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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366431	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenue at Aurora	425 South Chillicothe Road Aurora, OH 44202

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013 Based on observation, interview, record review, and review of facility policy the facility failed to ensure a resident was assisted with dressing and provided incontinence care timely. This affected one resident (#57) of three residents reviewed for Activity of Daily Living. The facility census was 91. Findings include: Review of Resident #57's medical record revealed an admitted [DATE] and diagnoses included sepsis, unspecified organism, type two diabetes mellitus with ketoacidosis without coma, cellulitis of lower limb and acute respiratory failure with hypoxia. Review of Resident #57's care plan dated 04/01/24 included Resident #57 had bladder incontinence. Resident #57 would decrease frequency of urinary incontinence through the next review date. Interventions included to check every two hours and as required for incontinence, and to wash, rinse, and dry perineum and change clothing as needed after incontinence episodes. Resident #57 was dependent on staff for meeting emotional, intellectual, physical and social needs due to physical limitations. Interventions included encouraging and allowing choice, self-expression and responsibility. Resident #57 had an ADL (Activity of Daily Living) self-care performance deficit related to sepsis and diagnoses. Resident #57 would improve current level of function in ADL's through the review date of 07/11/24. Interventions included Resident #57 required assistance of one staff with bathing and showering as necessary; Resident #57 required assistance of one staff to dress; Resident #57 required assistance of one staff with personal hygiene and oral care. Resident #57 required assistance of one staff to turn and reposition in bed every two hours and as necessary. Resident #57 was a two person assist with slide board for all transfers. Review of Resident #57's Admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #57 was cognitively intact. Resident #57 was always incontinent of urine and frequently incontinent of bowel. Observation on 05/15/24 at 2:24 P.M. of Resident #57's room revealed a light was blinking above the door to her room indicating Resident #57 had activated her call light. Interview on 05/15/24 at 2:24 P.M. of Family Member (FM) #270 revealed she was visiting her mother, and on 05/15/24 around 12:00 P.M. FM #270 noticed Resident #57's call light was activated. FM #270 stated Resident #57's call light was on the entire two hours she visited her mother. (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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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 05/15/24 at 2:26 P.M. of State tested Nursing Assistant (STNA) #211 revealed she entered Resident #57's room to answer the call light. STNA #211 walked out of Resident #57's room and stated she was assigned to take care of Resident #57 from 6:00 A.M. until 6:00 P.M. STNA #211 accompanied the surveyor to the nurses station and confirmed the monitor had resident rooms displayed indicating call lights were activated, but no sound could be heard from the monitor. STNA #211 stated there should be a beeping sound coming from the monitor. Observation on 05/15/24 at 2:30 P.M. of Resident #57 revealed she was lying in bed, the blinds covering the window were closed and the lighting in the room was dim. Resident #57 was wearing a hospital gown and the bottom half of the gown was observed to be very wet. Resident #57 stated the gown was very wet with urine. Interview on 05/15/24 at 2:30 P.M. revealed Resident #57 stated she wanted to get out of bed, and she had her light on for at least 45 minutes. Resident #57 stated when the facility was short handed her call light was on a long time before it was answered. Resident #57 stated she talked to STNA #211 at around 8:30 A.M., and STNA #211 was too busy at that time to give her a shower, but told her she would be back to dress her, then she could have her shower later in the day. Resident #57 indicated STNA #211 never returned to help her get dressed, and now her gown was wet from her diaper because she could not hold her urine. Resident #57 stated her incontinence brief was soaked with urine, her gown was soaked with urine, she was still in her pajamas at 2:30 P.M., and shouldn't the staff check her every two hours to see if her incontinence brief needed changed? Resident #57 again stated she wanted out of bed and the blind on the window needed to be raised if nothing else could be done. Resident #57 stated the blinds were closed all day, and she could not look out of the window. Interview on 05/15/24 at 2:39 P.M. of Licensed Practical Nurse (LPN) #170 revealed she was sitting at the South nursing unit nurse's station and stated it had been a very busy day. LPN #170 confirmed the monitor at the nurses station showed resident call lights were activated, but the monitor was not making a beeping sound, or any sound at all to alert staff a call light was activated. LPN #170 stated she had not heard any sound from the monitor all day, including beeping, and did not know how to adjust the volume. LPN #170 stated she was supposed to be finished with her shift at 2:30 P.M., but she did not have time until now to complete her charting, and she would stay until she was finished. Interview on 05/15/24 at 3:10 P.M. of the Administrator and Director of Nursing (DON) revealed staff answered resident call lights when they were activated, but call lights were left on until the resident's need was met. Interview on 05/15/24 at 3:57 P.M. of STNA #211 revealed her usual assignment included Resident #57. STNA #211 confirmed she was too busy on 05/15/24 to give Resident #57 her shower until 3:00 P.M., and she was too busy to get back to her room to change her gown and help her get dressed until she gave Resident #57 a shower at 3:00 P.M. STNA #211 stated she told Resident #57 around 8:30 A.M. she would be back to help her get dressed, but things went haywire and she could not get back to Resident #57 to assist her. STNA #211 stated when she finally was able to get back to Resident #57 her gown and incontinence brief were saturated with urine. STNA #211 indicated Resident #57 wanted to get up earlier today, but she did not have time to get her up until 3:00 P.M. when she received her shower. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Resident Call System revised 03/2023 included the staff would provide an environment to assist in meeting the needs of the resident and to provide an environment which supported and enhanced each resident's quality of life, providing the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. Respond to resident's call lights in a timely manner. Do not turn off the light if you were unable to meet the resident's needs. Review of the facility policy titled incontinence care dated 2022 included to 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 non-compliance investigated under Complaint Number OH00153017.

