

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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 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>		