STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365603	A. Building B. Wing	04/17/2024

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

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44412 Based on medical record review, review of facility Self-Reported Incident (SRI), review of daily staffing sheet, review of time clock records, resident interview, staff interview, and review of the facility policy the facility failed to ensure residents were protected during abuse investigations. This affected one (Resident #14) of one reviewed for abuse. The facility census was 78. Findings include: Review of the medical record for Resident #14 revealed an admitted [DATE] with diagnoses including acute and respiratory failure with hypercapnia, congestive heart failure (CHF), bipolar disorder, chronic kidney disease stage three, and type two diabetes mellitus. Review of the Minimum Data Set (MDS) assessment for Resident #14 dated 02/05/24 revealed the resident had intact cognition, required setup with eating, and was dependent on staff assistance with toileting, bathing, dressing, and transfers. Review of the Self-Reported Incident (SRI) #245840 for Resident #14 dated 04/01/24 timed at 2:11 P.M. revealed the resident alleged that on 03/11/24 State tested Aide (STNA) #361 and STNA #432 raised her too high in the stand lift after requesting them to stop. Resident #14 alleged she then passed out from the pain and fell to the ground. STNA #361 and STNA #432 stated Resident #14 let go of the stand lift and slid out and onto the floor. STNA #361 and STNA #432 notified Registered Nurse (RN) #393 of the incident immediately. RN #393 assessed Resident #14 with no injuries noted besides complaint of pain to shoulders. RN #393, STNA #361, and STNA #432 assisted Resident #14 back into bed using the Hoyer lift. Further review of the SRI revealed the Alleged Perpetrators (APs), STNAs #361 and #432 were suspended during the abuse investigation. Review of the daily staffing sheet for 04/01/24 revealed STNA #361 and STNA #432 were working on the floor. Review of the time sheet for STNA #361 dated 04/01/24 revealed the employee did not clock out until 5:00 P. M. which was almost three hours after the SRI was initiated. Review of the time sheet for STNA #432 dated 04/01/24 revealed the employee did not clock out until 4:44 P. M. which was two and a half hours after the SRI was initiated. (continued on next page)

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/01/24 at 12:55 P.M. with Resident #14 confirmed the resident made an allegtation of abuse which occurred on 03/11/24 per STNAs #361 and STNA #432 who were assisting her with a transfer in the stand lift. Resident #14 confirmed she asked the aides to stop lifting her because she was in pain, but they intentionally ignored her request to stop lifting her. Resident #14 confirmed she was in so much pain she passed out and woke up on the floor. Interview on 04/03/24 at 12:31 P.M. with the Administrator confirmed the Surveyor notified him on 04/01/24 at approximately 1:15 P.M. that Resident #14 had made an allegation of physical abuse per STNAs #361 and #432 which allegedly occurred on 03/11/24. The Administrator confirmed he initiated the SRI for abuse for Resident #14 on 04/01/24 at 2:11 P.M. but he did not suspend STNAs #361 and #432 immediately. The Administrator confirmed STNA #361 was permitted to work until 5:00 P.M. on 04/01/24 and STNA #432 was permitted to work until 4:44 P.M. on 04/01/24. Review of the facility policy titled Abuse dated 07/20/23 revealed the facility would ensure residents were protected during the investigation of allegations of abuse. Facility employees who had been accused of or suspected of resident abuse would be suspended immediately.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 44069 Based on medical record review, staff interview, review of the facility policy, the facility failed to conduct care conferences as required. This affected four (Residents #16, #19, #23, and #41) of five residents reviewed for care planning. The facility census was 78. Findings include: 1. Review of the medical record for Resident #16 revealed an admitted [DATE] with diagnoses including necrotizing fasciitis, generalized anxiety disorder, type two diabetes mellitus, peripheral vascular disease, anemia, lumbar spina bifida without hydrocephalus, atrial fibrillation, depression, and arthropathy. Review of the quarterly Minimum Data Set (MDS) assessment for Resident #16 dated 02/26/24 revealed the resident had intact cognition, required setup assistance for eating, moderate assistance for oral hygiene, and maximal assistance for toileting, bathing, dressing, personal hygiene, bed mobility and transfer. Review of the social services progress note for Resident #16 dated 10/27/23 revealed the facility held a care conference with Resident #16. Further review of the social services progress notes revealed no further documentation related to care conferences. Interview on 04/09/24 at 12:37 P.M. with Social Services Director (SSD) #383 confirmed the facility had not had a care conference for Resident #16 since the one on10/27/23. 44412 2. Review of the medical record for Resident #23 revealed an admitted [DATE] with diagnoses including congestive heart failure (CHF), type two diabetes mellitus (DM II), acute and chronic respiratory failure, Alzheimer's disease, anxiety disorder, and major depressive disorder. Review of the MDS assessment for Resident #23 dated 03/11/24 revealed the resident had severe cognitive impairment and required setup with eating, toileting, and bathing, and supervision with dressing and transfers. Review of the progress note for Resident #23 dated 08/08/23 revealed the resident was scheduled for a care conference on 08/14/23. Review of the medical record for Resident #23 revealed the only recent care conference completed for the resident was held 08/14/23. Interview on 04/03/24 at 3:24 P.M. SSD #383 confirmed the facility had not had a care conference for Resident #23 since the one on 08/14/23. 