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	07/10/2024

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

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on medical record review, resident interview, staff interview, and review of the facility policy, the facility failed to ensure resident bathing preferences were honored. This affected four (Residents #21, #29, #34, and #58) of six residents reviewed for accommodation of needs. The facility also failed to ensure residents preferences regarding transfer in and out of bed were honored. This affected two (Residents #21 and #65) of six residents reviewed for accommodation of needs. The facility census was 91 residents. Findings include: 1.Review of the medical record for Resident #21 revealed an admitted [DATE] with diagnoses including exocrine pancreatic insufficiency, muscle weakness, and difficulty in walking. Review of the care plan for Resident #21 dated [DATE] the resident had an activities of daily living (ADL) self-care performance deficit. Interventions included the following: provide assistance by staff with bathing/showering two times a week and as necessary, provide assistance by staff to move between surfaces and as necessary. The care plan for Resident #21 did not describe how the resident should be transferred or how many staff members were needed to transfer the resident. Review of the Minimum Data Set (MDS) assessment for Resident #21 dated [DATE] revealed the resident was cognitively intact and required substantial/maximum assistance with shower/bathing and partial moderate assistance with transfers and wheelchair mobility. Review of the shower schedule for Resident #21 revealed showers were scheduled according to room number for the resident on Wednesdays and Saturdays on day shift. Review of the shower sheets for Resident #21 dated [DATE] through [DATE] revealed the resident received bed baths only. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on [DATE] at 1:25 P.M. with Resident #21 confirmed he had not received a shower since being admitted to the facility on [DATE]. Resident #21 confirmed he preferred showers, but the State tested Nursing Assistants (STNAs) only offered bed baths two times a week and he preferred a shower daily. Resident #21 confirmed he had not had a shower in over three months and was denied a bed bath daily and staff told him it was not his scheduled day. Resident #21 confirmed he asked several staff members, including the Director of Nursing (DON) for a shower and was denied. Resident #21 also confirmed he preferred to get out of bed for breakfast, stay up for about three hours then lay back down because he got tired, and then would like back up again later in the day. Resident #21 confirmed the female STNA's would use a mechanical lift to transfer him, and it took two of them. Resident #21 confirmed he was told many times by the female STNAs that that transferring more than once per shift in a 12-hour shift could not be done. Resident #21 confirmed the STNAs told him either he needed to stay up all day if he decided to get up, or stay in bed all day, but he was not permitted to get up, lay back down then get up again during their shift. Resident #21 confirmed this was frustrating for him because he did not want to stay in bed all day, but he did not have the energy to sit up all day. Interview on [DATE] at 4:12 P.M. with STNA # 406 confirmed night shift transferred most of the residents who required assistance out of bed for the day by 5:00 A.M. The residents stayed up throughout the shift to ensure they were up for meals then transferred back to bed for the night after dinner which usually occurred after 5:30 P.M. Interview on [DATE] at 9:25 A.M. with Registered Nurse (RN) #372 confirmed the shower schedule was based on resident room numbers and each room was scheduled for two showers a week. When a resident was admitted to the facility, the preassigned schedule would automatically determine when the resident received their shower, and which shift it would be received on according to the room number. RN #372 further confirmed Resident #21 had not received daily showers as per his preference. Interview on [DATE] at 4:30 P.M. with Administrator confirmed residents had the right to get out of bed and go back to bed when they wanted, and residents should be bathed according to their preference and should get a bath more frequently than twice per week if requested. 2. Review of the medical record for Resident #29 revealed an admitted [DATE] with diagnoses including cerebral infarction, hemiplegia and hemiparesis affecting the right dominant side. Review of the care plan dated for Resident #29 dated [DATE] revealed the resident had an ADL self-performance deficit. Interventions included following: Hoyer lift assistance by two staff for transfers, provide sponge bath when a full bath or shower cannot be tolerated, anticipate and meet needs. Review of the quarterly MDS assessment for Resident #29 dated [DATE] revealed the resident was cognitively intact, had impairment to one side upper and lower extremity, used a wheelchair, and was dependent for showers. Record review of the shower schedule revealed Resident #29 was to receive a shower on Mondays and Thursdays on night shift. Review of the Resident Council minutes dated [DATE] timed at 1:30 P.M. unsigned revealed under Resident #29 expressed concerns he was not getting showers. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the concern form dated [DATE] revealed Resident #29 had not received a shower in months and did not refuse. The follow-up revealed staff were educated, staff gave resident a shower, and the issue would be checked weekly by the Unit Manager. The form was signed and dated [DATE] per the Administrator and the DON. Review of the shower records for Resident #29 dated [DATE] through [DATE] revealed the resident received one shower on [DATE], but the remaining showers were bed baths or resident refusals on the scheduled days. Interview on [DATE] at 2:03 P.M. with Resident #29 confirmed he had not had a shower in three months, and staff only washed him up. Resident #29 confirmed he was scheduled for night shift showers and staff woke him up in the middle of the night and he didn't like it. Resident #29 confirmed he reported his concerns regarding his showers in the resident council, but the facility had not responded. Interview on [DATE] at 8:44 A.M. with the Administrator confirmed if a concern was expressed in the Resident Council Meeting, the concern should be written down, given to the responsible department head by the activities department staff and then returned to activities department when the concern was resolved, and then the activities department signed off on them. Interview on [DATE] at 8:44 A.M. with Unit Manager (#410) confirmed she received the concern form from [DATE] from Resident Council regarding Resident #29 not receiving showers. UM #410 confirmed she spoke with the Assistant Director of Nursing (ADON) and the nurse on the unit to make sure he received a shower and told them to document it on the shower sheet. UM #410 confirmed when she followed up with Resident #29 a week later, he told her he still did not receive a shower, so she talked to the nurse again. She then told the DON he still never a shower. UM #410 confirmed there was no further follow up for Resident #29. UM #410 confirmed Resident #29 received showers on night shift because that's where his room number fell on the shower schedule. 3. Review of the medical record for Resident #34 revealed an admitted [DATE] with diagnoses including complete traumatic amputation at level between right hip and knee, acquired absence of left leg below the knee and right leg above the knee, unqualified visual loss both eyes, muscle weakness, and need for assistance with personal care. Review of the quarterly MDS assessment for Resident #34 dated [DATE] revealed the resident was cognitively intact, used a wheelchair for mobility, and was dependent for showers. Review of the care plan for Resident #34 dated [DATE] revealed the resident had an ADL self-performance deficit related to impaired balance and need for assistance with personal care. Interventions included to use a Hoyer lift for all transfers and staff to assist with bathing/showering two times a week and as necessary. Record review of the shower schedule for Resident #34 revealed the resident was to receive a shower every Wednesday and Saturday on night shift. Review of the shower sheets for Resident #34 dated [DATE] through [DATE] revealed the resident received one shower on [DATE] with no further showers documented. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on [DATE] at 930 A.M. with Resident #34 confirmed she only received bed baths, but her preference was to have showers. Resident #34 further confirmed staff told her she had to have bed baths. 4. Review of the medical record for Resident #58 revealed an admitted [DATE] with diagnoses included paraplegia, diabetes mellitus, muscle weakness, and need for assistance with personal care. Review of the MDS assessment for Resident #58 dated [DATE] revealed the resident was cognitively intact, had impairment on both sides of the lower extremities, used a wheelchair, and was dependent for showers. Review of the care plan for Resident #58 dated [DATE] revealed the resident #58 had an ADL self-performance deficit related to impaired balance, muscle weakness, and need for assistance with personal care. Interventions included the resident required a Hoyer lift assistance by two staff for all transfers between surfaces every two hours and as necessary and required assistance by staff with bathing/showering two times a week and as necessary. Record review of the shower schedule for Resident #58 revealed the resident was to receive a shower every Monday and Thursday on night shift. Review of the shower schedule for Resident #58 dated [DATE] through [DATE] revealed the resident received or refused a bed bath two times a week and there was no documentation of showers given. Interview on [DATE] at 6:15 A.M. with STNA #478 confirmed if a resident was able bodied and could get up on their own, they could have a shower. STNA #478 further confirmed she was told if a resident couldn't get up by themselves, they should get a bed bath. Interview on [DATE] between 6:15 A.M. and 6:30 A.M. with STNAs #310, #367, and #444 confirmed they gave night shift showers around 4:00 A.M. before they started getting residents up at 5:00 A.M. Interview on [DATE] at 6:30 A.M. with STNA # 342 confirmed she did