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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** 42013 Based on interview, record review, and review of manufacturer's instructions the facility failed to ensure a resident had physician orders and instructions for the care and monitoring of her wound incision management system. This affected one resident (#92) out of three residents reviewed for post surgical care. The facility census was 91. Findings include: Review of Resident #92's medical record revealed an admitted [DATE] and diagnoses included displaced malleolar fracture of left lower leg, schizoaffective disorder, and bipolar disorder. Resident #92 was discharged from the facility on 04/12/24. Review of Resident #92's After Visit Summary for hospital stay dated 03/02/24 through 03/08/24 included Resident #92 had a left trimalleolar ankle fracture with a planned surgery scheduled on 03/12/24. Review of Resident #92's Physician progress notes dated 03/11/24 at 8:36 P.M. included Resident #92 had a left ankle trimalleolar fracture and surgery was planned for 03/12/24. Review of Resident #92's progress notes dated 03/12/24 at 9:17 A.M. revealed Resident #92 was having a procedure done at the local hospital. Review of Resident #92's After Visit Summary dated 03/12/24 included Resident #92 had an operation and the procedure was ORIF (open reduction internal fixation) ankle trimalleolar, without fixation posterior lip, Accumed fibular nail (left). A type of surgery used to stabilize and heal a broken bone. Review of Resident #92's care plan did not reveal a care plan for monitoring and ensuring Resident #92's surgical vac was functioning appropriately. Review of Resident #92's progress notes dated 03/12/24 did not reveal evidence Resident #92 returned to the facility after having surgery, no evidence an assessment of the surgical site was completed including if she had a cast on her left leg, or if Resident #92 returned to the facility with a surgical vac. The progress notes did not state Resident #92 returned with discharge instruction orders. Review of Resident #92's progress notes from 03/12/24 through 03/15/24 did not reveal evidence Resident #92 had an assessment of her surgical site, cast on left leg, or a surgical vac. Review of Resident #92's physician orders dated 03/12/24 revealed Provena wound vac on for 14 days. Review of Resident #92's physician orders from 03/12/24 through her discharge on 04/12/24 did not reveal instructions for the care and monitoring of Resident #92's surgical vac to ensure the surgical vac was functioning appropriately. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of FAQ (frequently asked questions) information regarding Provena Incision Management System, (undated), included if at any time while using the Provena Incision Management System the cannister became full of fluid other than blood, indicated by a Maximum Capacity alert or visual inspection, turn therapy unit off and contact the treating physician. A small amount of drainage was expected in the cannister. If the cannister filled in one to two days, notify the physician. If there was no drainage from the wound, and wound V.A.C was turned on the dressing was compressed. The Wound V.A.C. was working to pull the wound edges together and increase the rate of healing. By double pressing the on and off button, the unit would display the leak rate of the system for three seconds. To prevent nuisance leak alarms, the leak rate status should be Best (one light illuminated) or Good (two lights illuminated). Review of Resident #92's Medication Administration Record (MAR) from 03/12/24 through 04/12/24 did not reveal Resident #92's surgical vac was monitored to ensure the surgical vac was functioning appropriately. Review of Resident #92's progress notes dated 03/15/24 at 11:57 A.M. included the nurse responded to Resident #92's call light and Resident #92 reported her wound vac had become disconnected. The nurse and another nurse reconnected the would vac but no suction was detected. The two nurse's attempted to achieve a suction but were unsuccessful. The oncoming nurse was notified. There was no documentation Resident #92's physician was notified of the wound vac becoming disconnected or the nurse was unable to achieve a suction. Review of Resident #92's Admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #92 had moderate cognitive impairment. Review of Resident #92's progress notes dated 03/15/24 through 03/23/24 did not reveal evidence Resident #92's wound vac was able to achieve a suction, and if it was draining appropriately. Review of Resident #92's progress notes dated 03/23/24 at 2:01 P.M. included the nurse spoke with Family Member (FM) #272 regarding Resident #92's surgical vac which was placed on 03/12/24 and was supposed to be on for two weeks. There was no documentation on the discharge paperwork from Resident #92's surgery that mentioned the surgical vac or how long it was supposed to stay on. Typically the surgical vac lasted five to seven days and shut off automatically. FM #272 stated the surgical vac just needed plugged in. The surgical vac had no drainage noted and Resident #92's surgeon was called for instructions on how the facility should proceed with the surgical vac. Would continue to monitor the wound vac. Review of Resident #92's progress notes dated 03/24/24 at 5:19 P.M. included Resident #92's wound vac was connected and running and no drainage was noted in the cannister or tubing. Review of Resident #92's progress notes dated 03/25/24 at 3:08 P.M. included the nurse spoke with Resident #92's surgeon and a new order was given to discontinue the wound vac. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/16/24 at 2:30 P.M. of the director of nursing (DON) and Unit Manager (UM) #109 revealed Resident #92 left for facility on 03/12/24 for a scheduled surgery, and returned the same day. The DON stated when Resident #92 returned to the facility, the ambulance driver did not have a packet with discharge instructions to give to the nurse. The DON indicated several days went by, and FM #272 found discharge instructions on 03/16/24 in a bag which came back with Resident #92 on 03/12/24 which was the day of her surgery. The DON and UM #109 stated in their realm sometimes papers got misplaced or taken home by families. The DON stated she spoke to Registered Nurse (RN) #164, the nurse who admitted Resident #92 back to the facility after her surgery. RN #164 told the DON that Resident #92 did not return from her surgery with any discharge instructions. The DON stated Resident #92 returned the same day she had her surgery, and her previous orders did not need to be verified. The DON confirmed there were no evidence of physician orders or instructions regarding the care of Resident #92's surgical vac in her medical record. The DON stated it was just part of Resident #92's daily assessment and did not have to be documented. The DON indicated the nurse's routinely did CMS checks (circulatory motor sensory) on Resident #92's left foot but it was not documented. Interview on 05/16/24 at 5:20 P.M. of Registered Nurse (RN) #164 revealed on 03/12/24 when Resident #92 returned to the facility after having surgery it was shift change and things were very chaotic. RN #164 stated that was probably why she did not document Resident #92 returned from surgery in the progress notes, and Resident #92 did not have orders when she returned. RN #164 stated Resident #92 had a pink cast on her left ankle, she checked her foot for warmth and capillary refill, and made sure the wound vac was working. RN #164 stated she did not remember specifics about Resident #92's return and if she had a dressing or where the wound vac was located. This deficiency represents non-compliance investigated under Complaint Number OH00153139.

