STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366454	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER Avenue at Macedonia		STREET ADDRESS, CITY, STATE, ZIP CODE 9730 Valley View Road Macedonia, OH 44056	

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43061 Based on record review, interviews, and facility policy review, the facility failed to ensure Resident #62 received quarterly care conferences. This affected one resident (Resident #62) out of three residents reviewed for care plan conferences. Census was 89. Findings include: Record review revealed Resident #62 was admitted to the facility on [DATE] with diagnosis included but not limited to Alzheimer's Disease, Dementia, adult failure to thrive, and delusional disorders. Review of the quarterly Minimum Data Set (MDS) assessment completed on 09/10/24 revealed Resident #62 had severely impaired cognition. Revealed Resident #62's Care Plan Conference Summary Forms revealed a care plan meeting was held on 05/30/23, 11/02/23, 02/01/24, and 04/18/24. Interview on 10/28/24 at 1:30 P.M. with Social Service Designee (SSD) 268 revealed care conference should be completed upon admission within the first five days then quarterly, annually, with significant changes, or if family/resident wants sooner. SSD #268 confirmed Resident #62's first care plan meeting was held on 05/30/23. SSD #268 unable to provide explanation as to why it wasn't completed timely. SSD #269 confirmed next care plan meeting should have been August 2023 and unable to provide explanation as to why next care meeting was held on 11/02/23. SSD #269 confirmed no meeting was held after the last meeting 04/18/24. SSD #269 was unable to explain why. Interview on 10/29/24 at 1:09 P.M. with MDS Nurse #231 confirmed Resident #62 should have had an initial care plan meeting before 05/08/23. MDS Nurse #231 was unable to explain why it didn't occur timely. MDS Nurse #231 reported care plan meetings are held upon admission, quarterly, annually, significant change, and if resident/family wants sooner. MDS Nurse #231 confirmed next care plan meeting should have been August 2023 and unable to provide explanation as to why next care meeting was held on 11/02/23. MDS Nurse #231 confirmed no meeting was held after the last meeting 04/18/24. MDS Nurse #231 was unable to explain why as she just started a couple months ago. Interview on 10/29/24 at 9:44 A.M. with Administrator confirmed Resident #62's care plan meetings were not held timely. (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: 366454	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER Avenue at Macedonia		STREET ADDRESS, CITY, STATE, ZIP CODE 9730 Valley View Road Macedonia, OH 44056	

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy, Care Conference, revised August 2022, revealed the Minimum Data Set (MDS) nurse will schedule and coordinate routine schedule of the resident's care conference and Social Services/Designee will send letters in advance of the meeting to the resident's responsible party and/or resident. Review of facility policy, Care Plan - Advanced Care Plan Process, revised December 2022, revealed resident and their sponsor will be invited to participate in the care plan process on admission, quarterly, and with significant change and as needed (PRN). This deficiency represents non-compliance investigated under complaint number OH0018928.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366454	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER Avenue at Macedonia		STREET ADDRESS, CITY, STATE, ZIP CODE 9730 Valley View Road Macedonia, OH 44056	

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 0684 Level of Harm - 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** 43061 Based on record review, facility policy review and interview, the facility failed to provide timely and necessary care/treatment for Resident #100 and Resident #102 following identified changes in condition. Actual Harm occurred beginning on 10/09/24 when Resident #100, who was severely cognitively impaired was noted by direct care staff (Certified Nursing Assistant 3249) to be favoring her right side, had bruising noted and wasn't right without evidence a licensed nurse assessed the resident or provided necessary intervention. On 10/11/24 licensed staff documented Resident #100 was sitting awkwardly in her chair and guarding her upper right side thigh area. Between 10/11/24 and 10/14/24 the resident exhibited signs of increased pain (facial grimacing and guarding of the leg) with an inability to obtain an x-ray of the area (due to positioning issues). On 10/14/24 (five days after the initial change was identified) the resident was transferred to the hospital and diagnosed with a right hip fracture which required surgery. The resident did not return to the facility after being transported to the