her bed baths between 3:00 A.M. and 4:00 A.M. and residents did not like it, but that was what the staff were supposed to do. STNA #342 confirmed residents who needed help were not given a choice between a bed bath or a shower. Residents who required transfer assistance received bed baths only. Interview on [DATE] at 6:40 A.M. with RN #302 confirmed showers were scheduled by room number not per resident preference. If a resident didn't like their assigned shower day and time they could refuse the shower. Interview on [DATE] at 6:45 A.M. with Licensed Practical Nurse (LPN) #411 confirmed residents got upset sometimes because they were awakened early for a shower, but they could refuse the shower. LPN #411 confirmed Resident #58 got very upset earlier in the morning of [DATE] because the aide awakened him for his bed bath. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on [DATE] at 9:35 A.M. with Resident #58 confirmed he had not received a shower since being admitted to the facility. Resident #58 confirmed he would prefer to have a shower and he had requested showers from the staff, but they refused and told him he could only have a bed bath. Resident #58 further confirmed he did not want to be awakened in the middle of the night for bathing and he would prefer to have a shower during the daytime. Interview on [DATE] at 9:05 A.M. with the DON confirmed Residents #21, #29, #34, or #58 had no physical restrictions from receiving showers. The DON confirmed residents were not asked on admission when they wanted a shower or bath or if they wanted a shower or bath. The DON confirmed showers were scheduled according to the room number and not per resident preference. 5. Review of the medical record for Resident #65 revealed an admitted [DATE] with a diagnosis of iron deficiency anemia secondary to chronic blood loss. Review of the care plan for Resident #65 dated [DATE] revealed the resident had an ADL self-care performance deficit related to impaired balance, muscle weakness and radiculopathy. Review of the physician orders for Resident #65 dated [DATE] revealed the resident required a Hoyer lift for all transfers. Review of the MDS assessment for Resident #65 dated [DATE] revealed the resident was cognitively intact, had impairment to one side of the lower extremity, used a walker and wheelchair, required partial/moderate assistance with toileting, bed mobility, transfers, and was occasionally incontinent of bladder and always incontinent of bowel. Observation on [DATE] at 1:45 P.M. of Resident #65 revealed the resident was up in her chair and there was a strong odor of stool in the room. Interview on [DATE] at 1:45 P.M. with Resident #65 confirmed staff told her once she went to bed, she had to stay there. Resident #65 confirmed she had been incontinent of stool and needed to have her incontinence brief changed but she did not want to go to bed to get her brief changed because if the STNAs changed her, she would have to stay in bed. Resident #65 confirmed the staff told her there was no getting up and down during the day because she was a Hoyer lift transfer changed then have to stay in bed. Resident #65 agreed with survey to receive incontinence care if she was assured, she could get back up after the care was provided. Observation on [DATE] at 2:06 P.M. of incontinence care for Resident #65 per surveyor request provided STNAs #442 and #476 revealed the resident's pants were saturated with urine and stool. Interview on [DATE] at 2:16 P.M. of STNAs #442 and #476 confirmed Resident #65 was assisted out of bed around 5:00 A.M. per night shift staff. STNA #442 and #476 confirmed this was the first set of rounds on their shift for Resident #65, because the resident just returned from dialysis around 11:00 A.M. Review of the facility policy titled Resident Rights dated [DATE] revealed the facility would ensure the residents' personal dignity, well-being and self-determination were maintained and would assure the residents were knowledgeable of their rights and responsibilities in this regard. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy titled Bathing- Personal Care revised [DATE] revealed the residents of the health care facilities would receive personal care in the facility according to the residents' plan of care to promote dignity, cleanliness, and general well-being. A shower, bed bath, or tub bath were offered to the residents twice a week, as needed, and as often as the resident would like per choice. Bed baths would be offered to the resident on other days that a shower or bed bath were not scheduled and/ or as often as the resident would like, per resident choice. This deficiency represents noncompliance investigated under Complaint Number OH00154767.