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	08/04/2025

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow resident to participate in the development and implementation of his or her person-centered plan of care. (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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews the facility did not ensure care conference meetings were offered or held for residents #6, #22, #41 and #80. This affected four residents (#6, #22, #41 and #80) of four residents reviewed for participation in care planning. The census was 91. 1.Review of the medical record for Resident #6 revealed an admission date of 10/27/24. Diagnoses included atrial fibrillation, hypertension and anemia. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #6 was cognitively intact. Review of the MDS report from March 2025 to July 2025 revealed Resident #6 had quarterly assessments completed on 03/15/25 and 06/13/25. Review of the miscellaneous tab in the electronic medical record (EMR) revealed the last documented care plan meeting was Resident #6's 72-hour meeting at admission. An interview on 07/28/25 at 2:29 P.M. with Resident #6 revealed he was only invited to one meeting, besides the 72-hour meeting, however he missed it. 2.Review of the medical record for Resident #22 revealed an admission date of 09/08/23. Diagnoses included hemiplegia and hemiparesis, diabetes and anxiety. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #22 was cognitively intact. Review of the MDS report from March 2025 to July 2025 revealed Resident #22 had quarterly assessments completed on 04/01/25 and 07/11/25. Review of the miscellaneous tab in the EMR revealed the last documented care plan meeting was on 12/09/24 for Resident #22. Interview on 07/28/25 at 1:58 P.M. with Resident #22 and his mother revealed she used to receive invitations but had not gotten one in a while. Resident #22 stated he had not been invited to attend any care plan meetings. 3.Review of the medical record for Resident #41 revealed an admission date of 09/06/23. Diagnoses included end stage renal disease, respiratory failure and dysphagia. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #41 was cognitively impaired. Review of the MDS report from March 2025 to July 2025 revealed Resident #41 had quarterly assessments completed on 03/06/25 and 06/06/25. Review of the miscellaneous tab in the EMR revealed the last documented care plan meeting was 12/09/24. Phone interview on 07/28/25 at 1:10 P.M. with family of Resident #41 revealed the facility did not communicate with her even when she was visiting in the facility and she was not being invited to plan of care meetings. 4. Review of the medical record for Resident #80 revealed an admission date of 08/30/24. Diagnoses included quadriplegia, chronic pain syndrome and emphysema. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed he was cognitively intact. Review of the MDS report from March 2025 to July 2025 revealed Resident #80 had quarterly assessments completed on 03/07/25 and 06/06/25. Review of the miscellaneous tab in the EMR revealed the last documented care plan meeting was 02/10/25. An interview on 07/28/25 at 9:30 A.M. with Resident #80 revealed he was not involved in plan of care meetings in the year he had been there. An interview on 07/29/25 at 1:40 P.M. with licensed Social Worker (LSW) #560 revealed she identified an issue with the facility not offering care plan meetings possibly due to changes in LSW position and coverage from other buildings. She stated they had a few meetings for discharge planning. The team had not yet implemented a schedule or system for plan of care meetings. An interview on 07/30/25 at 10:07 A.M. with Licensed Practical Nurse (LPN) #538 revealed they have had some plan of care meetings for discharge planning however they have not had plan of care meetings for all residents as required. An interview on 07/30/25 at 3:00 P.M. with Regional MDS Registered Nurse (RN) revealed meetings should be held at 72-hour after admission, quarterly, annually and with a significant change. Review of the facility policy titled Plan of Care Overview, not dated, revealed the purpose of the policy was to provide guidance to the facility to support the inclusion of the resident or resident representative in all aspects of person-centered care planning. The policy read residents/representatives would be informed of their plan of care in the most understandable manner possible and would be offered opportunities to voice their view. They would be allowed to request meetings, be included in planning process and establish goals. The facility would hold meetings at a time when resident was functioning at his/her best and schedule meeting to accommodate a resident's representative that may include conference calls, video conference sessions of live sessions. This deficiency represents non-compliance investigated under Complaint Number 1300240.

