| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365603 | A. Building<br>B. Wing | 11/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Aventura at West Park | 2950 West Park Drive<br>Cincinnati, OH 45238 |

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 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42731<br><br>THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.<br><br>Based on medical record review, review of facility Self-Reported Incidents (SRI), staff interview, and policy review, the facility failed to ensure residents were free from verbal abuse. This affected one (#64) of three residents reviewed for abuse. The facility census was 89.<br><br>Findings include:<br><br>Review of the medical record of Resident #64 revealed an admitted [DATE]. Diagnoses included Alzheimer's disease, anxiety disorder, dementia with behavioral disturbance, rheumatoid arthritis, delusional disorders, essential hypertension, heart failure, benign prostatic hyperplasia, unsteadiness on feet, and major depressive disorder.<br><br>Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severely impaired cognition. The resident exhibited fluctuating inattention and continuous disorganized thinking during the assessment period. The resident utilized a walker and required partial/moderate assistance with transfers and supervision or touching assistance for walking 10 feet.<br><br>Review of the care plan dated 12/21/23 revealed Resident #64 had the potential for behavioral issues related to a diagnosis of Alzheimers dementia with behavioral disturbance and a history of episodes of increased anxiety, agitation, paranoia, and delusions. The resident was noted to attempt to put himself on the floor and say God wanted him to do it. Interventions included to approach in a calm and gentle manner.<br><br>Review of a progress note dated 10/18/24 at 9:04 A.M. revealed the nursing assistant informed the nurse Resident #64 was on the floor. The resident was observed sitting on the floor, leaning on the couch and the aid stated she was helping him walk from bed to the couch when the resident became aggressive and resistive to care and slid to the floor. The resident was assessed and no injuries were noted.<br><br>(continued on next page) |



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

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the SRI dated 10/18/24 revealed Resident #64's family alleged State tested Nursing Assistant (STNA) #300 dropped Resident #64 during a transfer. STNA #300 was assisting Resident #64 with personal care and transferring him to his chair when the resident had a behavioral episode and began to stiffen and would not move, stating, God told him to do it. STNA #300 then began trying to move the resident to sit on the couch and the resident began falling to the floor during the transfer stating, God told me to do it. The STNA told the resident to get his behind up and the STNA let go of the resident, as he was already down, and went to get help. As a result of the investigation, physical abuse was not substantiated, however the facility felt STNA #300 was inappropriate with the resident. STNA #300 was suspended immediately upon learning of the incident and was terminated at the conclusion of the investigation. The police were notified. The resident received psychosocial follow-up and staff was educated on the facility abuse policy and transferring a patient.<br><br>Review of the SRI dated 10/25/24 revealed, through an investigation, it was found an STNA was verbally inappropriate with Resident #64. During the investigation for the SRI dated 10/18/24, the STNA admitted saying, Come on man. Get your ass up. The facility substantiated verbal abuse.<br><br>Interview on 11/18/24 at 12:55 P.M., the Administrator stated, following the investigation from the first SRI filed, Resident #64's family shared video footage of the incident and stated they felt as if STNA #300 dropped Resident #64. The Administrator stated the video footage was reviewed and did not support the aide dropping the resident, however the aide attempted to get the resident back up without assistance and said, Get your ass up. The Administrator stated STNA #300 had been suspended and then terminated following the first investigation because the aid did not follow policy and attempted to get the resident up without notifying the nurse. Upon review of the video, the Administrator discussed the video footage with STNA #300 and, when questioned, STNA #300 stated she, may have said that. The Administrator stated any swearing to residents is not tolerated.<br><br>Observation on 11/18/24 at 2:00 P.M. with the Administrator and Director of Nursing (DON) of in-room surveillance video revealed STNA #300 standing behind Resident #64, who was standing at his walker. STNA #300 was assisting the resident to transfer onto his couch when the resident said something (unclear in video footage) and his body went limp and was lowered to the ground. STNA #300 attempted to assist Resident #64 off the floor and stated, Get your ass up, come on man.<br><br>Interview at the same time, the Administrator verified STNA #300's statement to Resident #64 and verified this was a form of verbal abuse.<br><br>Review of the facility policy titled, Resident's Right to Freedom from Abuse, Neglect, and Exploitation, dated 2024, revealed the facility residents have the right to be free from abuse, including verbally aggressive behavior such as curing, bossing around, or demanding.<br><br>The deficient practice was corrected on 10/25/24 when the facility implemented the following corrective actions:<br><br>-On 10/18/24 at 9:45 A.M., STNA #300 was providing care to Resident #64 in his room when, while walking to the couch, he dropped to his knees, landing his upper body on the couch and knees on the floor, stating God told me to do it.<br><br>-On 10/18/24 at 9:54 A.M., Resident #64's daughter sent a video to Assistant Director of Nursing (ADON) #533 for review of an interaction between Resident #64 and STNA #300<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -On 10/18/24 at 10:00 A.M., STNA #300 went to get LPN #310 and LPN Unit Manager (UM) #193 to come and assist and assess Resident #64 for injury and assist off the floor. Resident #64 did not have any injuries.<br><br>-On 10/18/24 at 10:00 A.M. ADON #533 went and removed STNA #300 from Resident #64's room and, with the Administrator, took her statement and suspended STNA #300 immediately, pending investigation.<br><br>-On 10/18/24 at 10:10 A.M., UM #193, LPN #864, and ADON #533 began inservicing staff in the facility regarding the abuse policy, started questioning residents about abuse, and obtained statements from staff.<br><br>-Interviews on 11/19/24 with STNA #330, Housekeeping Aid #335, STNA #345, LPN #360, and Social Services Assistant #377 confirmed they had received education on the facility abuse policy on 10/18/24.<br><br>-On 10/18/24 at 10:15 A.M., the Administrator opened an SRI.<br><br>On 10/18/24 at 10:15 A.M., the Administrator, LPN #864, UM #193, and ADON #533 spoke with Resident #64's family in the facility to discuss the video and how the facility would handle the situation. The family was surprised the aid was suspended and stated they did not want her to lose her job.<br><br>-On 10/18/24 at 10:30 A.M., UM #193 notified Medical Director #786 of the fall and allegation of abuse of Resident #64. Orders were received for an x-ray of the right ankle (negative results on 10/21/24) and a medication review by psychiatry.<br><br>-On 10/18/24 at 3:00 P.M., the Clinical Management team conducted a QAPI meeting with Corporate Risk Management to discuss the findings of the investigation. The root-cause analysis of the incident was Resident #64 having behaviors (God told him to do it), which made him drop to the ground.<br><br>-On 10/19/24 at 2:00 P.M., the Clinical Management team met again to discuss the investigation. The determination was made to terminate STNA #300.<br><br>-On 10/19/24 at 3:00 P.M., the Administrator and DON terminated STNA #300's employment at the facility.<br><br>-On 10/21/24 at 11:00 A.M., Social Services employees continued follow-up with Resident #64 for psychosocial follow-up.<br><br>-On 10/24/24, the DON and Administrator began completing daily audits five days a week, which included rounding the entire facility, talking with residents to ensure they know how to report abuse and asking if there are any concerns.<br><br>-On 10/25/24, the DON submitted the final SRI unsubstantiating physical abuse.<br><br>-On 10/25/24, the DON opened an additional SRI for verbal abuse and continued abuse education and psychosocial follow-up on Resident #64.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00159133. |