

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 01/16/2025
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42733</p> <p>Based on observation, interview, and medical record review, the facility failed to ensure residents were treated in a respectful and dignified manner. This affected three residents (#31, #68, and #70) of six observed for dignified treatment. The facility census was 71.</p> <p>Findings include:</p> <p>1. Review of Resident #31's medical records revealed an admitted [DATE]. Diagnoses included developmental disorder, bladder dysfunction and Parkinson.</p> <p>Review of MDS assessment dated [DATE] revealed Resident #31 had impaired cognition. Resident #31 required maximum assistance with toileting, bathing and personal hygiene. Resident #31 had a urinary catheter for elimination.</p> <p>Review of Resident #31's physician orders for January 2025 revealed to keep foley bag covered with privacy bag.</p> <p>Observations on 01/13/25 from 11:16 A.M. to 11:20 A.M. revealed Resident #31's urinary drainage bag was visible from the doorway and did not have privacy cover in place. Resident #31 was not interviewable.</p> <p>Interview with Certified Nurse Aide (CNA) #317 on 01/13/25 at 11:25 A.M. confirmed Resident #31's catheter bag was visible from the doorway and CNA #317 stated she was unsure if the facility had privacy bags as she had not seen privacy bags in use.</p> <p>2. Review of Resident #68's medical records revealed an admitted [DATE]. Diagnoses included dementia.</p> <p>Review of MDS assessment dated [DATE] revealed Resident #68 had impaired cognition. Resident #68 required set up assistance with toileting, bathing and personal hygiene. Resident #68 had a urinary catheter for elimination.</p> <p>Review Resident #68's of physician orders for January 2025 revealed to keep foley bag covered with privacy bag.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observations on 01/13/25 from 11:16 A.M. to 11:20 A.M. revealed Resident #68's urinary drainage bag was visible from the doorway and did not have privacy cover in place. Resident #68 was not interviewable.</p> <p>Interview with CNA #317 on 01/13/25 at 11:25 A.M. confirmed Resident #68's catheter bag was visible from the doorway and CNA #317 stated she was unsure if the facility had privacy bags as she had not seen privacy bags in use.</p> <p>3. Review of Resident #70's medical records revealed an admitted [DATE]. Diagnoses included stroke with left-sided weakness, aphasia (difficulty speaking), and dementia.</p> <p>Review of MDS dated [DATE] revealed Resident #70 had no cognition score as the resident was rarely understood. Resident #70 was dependent on staff for toileting, bathing, and personal hygiene tasks.</p> <p>Observation on 01/13/25 at 11:44 A.M. revealed CNA #313 was standing in the hallway outside of Resident #70's room, while Resident #70 was in a wheelchair. CNA #313 was observed to have been repeating the word NO! as Resident #70 attempted to push his wheelchair around CNA #313. Resident #70 had continued to attempt to push his wheelchair around CNA #313 and enter his room when CNA #313 stated go ahead and try to get in, I dare you in an intimidating and rude manner.</p> <p>Interview on 01/13/25 at 11:45 A.M. with CNA #313 revealed Resident #70's roommate had recently passed away and she was supposed to stand with the resident so he was unable to enter the room. CNA #313 was asked if anyone had explained the situation to Resident #70, and CNA #313 responded rudely, I don't know, they just told me to stand here with him. CNA #313 appeared frustrated with Resident #70, who continued to attempt to enter his room, until CNA #313 walked away at 11:50 A.M., leaving Resident #70 unattended in the hallway.</p> <p>Interview on 01/13/25 at 12:30 P.M. with Assistant Director of Nursing (ADON) revealed the ADON was informed of the prior interaction with CNA #313 and Resident #70. The ADON stated she would immediately inform the Director of Nursing (DON) and the Administrator of CNA #313's behavior towards Resident #70.</p> <p>Interview on 01/13/25 at 12:31 P.M. with the DON and Administrator confirmed they would begin an investigation into CNA #313's previous interactions with Resident #70.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00161010 and OH00160958.</p>		