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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 facility policy the facility failed to ensure a resident had a comprehensive pain assessment upon admission and failed to ensure a comprehensive pain reevaluation after a narcotic medication was discontinued. Additionally the facility failed to ensure Resident #95's narcotic pain medication was available. This affected one resident (#95) out of three residents reviewed for pain. Findings include: Review of Resident #95's medical record revealed an admitted [DATE] and diagnoses included burn of unspecified degree of right lower leg, burn of unspecified body region, and personal history of malignant neoplasm of other organs and systems. Review of Resident #95's progress notes dated [DATE] at 7:45 P.M. included Resident #95 was admitted to the facility via ambulance from the local hospital. Resident #95's admitting diagnosis was burn on right leg. Resident #95 was alert and oriented times four (person, place, time, event) and able to make needs known. Review of Resident #95's Nursing: Pain assessment dated [DATE] revealed it was not started or completed. Review of Resident #95's physician orders dated [DATE] revealed to assess pain every shift. If pain present, intervention and documentation required. Attempt and document non-pharmacological interventions prior to medication administration. Review of Resident #95's physician orders dated [DATE] revealed oxycodone HCl oral tablet 5 milligram (mg), give one tablet by mouth every four hours as needed for pain (burn on leg) for three days. Resident #95's order for oxycodone was discontinued on [DATE] and his medical record did not reveal evidence a comprehensive pain assessment was completed after the oxycodone was discontinued. Review of Resident #95's Medication Administration Record (MAR) dated [DATE] included to assess pain every shift. If pain present, intervention, and documentation required. Attempt and document non-pharmacological interventions prior to medication administration, every shift for routine monitoring. Further review revealed Resident #95's pain level was a zero on a scale of one to ten, and ten being the worst pain. There were no non-pharmacological interventions implemented. Review of Resident #95's hospital History and Physical dated [DATE] included Resident #95 was recently admitted to the hospital due to burn on his right leg. Resident #95 was admitted to the burn unit, and taken to the OR (operating room) several times for excision and grafting, debridement and polynovo placement (a biodegradable temporizing dermal matrix designed to aid the body in regenerating new tissue for wound closure and reconstruction of complex wounds). Wound doctor had been consulted and would be responsible for the evaluation and comprehensive management of the wound including appropriate control of complicating factors such as unrelieved pressure, infection, vascular and, or uncontrolled metabolic derangement and, or nutritional deficiency in addition to appropriate debridement. (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 #95's Physical Therapy Evaluation dated [DATE] included Resident #95 had a burn of unspecified degree of right lower leg and burn of unspecified body region. Resident #95's car caught on fire while he was driving it, which resulted in a right foot burn, and he was hospitalized for severe right foot burns and subsequent skin grafting. This resulted in a new onset in decreased ability to perform functional mobility tasks at independence level required for Resident #95 to safely return to his previous living situation at this time Resident #95 stated he had pain and hurting in the last five days, and had pain that interfered with and limited functional activity. Nursing to address if skilled therapy was needed to address pain. Resident #95 had moderate pain in the right lower extremity. Review of Resident #95's Occupational Therapy Evaluation dated [DATE] included Resident #95 had pain or hurting in the last five days, and the pain was severe. The location of the pain was Resident #95's right ankle, foot, leg. Further review included due to the documented deficits and Resident #95's pain severity level and severity of functional limitations, without skilled therapeutic intervention, Resident #95 was at risk for rehospitalization , decreased ability to return to prior level of function, decreased ability to return to prior living environment, inability to remain at home, decrease in level of mobility, decreased participation with functional tasks, decreased participation in occupations of choice, falls, further decline in function and increased dependency upon caregivers. Review of Resident #95's MAR with a start date of [DATE] included to assess pain every shift. If pain present, intervention, and documentation required. Attempt and document non-pharmacological interventions prior to medication administration. Further review on [DATE], [DATE], and [DATE] revealed there was no pain assessment documented including a pain level score for pain on a scale of zero to ten, and ten being the worst pain. On [DATE] a pain level score of zero was documented with no non-pharmacological interventions implemented. Review of Resident #95's MAR dated [DATE] through [DATE] revealed to assess pain every shift, if pain present, intervention and documentation required. Attempt and document non-pharmacological interventions prior to medication administration. There were check marks documented on the MAR each shift, but no pain level was recorded. Review of Resident #95's MAR dated [DATE] revealed oxycodone HCl oral tablet 5 mg was administered at 4:04 P.M. for a pain level of 3 on a pain scale of zero to ten and ten being the worst pain, and it was effective. (Resident #95 received acetaminophen 650 mg at the same time). Further review from [DATE] at 4:04 P.M. through [DATE] revealed no oxycodone was administered. Review of Resident #95's MAR dated [DATE] revealed acetaminophen oral tablet 325 mg, give two tablets by mouth every six hours as needed for pain. Resident #95 received two Tylenol tablets at 4:05 P.M. for a pain level of four, on a scale of one to ten, and it was effective. Further review revealed on [DATE] at 7:39 P. M. Resident #95 received two Tylenol tablets for a pain level of two and it was effective. Review of Resident #95's MAR dated [DATE] at 10:39 A.M. revealed Resident #95 received acetaminophen 325 mg, two tablets and ibuprofen 400 mg by mouth for a pain level of 3. (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 [DATE] at 11:47 A.M. of Resident #95 revealed the transition from the hospital to the facility revealed differences in the way things were done. Resident #95 stated he had to ask for pain medication in the facility and it was not automatically given when it was due. Resident #95 stated it was not explained to him when he was admitted that he would have to ask for