STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366454	A. Building B. Wing	02/27/2025

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

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51526 Based on record review, observation, and interviews, the facility failed to ensure call lights were within reach for Residents #6 and #8. This affected two residents (#6 and #8) of five observed for accommodation of needs. The facility census was 88. Findings include: 1. Review of the medical record for Resident #6 revealed an admitted [DATE] with diagnoses including multiple sclerosis (disease that affects the central nervous system which causes numbness, weakness, difficulty walking, vision changes and other symptoms) and contractures. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #6 had severe cognitive impairment. She was dependent on staff for oral care and hygiene. Review of the care plan dated 06/07/19 for Resident #6 revealed she had self-care performance deficit for activities of daily living related to limited mobility and contractures. Interventions revealed she was dependent on one staff for activities of daily living and the staff were to ensure the call light was within reach for her to utilize. Observation and interview on 02/24/25 at 9:33 A.M. revealed Resident #6's paddle push call light was out of Resident #6's reach; it was hanging on the bedrail. Resident #6 stated she was able to utilize the call light when it was positioned correctly by her head. Resident #6 stated she was unable to call for help as the staff had not placed the call light in the correct position at the side of her head. Interview on 02/24/25 at 9:19 A.M. with Licensed Practical Nurse (LPN) #556 verified Resident #6's call light was out of reach. LPN #556 stated Resident #6 was able to use the paddle push call light with her head when staff positioned it correctly. LPN #556 stated the staff forgot to place the call light in the correct position after they finished assisting her with breakfast. Additional observation on 02/26/25 at 8:12 A.M. revealed Resident #6 lying in bed with the pressure push pad call light out of her reach. Because of the positioning of the call light Resident #6 could not activate the call light. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/26/25 at 8:14 A.M. with Dietician #600 verified Resident #6's call light was out of the resident's reach and because of the position of the call light, Resident #6 could not be activate by using her head. Review of the facility policy Resident Call System dated November 2016, revealed when leaving the room, staff were to ensure call light was placed within the resident's reach. 2. Review of Resident #8's medical record revealed she was admitted on [DATE] with diagnoses including hemiplegia (paralysis on one side of the body), contractures, seizures, dementia and depression. Review of Resident #8's care plan dated 11/05/19 revealed she had impaired musculoskeletal status related to contractures and right below the elbow amputation. Interventions included for staff to encourage Resident #8 to ask for assistance when needed. Resident #8 also was at risk for decline in activities of daily living related to hemiplegia, dementia, depression and contractures. Interventions included for Resident #8 to utilize a soft touch call light button. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #8 had moderate cognitive impairment. Resident #8 had impairment to both upper and lower extremities and was dependent on staff for all activities of daily living. Observation on 02/24/25 at 9:50 A.M. revealed Resident #8's soft touch call light button was out of reach for her to utilize as it was on the right side at the head of her bed. Observation and interview on 02/24/25 at 9:55 A.M. with Certified Nursing Assistant (CNA) #576 verified Resident #8's call light was on the right side at the head of the bed and not within Resident #8's reach. CNA #576 stated Resident #8 was able to activate the soft touch button by pressing on it with her right shoulder. Resident #8 could not use her left arm to activate the call light because of a contracture. CNA #576 confirmed the call light was not placed within Resident #8's reach after care was provided. An observation on 02/25/25 at 1:37 P.M. revealed Resident #8 was sitting in wheelchair and the call light was not within her reach; the call light was on the bed. An observation and interview on 02/25/25 at 1:39 P.M. with Registered Nurse #526 verified Resident #8's call light was out of reach. Review of the facility policy Resident Call System dated November 2016, revealed when leaving the room, staff were to ensure the call light was placed within the resident's reach.