49771 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of the medical record for Resident #19 revealed an admitted [DATE] with diagnoses including unspecified dementia without behavioral disturbance, aphasia following cerebral infarction, abnormalities of gait and mobility, and other problems related to life management difficulty. Review of the MDS assessment for Resident #19 dated 01/08/24 revealed the resident had severely impaired cognition and required extensive assistance for bed mobility, transfers, locomotion, dressing, toileting, and personal hygiene. Review of care conference documentation for Resident #19 revealed no care plan conferences were conducted for the second and third quarters of 2023 or for the first quarter of 2024. Resident #19 had a care conference on 10/02/23. Review of the census revealed resident #19 was in the facility continuously from 04/01/23 to 04/01/24. Interview on 04/05/24 at 10:21 A.M. Resident #19's representative confirmed the facility did not conduct care plan conferences for the second and third quarters of 2023 (April to September) or for the first quarter of 2024 (January to March). 4. Review of the medical record for Resident #41 revealed an admitted [DATE] with diagnoses including cerebral infarction, left sided hemiparesis, diabetes mellitus type two, chronic kidney disease, obstructive and reflux uropathy, and long-term use of anticoagulants. Review of the MDS assessment for Resident #41 dated 02/04/24 revealed the resident had intact cognition and required staff assistance with ADLs. Review of care conference documentation for Resident #41 revealed no care conference was conducted in the first quarter of 2024. A care conference was documented on 11/03/23. Review of the census for resident #41 revealed resident #41 was in the facility continuously during the period of 01/01/24 to 04/01/24. Interview on 04/03/24 at 3:43 P.M. with Resident #41 confirmed the facility had not conducted a care conference with her in the first quarter of 2024 (January to March). Interview on 04/03/24 at 3:25 P.M. with SW #383 confirmed the facility should be conducting care plan conferences with the resident and/or resident representative on a quarterly basis. SW #383 confirmed facility did not have quarterly care plan conferences with the representative for Resident #19 for the second and third quarters of 2023 and the first quarter of 2024, and confirmed the facility failed to conduct a quarterly care conference with Resident #41 during the first quarter of 2024. Review of the facility policy titled Care Planning - Interdisciplinary Team revised August 2022 revealed the resident and/or resident's representative were encouraged to participate in the development of and revisions to the resident's care plan. Care plan meetings were to be scheduled at the best time of the day for the resident and family.

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42731 Based on medical record review, staff interview, Physician Assistant (PA) interview, review of facility witness statements, review of facility policy and review of the American Heart Association (AHA) guidelines, the facility failed to ensure cardiopulmonary resuscitation (CPR) was provided to a resident who was a full code. This resulted in Immediate Jeopardy and the potential for serious life-threatening harm and/or death when Resident #76, who was a full code, was found unresponsive and without vital signs on [DATE] at 7:20 A.M. and staff failed to immediately perform CPR and the resident was subsequently pronounced dead. This affected one (Resident #76) of three residents reviewed for death over the last three months. The facility census was 78. On [DATE] at 1:25 P.M., the Administrator, Regional Director of Clinical Operations (RDCO) #508, the Director of Nursing (DON), and Director of Operations (DO) #517 were notified of the Immediate Jeopardy, which began on [DATE] at approximately 7:20 A.M. when the facility failed to initiate CPR for Resident #76 who was a full code and was found unresponsive and without vital signs. Registered Nurse (RN) #393 was completing morning rounds on [DATE] at 7:20 A.M. when she found Resident #76 unresponsive and absent of all vital signs. RN #393 then called for help and left the room to summon assistance from PA #500. RN #385 called nine-one-one (911). The facility staff did not initiate CPR for Resident #76. The Immediate Jeopardy was removed on [DATE] when the facility implemented the following corrective actions: - On [DATE], Resident #76 expired in the facility and was transferred to the funeral home. - On [DATE], the facility obtained written statements from staff involved in the incident with Resident #76 on the following dates and times: on [DATE] at 7:45 A.M. from Licensed Practical Nurse (LPN) #406, on [DATE] at 8:00 A.M. from RN #385, on [DATE] at 8:15 A.M. from State tested Nursing Assistant (STNA) #432, on [DATE] at 2:50 P.M. from RN #393, on [DATE] at 5:26 P.M. from LPN #341, on [DATE] at 5:54 P.M. from LPN #507, and on [DATE] at 9:00 A.M. from STNA #337. - On [DATE] at 2:00 P.M., [NAME] President of Clinical Operations (VPCO) #510 reviewed the facility policies titled Advanced Directives, Change-in-Condition, and Emergency Procedure-Cardiopulmonary Resuscitation and made no changes or revisions. - On [DATE] starting at 2:45 P.M. to 7:10 P.M., RDCO #508 educated the Administrator and the DON on the facility policies titled Emergency Procedure-Cardiopulmonary Resuscitation and Change in a Resident's Condition or Status. The Administrator and DON educated the management team on the policies. The management team then educated all staff in all departments, excluding agency staff, on the policies. - On [DATE] at 9:30 A.M., the Administrator, the DON, Assistant Director of Nursing (ADON) #392, and LPN #406 started audits five times a week for four weeks to ensure the residents' code status was honored. No additional codes occurred during this time period. The audits were completed on [DATE]. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	- On [DATE] at 3:00 P.M., the Administrator and the DON educated PA #500 on the facility policies titled Emergency Procedure-Cardiopulmonary Resuscitation and Change in a Resident's Condition or Status. - On [DATE] at 4:27 P.M., the facility held an ad-hoc Quality Assurance Performance Improvement (QAPI) committee meeting to discuss the root-cause of why CPR was not provided to Resident #76 who was a full code status, and to discuss the steps that were necessary to show performance improvement moving forward. The attendees were as follows: the Administrator, the DON, ADON #392, LPN #374, LPN #406, Social Worker (SW) #383, SW #324, LPN #315, Activities Director (AD) #304, Maintenance Director (MD) #307, Human Resources Manager (HRM) #316, Staffing Coordinator (SC) #421, and Medical Director #512 via phone. The committee discussed the results of the interviews with the staff working the night prior to the incident with Resident #76 and with the staff working at