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<p>F 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow resident to participate in the development and implementation of his or her person-centered plan of care.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42733</p> <p>Based on record review, staff and family interview, and review of the facility policy, the facility failed to ensure residents and their responsible parties were included in the development and implementation of the plan of care. This affected one resident (Resident #11) of three residents reviewed for care planning. The facility census was 71.</p> <p>Finding include:</p> <p>Review of Resident #11's medical records revealed an admitted [DATE]. Diagnoses included paraplegia and bladder dysfunction.</p> <p>Review of Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #11 had intact cognition.</p> <p>Telephone interview on 01/13/25 at 10:33 A.M. with Resident #11's Power of Attorney (POA) revealed she had attempted multiple times to arrange a care planning conference to discuss Resident #11's needs, however no care planning conference had ever been scheduled.</p> <p>Interview on 01/13/25 at 3:03 P.M. with Social Services Designee (SSD) #332 revealed care planning conferences were to be done upon admission and then on a quarterly basis. SSD #332 stated the care planning conferences were then documented in the resident's electronic medical records.</p> <p>Review of Resident #11's medical records revealed no documented care planning conference.</p> <p>Follow up interview on 01/14/25 at 1:49 P.M. with SSD #332 revealed she had spoken with Resident #11's POA, however she could not recall a time frame or what the discussion entailed. SSD #332 confirmed Resident #11's medical records had not included a documented care planning conference and SSD #332 was unable to provide documentation of a care planning conference being held.</p> <p>Review of the policy Comprehensive Person-Centered Care Plans revised 03/16/23 revealed a comprehensive, person-centered care plan is developed and implemented for each resident. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. Each resident's comprehensive person-centered care plan is consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to participate in the planning process, request meetings, and to participate in establishing the expected goals and outcomes. The resident is informed of his or her right to participate in his or her treatment and provided advance notice of care planning conferences. If the participation of the resident and his/her resident representative in developing the resident's plan of care is determined to not be practicable, an explanation is documented in the resident's medical record. The explanation should include what steps were taken to include the resident or representative in the process.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00161010.</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42733</p> <p>Based on record review, interview, and review of facility policy, the facility failed to timely address resident and family concerns. This affected two residents (#11 and #67) of four residents reviewed for concerns. The facility census was 71.</p> <p>Findings include:</p> <p>Review of the facility's grievance log revealed no logged grievances for December 2024 or January 2025 to date.</p> <p>1. Review of Resident #11's medical records revealed an admitted [DATE]. Diagnoses included paraplegia and bladder dysfunction. Resident #11's record indicated he had a chronic, indwelling suprapubic (surgically created opening in the abdomen in which a urinary catheter is inserted into to allow for continuous bladder drainage) catheter present upon admission.</p> <p>Review of Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #11 had intact cognition. Resident #11 was dependent with toileting, and required maximum assistance with bathing and personal hygiene. Resident #11 had a urinary catheter for elimination.</p> <p>Review of Resident #11's physician orders for December 2024 and January 2025 revealed to flush urinary catheter with 60 milliliters (mL) of normal saline for possible blockage every twenty-four hours as needed.</p> <p>Review of Treatment Administration Record (TAR) for December 2024 and January 2025 revealed no documented urinary catheter flushes.</p> <p>Interview on 01/13/25 at 9:10 A.M. with Resident #11 revealed he had expressed concerns related to urinary catheter to the nursing staff. Resident #11 was asked if he had reported his concerns to the Director of Nursing (DON) and Resident #11 replied who's that?</p> <p>Telephone interview on 01/13/25 at 10:33 A.M. with Resident #11's Power of Attorney (POA) revealed she had attempted to contact the DON of multiple occasions to discuss his care. POA stated on 11/23/24 Resident #11 had called her to inform her that his catheter had been leaking and stated the nurse had not done anything about it. POA stated she had informed the nurse (name unknown) to have the DON call her the next day to discuss the concerns, however the DON nor any other facility staff had returned her call to discuss her concerns.</p> <p>Interview on 01/14/25 at 2:17 P.M. with Administrator and DON revealed they had spoken with Resident #11 and his family regarding their concerns related to his catheter. DON stated the SR had requested his catheter to be flushed more times that what had been ordered, and stated she had explained the physician's orders to Resident #11. Administrator stated he had spoken with the Resident #11's POA about Resident #11's catheter leaking and he and the DON would investigate the resident and family's concern.