STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366431	A. Building B. Wing	08/18/2025

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 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. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview and facility policy review, the facility failed to ensure fall prevention interventions were in place for Residents #59 and #86. This affected two (Residents #59 and #86) of three residents reviewed for accidents. The facility census was 91. Findings include:1. Review of the medical record for Resident #59 revealed an admission date of 07/02/25 with diagnoses including progressive supranuclear opthamoplegia (a rare, degenerative brain disease that affects movement, balance, and eye control), muscle weakness, colon cancer, failure to thrive, depression, and abnormal gait and mobility. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #59 was severely cognitively impaired and required setup help for eating, supervision for personal hygiene, partial to moderate assistance for oral hygiene, substantial to maximum assistance for showering and was totally dependent on staff for toileting. Review of the fall risk assessment dated [DATE] revealed Resident #59 was at risk for falls. Review of the care plan dated 08/05/25 revealed Resident #59 was at risk for falls due to weakness, history of falls and abnormal gait. Interventions included a perimeter mattress to the bed, ensuring the call light was in reach, ensuring nonslip socks were in use while in bed and ensuring she had a reacher. Review of the nursing note dated 08/07/25 at 12:00 A.M. revealed Resident #59 had an unwitnessed fall and was observed on the floor. No injury was noted; the resident's physician and daughter were notified. The resident was assessed, and her vital signs were blood pressure 144/83, temperature 97.2 degrees Fahrenheit (F), heart rate 81, and respirations 18. Review of the interdisciplinary team (IDT) fall investigation dated 08/07/25 revealed all interventions were in place at the time of the fall for Resident #59, the resident was confused and wearing improper footwear. An immediate intervention was added to encourage the resident to remain in the day room when family was not present. Observation and interview on 08/18/25 at 10:26 A.M. with Certified Nurse Aide (CNA) #204 of Resident #59's room revealed no evidence a perimeter mattress was in place nor was there a reacher anywhere in Resident #59's room. CNA #204 had no knowledge of Resident #59 having a reacher and confirmed there was not one anywhere in her room. She also confirmed Resident #59's mattress was not a perimeter mattress. Interview on 08/18/25 at 11:44 A.M, with the Director of Nursing (DON) confirmed Resident #59 had moved rooms over the weekend, and her perimeter mattress was not currently in place. She also acknowledged Resident #59 did not have her reacher in her room. 2. Review of the medical record for Resident #86 revealed an admission date of 06/27/25 with diagnoses including cerebral vascular disease, weakness of the left non-dominant side, diabetes, dementia, muscle weakness, insomnia and difficulty walking. Review of the comprehensive MDS assessment dated [DATE] revealed Resident #86 was moderately cognitively impaired. He required setup help for eating, supervision for oral care, partial to moderate assistance for toileting, dressing and personal hygiene, and substantial to maximum assistance for showering. Review of the care plan dated 06/30/25 revealed resident number 86 was at risk for falls due to limited mobility, difficulty walking and weakness. Interventions included ensuring the call light was within reach, ensuring nonslip footwear went out of bed, placing a call before you fall sign in his room in therapy as needed. Review of the fall risk assessment dated [DATE] revealed Resident #86 was at risk for falls. Review of the nursing progress note dated 07/03/25 at 6:04 P.M. revealed Resident # 86 was transferring himself from the wheelchair to the toilet. He stated his legs began to give out, and when he tried to sit back in his wheelchair, he missed. He was assessed, and his blood pressure was 130/69, heart rate 93, respirations 18, temperature 98.6 degrees F, and pulse ox 97%. No injuries were noted. The residents' family and physician were notified. Review of the IDT fall investigation dated 07/03/25 revealed no predisposing factors could be identified regarding the fall. An immediate intervention was recommended to add a call before you fall sign to Resident #86's room. Observation and interview on 08/18/25 at 10:26 A.M. with CNA #204 revealed she was unaware Resident #86 had falls since his admission, and she was unaware of any fall prevention interventions for him. Observation at the time of the interview revealed no evidence of a call before you fall sign in Resident #86's room. CNA #204 confirmed the observation. Interview on 08/18/25 at 11:44 A.M, with the DON confirmed there was no reminder to call for help sign in Resident #86's room. Review of the facility policy titled Fall Management, dated December 2022, revealed the facility would identify residents at risk for falls and develop a care plan with interventions to manage those falls. Care plans would be updated as needed with interventions to attempt to prevent further falls. This deficiency represents noncompliance investigated under Complaint Number 2581235