STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366158	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Pavilion Rehabilitation and Nursing Center	13900 Bennett Road North Royalton, OH 44133

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38091 Based on record review, resident interview and staff interview the facility failed to ensure residents had accurate advance directive orders and information in place through out the medical record. This affected one (Resident #16) of one resident reviewed for advanced directives. The facility census was 43. Findings Include: Resident #16 was admitted to the facility on [DATE] with diagnoses that included alcohol dependence, schizoaffective disorder, bipolar disorder and cocaine abuse. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #16 was cognitively intact, required supervision for completing his activities of daily living and received hospice services. Review of the electronic physicians orders for [DATE] revealed an order for full code (full medical support which includes cardiopulmonary resuscitation (CPR) would be performed on Resident #16 in the event of medical emergency). Review of the care plan dated [DATE] revealed Resident #16 desired to be a full code. Review of the second page of Resident #16's hard medical chart revealed an undated hospice election form (document indicating Resident #16 has chosen hospice benefits) indicating Resident #16 had a DNR (do not resuscitate) pending Review of the third page of Resident #16's hard medical chart revealed a red piece of paper in an electronic sleeve with the words DNRCC (do not resuscitate comfort care) typed on it. On the back of the same page was a signed DNRCC form (document indicating Resident #16 desires to only be kept comfortable in the event of a medical emergency or cardiac arrest and does not desire any medical interventions in such occasions). Interview with Resident #16 on [DATE] at 10:07 A.M. revealed he desires to have his DNRCC code status remain in effect. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Nursing (DON) on [DATE] at 10:30 A.M. verified the inconsistent and incorrect information regarding Resident #16's code status through out the medical record. Review of the policy entitled Advanced Directives dated [DATE] revealed The plan of care for each resident will be consistent with his or her documented treatment preferences and/or advanced directive the policy further noted The Director of Nursing Services or designee will notify the Attending Physician of advanced directive so that appropriate order can be documented in the resident's medical record or plan of care.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38091 Based on medical record review, review of the Resident Assessment Instrument (RAI), policy review and staff interview the facility failed to complete a Minimum Data Set (MDS) 3.0 assessment as required upon resident self initiated discharge from the facility. This affected one (Resident #14) of one resident reviewed for MDS timing/accuracy. The facility census was 43. Findings include: Review of the medical record for Resident #14 revealed the resident was admitted to the facility on [DATE] with diagnoses that included paraplegia, bipolar disorder, opioid dependence and drug induced constipation. Review of the progress note dated 06/17/24 at 4:54 P.M. revealed Resident #14 left the facility against medical advice (AMA) and was given methadone (medication used to treat drug addiction) prior to his departure. Further review of the progress notes revealed a another entry on 06/17/24 at 11:45 P.M. indicating Resident #14 returned to the facility from a local hospital via ambulance. Review of the MDS data for Resident #14 revealed a required discharge return not anticipated assessment was not completed and subsequently neither was a required entry assessment completed on 06/17/24. On 01/07/25 at 4:14 P.M. interview with MDS Nurse #545 verified no discharge assessment or entry assessment was completed as required. Review of the Resident Assessment Instrument (RAI) (manual used for instructions on how to meet regulatory guidelines for completing MDS assessments) revealed on Page 2-40: Assessment Management Requirements and Tips for OBRA Discharge Assessments revealed For unplanned discharges, the facility should complete the OBRA Discharge assessment to the best of its abilities. - An unplanned discharge includes, for example: Resident unexpectedly leaving the facility against medical advice. Review of the policy entitled MDS 3.0 Sections dated 10/01/23 revealed The MDS 3.0 is to be completed within the time frames specified in by the state and federal guidelines.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38091 Based on record review and staff interview the facility failed to ensure a valid Pre Admission Screen and Resident Review (PASRR) was in place and completed timely for Residents #14 and #27. This affected two of two residents reviewed for PASRR status. The facility census was 43. Findings Include: 1. Review of the medical record for Resident #14 revealed the resident was admitted to the facility on [DATE] with diagnoses that included paraplegia, bipolar disorder, opioid dependence and drug induced constipation. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #14 was cognitively intact and required hands on assistance for completing his activities of daily living. Review of census records revealed Resident #14 was readmitted to the facility from a local hospital after signing out of the facility against medical advice (AMA) on 06/17/24. Review of the both the electronic and hard chart revealed a PASRR assessment was not completed prior to or after Resident #14 was readmitted to the facility. On 01/07/25 at 4:14 P.M. interview with MDS Nurse #545 verified no PASRR assessment was completed as required after Resident #14's admission to the facility. 2. Review of the medical record for Resident #27 revealed the resident was admitted to the facility on [DATE] with diagnoses that included bipolar disorder, anxiety disorder and opioid dependence. Review of the most recent MDS 3.0 assessment dated [DATE] revealed Resident #14 was dependent on one staff person for completing her activities of daily living. Further review of Resident #27's medical record revealed Resident #27 was admitted to the facility with a hospital exemption (document from Resident #27's admitting hospital indicating that Resident #27 required less than a 30 day stay at the nursing facility and was subsequently exempt from PASRR requirements for 30 days). Review of census records for Resident #27 revealed Resident #27 has remained at the facility with no discharge back to a community setting. Review of both the electronic and hard charts revealed a full PASRR assessment was not conducted after Resident #27's 30 days at the facility had past. Interview with Social Service Designee (SSD) #546 on 01/09/25 at 9:00 A.M. verified a full PASRR assessment was not completed for Resident #27 prior to her 31st day in the facility as required. `

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43063 Based on record review and interview, the facility failed to ensure Resident #148's care plan was revised to reflect wandering behaviors. This affected one (Resident #148) of 17 residents reviewed for care planning. The facility census was 43. Findings include: Review of the medical record for Resident #148 revealed an admitted [DATE] with diagnoses including schizophrenia (mental health disorder with psychotic symptoms including hallucinations, delusions, mania and depression). Review of the elopement assessment dated [DATE] for Resident #148 revealed she was at high risk for elopement related to being ambulatory or in a wheelchair, having schizophrenia and a cognitive delay, being a new admission and being alert. Review of Resident #148's care plan dated 12/14/24 revealed she did not have a care plan for wandering or for having the potential for elopement. Review of the comprehensive Minimum Data Set (MDS) 3.0 Assessment for Resident #148 revealed she had impaired cognition. She had inattention, disorganized thinking and altered level of consciousness that fluctuated. She was independent with ambulating. Review of Resident #148's nursing progress note dated 12/19/24 at 4:42 P.M. revealed during a supervised smoke break Resident #148 went off the patio. Staff were able to redirect the resident back onto the patio and into the building. Resident #148 had a wanderguard placed on her right ankle and staff were to check on her every 15 minutes. Review of the physician's orders for Resident #148 dated 12/19/24 revealed she had a wanderguard and staff were to check the location, placement, function, expiration date and skin check under the bracelet every shift for elopement prevention as well as for staff to check on her every 15 minutes. Interview on 01/07/25 at 2:08 P.M. with Regional Director of Clinical Services #544 verified Resident #148 did not have a care plan for wandering or the potential for elopement.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37095 Based on record review and interview, the facility failed to ensure pharmacy recommendations were acted on when accepted. This affected two (Resident #36 and #11) out of five residents reviewed for unnecessary medications. The total census was 43. Findings include: 1. Record review of Resident #36 revealed she was admitted [DATE] and had diagnoses including unspecified convulsions, hypothyroidism, and anxiety disorder. She had an active order dated 09/20/24 for 10 milligrams (mg) of Hydroxyzine to be given three times per day for anxiety, an active order dated 06/21/24 for 400 mg of magnesium oxide to be given twice daily for supplement (scheduled for 6:00 A.M. and 6:00 P. M.), and an active order dated 06/19/24 for 100 micrograms of Levothyroxine (scheduled for 6:00 A.M.) to be given daily for hypothyroidism. Record review of Resident #36's pharmacy recommendations revealed multiple recommendations dated 11/08/24 which included the following: for Hydroxyzine to have a dose reduction to 10 mg twice per day unless contraindicated, for a blood magnesium level to be drawn to monitor the magnesium, for a thyroid stimulating hormone (TSH) and Thyroxine (T4) blood level to be drawn to monitor the Levothyroxine, and for the Levothyroxine and magnesium to be administered over four hours apart due to magnesium's ability to interfere with the absorption of Levothyroxine. All of these recommendations had the agree box checked and were signed by the nurse practitioner or physician. Record review of Resident #36 revealed no evidence magnesium, TSH, or T4 blood levels were ordered or drawn following the pharmacy recommendation, no evidence the Hydroxyzine dose was reduced or reviewed for reduction, and no evidence the Levothyroxine or magnesium medication administration times were changed to be given separately from each other. Interview with the Director of Nursing on 01/08/35 at 1:10 P.M. confirmed the above findings. 