STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366407	A. Building B. Wing	12/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenue at Medina	699 East Smith Road Medina, OH 44256

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 - Minimal harm or potential for actual harm Residents Affected - Few	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** 42013 Based on observation, interviews, record review and review of the facility policy, the facility failed to ensure Resident's #58 and #66 had comprehensive post-fall assessments completed, failed to ensure Resident #58's care planned interventions were implemented, and failed to ensure Resident #58 had an individualized care planned intervention placed after a fall. This affected two residents (#58 and #66) out of three reviewed for falls. The facility census was 60. Findings include: 1. Review of Resident #58's medical record revealed an admitted [DATE] with diagnoses including aftercare following joint replacement surgery, pneumonia, Parkinsonism, leukemia, personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits. Review of Resident #58's Fall Risk assessment dated [DATE] revealed Resident #58 was at risk for falls. Review of Resident #58's care plan dated 11/25/24 included Resident #58 was at risk for falls related to gait and balance problems. Resident #58 would be free of falls through the review date. Interventions included to be sure Resident #58's call light was within reach and encourage Resident #58 to use it for assistance as needed, and Resident #58 needed prompt response to all requests for assistance; follow facility fall protocol. Review of Resident #58's Fall Risk assessment dated [DATE] revealed Resident #58 was not a risk for falls. Review of the Admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #58 had moderate cognitive impairment. Resident #58 required substantial to maximal assistance for toileting and personal hygiene and the ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed. Resident #58 required partial to moderate assistance to walk ten feet and to get on and off a toilet or commode. Resident #58 was always continent of urine and bowel. Further review of Resident #58's care plan revealed an intervention dated 11/30/24 and revised 12/02/24 for call not fall sign in Resident #58's view (Resident #58 activated his call light before his fall on 11/30/24). (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366407	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/03/2024
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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #58's fall investigation dated 11/30/24 at 7:15 A.M. included Resident #58 was ambulating self to the bathroom, made it near the bathroom door, felt like he needed to sit down, the rollator was not near, he had nothing to grab so he let himself fall to the floor. Resident #58 stated he had a bad case of diarrhea this morning, he was trying to get to the bathroom, he did not have anything to hold onto, so he just let himself fall. No injuries were observed at the time of the incident or post incident. Resident #58 was alert and oriented to person and situation and was wheelchair bound. Resident #58's call light was initiated, he was incontinent, had gait imbalance and weakness. Resident #58 was ambulating without assistance. On 12/02/24 notes indicated no visible injuries were noted, appropriate parties were notified, and Resident #58 was educated to ask staff for toileting needs and a call not fall sign was placed in Resident #58's view. (Resident #58's call light was activated at the time of the incident on 11/30/24). Review of Resident #58's nursing progress notes dated 11/30/24 at 10:15 A.M. revealed Resident #58 fell in his room in the morning while trying to take himself to the bathroom. Resident #58 stated he had a bad case of diarrhea, his brief was lying on the floor next to the bed, and he made it near the bathroom door before falling. Resident #58 was assisted off the floor and placed back in his wheelchair and taken into the bathroom to be cleaned. Neuro checks were started, and vital signs were stable. The physician and responsible party were notified, and Resident #58 would continue to be monitored. Review of Resident #58's medical record including progress notes and assessments dated 11/30/24 through 12/03/24 did not reveal evidence Resident #58 had post fall assessments, fall risk assessments, or pain assessments completed. Interview on 12/03/24 at 9:06 A.M. of the Director of Nursing (DON) revealed when a resident had a fall there should be documentation in the progress notes. The DON stated sometimes she had to follow-up with the nurses because they completed the incident report in the risk management area of the electronic record but forgot to click the final box that transferred the documentation to the resident's progress notes. The DON stated the assessment area of the resident's medical record should include 72-hour post fall assessments, a fall risk assessment, and pain assessments. Neuro