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	10/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Pavilion Rehabilitation and Nursing Center	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)
F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on medical record review, interviews with facility staff and resident and review of the facility policy for administering medications, the facility failed to ensure four Residents (Residents #95, #92, #90 and #40) received significant medications as ordered by the physician. This resulted in Immediate Jeopardy and the potential for serious life-threatening harm when Resident #90, who had a diagnosis of diabetes mellitus (DM), did not receive insulin or a blood sugar (BS) assessment on 09/24/22 resulting in an elevated BS of 451 mg/dl (normal BS is 99 milligrams per deciliter (mg/dl)), Resident #95 was admitted to the facility with diagnoses including acute embolism (obstruction of an artery usually by a blot clot or air bubble) and thrombosis (blood clot) of deep veins of the bilateral lower extremities and did not receive five doses of the ordered medication Eliquis (blood thinner) and seven doses of the ordered medication metoprolol (used to decrease high blood pressure) and Resident #92, who was admitted to the facility with a diagnosis of diabetes did not receive routine ordered insulin medication on 09/30/22, 10/01/22, or 10/02/22 and Resident #92's BS was not monitored before meals as ordered between 09/30/22 to 10/03/22 with use of a sliding scale insulin if the blood sugar level was 151 mg/dl or higher. On 10/03/22 at 4:30 P.M. Resident #92's blood sugar was 344 mg/dl, and on 10/04/22 at 6:30 A.M. Resident #92's blood sugar was 451mg/dl. In addition, a deficient practice that did not rise to the level of Immediate Jeopardy was identified related to the facility's failure to administer insulin or monitor blood glucose levels per physician order for Resident #40 on 08/26/22 and again the morning of 08/27/22. This affected four of five residents reviewed for significant medication errors. The facility census was 40. On 10/12/22 at 1:01 P.M., the Administrator, RDCS #500, and Regional Director of Operation (RDO) #502 were notified the Immediate Jeopardy began on 09/24/22 when Resident #90, admitted to the facility with diabetes, did not receive insulin medication or a blood sugar assessment. On 09/25/22 at 9:30 P.M., Resident #90's BS elevated to 451mg/dl. Resident #95 was admitted to the facility with acute embolism and thrombosis of deep veins of the bilateral lower extremities and missed five doses of the ordered medication Eliquis and seven doses of the ordered medication metoprolol. Resident #92 was admitted to the facility with a diagnosis of diabetes on 09/29/22. Resident #92 did not receive her routine ordered insulin medication at bedtime on 09/30/22, 10/01/22, or 10/02/22. Resident #92's blood sugar (BS) was not monitored before meals as ordered with use of a sliding scale insulin if the blood sugar level was 151mg/dl or higher, resulting in a BS of 344 mg/dl on 10/03/22 at 4:30 P.M. and on 10/04/22 at 6:30 A.M. Resident #92's blood sugar was 451mg/dl. The Immediate Jeopardy was removed on 10/12/22 when the facility implemented the following corrective actions: (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	10/12/22 at 4:07 P.M. Resident # 92 was assessed by Registered Nurse (RN) [NAME] President of Clinical Services (VPCS) #501 for signs and symptoms of hypoglycemia and hyperglycemia this time related to missed insulin doses and glucose assessments. 10/12/22 at 4:17 P.M. Resident #95 was assessed by RN VPCS #501 for increase signs and symptoms of deep vein thrombosis (DVT) or clots in lower extremities noted for missed doses of Eliquis. 10/12/22 at 5:29 P.M. Resident #90 was assessed by RN VPCS #501 for signs and symptoms of hyperglycemia and hypoglycemia related to blood sugars and insulins that were omitted related to elevated blood sugars and residents' current medications were reviewed. 10/12/22 at 4:27 P.M. CNP #162 was notified of medication errors for resident # 92 on all insulins not being administered and missed blood sugar assessments and current orders were verified by RN VPCS #501. 10/12/2022 at 4:29 P.M. CNP #162 was notified medication errors for Resident #90 not being administered, missed blood sugar assessments, elevated blood sugars, and not being notified. Current medication orders were verified by RN VPCS #501. 