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43063 Based on record review, observation and interview, the facility failed to maintain resident rooms in a clean and sanitary manner. This affected one (Resident #41) of two residents reviewed for enteral feedings. The facility census was 88. Findings include: Review of the medical record for Resident #41 revealed an admitted [DATE] with diagnoses including hemiplegia (paralysis on one side of the body) and gastrostomy. Observation of Resident #41's room on 02/25/25 at 8:23 A.M. revealed there was yellowed dried enteral feeding on the floor and on the feeding tube pole. Observation on 02/25/25 at 9:58 A.M. revealed yellow dried enteral feeding on the floor by Resident #41's bed and on the feeding tube pole. Observation of Resident #41's room on 02/25/24 at 1:25 P.M. revealed the trash can was empty with no trash bag liner currently in place and there was thick yellow dried enteral feeding on the bottom of the can. There was dried tube feeding also noted to Resident #41's tray table, the bottom of the tray table, on the floor under the tube feeding pole and on the tube feeding pole. Observation of Resident #41's room on 02/26/25 at 3:11 P.M. with Certified Nursing Assistant (CNA) # 567 verified the trash can had dried enteral feeding on the bottom, the trash can did not have a liner, the floor had dried enteral feeding under the feeding tube pole, and there was dried enteral feeding on the feeding tube pole, on Resident #41's tray table and below the tray table. Interview with CNA #567, at the time of the observation, revealed resident rooms were to be cleaned daily. This deficiency represents non-compliance investigated under Complaint Number OH00161919.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43063 Based on interviews and record review, the facility failed to ensure resident assessments were completed as required and/or accurate. This affected two (Resident #79 and Resident #197) of 27 residents reviewed for Minimum Data Set (MDS) 3.0 assessments. The facility census was 88. Findings include: 1. Review of the medical record for Resident #79 revealed an admitted [DATE] with diagnoses including Alzheimer's disease, anxiety and hypertension. Resident #79 was discharged to the hospital on 10/14/24 and did not return to the facility. Review of Resident #79's MDS assessments revealed she had a quarterly assessment on 10/01/24. There were no assessments completed after that date. Interview on 02/25/25 at 10:37 A.M. with Registered Nurse (RN) #526 verified she had not completed a discharge return not anticipated MDS assessment for Resident #79 after she was discharged and did not return to the facility. 2. Review of the medical record for Resident #197 revealed an admitted [DATE] with diagnoses including diabetes mellitus, hypertension and dementia. Review of the nursing progress note dated 10/30/24 timed 7:00 P.M. for Resident #197 revealed nursing had observed a dark red area on the left heel side of her heel. Review of the wound physician documentation dated 11/01/24 revealed Resident #197 was seen for an initial consultation for suspected deep tissue pressure ulcer that was acquired in-house. Review of the wound physician documentation dated 01/03/25 revealed continued assessment of Resident #197 left heel, which was now a stage two pressure ulcer. Review of the quarterly MDS assessment dated [DATE] revealed Resident #197 had a pressure ulcer stage two that was present on admission. Interview on 02/26/25 at 8:15 A.M. with Regional Director of Clinical Services #599 verified Resident #197's MDS assessment dated [DATE] was inaccurate under section M as she had a stage two pressure ulcer that was acquired in-house.

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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** 51526 Based on record review, observation, and interviews, the facility failed to ensure residents who were unable to carry out activities of daily living (ADLs) received the necessary services for incontinence care, oral hygiene, and feeding assistance. This affected three (Residents #6, #56 and #59) out of four residents reviewed for ADL assistance. The facility census was 88. Findings include: 1. Review of the medical record for Resident #6 revealed an admitted [DATE] with diagnoses including multiple sclerosis (disease that affects the central nervous system which causes numbness, weakness, difficulty walking, vision changes and other symptoms) and contractures. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #6 had severe cognitive impairment and was dependent on staff for oral care and hygiene. Review of Resident #6's care plan dated 12/01/24 revealed she had self-care performance deficit for activities of daily living related to limited mobility and contractures. Interventions revealed she was dependent on one staff for personal hygiene and oral care. Observation on 02/24/25 at 9:33 A.M. revealed a large amount food debris covering Resident #6's upper teeth. Resident #6 denied any recent mouth care by staff. Resident #6's call light light was not within reach for her to be able to call for care needs. Observation on 02/25/25 at 9:19 A.M. revealed a large amount of food debris remained on Resident #6's upper teeth. Observation and interview on 02/25/25 at 9:25 A.M. with Licensed Practical Nurse (LPN) #556 verified Resident #6 had not received mouth care and Resident #6 had a large amount of food debris on her teeth. Interview with Resident #6, at the time of the observation and interview with LPN #556, confirmed she had not received oral care from staff and was unsure of the last time oral care had been completed. Review of the facility policy Activities of Daily Living (ADLs), dated March 2023, revealed the facility staff would provide care and services for hygiene including grooming and oral care. 2. Review of medical record for Resident #59 revealed an admitted [DATE] with diagnoses including cerebral infarction (stroke), epilepsy (seizures) and major depressive disorder. Review of Resident #59's care plan dated 09/21/24 revealed he had self-care performance deficit for activities of daily living (ADLs) related to epilepsy, diabetes, and heart disease. Interventions included one staff member to assist Resident #59 with toileting. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #59 was occasionally incontinent of urine and needed substantial to maximal assistance with toileting hygiene. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 02/24/25 at 9:21 A.M. revealed Resident #59 was lying in bed with visibly wet sheets with yellow stains. There was a strong odor of urine in the room and on the resident. Observation on 02/24/25 at 11:21 A.M. revealed Resident #59 was still lying in bed and bed sheets were still saturated with urine. There was a strong odor still present when opening Resident #59's door. Interview with Licensed Practice Nurse (LPN) #562 on 02/24/25 at 11:23 A.M. revealed Resident #59 had not previously refused any care from staff. LPN #562 stated there were only two certified nursing assistants (CNAs) assigned to the floor which had high volume of maximum assistance/dependent care residents. LPN #562 stated both aides were giving showers to other residents which required two assistants. Interview and observation with LPN #574 on 02/24/25 at 11:28 A.M. revealed Resident #59 was still saturated with urine. LPN #574 stated the expectation was that staff were to check on residents every two hours or more often if needed to ensure care was provided as needed. LPN # 574 verified the strong odor of urine in Resident #59's room and on the resident. LPN #574 also confirmed the soiled bedding with wet urine stains on it and Resident #59's damp clothing. LPN #574 asked the resident when he was changed last and he stated it had been a long time. Resident #59 agreed to allow LPN #574 to assist him with incontinence care. Review of the facility policy Activities of Daily Living (ADLs), dated March 2023, revealed the facility staff would provide care and services for hygiene including grooming and oral care. 35768 3. Review of Resident #56's medical record revealed Resident #56 was admitted on [DATE]. Diagnoses included schizoaffective disorder, paranoid schizophrenia, unspecified dementia, muscle weakness, and functional quadriplegia. Review of the comprehensive Minimum Data Set (MDS) assessment, dated 01/15/25, revealed Resident #56 had impaired cognition and required set-up and clean-up for eating and was dependent with mobility. Resident #56 was receiving a pureed diet to help reduce risk of aspiration. Review of the facility Dietary Nutritional assessment dated [DATE] revealed Resident #56 required supervision for feeding, her appetite could vary at times, and supervision was required at meals following tray set-up. Review of the plan of care dated 02/02/25 revealed Resident #56 was at risk for decline in activities of daily living due to schizoaffective disorder, dementia, and quadriplegia. Interventions included one person assist for eating. Observations on 02/24/25 at 10:24 A.M. revealed Resident #56 was sleeping in a Broda chair located in the hallway in front of the entrance to her room. Resident #56's breakfast tray was on the bedside table and the warming lid was removed. The breakfast plate looked to be untouched. No staff or residents were observed in the hallway. The food looked coagulated. Resident #56 woke up and quickly ate the food without assistance or supervision. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/24/25 at 10:26 A.M. with Certified Nurse Assistant (CNA) #534 revealed Resident #56 was placed in the hall so staff could monitor her because she was at risk for falls. Interview on 02/24/25 at 10:34 A.M. with Registered Nurse (RN) #579 revealed Resident #56 was placed in the hallway so staff could watch her. RN #579 stated the breakfast trays were delivered around 8:00 A.M. and there should be someone supervising Resident #56 while eating. Interview on 02/26/25 at 8:54 A.M. with Dietitian #500 revealed staff were usually with Resident #56 when she was eating. Dietitian #500 stated Resident #56 was on a mechanical soft diet due to concerns with swallowing and required supervision when eating. Interview on 02/26/25 at 9:30 A.M. with Regional Director of Clinical Operations (RDCO) #599 revealed staff were to provide supervision with meals as defined in the activity of daily living flow chart in the Resident Assessment Instrument (RAI) manual. Review of the RAI coding in the manual revealed supervision was defined as providing oversight, encouragement, or cueing. This deficiency represents non-compliance investigated under Complaint Numbers OH00161919 and OH00161679.

