

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365705	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/18/2024
NAME OF PROVIDER OR SUPPLIER Aventura at Walton Hills		STREET ADDRESS, CITY, STATE, ZIP CODE 19859 Alexander Rd Walton Hills, OH 44146	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34297</p> <p>Based on record review and interview, the facility failed to ensure Resident #50's pressure ulcer wound care was completed as ordered. This finding affected one (Resident #50) of three residents reviewed for pressure ulcers.</p> <p>Findings include:</p> <p>Review of Resident #50's medical record revealed the resident was admitted on [DATE] with diagnoses including unspecified dementia, generalized anxiety disorder and unspecified osteoarthritis.</p> <p>Review of Resident #50's Admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited severe cognitive impairment.</p> <p>Review of Resident #50's Admission Nursing Evaluation form dated 08/05/24 revealed the resident had bruising to the right antecubital, right buttock and left buttock.</p> <p>Review of Resident #50's Wound Observation form dated 08/06/24 revealed the resident had bilateral buttocks dermatitis first acquired 08/05/24. The resident was discharged from wound care.</p> <p>Review of Resident #50's Braden Scale for Predicting Pressure Sore Risk form dated 08/12/24 revealed the resident was high risk for developing pressure ulcer wounds.</p> <p>Review of Resident #50's progress note dated 08/31/24 at 4:00 P.M. authored by Licensed Practical Nurse (LPN) #839 revealed while performing activities of daily living (ADL) care on the resident, the State tested Nursing Assistant (STNA) and daughter had observed three open areas on the buttocks. The area was cleansed with normal saline at this time. The nurse attempted to apply a border foam dressing and the resident's daughter denied. Hospice and the Director of Nursing (DON) were made aware.</p> <p>Review of Resident #50's progress note dated 08/31/24 at 6:30 P.M. authored by LPN #839 revealed the hospice nurse arrived with new orders to clean the area with normal saline, pat dry, apply a foam border dressing daily and as needed.</p> <p>Review of Resident #50's hospice Visit Summary form dated 08/31/24 authored by Hospice Registered Nurse (RN) #925 indicated three new open areas to the buttocks were identified and the wound nurse was to assess. New orders were provided to clean the area and apply a foam border dressing until the wound nurses assesses the resident.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #50's medication administration records (MARS) and treatment administration records (TARS) from 08/31/24 to 09/16/24 did not reveal evidence wound care to the bilateral buttocks were ordered or completed on 09/01/24 and 09/02/24.</p> <p>Review of Resident #50's Wound Observation Evaluation form dated 09/03/24 revealed the resident had bilateral buttocks Kennedy ulcer (a dark, irregularly shaped sore that develops rapidly in the final stages of life) first identified 08/31/24 with full thickness with fat layer exposed and the documentation indicated 30% epithelial tissue, 50% granulation tissue and 20% slough. The treatment included to cleanse with normal saline or sterile water, cleanse with Dakins antibacterial cleanser solution, cover wound bed with oil emulsion dressing and then cover with a clean dry dressing. The wound measurements were 6.1 centimeters (cm) length by 15.3 cm width by 0.2 cm depth.</p> <p>Interviews on 09/17/24 at 8:08 A.M. with the DON and Assistant Director of Nursing (ADON) #805 confirmed Resident #50's medical record did not have evidence of bilateral buttocks pressure ulcer wound care was ordered accurately in the resident's electronic health record (EHR) or completed as ordered by hospice services on 09/01/24 and 09/02/24. The DON and ADON #805 confirmed the resident's bilateral pressure wounds were documented by hospice services as [NAME] Ulcers.</p> <p>Review of the undated Wound Care Management policy revealed the policy was to ensure that all residents were assessed on admission, quarterly and with a change in condition for the potential of skin breakdown and to ensure interventions were in place to maintain skin integrity.</p> <p>This deficiency represents non-compliance investigated under Complaint Numbers OH00157839 and OH00157857.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44457</p> <p>Based on interview and record review, the facility failed to ensure resident safety when not returning from a leave of absence. This affected one Resident (#27) of three reviewed for safety hazards. The facility census was 72.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #27 revealed an admitted [DATE]. Diagnoses included epilepsy, diabetes mellitus, Wernicke's encephalopathy, generalized muscle weakness, major depressive disorder, cognitive communication deficit, alcohol use, restlessness and agitation, and anxiety disorder.</p> <p>Review of the Medicare Quarterly Minimum Data Set (MDS) assessment, dated 06/07/24, revealed Resident #27 had intact cognition. Resident #27 was independent for bed mobility, ambulation, and transfers.