STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365705	A. Building B. Wing	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aventura at Walton Hills	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and review of the facility policy, the facility failed to notify the guardian of Resident #77's elopement. This affected one resident (#77) of three residents reviewed for elopement. The facility census was 79.Findings include:Review of Resident #77's medical record revealed an admission date of 02/07/24 and diagnoses including anxiety, chronic kidney disease, type two diabetes, cognitive communication deficit, Parkinson's disease without dyskinesia and dementia without behavioral disturbance. Resident #77's daughter was listed as his legal guardian.Review of a discharge, return-anticipated Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #77's memory was intact, he did not wander and required partial to moderate assistance for ambulation using a wheelchair.Review of a progress note dated 02/15/26 at 3:00 P.M. and authored by Registered Nurse (RN) #316 revealed the following information: Resident #77 pushed on exit door, activating door alarm. Staff member (not specified) immediately responded to alarm and found Resident #77 on his right side with wheelchair beside him. Fall was unwitnessed. Nurse completed head to toe assessment. Range of motion equal bilaterally. Neurological assessment initiated per protocol. Vital signs obtained. Resident alert and responsive. Resident denies pain or discomfort at this time. Staff members times four (not specified) assisted Resident #77 back into wheelchair. Resident #77 brought back to nursing station for closer monitoring. The progress note did not indicate Resident #77's guardian had been notified regarding his elopement.Review of a facility investigation regarding Resident #77's elopement on 02/15/26 revealed Resident #77 had exited out an emergency exit door off the 200 hall which was under construction and not occupied and had been outside less than five minutes. Resident #77 had been last seen at the nurses' station five minutes prior. The facility's alarm and egress doors had worked properly, and staff had responded immediately to the alarm and to Resident #77 who had been found lying on his right side on the ground with his wheelchair beside him.Review of a care plan initiated 02/16/26 revealed Resident #77 had the potential for elopement and associated injury related to exit-seeking behavior. All listed interventions were initiated on 02/16/26.Telephone interview on 03/04/26 at 12:50 P.M. with Resident #77's legal guardian revealed she had only been notified of Resident #77's fall on 02/15/26 and had not been aware he had gotten outside and eloped that date until the phone call with the surveyor. Resident #77's guardian denied Resident #77 having a history of exit seeking and indicated while he was able to answer yes and no questions, he was not really interviewable.Telephone interview was attempted with RN #316 on 03/04/26 at 1:01 P.M. but was not successful.During an interview on 03/04/26 at 1:45 P.M. the Administrator and the Director of Nursing (DON) were made aware Resident #77's medical record lacked evidence Resident #77's legal guardian was notified of his elopement on 02/15/26. The DON stated the incident report (part of risk documentation and not part of the medical record) contained evidence the family had been notified of the incident (not specified) and transfer to the hospital but acknowledged this did not ascertain to which incident the family was notified regarding, Resident #77's elopement or his fall this date.Review of the facility policy, Change in a Resident's Condition or Status, dated 2001, revealed unless otherwise instructed by the resident, a (continued on next page)

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

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 03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nurse will notify the resident's representative when the resident was involved in any accident or incident that results in an injury or there was a significant change in the resident's physical, mental or psychosocial status.This deficiency represents noncompliance investigated under Complaint Number 2791655.

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	365705	A. Building B. Wing	03/04/2026

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and review of the facility policy, the facility failed to timely develop care plans relative to elopement risk. This affected one resident (#77) of three residents reviewed for elopement. The facility census was 79. Findings include:Review of Resident #77's medical record revealed an admission date of 02/07/24 and diagnoses including anxiety, chronic kidney disease, type two diabetes, cognitive communication deficit, Parkinson's disease without dyskinesia and dementia without behavioral disturbance. Resident #77's daughter was listed as his legal guardian.Review of a wander-risk evaluation dated 10/29/25 revealed Resident #77 was a low risk for wandering.Review of an annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #77 was cognitively intact, did not wander and required partial to moderate assistance with ambulation using a wheelchair.Review of a wander-risk evaluation dated 01/29/26 and completed by Licensed Practical Nurse (LPN) #225 revealed Resident #77 was a moderate risk for wandering. The section under care plan probing what interventions are going to be care planned was left blank.Review of a discharge, return-anticipated MDS 3.0 assessment dated [DATE] revealed Resident #77 had okay memory, did not wander and required partial to moderate assistance for ambulation using a wheelchair.Review of a wander-risk evaluation dated 02/15/26 and completed by MDS/Registered Nurse (RN) #212 revealed Resident #77 was a high risk for wandering. The section under care plan probing what interventions are going to be care planned was left blank.Review of a progress note dated 02/15/26 at 3:00 P.M. and authored by RN #316 revealed the following information: Resident #77 pushed on exit door, activating door alarm. Staff member (not specified) immediately responded to alarm and found Resident #77 on his right side with wheelchair beside him. Fall was unwitnessed. Nurse completed head to toe assessment. Range of motion equal bilaterally. Neurological assessment initiated per protocol. Vital signs obtained. Resident alert and responsive. Resident denies pain or discomfort at this time. Staff members times four (not specified) assisted Resident #77 back into wheelchair. Resident #77 brought back to nursing station for closer monitoring.Review of a facility investigation regarding Resident #77's elopement on 02/15/26 revealed Resident #77 had exited out an emergency exit door off the 200 hall which was under construction and not occupied and had been outside less than five minutes. Resident #77 had been last seen five minutes prior at the nurses' station. The facility's alarm and egress doors had worked properly when pressed upon and staff responded immediately to the alarm and to Resident #77.Review of a care plan initiated 02/16/26 revealed Resident #77 had the potential for elopement and associated injury related to exit-seeking behavior. All listed interventions were initiated on 02/16/26.Interview on 03/04/26 at 11:44 A.M. with LPN #225 revealed nurses were responsible for completing wander-risk assessments and MDS/RN #212 did the care plans. When asked about the care plan interventions section of the wander-risk assessment, LPN #225 stated she'd never filled out that section and could not speak further to that part of the assessment.Interview on 03/04/26 at 1:07 P.M. with MDS/RN #212 revealed she care-planned elopement risk based on Interdisciplinary Team (IDT) discussions in addition to the risk identified on the resident's wander-risk assessment. MDS/RN #212 stated some residents could have a higher score on this assessment yet not be at risk for elopement. When asked about Resident #77 going from low to moderate risk per the wander-risk assessment dated [DATE], MDS/RN #212 stated we [the IDT] believed at the time Resident #77 was not an elopement risk but had more wandering behavior and she did not put a care plan in just for a resident wandering.Interview on 03/04/26 at 1:45 P.M. with the Administrator and the Director of Nursing (DON) revealed when Resident #77 started to self-propel around the facility in his wheelchair that is when he went from low to moderate wander-risk. The Administrator verified a care plan should have been put into place for Resident #77 when he started wandering in this manner and verified this was not done until after his elopement on (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Aventura at Walton Hills		STREET ADDRESS, CITY, STATE, ZIP CODE 19859 Alexander Rd Walton Hills, OH 44146	

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	02/15/26.Review of the facility policy, Care Plans, Comprehensive-Person Centered, dated 2001 revealed assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.This deficiency represents noncompliance investigated under Complaint Number 2791655.