

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366158	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/19/2025
NAME OF PROVIDER OR SUPPLIER The Pavilion Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35771</p> <p>THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.</p> <p>Based on observation, medical record review, review of witness statements, review of the daily per patient day (PPD) schedule, review of disciplinary action forms, and interview, the facility failed to provide appropriate supervision to residents while assigned nursing staff were sleeping. This affected three residents (Residents #44, #8 and #14) who the facility identified as high risk for elopement residing on the 100 or 300-halls and had the potential to affect all nine residents who resided on the 100-hall (Residents #29, #3, #33, #41, #14, #7, #13, #26 and #2) and all 14 residents who resided on the 300-hall (Residents #17, #4, #38, #5, #31, #23, #12, #36, #18, #15, #44, #1, #34, and #19). The census was 44.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #44 revealed an admitted [DATE] with diagnoses of dementia with behavioral disturbance, anxiety disorder, cognitive communication deficit and schizophrenia. Resident #44 had a legal guardian and resided on the 300-hall.</p> <p>Review of the impaired cognitive function/dementia care plan updated 04/13/24 revealed Resident #44 had impaired cognitive function/dementia or impaired thought process related to diagnoses of dementia and cognitive communication deficit with an intervention to cue, reorient and supervise as needed.</p> <p>Review of the elopement care plan updated 08/12/24 revealed Resident #44 was an elopement risk/wanderer, required a legal guardian, had a history of attempts to leave the facility unattended, impaired safety, impaired cognition and diagnoses of dementia and schizophrenia. Interventions included distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, reading material and identify pattern of wandering; divert as needed and intervene as appropriate.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the Minimum Data Set (MDS) 3.0 quarterly assessment dated [DATE] revealed Resident #44 had short and long-term memory problems, was severely impaired with making decisions regarding tasks of daily life, and had inattention, disorganized thinking and altered level of consciousness continuously. Resident #44 was independent with walking 150 feet and required partial/moderate assistance with toileting, bathing, dressing, personal hygiene, bed mobility and transferring.</p> <p>Review of the Elopement Review assessment dated [DATE] revealed Resident #44 was at high risk for elopement due to being ambulatory, always disoriented, poor safety/environmental awareness and a dementia with behavioral disturbance diagnosis. Resident #44 had a wanderguard (an electronic device to alert staff if a resident attempted to exit the facility) placed on her right ankle.</p> <p>Review of the medical record for Resident #8 revealed an admitted [DATE] with diagnoses of vascular dementia, schizophreniform disorder, alcohol use, anxiety disorder, psychosis not due to a substance or known physiological condition, schizoaffective disorder bipolar type and bipolar disorder. Resident #8 had a legal guardian and resided on the 100-hall.</p> <p>Review of the cognition care plan updated 09/20/24 revealed Resident #8 had impaired cognitive function/dementia or impaired thought processes related to vascular dementia with an intervention to cue, reorient and supervise as needed.</p> <p>Review of the elopement care plan updated 09/20/24 revealed Resident #8 had an elopement risk/wandered, was disoriented to place, had a history of attempts to leave the facility unattended, and impaired safety.</p> <p>Review of the MDS 3.0 quarterly assessment dated [DATE] revealed Resident #8 had short and long-term memory problems, was severely impaired for cognitive skills for daily decision making, wandered four to six days during the assessment, and was independent with transferring and walking 150 feet.</p> <p>Review of the Elopement Review assessment dated [DATE] revealed Resident #8 was high risk for elopement due to being ambulatory and always disoriented.</p> <p>Review of the medical record for Resident #14 revealed an admitted [DATE] with diagnoses of schizophrenia, disorders of psychological development, and schizoaffective disorder. Resident #14 had a legal guardian and resided on the 100-hall.</p> <p>Review of the Elopement Review assessment dated [DATE] revealed Resident #14 was high risk for elopement due to being ambulatory, predisposing diseases of schizophrenia and cognitive delay and being a new admission.</p> <p>Review of the MDS 3.0 admission assessment dated [DATE] revealed Resident #14 was moderately cognitively impaired, had acute onset mental status change related to inattention and disorganized thinking, and was independent with transferring and walking 150 feet.</p> <p>Review of the elopement care plan dated 01/29/25 revealed Resident #14 was an elopement risk/wanderer and at high risk of elopement with an intervention to provide supervision for off unit activities.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the daily per patient day (PPD) schedule dated 01/17/25 revealed Certified Nurse Aide (CNA) #13, CNA #9 and CNA #22 worked night shift from 7:00 P.M. on 01/17/25 to 7:00 A.M. on 01/18/25. CNA #13 was assigned to the 100-hall, CNA #9 was assigned to the 300-hall and CNA #22 was assigned to float to different halls. Licensed Practical Nurse (LPN) #7 was assigned to the 100 and 300-halls and LPN #23 was assigned to the 100 and 200-halls.