STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366477	A. Building B. Wing	04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenue at North Ridgeville	6200 Lear Nagle Road North Ridgeville, OH 44039

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47990 Based on observation, staff interview, record review, policy review, and review of a self-reported incident, the facility failed to ensure Resident #89 was treated with respect and dignity during care. Additionally, the facility failed to ensure privacy and dignity was provided to Resident #02 while toileting, and failed to ensure indwelling urinary catheter drainage bags were covered in a dignified manner for Residents #39 and #56. This affected four (Residents #89, #02, #39, and #56) of seven residents reviewed for activities of daily living and dignity. The facility census was 96. Findings include: 1. Review of the medical record for Resident #89 revealed an admitted [DATE]. Medical diagnoses included congestive heart failure, chronic obstructive pulmonary disease, iron deficiency anemia, and muscle weakness. Review of Resident #89's Minimum Data Set (MDS) 3.0 admission assessment dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Resident #89 had no hallucinations or delusions, and was noted to have verbal behavioral symptoms towards others on one to three days during the seven-day lookback period. Resident #89 required substantial/maximum assistance with activities of daily living and was dependent on staff for transfers. Review of Resident #89's care plan dated 04/02/24, revealed Resident #89 was identified to have behaviors of yelling at staff and accusing staff of not providing him a meal tray. Care planned interventions included to anticipate the resident's needs, praise positive behavior, explain why behaviors are not appropriate, and intervene as necessary to protect the safety and rights of others. Review of the Self-Reported Incident (SRI) initiated on 04/03/24 and completed on 04/08/24, revealed the facility learned of Resident #89's care concerns via a review posted by a family member on a public website. The investigation stated there were specifically allegations of poor care related to changing of bed linens, a concern with the delivery of meal trays, and staff using profanity, with Registered Nurse (RN) #336 listed as the alleged perpetrator. The SRI investigation revealed the facility unsubstantiated the allegations indicating no abuse occurred. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a handwritten statement by RN #336 dated 04/04/24, revealed Resident #89 as constantly on his call light and would frequently yell and curse at staff. The statement indicated RN #336 walked into Resident #89's room and sternly stated, You will not speak to me or the staff in this manner and you will not say F off to me. The statement continued on that an unnamed State tested Nurse Aide (STNA) then entered the room, took over the situation, with the resident heard stating he did not say those things. RN #336 then stated, Yes you did and continue to say these things clearly to all the staff. RN #336 then exited the room. Review of a statement by STNA #387 dated 04/04/24, revealed she entered Resident #89's room on 03/31/24 and RN #336 was in the room having a conversation with the resident that was somewhat argumentative. Resident #89 was heard using the F word several times towards RN #336, and RN #336 responded back that he would not tolerate being spoken to in that manner. RN #336 stated if the resident was not happy here he could initiate a discharge to another facility. Resident #89 responded with F you, to which RN #336 exited the room while stating F this. The statement concluded with STNA #387 identifying she stayed to assist Resident #89 in calming down prior to her departure from the room. An interview on 04/09/24 at 9:01 A.M. with Resident #89 revealed an interaction that occurred on 03/31/24. Resident #89 stated RN #336 cursed at him and treated him disrespectfully, stating F you during the interaction and You and your wife are nasty. Resident #89 felt offended and disrespected by the verbal interaction. An interview on 04/09/24 at 12:57 P.M. with RN #336 revealed he recalled the interaction with Resident #89 on 03/31/24. RN #336 stated he would frequently care for Resident #89 and when he would answer his call light Resident #89 would respond with a F you statement. RN #336 stated on 03/31/24, he had enough, he was frustrated, and he told Resident #89 he was, Tired of the 'F you' and 'F them' responses, and that Resident #89's negative treatment of staff had to stop. RN #336 stated Resident #89 continued to curse and yell and mistreat staff, and finally he exited the room when STNA #387 entered the room. RN #336 verified he was frustrated and may have said F this when leaving the room, but he was not for sure. RN #336 stated he was told by an unknown staff member that he cannot curse at residents, he verified it was disrespectful, but was tired of being treated poorly when he aimed to help Resident #89. An interview on 04/09/24 at 1:41 P.M. with STNA #387 