hospital. Actual Harm occurred on 09/21/24 when Resident #102, who was severely cognitively impaired sustained a witnessed fall that resulted in a fracture. However, at the time of the incident the resident was not comprehensively assessed for injury or need for additional medical treatment nor was there documentation of the incident at the time it occurred. On 09/24/24 (three days after the fall occurred), Resident #102 was transported to the hospital with bilateral hip pain and diagnosed with a pelvic fracture. The resident did not return to the facility after being transported to the hospital. This affected two residents (#100 and #102) of three residents reviewed for change in condition. Findings include: 1. Review of the closed medical record for Resident #100 revealed an admitted [DATE] with diagnoses including Alzheimer's disease, anxiety disorder, disorder of bone density and structure, osteoarthritis, subsequent encounter for closed fracture of left femur, hypercholesterolemia, hypertension, muscle weakness, dysphagia, and difficulty walking. Resident #100 was discharged to the hospital on 10/14/24. Review of the fall assessment completed on 04/15/24 revealed Resident #100 was at risk for falls. Review of next fall assessment, still showing in progress, dated 09/24/24 revealed Resident #100 was not at risk for falls. Review of the care plan dated 07/18/24 revealed Resident #100 was at risk for falls. Interventions included two-person transfer assist for transfers, educate resident and family to call for assistance before transferring, maintain food/fluids/ and needed items within reach, implement preventative fall interventions/devices, maintain call light within reach and educate resident to use call light, and monitor for changes in mobility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366454	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER Avenue at Macedonia		STREET ADDRESS, CITY, STATE, ZIP CODE 9730 Valley View Road Macedonia, OH 44056	

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 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the care plan dated 07/18/24 revealed Resident #100 had potential for pain. Interventions included administer medications per physician orders and monitor for side effects and effectiveness, notify physician if current pain medication is ineffective, determine what the resident's optimal pain level is for day-to-day function and quality of life, encourage resident to request pain medication before the pain becomes too intense or prior to activities, monitor for any change sin usual activities, monitor for changes in behavior such as screaming, refusals, monitor for changes in mood that may be indicators of pain, monitor for changes in sleep, monitor for verbal and non-verbal signs and symptoms relating to pain: grimacing, guarding, moaning, crying, increased anxiety, and offer non-pharmacological interventions to relieve pain and monitor for effectiveness. Review of the quarterly Minimum Data Set (MDS) Assessment, dated 10/01/24, revealed Resident #100 had severely impaired cognition, utilized a wheelchair for mobility, and required substantial or maximum assistance for all activities of daily living (ADLs). Review of a progress note dated 10/11/24 at 4:44 P.M. revealed Resident #100 was sitting awkwardly in her chair and guarding her upper right side thigh area. Resident #100 was transferred to bed and Registered Nurse (RN) 334 noted two bruises approximately three inches in length on the dorsal aspect of the right thigh. Resident #100 was actively guarding and fighting against the assessment of the area. The note revealed there was no warmth, redness, or distinctive swelling identified. Resident #100 was unable to report if she was having pain. There was no knowledge of any falls. RN #334 notified Resident #100's nurse practitioner and new orders were received for x-rays of the right hip and thigh areas. RN #334 notified the unit manager and DON. Review of the pain assessment for October 2024 revealed Resident #100 had pain rated a three on a pain scale (scale of 1 the least pain to 10 the worse pain) on 10/11/24. Review of the progress note dated 10/11/24 at 5:48 P.M. revealed Resident #100's daughter was notified of the bruising and the orders for x-rays. Review of the undated photos (identified by family to be taken on 10/12/24) provided by Resident #100's family revealed four (4) photos of Resident #100. The first and second photo of Resident #100 showed her front right thigh with large bruising, left lower arm/hand with bruising, with CNA #207's body and badge visible in the photo. The third and fourth photo showed Resident #100's right posterior thigh area with large bruising. Review of Resident #100's progress note dated 10/12/24 at 7:06 P.M. revealed the x-ray technician was unable to obtain x-rays this shift and would attempt to obtain x-rays later this evening or the following morning. Review of the Medication Administration Records (MARS) and Treatment Administration Records (TARS) for October 2024 revealed Resident #100 received Tylenol on 10/13/24 at 2:00 P.M. for pain rated a level three. However, the medical record contained no information on where the resident's pain was, how the resident's pain was being monitored or treated further on this day. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366454	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER: Avenue at Macedonia		STREET ADDRESS, CITY, STATE, ZIP CODE: 9730 Valley View Road Macedonia, OH 44056	