oxycodone. Resident #95 stated he did not have oxycodone for days, and when he did ask for oxycodone the nurse told him he could not have it. Resident #95 stated his leg was throbbing, he could not sleep, and he was not given oxycodone, and this happened yesterday ([DATE]). Resident #95 stated it was hard to get answers at the facility, and the hospital was easy. Resident #95 indicated his oxycodone was not ordered, and was only ordered for a couple days, and he had to fight to have Motrin (ibuprofen) administered. Resident #95 stated he had a burn on his leg because he was driving his pickup truck, it caught on fire, he should have jumped out sooner than he did, and his leg was burned. Resident #95 stated the burn was bad, was from the knee down and the pain was horrible. Resident #95 stated he did not jump out of his pickup truck sooner because he did not want to hit a house and burn it down. Resident #95 indicated he already had two surgeries for the burns and he needed to have a third surgery. Resident #95 stated he left the hospital, they said everything would be fine and it was not fine at the facility. Resident #95 stated the Physical Therapy was so painful he was not able to do it, he asked for something for pain, and asked for oxycodone. Resident #95 stated he needed the oxycodone and last night he was in misery. Review of Resident #95's physician orders dated [DATE] at 11:49 A.M. revealed oxycodone HCl oral tablet 5 mg, give one tablet by mouth every six hours as needed for pain (burn on leg). Interview on [DATE] at 12:04 P.M. of Licensed Practical Nurse (LPN) #186 revealed she gave Resident #95 Tylenol and ibuprofen at 10:30 A.M. LPN #186 stated Resident #95 had a three day prescription for oxycodone that had to be reinstated, and she placed a call to Resident #95's Nurse Practitioner about 30 minutes ago. LPN #186 stated she did not work on [DATE] and did not know why Resident #95's oxycodone was not ordered before today. Interview on [DATE] at 2:17 P.M. of the Director of Nursing (DON) revealed when a resident was admitted to the facility the Admission Assessment should be completed within 24 hours and the other Assessments such as the Nursing Pain Assessment should be completed within three days. The DON confirmed Resident #95's Pain Assessment was not completed. The DON confirmed Resident #95's MAR had check marks each shift indicating Resident #95's pain was assessed, but there was no evidence pain assessments were completed for each shift from [DATE] through [DATE]. The DON stated Resident #95 was not consistent with taking oxy, and some nurses start with Tylenol (acetaminophen) and progress as needed. The DON stated LPN #183 educated Resident #95 that he needed to ask for pain medication, and confirmed there was no evidence of the education in Resident #95's progress notes. (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 [DATE] at 2:02 P.M. of Director of Rehab (DOR) #273 revealed Resident #95 had Physical Therapy and Occupational Therapy, and needed to participate more in his therapy. DOR #273 stated Resident #95 was only out of bed for 20 minutes and he requested to go back to bed. DOR #273 stated Resident #95 stood up one time, said he was in pain and his pain level was a ten (severe pain on a pain scale of one to ten, ten being the worst pain). DOR #273 stated Resident #95's leg caught on fire. After Resident #95 was assisted back to bed DOR #273 stated he followed up at 1:00 P.M. and was told Resident #95 received Tylenol and ibuprofen at 10:30 A.M. DOR #273 stated at 1:00 P.M. Resident #95 confirmed he received Tylenol and ibuprofen, but said he was in too much pain because the effects of the medication were wearing off and he did not want to try therapy. DOR #273 stated Resident #95 told him there was an issue with his pain medication (oxycodone) being available to him, and if he received his pain medication, he would do therapy. Review of Resident #95's Physical Therapy Treatment Encounter Noted dated [DATE] at 2:02 P.M. revealed response to treatment included Resident #95 limited the session due to increased pain in the right lower extremity. Resident #95 requested to go back to bed despite before being up for 30 minutes prior to session. Resident #95 encouraged to increase his OOB (out of bed) time as Resident #95 routinely requested to go back to bed shortly after getting up saying shaving and toileting take a lot out of him. Resident #95 and the PTA (physical therapy assistant) discussed scheduling sessions around pain medications to maximize outcomes which Resident #95 agreed to. Resident #95 declined to have therapy after Tylenol (acetaminophen) was administered due to pain in right lower extremity. Review of Resident #95's Physical Therapy Treatment Encounter Note dated [DATE] at 2:23 P.M. included there were changes to the previous note. Resident #95 limited the session due to increased pain in right lower extremity. Observation on [DATE] at 4:02 P.M. of State tested Nurse Aide (STNA) #194 revealed she walked in Resident #95's room and had a conversation with him. STNA #194 stated Resident #95 told her his pain medication was expired and he was not receiving it and he wanted his pain medication. Interview on [DATE] at 4:30 P.M. of State tested Nursing Assistant (STNA) #233 revealed she worked on [DATE] from 6:00 P.M. through [DATE] at 6:00 A.M. STNA #233 stated Resident #95 had a burn and a skin graft, he said he was in pain and would like his pain medication. Resident #95 stated earlier in the day it was explained to him that he had to ask for his pain medication. STNA #233 stated Resident #95 said he wanted his oxycodone, and wanted to know why he could not have it. STNA #233 indicated she told the nurse Resident #95 wanted his oxycodone. Review of the facility policy titled Pain Management revised ,d+[DATE] included the purpose 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 significant change, new onset of pain and incident. Indicators of pain included non-verbal behavior such as resisting care, decreased participation in usual physical and or social activities and difficulty sleeping. The licensed nurse would assess the following as necessary including impact of pain on day-to-day activities, and activities or treatments that might precipitate pain. Discuss resident's goals for pain management and effectiveness with the current level of pain control. This deficiency represents incidental findings of non-compliance investigated under Complaint Number OH00153139.