

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366222	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2025
NAME OF PROVIDER OR SUPPLIER Falls Village Skilled Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 330 Broadway East Cuyahoga Falls, OH 44221	

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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35768</p> <p>Based on record review, interview, and policy review the facility failed to ensure pain relieving medications were available to administer as ordered. This affected one (Resident #72) of three residents reviewed for medications.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #72 revealed an admitted [DATE]. Resident #72 had a discharge date of [DATE]. Diagnoses included primary osteoarthritis, malignant neoplasm of the bladder, cervicalgia, anxiety disorder and pain, unspecified.</p> <p>Review of physician order dated 01/25/25 revealed Resident #72 was to receive belbuca buccal film 150 micrograms, one patch every 12 hours for chronic pain. The order had no stop date. Review of the admission medication list revealed Resident #72 was admitted with a seven-day supply of the belbuca film.</p> <p>Review of the plan of care dated 01/27/25 revealed Resident #72 could experience altered comfort. Interventions included to administer analgesic medications as ordered and encourage the resident to notify staff at the onset of pain.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment, dated 01/31/25, revealed Resident #72 had intact cognition, required moderate assistance with activities of daily living, and was on a pain management regimen program.</p> <p>Review of the facility Pain Assessment Tool dated 01/31/25 revealed Resident #72 was in constant pain.</p> <p>Review of the medication administration record (MAR) for February 2025 noted Resident #72 did not receive the belbuca buccal medication on 02/01/25 and 02/02/25. The MAR indicated Resident #72 received 1000 milligrams of acetaminophen on 02/01/25 for a pain level of 10 out of 10. Further review revealed documentation Resident #72's pain level went down to five out of ten after the administration of the acetaminophen.</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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of the nurse progress note dated 02/01/25 timed 10:18 P.M. revealed the belbuca buccal film was not available. Review of the nurse progress note dated 02/02/25 timed 8:20 A.M. noted the facility was waiting on the pharmacy to deliver the belbuca buccal film.</p> <p>Interview on 05/02/25 at 9:32 A.M. with Resident #72 revealed he was receiving the belbuca buccal medication twice a day from 01/24/25 to 01/31/25. Resident #72 stated he went two days without the belbuca medication because the facility would not refill the order. Resident #72 stated he spoke to a day shift nurse on 02/01/25 regarding the belbuca medication and the nurse told him the belbuca was ordered and awaiting pharmacy delivery. Resident #72 said he told the nurses that he was in pain and spoke with three additional nurses from 02/01/25 through 02/02/25 who stated the belbuca medication was ordered and they were waiting for the delivery.</p> <p>Interview on 05/02/25 at 12:28 P.M. with Nurse Practitioner (NP) #205 revealed staff did not inform her of the need to refill the belbuca pain medication for Resident #72. NP #205 stated the facility was in contact with her and the primary physician frequently due to other medical concerns for Resident #72 so she was not sure why staff did not ask for a refill.</p> <p>Interview on 05/02/25 at 12:33 P.M. with the pharmacist that provided medication for the facility revealed the facility did not contact the pharmacy to refill the order for belbuca pain medication.</p> <p>Review of the facility policy Pain-Clinical Protocol, dated 2022 revealed the physician would order appropriate non-pharmacologic and medication interventions to address an individual's pain.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00162692.</p>		