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F 0680 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure the activities program is directed by a qualified professional. 42734 Based on review of personnel files and staff interview the facility failed to ensure the activities program was directed by a qualified professional. This had the potential to affect all 88 residents. Findings include: Review of the personnel file for Activity Director (AD) #514 revealed no evidence to support AD #514 had the appropriate qualifications for holding the position of activity director. AD #514's hire date was 10/28/24. Interview and record review on 02/27/25 at 11:30 A.M. with Human Resource Director (HR) #554 revealed HR #554 was unaware of the qualifications AD #514 held for directing the activity program. A subsequent interview on 02/27/25 at 11:43 A.M. revealed AD #514 was in the process of completing a training course approved by the state. HR #554 stated the former AD, now the current Admissions Director (Admissions Director #545) still worked at the facility and trained AD #514. Review of Admission Director #514's personnel file revealed Admission Director #545 did not meet the qualifications to direct the activities program and had not completed a training course approved by the state. Review of the job description titled Progressive Quality Care Activity Director revealed a header for Qualifications with no additional information after it. AD #514 signed the job description on 10/24/24.

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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** 51526 Based on record review, observation, and interviews the facility failed to ensure Vancomycin (antibiotic) levels were monitored. This had the potential to affect one (Resident #195) of one resident reviewed for Vancomycin administration. The facility census was 88. Findings include: Review of medical record for Resident #195 revealed an admitted [DATE] with diagnoses including bacteremia and streptococcal polyarthritis (inflammatory joint condition). Review of the physician's orders for Resident #195 for February 2024 revealed an order for Vancomycin intravenous solution 500 milligrams (mg), use 1.75 grams intravenously every 12 hours at 8:00 A.M. and 8:00 P.M. for 22 days dated 02/20/25. There were no laboratory orders to monitor for Vancomycin levels to ensure appropriate levels and efficacy. Observation and interview on 02/25/25 at 12:00 P.M. revealed Licensed Practical Nurse (LPN) #556 administering Vancomycin to Resident #195. After administration, LPN #556 was unable to state how the facility was monitoring the Vancomycin serum levels. Interview on 02/26/25 at 11:10 A.M. with Regional Director of Nursing (DON) #599 verified there were no orders for Vancomycin serum monitoring. DON #599 stated the nurse practitioner had ordered laboratory testing for Resident #195, however, when she had entered the orders in the computer, she failed to order a Vancomycin serum level. Review of the facility policy titled, Medication Administration-General Guidelines, dated August 2014, revealed there were no directives related to Vancomycin serum levels.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45441 Based on record review and interview, the facility failed to ensure residents received recommended ancillary services. This affected one resident (Resident #47) of three reviewed for vision and hearing. The census was 88 residents. Findings include: Review of the medical record for Resident #47 revealed an admitted [DATE]. Diagnoses included kidney disease, diabetes, heart failure, and depression. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #47 was cognitively intact. Resident #47 required set up help for eating and oral hygiene, partial to moderate assistance for showering and personal hygiene and was dependent for toileting. Resident #47's vision was adequate and she did not have corrective lenses. Interview on 02/24/25 at 9:43 A.M. with Resident #47 revealed she had a cataract and the facility had not assisted her in setting up an appointment for surgery. Review of the optometrist note dated 03/13/24 revealed Resident #47 had cataracts which were visually significant. A recommendation was made for Resident #47 to have a cataract evaluation. Review of the progress note dated 05/09/24 revealed Resident #47 left the facility for cataract surgery and returned later that day. The surgery was not performed. Review of the optometrist note dated 09/30/24 revealed Resident #47 was not seen due to time constraints. Review of the optometrist notes dated 10/21/24 and 11/18/24 revealed Resident #47 refused to be seen. Review of the optometrist note dated 01/24/25 revealed Resident #47 was not brought down to be seen by the optometrist while he was at the facility, they were unable to locate Resident #47 despite several attempts and facility staff did not assist in locating Resident #47. Interview on 02/27/25 at 9:47 A.M. with the Director of Nursing (DON) confirmed there was no other evidence the facility had made any efforts to assist Resident #47 with scheduling her cataract surgery. Review of the Ohio Revised Code Section 3721.13, Residents" Rights dated 10/03/23 as provided by the facility revealed residents had the right to adequate and appropriate medical care and services, including ancillary services.