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013 Based on observation, interview, record review, and policy review, the facility failed to provide sufficient staff to provide the needed care and services to all residents. This had the potential to affect all 91 residents in the facility. The facility census was 91. Findings include: Review of Resident Council Minutes dated 03/25/24 revealed residents stated call light response times were at times longer than they would like, however residents were unable to give time of day, night or weekend, weekday. Review of Resident #57's medical record revealed an admitted [DATE] and diagnoses included sepsis, unspecified organism, type two diabetes mellitus with ketoacidosis without coma, cellulitis of lower limb and acute respiratory failure with hypoxia. Review of Resident #57's care plan dated 04/01/24 included Resident #57 had bladder incontinence. Resident #57 would decrease frequency of urinary incontinence through the next review date. Interventions included to check every two hours and as required for incontinence, and to wash, rinse, and dry perineum and change clothing as needed after incontinence episodes. Resident #57 was dependent on staff for meeting emotional, intellectual, physical and social needs due to physical limitations. Interventions included encouraging and allowing choice, self-expression and responsibility. Resident #57 had an ADL (Activity of Daily Living) self-care performance deficit related to sepsis and diagnoses. Resident #57 would improve current level of function in ADL's through the review date of 07/11/24. Interventions included Resident #57 required assistance of one staff with bathing and showering as necessary; Resident #57 required assistance of one staff to dress; Resident #57 required assistance of one staff with personal hygiene and oral care. Resident #57 required assistance of one staff to turn and reposition in bed every two hours and as necessary. Resident #57 was a two person assist with slide board for all transfers. Review of Resident #57's Admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #57 was cognitively intact. Resident #57 was always incontinent of urine and frequently incontinent of bowel. Observation on 05/15/24 at 2:24 P.M. of Resident #57's room revealed a light was blinking above the door to her room indicating Resident #57 had activated her call light. Interview on 05/15/24 at 2:24 P.M. of Family Member (FM) #270 revealed she was visiting her mother, and on 05/15/24 around 12:00 P.M. FM #270 noticed Resident #57's call light was activated. FM #270 stated Resident #57's call light was on the entire two hours she visited her mother. Observation on 05/15/24 at 2:24 P.M. of the south side nurses station revealed a monitor sitting on the desk at the nurses station. Several resident rooms were displayed on the monitor including Resident #57's indicating call lights were activated but there no sound heard from the monitor to alert staff call lights were activated. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 05/15/24 at 2:26 P.M. of State tested Nursing Assistant (STNA) #211 revealed she entered Resident #57's room to answer the call light. STNA #211 walked out of Resident #57's room and stated she was assigned to take care of Resident #57 from 6:00 A.M. until 6:00 P.M. STNA #211 accompanied the surveyor to the nurses station and confirmed the monitor had resident rooms displayed indicating call lights were activated, but no sound could be heard from the monitor. STNA #211 stated there should be a beeping sound coming from the monitor. Observation on 05/15/24 at 2:30 P.M. of Resident #57 revealed she was lying in bed, the blinds covering the window were closed and the lighting in the room was dim. Resident #57 was wearing a hospital gown and the bottom half of the gown was observed to be very wet. Resident #57 stated the gown was very wet with urine. Interview on 05/15/24 at 2:30 P.M. revealed Resident #57 stated she wanted to get out of bed, and she had her light on for at least 45 minutes. Resident #57 stated when the facility was short handed her call light was on a long time before it was answered. Resident #57 stated she talked to STNA #211 at around 8:30 A.M., and STNA #211 was too busy at that time to give her a shower, but told her she would be back to dress her, then she could have her shower later in the day. Resident #57 indicated STNA #211 never returned to help her get dressed, and now her gown was wet from her diaper because she could not hold her urine. Resident #57 stated her incontinence brief was soaked with urine, her gown was soaked with urine, she was still in her pajamas at 2:30 P.M., and shouldn't the staff check her every two hours to see if her incontinence brief needed changed? Resident #57 again stated she wanted out of bed and the blind on the window needed to be raised if nothing else could be done. Resident #57 stated the blinds were closed all day, and she could not look out of the window. Interview on 05/15/24 at 2:43 P.M. revealed STNA #211 stated the only way to know call lights were activated was to hear beeping from the monitor on the desk at the nurses station or to see the light flashing above the resident's door. Interview on 05/15/24 at 2:39 P.M. of Licensed Practical Nurse (LPN) #170 revealed she was sitting at the South nursing unit nurse's station and stated it had been a very busy day. LPN #170 confirmed the monitor at the nurses station showed resident call lights were activated, but the monitor was not making a beeping sound, or any sound at all to alert staff a call light was activated. LPN #170 stated she had not heard any sound from the monitor all day, including beeping, and did not know how to adjust the volume. LPN #170 stated she was supposed to be finished with her shift at 2:30 P.M., but she did not have time until now to complete her charting, and she would stay until she was finished. LPN #170 revealed she usually stayed 15 to 30 minutes past her shift to finish her charting. Interview on 05/15/24 at 3:10 P.M. of the Administrator and Director of Nursing (DON) revealed staff answered resident call lights when they were activated, but call lights were left on until the resident's need was met. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 05/15/24 at 3:57 P.M. of STNA #211 revealed her usual assignment included Resident #57. STNA #211 confirmed she was too busy on 05/15/24 to give Resident #57 her shower until 3:00 P.M., and she was too busy to get back to her room to change her gown and help her get dressed until she gave Resident #57 a shower at 3:00 P.M. STNA #211 stated she told Resident #57 around 8:30 A.M. she would be back to help her get dressed, but things went haywire and she could not get back to Resident #57 to assist her. STNA #211 stated when she finally was able to get back to Resident #57 her gown and incontinence brief were saturated with urine. STNA #211 stated only three STNA's were assigned to the South nursing unit today from 6:00 A.M. until 2:00 P.M. and there were usually four STNA's assigned, but sometimes the STNA's did not show up. STNA #211 was not sure why there were only three STNA's today. STNA #211 indicated Resident #57 wanted to get up earlier today, but she did not have time to get her up until 3:00 P.M. when she received her shower. STNA #211 stated her assignment included resident's in two hallways of the nursing