</p> <p>Review of physician's order, dated 08/09/24, revealed Resident #27 may go on leave of absence (LOA) with supervision with medications unless contraindicated.</p> <p>Review of physician's orders for September 2024 revealed Resident #27 had orders for Empagliflozin (medication used to control high blood sugar in people with type two diabetes mellitus) 10 milligrams (mg) by mouth in the morning, Topiramate (anticonvulsant medication used to prevent and control seizures) 200 mg by mouth twice daily, Levetiracetam (antiepileptic medication) 500 mg by mouth twice daily, and Levetiracetam 750 mg by mouth twice daily.</p> <p>Review of progress note dated 09/03/24 at 7:48 P.M. revealed Resident #27 was picked up for LOA during shift.</p> <p>Further review of Resident #27's medical record revealed no evidence Resident #27 had taken a supply of her medications on 09/03/24 LOA.</p> <p>Review of Medication Administration Note dated 09/03/24 at 11:59 P.M. revealed Resident #27 was on LOA.</p> <p>Review of medication administration record (MAR) and treatment administration record (TAR) for September 2024 revealed nursing staff documented Resident #27 was on LOA for bedtime medications on 09/03/24. The LOA was documented to extend to morning medications on 09/07/24. Resident #27 was then documented to be hospitalized from 09/07/24 to 09/10/24.</p> <p>Review of progress note dated 09/04/24 at 6:38 A.M. revealed Resident #27 remained on LOA and the Director of Nursing (DON) was made aware. There was no evidence in the medical record of attempts to contact resident/family on 09/03/24 when the resident did not return that night.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Euclid Police Call for Service dated 09/04/24 at 11:00 A.M. revealed Euclid police were called for welfare check of Resident #27 by DON. Police arrived on scene at 11:13 A.M. and were unable to locate Resident #27 at residence. The call for service was cleared as of 09/04/24 at 11:50 A.M.</p> <p>Review of progress note dated 09/04/24 at 1:07 P.M. revealed Resident #27 had not returned from LOA. Authorities, family, DON and Administrator were notified.</p> <p>Review of progress note dated 09/04/24 at 2:42 P.M. revealed Resident #27 was still on LOA.</p> <p>Review of the policy report received 09/04/24 at 4:37 P.M., dispatched on 09/04/24 at 4:45 P.M., titled, MISSING PERSON revealed on 09/04/24 at approximately 4:37 P.M. dispatch advised that the facility wanted to report a missing person that walked off their property yesterday between 11:30 A.M. and 12:00 P. M. Administrator of the facility advised the resident as spotted yesterday 09/03/24 leaving on foot by the housekeeper. The housekeeper was able to give her a clothing description wearing a beige [NAME] hoodie, dark blue jeans cuffed at the bottom, white [NAME] tennis shoes with red and blue lettering or marks ,peach colored purse and wearing a pony tail. Administrator stated the resident normally leaves with her mother about once a month at the beginning of the month with permission. Facility staff assumed the resident was leaving with her mother again, however when the resident did not return, staff contacted the resident's mother and she stated she did not pick up the resident and would have no idea where she was. Staff then went to her home and also went to the resident's boyfriend's house and he stated he had not seen her in four to five months. Staff then called the police department to do welfare checks. Administrator was labeled to give a list of medications the resident takes and that she did not have access to any of it. In the past, the resident has walked out of other homes and has not returned as this is normal behavior. She has been found in hospitals in the past. Administrator stated the resident is her own guardian however has some severe medical issues that interfere with her decision-making skills especially if she consumes alcohol and/or does any drugs. The resident has epilepsy and is on medication for her seizures. The medication needs to be taken twice daily. The resident also has a pacemaker. The resident does have a history of drug abuse with heroin. The sergeant contacted hospitals and phone numbers that were associated with the resident to no avail. The resident was entered as a missing person.</p> <p>Review of Prehospital Care Report Summary dated 09/05/24 at 12:34 A.M. revealed Emergency Medical Services (EMS) were called for Resident #27 at a residential apartment in Euclid, Ohio. Resident #27 was complaining of headache and a racing heart. Resident #27 was transported to the hospital.</p> <p>Review of Medication Administration Note dated 09/05/24 at 8:57 P.M. revealed Resident #27 was on LOA.</p> <p>Review of hospital History and Physical Examination dated 09/05/24 revealed Resident #27 presented to the hospital with headache and weakness. Resident #27 reported nausea with a single episode of vomiting, significant fatigue, blurred vision, and mild photosensitivity.</p> <p>Review of hospital Psychiatry Initial Consultation Note dated 09/06/24 revealed Resident #27 had history of traumatic brain injury, dementia, and polysubstance abuse. Resident #27 was oriented to person and place with moderately impaired memory. Resident #27 was vague with history and had little recall of what had happened to her.