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Resident #68 had access to his social security allowance as required. This affected one resident (#68) of five residents reviewed for funds. The facility census was 91.Findings include:Review of the medical record for Resident #68 revealed and admission date of 03/01/24 with diagnoses including depression, quadriplegia, and need for personal care.Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed that Resident #68 was cognitively intact. Review of Resident #68's personal fund authorization was witnessed by two people that were not associated with the facility on 12/20/24.Review of the first quarterly statement for 2025 revealed that the facility received Resident #68's social security (SS) check was deposited into his personal funds account. Further review of the first quarterly statement of 2025 revealed that SS asked for his SS check to be returned, which was returned 02/18/25.Further review of the first quarterly statement of 2025 revealed that Resident #68's SS check was deposited, and he received his $50.00 allowance in March 2025. Review of the receipt dated 03/25/25 revealed that Resident #68 signed that he withdrew $50.00.Review of the second quarterly statement revealed that Resident #68's SS check for April was deposited on 04/03/25 and Resident #68's $50.00 allowance was allotted to him. Further review of the second quarterly statement revealed that Resident #68's SS check for February was deposited on 04/14/25 however Resident #68 was not given his $50.00 allowance retroactive from February. Resident #68 did not withdraw any monies in April 2025.Review of the second quarterly statement revealed that Resident #68's SS check for May was deposited on 05/02/25 and Resident #68's $50.00 allowance was allotted to him. Review of the receipt dated 05/08/25 revealed that Resident #68 signed that he withdrew $50.00.Review of the second quarterly statement revealed that Resident #68's SS check for June was deposited on 06/03/25 and Resident #68's $50.00 allowance was allotted to him. Review of the receipt dated 06/10/25 revealed that Resident #68 signed that he withdrew $10.00.Review of the receipt dated 06/18/25 revealed that Resident #68 signed that he withdrew $40.00. Interview on 08/04/25 at 2:28 P.M. with Regional Business Office Manager (RBOM) #900 revealed that Resident #68's SS check in February was recalled by SS, so the check was not deposited. Resident #68 ‘s February check was deposited in April, so the system would not have recognized that Resident #68 should have been given his allowance of $50.00 retroactive from February. RBOM #900 verified the facility did not ensure Resident #68 received his $50 allowance from his February SS check as required. This deficiency represents non-compliance investigated under Complaint Number 1300243.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide residents with foods to accommodate their allergies and preferences during meals. This affected three residents (#13, #40, and #46) of three reviewed for food/nutrition. The facility census was 91.Findings include: 1. Review of Resident #13's medical record revealed the resident was admitted on [DATE] with diagnoses including anxiety disorder, major depressive disorder, and panic disorder. Review of Resident #13's physician orders for July 2025 revealed an order for a regular diet, thin liquid consistency. Resident #13 was ordered as allergic to eggs and egg products. Review of Resident #13's quarterly Minimum Data Set 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition and was independent for eating. Observation and interview on 07/30/25 at 12:04 P.M. revealed that Resident #13's tray was completed and put into the food cart to be delivered for lunch. Resident #13's tray ticket stated that she was to receive a #10 scoop of ground fruit cocktail as a preference. Dietary Manager (DM) #808 moved Resident #13's tray from food cart and verified that her diet ticket stated that Resident #13 was to get ground fruit cocktail but was served regular fruit cocktail. DM #808 removed the regular fruit cocktail and made ground fruit cocktail. This was verified by DM #808 at time of observation. 2. Review of Resident #40's medical record revealed the resident was admitted on [DATE] with diagnoses including anxiety disorder, major depressive disorder, and moderate protein malnutrition. Review of Resident #40's physician orders for July 2025 revealed an order for a regular dysphagia advance diet, thin liquid consistency. Resident #40 was to receive double entree all meals. Review of Resident #40's quarterly MDS 3.0 assessment dated [DATE] revealed the resident exhibited moderate impaired cognition and was independent for eating. Observation and interview on 07/30/25 at 11:53 A.M. revealed that Resident #40's tray was completed and put into the food cart to be delivered. Resident #40's tray ticket stated that he had an order for double portions. Dietary Aide (DA) #801 removed Resident #40's tray from the food cart and verified that his tray ticket stated that Resident #40 was to receive double portions and was served a regular size portion of chicken piccata. This was verified by Regional Dietary Manager (RDM) #809 at time of observation. 3. Review of Resident #46's medical record revealed the resident was admitted on [DATE] with diagnoses including anxiety disorder, depression, and chronic kidney disease. Review of Resident #46's physician orders for July 2025 revealed an order for a carbohydrate control renal diet, thin liquid consistency. Resident #46 was allergic to lactose. Review of Resident #46's quarterly MDS 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition and was independent for eating.Review of the recipe for chicken piccata revealed that an ingredient was two percent milk. Observation and interview on 07/30/25 at 11:47 A.M. revealed that Resident #46's tray was completed and put into the food cart to be delivered. Resident #46 tray ticket stated that she had a dairy allergen and was to receive a three ounce baked chicken breast instead of the chicken piccata being served as the main entree'. RDM #809 removed Resident #46's tray from the food cart and verified that her diet ticket stated that Resident #46 had a dietary allergen, was to receive a baked chicken breast but was served chicken piccata. This was verified by RDM #809 at time of observation. This deficiency represents non-compliance investigated under Complaint Number 1300241, Complaint Number 1300243, and Complaint Number 1300248.