STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366186	A. Building B. Wing	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aventura at Humility House	755 Ohltown Road Austintown, OH 44515

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48567 Based on observation, interview, medical record review, and review of facility policy, the facility failed to ensure wound care was completed per physician orders for one resident (Resident #10) of three residents who were reviewed for appropriate wound care services. The facility census was 68. Findings include: Review of the medical record for Resident #10 revealed an admitted [DATE] with diagnoses including acute and chronic respiratory failure, cardiomegaly, sleep related hypoventilation, systolic and diastolic congestive heart failure, hypertension, atrial fibrillation, stage three chronic kidney disease, glaucoma, pleural plaque with asbestos, venous insufficiency, and lymphedema. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment revealed Resident #10 had intact cognition, had an impairment on one side of his upper extremities, and was dependent on a wheelchair for locomotion. Further review of the MDS revealed Resident #10 was dependent on staff for toileting, bathing, dressing his lower extremities, and personal hygiene. Review of the care plan initiated 03/18/24 revealed Resident #10 was at risk for impaired skin integrity related to respiratory failure and poor mobility. Interventions included application of appropriate wound dressings per wound doctor orders, assessments of wounds with each dressing change, elevation of legs to promote circulation and decrease fluid build-up, and appropriate wound management based on the stages of healing. Review of the physician orders revealed an order dated 08/12/24 for wound care to include a Dakin's solution cleanse to Resident #10's bilateral lower legs, ankles, and feet, then staff were to apply Neosporin ointment, cover with abdominal pads (ABDs), wrap with gauze from the toes to the knees, and then wrap with Coban (self-adhering elastic wrap) each day shift and each night shift and as needed. Review of the wound care physician's progress notes from the wound visit dated 08/07/24 revealed Resident #10 was being treated for bilateral leg lymphedema with open venous lymphatic wounds. The progress note further revealed if Coban was used, it should not be wrapped tight and Tubigrip stockings (tubular bandages) were not to be used. (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

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 08/13/24 from 3:50 P.M. to 4:30 P.M. of wound care revealed Resident #10 sat in his wheelchair with both feet placed on the floor, covered with a plastic barrier. Licensed Practical Nurse (LPN) #350 removed the old dressing from Resident #10's bilateral lower legs, starting with the Tubigrip stockings, exposing the gauze that was wrapped from his ankles up to below his knees. The removed gauze wrap from Resident #10's right leg had a moderate amount of serosanguinous drainage, and the ABD pads had scant serosanguinous drainage. The ABD pads removed from Resident #10's left leg had scant serous and serosanguinous drainage, and the ABD pad removed from the left lateral aspect of the middle of Resident #10's lower leg was noted to hold a small to moderate amount of yellowish-brown purulent drainage. Once the old dressings were removed, LPN #350 indicated she had difficulty visualizing all the open areas due to Resident #10's leg position while sitting in his wheelchair and his limited ability to lift his legs. After cleansing the open areas with Dakin's solution-soaked gauze, LPN #35 proceeded to apply Neosporin to the visible open areas, apply ABD pad, and then wrap the right leg with gauze from just above the ankle to mid-calf, and the left leg from the ankle to the top of the calf. Further observation revealed LPN #350 wrapped both lower legs from the ankle to the top of the calves, and then reapplied his Tubigrip stockings on each leg. During the observation, no wound care or dressing was noted involving Resident #10's ankles or feet, with the exception that a dry gauze pad was used to dab moisture off the top of Resident #10's reddened, edematous feet prior to putting on his socks. Interview on 08/13/24 at 4:40 P.M. with LPN #350 confirmed she wrapped Resident #10's right leg with gauze from his ankle to mid-calf and the left leg from just above his ankle to the top of his calf. During the interview, LPN #350 further confirmed both legs were then wrapped with Coban from above the ankle to the top of each calf and Tubigrip stockings were applied to both lower legs. Interview on 08/14/24 at 9:55 A.M. with wound care Physician #324 confirmed Resident #10 had chronic lymphedema and circulatory issues due to heart failure, was at risk for infection, and had a history of blisters and open sores. Physician #324 further confirmed Resident #10 should not have any compression, including application of Tubigrip stockings, until his wounds were closed and there was no evidence of infection. During the interview, Physician #324 also confirmed Resident #10 should have his dressings wrapped from his feet up to his knees due to chronic lymphedema. Interview on 08/14/24 at 3:43 P.M. with Registered Nurse (RN) Unit Manager #328 confirmed Resident #10 was to have his bilateral legs wound dressings wrapped from his feet up to his knees and Tubigrip stockings were not to be applied. Review of the policy titled Wound Care dated September 2022 revealed the physician's order was to be verified for the wound care procedure and the care plan was to be reviewed for any additional needs related to the resident's wound care. This deficiency represents non-compliance investigated under Complaint Number OH00156607 and OH00155890.