unit, and it was hard to know when a call light was activated on the first part of her assignment. STNA #211 indicated if call lights were activated on the first part of her assignment, which included Resident #57, she had to walk around the corner and look above resident's doors or check the monitor at the nurses station which should be beeping to alert her call lights were activated. Observation on 05/15/24 at 3:57 P.M. of the South nursing unit and STNA #211's resident assignment revealed the South nursing unit hall which included Resident #57's room intersected a second long hall, and a left turn around a corner had to be made to access the rest of the resident rooms in STNA #211's assignment. Call lights could only be visualized if staff walked to the intersection of the two halls, or checked the monitor at the nurses station. Interview on 05/16/24 at 8:36 A.M. Unit Manager (UM) #181 revealed she did not adjust the volume on the call light monitor located at the South nursing unit nurse's station. UM #181 stated she did not know how the volume was adjusted on the monitor, and if she could not hear the alarm beeping on the monitor she called Maintenance Supervisor (MS) #601. UM #181 stated she assisted staff with answering call lights and tried to meet resident needs. Interview on 05/16/24 at 8:54 A.M. of Maintenance Staff (MS) #601 revealed he did not know how the call light system worked, and he was not handy with computers. MS #601 stated staff did not call him with call light monitor volume issues, and he was not called when the volume on the call light monitors located at the nursing station needed turned up or down. Interview on 05/16/24 at 9:00 A.M. of STNA #235 revealed the volume on the South nursing unit call light monitor located at the nurse's station was sometimes turned off. STNA #235 stated she had Resident #57 in her assignment and walked back and forth constantly between the two halls to check call lights. STNA #235 stated you have to keep your head on a swivel to know if call lights were on in the hall around the corner. STNA #235 stated when only three STNA's were assigned to the South nursing unit it was essential to work as a team, and if an STNA who wasn't a team player was assigned it was hard to complete the work that needed done. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 05/16/24 at 9:09 A.M. of the Administrator revealed she did not adjust the volume of the call light monitors located at the nurse's stations, and thought the volume could be turned up and down at the nurses station. The Administrator stated she did not know how the call light system worked, and the system had been in operation since she started working at the facility. The Administrator indicated she walked up and down the halls and answered call lights if she saw them blinking above resident doors. The Administrator stated there was not a central location for turning the call light volume on or off, or adjusting the volume. Observation on 05/16/24 at 2:25 P.M. of Unit Manager (UM) #109 revealed she pointed to the lower left corner of the call light monitor at a volume icon, and stated that was how the volume was adjusted. Observation on 05/20/24 revealed Resident #95's call light was activated from 9:08 A.M. until 9:36 A.M. (18 minutes) before it was answered by STNA #203. Interview on 05/20/24 at 9:34 A.M. of Resident #65 revealed call light response times were not very fast, she waited a long time for her call light to be answered, but could not state when her call light was not answered timely. Interview on 05/20/24 at 9:36 A.M. of STNA #203 revealed she was in a resident room assisting with bathing, and did not know Resident #95's call light was activated. STNA #203 stated when she was in a room assisting a resident the other STNA's and nurses should watch for call lights and answer them promptly. Interview on 05/20/24 at 9:51 A.M. of Resident #85 revealed the length of time it took for call lights to be answered depended on what was going on when the call light was activated. Resident #85 stated if the STNA's were passing meal trays they did not stop to answer call lights, and it took awhile to get the call light answered during meal times. Resident #85 indicated she was independent with most of her care, did not require a lot of help from the STNA's, and her call light was usually answered in about 15 to 20 minutes. Resident #85 stated the STNA's taking care of her were very good, but other residents waited much longer for their call lights to be answered by the staff. Interview on 05/20/24 at 10:23 A.M. of Resident #42 revealed she was the Resident Council President. Resident #42 stated when the facility was short handed call lights were not answered timely. Resident #42 indicated when Residents told her their call lights did not get answered timely, she told them not to be upset and to be patient because the facility was short staffed and would eventually get to them. Interview on 05/20/24 at 11:47 A.M. of Resident #95 revealed his call light was on today for around 15 to 20 minutes, it was not too long of a wait, but by the time the STNA came in to help him he was feeling like he wasn't going to be able to hold his urine. Resident #95 stated he had waited as long as an hour and a half for his call light to be answered. Resident #95 stated the staff did not come in timely to see if what he needed was urgent, or to tell him when they would be able to assist him, and they just came in his room when they were ready. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 05/20/24 at 12:59 P.M. of the Administrator and Director of Nursing (DON) revealed Resident #57 refused to dress until she had her shower, and she had her shower later in the day. The Administrator stated call light audits were completed and most of the call lights were answered in about 10 to 15 minutes and that was a reasonable time frame. The Administrator stated 18 minutes was not an unreasonable amount of time to wait for a call light to be answered, and the question to ask was were the residents needs met? The DON stated resident perception could be that it took longer than it actually was for the call light to be answered. Review of a facility list of alert and oriented residents included Resident's #42, #57, #58, #65, #83 were alert and oriented. Review of the facility policy titled Resident Call System revised 03/2023 included the staff would provide an environment to assist in meeting the needs of the resident and to provide an environment which supported and enhanced each resident's quality of life, providing the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. Respond to resident's call lights in a timely manner. Do not turn off the light if you were unable to meet the resident's needs. Review of the facility policy titled incontinence care dated 2022 included to 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 non-compliance investigated under Complaint Number OH00153017.