51067 2. Review of the medical record for Resident #11 revealed an admitted [DATE] with diagnoses including dementia, schizophrenia, and insomnia. Review of the physician's orders for Resident #11 revealed he had an active order dated 09/06/23 for Diphenhydramine 25 milligrams (mg) to be given every six hours as needed for itching. Review of the pharmacy recommendations dated 08/06/24 for Resident #11 revealed recommendation to discontinue Diphenhydramine 25 mg by the pharmacist. The nurse practitioner had agreed to the discontinuation and signed the recommendation. Interview on 01/07/25 at 4:48 P.M. with the Director of Nursing (DON) verified Resident #11's Diphenydramine 25 mg should have been discontinued on 08/06/24 when the nurse practitioner had agreed with the pharmacy recommendation.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 37095 Based on interview and record review, the facility failed to appropriately monitor relevant lab values before administering Warfarin. This affected one of five residents reviewed for unnecessary medications (Resident #9). The total census was 43. Findings include: Record review of Resident #9 revealed she was admitted to the facility 08/07/24 and had diagnoses including antiphospholipid syndrome, systemic lupus, and a history of venous thrombosis. She had an active order dated 08/16/24 for an International Normalized Ratio (INR, a common mechanism to track Warfarin effectiveness) lab draw every Monday, Wednesday, and Friday, and to report it to the medical provider. She had an active order dated 09/28/24 for 6 milligrams of Warfarin to be given daily. Review of Resident #9's medication administration record revealed Warfarin was given every day in January except 01/05/25. Review of Resident #9's progress notes revealed she had a 01/03/25 INR lab draw that was not reported to the practitioner until 01/05/25, who ordered to hold the Warfarin and a STAT INR draw. Record review of Resident #9's lab results revealed her INR was drawn 01/03/25 at 4:16 A.M. and was reported 12:18 P.M. with a value of 4.1. The lab tracking also noted that standard anticoagulant values were between 2.0 and 3.0. A handwritten note dated 01/05/25 revealed staff were to hold Coumadin on 01/05/25 and draw a STAT lab. The INR lab result for 01/05/25 revealed a result of 5.1, which was identified as a critical result. A handwritten note dated 01/05/25 revealed the value was reported and they would redraw on 01/06/25. The INR draw on 01/06/25 was 2.6, and a written note said it was reported to the practitioner who said to restart the Warfarin at its normal dose. Interview with Resident #9 on 01/06/25 at 10:02 A.M. revealed she took Warfarin (a blood-thinner) to manage her lupus disease. Her INR level was drawn 01/03/25 and she asked the nurse what the result was, and they never responded. She took the Warfarin on 01/03/25 and 01/04/25, then learned the INR result was 4.1 on 01/03/25 and was 5.1 on 01/05/25 (therapeutic INR value for Warfarin therapy is typically between 2.0 and 3.0). Staff then held the dose on 01/05/25, but they should have held it the other two days as she was now at risk for excessive bruising or bleeding. She did not want to take a shower until the INR level came down due to the risk of injury, and she said she would refuse Warfarin doses from now on unless staff could tell her the current INR. Interview with Assistant Director of Nursing (ADON) #500 on 01/08/25 at 9:05 A.M. revealed she was the nurse who administered Warfarin to Resident #9 on 01/03/25. She said the INR should have been reported from the shift before, so because she did not hear any concerns with the INR she thought it was acceptable. She confirmed the INR lab draw on 01/03/25 was 4.1 and that according to the lab form it was collected at 4:16 A.M. and reported 12:18 P.M. Interview with the Director of Nursing on 01/08/35 at 1:10 P.M. confirmed Resident #9's Warfarin should have been held starting 01/03/25 until the INR was within normal limits.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 37095 Based observation and interview, the facility failed to ensure controlled medications were stored in a separately locked and permanently affixed compartment. This affected two residents (Resident #14 and #15) of two residents reviewed for Methadone storage. Findings include: 1. Observation of medication administration for Resident #14 on 01/08/25 at 8:12 A.M. from the 200 hall medication cart revealed he was given Methadone (an opioid and 'Schedule 2' medication with high potential for abuse). The methadone was stored in a black box inside the medication cart with no permanent fixture or separate locked compartment preventing it from being removed from the medication drawer. The box had a lid that locked automatically when closed properly, however it was not fully closed and the nurse was able to remove the Methadone without unlocking it. The surveyor confirmed these findings with Licensed Practical Nurse (LPN) #517 on 01/08/25 at 8:20 A.M. 2. Observation of the 300 hall medication cart on 01/08/25 at 9:45 A.M. revealed the Methadone for Resident #15 was stored in a locked black box which was not permanently affixed to the cart. The surveyor confirmed this finding with LPN #512 at the time of observation. Review of the medication storage policy dated 2001 revealed no specific mention of where or how to store controlled medications.