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48567 Based on observation, interview, medical record review and review of facility policy, the facility failed to ensure a medication error rate of less than five percent. A total of 35 medication administration opportunities revealed four medication errors, resulting in an 11.4 percent (%) error rate. This affected one resident (Resident #10) of four residents (#10, #14, #3, and #58) reviewed for medication administration. The facility census was 68. Findings included: Review of the medical record for Resident #10 revealed an admitted [DATE] with diagnoses including acute and chronic respiratory failure, cardiomegaly, sleep related hypoventilation, systolic and diastolic congestive heart failure, hypertension, atrial fibrillation, stage three chronic kidney disease, glaucoma, pleural plaque with asbestos, venous insufficiency, and lymphedema. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment revealed Resident #10 had intact cognition and was dependent on staff for toileting, bathing, and personal hygiene. Further review of the MDS revealed Resident #10 had a history of heart failure and received oxygen therapy. Review of the care plan initiated 03/18/24 revealed Resident #10 had an altered respiratory status and received oxygen therapy, was at risk for nutritional problems secondary to diuretic use, and had visual problems related to glaucoma. Interventions for these listed risks included administering breathing treatments as ordered, medications as prescribed, and eye medications per physician orders. Observation on 08/12/24 from 11:55 A.M. to 12:03 P.M. revealed Licensed Practical Nurse (LPN) #302 prepared 12 prescribed routine medications and one as needed medication for Resident #10's report of pain. During the observation, LPN #302 confirmed she would be administering some of the morning medication that were typically scheduled to be given between 7:00 A.M. to 10:00 A.M. with the afternoon medication pass. Observation of medication administration on 08/12/24 at 12:05 P.M. revealed Resident #10 refused his prescribed fluticasone nasal spray but took the oral medications that were placed in the medicine cup by LPN #302, including Mucinex 400 milligram (mg), 1.5 tablets (600 mg total). During medication administration observation, LPN #302 failed to administer Potassium 20 milliequivalents (mEq) oral tablet, Breztri inhalation aerosol 160-9-4.8 micrograms (mcg) per actuation, and Brimonidine 0.15% ophthalmic solution. Review of the physician orders revealed the following orders: 1. An order dated 03/06/24 for Mucinex extended release (ER) 12-hour 600 mg tablets, give two tablets by mouth two times daily for nasal congestion. 2. An order dated 08/06/24 for Potassium oral tablet, give 20 mEq once daily for seven days to start on 08/07/24. 3. An order dated 03/25/24 for Breztri Aerosphere inhalation aerosol 160-9-4.8 mcg/actuation, inhale two puffs orally two times a day related to acute and chronic respiratory failure. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. An order dated 05/02/24 for Brimonidine Tartrate ophthalmic solution 0.15, instill one drop in both eyes three times a day for glaucoma. Interview on 08/12/24 at 3:45 P.M. with Resident #10 confirmed he did not receive any inhalation or respiratory treatments at all this date so far and he did not get all his eye drops, but could not determine which he did not get, stating I rely on the nurses to know what I am supposed to get. During the interview, Resident #10 revealed he had glaucoma and had several different types of eye drops prescribed, but he did not always get them, adding his eye drops sometimes got lost or left on the bedside table and accidentally thrown in the trash and he had to wait until the facility ordered replacement drops. Interview on 08/12/24 at 4:30 P.M. with LPN #302 confirmed Resident #10 did not get all three prescribed eye drops, potassium, or his Breztri inhaler. LPN #302 further confirmed the Mucinex administered to Resident #10 was not two tablets of the 600 mg extended-release formulation, but 1.5 tablets of the 400 mg Mucinex taken from a facility stocked medication bottle. During the interview, LPN #302 also confirmed the medication administration record (MAR) contained checkmarks for all Resident #10's morning and afternoon medications, even the medications she did not administer, including potassium, Breztri, and the Brimonidine eye drops. Review of the policy titled Medication Administration and General Guidelines from the Pharmacare USA policy & Procedure 2022 edition revealed medications were to be administered as prescribed and in accordance with the orders of the attending physician and within one hour of the scheduled time. This deficiency represents non-compliance investigated under Complaint Number OH00156293 and Complaint OH00155890.