with diagnoses including unspecified dementia, essential hypertension and bipolar disorder. Review of Resident #68's physician orders revealed an order dated 06/28/24 for a regular diet, regular texture with regular consistency. Review of Resident #68's Hot Liquid Evaluation form dated 09/26/24 revealed the resident did not have indicators for severe cognitive impairment, poor safety awareness, tremors, contractures, weakness or posture concerns. The assessment revealed there were no other indicators not listed above. Review of Resident #68's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited moderate cognitive impairment. The resident resided on the secured memory care unit on the second floor. Review of a facility Occurrence Form #1223725 dated 12/03/24 at 4:11 P.M. revealed the nurse was sitting at the nursing station charting and the resident was handed a cooked noodle cup by the Certified Nursing Assistant (CNA). The resident sat the noodle cup on her roller walker and took a step backwards and lost her balance falling onto the floor. The incident was witnessed by staff. (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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #68's Acute Visit Nurse Practitioner (NP) note dated 12/03/24 authored by NP #815 revealed the resident had a past medical history (PMH) of hypertension, diabetes, bipolar fell on to the floor in the secured unit. This was a witnessed fall. She hit her head to the floor with no bleeding, no hematoma and neurological checks were initiated. Her mental status was per the baseline and range of motion was per the baseline. The resident stood up with assistance and started walking with the walker. She also had spilled hot soup on her right hand and complained of burning. No blisters and an ice pack was applied. Review of Resident #68's Skin Grid Non-Pressure form dated 12/03/24 at 4:12 P.M. revealed the resident had right hand (back) redness which was classified as a burn. The wound measured one cm (centimeter) length by 2.0 cm width with no depth. The wound was red, moist grainy, with optimal granulation color and pain. Review of Resident #68's progress note dated 12/03/24 at 8:31 P.M. authored by Licensed Practical Nurse (LPN) #810 revealed while the nurse was sitting at the nursing station charting, the resident was handed a cooked noodle cup by the CNA. The resident sat the noodle cup on the roller walker and took a step backwards. She lost her balance and fell on to the floor. The resident was observed hitting her head but denied pain due to the recent fall. The skin was intact, and no injury was noted. The resident complained of pain to the right hand and stated the noodle cup got on her hand. The NP was made aware and assessed the resident. An ice pack to the right hand was ordered and neurological checks were ordered. The power of attorney (POA) was made aware, and urine was sent to the lab this morning. Review of Resident #68's progress note dated 12/04/24 at 1:00 A.M. authored by NP #815 revealed the encounter was a follow up post fall and burns to the right hand. The resident was seen in the hallway sitting in the walker seat. The resident denied a new headache, mental status at baseline and neurological checks continued. The resident complained of right elbow pain post fall and elbow redness was found on the bony area. No dislocation was identified and burns to the right hand. Bacitracin external ointment twice daily was ordered. Review of Resident #68's physician orders revealed an order dated 12/04/24 at 5:00 P.M. authored by NP #815 for bacitracin external ointment 500 units/gram apply to right hand/wrist two times a day. Review of Resident #68's physician orders revealed an order dated 12/04/24 to apply an ice pack to the right hand due to complaints of pain as tolerated by the resident; an order dated 12/04/24 for bacitracin external ointment 500 units/gram apply to right hand/wrist topically two times a day for seven days for a burn; and an order dated 12/12/24 to cleanse the right dorsal hand second degree burn with wound cleanser, apply Silvadene cream 1% (silver Sulfadiazine) to base of the wound, leave open to air and complete twice daily and as needed. Review of Resident #68's medication administration records (MARS) and treatment administration records (TARS) from 12/03/24 to 12/17/24 revealed treatments were completed as ordered. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #68's Skin and Wound Note dated 12/13/24 at 3:30 P.M. revealed the visit was for a new skin and wound consult. Resident #68 presented with a burn to the dorsal right hand. The wound was new and was 1.5 cm length by one cm width with 0.1 cm depth with dryness to the peri wound and scant amount of serous exudate. The wound was classified as a right dorsal hand second degree burn. The order was to cleanse the right hand with Silvadene cream 1% to the base of the wound and leave open to air twice daily. Interview on 12/17/24 at 6:57 A.M. with CNA #808 revealed Resident #68 did not like the facility food and the resident's daughter would bring in ramen noodle cups for the resident. She revealed on 12/03/24 at approximately 8:25 P.M. she heated up a ramen noodle cup for Resident #68 at (approximately) one minute and 30 seconds in the microwave. The CNA stated the resident said it was not hot enough and she heated it for another 60 seconds in the microwave and then handed it to the resident. She revealed Resident #68 put the soup down on her walker and some of the soup splashed onto her hand. CNA #808 revealed the resident became startled and took a step back falling to the floor and hitting her elbow and head. CNA #808 revealed she was aware the facility policy indicated not to heat foods for residents, but she stated she had always heated Resident #68's noodle soup. She confirmed the resident had cognitive impairment and resided on the secured memory care unit. Interview on 12/17/24 at 7:26 A.M. with LPN #810 revealed he was sitting at the nursing station on 12/03/24 when CNA #808 handed Resident #68 her soup. LPN #810 confirmed the resident's family does bring in food for the resident. He revealed at the time of the incident, the resident stepped back and fell backwards to the floor striking her elbow and head on the floor. He revealed he did not see injuries to her hand but was more concerned about the injuries to her elbow and head. He confirmed staff were not supposed to be heating soup up for the residents and he stated he called the resident's daughter and NP following the incident with the resident. An attempted interview on 12/17/24 at 10:47 A.M. with Resident #68 revealed she was not able to answer interview questions. Observation of Resident #68's right hand at the time of the interview revealed she had a healing burn on the right hand between the thumb and first finger which appeared shiny pink and it had a scabbed area in the middle of the shiny pink area which appeared to be a healing blister. Interview on 12/17/24 at 12:22 P.M. with NP #815 revealed on 12/03/24 Resident #68 had soup on the seat of her walker) and burned her hand on it which caused her to fall backwards to the floor and hit her head. NP #815 revealed she had assessed the resident while she was still on the floor because she was in the building. She revealed Resident #68 did not have injuries to her shoulder and had a bruise to the right elbow and a burn to the right hand. She revealed at the time of the observation the resident's hand was just reddened, and she ordered an ice pack to be applied to the area. NP #815 revealed she assessed the resident on 12/04/24 and noted the resident's top layer of skin on the resident's right hand was peeling. She denied the resident had blisters at this time. Interview on 12/17/24 at 12:50 P.M. with the Interim Director of Nursing (DON) revealed Resident #68 developed a blister on 12/06/24 between the thumb and pointer finger (top uppermost part) as a result of the burn on 12/03/24. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the undated Storage of Resident Food policy indicated dietary services would provide any re-heating of foods but in the event dietary staff were not available, a trained staff member may re-heat foods brought in from outside sources. Foods must be re-heated in 15 second increments until the temperature reaches 165 degrees Fahrenheit. Allow the food to cool prior to serving for resident preference and palatability. The deficiency was corrected on 12/04/24 when the facility implemented the following corrective actions: On 12/03/24 at 4:08 P.M., LPN Unit Manager (UM) #825 completed a skin assessment on Resident #68 and noted redness to the right hand measuring one cm length by two cm width with no depth. The resident's skin was intact at this time. On 12/03/24 at 4:20 P.M. LPN UM #825 completed interviews with unit staff. The staff reported Resident #68 lost her balance due to being distracted and talking to other residents. On 12/03/24 at 4:30 P.M., the Interim DON was notified of the incident by LPN UM #825. On 12/03/24 at 4:31 P.M. the Interim DON reviewed Resident #68's diet order. The order was for a regular/regular/regular diet with no devices. On 12/03/24 at 4:45 P.M., the Interim DON reviewed Resident #68's MDS and Care Plans and no diet modifications were noted. On 12/03/24 at 4:45 P.M. the Interim DON completed an audit by assessing all residents in house for potential for risk of injury due to hot food items/liquids. No abnormal findings were identified. On 12/03/24 at 