the time of the incident and determined the resident had not experienced an obvious change in condition prior to the incident. The committee discussed VPCO #510's review of the facility policies titled Advanced Directives, Change-in-Condition, and Emergency Procedure-Cardiopulmonary Resuscitation, and made no changes to the policies. The committee discussed and assigned audits to the nursing management on ensuring residents' code status was honored and they were to be completed over a four-week period, for four weeks. - On [DATE] at 6:15 P.M., RDCO #508 educated the following members of the management team on the facility's policies titled Emergency Procedure-Cardiopulmonary Resuscitation and Change in a Resident's Condition or Status: the Administrator, the DON, ADON #392, LPN #374, LPN #406, SC #421, AD #304, MD #307, HRM #316, Business Office Manager (BOM) #443, and Speech Therapist (ST) #372. - On [DATE] between 6:30 P.M. and 8:12 P.M., ADON #392, Unit Managers (LPN #406 and LPN #374), and floor nurses (RN #385, LPN #416, LPN #435, LPN #351, and RN #301) evaluated all 76 residents. None of the residents were experiencing an active change in condition that warranted immediate physician intervention. - On [DATE] at 6:45 P.M., the DON completed an audit of all residents' charts to ensure the residents' code status was honored. No additional codes had occurred from [DATE] to [DATE]. - On [DATE] at 7:00 P.M., the management team (the Administrator, the DON, ADON #392, LPN #374, LPN #406, SC #421, AD #304, MD #307, HRM #316, BOM #443, and ST #372) began to educate the line staff on the CPR policy and the Change in Condition policy. If the management team members were unable to reach line staff upon first attempt on [DATE], the staff was educated prior to starting their next scheduled shift. The education provided included the following information: CPR o The resident had the right to formulate an advanced directive. o If a resident was found unresponsive and not breathing and/or had no pulse, a nurse who was certified in CPR/basic life support (BLS) should initiate CPR. All nurses were required to be CPR certified including agency nurses. If nurses were not CPR certified, they would not be permitted to work in the building. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	o Prior to initiating CPR, the nurse must verify code status in the resident's electronic medical record (EMR) order. CPR should not be performed if the resident had an order for DNR. If resident was a full code, CPR was provided immediately. o Upon finding a resident who was unresponsive and not breathing and/or had no pulse and was a full code, a staff member should page Code Blue overhead and initiate CPR. o A staff member should immediately bring the crash cart to the scene. o A staff member should immediately call 911. o The Nurse should continue CPR until emergency medical personnel arrived and took over CPR. o CPR must continue until a Medical Doctor, PA, Nurse Practitioner (NP) or paramedics pronounced death. Change in Resident Condition of Status o The nurse must promptly notify the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status. o If a staff member noted a change in the resident's medical/mental condition and/or status, he/she must immediately inform the nurse. o The nurse must assess the resident, notify the MD/PA/NP of the change in condition, and initiate any new orders received. o Examples of a change in resident condition/status include, but are not limited to, the following: significant change in the resident's physical/emotional/mental condition, abnormal breathing, need to transfer the resident to a hospital, accident or incident involving the resident such as a fall. - On [DATE] at 7:15 P.M., the DON, ADON #392, LPN #406, LPN #374, and SC #421 began to provide education on the facility policies titled Emergency Procedure-Cardiopulmonary Resuscitation and Change in a Resident's Condition or Status to all agency nurses and STNAs prior to their first shift worked. - On [DATE] at 7:45 P.M., the DON educated NP #514 on the facility policies titled Emergency Procedure-Cardiopulmonary Resuscitation and Change in a Resident's Condition or Status. - On [DATE] at 8:03 P.M., the DON educated Medical Director (MD) #513 on the facility policies titled Emergency Procedure-Cardiopulmonary Resuscitation and Change in a Resident's Condition or Status. MD #513 also reviewed the facility's abatement plan. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	- On [DATE] at 8:30 P.M., HRM #316 completed an audit of all nurses to ensure current CPR certification. LPN #515 who was on leave had expired CPR certification and had not worked since the incident on [DATE]. LPN #515 would not be permitted to return to work until CPR certification was obtained. LPN #317's CPR certification was set to expire on [DATE]. LPN #317 was educated to have new CPR certification prior to the next shift worked. - On [DATE] at 9:05 P.M., LPN/Minimum Data Set (MDS) Coordinator #315 completed a facility-wide audit to ensure reconciliation of the residents' code status orders, code status care plans, and, if applicable, the state of Ohio do not resuscitate (DNR) forms with no issues noted. - Starting on [DATE], the Administrator and nursing management (DON, ADON #392, LPN #374, and LPN #406) began chart audits of advanced directives for all newly admitted residents, five times per week for four weeks. - Starting on [DATE], the Administrator and nursing management (DON, ADON #392, LPN #374, and LPN #406) began chart audits of all residents to ensure resident code status was honored, five times per week for four weeks. They also audited three charts weekly to ensure change in resident condition was addressed appropriately, five time per week for four weeks. - On [DATE] at 6:30 A.M., the DON, ADON #392, LPN #374, and LPN #406 conducted a code blue drill with the following staff members: RN #301, LPN #507, LPN #357, STNA #386, STNA #441, LPN #516, and LPN #351. No issues were identified. - Starting on [DATE], nursing management (DON, ADON #392, LPN #374, LPN #406, RN #335, and RN #302) completed a mock code drill with follow up evaluation and education three times a week for four weeks. The results of the mock code drills would be submitted to the QAPI committee. - Starting on [DATE], the DON began to interview five staff members, three times per week for five weeks, to validate understanding of CPR administration. - On [DATE], LPN #374 and LPN #406 conducted an audit to ensure all emergency equipment