</p> <p>Review of the undated witness statement authored by the Administrator revealed, [Regional Director of Clinical Services (RDCS) #11 and I came to the building at 12:15 A.M. on the night of 01/17/25 into 01/18/25 and when we got on the floor, we saw a staff member with their eyes closed. We then rounded the building, came down to the conference room for a little while to catch up on work. We then went back up on the floor from separate ends of the building around 2:30 A.M., before leaving the building and saw two more staff members with their eyes closed .</p> <p>Review of the undated witness statement authored by RDCS #11 revealed, [the Administrator] and I rounded the facility on 01/18/25 approximately 12:00 A.M. to 12:15 A.M. We found an employee appearing to be sleeping. Later that night around 2:30 A.M., [the Administrator] and I split up as he went the stairs and I used the elevator and we identified two other members with their eyes closed .</p> <p>Review of the Employee Warning Notice dated 01/18/25 revealed CNA #13 received a final written warning for employee noted sleeping on duty in a common area.</p> <p>Review of the Employee Warning Notice dated 01/18/25 revealed CNA #9 received a final written warning for employee noted sleeping on duty in a common area.</p> <p>Review of the Employee Warning Notice dated 01/18/25 revealed CNA #22 received a final written warning for employee noted sleeping on duty in a common area.</p> <p>Observation on 02/18/25 at 10:30 A.M. revealed Resident #8 was wandering with her head down back-and-forth on the 300-hall. Resident #8 had a wanderguard on her right ankle.</p> <p>Observation on 02/18/25 at 10:35 A.M. revealed Resident #44 was lying in bed, sleeping with a wanderguard on her right ankle. An interview, during the observation, with Resident #44 was attempted however the resident answered with incomprehensible sentences. At 10:35 A.M., Resident #44 was walking in her room.</p> <p>Observation on 02/18/25 at 2:26 P.M. revealed Resident #8 was wandering with her head down back-and-forth on the 300-hall with a tennis shoe on her right foot and only a sock on her left foot. Resident #8 had a wanderguard on her right ankle.</p> <p>Observation on 02/19/25 at 8:08 A.M. revealed Resident #8 was wandering with her head down back-and-forth on the 300-hallway with socks on her feet. Resident #8 had a wanderguard on her right ankle.</p> <p>Interview on 02/19/25 at 9:15 A.M. with Resident #44's sister/guardian revealed former Resident #48 had shown Resident #44's sister/guardian pictures of several nursing staff, including CNA #9, sleeping at the nursing station.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 02/19/25 at 11:55 A.M. revealed Resident #8 was sitting on the edge of her bed with her lunch meal sitting in front of her on her overbed table, staring at the privacy curtain in her room. An attempt to interview Resident #8 during the observation was unsuccessful. When asked how long she had resided at the facility Resident #8 answered, good and did not make eye contact.</p> <p>Interview on 02/19/25 with the Administrator and RDCS #11 verified they observed some nursing staff members sleeping in common areas when they were at the facility during night shift on 01/18/25. The Administrator and RDCS #11 also verified that CNA #13 was assigned to the 100-hall and CNA #9 was assigned to the 300-hall with the two nurses splitting the 100 and 300-hall so there was potential for the residents residing on the 100 and 300-hall to be unsupervised while CNA #13 and CNA #9 were sleeping.</p> <p>Review of the census provided by the facility revealed Residents #29, #3, #33, #41, #14, #7, #13, #26 and #2 resided on the 100-hall and Residents #17, #4, #38, #5, #31, #23, #12, #36, #18, #15, #44, #1, #34, and #19 resided on the 300-hall.</p> <p>The deficient practice was corrected on 01/27/25 when the facility implemented the following corrective actions:</p> <p>On 01/18/25, all staff were educated they were not to sleep on the clock by the Director of Nursing. This was confirmed by review of inservice sign in sheets.</p> <p>On 01/18/25, a Quality Assurance and Performance Improvement (QAPI) meeting was held with the Administrator, Social Services Designee (SSD) #10, Business Officer Manager (BOM) #17, Scheduler #5, Admissions Director #16, the DON, Activities Director (AD) #18, Maintenance Director #19, Medical Director #21, Assistant Director of Nursing (ADON) #2 and RDCS #11. Observations of the sleeping staff was discussed and a plan of correction was developed.</p> <p>On 01/18/25, a calendar was created to assign department heads to visit the facility unannounced during night shift during January 2025 and February 2025. The department heads consisted of the Administrator, RDCS #11, the DON, Admissions Director #16, Scheduler #5, BOM #17, AD #18, Maintenance Director #19, ADON #2, and SSD #10</p> <p>Beginning on 01/20/25, the assigned department head began auditing the facility unannounced during the night shift daily. Review of the audits revealed by 01/27/25 a full week of audits had been completed with no concerns noted.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00161783.</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35771</p> <p>Based on medical record review, Self-Reported Incident review, witness statement review, policy review and interview, the facility failed to ensure staff provided appropriate dementia care when Resident #44, who had a diagnosis of dementia with behavioral disturbance began to display wandering behaviors. This affected one (Resident #44) of three residents reviewed for dementia care. The census was 44.