6:05 P.M. LPN UM #825 educated all facility staff on Hot Liquids and initiated an in-service. On 12/03/24 at 6:38 P.M., NP #815 ordered an ice pack to Resident #68's right hand twice daily as tolerated, and the ice pack was added to the resident order list. Review of the Outside Food policy by the Administrator and DON on 12/4/2024 revealed no changes were made. On 12/04/24 at 4:15 P.M. NP #815 assessed Resident #68. No swelling to the head was observed. Redness to the right hand was observed with intact skin. Neurological checks were within normal limits (WNL) and range of motion (ROM) was WNL. A verbal order for an ice pack was received and initiated. On 12/04/24 at 9:50 A.M., an interdisciplinary team meeting was held regarding the incident which included the Administrator, Interim DON, LPN UM #832, LPN UM #825, LPN MDS #861, Therapy #602, Licensed Social Worker (LSW) #603. On 12/04/24 at 2:30 P.M., NP #815 followed up with Resident #68 and treatment orders were obtained and implemented. On 12/04/24 at 3:00 P.M., NP #815 ordered bacitracin ointment to the right hand twice daily. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 12/04/24 at 4:00 P.M. the Interim DON initiated ongoing monitoring audits three times a week for four weeks related to monitoring residents for risk for injury related to hot liquids/foods. The audits were being monitored for compliance by the DON in conjunction with the Administrator daily during the clinical meeting and weekly during the nursing risk meeting. On 12/04/24 at 5:00 P.M. LPN UM #825 completed Storage of Resident Food Hot policy in-service with focus on hot liquids/foods to all facility staff. On 12/05/24 at 11:46 A.M., Speech Therapy evaluation was completed by Speech Therapist #604 and an order received for ST services three times a week for four weeks for cognitive skills development On 12/06/24 at 10:33 A.M., a skin evaluation was completed on Resident #68's right hand burn. The resident was added to wound care rounds with Wound NP #985 (routine). The burn to the right hand measured one cm length by two cm width with no depth and was red in color with no exudate and no pain. The physician orders were to continue the treatment of Bacitracin topically twice daily. The resident's right hand had an intact blister which was noted to the center of the burn. On 12/12/24 at 4:00 P.M. a wound assessment was completed with the facility wound nurse LPN UM #825 and Wound NP #985. The burn to the right hand measured at 1.5 cm length by one cm width with 0.1 cm depth. Dryness was noted to the periwound with scant serous exudate. The treatment orders was changed to Silverdene cream 1% twice daily and as needed. On 12/12/24 at 8:04 P.M. the treatment order for Resident #68 was changed to Silvadene twice daily and as needed by Wound NP #985. This deficiency represents non-compliance investigated under Complaint Number OH00160640.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34297 Based on closed record review and interview, the facility failed to implement comprehensive, individualized and effective behavioral health interventions for Resident #107, who was diagnosed with dementia and had a history of inappropriate sexual behaviors, to prevent additional inappropriate sexual behaviors from occurring. This affected one resident (#107) of nineteen residents who resided on the SMCU. Findings include: Review of Resident #107's closed medical record revealed the resident was admitted on [DATE] and discharged on [DATE] with diagnoses including vascular dementia, anxiety disorder and depression. Resident #107 was listed as the resident representative. Review of Resident #107's behavior care plans revealed interventions including administer medications as ordered dated 08/19/24; speak in a calm manor dated 08/19/24; encourage to express feelings dated 08/19/24; intervene as necessary dated 08/19/24; monitor behavior episodes and attempt to determine underlying causes dated 08/19/24, observe and anticipate resident needs dated 08/19/24; behavioral health consults as needed dated 08/19/24; and monitor for inappropriate sexual behaviors dated 10/07/24. Review of the plan of care revealed no updated or new interventions were included following an incident on 09/29/24 until 10/07/24 when the intervention to monitor for inappropriate sexual behaviors was added. Review of Resident #107's Admission MDS 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition. Review of Resident #107's Behavior Note dated 09/29/24 at 9:45 P.M. revealed the resident was observed by staff being sexually inappropriate with a male resident. The note indicated staff separated the residents. Review of a facility submitted Self-Reported Incident (SRI) Investigation, Tracking Number 252563, completed 