used to perform CPR was present and functional with no concerns noted. - Interviews on [DATE] between 11:45 A.M. and 12:10 P.M. with STNAs #349, #355, #367, #381, and #448, LPNs #305, #315, #416, #418, and RN #393 confirmed they had received education regarding CPR and change in condition. Although the Immediate Jeopardy was removed on [DATE], the deficiency remained at Severity Level 2 (no actual harm with potential for more than minimal harm that was not Immediate Jeopardy) as the facility was in the process of implementing their corrective action plan and monitoring to ensure ongoing compliance. Findings include: (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the closed medical record of Resident #76 revealed an admitted [DATE]. The resident died in the facility on [DATE]. Diagnoses included left hip fracture, essential hypertension, paralytic ileus, pancytopenia, cachexia, chronic iron deficiency anemia secondary to blood loss, congestive heart failure, adult failure to thrive, severe protein-calorie malnutrition, atrial fibrillation, chronic thromboembolic pulmonary hypertension, and gastro-esophageal reflux disease (GERD). Review of the comprehensive Minimum Data Set (MDS) assessment for Resident #76 dated [DATE] revealed the resident had severe cognitive impairment. Review of the physician orders for Resident #76 revealed an order dated [DATE] for the resident to be a full code. Review of the care plan dated [DATE] revealed the resident was a full code. Review of the nurse's progress note for Resident #76 dated [DATE] timed at 8:06 A.M. per RN #393 revealed the nurse arrived on the unit, received report, and went to assess Resident #76. The nurse called to Resident #76, and he did not respond. Resident #76 was not breathing and did not have a pulse. PA #500 was made aware of Resident #76's condition, 911 was called, and the crash cart was brought to the room. Resident #76 was pronounced expired at 7:20 A.M. Review of the nurse's progress note for Resident #76 dated [DATE] timed at 8:59 A.M. per LPN #404 revealed the nurse arrived on the unit and staff nurses and PA #500 were in Resident #76's room. Resident #76 was absent of breath sounds and had no pulse. 911 had been called and the crash cart was in Resident #76's room. Resident #76's skin was noted to be cold. 911 arrived, hooked the resident to the monitor and had no results. Time of death was called at 7:20 A.M. Review of the progress note for Resident #76 per PA #500 dated [DATE] timed at 3:56 P.M. revealed on [DATE] PA #500 was asked to examine Resident #76 because the resident was not responding. Upon examination, Resident #76 was not responding to verbal or tactile stimuli, was not breathing, and did not have a pulse. 911 was called and the crash cart was obtained. Emergency Medical Services (EMS) arrived, assessed the resident, determined the resident had expired, and EMS left the building. Review of the death certificate for Resident #76 dated [DATE] revealed the cause of the resident's death on [DATE] was determined to be acute respiratory failure with underlying hypoxia. Interview on [DATE] at 11:51 A.M. with RN #393 confirmed she was Resident #76's nurse on the morning he was found not responding, not breathing, and without a pulse. RN #393 confirmed Resident #76 was a full code. RN #393 confirmed CPR was not initiated for the resident. RN #393 stated she asked PA #500 to assess the resident and the PA stated the resident had already died . Interview on [DATE] at 10:22 A.M. with LPN #406 confirmed on the morning of [DATE], she arrived on the unit between 7:15 A.M. and 7:30 A.M. and was alerted there was something going on in Resident #76's room. LPN #406 confirmed as she was walking to Resident #76's room, RN #393 and PA #500 were coming out of Resident #76's room and she heard PA #500 state the resident was gone. LPN #406 stated CPR was not initiated because it was obvious he was gone. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	A follow-up telephone interview on [DATE] at 10:36 A.M. with RN #393 confirmed upon finding Resident #76 without vital signs on [DATE] she asked PA #500 to come to Resident #76's room to assess the resident. RN #393 stated PA #500 assessed the resident, pronounced the resident's death, and advised RN #393 not to do CPR. RN #393 stated she had directed the staff to call 911 before PA #500 entered Resident #76's room. RN #393 stated she was unsure how long it took for EMS to arrive, but when they arrived, they checked for a pulse and heart rate, and did not do anything further with the resident. Interview on [DATE] at 11:08 A.M. with the DON confirmed if a nurse found a resident who was a full code to be without vital signs, the nurse should immediately initiate CPR. The DON further confirmed the facility staff failed to initiate CPR for Resident #76 who was a full code and was found without vital signs on [DATE]. Telephone interview on [DATE] at 12:57 P.M. with PA #500 confirmed RN #393 asked him to assess Resident #76 and the nurse told the PA the resident was a full code. PA #500 stated he went to assess Resident #76 and told RN #393 to run the code and call 911. PA #500 stated he did not pronounce Resident #76's death. PA #500 stated he then left the room as he felt the situation was under control with the nurses, though he did not witness anybody start CPR on Resident #76. PA #500 confirmed he stopped coming to the facility around [DATE] because the facility had a nurse practitioner who began coming to the facility three times per week. Review of a written statement dated [DATE] per LPN #406 revealed upon arriving on the unit, she was informed Resident #76 had coded. As LPN #406 was on her way to Resident #76's room, PA #500 and nurses were coming out of the room. One nurse was on the phone giving 911 information, and PA #500 stated Resident #76 was gone but he was a full code. Another nurse stated he was cold. LPN #406 asked another nurse to get the crash cart. As the crash cart was being brought up the hall, paramedics arrived on the unit. LPN #406 told the paramedics that PA #500 had stated Resident #76 was deceased , but the resident was a full code. Paramedics went to the room and hooked the resident up to a monitor. After a minute or two, the paramedics removed the monitor and asked what time the nurse found him. The nurse stated 7:20 A.M. The paramedic stated the time of death was 7:20 A.M., and the paramedics left. Review of the facility policy titled Advanced Directives dated [DATE] revealed advanced directives would be respected in accordance with state law and facility policy. Review of the facility policy titled Emergency Procedure-Cardiopulmonary Resuscitation dated [DATE] revealed if a resident was found unresponsive and not breathing normally, a licensed staff member who was certified in CPR/BLS (basic life support) shall initiate CPR. Review of the American Heart Association (AHA) guidelines dated [DATE] revealed the AHA urged all potential rescuers to immediately start CPR unless a valid DNR order was in place or there were obvious clinical signs of irreversible death present (e.g. rigor mortis, dependent lividity, decapitation, transection, or decomposition) or initiating CPR could cause injury or peril to the rescuer.