checks were completed on paper and kept with the hard chart. Interview on 12/03/24 at 10:30 A.M. of Registered Nurse (RN) #200 revealed she worked 11/30/24 and 12/01/24 and confirmed Resident #58 fell while trying to take himself to the bathroom. RN #200 stated Resident #58's call light was activated at the time of the fall. RN #200 indicated she completed the documentation regarding the fall including neuro checks, risk management, and a fall assessment. Observation on 12/03/24 at 11:23 A.M. of Resident #58 revealed he was sitting in a wheelchair in his room. Resident #58 stated he was not feeling very well; he had been having large amounts of diarrhea the last few days, and the facility was supposed to collect a fecal sample to have it tested . Resident #58 made a face indicating he did not feel well. Resident #58 stated he had a fall the other day, he had to go to the bathroom but could not remember a lot of details because he was not feeling well at all when the fall occurred. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/03/24 at 2:23 P.M. of Certified Nursing Assistant (CNA) #201 revealed he worked on 11/30/24, and Resident #58 tried to go to the bathroom and fell . CNA #201 stated he had to get a resident up for dialysis and did not see Resident #58's call light because he might have been in that resident's room when Resident #58 activated his call light. CNA #201 indicated when he was in a resident room, the nurses and other CNA's watch the call lights but the other aide must have also been in a resident room providing care. CNA #201 revealed when Resident #58 fell he was incontinent of diarrhea, needed to be cleaned up, and CNA #201 assisted him to the toilet so he could finish going to the bathroom. Interview on 12/03/24 at 3:21 P.M. of the DON confirmed after a fall on 11/30/24, Resident #58 did not have post fall assessments, a fall risk assessment or pain assessments completed, but did have neuro checks completed. The DON confirmed Resident #58's fall risk assessments stated on 11/21/24 he was at risk for falls and on 11/25/24 the fall risk assessment was not at risk, and the DON did not know why he was assessed for not at risk for falls but would look into it. The DON confirmed Resident #58 activated his call light on 11/30/24 before his fall and the immediate intervention implemented was to place a call not fall sign in his view. The DON confirmed a different intervention should have been implemented. Review of the facility policy titled Fall Management, revised 12/2022, included the licensed nurse would assess the resident for fall risk through the Fall Risk Assessment upon admission, quarterly and with a significant change. If a fall occurred, the licensed nurse would assess the resident for injury from the fall immediately, initiate an investigation of the reason for the fall and implement an immediate intervention to attempt to prevent future falls. The licensed nurse would update the Fall Risk and Pain Assessment at the time of the fall. The interdisciplinary team would review the falls routinely to determine the most appropriate type of intervention to be implemented to attempt to prevent future incidents from occurring. 2. Review of Resident #66's medical record revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included atherosclerotic heart disease of native coronary artery without angina pectoris, malignant neoplasm of the prostate, and unspecified fall. Review of Resident #66's progress notes dated 10/11/24 at 3:11 A.M. included Resident #66's bed was kept in the low position. Review of Resident #66's progress notes dated 10/11/24 at 8:49 A.M. included Resident #66 was heard screaming mama help and the nurse went to his room to find Resident #66 lying on the left side with his arm under the top part of the bed and left knee sliding under the bed. The bed was moved sideways by Resident #66, and a large bruise was observed on his left elbow. ROM (range of motion) was intact. The physician was notified, and an x-ray was ordered of Resident #66's left elbow. The DON and family were notified. Resident #66's daughter stated the bruise on Resident #66's left elbow was already there but would like an x-ray just in case. Review of Resident #66's physician order dated 10/11/24 at 9:42 A.M. revealed fall mat to the open side of the bed, every shift for safety. Review of Resident #66's assessments dated 10/11/24 through 10/13/24 did not reveal 72-hour post fall assessments, a fall risk assessment or a pain assessment. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #66's progress notes dated 10/12/24 through 10/17/24 did not reveal documentation regarding Resident #66's fall on 10/13/24. Review of Resident #66's fall incident report dated 10/12/24 at 7:40 A.M. included Resident #66 was confused, oriented to person, incontinent, had a recent change in cognition, a recent illness, impaired memory and weakness. Resident #66's fall occurred when Resident #66 was ambulating without assistance and during transfer. Notes on 10/14/24 included Resident #66 was assessed; x-ray of his arm was negative, and a new order for the bed in the lowest position. Review of Resident #66's fall incident report dated 10/13/24 at 1:17 A.M. included a Certified Nursing Assistant (CNA) reported on 10/12/24 at 6:15 P.M. that Resident #66 was on the floor on the fall mat in his room. Resident #66 was found in the prone position with his legs straight down and arms bent above his head flat on the floor. The bed was in the lowest position. Resident #66 stated he had lower back pain which was present previously. No visible injuries except older bruises from previous falls. Resident #66's blood pressure was 129/88, heart rate 81, respirations 16 and oxygen saturation was 95 percent. The family and physician were contacted. Resident #66 stated his feet slipped. The immediate action taken was Resident #66 would wear gripper socks and was educated about the importance of using the call light. Resident #66 was confused, oriented to person and situation, his call light was not initiated, and he was incontinent. Resident #66 was wearing improper footwear and was admitted within the last 72 hours. Review of Resident #66's assessments revealed on 10/13/24 Resident #66 had a pain assessment, a fall risk assessment, and a 72-hour post fall assessment. Review of Resident #66's assessments revealed for Resident #66's fall on 10/13/24 there were no72-hour post fall assessments completed on 10/15/24 or 10/16/24. Review of Resident #66's Admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #66 had severe cognitive impairment. Resident #66 required substantial to maximal assistance for toileting hygiene, lower body dressing, and putting on and taking off footwear. Resident #66 required substantial to maximal assistance for sit to stand, chair, bed-to-chair transfer and toilet transfers. Resident #66 was frequently incontinent of urine and always continent of bowel. Review of Resident #66's fall incident report dated 10/18/24 at 5:10 P.M. included the nurse entered Resident #66's room and witnessed Resident #66 hanging onto the grab bar and lowered self to floor after yelling for a period of time. When Resident #66 got to the floor and was sitting on his bottom, he turned and laid down placing his head on a pillow on the floor at the foot end of the bed and began yelling out again. Resident #66's vital signs were stable. Resident #66 was unable to give a description of the incident. No injuries observed at the time of incident. The immediate action taken was the DON was notified of what happened so the care plan could be updated. Resident #66 was confused, oriented to person. The physician, responsible parties, and DON were notified. Review of Resident #66's assessments revealed there were no 72-hour post fall assessments completed on 10/19/24, 10/20/24 or 10/21/24. Review of the facility incident log revealed Resident #66 had falls on10/12/24 at 7:40 A.M. and 10/13/24 at 1:17 A.M. There was no fall documented for 10/11/24 at 8:49 A.M. or 10/18/24 at 5:10 P.M. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #66's care plan dated 10/21/24 included Resident #66 was at risk for falls related to confusion, gait and balance problems and was unaware of safety needs. Resident #66 would be free of falls. Interventions included to be sure Resident #66's call light was within reach and encourage Resident #66 to use it for assistance as needed, and Resident #66 needed prompt response to all requests for assistance; follow facility fall protocol. Interview on 12/03/24 at 9:06 A.M. of the DON revealed when a resident had a fall there should be documentation in the progress notes. The DON stated sometimes she had to follow-up with the nurses because they completed the incident report in the risk management area of the electronic record but forgot to click the final box that transferred the documentation to the resident's progress notes. The DON stated the assessment area of the resident's medical record should include 72-hour post fall assessments, a fall risk assessment, and pain assessments. Neuro checks were completed on paper and kept with the hard chart. Interview on 12/03/24 at 3:21 P.M. of the DON revealed Resident #66 had a fall on 10/11/24 which was not documented on the incident log until 10/12/24 at 7:40 A.M. because the nurse forgot to do the risk management documentation and had to be reminded. The DON stated there was no fall on 10/12/24. The DON confirmed from 10/11/24 through 10/13/24 Resident #66 did not have a fall risk assessment, a pain assessment or post fall 72-hour assessments completed. The DON confirmed Resident #66 had a fall on 10/13/24, and there were no 72-hour post fall assessments completed on 10/15/24 or 10/16/24. The DON confirmed Resident #66 had a fall on 10/18/24 and there were no 72-hour post fall assessments completed on 10/19/24, 10/20/24 or 10/21/24. The DON confirmed Resident #66's progress notes did not reveal documentation regarding Resident #66's fall on 10/13/24. The DON confirmed the incident log did not have evidence Resident #66 had a fall on 10/18/24 at 5:10 