recalled the incident from 03/31/24 with Resident #89 and RN #336. STNA #387 recalled the resident initiating a verbal altercation, but RN #336 became increasingly frustrated and 'lost his cool' with Resident #89. STNA #387 did not believe RN #336 intended to become aggressive or inappropriate with the resident, but he did curse around the resident, stating the F word multiple times. An interview on 04/09/24 3:41 P.M. with the Administrator verified RN #336's interaction with Resident #89 did not meet the facility's customer service expectations. The Administrator stated it was never appropriate to curse in front of or at residents and RN #336 should have excused himself from the room instead of continuing to engage with Resident #89 while he was upset. The Administrator verified RN #336 needed and will receive additional customer service training. 2. Review of the medical record for Resident #02 revealed an admitted [DATE]. Medical diagnoses included Alzheimer's disease, chronic obstructive pulmonary disease, congestive heart failure, unsteadiness on feet, and muscle weakness. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #02's Minimum Data Set (MDS) 3.0 assessment dated [DATE], revealed the resident had a BIMS score of three, indicative of severely impaired cognition. Resident #02 required partial/moderate assistance with toileting hygiene and toilet transfers. An observation on 04/01/24 at 9:25 A.M. revealed Resident #02 repeatedly yelling help me, help me, help me. Resident #02's call light was activated and ringing outside of the room. The door to Resident #02's room was open, as was the door to his bathroom, where Resident #02 was nude and seated on the toilet and clearly visible from the hallway. A continuous observation for 10 minutes was made of Resident #02 yelling out for help, attempting to stand up, and no staff members visible in the long corridor or the nurse's station across from Resident #02's room. The call light was answered at 9:35 A.M. by State tested Nurse Aide (STNA) #367 who closed the door after he entered Resident #02's room. A follow up interview with STNA #367 on 04/01/24 at 9:42 A.M. upon exiting the resident's room, revealed he answered Resident #02's call light as fast as he could after he finished up with another resident's care. STNA #367 verified he had left Resident #02's door open to the room and the bathroom, and Resident #02 was not provided privacy while toileting. An interview on 04/02/24 at 9:51 A.M. with Unit Manager (UM) #373 stated privacy should be provided to residents when toileting and the door to either the room or the bathroom should have been closed for Resident #02. 3. Review of the medical record for Resident #39 revealed an admitted [DATE]. Medical diagnoses included neurocognitive disorder with lewy bodies, type II diabetes mellitus, obstructive uropathy, and muscle weakness. Review of Resident #39's MDS 3.0 quarterly assessment dated [DATE], revealed Resident #39 had a BIMS score of three, indicating severely impaired cognition. The assessment reflected he had an indwelling urinary catheter. An observation on 03/28/24 at 2:48 P.M. revealed Resident #39 seated in his wheelchair in the 200-hallway lounge area. His urinary catheter drainage bag was observed to extend out of the right side of his pant leg and was hanging beneath the wheelchair. The drainage bag was uncovered and approximately 350 milliliters (ml) of amber colored urine was visible in the tubing and urinary drainage bag. An interview on 03/28/24 at 2:59 P.M. with STNA #374 verified Resident 39's catheter bag was uncovered and should have had a privacy cover on the drainage bag. A subsequent observation on 04/09/24 at 12:14 P.M. revealed Resident #39 seated in his wheelchair in the 200-hallway lounge area. Five other residents were present in the lounge area. Resident #39's urinary catheter drainage bag was extended out of the right side of his pant leg and was hanging beneath the wheelchair. The drainage bag was uncovered and revealed approximately 300 ml of yellow urine in the drainage bag. Licensed Practical Nurse (LPN) #365 verified the finding at the time of observation and stated the urinary catheter drainage bag should be covered for dignity. 4. Review of the medical record for Resident #56 revealed an admitted [DATE]. Medical diagnoses included multiple sclerosis, Alzheimer's disease with late onset, neuromuscular dysfunction of the bladder, and muscle weakness. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #56's MDS quarterly assessment, dated 01/01/24, revealed Resident #56 had a BIMS score of three, indicating severely impaired cognition. The assessment reflected he had an indwelling urinary catheter. An observation on 03/28/24 at 2:55 P.M. revealed Resident #56 seated in his wheelchair next to Resident #39 in the 200-hallway common area. Resident #56's urinary drainage bag was connected to the side of his wheelchair and was uncovered, with yellow urine visible in the urinary drainage bag. There were three other residents seated in the 200-hallway lounge area and various staff and family members who were present in the hallways. An interview on 03/28/24 at 2:59 P.M. with STNA #374 verified Resident #56's catheter bag was uncovered and should have had a privacy cover on the drainage bag. An interview on 04/02/24 at 9:51 A.M. with UM #373 verified privacy covers should be in place for urinary drainage bags, and typically the facility carried urinary drainage bags with built in privacy covers. Review of the policy titled, Resident Rights, revised in October 2017, revealed the facility's practice is to assure the resident's personal dignity, well-being, and self determination is maintained. This deficiency represents non-compliance investigated under Master Complaint Number OH00152660.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47990 Based on observation, staff and resident interview, and record review, the facility failed to complete a Minimum Data Set (MDS) 3.0 significant change assessment for a resident who sustained a significant decline in functional abilities following a fall with upper extremity fracture. This affected one (Resident #20) of ten residents reviewed for accuracy of assessments. The facility census was 96. Findings include: Review of the medical record for Resident #20 revealed an admitted [DATE]. Medical diagnoses included Sjogren syndrome, lack of coordination, muscle weakness, and a displaced fracture of the surgical neck of the left humerus. The resident sustained a fall with a left humerus fracture at the facility on 02/22/24. Review of an incident report dated 02/22/24 at 5:35 P.M. revealed Resident #20 sustained a fall after attempting to get up unassisted to walk to the bathroom. The resident landed on her left shoulder and did not hit her head. The nurse on duty was present outside of Resident #20's room and witnessed the fall. An x-ray was ordered and completed at the facility and indicated the resident had a fracture to her left upper extremity. She was transported to the local emergency department where the fracture was confirmed. Resident #20 had an unrelated hospitalization due to pneumonia from 02/27/24 to 03/03/24. The resident returned to the facility on [DATE]. Review of Resident #20's interdisciplinary progress notes revealed a noted dated 03/03/24 at 12:30 P.M. indicating that report was received from the receiving hospital and Resident #20 was en route back to the facility. The note referenced Resident #20 was seen by orthopedics while inpatient at the hospital and the left upper extremity sling was to remain in place, non-weight bearing to the left arm, as no surgical intervention had been indicated. The note additionally referenced Resident #20 had an indwelling urinary catheter that was to remain in place until 03/05/24 due to urinary retention. Review of Resident #20's physician's orders revealed an order dated 03/03/24 to remove Resident #20's indwelling urinary catheter on the night shift of 03/04/24 between 6 P.M. and 6 A.M. The resident had two separate orders, one dated 03/03/24 and one dated 03/10/24 to provide urinary catheter care every shift. Review of Resident #20's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for March 2024 revealed the task of removing the indwelling urinary catheter was signed off and marked completed on the evening shift of 03/04/24 as scheduled by Licensed Practical Nurse (LPN) #429. The records also indicated beginning on 03/10/24, urinary catheter output was documented daily through the month of March 2024. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #20's interdisciplinary progress notes referenced narrative notes on 03/12/24 and 03/26/24 stating Resident #20 had an indwelling urinary catheter to continuous drainage. There was no indication in the progress notes that the catheter was ever removed as ordered and re-inserted. There was no notation per nursing or the physician on why Resident #20 required the continued use of a urinary catheter. Review of Resident #20's MDS 3.0 Medicare 5-day assessment dated [DATE], revealed Resident #20 had a noted decline in her functional abilities since her prior MDS quarterly assessment dated [DATE]. The 03/10/24 assessment reflected Resident #20 required substantial/maximum assistance for upper body dressing, was dependent for lower body dressing, and was marked as not applicable for donning and doffing footwear. The resident was previously coded as able to do these three tasks with only partial/moderate assistance on the prior quarterly assessment dated [DATE]. Resident #20 was also noted to have had a significant decline in her mobility, with her ability to roll left and right, go from a sitting to a lying position, go from a lying to a sitting position, chair to bed transfers, and toilet transfers all coded as dependent on the 03/10/24 MDS, when she was previously able to complete the mobility tasks with only partial/moderate assist on the 01/12/24 MDS. In total, Resident #20 was observed to have a decline in three areas of activities of daily living and in six areas of mobility compared with the prior quarterly MDS assessment. The assessment dated [DATE] additionally referenced Resident #20 being occasionally incontinent