10/12/22 at 4:45 P.M. An ad hoc QAPI meeting was conducted and in attendance was the Administrator, RN VPCS #501, RDO #502, RDCS #500, Maintenance Director #145, Business Office Manager (BOM) #133, Social Services #505, Admission Director #504, Housekeeping Director #130, Activity Director #101, Therapy Director #508, Minimum Data Assessment (MDS) Licensed Practical Nurse (LPN) #146, Scheduler #148 and Medical Director #405 by phone. A discussion of initial audits and missed doses of insulin and anticoagulation therapy was held. Topics discussed included the admission process and how to correctly input orders to the pharmacy, timely notification to the physician on admission and verification of orders, change in condition or status including missed doses of medications, controlled substance Emergency Kit, STAT emergency orders and deliveries, emergency medications, obtaining a fingerstick and notification to physician, administering medications and insulin administration. It was determined QAPI will be held weekly for 4 weeks. Notification to the physician will occur at the time of omission of an order or change in condition to primary care or NP by floor nurse if no response from physician or (Certified Nurse Practitioner (CNP)) occurs and the Medical Director will be contacted within 24 hours by nurse management. 10/12/2022 at 4:50 P.M. Medical Director #405 was notified of medication errors on Resident #95 and missed Eliquis doses on admission and current orders confirmed for all medications by RN VPCS #501. 10/12/22 at 4:55 P.M. All residents with anticoagulants (Resident # 20, 15, 6) were reviewed to ensure no other doses of anticoagulants had been missed per audits conducted by RN VPCS #501. 10/12/22 at 5:00 P.M. All residents (#21, 31, 93) with insulin and blood sugar assessments were reviewed by RN VPCS #501 to ensure no other residents had missed doses. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	10/12/2022 by 6:00 P.M. All licensed staff were educated on admission process, timely notification of admission to physician, and how to correctly input orders to the pharmacy. All licensed staff were also educated on timely notification of changes to physicians which included missed doses of medications, sliding scale insulin and blood sugar assessments by RDCS #500. Nurses who have not been educated will not start shift prior to education from DON/designee. Agency nurses were contacted who are working the next few days and educated by RDCS #500. Education is expected to be completed by 10/14/2022. Agency nurses who are not on the schedule or replace call offs will be required to review and sign education in agency book related to admission process and how to correctly input orders to the pharmacy, timely notification to physician on admission and verification of orders, change in condition or status including missed doses of medications, controlled substance Emergency Kit, STAT Emergency orders and deliveries, emergency medications, obtaining a fingerstick and notification to physician, administering medications and insulin administration. The following staff were educated on 10/12/22: Agency nurses: five LPNs and four RNs and facility employees: three LPNs, one RN and two Medication Aides. 10/12/22 at 6:10 P.M. All insulin medication for residents # 92,90,21, 31, 93, was checked and present to ensure that insulin can be administered per order or sliding scale by RN RDCS #500. 10/12/22 at 6:15 P.M. Resident #90, Resident #92, and Resident #95, medications were reviewed by RN, RDCS #500, to ensure all medications were present for administration. 10/12/22 at 7:30 P.M. Medication carts were compared to Medication Administration Records were checked and all residents' medications are present by RN RDCS #500. 10/12/22 at 10:00 P.M. RN VPCS #501 audited all new admissions for the last 30 days who currently are in the facility to ensure discharge orders from the hospital were reviewed, orders were accurate, and the Physician was notified of the admission. 10/12/22 at 10:30 P.M. Blood sugars were reviewed to ensure assessment was complete and that appropriate sliding scale was administered per physician order or that physician was notified by RN VPCS #501 of clinical services. Audits will be conducted by DON or the Administrator daily to ensure admission orders are completed accurately and medications are administered as per physician orders and physician was notified timely of new admission for four weeks then weekly for four weeks then ongoing. Audits will be conducted by DON or the Nursing Home Administrator daily to ensure that insulin is administered and that blood sugar assessments are completed as per physician orders and that missed doses or abnormal blood glucose levels are reported to the physician timely for four weeks then weekly for four weeks then ongoing. All findings will be reported to the Quality Assurance Performance Improvement Committee for review and recommendations. Although the Immediate Jeopardy was removed on 10/12/22, the facility remained out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was in the process of implementing their corrective action plan and monitoring to ensure on-going compliance. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Findings include: 1. Record review for Resident #95 revealed an admitted [DATE]. Diagnosis included acute embolism and thrombosis of unspecified deep veins of unspecified lower extremities, heart failure, hypertension, and unspecified intellectual disabilities. Record review of the care plan dated 10/04/22 for Resident #95 revealed Resident #95 had a diagnosis of deep vein thrombosis (DVT). Interventions included to give medications as ordered. Resident #95 also had a care plan that included the resident had congestive heart failure. Interventions included to give cardiac medications as ordered. Record review of the Admission Summary dated 10/01/22 at 6:52 A.M. revealed Resident #95 was alert to person and place but not situation. Resident #95 was admitted with bilateral lower extremity DVTs and was on Eliquis for treatment of the DVTs. Record review of the discharge physician orders from Hospital #404 for Resident #95 dated 09/30/22 revealed orders for Eliquis five milligrams (mg) take two tablets (10 mg) by mouth twice daily for 12 doses and on 10/04/22 start taking Eliquis one tablet (five mg) by mouth daily. Orders also included metoprolol tartrate 12.5 mg every eight hours for hypertension. Record review of the Medication Administration Record (MAR) for Resident #95 revealed Resident #95 did not receive Eliquis until 10/03/22 at 6:00 P.M. (admitted [DATE], five doses not administered) and Resident #95 also did not receive metoprolol until 10/03/22 at 2:00 P.M. (seven doses not administered). Interview on 10/04/22 at 11:00 A.M. with Resident #95 revealed Resident #95 was confused and unable to answer questions appropriately. Resident #95 was rambling incoherently. Interview on 10/04/22 at 3:36 P.M. with LPN #407 confirmed Resident #95 was confused. LPN #407 revealed when Resident #95 was admitted on [DATE] at 11:00 P.M., the admitting nurse did not put all needed personal information for Resident #95 into the electronic medical system (she left out Resident #95's sex). Because there was information left out, the orders did not transmit to the pharmacy, so the pharmacy was unaware of Resident #95's admission to the facility and medication orders. LPN #407 confirmed the medications were written on the MAR for the nurses to see and none of the nurses had corrected the error. As a result, Resident #95 did not receive her medications as ordered until LPN #407 corrected it on 10/03/22. LPN #407 verified Resident #95 did not receive medications per physician orders. Record review on 10/04/22 at 3:13 P.M. revealed Medical Director #405 (the primary physician to care for Resident #95 while at the facility) was not notified of Resident #95's admission or the missed medications. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 10/04/22 at 6:33 P.M. with CNP #406 (who worked directly with MD #405) confirmed the physician assigned to Resident #95, MD #405, was not notified of the admission to verify medications and was not notified of Resident #95 not receiving medications. CNP #406 revealed she checked with all physicians on call including Physician #405 and none had been notified of the resident's admission or missed medications. CNP #406 revealed this would be a concern for Resident #95 explaining skilled assessments including vital signs should have been done daily and Resident #95 receiving her medications would have been of upmost importance to prevent a possible pulmonary embolism and/or possible death from complications. CNP #406 revealed on 10/03/22 a nurse left a message for her that a resident missed their medications, the nurse did not leave the residents name, or the name of the medications missed. Interview on 10/06/22 at 2:00 P.M. with CNP #406 revealed she visited Resident #95 on 10/05/22 and found the medication Eliquis was originally ordered by the hospital to decrease on 10/04/22 to five mg daily. CNP #406 revealed the facility did not clarify with the physician or herself how to correctly dose the Eliquis since Resident #95 did not receive the medication for the first five doses and the facility did not decrease the dose per the hospital orders on 10/04/22. CNP #406 revealed the medication needed to be adjusted with the missed doses. Record review of the MAR revealed Resident #95 continued to receive Eliquis 10 mg by mouth two times a day from 10/03/22 at 6:00 P.M. through 10/05/22 at 6:00 A.M. when CNP #406 decreased the medication to five mg two times a day. 2. Record review for Resident #92 revealed an admitted [DATE] with diagnoses including type two diabetes mellitus and essential hypertension. Record review of the care plan dated 10/03/22 revealed Resident #92 had diabetes mellitus. Interventions included medication as ordered by the physician, monitor, and document any signs or symptoms of hyperglycemia (symptoms include confusion). The resident had potential for altered cardiovascular status related to hypertension. Interventions included medications as ordered. Record review of the Nursing Progress note dated 09/29/22 at 9:49 P.M. completed by Registered Nurse (RN) #408 revealed Resident #92 was admitted to the facility around 6:50 P.M. Resident #92 was pleasant, cooperative and was alert and oriented to person, place, and time. Record review of the physician orders dated 09/30/22 for Resident #92 included insulin glargine 100 units per milliliter (ml,) inject 12 units subcutaneously (SQ) at bedtime. Orders also included Humalog insulin inject as per sliding scale (SS) if 151mg/dl - 200 mg/dl give 2 units; 201mg/dl - 250 mg/dl give 3 units; 