P.M. Review of the facility policy titled Fall Management, revised 12/2022, included the licensed nurse would assess the resident for fall risk through the Fall Risk Assessment upon admission, quarterly and with a significant change. If a fall occurred the licensed nurse would assess the resident for injury from the fall immediately, initiate an investigation of the reason for the fall and implement an immediate intervention to attempt to prevent future falls. The licensed nurse would update the Fall Risk and Pain Assessment at the time of the fall. The interdisciplinary team would review the falls routinely to determine the most appropriate type of intervention to be implemented to attempt to prevent future incidents from occurring. This deficiency represents non-compliance investigated under Complaint Number OH00158853.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013 Based on observation, interview, record review and review of the facility policy, the facility failed to ensure Resident #32 had a timely comprehensive pain assessment. This affected one resident (Resident #32) out of three residents reviewed for medication administration. The facility census was 60. Findings include: Review of Resident #32's medical record revealed an admitted [DATE] with diagnoses including spinal stenosis, lumbosacral region, functional quadriplegia, and type two diabetes mellitus without complications. Review of Resident #32's Admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] included Resident #32 was cognitively intact. Resident #32 required partial to moderate assistance with toileting hygiene, bathing and dressing. Resident #32 frequently had pain or hurting in the last five days, the pain occasionally made it hard to sleep at night, and Resident #32 frequently limited his participation in rehabilitation therapy sessions due to pain. Review of Resident #32's care plan dated 11/26/24 included Resident #32 had pain related to lumbar stenosis, recent fall, and chronic low back pain. Resident #32 would not have discomfort related to side effects of analgesia through the review date. Interventions included to anticipate Resident #32's need for pain relief and respond immediately to any complaint of pain; document nonpharmacological intervention attempts prior to administration of pharmacological intervention; evaluate the effectiveness of pain interventions after treatment and as needed; notify the physician if interventions were unsuccessful or if the current complaint was a significant change from Resident #32's past experience of pain. Review of Resident #32's Medication Administration Record (MAR) dated 11/29/24 from 6:00 P.M. to 11/30/24 at 6:00 A.M. revealed Resident #32's pain level was a seven on a scale of zero to ten, ten being the worst pain. Review of Resident #32's MAR dated 11/29/24 at 7:47 P.M. revealed oxycodone HCl tablet 5 milligrams (mg) (opioid pain medication) was administered and was ineffective. Review of Resident #32's MAR dated 11/29/24 at 7:47 P.M. through 12/01/24 at 1:55 A.M. did not reveal oxycodone HCl tablet 5 mg was administered for pain. Review of Resident #32's progress notes dated 11/30/24 at 3:48 A.M. revealed oxycodone HCL tablet 5 mg, follow-up pain scale was an eight on a scale of zero to ten, ten being the worst pain. The oxycodone was ineffective. Review of Resident #32's MAR dated 11/30/24 at 6:00 A.M. through 12/01/24 at 6:00 A.M. revealed Resident #32's pain was zero on a scale of zero to ten, ten being the worst pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #32's MAR dated 12/01/24 at 1:55 A.M. revealed oxycodone 5 mg tablet was administered for a pain level of six, and it was effective. Review of Resident #32's progress notes dated 12/01/24 at 4:54 A.M. revealed oxycodone HCl tablet 5 mg follow up pain scale was a one. Review of Resident #32's MAR dated 12/01/24 from 6:00 A.M. through 6:00 P.M. revealed Resident #32's pain level was a four on a scale of zero to ten, and nonpharmacological interventions were attempted. Review of Resident #32's MAR dated 12/01/24 at 9:40 A.M. revealed Tylenol extra strength oral tablet 500 mg, give two tablets by mouth every eight hours as needed for pain was administered for a pain level of seven, and it was effective. Review of Resident #32's progress notes dated 12/01/24 at 9:51 A.M. revealed Tylenol extra strength oral tablet 500 mg follow up pain scale was a one. Review of Resident #32's progress notes dated 12/01/24 at 11:10 P.M. included turn and reposition was ineffective, and oxycodone HCl tablet 5 mg was administered for pain. Review of Resident #32's MAR dated 12/01/24 at 11:10 P.M. revealed oxycodone 5 mg tablet was administered for a pain level of seven, and it was effective. Review of Resident #32's progress notes dated 12/02/24 at 2:02 A.M. revealed oxycodone HCl tablet 5 mg follow up pain scale was a three. Review of Resident #32's MAR dated 12/02/24 revealed oxycodone 5 mg tablet was administered at 8:24 A. M. for a pain level of eight, and it was effective. Review of Resident #32's progress