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48567 Based on observation, interview, and review of facility policy, the facility failed to ensure appropriate infection control procedures were followed during medication administration. This affected three residents (Residents #10, #14, and #35) of four residents observed for medication administration and had the potential to affect all 17 residents residing in the Northeast Hall. Also, the facility failed to implement an infection control program that included the use of enhanced barrier precautions. This had the potential to affect all residents. The facility census was 68. Findings include: 1. Observation on 08/12/24 from 11:55 A.M. to 12:40 P.M. of medication administration on the northeast hall by Licensed Practical Nurse (LPN) #302 revealed the following: a. LPN #302 was observed preparing medications for Resident #10 on 08/12/24 at 11:55 A.M. after exiting another resident's room without first performing hand hygiene. During this observation, LPN #302 removed two 400 milligram (mg) tablets of Mucinex from a facility-stocked medication bottle, one tablet of which dropped onto the surface of the medication cart. LPN #302 proceeded to pick up the tablet, break it in half with her bare hands, then place 1/2 tablet into Resident #10's medicine cup and the other half back into the original bottle. Further observation revealed Resident #10 was administered medication at 12:05 P.M. During medication administration, LPN #302 handled several items on Resident #10's bedside table, gave him his oral medications, donned a pair of gloves to administer eye drops, removed the gloves, then exited Resident #10's room. No hand hygiene was performed before or after entering or exiting Resident #10's room nor after removal of the gloves. b. LPN #302 was observed preparing medications for Resident #35 on 08/12/24 beginning approximately 12:15 P.M. During the observation, LPN #302 was observed popping clonazepam 0.5 mg, 1/2 tablet directly from the unit dose packet into her hand and using the other hand to place it into a medicine cup and then popping a Zofran 4 mg tablet into her left hand and then using her right hand to place the Zofran into the medicine cup. No gloves were worn and no hand hygiene was performed before or after medication preparation. At 12:20 P.M., Resident #3 was given his medication and then LPN #302 checked his blood pressure in his left wrist. During the observation, no hand hygiene was performed after direct contact with Resident #35. c. LPN #302 was observed preparing medications for Resident #14 on 08/12/24 beginning approximately 12:25 P.M. During the observation, LPN #302 was observed popping one Sinemet 25-100 mg tablet directly from the unit dose packet into her hand and using the other hand to place it into a medicine cup. Afterward, LPN #302 removed a facility-stocked bottle of docusate sodium 100 mg from the medication cart, pouring a tablet into her hand, breaking the tablet in half, then placing 1/2 tablet into the medicine cup and the other half back into the bottle. Further observation revealed LPN #302 popped a tramadol 50 mg tablet from the unit dose packet stored in the locked controlled substance drawer then placing it into the medicine cup. No gloves were used when handling the medication and no hand hygiene was performed at any time between touching the pills with her bare hands. Resident #14 had a blood pressure cuff placed on her left arm at 12:38 P.M., then LPN #302 donned gloves, administered eye drops, removed gloves, and removed the blood pressure cuff and exited the room. No hand hygiene was performed after exiting Resident #14's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 08/12/24 at 12:40 P.M. with LPN #302 confirmed she did not wash her hands or use hand sanitizer between each resident and did not know what the policy was for hand hygiene during medication administration if she was just passing pills, but confirmed she was aware hand hygiene was required after direct contact with residents and after glove removal. LPN #302 confirmed at this time she had direct contact with Resident #14 and Resident #35. Further interview confirmed LPN #302 handled medications with her bare hands, including breaking some of the tablets from community-stocked medication bottles and placing the other half of those pills into the Mucinex and the Docusate sodium bottles. LPN #302 confirmed other residents used medications out of those bottles. During the interview, LPN #302 was unable to locate hand sanitizer on the medication cart and demonstrated she did not know where to find the hand sanitizer dispensers in resident rooms. Interview on 08/12/24 at 5:15 P.M. with the Director of Nursing (DON) confirmed hand hygiene should be performed between residents, after direct contact with residents, and after glove removal during medication administration. The