of urine, when the resident continued to have an indwelling urinary catheter. Further review of MDS assessments revealed a significant change MDS was not completed. An interview on 04/02/24 at 10:45 A.M. with MDS Nurse #333 and MDS Nurse #345 stated they were unsure if Resident #20 had been evaluated by the interdisciplinary team as requiring a significant change in status assessment following her 02/22/24 fall with fracture but would check their records. They stated they were both unaware that Resident #20 continued to have an indwelling urinary catheter. A follow up interview on 04/02/24 at 3:01 P.M. with MDS Nurse #345 stated she had checked Resident #20's assessments and did not recognize a decline in functional abilities in more than two areas. MDS Nurse #345 then pulled up Resident #20's MDS assessments dated 01/12/24 and 03/10/24 and compared them side by side and verified Resident #20 had decline in more than two areas since her prior assessment. MDS Nurse #345 stated they would initiate a significant change assessment. MDS Nurse #345 additionally verified Resident #20 should have also been marked as having an indwelling urinary catheter on the 03/10/24 MDS. Review of the, Resident Assessment Instrument (RAI) Manual, revised in October 2023 revealed a significant change in status assessment is a comprehensive assessment that must be completed when the resident meets significant change guidelines. A significant change is a major decline or improvement that will not normally resolve itself without intervention by staff, the decline is not considered self-limiting, impacts more than one area of the resident's health and requires interdisciplinary review and/or revision of the care plan. The RAI manual provided additional instructions that a significant change should be completed if there were declines in two or more areas, of which can include, but was not limited to, any decline in an activity of daily living (ADL) physical functioning area (self-care or mobility) where the resident is newly coded as requiring more assistance and does not reflect normal fluctuations in that individual's functioning and the resident's incontinence patter changed or there was placement of an indwelling urinary catheter. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents an incidental finding discovered during the course of the complaint investigation.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47990 Based on interview, record review, and policy review, the facility failed to ensure a baseline care plan was developed and a summary provided to Resident #100 and/or their representative. The facility also failed to ensure a summary of Resident #111's baseline plan of care was provided to the resident and/or their representative. This affected two (Residents #100 and #111) of four residents reviewed for care planning. The facility census was 96. Findings include: 1. Review of the medical record for Resident #100 revealed an admitted [DATE]. Medical diagnoses included cerebrovascular accident (stroke) with residual right sided weakness, type II diabetes mellitus, and frequent falls. Resident #100 was transferred to a local hospital on 03/07/24 and did not return to the facility. Review of the Minimum Data Set (MDS) 3.0 Medicare 5-day and discharge return not anticipated assessment, dated 03/07/24, revealed Resident #100 had a Brief Interview for Mental Status (BIMS) score of a 00, indicating severely impaired cognition. Resident #100 was recorded as sometimes being understood and sometimes understanding. The assessment referenced Resident #100 required substantial/maximum assistance with activities of daily living and transfers. The resident was recorded as having one fall with no injury and one fall with major injury since admission to the facility. Further review of Resident #100's medical record revealed no evidence that a baseline care plan had been developed or implemented with Resident #100's individualized goals and relevant healthcare information. Resident #100's electronic medical record revealed there was no admission care plan completed. There was no document in Resident #100's records to indicate any type of care conference or care planning meeting had taken place. A falls plan of care was initiated for Resident #100 on 03/04/24 after she had sustained a fall at the facility on 03/03/24. An interview on 03/27/24 at 3:46 P.M. with a family member of Resident #100 revealed Resident #100 resided at the facility for only a few days. The family had never been contacted by phone to participate in the development of Resident #100's baseline care plan, nor had a summary of Resident #100's plan of care provided to the family. The family member of Resident #100 stated they actually had attempted to phone the facility on multiple occasions and had difficulty getting the staff to answer the phone, and difficulty reaching the nurse on duty to receive updates on Resident #100's care. The family member of Resident #100 was unclear what the facility was doing to prevent future falls for Resident #100 and was unsure if or when she had received therapy. 