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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** 51067 Based on record review and interview, the facility failed to ensure Resident #11 and #24's medical record were accurate and complete related to laboratory findings. This affected two (Residents #11 and #24) of 17 resident medical records reviewed during the survey. The facility census was 43. Findings include: 1. Medical record review revealed Resident #11 was admitted to the facility on [DATE] with diagnosis of dementia, schizophrenia, and insomnia. Review of Resident #11's physician order dated 09/26/24 revealed the resident was to have a Depakote laboratory test drawn. Review of Resident #11's electronic and paper medical record revealed there were no laboratory results after 07/11/24 for Resident #11. Interview on 01/07/25 at 9:20 A.M. with Licensed Practical Nurse (LPN) #512 revealed there were no laboratory results in Resident #11's medical record beyond 07/11/24. LPN #512 then accessed the laboratory website and located the labs from the 09/26/24 order to print for Resident #11's medical record. 43063 2. Review of the medical record for Resident #24 revealed an admitted [DATE] with diagnoses including cognitive communication deficit, dementia and hypertension. Review of the physician's orders for Resident #24 revealed she had an order dated 01/03/23 to have Valproic Acid laboratory testing done every three months. Review of the complete electronic and paper medical record revealed there were no laboratory results after 07/09/24 for Resident #24. Interview on 01/07/25 at 9:47 A.M. with Licensed Practical Nurse (LPN) #512 verified there were no laboratory results in Resident #24's medical record after 07/09/24. LPN #512 logged onto the laboratory company's website and printed off Resident #24's results from laboratory studies that were drawn as the physician had ordered. She stated the results should have been in Resident #24's paper chart.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 38091 Based on observation and staff interview the facility failed to maintain a clean, sanitary and well maintained environment. This had the potential to affect all 43 residents in the facility. Findings Include: An environmental tour was conducted on 01/07/25 with Maintenance Director (MD) #700 on 01/07/25 between 10:30 A.M. and 11:00 A.M. the following was observed an verified at the time of discovery: -An active leak in ceiling that required removal of multiple ceiling tiles in 1st floor common area. -The room occupied by Residents #2 had noticeable scratches on the floor. -The floor air vent in the room occupied by Resident #9 was covered by blue industrial tape completely blocking air flow. -The shower chair in the bathroom of Resident #35's room was significantly rusted around the legs. -The rooms occupied by Residents #13 and #15 had no privacy curtain. -The outlet covering around the plug into Resident #37's heater/air conditioning (ac) unit in her room was off. -The outlet covering around the plug into Resident #8's heater/(ac) unit in his room was loose. -The ceiling in Resident #149's room had noticeable cobwebs. -The shower head in Resident #149's was observed to continually leak water at moderate drip. -In the 300-hall dining room the walls were noted with significant brown stains along with numerous areas of significant scuffing and scratches on the walls. In the dining rooms common use fridge multiple oranges were in a plastic container that contained signs of mold along with a sandwich bag with an apple in it that was completely rotted and brown in color with an open package of cheddar jalapeno smoked sausages. The vegetable crisper drawer of the refrigerator was noted to be brown in color with various unknown debris inside of it. -In the main dining room, the tables used by residents were extremely scuffed and scratched up. One of the tables was noted to be held together by duct tape around the base. -Numerous areas of cracks in the ceilings and water stains were noted throughout the common areas of the facility. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The nonskid strips in front of the recliner in the room occupied by Resident #36 were half torn of the floor. -The blanket that utilized by Resident #22 had easily noticeable brown stains. -The wall area around the heating/ac unit in Resident #22's room appeared to be crumbling. -The bed sheet in place and ready to be utilized by #14 had numerous brown stains. -The geriatric chair (a large, padded chair that is designed to help seniors with limited mobility) used by Resident #33 had noticeable food crumbs in the side of the seating cushion. A full pretzel stick was noted at the bottom of the chair. -Resident #17 and #24's room had numerous brown dots of an unknown substance. -Numerous areas of wallpaper in Residents #19, #27 and #41's room had fallen off or was in process of falling off the wall. -The wall area above Resident #26 bed had a noticeable outline of a hole that was patched, not sanded and not filled in. -The wheelchair in Resident #105's room had no padding on the arms. Immediately after the observation Resident #105 was observed ambulating the hallway in another manual wheelchair in which the padding on the arms of the wheelchair were torn up and noticeable dirt and debris was visible on the inside of the wheelchair. - A large unknown red stain was observed on the floor of Resident #105's room. -The handrails in the common areas throughout the facility hand various levels of chips and scratches in the wood. -The overbed light in Resident #2 and Resident #12's room had no cover on it. -The walls in Residents #16, #17, #24, #31 and #43's room were extremely scuffed, scrapped and scratched up. -The bathroom walls in Resident #28's room were extremely scuffed and scrapped.