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 0684 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #100's progress note dated 10/13/24 at 07:35 A.M. revealed x-ray technician arrived to perform x-rays to right hip, pelvis, and femur. Resident #100 resisted positioning of x-rays. A call was placed to the resident's power of attorney (POA) per request for additional help with positioning. The resident's daughter did arrive and did attempt several times to assist with positioning. Resident #100 continued to resist assistance. A call placed to physician answering service and facility was awaiting call back. Review of Resident #100's progress note dated 10/13/24 at 09:17 A.M. revealed a call back was received from the on-call nurse practitioner with new orders for Flexeril (muscle relaxant) five milligrams (mg) one hour prior to x-rays being obtained on Monday 10/14/24 at 7:30 A.M. Resident #100's POA was notified. Review of Resident #100's progress note dated 10/13/24 at 11:05 A.M. revealed call placed to NP regarding signs and symptoms of pain observed during transferring and the facility was awaiting call back. Review of Resident #100's progress noted dated 10/13/24 at 12:02 P.M. revealed NP #345 returned call with new orders for Tylenol increased to 1000 milligrams (mg) every eight hours and as needed (PRN). Resident #100's POA was notified. Review of Resident #100's progress note dated 10/14/24 at 1:00 P.M., authored by the DON, identified a change of condition, but had no additional documentation completed to identify what the change in condition was or why the change in condition occurred. Review of a progress noted dated 10/14/24 at 2:00 P.M. revealed Resident #100 was transferred to hospital due to an inability to obtain an x-ray of resident's right hip. Resident #100's family was notified. The NP and DON were made aware of transfer. Review of the progress noted dated 10/14/24 at 9:00 P.M., authored by the DON, revealed Resident #100 transferred to a different hospital for trauma with right hip fracture. The resident's POA at bedside and notified at this time. Review of hospital orthopedic surgery operative note dated 10/15/24 revealed Resident #100 was seen in the emergency room and had presented as a patient who fell and injured their right hip which required surgery. X-rays were taken and revealed the resident sustained an intertrochanteric fracture with subtrochanteric extension of the right hip. Record review revealed the facility submitted a self-reported incident (SRI), tracking number 252914 to the State agency involving Resident #100. The SRI submitted by the DON revealed on 10/12/24 the receptionist notified the Administrator Resident #100's family was alleging the resident had an injury of unknown origin. Upon investigation, it was discovered a skin assessment was completed, and family and physician had been contacted on 10/11/24 with orders for an x-ray after a CNA reported the resident had a change in condition. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366454	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER: Avenue at Macedonia		STREET ADDRESS, CITY, STATE, ZIP CODE: 9730 Valley View Road Macedonia, OH 44056	

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 0684 Level of Harm - Actual harm Residents Affected - Few	Interview on 10/29/24 at 1:25 P.M. with Receptionist #260 revealed on Saturday, 10/12/24 Resident #100's daughter came to front desk, was upset, and showed pictures of bruises to Resident #100's inner thigh (couldn't remember which side). Receptionist #260 revealed she reported this immediately via telephone to the Administrator, the abuse coordinator. Receptionist #260 stated she saw the pictures on the phone and couldn't see how anyone else change/bathing the resident could not see the bruising. Interview on 10/30/24 at 9:15 A.M. with Resident #100's family revealed she was notified on 10/11/24 at 5:45 P.M. from someone at the facility that Resident #100 had slight bruising to right thigh and was favoring it. Resident #100's family reported she went to the facility on Saturday, 10/12/24 and found Resident #100 out in the lounge and asked CNA #207 to assist the