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #44 revealed an admitted [DATE] with diagnoses of dementia with behavioral disturbance, anxiety disorder, cognitive communication deficit and schizophrenia. Resident #44 had a legal guardian and resided on the 300-hall.</p> <p>Review of the elopement care plan updated 08/12/24 revealed Resident #44 was an elopement risk/wanderer, required a legal guardian, had a history of attempting to leave the facility unattended, had impaired safety awareness, impaired cognition and diagnoses of dementia and schizophrenia. Interventions included distracting resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, reading material and identify pattern of wandering; divert as needed and intervene as appropriate.</p> <p>Review of the Minimum Data Set (MDS) 3.0 quarterly assessment dated [DATE] revealed Resident #44 had short and long-term memory problems, was severely impaired with making decisions regarding tasks of daily life, and had continuous inattention, disorganized thinking and altered level of consciousness. Resident #44 was independent with walking 150 feet and required partial/moderate assistance with toileting, bathing, dressing, personal hygiene, bed mobility and transferring.</p> <p>Review of the Self-Reported Incident (SRI) dated 01/18/25 revealed there was an allegation of Certified Nurse Aide (CNA) #13 taunting Resident #44.</p> <p>(continued on next page)</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of CNA #13's verbal witness statement authored and signed by the Administrator dated 01/18/25 revealed, on January 15th, I was assigned to work on 300-hall where I had to care for [Resident #44] and other residents even though I asked to not be put over on that hall because due to me being a new face. [Resident #44] doesn't take me very well as she sometimes would with other employees that have been there longer. So as [Resident #44] was sundowning, she started taking her clothing off, me and [Registered Nurse (RN) #3] tried assisting her with putting them back on but when we did, she tried hitting us so [Licensed Practical Nurse (LPN) #6] talked to her and she did but after she left, [Resident #44] continued getting up and going in other resident's rooms while me and the nurse [RN #3] tried numerous of times approaching [Resident #44] with a light calm voice even saying, come on, sweetheart, let's go over here and take a seat. While at times, it did work until it didn't so then [Resident #44] would sit and be back at it again but this time she happened to had a mood swing and was angered because we didn't allow her to go into other resident's rooms and we stopped her by holding the door until she began to swing and hit me so then [RN #3] tried approaching and taking her to her room with [Resident #44] went and stayed in for their of all 10 minutes and she was back to going in other peoples rooms. Me and the nurse [RN #3] repeated this several times, but it never really lasted and I knew that I had to keep other residents safe because while some knew and understood [Resident #44's] condition there were some that didn't care and would get angry with her coming into their rooms. I was trying to prevent there being an altercation. I knew that me trying to redirect her resulted her getting mad and trying to hit me so I had the idea of putting the two chairs by the entry hall of 900-913 because that was the hall that she frequently kept going down and I stood in front of the chairs and monitor to make sure if any resident came out of their room which none did but one which is a resident named [Resident #48]. I let him through but after [Resident #44] came and moved the chairs, I saw that no longer works so I put the chairs back.</p> <p>Review of the Elopement review assessment dated [DATE] revealed Resident #44 was at high risk for elopement due to being ambulatory, always disoriented, poor safety/environmental awareness and dementia with behavioral disturbance diagnosis. Resident #44 had a wanderguard (an electronic device to alert staff of a resident attempting to exit the facility) placed on her right ankle.</p> <p>Observation on 02/18/25 at 10:35 A.M. revealed Resident #44 was lying in bed, sleeping with a wanderguard on her right ankle. Interview, during the observation, with Resident #44 was attempted however the resident answered with incomprehensible sentences. At 10:35 A.M., Resident #44 was walking in her room.</p> <p>Interview on 02/19/25 at 9:15 A.M. with Resident #44's sister/guardian revealed former Resident #48 had shown Resident #44's sister/guardian a picture of three large chairs (with one of the chairs turned on its side) blocking an entrance to a hallway.</p> <p>Interview on 02/19/25 at 12:00 P.M. with Regional Director of Operations (RDO) #1 verified that according to CNA #13's witness statement dated 01/18/25, CNA #13 obstructed an area with chairs blocking and confining Resident #44 to a section of the facility.</p> <p>Interview on 02/19/25 at 2:00 P.M. with the Administrator revealed the entry hall of 900-913 in CNA #13's witness statement was a typo. The Administrator meant to type, the entry hall of Rooms 300 to 313.</p> <p>(continued on next page)</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's Abuse, Neglect, Exploitation and Misappropriation of Resident Property policy revised on 11/01/19 revealed the facility would not tolerate Abuse, Neglect, Exploitation of its residents or the Misappropriation of resident property. Involuntary Seclusion was defined as separation of a resident from other residents or from his or her room or confinement to his or her room (with or without roommates) against the resident's will, or the will of the resident's legal guardian.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00161783.</p>		