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

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44412 Based on record review, observation, staff interview, and review of the facility policy, the facility failed to properly transfer the resident using an appropriate assistive lift device. This affected one (Resident #14) resident of two residents reviewed for falls. The facility census was 78. Findings include: Review of the medical record for Resident #14 revealed an admitted [DATE] with diagnoses including acute and respiratory failure with hypercapnia, congestive heart failure (CHF), bipolar disorder, chronic kidney disease stage three, and type two diabetes mellitus (DM II). Review of the care plan for Resident #14 dated 02/01/24 revealed the resident was at risk for falls related to DM II and CHF. Interventions included the following: call light and personal items within reach while in room, staff to ensure a clutter-free environment and adequate lighting, staff to observe for safety, staff to provide rest periods, staff to use proper assistive devices. Review of the Minimum Data Set (MDS) assessment for Resident #14 dated 02/05/24 revealed the resident had intact cognition, required setup with eating, and was dependent on staff with toileting, bathing, dressing, and transfers. Review of the progress note for Resident #14 dated 03/11/24 timed at 6:33 P.M. revealed the resident slid out of sit-to-stand lift while two staff transferred the resident to the bed and the resident landed on the floor. The nurse assessed Resident #14 for injuries and found none. Staff assisted the resident into bed using a Hoyer lift. Review of the progress note for Resident #14 dated 03/13/24 timed at 12:57 P.M. revealed the interdisciplinary team (IDT) met to discuss the resident's fall on 03/11/24. The IDT determined the resident should be evaluated and treated by physical therapy and staff should utilize a Hoyer lift for transfers to prevent further falls. Review of the physical therapy note for Resident #14 dated 04/01/24 revealed staff should utilize a Hoyer lift for all transfers in and out of bed for resident and staff safety. Observation on 04/04/24 at 11:38 A.M. revealed State tested Nursing Assistants (STNAs) #311 and STNA #518 transferred Resident #14 from bed to wheelchair using the sit to stand lift. Interview on 04/09/24 at 11:22 A.M. with Physical Therapist (PT) #314 confirmed staff should be utilizing the Hoyer lift when transferring Resident #14. Review of the facility policy titled Lifting Machine, Using a Mechanical Lift dated October 2022 revealed staff would follow general principles of safe lifting using a mechanical lifting device. Before using a lift, staff should assess the resident's condition to determine the resident's appropriateness for transfer using a mechanical lift. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents noncompliance investigated under Complaint Number OH00152118.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44069 Based on medical record review, staff interview, and review of the facility policy, the facility failed to implement nutritional recommendations made per the licensed dietitian for residents with weight loss. This affected one (Resident #11) of three residents reviewed for nutrition. The facility census was 78. Findings include: Review of the medical record for Resident #11 an admitted [DATE] with diagnoses including polyneuropathy, cellulitis of right lower limb, generalized anxiety disorder, major depressive disorder, dementia, other cervical disc degeneration, and peripheral vascular disease. Review of the plan of care dated for Resident #11 dated 01/03/24 revealed the resident was at risk for alteration in nutrition related to polyneuropathy, depression, hypertension, cervical disc degeneration, peripheral vascular disease, anemia, cognitive communication deficit, and anxiety. The plan of care also indicated the resident was at risk for malnutrition due to history of weight fluctuations and advanced age. Interventions included the following: administer medications as ordered, honor food preferences as able, offer substitutes as needed, provide and serve diet as ordered, provide and serve supplements as ordered, registered dietician to evaluate and make diet change recommendations as needed. Review of the physician orders for Resident #11 revealed an order dated 01/15/24 for a house supplement in the morning. Review of the quarterly Minimum Data Set (MDS) assessment for Resident #11 dated 03/01/24 revealed the resident had moderately impaired cognition and required setup assistance for eating. Review of the weight records revealed Resident #11 weighed 122 pounds on 01/12/24, 117 pounds on 02/04/24, 113 pounds on 03/03/24, 109 pounds on 04/03/24, and 113 pounds on 04/09/24. Review of the nutrition assessment for Resident #11 dated 03/03/24 completed per Diet Technician (DT) #511 revealed the resident had a significant weight loss trend in the last 90 days with a recommendation to increase the house supplement to twice a day between meals due to significant weight loss. Review of the April 2024 physician orders for Resident #11 revealed the resident's order for house supplement once per day dated 01/25/24 had not been updated to reflect DT #511's recommendation to increase the house supplement to twice daily. Interview on 04/09/24 at 5:16 P.M. with the Director of Nursing (DON) confirmed the order for a house supplement for Resident #11 had not been increased per the recommendation of DT #511 made on 03/03/24. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Weight Assessment and Intervention dated August 2023 revealed the facility staff would implement interventions for undesirable weight loss based upon resident choices and preferences and the nutritional needs of the resident.