resident to the bathroom and change her. Resident #100's family reported she saw large bruising on the resident's leg and took photos. Resident #100's family reported on 10/12/24 she showed the photos to Receptionist #260, who told her she was going to report this to the administrator. Interview on 10/31/24 at 2:24 P.M. with the DON revealed LPN #339 was terminated because she worked on 10/09/24 and it was reported to her by CNA #249 that Resident #100 was favoring her right side, bruising was noted, and something wasn't right with the resident. The DON reported LPN #339 failed to report the findings, there was no assessment or treatment of the resident, as the nurse did nothing. Interview on 11/04/24 at 8:24 A.M. via telephone with CNA #249 revealed on the morning of 10/09/24 while attempting to get Resident #100 up, she noticed she was holding onto her right leg like it was hurting when she attempted to straighten it, and the resident appeared to be in pain by making grimacing faces. CNA #249 revealed she notified LPN #339 Resident #100 was holding onto her right leg and grimacing, like she was in pain and LPN #339 stated okay. CNA #249 reported on 10/11/24 Resident #100 presented the same way, holding right leg in pain and grimacing. CNA #249 reported she notified LPN #318 of Resident #100's pain in her right leg and LPN #318 said okay. CNA #249 revealed on 10/11/24 in the morning while getting Resident #100 ready she was making noises like she was in pain, grimacing, and holding the right leg. CNA #249 stopped dressing her and immediately notified LPN #339 of the pain and stated something was wrong with the resident's right leg. LPN #339 informed CNA #249 Resident #100 was getting an x-ray. Interview on 11/04/24 at 12:31 P.M. via telephone with RN #334 revealed on 10/11/24 CNA #249 notified her Resident #100 was sitting in her chair funny and guarding her leg. RN #334 reported she assessed Resident #100 and found two bruises on the back lower thigh area of her right leg. RN #334 stated she notified the physician, unit manager, RN #258, the DON, and resident's family. RN #334 reported Resident #100 seemed in pain, and she was acting differently. RN #334 reported it was hard to tell due to her being non-verbal about what happened. RN #334 reported she didn't know how the resident got the bruising due to there being no reported falls. RN #334 revealed she was trying to figure out what happened. RN #334 confirmed she did not report to the Administrator, the abuse coordinator, because she didn't think to notify her and didn't know what was going on. Interview on 11/04/24 at 12:50 P.M. with CNA #206 revealed she was working on 10/11/24 and Resident #100 was not acting herself and noted her right leg was swollen. CNA #206 reported she notified RN #334 who assessed the resident and noted a bruise in her inner right thigh. CNA #206 reported Resident #100 was holding her right thigh, digging into it and didn't want anyone to touch it. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366454	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER Avenue at Macedonia		STREET ADDRESS, CITY, STATE, ZIP CODE 9730 Valley View Road Macedonia, OH 44056	

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 0684 Level of Harm - Actual harm Residents Affected - Few	Interview on 11/04/24 at 1:09 P.M. and on 11/05/24 at 9:38 A.M. with LPN #339 revealed on 10/09/24 CNA #249 notified her Resident #100 was guarding her right side and it was during change of shift, and LPN #339 had to go pick up her daughter. LPN #339 confirmed she did not do an assessment because it was during change of shift, and she had to go. LPN #339 reported on 10/09/24 she notified the oncoming nurse, LPN #270, Resident #100 needed assessed. LPN #339 reported on 10/11/24 the nurse, (she didn't remember who), during report notified her she needed to order an x-ray for Resident #100. LPN #339 denied any CNA notified her of Resident #100 having pain in her leg. LPN #339 reported she got in trouble, was suspended on Saturday, 10/12/24 and then fired by phone on either 10/14/24 or 10/15/24, but couldn't remember for sure. Interview on 11/04/24 at 2:17 P.M. with LPN #250 revealed she worked on 10/12/24 and Resident #100 was exhibiting signs of pain around her hip area by wincing and pushing away staff. LPN #250 reported she was told by LPN #339 Resident #100 was awaiting x-rays and denied being told the resident needed assessed. Interview on 11/05/24 at 11:20 A.M. with CNA #207 revealed he worked on Saturday 10/12/24 and Resident #100's family requested he take the resident to the bathroom and change her. CNA #207 revealed the resident had bruises on her thigh, could not remember which thigh and stated the family took photos. Interview on 11/05/24 at 12:02 P.M. with the Administrator and Regional Nurse (RN) #338 revealed LPN #339 was suspended