

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 01/22/2025
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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45441</p> <p>Based on record review, review of a facility self-reported incident and investigation, personnel file review, facility policy review, Centers for Medicare and Medicaid guidance and interview, the facility failed to ensure an employee (Laundry Aide #201) did not engage in an inappropriate relationship with Resident #91 which had the potential to be considered an abuse of power and resulted in an allegation of staff to resident sexual abuse reported by the resident. This affected one resident (#91) of three residents reviewed for abuse. The facility census was 92.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #91 revealed an admitted [DATE] with diagnoses including emphysema, diabetes, alcohol abuse, depression, hypertension and history of right arm fracture.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #91 was cognitively intact. The assessment revealed the resident had hallucinations, delusions or behaviors and was independent in all activities of daily living (ADL).</p> <p>Review of a nursing progress note dated 11/10/24 at 5:04 P.M. revealed Resident #91 was not in his room when dinner trays were delivered. A handwritten note was observed stating Resident #91 was on leave of absence (LOA) and would return after 7:00 P.M.</p> <p>Review of a nursing progress note dated 11/11/24 revealed Resident #91 returned from LOA in the Administrator's vehicle at 9:45 A.M. Resident #91 had a notable odor of alcohol but denied drinking. The resident was assessed and presented with a facial edema (swelling) but refused any further assessment. Nurse Practitioner (NP) #212 was notified and ordered the resident to be sent to the emergency department (ED) for further evaluation. When emergency medical transportation arrived, Resident #91 refused to go to the hospital. NP #212 ordered blood work and a urine toxicology screen. Resident #91 refused to provide a urine sample. The complete blood count (CBC) with differential (diff) and basic metabolic panel (BMP) was obtained and did not show anything remarkable.</p> <p>Review of a progress note dated 11/12/24 written by Physician's Assistant (PA) #214 revealed Resident #91 went on LOA on 11/10/24 and returned on 11/11/24 at 9:45 A.M. Resident #91 reported he took an Uber to visit a friend in the hospital, but the driver took him to the wrong hospital. When asked if he had any alcohol or returned to the facility in an intoxicated state, he said he did not believe he did.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of an assessment titled Evaluation for Resident Sexual/Intimate Relationship dated 11/12/24 revealed that Resident #91 was aware of who was initiating sexual contact and had the ability to say no to uninvited sexual contact.</p> <p>A facility investigation revealed on 01/10/25 at approximately 5:30 P.M. Resident #91 told Receptionist #213 he was taken out of the facility and to a motel by Laundry Aide #201. He stated they did sexual things.</p> <p>Interview on 01/15/25 at 9:26 A.M. with the Administrator revealed she received a call the evening of 11/10/24 stating Resident #91 left a note at his bedside stating he was going to visit another resident in the hospital. The Administrator attempted calling Resident #91 on his cell phone multiple times with no answer. Resident #91 returned a text to the Administrator and told her he was okay and was on LOA. The next morning, the Administrator received a call from the Director of Nursing (DON) stating Resident #91 had not returned. The Administrator reached out to Resident #91 who stated he was at a gas station in town, his Uber broke down, and he was stranded. The Administrator got in her own vehicle and headed to the area where Resident #91 claimed to be. While sitting in her car at a stop sign, she looked over and noticed Laundry Aide #201 in her own vehicle and she appeared to be looking for someone. The Administrator followed Laundry Aide #201 to a local motel. Laundry Aide #201 drove around the back of the motel, and the Administrator saw Resident #91 standing in the doorway of the motel room talking to Laundry Aide #201. The Administrator asked Resident #91 if he would like a ride back to the facility. Resident #91 got in the Administrator's car and apologized for worrying her and they returned to the facility. The Administrator revealed at the time of the incident she had text messages with Resident #91 who said he was ok. However, the Administrator verified she did not interview Laundry Aide #201 at that time. The Administrator revealed Laundry Aide #201 was employed at the facility until 01/10/25 when she was suspended. The Administrator revealed at the time of the incident on 11/11/24, she did not question Laundry Aide #201 about why she was with Resident #91 because Laundry Aide #201 was not working at the time, and the facility believed they had no right to question anyone about what they were doing off company time. She added the facility did not have a policy to address staff relationships with residents outside of work.</p> <p>Interview on 01/15/25 at 10:22 A.M. with Badge #D51 revealed there was an open police investigation involving Resident #91; however, the police report could not be released as the investigation was currently still open.