notes from 11/29/24 at 7:47 P.M. through 12/02/24 at 8:24 A.M. did not reveal Resident #32's physician was contacted regarding Resident #32's pain, and there was no documented evidence a pain assessment was completed. Observation on 12/02/24 at 8:20 A.M. of Licensed Practical Nurse (LPN) #202 revealed he was preparing to administer Resident #32's medication. After preparing the medications, LPN #202 entered Resident #32's room and administered his medications. Resident #32 stated he was in a lot of pain and wanted oxycodone and had already received Tylenol. Resident #32 stated he was hurting bad, grimaced and held his left flank, and said he had severe pain in his kidneys and it was not normal for him. Resident #32 stated he was hurting all weekend, told the nurse he was having pain, and the nurse told him Nurse Practitioner (NP) #203 would be in on Monday. Resident #32 stated right now his pain was an eight out of a ten, ten being the worst pain. Resident #32's facial expression and body movements indicated he was experiencing moderate to severe pain. LPN #202 stated he did not work Saturday or Sunday, checked Resident #32's electronic record and did not see anything in the computer about Resident #32's pain. LPN #202 indicated he worked on Friday, and Resident #32 was having pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/02/24 at 11:46 A.M. of NP #203 revealed Resident #32 was having pain on Friday. NP #203 stated he did not work on Saturdays or Sundays and if Resident #32 was having pain over the weekend Medical Director #204 should have been contacted, and he did not know if Medical Director #204 was contacted. NP #203 stated he offered to increase Resident #32's muscle relaxant, but Resident #32 declined because he felt the problem he was having was related to his kidneys. NP #203 indicated Resident #32's pain was worse today than it was on Friday, and he was changing Resident #32's oxycodone to Ultram (opioid pain medication). Interview on 12/03/24 at 3:13 P.M. of Certified Nursing Assistant (CNA) #205 revealed Resident #32 was included in her assignment over the weekend and he said his kidney was hurting him on both Saturday and Sunday. CNA #205 stated Resident #32 wanted to drink cranberry juice because he said he had kidney problems. CNA #205 indicated Resident #32 looked like he was in pain both Saturday and Sunday, and she told the nurse he was having pain, but she could not remember which nurse she told. Interview on 12/03/24 at 4:12 P.M. of LPN #206 revealed she worked Saturday and Sunday but could not remember if Resident #32 was in pain. LPN #206 stated she remembered his right leg was hurting and she put a lidocaine patch on it, but that is all she remembered. LPN #206 stated she did not call Medical Director #204, and he did not make rounds while she was working. Interview on 12/03/24 at 4:22 P.M. of LPN #207 revealed she worked Saturday and Sunday night shift and Resident #32 was in pain and he was medicated all weekend. LPN #207 stated Resident #32 had oxycodone ordered, and he told Nurse Practitioner (NP) #203 on 12/02/24 his oxycodone was not working for him, then Tramadol (Ultram) was ordered. LPN #207 stated Resident #32 thought he had a kidney stone, and she gave him a heat pack. LPN #207 stated Resident #32's pain over the weekend was a seven out of a ten, ten being the worst pain, and she did not call or fax Resident #32's physician (Medical Director #204) about Resident #32's pain. Review of the facility policy titled Pain Management, revised 02/2023, included the purpose of the policy was to ensure residents received the treatment and care in accordance with professional standards of practice, the comprehensive care plan, and the resident's choices, related to pain management. The licensed nurse would perform a pain assessment upon admission, quarterly, with a significant change, new onset of pain and incident. The licensed nurse would assess as necessary and include the impact of pain on day-to-day activities, strategies that reduce pain, review of current medical conditions and medications. If the resident was assessed to be experiencing pain the nurse would explore pharmacological and non-pharmacological interventions as appropriate per the resident's comprehensive assessment, plan of care and standards of practice. This deficiency represents non-compliance investigated under Master Complaint Number OH00159596.