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43063 Based on record review, observation, and interview the facility failed to ensure Resident #15's enteral feeding was delivered per the physician's orders. This affected one (Resident #15) of one resident reviewed for enteral feedings. The facility census was 88. Findings include: Review of the medical record for Resident #15 revealed an admitted [DATE] with diagnoses including cerebral palsy (condition that affects movement and posture) and gastrostomy status. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #15 was dependent on staff for eating and received 51 percent (%) of his total calories through tube feeding. Review of the physician's orders for Resident #15 revealed an order for enteral feeding at 70 milliliters (mL) per hour, up at 11:00 P.M. and down at 11:00 A.M. dated 02/20/25. Review of the Medication Administration Record (MAR) for February 2025 for Resident #15 revealed the nurse had documented on 02/25/25 for the 6:00 A.M. to 6:00 P.M. shift the enteral feeding was taken down at 11:00 A.M. Observation on 02/25/25 at 11:01 A.M. of Resident #15 revealed he had his enteral feeding running at 70 mL per hour. There was one inch of tube feeding left in the feeding tube bag. Observation on 02/25/25 at 1:01 P.M. revealed the enteral feeding was still on and set to 70 mL an hour and the delivery pump was beeping to alert the nurse. Observation on 02/25/25 at 1:33 P.M. revealed Resident #15's enteral feeding was on and set to 70 mL. The delivery pump was still beeping to alert the nurse and there was no feeding left in the bag. Interview on 02/25/25 at 1:33 P.M. with Licensed Practical Nurse (LPN) #504 verified Resident #15's enteral feeding was to be administered from 11:00 P.M. to 11:00 A.M. daily. She stated it should have been turned off at 11:00 A.M. Review of the facility policy titled, Enteral Feeding, undated, revealed enteral feeding orders were determined by the physician which included the hours of feeding and total volume.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45441 Based on observation, record review, interview, and facility policy review, the facility failed to implement and follow transmissions based precautions (TBP) and enhanced barrier precautions (EBP) as required. This affected three residents (Residents #5, #73 and #195) of five reviewed for TBP. The facility identified four residents (Residents #52, #60, #64 and #72) on droplet TBP and 14 residents (Residents #2, #3, #5, #6, #12, #14, #30, #39, #41, #46, #56, #69, #80 and #89) on EBP. The facility census was 88. Findings include: 1. Review of the medical record for Resident #73 revealed an admitted [DATE]. Diagnoses included diabetes, hypertension, depression, dementia and kidney disease. Review the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #73 was severely cognitively impaired. Resident #73 required setting up for eating, partial to moderate assistance for oral hygiene and substantial or maximum assistance for toileting and showering. Review of the progress note dated 02/21/25 revealed Resident #73 tested positive for COVID. Observation on 02/26/25 at 9:34 A.M. of Resident #73's room revealed she was on droplet precautions. Certified Nurse Aid (CNA) #506 was delivering breakfast to Resident #73. CNA #506 entered Resident #73's room wearing a gown and an N95 face mask. Interview on 02/26/25 at 9: 41 A.M. with CNA #506 upon exiting Resident #73's room confirmed he was not wearing gloves, shoe coverings or eye protection when he entered Resident #73's room. Review of the facility policy Isolation - Categories of Transmission Based Precautions dated September 2022 revealed when entering the room of a resident on droplet precautions, masks, gown, gloves and goggles should be worn. 43063 2. Review of the medical record for Resident #5 revealed an admitted [DATE] with diagnoses including diabetes mellitus, hypertension and urinary tract infection. Review of the physician's orders for Resident #5 revealed an order for isolation precautions due to diagnosis of extended-spectrum beta-lactamases (ESBL) (bacteria enzyme that makes some antibiotics ineffective in treating certain bacterial infections, also known as a multidrug-resistant organism) dated 02/19/25 without a stop date. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366454	A. Building B. Wing	02/27/2025