</p> <p>Interview on 01/15/25 at 12:10 P.M. with Laundry Aide #201 revealed she admitted to taking Resident #91 out of the facility and to a motel in November 2024. She reported she got him a few drinks and stayed in the motel with him for a bit but did not stay overnight. She stated she returned the following morning to take him back to the facility, at which time the Administrator pulled into the motel behind her. During the interview, the employee admitted to having intimate moments with Resident #91 which involved consensual kissing.</p> <p>Interview on 01/15/25 at 12:50 P.M. with Resident #91 revealed he left the facility with Laundry Aide #201 on 11/10/24 at approximately 2:15 P.M. He reported both he and Laundry Aide #201 stayed in the motel for a while and drank alcohol, but Laundry Aide #201 did not stay overnight. He stated the Administrator picked him up at the motel on the morning of 11/11/24.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Interview on 01/15/25 at 2:22 P.M. with Human Resources (HR) #211 revealed if an employee approached her about beginning a relationship with a resident, she would tell them they would need to talk to the Administrator but would advise against it. She believed it would be a conflict of interest, and did not think it would be allowed. If she found out it had happened, she stated she would notify the Administrator. She revealed if the employee was not on the clock, she felt the situation might be different if they were consenting adults, but stated she would still tell the Administrator.</p> <p>Review of the facility SRI tracking number 255983 created on 01/10/25 at 6:33 P.M. and completed on 01/16/25 at 5:39 P.M. by the Administrator revealed on 01/10/2025 at approximately 7:00 P.M. Receptionist #213 called the Administrator stating Resident #91 was alleging an employee (Laundry Aide #201) on a previous date, took him out of facility against his will, got him drunk against his will and took advantage of him. The Administrator suspended alleged Laundry Aide #201 and opened an investigation on this date. The local police were notified on the evening of 01/10/25 and their investigation was still pending. A head-to-the assessment completed on Resident #91 revealed no concerns. Resident #91 was his own responsible party, and the physician was notified of the allegation.</p> <p>The facility investigation and SRI revealed upon interviewing Resident #91 on 01/16/25, he stated Laundry Aide #201 did not force him out of the facility, she took his hand and he followed; she did not force him to drink, but made a bottle of vodka readily available in the backseat and he, at the time, did not have the ability to choose to say no. The resident stated Laundry Aide #201 did not force him into the hotel, but he took her hand and followed her into the room. Resident #91 stated Laundry Aide #201 did essentially rape him. The local police were notified a second time, due to the resident alleging he was raped by the employee on 01/16/25. Laundry Aide #201's statement was received, along with text messages and phone calls from the night in question and following the event. Resident #91 had a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact, with diagnoses of alcohol abuse and depressive disorder. Statements were collected from employees regarding conversations with Resident #91, and no concerns were noted upon return, including allegations of abuse. The facility did not substantiate the allegation of sexual abuse indicating communications were reviewed between Resident #91 and Laundry Aide #201 which revealed both were consenting adults. The police investigation was still pending as of this date.</p> <p>Interview on 01/16/25 at 1:43 P.M with Resident #91, when asked if he was raped (as alleged), he stated Rape? Isn't that when a man does it to another man? Is that what I said? No additional information was provided from the resident regarding the allegation or circumstances of 11/10/24-11/11/24.</p> <p>Review of the personnel file for Laundry Aide #201 revealed a hire date of 08/27/24. The file contained the appropriate background checks, abuse education, and abuse registration verifications. Laundry Aide #201 was an employee of the facility until a contracted laundry service took over services at the facility at which time she remained on as a contracted employee. The contracted company took over two days after the hotel incident, which occurred on 11/10/24 and 11/11/24.</p> <p>Review of the undated facility Abuse Prohibition policy revealed it did not address personal relationships between staff and residents.</p> <p>An ethical concern is created with the existence of a significant power dynamic between nursing home staff and residents, making any romantic relationship potentially exploitative. Lastly, nursing home residents may be particularly vulnerable to undue influence or manipulation, making a romantic relationship with staff problematic.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>The Centers for Medicare and Medicaid provide the following guidance regarding employee-resident relationships. Nursing home staff are entrusted with the responsibility to protect and care for the residents of that facility. Nursing home staff are expected to recognize that engaging in a sexual relationship with a resident, even an apparently willingly engaged and consensual relationship, is not consistent with the staff member's role as a caregiver and will be considered an abuse of power.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00161549.</p>		