STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365783	A. Building B. Wing	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aventura at Assumption Village	9800 Market Street North Lima, OH 44452

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 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** 47570 Based on record review, observation and interview the facility failed to develop and implement a comprehensive, person-centered care plan to meet the needs of Resident #65 for his highest practicable well-being regarding leave of absence (LOA) from the facility. This affected one resident (#65) of three residents reviewed for care plans. The facility census was 104. Findings include: Record review for Resident #65 revealed an admitted [DATE] with diagnoses including multiple sclerosis, paraplegia, type two diabetes, severe protein calorie malnutrition, pressure ulcer sacral region stage four, neuromuscular dysfunction on bladder, anemia, hypertension, acute kidney failure, major depressive disorder, absence of left toes, absence of right toes, absence of fingers, colostomy, chronic ulcer of foot. Record review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #65 was cognitively intact, used a wheelchair for mobility, did not attempt to walk and was dependent on staff for transfers from bed to chair. Resident #65 had an indwelling urinary catheter, received pressure ulcer care by application of nonsurgical dressings, ointments and dressings to feet. Review of a physician order dated [DATE] revealed Resident #65 may go on a LOA with medications. Review of a nurse progress note dated [DATE] at 5:32 P.M. written by LPN # 463 revealed the facility protocol was not followed when Resident #65 did not sign out on LOA. He ended up getting stuck at the bus station due to his wheelchair not working where he was picked up by the local EMS (emergency medical services) and taken to the local hospital for examination before returning to the facility. Review of the EMS run report dated [DATE] revealed Resident #65 was found sitting in his motorized wheelchair at the bus station and he complained of foot pain and said he had missed the bus to go back to the facility because his wheelchair died . EMS took him to the hospital for an evaluation due to the foot pain. His assessment was normal besides the foot pain. Review of the hospital documents dated [DATE] revealed Resident #65 presented to the hospital complaining of right ankle pain. He was diagnosed and treated for right lower extremity cellulitis associated with diabetes, and discharged back to the facility in stable condition on [DATE]. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a nurse progress note dated [DATE] at 3:50 P.M. written by Registered Nurse #329 revealed resident #65 returned to the facility from the hospital in stable condition. Further review of the medical record revealed a nurse progress note dated [DATE] at 4:07 A.M. that Resident #65 was not in the facility. On [DATE] at 9:46 A.M. a note revealed Resident #65 returned to the facility via Physician's ambulance. There was nothing in the record to explain when Resident #65 had left the facility prior to his return. Review of the Youngstown Police Department Master Call Table document dated [DATE] revealed the police found Resident #65 sitting at the bus station in his wheelchair and he had been there for several hours. Review of the Medication Administration Record (MAR) for [DATE] revealed on [DATE] and [DATE] Resident #65 was on an LOA for the evening medication pass between 7:00 P.M. and 10:00 P.M. Review of the facility LOA book revealed Resident #65 had not signed out on [DATE] or [DATE]. Review of Resident #65's plan of care dated [DATE] revealed the resident had an activity of daily living (ADL) self-care deficit related to paraplegia, pressure ulcers, finger and toe amputations, colostomy and foley (indwelling urinary catheter) use and required maximum assistance with self -care and mobility due to paraplegia and weakness requiring a mechanical lift for transfers. The resident had a motorized wheelchair. Interventions included assist with mobility, transfers and care as needed, provided necessary items with set up for self care, and use mechanical lift for transfers. In addition, the care plan identified Resident #65 had diabetes mellitus with insulin use placing him at risk for low and high blood glucose levels. Interventions included avoiding exposure to heat and cold and give diabetes medications as ordered by the doctor. There was nothing in the care plan to indicate Resident #65 preferred to go on LOA from the facility nor did it identify any of his needs when on a LOA including but not limited to taking his medications with him when on LOA per physician order. There was no mention of the incidents on [DATE] and [DATE] regarding the problem of his wheelchair battery losing charge and preventing him from returning to the facility and not having a way to