on 10/25/24 once they discovered Resident #100's change in condition and when they received statement from CNA #249 that the CNA notified LPN #339 regarding the concerns with Resident #100. Information obtained via email on 11/08/24 at 11:43 from Nurse Practitioner (NP) #345 revealed the on-call NP was notified of Resident #100's pain making it hard to get x-ray images on 10/13/24. NP #345 reported Resident #100 was known to be resistant to care. NP #345 reported the resident was ordered Tylenol and Flexeril to be given prior to getting the x-ray. NP #345 reported being notified later that day of Resident #100's pain to right lower extremity with repositioning and transfer. NP #345 gave an order to increase Tylenol to 1000 milligrams and change to three times a day. NP #345 reported on 10/14/23 the facility was still unable to get an x-ray, the pain was persistent and Resident #100 was sent to emergency department for evaluation. Review of the employee file for LPN #339 revealed she had a discipline for corrective action form dated 10/17/24 for performance/policy violation for incident/accident policy and not reporting a change in condition and was terminated via phone. Review of the facility policy, Resident Change In Condition, dated July 28, 2022 revealed the facility ensured staff provide timely and appropriate care and services when resident experienced a change in condition that has or was likely to cause serious life-threatening harm or injuries and/or adverse negative health outcomes. The facility would promptly notify resident, his/her attending physician, and responsible party of changes in the resident's condition and/or status. The licensed nurse would take immediate action to ensure timely and appropriate care and services are met when a resident change in condition was identified. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366454	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER Avenue at Macedonia		STREET ADDRESS, CITY, STATE, ZIP CODE 9730 Valley View Road Macedonia, OH 44056	

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 0684 Level of Harm - Actual harm Residents Affected - Few	2. Review of the closed medical record for Resident #102 revealed an admitted [DATE] and a discharge date of [DATE] with diagnoses including but not limited to acute chronic respiratory failure with hypoxia, congestive heart failure, encephalopathy, ventricular tachycardia, and history of malignant neoplasm of breast. Review of the quarterly Minimum Data Set (MDS) Assessment, dated 07/21/24, revealed Resident #102 had severely impaired cognition, utilized a wheelchair for mobility, and required substantial or maximum assistance for all activities of daily living (ADLs). Review of the most recent completed fall assessment dated [DATE] revealed Resident #102 was at risk for falls. Review of the care plan dated 04/15/24 revealed the resident was at risk for falls. Interventions included educate resident/family to call for assistance before transferring, implement preventative fall interventions/devices, maintain call light/food/fluids within reach, educate resident to use call light, and monitor for changes in mobility, Review of Resident #102's care plan dated 04/15/24 revealed resident had potential for pain. Interventions included administer medications per physician order and monitor for side effects, determine what the resident's optimal pain level is for day-to-day function and quality of life, encourage resident to request pain medication before pain becomes too intense, monitor any change sin usual activities, monitor for changes in behavior that may be indicators of pain such as kicking, screaming, refusals, monitor for changes in mood, monitor for changes sleep pattern, monitor for verbal and non-verbal signs and symptoms relating to pain: grimacing, guarding, crying, moaning, and increased anxiety, offer non-pharmacological interventions to relieve pain, provide rest periods, therapy screen/eval as needed (PRN), and refer to ancillary services PRN. Review of Resident #102's medical record revealed no progress notes were documented for the resident on 09/21/24. Review of a progress note dated 09/24/24 at 4:18 P.M., authored by LPN #342, revealed Resident #102 had a change in condition. However, no additional information about the resident's condition was noted at that time. Review of a hospital transfer form revealed Resident #102 was transferred to the hospital on 09/24/24 at 4:17 P.M. for a change in condition after falling and having bilateral hip pain. However, review of the resident's medical record revealed no additional information about a fall or bilateral hip pain prior to this documentation or evidence the resident had been assessed and/or monitored for pain following a fall. Review of a progress note dated 09/25/24 at 08:00 A.M., (as a late entry note), authored by the Director of Nursing (DON), revealed the DON called the hospital to follow up on Resident #102 who was sent to hospital with right hip pain. The hospital reported Resident #102 was admitted with a pelvic fracture. The resident did not return to the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366454	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER: Avenue at Macedonia		STREET ADDRESS, CITY, STATE, ZIP CODE: 9730 Valley View Road Macedonia, OH 44056	