251mg/dl - 300 mg/dl give 4 units; 301mg/dl - 350 mg/dl give 5 units; 351 mg/dl - 400 mg/dl give 6 units, SQ three times a day related to diabetes mellitus. Record review of physician orders for September and October 2022 revealed the order for the Humalog insulin inject as per sliding scale was discontinued by RN #408 on 09/30/22. The orders further revealed the Humalog insulin was to be replaced by Admelog Solostar insulin 100 units per milliliter (u/ml) solution inject as per sliding scale: if 151mg/dl - 200 mg/dl give 2 units; 201 mg/dl - 250 mg/dl give 3 units; 251mg/dl - 300 mg/dl give 4 units; 301 mg/dl - 350 mg/dl give 5 units; 351mg/dl - 400 mg/dl give 6 units SQ before meals and if over 400 mg/dl call the physician or CNP. The order for the Admelog Solostar was not processed until 10/03/22 at 4:30 P.M. when LPN #407 initiated the order. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview and observation on 10/03/22 at 1:46 P.M. with Resident #92 revealed she did not receive her medications as ordered including her insulin and felt the nursing staff was just ignoring her when she tried to tell them she was not getting her medications. Throughout the interview, Resident #92 presented as anxious as she spoke about not getting her medications. Interview on 10/03/22 at 2:00 P.M. with LPN #407 revealed Resident #92 was always saying she wasn't getting her medications and according to LPN #407, Resident #92 was just confused. LPN #407 indicated the resident was getting her medications. Record review of the progress note for Resident #92 dated 10/03/22 at 2:49 P.M. completed by LPN #407 revealed Resident #92 had increased anxiety causing her to itch and request medication. Record review of the progress note for Resident #92 dated 10/03/22 at 3:20 P.M. completed by LPN #407 revealed Resident #92 was very confused throughout the day forgetting she was on isolation. The note indicated the resident had received her medication. LPN #407 added she reminded Resident #92 throughout the day she had received her medications. Record review of the MAR for September and October 2022 revealed Resident #92 did not receive her insulin glargine (100 units per ml, inject 12 units SQ at bedtime) on 09/30/22, 10/01/22, or 10/02/22. Resident #92's blood sugar was not being monitored according to the physician orders to determine the need for the sliding scale insulin from 09/30/22 to 10/03/22 at 4:30 P.M. On 10/03/22 at 4:30 P.M. LPN #407 obtained a BS on Resident #92 indicating 344 mg/dl. LPN #407 initiated the physician order for Admelog Solostar 100 u/ml solution inject as per sliding scale and administered insulin coverage. On 10/04/22 at 6:30 A.M. Resident #92's blood sugar was 451 mg/dl. No further assessment or interventions were implemented for the elevated blood sugar. Interview on 10/06/22 at 8:24 A.M. with the DON confirmed Resident #92 did not receive the routine insulin glargine on 09/30/22, 10/01/22 or 10/02/22 and Resident #92 did not receive the sliding scale insulin from 09/30/22 until 10/03/22 at 4:30 P.M. because there was a pharmacy therapeutic interchange on 09/30/22 with Humalog and Admelog insulin. The Admelog should have started as soon as the Humalog was discontinued on 09/30/22 and did not start until 10/03/22. The nurse removed the Humalog but did not put the Admelog Solostar in the electronic records. The DON confirmed on 10/04/22 at 6:30 A.M. Resident #92's blood sugar was 451mg/dl. The DON confirmed the medication was held and the physician was not notified. The DON revealed the facility had a system failure with new admissions and staff not putting correct orders in the electronical medical system. Phone interview on 10/06/22 at 8:50 A.M. with Registered Nurse (RN) #408 confirmed RN #408 discontinued Resident #92 sliding scale insulin orders on 09/30/22 without a physician order to discontinue the orders. RN #408 revealed she discontinued the order in error. The DON was also present during the phone interview with RN #408. Interview on 10/10/22 at 1:55 P.M. with Resident #92's primary physician, Physician #161 confirmed he was not updated on Resident #92's blood sugar of 451mg/dl. Physician #161 confirmed he would have ordered additional medication for Resident #92. Physician #161 reported the facility might have spoken with CNP #162 for the orders. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 10/10/22 at 2:20 P.M. with CNP #162 confirmed he was not notified of Resident #92's blood sugar of 451 mg/dl. CNP #162 confirmed he should have been notified and if he were he would have added additional units of insulin to the scheduled sliding scale order at the time the blood sugar was 451 mg/dl. 3. Resident #90 was admitted on [DATE] with diagnoses including diabetes mellitus, hypothyroidism, hypertension, psychoactive substance abuse, bipolar disorder, and cirrhosis of the liver. Review of admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #90 had intact cognition. Resident #90 was independent with no set up help for all activities of daily living except for bathing, he was independent with set up