communicate with the facility such as with his cell phone. Interview and observation was conducted on [DATE] at 8:56 A.M. with Resident #65 and revealed he was alert and able to answer questions. Resident #65 said he liked to leave the facility on the public bus to go eat at the mall and used his power wheelchair to get around. Resident #65 said he did not tell any staff nor sign out in the LOA book when he would leave. Resident #65 showed the surveyor receipts from the dates [DATE] and [DATE] when he was at the mall and had bought himself food. Resident #65 verified he used the public bus stop on the Market Street entrance to the facility to go on LOAs in his power wheelchair because the bus was able to transport him in the wheelchair. Resident #65 offered no complaints regarding his LOAs besides the battery in his power wheelchair had died and left him stranded. Interview on [DATE] at 11:00 A.M. with LPN # 463 who was Resident #65's nurse the night of [DATE] stated they were not sure how long Resident #65 was out of the facility because he did not sign out in the LOA book or notify the nurse he needed medication for LOA. LPN #463 verified Resident #65's MAR indicated he was on LOA for the evening medication pass on [DATE] and [DATE]. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 11:45 A.M. with unit manager Registered Nurse (RN) #358 and unit manager Licensed Practical Nurse (LPN) #331 revealed they were aware Resident #65 liked to leave the facility on the public bus to go buy lunch in the community. Both verified Resident #65 did not sign out when he left on [DATE] and [DATE] and the plan of care did not address his LOA preference and had not been updated when Resident #65 returned to the facility on [DATE] and [DATE] to identify his preference and needs for LOA. Interview on [DATE] at 4:21 P.M. with LPN # 417 who worked on [DATE] revealed LPN #417 called the Director of Nursing (DON) when she was concerned Resident #65 was not back from an LOA . The DON gave the direction to call the Administrator. LPN #417 stated when the Administrator was notified, she stated there was nothing the facility could do because he was on a LOA. After the emergency contact was notified the emergency contact called the police to find Resident #65. Interview on [DATE] at 4:22 P.M. with the Administrator revealed she knew Resident #65 very well from another facility he had been at where she had worked and she knew he had a tendency to be impulsive and was a poor planner even though he was alert and oriented. The Administrator revealed Resident #65 liked to go on LOA on Saturdays and he had a cell phone but would either forget to charge it or forget to take the charger with him so he could communicate with the facility while on LOA. The Administrator verified Resident #65 got stranded at the bus station twice in July and could not get back to the facility because his wheelchair battery had died so he could not get back onto the bus. The Administrator said after the [DATE] incident she had educated residents including Resident #65 at the resident council meeting on the LOA policy and that they had to sign out and a let a staff person know when they left the facility. The Administrator verified the care plan did not address Resident #65's preference to go LOA, his need to have his power wheelchair fully charged, have his cell phone and cell phone charger with him on LOA and be reminded to sign out in the LOA book since the facility knew his preference of going LOA on Saturdays. The Administrator verified the staff knew he liked to go LOA on Saturdays, and both of the incidents of him getting stranded at the bus station occurred on Saturday. The Administrator said Resident #65 was not good at planning things out, so the staff needed to be more proactive to ensure he had what he needed to go on LOA safely. The Administrator said she would ensure the care plan was updated and would speak to Resident #65 about putting a wanderguard bracelet (a device that emits a noise when near facility exit doors) on his wheelchair so it would alert staff when he was leaving the facility, as he might not remember to tell the staff he was leaving. Interview on [DATE] at 5:32 P.M. with Resident #65's emergency contact revealed the facility notified her on [DATE] at 11:00 P.M. that Resident #65 had not returned to the facility so the emergency contact decided to call the police to report him missing. Review of facility policy titled Resident LOA, dated [DATE], revealed all residents leaving the premises must be signed out. Medications must be administered while the resident was out would be given to the resident/person who signed the resident out. Written and oral instructions on how to administer medication will be given. Any restrictions to leave of absence would be noted in physician order. There was nothing in the policy to include adding LOA preferences to the care plan. The facility did not provide any policy regarding plan of care.