2. Review of the medical record for Resident #111 revealed an admitted [DATE]. Medical diagnoses included a wedge compression fracture of the T5-T6 vertebra, adult failure to thrive, iron deficiency anemia, and anxiety. The resident was transferred to the hospital on 03/10/24 and did not return to the facility. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #111's baseline care plan dated 03/07/24, revealed a baseline care plan was initiated for Resident #111 by the admitting nurse. There was no indication in the medical record that Resident #111 or their family had received a summary of the baseline care plan. An interview on 03/27/24 at 11:57 A.M. with a family member of Resident #111 revealed they were never contacted by the facility to participate in Resident #111's baseline care plan, nor were they offered or provided with a summary of the baseline plan of care. An interview on 04/01/24 at 11:02 A.M. with Unit Manager (UM) #373 revealed the admitting nurse is the one responsible to complete the baseline plan of care. UM #373 stated typically after that is completed, the facility schedules an admission care conference for approximately two weeks post-admission. If the family requests a copy of the care plan, one would be provided, but they are typically not automatically provided. UM #373 verified an baseline care plan was never initiated for Resident #100 and there was no evidence that a baseline care plan had been provided to the resident or representative of Residents #100 and #111. Review of the policy titled, Care Plan - Advanced Care Plan Process, revised December 2022, revealed the interdisiciplinary team will coordinate with the resident and/or their responsible party and will initiate an interim plan of care within 48 hours of the resident's admission. The interim care plan should include at minimum, the necessary healthcare information to properly care for a resident. The admission care plan assessment facilitates care until the comprehensive interdisciplinary plan of care is developed within 7 days after completion of the comprehensive assessment. This deficiency represents non-compliance investigated under Complaint Numbers OH00152167 and OH00152100.

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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** 47990 Based on observation, staff and resident interview, and record review, the facility failed to ensure resident care plans were updated to reflect individualized and necessary components of the residents' care. This affected two (Residents #20 and #94) of ten residents reviewed for care plans. The facility census was 96. Findings include: 1. Review of the medical record for Resident #20 revealed an admitted [DATE]. Medical diagnoses included Sjogren syndrome, lack of coordination, muscle weakness, and a displaced fracture of the surgical neck of the left humerus. The resident was recorded to have had a fall with fracture with an overnight hospitalization from [DATE] to 02/24/24. The resident had a second hospitalization for pneumonia from 02/27/24 to 03/03/24. Review of the Minimum Data Set (MDS) 3.0 Medicare 5-day assessment dated [DATE], revealed Resident #20 to have a Brief Interview for Mental Status (BIMS) score of eight, indicative of moderately impaired cognition. Review of the incident report dated 02/22/24 at 5:35 P.M. revealed a nurse was outside Resident #20's room and heard the resident yell. As the nurse turned around, she observed the resident fall out of her recliner onto the floor, landing on her left shoulder. Resident #20 was not observed to hit her head, and stated she had been trying to get up to walk to the bathroom. The nurse assessed the resident for injuries and staff assisted her into the bed. The resident complained of pain to her left arm. The provider was contacted and ordered x-ray examination. An entry regarding the fall was also recorded in Resident #20's interdisciplinary progress notes. Review of Resident #20's interdisciplinary progress notes reflected a note dated 02/22/24 at 9:25 P.M. that x-ray results were reported to the facility's Nurse Practitioner, who gave an order for Resident #20 to be transferred to a local emergency room . Resident #20's family was notified and she was transferred to the hospital on 02/22/24. An additional progress note dated 02/23/24 revealing Resident #20 returned from the hospital with a prescription for pain medication and an order to follow up with an orthopedic specialist. Subsequent progress notes identified Resident #20 was sent to the hospital on 02/27/24 where she was admitted to the hospital for possible pneumonia until 03/03/24 when she returned to the facility. A progress note dated 03/03/24 at 12:30 P.M. revealed Resident #20 was en route back to the facility for readmission. The progress note identified that an orthopedic specialist had seen Resident #20 while in the hospital and ordered a sling to her left upper extremity to remain in place, as no surgical intervention was indicated. The note stated Resident #20 was to remain non-weight bearing on the left arm and identified she had an indwelling urinary catheter in place for urinary retention that was to remain in until 03/05/24. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #20's plan of care revealed a care plan focus of a left arm fracture initiated on 02/22/24, with listed interventions which included assist with ambulation and exercises as ordered by physical therapy, give analgesics as ordered and monitor response, sling to the left arm as MD ordered, and support involved limb when moving the resident. The care plan did not include a notation that Resident #20 was non-weight bearing to the left upper extremity. An additional care plan focus of bowel and bladder incontinence, initiated on 06/03/22 and revised on 06/28/22, referenced Resident #20 being frequently incontinent of bowel and bladder. There was no mention of Resident #20 having an indwelling urinary catheter or an indication for use of an indwelling urinary catheter. An observation and interview on 03/27/24 at 3:08 P.M. with Resident #20 and a visitor of Resident #20 revealed the resident had an indwelling urinary catheter since she returned back from the hospital. Both Resident #20 and her visitor denied the catheter having been removed and re-inserted. Subsequent observations on 03/28/24 at 9:15 A.M. and 04/02/24 at 6:22 A.M. revealed Resident #20 continued to have an indwelling urinary catheter in place. An interview conducted on 04/02/24 at 8:41 A.M. with State tested Nurse Aide (STNA) #418 verified Resident #20 had her indwelling urinary catheter and a sling to her left upper arm since her return from the hospital in early March. An interview conducted on 04/02/24 at 8:47 A.M. with Licensed Practical Nurse (LPN) #421 verified Resident #20 has had the indwelling catheter since her return to the facility earlier in the month of March and it had not been removed. An interview on 04/02/24 at 9:51 A.M. with Unit Manager (UM) #373 revealed she had transcribed the order for Resident #20's catheter to be removed upon her return from the hospital. UM #373 stated she was unsure why she still had the urinary catheter and would have to check, as she thought it had been discontinued. UM #373 verified there should be orders and a care plan for the indwelling urinary catheter. An interview on 04/02/24 at 3:01 P.M. with MDS Nurse #345 revealed clarification had been received regarding Resident #20's urinary catheter, with the provider ordering the removal of the indwelling urinary catheter on 04/02/24, providing instruction to monitor the resident for her ability to void and provided instructions on re-insertion if unable to void for more than 24 hours. MDS Nurse #345 additionally relayed that an appointment was made for Resident #20 to see her orthopedic specialist on 04/04/24 at 1:00 P.M. with the facility transporting the resident to that appointment. MDS Nurse #345 verified Resident #20's plan of care was updated to reflect the sling but the catheter was not added to the care plan due to the order given by the provider to discontinue the indwelling urinary catheter. 2. Review of the medical record for Resident #94 revealed an admitted [DATE]. Medical diagnoses included displaced fracture of the first cervical vertebrae (neck fracture), dementia, muscle weakness, and a history of falls. Resident #94 sustained a fall on 03/09/24, was transferred to a local emergency department, and returned back to the facility the same day. Resident #94 had been receiving hospice services at the facility since admission. Review of the MDS 3.0 quarterly assessment dated [DATE], revealed Resident #94 to have a BIMS score of one, indicative of severely impaired cognition. (continued on next page)

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	366477	A. Building B. Wing	04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenue at North Ridgeville	6200 Lear Nagle Road North Ridgeville, OH 44039

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an incident report dated 03/09/24 at 11:09 A.M. revealed the nurse was summoned to Resident #94's room by an unnamed STNA. Resident #94 was observed on her back, on the floor between her bed and dresser. The resident was unable to provide a clear description of what happened. Resident #94 was assessed for injury with copious amounts of blood around her head. A second nurse provided assistance and applied pressure to head. Emergency medical services was summoned and Resident #94 was not moved until the squad arrived to transport Resident #94 to the hospital. The report indicated that multiple interventions were placed following the fall including a new mattress with a defined perimeter, fall mats, and a broda chair for positioning. Review of the interdisciplinary progress notes revealed Resident #94 returned to the facility on the same date of the fall, 03/09/24. Review of the hospital after visit summary dated 03/09/24, revealed Resident #94 had a fracture of her cervical spine (neck). Instructions were provided to keep the collar on her neck at all times, with explicit instructions Do NOT remove it! Review of Resident #94's physician orders revealed no order for a neck brace/collar in the