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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** 35770 Based on record review, staff interview, and review of the facility policy, the facility failed to implement physician orders following pharmacy recommendations. This affected three (Residents #5, #16, and #23) of five residents reviewed for unnecessary medications. The facility census was 78. Findings include: 1. Review of the medical record for Resident #5 revealed an admitted [DATE] with diagnoses including cerebral infarction, schizophrenia, anxiety, expressive language disorder, depression, and dementia. Review of the Minimum Data Set (MDS) assessment for Resident #5 dated 01/15/24 revealed the resident had severe cognitive deficits and required extensive to total dependence with activities of daily living (ADLs.) Review of pharmacy recommendation for Resident #5 dated 06/21/23 revealed a recommendation to discontinue Seroquel 25 milligrams (mg) by mouth at bedtime signed by the medical director on 07/17/23 indicating agreement with the recommendation. Review of the physician orders for Resident #5 revealed an order dated 11/03/23 to discontinue Seroquel 25 mg. Interview on 04/10/24 at 12:50 PM with the Director of Nursing (DON) confirmed the pharmacist made a recommendation on 06/21/23 to discontinue Seroquel 25 mg for Resident #5. The physician signed in agreement of the recommendation on 07/17/23 but the recommendation was not implemented until Seroquel 25mg was discontinued on 11/03/23. 2. Review of the medical record for Resident #23 revealed an admitted [DATE] with diagnoses including congestive heart failure (CHF), type two diabetes mellitus (DM II), acute and chronic respiratory failure, Alzheimer's disease, anxiety disorder, and major depressive disorder. Review of the MDS assessment for Resident #23 dated 03/11/24 revealed the resident had severe cognitive impairment and required supervision with ADLs. Review of the pharmacy recommendation for Resident #23 dated 07/17/23 revealed a recommendation to increase lisinopril to 30 mg once daily. The physician signed agreement with the recommendation. Review of the physician order for Resident #23 dated 10/03/23 revealed an order for lisinopril 30 mg every day. Review of the pharmacy recommendation for Resident #23 dated 02/13/24 revealed a recommendation to increase Novolog insulin six units three times daily with meals. The physician signed agreement with the recommendation. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the physician orders for April 2024 for Resident #23 revealed there was no order for six units of Novolog to be given three times a day with meals. Interview on 04/10/24 at 10:06 A.M. with the Assistant Director of Nursing (ADON) confirmed the pharmacist made a recommendation on 07/17/23 to increase Resident #23's lisinopril. The physician signed agreement to increase the lisinopril, but the recommendation was not implemented until 10/03/23. Interview with the ADON also confirmed the pharmacist made a recommendation to increase Resident #23's Novolog insulin to six units three times per day with meals. The physician signed agreement to increase the resident's insulin, but the facility had not implemented the recommendation. 44069 3. Review of the medical record for Resident #16 revealed an admitted [DATE] with diagnoses including necrotizing fasciitis, generalized anxiety disorder, type two diabetes mellitus, peripheral vascular disease, anemia, lumbar spina bifida without hydrocephalus, atrial fibrillation, depression, and arthropathy. Review of the MDS assessment for Resident #16 dated 02/26/24 revealed the resident had intact cognition and required staff assistance with ADLs. Review of the pharmacy recommendation for Resident #16 dated 02/13/24 revealed a recommendation to start a dose of Insulin Lispro at two units daily. Nurse Practitioner (NP)#514 signed agreement with the recommendation on 02/23/24. Review of the April 2024 physician orders for Residents #16 revealed there were no orders for insulin Lispro two units. Interview on 04/09/24 at 5:10 P.M. with the DON confirmed the pharmacist made a recommendation on 02/13/24 to start insulin Lispro two units which NP #514 signed in agreement on 02/23/24. Interview with the DON confirmed the facility had not implemented the pharmacist's recommendation. Review of the facility policy titled Medication Therapy revised April 2007 revealed shortly after admission and periodically thereafter, the facility and practitioner with the assistance of the Consultant Pharmacist would review a resident's medication regimen to identify whether there was a clear indication for use of the medication, appropriate dosage, frequency of administration and duration of use are appropriate, and any potential or suspected side effects that are present.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35770 Based on medical record review, observation, staff interview, and review of the facility policy, the facility failed to ensure a medication error of below five percent for medication administration observation. The medication error rate was eight percent (%.) This affected one (Resident #55) of four residents observed for medication administration. The facility census was 78. Findings include: Review of the medical record for Resident #55 revealed an admitted [DATE] with diagnoses including diabetes, atrial fibrillation, insomnia, hypertension, and Asperger's syndrome. Review of the Minimum Data Set (MDS) for Resident #55 dated 02/19/24 revealed the resident was cognitively impaired and required staff assistance with activities of daily living (ADLs). Review of physician orders for Resident #55 revealed the resident had an orders for pantoprazole 40 milligrams in the morning and Flonase nasal spray two sprays in each nostril each morning. Observation on 04/03/24 at 9:03 A.M. of medication administration for Resident #55 per Licensed Practical Nurse (LPN #505) revealed the nurse administered the resident's morning medications but omitted administration of pantoprazole and Flonase. LPN #505 signed the medications off in the electronic medical record (EMR) as administered. Interview on 04/03/24 at 9:27 P.M. with LPN #505 confirmed she was nervous and did not know the people on that hall and she had signed Resident #55's pantoprazole and Flonase as administered but she had not given the medications to the resident. LPN #505 confirmed the medication error rate for medication administration observation was eight %. Interview on 04/04/24 at approximately 1:00 P.M. with Regional Director of Clinical Operations (RDCO) #508 confimred understanding that the medication error rate was eight % for the medication administration observation completed on 04/03/24. Review of the facility policy titled Administering Medications dated August 2022 revealed medications were administered in safe and timely manner, and as prescribed.