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013 Based on observation, interview, record review and review of the facility policy, the facility failed to ensure staff donned appropriate personal protective equipment (PPE) and used appropriate hand hygiene to potentially prevent the spread of infection for Resident #58 who was on contact precautions. In addition, the facility failed to ensure appropriate hand hygiene was completed before entering Resident #30's room to provide care. This affected two resident's (#30 and #58) and had the potential to affect 20 residents (#7, #8, #11, #15, #17, #22, #23, #26, #34, #35, #36, #38, #43, #49, #51, #53, #57, #58, #59, #62) on transmission-based precautions. The facility census was 60. Findings include: 1. Review of Resident #58's medical record revealed an admitted [DATE] with diagnoses including aftercare following joint replacement surgery, pneumonia, Parkinsonism, leukemia, and personal history of transient ischemic attack (TIA) and cerebral infarction without residual deficits. Review of Resident #58's progress notes dated 11/19/24 at 3:49 P.M. included Resident #58 was admitted to the facility and was status post right hip replacement. Resident #58 was alert and oriented times two with some short term memory loss. Resident #58 was complaining of right knee pain which he said started after the hip replacement. The resident was continent of bowel and bladder. Review of Resident #58's physician orders dated 11/19/24 through 12/02/24 did not reveal orders for Enhanced Barrier Precautions (EBP). Review of Resident #58's care plan dated 11/21/24 included Resident #58 had bowel incontinence. Resident #58 would establish an individual bowel and bladder routine. Interventions included bowel protocol as ordered; briefs, depends, or pantiliners when out of bed; toileting per request and as needed. Review of Resident #58's care plan dated 11/21/24 did not reveal a care plan for EBP or Contact Precautions. Review of Resident #58's Admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #58 had moderate cognitive impairment. Resident #58 required substantial to maximal assistance for toileting and personal hygiene and the ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed. Resident #58 required partial to moderate assistance to walk ten feet and to get on and off a toilet or commode. Resident #58 was always continent of urine and bowel. Review of Resident #58's physician orders dated 12/02/24 at 6:00 A.M. revealed contact isolation precautions due to diagnosis of C-Diff (Clostridium Difficile), a bacterium that causes an infection of the colon causing diarrhea. All services and meals were to be provided in Resident #32's private room, every shift for C-Diff isolation. Review of Resident #58's physician orders dated 12/02/24 at 1:00 P.M. revealed please collect stool for C-Diff, one time only for labs for five days. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366407	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenue at Medina	699 East Smith Road Medina, OH 44256

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #58's Medication Administration Record (MAR) dated 12/02/24 at 1:46 P.M. revealed Resident #58's stool specimen was collected. Review of physician orders dated 12/02/24 at 6:00 P.M. revealed vancocin (Vancomycin) oral capsule 125 milligrams (mg), give one capsule by mouth every six hours for prophylaxis (diarrhea, leukocytosis) for ten days pending stool sample results. Review of Resident #58's physician orders dated 12/03/24 at 6:00 P.M. revealed contact isolation due to possible C-Diff. All services and meals were to be provided in Resident #32's private room. Observation on 12/03/24 at 10:37 A.M. of the wall to the right of Resident #58's entrance to the room revealed a sign for EBP. The sign stated everyone must clean their hands, including before entering and when leaving the room. Providers and staff must also wear gloves and a gown for the following high-contact resident care activities: dressing, bathing, showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use (central line, urinary catheter, feeding tube, tracheostomy) wound care, any skin opening requiring a dressing. Do not wear the same gown and gloves for the care of more than one person. Further observation did not reveal a sign for contact precautions. Observation on 12/03/24 at 10:53 A.M. of Resident #58's room revealed Resident #58's call light was activated and a light alerting staff that Resident #58 activated his call light could be seen above the door to his room. Registered Nurse Unit Manager (RN/UM) #209 entered Resident #58's room to answer his call light and did not use hand sanitizer or don an isolation gown and gloves before entering the room. Further observation revealed RN/UM #209 assisted Resident #58 into the bathroom without an isolation gown or gloves on. After assisting Resident #58 to the bathroom RN/UM #209 exited the room and used hand sanitizer. When asked why she did not don an isolation gown or gloves before entering the room, UM/RN #209 stated she did not see the EBP sign before she entered the room and did not know Resident #58 was on precautions. When told Resident #58 had physician orders for contact isolation related to C-Diff, RN/UM #209 stated she did not know he was on precautions for C-Diff. RN/UM #209 confirmed she did not wash her hands before leaving the room but would do so immediately. RN/UM #209 confirmed Resident #58 did not have a contact precaution sign by the door to his room. Interview on 12/03/24 at 10:58 A.M. of Licensed Practical Nurse (LPN) #210 confirmed Resident #58 did not have a contact precaution sign by the entrance to his room. LPN #210 