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on medical record review, observation, resident interview, staff interview, and review of the facility policy, the facility failed to offer/provide timely incontinence care. This affected two (Residents #16 and #65) of three residents reviewed for incontinence care. The facility census was 91 residents. Findings include: 1. Review of the medical record for Resident #16 revealed an admitted [DATE] with a readmitted [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting right dominant side and Alzheimer disease with late onset. Review of the Minimum Data Set (MDS) assessment for Resident #16 dated 04/23/24 revealed the resident was cognitively impaired, had impairment to one side upper and lower extremity, used a wheelchair, required substantial/maximum assistance with toileting and personal hygiene, was dependent with transfers, and was always incontinent of bowel and bladder. Review of the care plan for Resident #16 dated 04/25/23 revealed the resident had bowel and bladder incontinence related to dementia and limited mobility. Interventions included to check for incontinence every two hours and as needed and to transfer the resident using a mechanical lift with assistance of two staff. Multiple observations on 07/03/24 between 1:10 P.M. and 3:55 P.M. revealed Resident #16 was up in her chair in the lounge. Resident #16 was sleeping in her chair and there was a strong odor of urine in the air. Interview on 07/03/24 at 3:55 P.M. with Licensed Practical Nurse (LPN) #303 confirmed staff transferred Resident #16 out of bed on night shift between 5:00 A.M. and 7:00 A.M. Interview on 07/03/24 at 4:20 P.M. with State tested Nursing Assistant (STNA) #472 confirmed she was Resident #16's primary STNA. STNA #472 confirmed third shift got Resident #16 up in her chair around 5:00 A.M. STNA #472 confirmed she did her first set of rounds before lunch and had offered to change Resident #16 at that time. Resident #16 refused to be changed sometimes because she didn't like to move so she assisted other residents and would offer again after dinner which was scheduled at 5:00 P.M. STNA # 472 confirmed Resident #16 had not been checked or changed since third shift got her out of bed. Observation on 07/03/24 at 4:23 P.M. revealed when the Surveyor requested to observe incontinence care for Resident #472 LPN #303 approached Resident #16, whispered in the resident's ear and told the Surveyor the resident didn't want to lay down. LPN #303 then walked away. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 07/03/24 at 4:51 P.M. revealed Unit Manager (UM) #311 asked Resident #16 if she could lay her down and assist her with incontinence care and the resident said yes. Observation of incontinence care for Resident #16 per UM #311 and STNA #417 revealed the resident's clothing and the resident's wheelchair cushion were saturated with urine. Interview on 07/03/24 at 4:59 P.M. with UM #311 confirmed Resident #16's clothing and wheelchair cushion were saturated with urine, and residents should be checked and changed every two hours and as needed. Interview on 07/08/24 at 1:04 P.M. with the Director of Nursing (DON) confirmed residents were to be checked and changed every two hours and as needed. If a confused resident refused, staff should attempt to encourage the resident to be checked and care provided if needed. 2. Review of the medical record for Resident #65 revealed an admitted [DATE] with a diagnosis of iron deficiency anemia secondary to chronic blood loss. Review of the care plan for Resident #65 dated 03/27/24 revealed the resident had an ADL self-care performance deficit related to impaired balance, muscle weakness and radiculopathy. Review of the physician orders for Resident #65 dated 04/25/24 revealed Resident #65 required a Hoyer lift for all transfers. Review of the MDS assessment for Resident #65 dated 06/27/24 revealed the resident was cognitively intact, had impairment to one side of the lower extremity, used a walker and wheelchair, required partial/moderate assistance with toileting, bed mobility, transfers, and was occasionally incontinent of bladder and always incontinent of bowel. Observation on 07/09/24 at 1:45 P.M. of Resident #65 revealed the resident was up in her chair and there was a strong odor of stool in the room. Interview on 07/09/24 at 1:45 P.M. with Resident #65 confirmed staff told her once she went to bed, she had to stay there. Resident #65 confirmed she had been incontinent of stool and needed to have her incontinence brief changed but she did not want to go to bed to get her brief changed because if the STNAs changed her, she would have to stay in bed. Resident #65 confirmed the staff told her there was no getting up and down during the day because she was a Hoyer lift transfer changed then have to stay in bed. Resident #65 agreed with survey to receive incontinence care if she was assured, she could get back up after the care was provided. Observation on 07/09/24 at 2:06 P.M. of incontinence care for Resident #65 per surveyor request provided per STNAs #442 and #476 revealed the resident's pants were saturated with urine and stool. Interview on 07/09/24 at 2:16 P.M. of STNAs #442 and #476 confirmed Resident #65's pants were saturated with urine and stool and the resident had been assisted out of bed around 5:00 A.M. per night shift staff. STNA #442 and #476 confirmed this was the first set of rounds on their shift for Resident #65, because the resident just returned from dialysis around 11:00 A.M. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Incontinence Care dated December 2022 revealed the facility should ensure a resident who was incontinent of bowel and or bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. This deficiency represents noncompliance investigated under Complaint Number OH00154767.