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Review of Resident #67's medical records revealed an admitted [DATE]. Diagnoses included right below the knee amputation and vision loss.</p> <p>Review of MDS dated [DATE] revealed Resident #67 had intact cognition. Resident #67 required maximum assistance with toileting, bathing and personal hygiene.</p> <p>Interview on 01/13/25 at 2:22 P.M. with Licensed Practical Nurse (LPN) #239 revealed she had been made aware Resident #67 had concerns related to being left in the bathroom for a long period of time on 01/12/25. LPN #239 stated she had sent a text message to the DON to inform of the situation and stated the DON told her she would address it on 01/13/25. LPN #239 stated she was not aware if the situation had been addressed.</p> <p>Interview on 01/14/25 at 8:28 A.M. with Resident #67 revealed on 01/12/25 she had been left in the bathroom for a long period of time. Resident #67 stated she had informed the nurse, who told her she would make a report about the incident, however Resident #67 was not aware if the situation had been handled and stated no one had spoken to her about it.</p> <p>Interview on 01/14/25 at 2:17 P.M. with the DON revealed the DON denied being aware of a concern with Resident #67 and stated she would investigate the situation with Resident #67's care.</p> <p>Review of the policy Resident and Family Concerns and Grievances Policy and Procedure dated 2024 revealed the purpose of the policy is to provide for the prompt resolution of medical and non-medical grievances. Residents or their family members, guardian, or representative may voice a grievance to the Facility staff in person, by telephone, or via written communication. The facility will keep a log of all grievances expressed either orally and/or in writing. The facility will follow up with resident or their family members, guardian, or representative within 72 hours of the filing of the grievance. The facility will provide the resident with a written Grievance Decision which shall include the date the grievance was received, a summary statement of the resident's grievance, steps taken to investigate the grievance, a summary of the pertinent findings or conclusions, a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken, and the date the written decision was issued.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00161010.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42733</p> <p>Based on record review, interview, review of facility policy, and review of the Ohio Department of Health (ODH) Certification and Licensure System (CALs), the facility failed to timely report an allegation of staff to resident verbal abuse to the State Agency as required. This affected one resident (Resident #72) of three residents reviewed for abuse. The facility census was 71.</p> <p>Findings include:</p> <p>Review of Resident #72's medical records revealed an admitted [DATE]. Diagnoses included Alzheimer's and failure to thrive.</p> <p>Review of MDS dated [DATE] revealed Resident #72 had impaired cognition. Resident #72 required maximum assistance with toileting, bathing, and personal hygiene tasks.</p> <p>Review of the ODH CALs website revealed an incident of alleged emotional/verbal abuse involving CNA #318's interactions with Resident #72 was reported to the State Agency on 01/13/25 at 12:08 P.M.</p> <p>Interview on 01/13/25 at 1:02 P.M. with Receptionist #278 revealed on 01/11/25 she had observed CNA #318 yelling at Resident #72. Receptionist #278 stated Resident #72 was near the nurse's station and was attempting to get CNA #318's attention by waving her hands. Receptionist #278 stated she had then heard CNA #318 yell leave me alone (residents name). Receptionist #278 stated she was unsure what to do and stated the following day on 01/12/25 she had written a statement about what occurred and had given it to Admissions Director (AD) #203. Receptionist #278 stated she had been asked about the situation on 01/13/25 by the Administrator and Director of Nursing (DON). Receptionist #278 stated that was not the first negative incident she had observed and reported between Resident #72 and CNA #318. Receptionist #278 stated she had not received any recent abuse training and was unsure what to do or who to report to when she first witnessed the incident between CNA #318 and Resident #72.</p> <p>Interview on 01/14/25 at 2:17 P.M. with Administrator and DON revealed they had been made aware of the incident that had occurred on 01/11/25 on the morning of 01/13/25. Administrator stated Receptionist #268 had provided a written statement to AD #203 on 01/12/25 and the statement given to him on 01/13/25. Administrator stated they had began a self-reported incident (SRI) on 01/13/25, however the allegation of staff to resident verbal abuse should have been reported on 01/11/25.