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

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 02/26/25 at 9:06 A.M. revealed Registered Nurse (RN) #579 was at Resident #5's room with a medication cart. RN #579 then pushed the medication cart inside Resident #5's room and began assisting Resident #5 with repositioning with the assistance of an aide. There was no isolation signage at the door nor personal protective equipment (PPE) available for staff to utilize directly outside of the room. When RN #579 had completed assisting Resident #5, she went back to the medication cart and the aide left the room. RN #579 stated Resident #5 did not have isolation orders and she had recently completed an antibiotic. RN #579 verified she did not have PPE on nor did the aide that assisted with Resident #5's care. Interview on 02/26/25 at 9:55 A.M. with Licensed Practical Nurse (LPN) #504 verified Resident #5 had an order for contact isolation due to ESBL in her urine, however, the order should have been discontinued on 02/23/25. LPN #504 stated Resident #5 should have been on enhanced barrier precautions (EBP) as she was susceptible to a multidrug-resistant organism. She also verified RN #579 should not have taken the medication cart into a resident room. Review of the facility policy titled, Enhanced Barrier Precautions, dated August 2022, revealed that EBP was indicated for residents infected or colonized with organisms including ESBL. 3. Review of the medical record for Resident #195 revealed an admitted [DATE] with diagnoses including bacteremia and streptococcal polyarthritis (inflammatory joint condition). Review of the physician's orders for February 2025 for Resident #195 revealed she did not have an order for isolation. Resident #195 was noted to have an orders for treatment to her right knee for a surgical wound and peripherally inserted central line care. Review of the care plan dated 02/20/25 for Resident #195 revealed she required Enhanced Barrier Precautions (EBP) to reduce transmission of multidrug-resistant organisms related to an indwelling device and wound. Interventions included to reinforce education to maintain compliance with isolation precautions and to use disposable gowns and gloves during high-contact care. Observation and interview on 02/26/25 at 12:29 P.M. with Licensed Practical Nurse (LPN) #504 and Regional Director of Clinical Services #599 revealed Resident #195's room did not have signage stating she was on EBP, an isolation cart or personal protective equipment (PPE) available for staff outside of her door. LPN #504 verified Resident #195 was on EBP and should have had a sign alerting staff as well as PPE available outside of the door. Review of the facility policy titled, Enhanced Barrier Precautions, dated August 2022, revealed that EBP was indicated for residents with wounds and/or indwelling medical devices.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366454	A. Building B. Wing	02/27/2025

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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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45441 Based on record review and interview the facility failed to maintain documentation the COVID-19 vaccine was offered to residents and residents were provided education regarding the benefits and risks associated with the COVID-19 vaccine annually. This affected four Residents (Residents #1, #31 #42 and #76) of five reviewed for immunizations. The census was 88. Findings include: Review of the medical record for Resident #1 revealed an admitted [DATE]. There was no evidence Resident #1 had been offered or educated regarding the COVID-19 vaccination within the past year. Review of the medical record for Resident #31 revealed an admitted [DATE]. There was no evidence Resident #31 had been offered or educated regarding the COVID-19 vaccination within the past year. Review of the medical record for Resident #42 revealed an admitted [DATE]. There was no evidence Resident #42 had been offered or educated regarding the COVID-19 vaccination within the past year. Review of the medical record for Resident #76 revealed an admitted [DATE]. There was no evidence Resident #1 had been offered or educated regarding the COVID-19 vaccination within the past year. Interview on 02/26/25 09:58 A.M. with Licensed Practical Nurse (LPN) #504 who was the Infection Control Preventionist, revealed she could provide no evidence Residents #1, #31 #42 or #76 had been offered or declined the COVID-19 vaccination. Review of the facility policy titled COVID-19 Vaccination dated 01/02/24 revealed all residents would be offered the COVID-19 vaccination. If the resident was unable to make decisions due to decreased mental capacity, the resident's designated representative would be provided with a fact sheet regarding the vaccine and given the option to administer on the resident's behalf.