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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** 42013 Based on interview, record review and review of the facility policy the facility failed to ensure residents were free from significant medication errors. This affected one resident (#92) out of four residents reviewed for medications per physician orders. The facility census was 91. Findings include: Review of Resident #92's medical record revealed an admitted [DATE] and diagnoses included displaced malleolar fracture of left lower leg, schizoaffective disorder, and bipolar disorder. Resident #92 was discharged from the facility on 04/12/24. Review of Resident #92's After Visit Summary for hospital stay dated 03/02/24 through 03/08/24 included Resident #92 had a left trimalleolar ankle fracture with a planned surgery scheduled on 03/12/24. Resident #92 was evaluated by psychiatry for her schizoaffective disorder and would need a risperidone injection on 03/15/24 either in the hospital or at the rehab (facility). Review of Resident #92's progress notes dated 03/08/24 at 10:30 P.M. included Resident #92 arrived to the facility from the hospital, orders were placed and Medical Director (MD) #271 reviewed and confirmed all orders. Review of Resident #92's progress notes from 03/08/24 through 03/14/24 did not reveal documentation regarding Resident #92's risperidone injection and why it was not ordered until 03/14/24, when it was included on Resident #92's discharge instructions from the hospital on 03/08/24. Review of Resident #92's Physician progress notes dated 03/11/24 at 8:36 P.M. included Resident #92 had a left ankle trimalleolar fracture and surgery was planned for 03/12/24. Resident #92 had schizoaffective disorder with intermittent hallucinations which was new. Continue Resident #92's medications and Resident #92 would need her biweekly risperidone shot on 03/15/24. Review of Resident #92's care plan dated 03/12/24 included Resident #92 used psychotropic (included antipsychotic) medications related to schizoaffective disorder and bipolar disorder. Resident #92 would remain free of psychotropic drug related complications, including movement disorder, discomfort, cognitive or behavioral impairment through the review date. Interventions included to administer psychotropic medications as ordered by the physician and monitor for side effects and effectiveness; to monitor, document, report adverse reactions of psychotropic medications including behavior symptom not usual. Resident #92 was on pain medication therapy related to fracture of left leg and other diagnoses. Resident #92 would be free of discomfort or adverse side effects from pain medication through the review date. Interventions included to administer analgesic medications as ordered by the physician and monitor, document for side effects and effectiveness. Review of Resident #92's After Visit Summary dated 03/12/24 included Resident #92 had an operation and the procedure was ORIF (open reduction internal fixation) ankle trimalleolar, without fixation posterior lip, Accumed fibular nail (left). A type of surgery used to stabilize and heal a broken bone. Further review included Resident #92 was to start taking Gabapentin (commonly know as neurontin) 300 mg capsule, take one capsule by mouth three times a day for 30 days. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #92's progress notes dated 03/12/24 did not reveal documentation Resident #92 returned to the facility after having surgery, an assessment of the surgical site was completed, and if she had discharge instruction orders. Review of Resident #92's physician orders dated 03/14/24 revealed risperidone ER intramuscular suspension, reconstituted ER 50 mg, inject 50 mg intramuscular in the morning every Friday related to schizoaffective disorder. Review of Resident #92's Admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #92 had moderate cognitive impairment. Resident #92 received antipsychotic medication. Review of Resident #92's progress notes dated 03/15/24 at 1:35 P.M. included risperidone ER intramuscular suspension reconstituted ER 50 milligrams (mg), inject 50 mg in the morning every Friday related to to schizoaffective disorder, unspecified. Patient was contacting physician office to see if Resident #92 could receive the risperidone injection at the office. There was no documentation explaining why Resident #92 did not receive the risperidone injection at the facility on 03/15/24 when it was ordered by her physician to be given, or that Resident #92's physician was notified Resident #92 did not receive the risperidone injection. Review of Resident #92's progress notes dated 03/15/24 through 03/27/24 did not reveal evidence MD #271 was notified Resident #92's risperidone injection was not administered. Review of Resident #92's physician orders dated 03/16/24 revealed Gabapentin oral capsule 300 mg, give 300 mg by mouth three times a day for leg pain for 30 days. Resident #92's After Visit Summary on 03/12/24 stated to start Gabapentin 300 mg capsule, three times a day, on 03/12/24. Review of Resident #92's Medication Administration Record (MAR) dated 03/12/24 through 03/16/24 did not reveal Gabapentin 300 mg oral capsule was administered until 03/16/24. Review of Resident #92's progress notes dated 03/18/24 the Health and Wellness Center where Resident #92 received her risperidone injection was contacted, and an appointment was made for 03/22/24. Resident #92 and Family Member (FM) #272 were notified. FM #272 stated she would call the physician office because Resident #92 should not wait that long for her injection. The nurse explained to FM #272 she called the physician office to call the risperidone in to the local pharmacy and the physician office stated it would be easier for Resident #92 to get the risperidone injection in the office. FM #272 stated she would call the physician office to see what could be done. Review of Resident #92's progress notes dated 03/22/24 at 3:31 P.M. included Resident #92 returned from her appointment and stated she did not get her shot while she was there. Resident #92 showed no behaviors this shift. Review of Resident #92's progress notes dated 03/22/24 through 03/27/24 did not reveal documentation why Resident #92 did not receive a risperidone injection while she was at her appointment on 03/22/24, what was being done to obtain the injection or when it would be administered. Review of Resident #92's physician orders dated 03/27/24 revealed risperidone ER intramuscular suspension, reconstituted ER 50 mg, inject 50 mg intramuscular in the morning every two weeks on Wednesdays related to schizoaffective disorder. (continued on next page)