DON also confirmed the list of other residents who were prescribed Mucinex and docusate sodium and that the medication should not have been placed back into the medication bottles so they were removed from the medication cart on this date. Review of the policy titled Medication Administration and General Guidelines from the Pharmacare USA policy & Procedure 2022 edition revealed staff administering medications were to adhere to universal precautions, using proper hand hygiene and gloves when appropriate, before beginning a medication pass, prior to handling any medication, and after coming into direct contact with a resident. The policy further specified staff should not handle pills with their bare hands and if breaking tablets was necessary, staff were to sanitize their hands, don gloves, use a tablet splitter to avoid contact with the medication, and dispose of unused portions of the medication per facility policy. 2. Observations made during the initial tour of the facility southeast, northwest, and northeast units on 08/12/24 between 10:10 A.M. and 10:25 A.M. revealed Rooms 15, 18, 25, 30, and 33 had white carts with three drawers containing personal protective equipment (PPE), but no signage indicating any type of transmission-based precautions, enhanced barrier precautions, or directions on what PPE was necessary, if any, to enter the nearby resident room. An additional white cart was observed sitting between room [ROOM NUMBER] and the emergency exit and a blanket was wadded up atop the cart and hung over the top of the top drawer. Initial observation of the secured (southwest) unit on 08/12/24 revealed no rooms had PPE carts, signage or any other indication residents residing on that unit required enhanced barrier precautions. Random intermittent observations throughout the facility during the survey from 08/12/24 through 08/14/24 revealed no staff donning PPE when entering any resident rooms near the white PPE carts. Observation of wound care on 08/13/24 from 3:50 P.M. to 4:30 P.M. for Resident #10's chronic bilateral lower leg lymphedema and venous lymphatic wounds revealed no gown was donned to render wound care. Interview on 08/14/24 at 11:10 A.M. with Registered Nurse (RN) #328 confirmed he had previously been the facility's infection preventionist and he did not believe there was an official policy, program, or list of residents on enhanced barrier precautions (EBP). During a follow-up interview on 08/14/24 at 11:20 A.M., RN #328 confirmed he verified with the Administrator and Director of Nursing (DON) that the facility had not fully implemented an EBP program yet and it was the facility's understanding that enhance barrier precautions came down as a recommendation and it was not a requirement. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations on 08/14/24 from 11:25 A.M. to 11:40 A.M. revealed Rooms 15, 18, 25, 30, and 33 had white carts with three drawers containing personal protective equipment (PPE), but no signage indicating any type of transmission-based precautions, enhanced barrier precautions, or directions on what PPE was necessary, if any, to enter the nearby resident room. Further observation revealed one white PPE cart at the end of the northeast hall between room [ROOM NUMBER] and the exit with the same blanket wadded on top of the cart as observed on 08/12/24. Interview on 08/14/24 at 11:40 A.M. with State tested Nurse Aide (STNA) #352 confirmed she did not know what the PPE cart between room [ROOM NUMBER] and the emergency exit was for but stated that based on her past experiences as an agency nurse working in other long-term care facilities, She assumed it held PPE that was necessary when caring for residents with feeding tubes and catheters. During the interview, STNA #352 was unable to say whether the facility had any residents who were ordered or care planned for enhanced barrier precautions. Interview on 08/14/24 at 3:25 P.M. with the DON confirmed two residents were on dialysis, four residents had urinary catheters, three residents had ostomies, and there were no residents with feeding tubes residing in the facility at the time of the survey. Interview on 08/14/24 at 3:43 P.M. with RN #328 confirmed the facility had six residents with chronic wounds, including Resident #10, and one resident with a multidrug-resistant organism (MDRO) residing in the facility. Review of the policy titled Standard Precautions last revised in November 2022 revealed no information regarding enhanced barrier precautions. Review of the policy titled Isolation - Categories of Transmission-Based Precautions last revised in August 2022 revealed no information regarding enhanced barrier precautions. Review of the Center for Clinical Standards and Quality/Quality, Safety & Oversight Group memorandum summary, reference number QSO-24-08-NH, issued 03/20/24, revealed enhanced barrier precautions (EBP) in in long-term care facilities was effective on 04/01/24 to align with nationally accepted standards. The QSO memorandum further revealed EBP was to include residents with chronic wounds and/or indwelling medical devices during high contact care regardless of their status related to multidrug-resistant organisms.