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44412 Based on medical record review, observation, staff interviews, and review of the facility policy, the facility failed to ensure insulin pens were properly labeled and stored. This affected two (Residents #23 and #55) of 39 residents with medications stored in the 700 hall cart. The facility census was 78. Findings include: Review of the medical record for Resident #23 revealed an admitted [DATE] with diagnoses including congestive heart failure (CHF), type two diabetes mellitus (DM II), and acute kidney failure. Review of the physician orders for Resident #23 revealed an order dated 01/17/24 for Lantus insulin inject ten units at bedtime. Review of the medical record for Resident #55 revealed an admitted [DATE] with diagnoses including type one diabetes mellitus, atrial fibrillation, and Asperger's syndrome. Review of the physician orders for Resident #55 revealed an order dated 01/17/24 for Lantus insulin inject 25 units and an order dated 03/29/24 for Humalog insulin inject four units. Observation on 04/03/24 at 4:02 P.M. of medication cart on 700 hall revealed Resident #23's Lantus insulin pen was opened without an open date. Resident #55's insulin pens, Humalog and Lantus, were opened without an open date. Interview on 04/03/24 at 4:04 P.M. with Licensed Practical Nurse (LPN) #502 confirmed insulin pens should be dated upon opening so staff would know when to discard them. LPN #502 further confirmed the insulin pens for Resident #23 and #55 were opened but undated. Review of the facility policy titled Administering Medications dated August 2022 revealed medications were administered in a safe and timely manner, and as prescribed. The expiration/beyond use date on the medication label was checked prior to administering. When opening a multi-dose container, the date opened was recorded on the container.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. 42731 Based on staff interview, observation, record review, and review of the facility policy, the facility failed to ensure all food temperatures were checked prior to the start of meal service. This had the potential to affect all 78 residents in the facility. Findings include: Interview on 04/03/24 at 4:00 P.M. with Dietary Cook (DC) #430 confirmed he only gets the temperature of one food on the steam table at the beginning of each meal because if one was hot, the rest will be hot. DC #430 further confirmed he would be testing the temperature of the chicken for the meal because it was the only food on the steam table which did not have foil over it in addition to the metal lid. DC #430 then tested the temperature of the chicken and the thermometer read 140 degrees Fahrenheit (F). DC #430 confirmed the chicken needed to be at least 165 degrees F and then placed the chicken back in the steamer. Observation on 04/03/24 at 4:10 P.M. revealed DC #430 retrieved the pan of chicken from the steamer and placed it in the steam table. DC #430 obtained the temperature of the chicken at 179 degrees F. DC #430 then began plating food for the dinner meal. DC #430 did not obtain the temperature of any other foods. Review of the food temperature log on 04/03/24 at 4:20 P.M. revealed there was an entry made on 04/03/24 for the chicken at 179.3 degrees F with DC #430's initials. There were no other food temperatures documented for the date and the previous and most recent temperatures were dated 03/15/24. Interview on 04/03/24 at 4:20 P.M. with DC #430 confirmed there were no other temperature log entries for the dinner meal on 04/03/24 Interview on 04/09/24 at 3:16 P.M. with Registered Dietetic Technician (DTR) #511 confirmed the temperature of all foods should be checked prior to the start of meal service. Review of the facility policy titled Food Temperatures undated revealed all hot food items must be held and served at a temperature of at least 135 degrees F and temperatures should be taken often to monitor for safe food holding temperatures above 135 degrees F for hot foods.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 42731 Based on observation, staff interview, and review of facility recipes, the facility failed to properly prepare pureed food. This had the potential to affect five (Residents #12, #22, #47, #49, #50) of five facility-identified residents who received a pureed diet. The facility census was 78. Findings include: Observation on 04/03/24 at 1:08 P.M. revealed Dietary Cook (DC) #430 began process of making pureed broccoli. DC #430 placed 6 scoops (3 cups) of broccoli into the blender pitcher and then placed the pitcher under the water spigot and filled the pitcher to the 6-cup line. Continued observation revealed DC #430 blended the broccoli mixture in the blender for approximately four minutes. DC #430 then poured the contents into a pan, covered the pan, and placed it in the steamer. The contents of the pitcher were liquified and runny. Interview on 04/03/24 at 1:10 P.M. with DC #430 confirmed he used equal parts of water and vegetables because he wanted to make sure the food was as watery as possible to ensure the residents could digest it without choking. DC #430 confirmed the mixture was runny and stated that's the way he wanted it to be mixed. Interview on 04/09/24 at 3:16 P.M. with Registered Dietetic Technician (DTR) #511 confirmed a ratio of one part vegetable to one part water would be too much water to maintain the nutritive value of the food. Review of the facility recipe for pureed vegetables revealed 1/4 cup of vegetables should be mixed with two teaspoons of water and 1/4 slice of bread and blended to a mashed potato consistency.