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	12/04/2025

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 - 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

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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 - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, review of facility fall investigations, review of hospital records, interviews and policy review, the facility failed to develop and implement a comprehensive, individualized and effective fall prevention program to ensure Resident #98's safety and supervisory needs were met to decrease the resident's risk of falls including a fall with major injury. The facility also failed to ensure fall safety interventions were in place as planned for Resident #53. This affected two (Resident #53 and #98) of three residents reviewed for falls. The facility census was 96. Actual Harm occurred on [DATE] when Resident #98, who was a new admission, was assessed at risk for falls with a history of falls following admission and with moderately impaired cognition, sustained an unwitnessed fall resulting in a cervical fracture and intracranial hemorrhage. At the time of the fall, Resident #98 was seated in a wheelchair in a common area with no staff supervision. The resident was transported to the hospital where he subsequently expired on [DATE]. Prior to the unwitnessed fall on [DATE], Resident #98 sustained falls on [DATE] and [DATE]. There was no evidence the facility had effective and individualized interventions in place or had interventions in place to meet the resident's supervisory needs to decrease his risk of falls. Findings Include: 1. Review of the closed medical record for Resident #98 revealed the resident was admitted to the facility on [DATE] with diagnoses including mild protein-calorie malnutrition, history of falls, diabetes, benign prostatic hyperplasia, mild cognitive impairment, congestive heart failure, right heel pressure ulcer, anxiety disorders, myeloproliferative disease, supraventricular tachycardia, benign paroxysmal vertigo, diverticulosis, and abnormalities of gait and mobility. Resident #98 was discharged to the hospital on [DATE] and expired at the hospital on [DATE].Review of the Fall Risk assessment dated [DATE] revealed Resident #98 was at risk for falls with a score of 20 (a score over 10 was at risk for falls).Review of the admission Care Plan dated [DATE] revealed Resident #98 was at risk for falls, safety, and elopement with a goal to minimize risks for falls and minimize injuries related to falls through the next review. Interventions included to encourage the use of a call light, instruct the resident on safety measures, maintain the call light within reach, educate the resident to use the call light, and therapy referral as needed.Review of an undated Nursing Assistant's Bedside Kardex Report for Resident #98 revealed, under the safety section, the call light was to be within reach and encourage the resident to use it for assistance as needed, encourage non-skid footwear when out of bed to minimize slipping as tolerated, follow facility fall protocol, use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface, and when conflict arises, remove resident to a calm safe environment and allow to vent and share feelings. The Kardex did not include the use of a Dycem (non-slip mat) to the resident's chair, a low bed, nor did the Kardex report address the resident's staff supervisory needs as it pertained to the resident's fall risk or accident prevention. Review of the physician orders dated [DATE] revealed Resident #98 had orders for physical therapy, occupational therapy, and bilateral grab bars for mobility and positioning.Review of the Physical Therapy Evaluation dated [DATE] revealed Resident #98 presented with a decline in functional mobility and strength after a recent hospital stay secondary to a fall (prior to admission). Upon assessment, the resident demonstrated bilateral lower extremity weakness, impaired bed mobility, impaired transfers, impaired gait, impaired balance, impaired functional activity tolerance, and guarded safety awareness preventing a safe return at home alone. The resident's needs exceeded the resources available to him as he currently required minimum assistance for bed mobility and contact guard assistance (light steady touch) for transfers and gate. Clinically the resident presented as evolving with changing characteristics recovering from the above deficits complicated by a history of congestive heart failure and recent coronavirus (COVID-19). For these reasons, the evaluation revealed the resident was a moderate complexity. It noted that physical therapy services were medically necessary at this time and if physical therapy services were not provided, the resident was at risk for further functional decline, increased dependency on others, falls, skin breakdown, social isolation, pneumonia, depression, and transitioning to an alternative living situation. The plan of treatment was for the resident to demonstrate good rehabilitation potential as evident by his ability to follow multi-step directions, he was able to make needs known, he was attentive to tasks, he had a high prior level of function, was motivated to participate, and had a strong family support system.Review of a late entry nursing note dated [DATE] at 6:58 P.M. revealed at the start of the shift Resident #98 was out in the common area sitting in a chair. At approximately 4:00 P.M. the nurse witnessed Certified Nursing Assistant (CNA) #334 assist