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 0684 Level of Harm - Actual harm Residents Affected - Few	Interview on 10/24/24 at 3:10 P.M. with the DON revealed the facility completed staff training on 09/25/24 related to reporting accidents/incidents because Resident #102 had sustained a fall (on 09/21/24) that was witnessed by LPN #342 and CNA #209, but the nurse did not report the incident, failed to document the fall occurred and failed to fill out an incident report. The DON reported she only found out about it because CNA #274 came forward and told the DON that the fall happened. Interview on 10/29/24 at 11:58 A.M. with Administrator and Regional Nurse (RN) 338 revealed it was discovered on 09/24/24 Resident #102 had a fall on 09/21/24 that wasn't reported, the resident was not assessed (until 09/24/24) and there was not an incident report completed. RN #338 reported after being made aware of the incident, she came to the facility to help with the investigation. RN #338 verified Resident #102 had a fall on 09/21/24 and CNA #274 and CNA #341 notified LPN #342. RN #338 confirmed LPN #342 never did an assessment, didn't report the incident, and no notifications (to the physician or family) were completed. RN #338 reported the DON found out about the fall on 09/24/24 when CNA #274 notified her. RN #338 reported LPN #342 was suspended pending investigation and then was terminated as a result of the incident. RN #338 reported CNA #209 found Resident #102 on the floor in her room. CNA #341 assisted and notified LPN #342 of the fall. CNA #274 was walking by the room, went to assist the resident, and notified LPN #342 of the fall. RN #338 reported all staff were educated and a plan of correction was put in place. Interview on 11/07/24 at 1:08 P.M. with CNA #209 revealed she was walking by Resident #102's room on 09/21/24 after breakfast when she heard her call out for help. CNA #209 reported she could see in the room the resident was on the floor, and she asked CNA #341 to notify the nurse of the fall. CNA #209 reported she immediately went into the room and found Resident #102 on the floor. CNA #341 returned to the room after she notified LPN #342 of the fall. CNA #209 reported CNA #274 came in to see if they needed help and if the nurse needed notification. CNA #209 informed CNA #274 LPN #342 was notified by CNA #341. Interview on 11/07/24 at 1:13 P.M. with CNA #274 revealed she was walking by Resident #102's room and saw her on the floor on 09/21/24 in the morning and CNAs #209 and #341 were assisting the resident. CNA #274 went into to see if they needed help. CNA #274 reported CNA #341 already notified LPN #342 of the fall. CNA #274 reported when she left the room, she notified LPN #342 of the fall. CNA #274 confirmed Resident #102 had a fall and LPN #342 was notified. CNA #274 revealed she was telling human resources how she hurt her back from the resident falling resulting in the DON discovering the resident has a fall. Attempts to interview LPN #342 on 11/07/24 1:25 P.M. and 11/12/24 at 9:15 A.M. were unsuccessful as the LPN was not available via telephone and did not return the surveyor's calls. Review of employee file for LPN #342 revealed a discipline on 09/24/24 of suspension for performance and safety/carelessness for failure to report an incident per policy and terminated. Review of facility policy, Fall Management, Revised December 2022, revealed that if a fall occurs, the licensed nurse would assess the resident for the injury from the fall immediately and initiate an investigation of the reason for the fall and implement an immediate intervention to attempt in preventing future falls. The licensed nurse would update the Fall Risk and Pain Assessment at the time of the fall. Physician and responsible party were notified promptly. Nurse would assess the resident for fall risk through the fall risk assessment upon admission, quarterly, and with significant change. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366454	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenue at Macedonia	9730 Valley View Road Macedonia, OH 44056

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 0684 Level of Harm - Actual harm Residents Affected - Few	This deficiency represents non-compliance investigated under Complaint Number OH00159351, Complaint Number OH00158985, and Complaint Number OH00158756.