stated he thought Resident #58 had a contact precaution sign on the door and he should be on contact isolation for C-Diff. LPN #210 stated he would make sure the EBP sign was replaced by a contact isolation sign. Observation on 12/03/24 at 11:23 A.M. of Resident #58 revealed he was sitting in a wheelchair in his room. Resident #58 stated he was not feeling very well, he had been having large amounts of diarrhea the last few days, and the facility was supposed to collect a fecal sample to have it tested . Resident #58 made a face indicating he did not feel well. Resident #58 stated he did not know why the fecal sample had not been collected because he was still having large amounts of diarrhea and so far, today had two large diarrhea stools. Interview on 12/03/24 at 3:32 P.M. of the Director of Nursing (DON) revealed Resident #58 got loose stools after he was administered the antibiotic Rocephin for a urinary tract infection. The DON stated Resident #58 was supposed to have a stool specimen sent for C-Diff and would investigate why the specimen had not been collected and sent yet. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366407	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/03/2024
NAME OF PROVIDER OR SUPPLIER: Avenue at Medina		STREET ADDRESS, CITY, STATE, ZIP CODE: 699 East Smith Road Medina, OH 44256	

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Isolation Categories of Transmission Based Precautions revised 09/2022 included contact precautions that were implemented for residents known or suspected to be infected with microorganisms that could be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. Contact precautions were also used in situations when a resident was experiencing fecal incontinence or diarrhea that could not be contained and suggested an increased potential for extensive environmental contamination and risk of transmission of a pathogen, even before a specific organism was identified. The individual on contact precautions was placed in a private room if possible. Staff and visitors wore gloves when entering the room. While caring for a resident, staff would change gloves after having contact with infective material. Gloves were removed and hand hygiene performed before leaving the room. Staff avoided touching potentially contaminated environmental surfaces in the resident's room after gloves were removed. Staff and visitors wear a disposable gown upon entering the room and remove before leaving the room and avoid touching potentially contaminated surfaces with clothing after the gown was removed. 2. Review of Resident #30's medical record revealed an admitted [DATE] with diagnoses including pneumonia, cerebral infarction due to unspecified occlusion or stenosis of right posterior cerebral artery, and congestive heart failure. Review of Resident #30's Admission MDS assessment dated [DATE] revealed Resident #30 had severe cognitive impairment. Resident #30 was always incontinent of urine and frequently incontinent of bowel. Observation on 12/03/24 at 10:48 A.M. of Certified Nursing Assistant (CNA) #211 revealed she was walking in the hall and was carrying a plastic bag full of soiled linens without gloves on. During the observation a reusable chux pad fell out of the bag and brushed the floor. A moderate amount of brown fecal material was visualized on the reusable chux pad, and CNA #211 reached down and picked up the soiled chux pad with her bare hands and attempted to put it back in the bag. CNA #211 was unsuccessful, and she continued to walk down the hall with the feces covered chux falling out of the bag, and the moderate to large amount of feces could be seen on the chux as she walked. CNA #211 entered the soiled utility room and disposed of the soiled linens and without washing her hands or using hand sanitizer walked out of the soiled utility room, down the hall and into Resident #30's room to assist another staff member with incontinence care without washing her hands or using hand sanitizer. After surveyor intervention CNA #211 washed her hands before providing care for Resident #30. CNA #211 confirmed she did not use hand sanitizer or wash her hands after handling the soiled linens and feces covered chux pad. Review of the facility policy titled Handwashing, revised 07/2022, included it was the policy of the facility to maintain the highest standard of hygiene in patient care through thorough handwashing procedures. All employees should wash their hands thoroughly with soap and running water in the following circumstances: staff involved in direct resident contact must perform hand hygiene (even if gloves were used) including before and after contact with the resident, after contact with blood, body fluids, visibly contaminated surfaces or after contact with objects in the resident's room. Alcohol-based hand sanitizers were highly effective against non-spore forming organisms, but they did not kill C-Difficile Spores or remove C-Difficile from the hands. This deficiency was an incidental finding identified during the complaint investigation.