help. Review of the physician orders for September 2022 revealed Resident #90 was ordered Lantus SoloStar Solution pen-injector 100 unit/ml (milliliter), (insulin glargine) inject 10 units subcutaneously at bedtime for diabetes). Resident #90 received the insulin for a blood sugar of 332 mg/dl on 09/23/22 at 9:30 P.M., then the Lantus SoloStar solution pen-injector 100 unit/ml was discontinued on 09/23/22. A new order for Insulin glargine 100 unit/ml solution pen-injector inject 10 unit subcutaneously at bedtime for diabetes, start date 09/25/22 at 9:30 P.M. There was no order for insulin on 09/24/22 that replaced the discontinued order of 09/23/22. No insulin was received on 09/24/22. Review of the MARs for September 2022 revealed an order for Lantus SoloStar solution pen-injector 100 unit/ml, (insulin glargine) inject 10 units subcutaneously at bedtime for diabetes mellitus. Resident #90 received the insulin for a blood sugar of 332 mg/dl on 09/23/22 at 9:30 P.M. then the Lantus SoloStar solution pen-injector 100 unit/ml was discontinued on 09/23/22. There was no new order for insulin for 09/24/22. On 09/25/22 a new order for glargine100 unit/ml inject 10 unit subcutaneously at bedtime for diabetes mellitus. On 09/25/22 Resident #90's blood sugar was 451mg/dl. Review of the MARs for October 2022 revealed an order for Insulin glargine 100 unit/ml solution pen-injector inject 10 unit subcutaneously at bedtime for diabetes, start date 09/25/22 at 2130. On 10/01/22 no insulin was provided as ordered per the physician. Interview on 10/12/22 at 9:12 A.M. with Physician #161 revealed Resident #90 should have had an insulin order for 09/24/22. Physician #161 reported the facility might have spoken with CNP #162 for the orders. Physician #161 stated he should have absolutely been notified or his CNP regarding Resident #90's high blood sugar of 451mg/dl. Physician #161 reported he was not aware Resident #90 had no insulin on 09/24/22 and should have had insulin coverage. Interview on 10/12/22 at 9:18 A.M. with CNP #162 revealed he was not notified of no insulin orders for 09/24/22 or the high blood sugar of 451 for Resident #90. CNP #162 reported he would have ordered insulin on 09/24/22 and ordered additional insulin on 09/25/22 for the high blood sugar of 451mg/dl. CNP #162 reported he would expect to be notified of high blood sugars and would have provided additional insulin coverage to prevent adverse symptoms of high blood sugars. Interview on 10/12/22 at 9:40 A.M. with RDCS #500 revealed insulin was not provided on 09/24/22 for Resident #90 and the resident had a high blood sugar on 9/25/22 at bedtime of 451mg/dl. RDCS #500 indicated the physician should have been notified. RDCS #500 confirmed on 10/01/22 insulin was not given per physician order to Resident #90. RDCS #500 reported best practice would be to contact the physician with blood sugar of 451mg/dl. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	4. Review of the medical record for Resident #40 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included acute respiratory failure, diabetes mellitus type two, and hypertension. Review of Resident #40's discharge hospital information dated 08/26/22 and timed at 2:09 P.M. revealed discharge orders for insulin glargine (Lantus Solostar insulin pen) 30 units subcutaneous (SQ) at bedtime, insulin lispro 0-10 units inject 0-10 units (to be used as a sliding scale) SQ with meals and check the resident's blood glucose level four times a day. Continued review revealed no evidence of when the resident last received a blood glucose check or insulin at the hospital. Review of Resident #40's admission assessment revealed the resident was assessed on 8/26/2022 at 9:40 A.M. There is no evidence in the resident's medical record of the actual time of the resident's arrival to the facility. The facility did not initiate any nursing notes regarding Resident #40 until 08/27/22 at 8:50 P.M. Review of Resident #40's August 2022 physician orders revealed the facility did not obtain an order for the resident's insulin lispro solution, insulin glargine solution, or blood sugars until 08/27/22 following the admission on 08/26/22. Review of Resident #40's August 2022 Medication Administration Record revealed the resident did not receive any blood sugar monitoring or insulin until 08/27/22 at 12:00 P.M., at which time Resident #40's blood sugar was 400 mg/dl. Interview on 10/13/22 at 1:23 P.M. with RDCS #500 verified the facility did not initiate Resident #40's insulin glargine 30 units at bedtime, insulin lispro per sliding scale, and blood glucose checks until 08/27/22, resulting in the resident missing blood glucose monitoring and insulin administration on 08/26/22 and the morning of 08/27/22. When the orders were obtained, and initiated the resident's blood glucose was 400 mg/dl. Review of the facility policy, Administering Medications, revised December 2012, revealed all medications must be administered in accordance with the orders, including any required time frame. This deficiency substantiates Complaint Number OH00136495. 42015