STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366394	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenue Care and Rehabilitation Center, The	4120 Interchange Corporate Center Road Warrensville Heights, OH 44128

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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44810 Based on closed record review and interview the facility failed to ensure Resident #94 was provided a safe transfer via mechanical lift to prevent a fall with injury. This affected one resident (#94) of five residents reviewed for accidents. The facility identified 20 additional residents (#11, #14, #17, #18, #24, #26, #27, #32, #33, #36, #41, #46, #47, #49, #55, #71, #75, #82, #84, and #92) who required a mechanical lift for transfers. The facility census was 87. Actual Harm occurred on 04/19/24 when Resident #94, who was a bilateral above the knee amputee, exhibited balance deficits, was moderately cognitively impaired and was dependent on staff for transfers sustained a fall during a staff assisted mechanical (Hoyer) lift transfer. At the time of the incident, State tested Nursing Assistant (STNA) #605 and STNA #617 were transferring Resident #94 from the bed to the chair. After placing Resident #94 in the chair, the staff removed the bottom half of the mechanical lift sling, and Resident #94 began sliding to the floor. As STNA #605 and STNA #617 attempted to lower Resident #94 to the ground, his left above the knee amputation site hit the ground causing his incision to reopen, bleeding profusely and causing the resident pain. The resident was transferred to the emergency room and required (per family interview) 26 stitches to the area. The resident did not return to the facility. Findings include: Review of the closed medical record for Resident #94 revealed an admitted [DATE] and a discharge date of [DATE]. Resident #94 had diagnoses including pleural effusions, peripheral vascular angioplasty status, peripheral vascular disease, chronic obstructive pulmonary disease, type two diabetes mellitus, absence of right and left leg above the knee. Review of the physician's order dated 04/16/24 revealed an order to administer Heparin (anticoagulant) 5000 units subcutaneously three times a day. Review of the medication administration record (MAR) revealed Resident #94 received his morning injection on 04/19/24 at 5:00 A.M. Review of the fall risk assessment dated [DATE] revealed Resident #94 was not identified as a fall risk. Review of the nursing care plan for Resident #94 dated 04/16/24 revealed a focus of rehabilitation potential with interventions including transferring with assistance of one staff member. (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the physical therapy evaluation dated 04/17/24 revealed Resident #94 presented with balance deficits, decreased dynamic balance, decreased functional capacity, decreased safety awareness, decreased static balance, deficits in judgement, decreased insight, muscle disuse/atrophy, which required skilled physical therapy services to analyze gait pattern, assess functional abilities, decrease complaints of pain, evaluate need for assistive devices, and facilitate discharge planning. Resident #94 was dependent for chair to bed and bed to chair transfers. Review of the occupational therapy evaluation dated 04/17/24 revealed Resident #94 was at risk for falls, required oxygen, and noted to keep the head of the resident's bed elevated 30 degrees. The therapy evaluation revealed Resident #94 was dependent (on staff) for transfers. Review of the five-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #94 had moderate cognitive impairment. The assessment revealed Resident #94 required substantial/maximal assistance for rolling left to right, sitting to lying, and lying to sitting. Resident #94 was dependent for chair to bed and bed to chair transfers. Review of the nursing progress note dated 04/19/24 at 7:50 A.M. revealed the nurse was informed by the nursing assistant Resident #94 slid out of his chair while they were getting him ready for dialysis and his left leg was bleeding profusely. Resident #94 was found sitting up on the floor leaning up against his chair with blood exuding from his left leg amputation incision site. Resident #94 was assessed and reported pain in his left leg, buttocks, and back. A towel was held to his left leg and 911 was called. Resident #94 was sent to the emergency room and his physician, his spouse, and the Director of Nursing (DON) were notified. Review of a repeat fall risk assessment dated [DATE] (after the resident slid out of the chair) revealed he was at a high risk for falls. Review of the facility fall investigation dated 04/19/24 revealed the nurse was informed by nursing assistants Resident #94 was lowered to the floor by two nursing assistants. The aides reported Resident #94 started to slide out of his chair while they were getting him ready for dialysis and that his left leg was bleeding profusely. The nurse observed Resident #94 sitting up on the floor leaning his back against his chair with blood exiting from his left leg. The nurse assessed the resident. Resident #94 complained of pain in his leg, buttocks, and back. Range of motion was within normal limits for his upper and lower extremities. The nurse held a towel to Resident #94's left leg and called 911. Resident #94 was sent to the emergency room and the spouse, and the DON were made aware of the situation. Resident #94 was medicated with Tylenol for pain prior to leaving. The investigation documented Resident #94 was alert and oriented to person and place. Interview on 04/24/24 at 12:39 P.M. with a family member of Resident #94 stated the resident was currently in intensive care and has thus far received 26 stitches and has major bruising. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on 04/24/24 at 2:00 P.M. with the Director of Nursing (DON) confirmed Resident #94 did sustain a fall in the facility. The DON reported the resident was newly admitted to the facility and had been a double amputee less than a month prior. She reported following the incident, she interviewed the two nursing assistants (STNA #605 and STNA #617) who were transferring Resident #94 with the mechanical lift from the bed to his wheelchair. They reported to her that when they were lowering Resident #94 into the chair, he was not positioned all the way to the back of the chair, so when they went to adjust him (since he had no legs to balance him), he began sliding forward. The DON reported one aide who was behind Resident #94 grabbed his pants and the aide in front of him positioned herself in front of him and hooked her arms underneath his armpits and placed her leg in between his legs and began lowering him to the ground. Resident #94 had both of his pant legs knotted at the ends with big knots due to his bilateral above the knee amputations and stated he landed right on top of the knots. One aide stayed with Resident #94 while the other went to get the nurse. While the aide was leaving the room she noticed the blood on the bottom of each of his pants. The nurse assessed the resident and reported to the DON the resident was on Heparin. Emergency medical services then transported Resident #94 to the emergency room . Interview on 04/24/24 at 2:20 P.M. with STNA #605 and STNA #617 revealed when they were getting Resident #94 up for dialysis (on 04/19/24), they placed him in the mechanical lift and then transferred him into his wheelchair. While they were placing him in the wheelchair, they noticed that he was not positioned far enough back. They removed the bottom straps of the mechanical lift harness and were going to position him back further in the chair. Resident #94 began screaming he was slipping. STNA #617 reported she was standing behind the wheelchair and went to grab his pants to stop him from sliding and pull him back. STNA #605 was standing in front of Resident #94 and reported because he was a bilateral above the knee amputation on both legs, she hooked her arms under his arm pits and then placed her right leg in between each stump to stop him from sliding but he was not stopping, so they both gently lowered him to the ground. Both ends of his pants were knotted in big knots due to his amputations and Resident #94 hit the ground right on top of those knots and then lowered to the ground causing his stumps to slide forward causing the knots on his pant ends to slide over his stump incisions. STNA #617 stayed with Resident #94 while STNA #605 went to get the nurse. STNA #605 reported as she was leaving the room she noticed the blood on the resident's left pant leg. The nurse came to assess Resident #94 and called the emergency services, and the nurse applied pressure to both stumps until the ambulance got there. They reported that they were both trained on mechanical lift transfers prior to being hired and reported the facility did retrain them on mechanical lift transfers after the incident. STNA #617 reported that they had already unhooked the bottom of the mechanical lift pad when they realized he was sitting on the edge of the chair, and he immediately began sliding. The top of the mechanical lift pad was still attached. Review of the facility policy, Fall Management, revised December 2022, revealed a fall can be defined as when a resident was found on the floor, a resident slid on the floor unassisted, a resident rolled out of bed or chair, a resident falls off or out of any equipment used for transferring or therapy. Review of the facility policy, Mechanical Lift, revised October 2022, revealed the health care facilities of Progressive Quality Care would maintain safety when lifting and transferring residents with a mechanical lift. The facility would also maintain adequate comfort and body alignment. The staff should position the lift over the chair, lower the resident into the chair, be sure that the resident was comfortable, and then remove the hooks from the lift. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	This deficiency represents non-compliance investigated under Complaint Number OH00153136.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44810 Based on observation, interview, record review and facility policy review, the facility failed to administer medications to Resident #52 without verifying that he ingested all the medications. This affected one resident (#52) of five residents reviewed for accidents. The facility census was 87. Findings include: Review of the medical record for Resident #52 revealed an admitted [DATE]. Diagnoses included cerebral infarction, asthma, hemiplegia, and hemiparesis following cerebral infarction, and chronic obstructive pulmonary disease. Review of the physician's order dated 05/03/22 revealed an order to administer vitamin B12 (supplement)1000 micrograms (mcg) daily in the morning to Resident #52. There also was an order dated the same date that Resident #52 may not self-administer his medications. Review of physician's order dated 11/29/22 revealed an order to administer metoprolol succinate (antihypertensive) 25 milligrams (mg) in the morning, and multivitamin daily to Resident #52. Review of physician's order dated 03/12/24 revealed an order to administer baclofen (antispasmodic) 20 mg three times a day to Resident #52. Review of physician's order dated 03/16/24 revealed an order to administer guaifenesin (expectorant) 600 mg twice a day, ferrous sulfate (iron supplement) 325 mg twice a day, Colace (stool softener) 100 mg twice a day to Resident #52. Review of physician's orders dated 03/30/24 revealed an order to administer Resident #52 Provera 5 mg daily in the morning for sexual behaviors. Review of physician's order dated 04/26/23 revealed an order to administer vitamin D3 (supplement) 25 mcg daily in the morning to Resident #52 Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #52 had intact cognition. Resident #52 required assistance with all activities of daily living. At the time of the assessment Resident #52 had received an anticoagulant in the past seven days. Review of the care plan dated 04/06/24 revealed Resident #52 was at risk for an adverse reaction due to polypharmacy. Interventions included monitoring for possible signs and symptoms of adverse reactions and requesting physician to review and evaluate medications. Interview on 04/24/24 at 9:43 A.M. with Resident #52 revealed a medicine cup on his breakfast tray with numerous pills in it. Resident #52 reported that the nurse had just given those to him and did not watch him take them. He was unsure what medication was in the cup. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/24/24 at 9:45 A.M. with Licensed Practical Nurse (LPN) #625 confirmed she did leave the medications in Resident #52's room, and she did not watch him take them. She reported that Resident #52 does not like for her to watch him swallow them. LPN #625 confirmed there were nine pills in the pill cup on Resident #52's breakfast tray but reported she was not sure if those were the same pills she left when she first administered them. Review of the facility policy, Medication Administration-General Guidelines, dated December 2017, revealed the resident is always observed after administration to ensure that the dose was completely ingested. If only a partial dose is ingested, this is noted on the medication administration record, and action is taken as appropriate. This deficiency was an incidental finding identified during the complaint investigation.