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42731 Based on observation, staff interview, and review of the facility policy, the facility failed to ensure kitchen equipment was maintained in a sanitary manner. The facility also failed to ensure staff wore hair restraints which fully contained the hair while preparing food. This had the potential to affect all 78 residents in the facility. Findings include: 1. Observation on 04/01/24 at 8:37 A.M. revealed the hood in the kitchen, which covered the fryer, stove, grill, and steamers, was covered with a black and grey fuzzy substance. Further observation revealed a sticker on the hood, which indicated the last cleaning was completed on June 2023. Interview on 04/01/24 at 8:37 A.M. with Food Service Manager (FSM) #503 confirmed the slats of the hood in the kitchen were in need of cleaning. FSM #503 confirmed the cleaning was past due, and the hood should be cleaned every three months. Review of the facility policy titled Cleaning Instructions: Hoods and Filters undated revealed stove hoods and filters should be cleaned at least monthly and professionally cleaned at least yearly. 2. Observation on 04/03/24 at 11:50 A.M. revealed Dietary Cook (DC) #430 was preparing food in the kitchen. DC #430 had a beard and did not have any type of covering over the facial hair. Interview on 04/03/24 at 11:50 A.M. with DC #430 confirmed he was not wearing anything to contain his facial hair. 3. Observation on 04/03/24 at 11:51 A.M. revealed DC #445 was assisting with food preparation. DC #445 had facial hair which was not covered. Interview on 04/03/24 at 11:51 A.M. with DC #445 confirmed he was not wearing anything to contain his facial hair while preparing food. Observation on 04/03/24 at 11:53 A.M. revealed DC #445 brought facial hair covers into the kitchen. DC #445 applied a beard net to his face, but it was tucked under his chin and did fully contain his facial hair. 4. Observation on 04/03/24 at 11:52 A.M., revealed Dietary Aide (DA) #338 was assisting with meal service and food preparation. DA #338 had facial hair and did not have any type of facial hair restraint. Interview on 04/03/24 at 11:52 A.M. with DA #338 confirmed he had facial hair and was not wearing a facial hair restraint while preparing food. Review of the facility policy titled Employee Sanitary Practices undated revealed all employees shall wear hair restraints to prevent hair from contacting exposed food.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 44412 Based on record review, staff interview, and review of the facility policy, the facility failed to properly implement the Legionella plan. This had the potential to affect all of the residents residing in the facility. The facility census was 78. Findings include: Review of the facility's water management records revealed the facility failed to complete water temperatures for the year of 2023 which was one of the specific control measures the facility was using to monitor Legionella. Review of the facility temperature log revealed water temperatures had only been completed from January 2024 through March 2024. There were no water temperatures recorded for 2023. Interview on 04/10/24 at 1:03 P.M. with Maintenance Director (MD) #307 confirmed the facility had not completed water temperatures for the year 2023. Review of the facility policy titled Legionella Water Management Program dated July 2017 revealed the facility was committed to the prevention, detection, and control of water-borne contaminants, including Legionella. The purpose of the water management program was to identify areas in the water system where legionella bacteria can grow and spread, and to reduce the risk of Legionnaire's disease. Specific measures used to control the introduction and/or spread of legionella included taking water temperatures and use of disinfectants.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365603	A. Building B. Wing	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aventura at West Park	2950 West Park Drive 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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44412 Based on record review, staff interview, and review of the facility policy, the facility failed to provide the pneumococcal vaccine in a timely manner. This affected three (Residents #10, #11, and #21) of five resident reviewed for vaccinations. The facility census was 78. Findings include: Review of the medical record for Resident #10 revealed an admitted [DATE] with diagnoses including type two diabetes mellitus, generalized anxiety, depression, and chronic kidney disease stage three. Review of the medical record for Resident #10 revealed Pneumococcal vaccine 23 (PPSV23) was given on 02/01/13. Resident #10 should have received PCV15 or PCV20 at least one year after PPSV23. Review of the medical record for Resident #11 revealed an admitted [DATE] with diagnoses including generalized anxiety disorder, major depressive disorder, and dementia. Review of the medical record for Resident #11 revealed the PPSV23 was given on 07/01/18. Resident #11 should have received PCV15 or PCV20 at least one year after PPSV23. Review of the medical record for Resident #21 revealed an admitted [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, type two diabetes mellitus (DM II), and depression. Review of the medical record for Resident #21 revealed the resident was not offered the pneumococcal vaccine since admission to the facility. Interview on 04/10/24 at 9:27 A.M. with Assistant Director of Nursing (ADON) confirmed Residents #10, #11, and #21 were not up to date on their pneumococcal vaccines. Review of the facility policy titled Pneumococcal Vaccine dated November 2023 revealed all residents were offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. Prior to or upon admission, residents were assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, were offered the vaccine series within thirty days of admission to the facility unless medically contraindicated or the resident had already been vaccinated.