10/02/24 for an allegation of sexual abuse revealed on 09/29/24 Resident #107 and Resident #57 were on the couch in the common area of the SMCU engaging in a sexual interaction. Review of Resident #107's Psychiatry note dated 10/08/24 revealed the resident had an encounter with another resident where they both appeared to be fondling one another. The resident's hands were allegedly near or in another male resident's pants and the other resident's hands were allegedly near or on this resident's breast per reports of staff. The resident denied the incident reported by staff and stated there was no physical interactions between her and any other residents. The resident did not appear to be sad, anxious or in any distress. The provider did not identify any safety concerns for Resident #107 or any other resident at this time. However, the note included frequent monitoring was encouraged when the resident was interacting with other residents. The resident denied any recollection of the incident and had very poor insight. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility submitted SRI, Tracking Number 253264, dated 10/23/24, for an allegation of sexual abuse revealed per conversation with CNA, she observed Resident #107 and Resident #60 in bed together. At the time of questioning the CNA reported that when she opened up the door to the room that both residents moved very quickly and she could not state if they had been touching one another, only that they had not been facing one another in bed. The CNA reported she was unsure if the male resident had both his pants and briefs lowered or just his pants. The CNA reported Resident #107 was fully unclothed and that her clothes were lying next to the bed on the floor. The CNA reported she had seen Resident #107 15 minutes prior and noted her to be positioned in the living room area. Review of the undated SRI Witness statement revealed on 10/23/24 at approximately 7:45 P.M., Resident #107 was in the living room wearing a sweatshirt and pants. The CNA went to provide care to another resident and upon return noticed Resident #107 was not in the living room. A search of the SMCU found Resident #107 in Resident #60's room. Upon entering Resident #60's room, the resident was in bed with Resident #107. Resident #60 had on a shirt, but his brief and pants were down to his knees. Resident #107 was completely naked. They were laying against each other with Resident #107's back facing Resident #60's stomach. Review of Resident #107's Behavior Note dated 10/23/24 at 8:45 P.M. revealed the resident was observed by a CNA in another resident's room in an inappropriate situation. Both residents (Residents #60 and #107) were immediately separated and the note revealed one to one maintained for the remainder of the shift. The family and doctor were notified. Review of Resident #107's Telehealth Notification progress note dated 10/24/24 revealed the resident was in bed with a male resident and both were undressed but had only been in bed for a short while. The Administration was notified. The note included, both resident's have dementia, not clear that either can consent but it did not appear that anything happened against either's will. The resident's brother was notified. Information obtained via email on 12/19/24 at 11:14 A.M. from Registered Nurse (RN) Regional #801 revealed on 10/07/24 in conjunction with the investigation, behavior monitoring orders were implemented for Resident #107's sexually inappropriate behaviors such as touching others inappropriately or touching herself in public locations with five non-pharmacological interventions listed to implement if necessary. A second email dated 12/19/24 at 12:04 P.M. from RN Regional #801 revealed Resident #107 was assessed by psych services after the first incident in September 2024, was cleared and her medications were reviewed. The resident had behavior monitoring implemented to reduce the risk, but the facility did not provide one to one monitoring indefinitely nor was this intervention included on the resident's plan of care. Regional #801 confirmed Resident #107 exhibited inappropriate sexual behaviors on 09/29/24 and displayed inappropriate sexual behaviors a second time on 10/23/24. Review of the Secured (Locked) Unit policy revised 2017 revealed it was the policy of the facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of those residents. Review of the undated Behavioral Management General policy revealed it was the policy of the facility to identify and safely manage residents who are exhibiting behaviors related to psychiatric diagnoses or who may present a danger to themselves or others. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents non-compliance investigated under Complaint Number OH00159742.