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 09/16/24 at 11:38 A.M. with DON revealed Resident #27 went on an LOA with her mother on 09/03/24. DON indicated the LOA was prearranged and Resident #27 was supposed to return the same day. DON indicated Resident #27 nor her mother signed out prior to leaving for the LOA. DON noted Resident #27 typically went on LOA with her mother over the weekends and would be gone for several days. DON indicated she was notified at approximately 10:00 P.M. when Resident #27 did not return to the facility. DON indicated she began calling Resident #27's mother with no response. DON indicated contact was not made with Resident #27 or the mother until 09/04/24. DON indicated she drove to Resident #27's mother's house to check on them in the morning on 09/04/24. DON indicated she was unable to locate Resident #27 but made contact with Resident #27's mother via phone. DON indicated Resident #27's mother would not locate Resident #27 or allow her entry to the home. DON indicated she called Euclid Police (local police for the mother's home) for a welfare check for Resident #27. DON indicated Resident #27's mother indicated Resident #27 was not at her house and would not allow police entry into her home. DON indicated she returned to the facility and called [NAME] Hills Police to report Resident #27 as a missing person. DON indicated after the news reported Resident #27 missing a neighbor to Resident #27's mother reporting seeing Resident #27 at her mother's home appearing very intoxicated. DON indicated at this time Resident #27 was transported to the hospital for evaluation by EMS.</p> <p>Interview on 09/16/24 at 2:40 P.M. with Administrator revealed Resident #27 left for LOA on 09/03/24 at approximately 11:00 A.M. and was expected to return that evening. Administrator confirmed Resident #27 did not return to the facility on [DATE]. Administrator indicated on 09/04/24 at approximately 10:30 A.M. she drove to Resident #27's significant other's home to look for Resident #27. Administrator indicated Resident #27 was not located at that time. Administrator indicated on 09/04/24 at 12:05 P.M. [NAME] Hills Police were notified Resident #27 was missing and had not had her medications since the morning of 09/03/24. Administrator indicated on 09/05/24 at 5:08 P.M. she was notified by [NAME] Hills Police that Resident #27 had been located and was currently at the hospital.</p> <p>Interview on 09/16/24 at 3:03 P.M. with Licensed Practical Nurse (LPN) #842 revealed she was notified Resident #27 was going on an LOA on 09/03/24 during report. LPN #842 indicated she gave Resident #27 her morning medication and Resident #27 mentioned she was going on a LOA. LPN #842 indicated Resident #27 and her mother did not notify her or sign out upon leaving for LOA. LPN #842 indicated she was unaware exactly when Resident #27 left the facility in the morning. LPN #842 indicated in the early afternoon it was noted Resident #27 had left with her mother. LPN #842 indicated she called Resident #27's mother several times to confirm they had gone together but was unable to reach her. LPN #842 indicated she informed the DON she was unable to locate Resident #27 or reach the mother by phone. LPN #842 indicated she did not see Resident #27 for the rest of her shift.</p> <p>Follow up interview on 09/16/24 at 3:24 P.M. with DON confirmed she was notified by LPN #842 that Resident #27 had left the facility. DON indicated she did not think anything of it because it was a planned LOA and Resident #27 was expected to return in the evening. DON indicated she was called between 9:00 P.M. and 10:00 P.M. on 09/03/24 when Resident #27 had not returned. DON indicated she began calling the mother but was unable to make contact. DON indicated she attempted to call Resident #27's mother again in the morning of 09/04/24 without making contact. DON indicated she then drove to the mother's home to attempt to make contact. DON indicated she notified Euclid Police for a welfare check on 09/04/24 between 10:00 A.M. and 11:00 A.M.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Follow up interview on 09/16/24 at 4:15 P.M. with Administrator revealed Physician Assistant (PA) #927 was notified via text message Resident #27 had not returned from LOA. Administrator reported PA #927 was notified on 09/04/24 at 4:06 P.M.</p> <p>Interview on 09/16/24 at 4:20 P.M. with Registered Nurse (RN) #878 via phone revealed she worked night shift on 09/03/24. RN #878 indicated she was told Resident #27 was on LOA and expected to return that evening. RN #878 indicated between 10:30 P.M. and 11:00 P.M. she noted Resident #27 had not returned. RN #878 indicated she had attempted to call the mother then notified the DON via phone. RN #878 indicated she was not instructed to do anything by the DON. RN #878 indicated Resident #27 did not return on her shift.</p> <p>Review of facility policy Resident LOA dated August 2022 revealed Residents leaving premises must be signed out. Inquiries concerning the signing out of residents should be referred to the director of nursing or to the administrator.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00157857.</p>		