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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	Review of Resident #92's progress notes dated 03/27/24 at 5:16 P.M. included Resident #92 received her Risperdal (risperidone) injection, which was 12 days after it was ordered to be given. Review of Resident #92's progress notes dated 03/08/24 through 03/27/24 did not reveal evidence FM #272 or Resident #92's physician were notified of the reason risperidone injection was not administered to Resident #92. Interview on 05/15/24 at 4:35 P.M. of FM #272 revealed during Resident #92's care conference on 03/14/24 Unit Manager (UM) #109 said she ordered Resident #92's risperidone 50 mg injection which was due on 03/15/24. FM #272 stated Resident #92 did not receive the risperidone injection on 03/15/24, no follow-up was done until 03/19/24 when UM #109 made an appointment on 03/22/24 with Resident #92's psychiatrist for her to receive the risperidone and she still did not receive the risperidone because her physician did not have it. FM #272 stated Resident #92 returned from her appointment without receiving the risperidone injection and there was no follow up by UM #109 or the nurse until the following Monday (03/27/24). FM #272 stated she had to call Resident #92's psychiatrist to have him send a prescription for risperidone to the local pharmacy, she picked the risperidone up from the pharmacy on 03/26/24 and took it to the facility. FM #272 indicated she handed the risperidone injection to Licensed Practical Nurse (LPN) #169 at around 4:30 P.M. and thought he was going to make sure Resident #92 received the risperidone, but Resident #92 did not receive the risperidone until the next day. FM #272 stated Resident #92 called her on 03/27/24, said she still did not get her injection, and asked who she gave the injection to. FM #272 revealed she called the Director of Nursing (DON) and asked why Resident #92 did not receive her risperidone, and the DON said she would look into it and call her back. FM #272 stated the DON did not call her back, but Resident #92 called her and told her she received her injection. UM #109 called and left a message stating Resident #92 received the risperidone injection. FM #272 stated Resident #92 had a behavioral health diagnosis and received her risperidone injection on 03/27/24 instead of 03/15/24, which was 12 days after it was ordered to be administered. FM #272 stated in addition to not receiving her risperidone injection as ordered by the physician Resident #92 did not receive Gabapentin which was ordered on 03/12/24 until 03/16/24. Interview on 05/16/24 at 2:17 P.M. of Licensed Practical Nurse (LPN) #169 revealed he remembered Resident #92 received a risperidone injection, and FM #272 picked it up from the pharmacy and brought it to the facility. LPN #169 stated the risperidone injection was not at the facility on the date it was supposed to start. LPN #169 indicated it was about 4:00 P.M., he was sitting at the nurse's station, FM #272 handed the risperidone injection to him, he did not administer Resident #92's risperidone injection, but put it in the refrigerator in the medication room. LPN #169 stated his usual practice was to notify UM #109 when a medication arrived, but he did not remember if he notified her. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366431	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/20/2024
NAME OF PROVIDER OR SUPPLIER: Avenue at Aurora		STREET ADDRESS, CITY, STATE, ZIP CODE: 425 South Chillicothe Road Aurora, OH 44202	

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/16/24 at 2:25 P.M. of UM #109 and the DON revealed they were aware on 03/08/24, when Resident #92 was admitted to the facility, that she needed a risperidone injection on 03/15/24. The DON stated Resident #92's risperidone injection was not obtained by the facility and administered to Resident #92 because it was too expensive. The DON stated FM #272 was asked if she had a risperidone injection at home they could give, but FM #272 said she did not have the medication at home. The DON stated UM #109 called Resident #92's physician, set up an appointment on 03/22/24 with the understanding she would receive the risperidone at the appointment, but Resident #92 did not receive risperidone injection at the appointment. The DON stated the physician office did not give it because they would have to pay for it. The DON stated she offered to have the risperidone called in to the local pharmacy but FM #272 wanted it given at the appointment. The DON stated because Resident #92 was receiving skilled services at the facility, the risperidone was not covered by insurance, and the facility and Resident #92's physician's office would have to eat the cost. The DON indicated that was the reason neither the facility nor the physician office administered the risperidone injection. Interview on 05/16/24 at 2:30 P.M. of the DON and UM #109 revealed Resident #92 left the faciity on [DATE] for a scheduled surgery, and returned the same day. The DON stated when Resident #92 returned to the facility, the ambulance driver did not have a packet with discharge instructions to give to the nurse. The DON indicated several days went by, and FM #272 found discharge instructions on 03/16/24 in a bag which came back with Resident #92 on 03/12/24 which was the day of her surgery. The DON stated the discharge instructions included orders for Gabapentin, FM #272 brought the instructions to their attention, and orders were placed on 03/16/24 for Gabapentin (anticonvulsant and nerve pain medication). The DON and UM #109 stated in their realm sometimes papers got misplaced or taken home by families. The DON stated she spoke to Registered Nurse (RN) #164, the nurse who admitted Resident #92 back to the facility after her surgery. RN #164 said Resident #92 did not return with any discharge instructions. The DON stated Resident #92 returned the same day she had her surgery, and her previous orders did not need to be verified. Interview on 05/16/24 at 5:20 P.M. of Registered Nurse (RN) #164 revealed on 03/12/24 when Resident #92 returned to the facility after having surgery it was shift change and things were very chaotic. RN #164 stated that was probably why she did not document Resident #92 returned from surgery in the progress notes, and Resident #92 did not have orders when she returned. Review of National Alliance on Mental Illness information on risperidone included if a dose of risperidone long-acting injection was missed, see your healthcare provider to receive your dose as soon as possible. Review of facility policy titled Medication Administration-Preparation and General Guidelines dated 12/2017 included medications were administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. The right resident, right drug, right dose, right route and right time were applied for each medication being administered. If a dose of regularly scheduled medication was withheld, refused, not available, or given at time other than the scheduled time an explanatory note was entered on the record. Nursing documents the notification and physician response. This deficiency represents non-compliance investigated under Complaint Number OH00153139.