</p> <p>Review of facility policy titled Abuse revised 04/20/23 revealed once a supervisor received the information they must notify the Administrator/Director of Nursing immediately and gather requested information. An investigation must be directed by the Administrator or designee immediately, and not later than, twenty four hours after the knowledge.</p> <p>This deficiency represents an incidental finding of non-compliance identified while investigating Master Complaint Number OH00161010 and Complaint Number OH00160958.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42733</p> <p>Based on observation, interview, record review, and review of the facility policy, the facility failed to ensure appropriate urinary catheter care had been performed. This affected one Resident (#11) of three observed for catheter care. The facility identified five residents with indwelling urinary catheters. The facility census was 71.</p> <p>Findings include:</p> <p>Review of Resident #11's medical records revealed an admitted [DATE]. Diagnoses included paraplegia and bladder dysfunction. Resident #11's record indicated he had a chronic, indwelling suprapubic (surgically created opening in the abdomen in which a urinary catheter is inserted into to allow for continuous bladder drainage) catheter present upon admission.</p> <p>Review of Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #11 had intact cognition. Resident #11 was dependent on staff for toileting, and required maximum assistance with bathing and personal hygiene tasks. Resident #11 had a urinary catheter for elimination.</p> <p>Review of Resident #11's physician orders for December 2024 and January 2025 revealed to flush urinary catheter with 60 milliliters (mL) of normal saline for possible blockage every 24 hours as needed, anchor catheter tubing, and check catheter placement every shift.</p> <p>Review of Treatment Administration Record (TAR) for December 2024 and January 2025 revealed no documented urinary catheter flushes. TAR for December 2024 and January 2025 included daily documentation of foley (urinary catheter) anchor being in place.</p> <p>Observation on 01/13/25 at 9:10 A.M. revealed Resident #11's call light was activated and Certified Nursing Assistant (CNA) #310 answered the call light and stated Resident #11 needed cleaned up. Interview with Resident #11 at time of observation revealed his urinary catheter had been leaking and his bed was wet with urine. Resident #11 stated he had asked the evening shift nurse the night before to flush his catheter as it often became clogged and leaked. Resident #11 stated the nurse had not flushed it, nor had the nurse performed any care of his catheter site. Resident #11 stated the only thing the nurse had done for his catheter was to empty the urinary drainage bag. Observation with CNA #310 and #317 revealed Resident #11's catheter insertion was not covered. A soiled dressing was hanging from the catheter tubing. Thick, white mucus-like drainage was observed around the resident's uncovered urinary insertion site which had a slight foul odor. Resident #11's catheter tubing was observed to have large amounts of thick sediment throughout the tubing and into the collection bag. Resident #11 stated he routinely asked for his catheter to be flushed due to the sediment contained in the urinary catheter tubing.</p> <p>Interview on 01/13/25 at 9:42 A.M. with Licensed Practical Nurse (LPN) #237 revealed Resident #11 had a physician order to flush the catheter with 60 milliliters mL of normal saline as needed for blockages. LPN #237 stated she had not flushed Resident #11's catheter during her shift. LPN #237 stated she would change Resident #11's catheter and needed to obtain supplies.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 01/13/25 at 10:11 A.M. revealed LPN #237 returned to Resident #11's room and stated she had informed the Nurse Practitioner (NP) of Resident #11's catheter and urine appearance and the NP had ordered for urinary labs to be collected. Observation of catheter care and changing with LPN #237 at time of interview confirmed the thick mucus around the insertion site as well and the large amounts of sediment in the tubing and collection bag. Further observation revealed a piece of tape around the tubing that was not anchored or secured to Resident #11's leg. LPN #237 confirmed there should have been an anchor placed on Resident #11's leg to prevent the tubing from moving or pulling. LPN #237 had changed Resident #11's urinary catheter and placed an anchor on his leg to secure the tubing.</p> <p>Review of the facility policy titled Urinary Catheter Care revised 09/14 revealed catheter irrigation may be ordered to prevent obstructions in residents at risk for obstructions. Ensure the catheter remains secured to reduce friction and movement at the insertion site.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00161010.</p>		