resident's record. Review of Resident #94's care plan revealed a focus area dated 03/14/24, of having an alteration in her musculoskeletal status related to a fracture of her cervical vertebra status-post fall. Care planned interventions included anticipating and meeting needs, follow provider orders for weight bearing status, monitor for fatigue and signs of complications related to arthritis, and monitor and document risk for falls. The care plan contained no indication that Resident #94 was supposed to wear a neck brace. Observations on 03/28/24 at 9:21 A.M. revealed Resident #96 seated in her wheelchair eating breakfast in the dining room. Her neck brace was in place. An observation on 04/01/24 at 4:41 P.M. revealed Resident #96 seated in her wheelchair in the common lounge area. She had a neck collar/brace in place and appeared asleep. An interview on 04/01/24 at 4:46 P.M. with LPN #421 revealed Resident #96 had the neck brace since returning from the emergency department post-fall a few weeks ago. LPN #421 revealed Resident #96 is mostly compliant with wearing the neck brace, but does have impaired cognition related to dementia and sometimes she removes it or tries to wear it like a hat and staff have to assist in re-applying. LPN #421 stated she was unsure if there was an order but stated there should be and probably is in her physical paper chart. LPN #421 stated she works Resident #96's unit consistently so she is aware of the residents and the care needs. An interview on 04/02/24 at 9:51 A.M. with UM #373 verified there was no order transcribed into the electronic medical record for Resident #94's neck brace, nor was their documentation of staff consistently applying or checking to be sure the neck brace was in place. UM #373 verified there should have been an order for the neck brace. An interview on 04/02/24 at 3:01 P.M. with MDS Nurse #345 verified there was no indication of Resident #94's neck brace/collar included in the resident's care plan until it was added on 04/02/24. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy titled, Care Plan - Advanced Care Plan Process, revised in December 2022 revealed the interdisciplinary team will coordinate with the resident and their responsible party an appropriate plan of care for the resident's needs or wishes, specific to person-centered care based on the assessment and re-assessment process. This deficiency represents an incidental finding discovered over the course of the complaint investigation.

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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** 47990 Based on family and staff interviews, record review, review of hospital records, review of facility policy, and review of facility fall investigations, the facility failed to ensure Resident #100 received adequate and timely care and treatment following an unwitnessed fall with major injury. Actual Harm occurred on 03/03/24 following an unwitnessed fall at 7:00 P.M. when the facility failed to adequately identify the resident's injury, treat the resident's pain, and timely obtain an x-ray for Resident #100, who, over the next few days, exhibited signs of pain (including verbal complaints of pain, facial grimacing and winching in pain during care and with movement). The Nurse Practitioner (NP) was notified of Resident #100's pain on 03/05/24 at 5:40 P.M. and ordered bilateral arm x-rays due to pain. The ordered x-rays were not obtained until the afternoon of 03/07/24, and results indicated a left arm fracture. The resident was subsequently transferred to the hospital on 03/07/24 at 4:40 P.M. for treatment where the resident was diagnosed with a markedly displaced fracture and the hospital questioned the facility as to why the resident wasn't sent to the hospital after the fall on 03/03/24. This affected one (Resident #100) of three residents reviewed for falls. The facility census was 96. Findings include: Review of the medical record for Resident #100 revealed an admitted [DATE]. Medical diagnoses included cerebrovascular accident (stroke) with residual right sided weakness, type II diabetes mellitus, and frequent falls. Resident #100 resided in the secured memory care unit. Resident #100 was transferred to a local hospital on 03/07/24 and did not return to the facility. Review of the Minimum Data Set (MDS) 3.0 Medicare 5-day and discharge return not anticipated assessment, dated 03/07/24, revealed Resident #100 had a Brief Interview for Mental Status (BIMS) score of a 00, indicating severely impaired cognition. Resident #100 was recorded as sometimes being understood and sometimes understanding. The assessment referenced Resident #100 required substantial/maximum assistance with activities of daily living and transfers. The resident was recorded as having one fall with major injury since admission to the facility. Review of Resident #100's physician's orders dated 03/03/24 revealed orders for aspirin 81 milligrams (mg) daily (a salicylate and platelet aggregation inhibitor that can cause easy bleeding and bruising) and clopidogrel 75 mg once daily (an antiplatelet medication that can cause easy bleeding and bruising). Review of Resident #100's plan of care revealed no baseline care plan had been implemented upon admission to the facility. A falls plan of care was initiated for Resident #100 on 03/04/24 after she had sustained the fall at the facility. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of an incident report dated 03/03/24 at 7:00 P.M. revealed Resident #100 was seated with the nurse at the nurse's station when the nurse went to provide care to another resident in the dining room. The nurse heard Resident #100 fall and responded. The nurse assessed the resident and noted a quarter sized knot to the left side of her forehead. The nurse and an unnamed State tested Nurse Aide (STNA) assisted Resident #100 back to her chair. The assessment noted neurological checks were initiated, and vital signs were within normal limits. The resident denied pain and had no signs or symptoms of distress. Notifications were completed to the physician and Resident #100's family. An intervention of a wheelchair change was completed, as the prior wheelchair's height was too high for Resident #100. An entry reflecting the fall was also recorded in Resident #100's interdisciplinary progress notes. Review of subsequent interdisciplinary progress notes dated 03/04/24 at 10:40 P.M. revealed Resident #100 continued neurological checks, with her forehead observed to have a dark purple color spot. Resident #100's range of motion was noted to be within normal limits without pain or discomfort. A subsequent progress note on 03/05/24 at 5:40 P.M. documented Resident #100 complained of bilateral arm pain and the facility nurse practitioner was notified, who ordered x-ray examinations to bilateral (both) arms. The progress note reflected family was notified of new orders. Review of a progress note dated 03/06/24 by Certified Nurse Practitioner (CNP) #250 revealed she assessed Resident #100 to be thin, frail, and in no visible distress. Her only skin condition was a bruise to the forehead. CNP #250 assessed Resident #100 to be confused and have right sided weakness. The assessment referenced CNP #250 was aware of Resident #100's recent fall and reports of bilateral arm pain and noted that x-rays were pending. Review of Resident #100's physician's orders revealed an order dated 03/05/24, transcribed by Registered Nurse (RN) #409, for bilateral arm x-rays. A second order dated 03/07/24, transcribed by RN #306, revealed an order for left upper extremity x-ray due to resident complaints of left arm pain. Review of Resident #100's radiology reports revealed only one report, dated 03/07/24, was present in the medical record. Resident #100 received an x-ray examination of her left upper extremity per mobile service at the facility on 03/07/24 and the report indicated an acute displaced supracondylar fracture of the left humerus. Review of Resident #100's medical record reflected only three skilled charting assessments since admission. These assessments were dated 03/05/24 at 1:54 P.M. (noted as incomplete), 03/06/24 at 4:36 P.M. and 03/06/24 at 9:41 P.M. and revealed on all three notes indicated Resident #100's skin condition as normal. There was no indication of the resident being post-fall or having any bruising or edema. Resident #100's musculoskeletal status was only noted to reflect the resident had a history of strokes with right sided weakness. Review of Resident #100's Medication Administration Record for March 2024 revealed pain was marked as Not Applicable or No pain on each shift from 03/04/24 to 03/07/24. There was no indication of what pain scale was used or how Resident #100's pain was assessed. Review of an interdisciplinary progress note dated 03/07/24 at 4:38 P.M. identified Resident #100 had an x-ray examination of her left arm which showed a possible fracture. The physician was called and ordered Resident #100 be sent to the local emergency room to be evaluated and treated. The note documented Resident #100's family was notified. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the local hospital records dated 03/07/24, revealed Resident #100 arrived at the local emergency department with a visible left arm injury. Initial reports recorded in the emergency department record indicated the hospital was told Resident #100 had a fall on 03/02/24, prior to arriving to the facility. A physical examination of Resident #100 revealed significant bruising above her left eye, forehead, and temporal region. Resident #100 was observed to have swelling and bruising over her left wrist, distal humerus, and pain upon range of motion of the left elbow. An x-ray examination completed at the hospital on 03/07/24 revealed a markedly displaced supracondylar fracture with suspected extension to the articular surface. The hospital records reflected multiple calls to unnamed staff at the facility who reported different versions of the events. The hospital first phoned the facility at 5:19 P.M. and was told Resident #100 fell out of bed on 03/03/24 but did not have any further details. The hospital then recorded a second call at 5:36 P.M. to Resident #100's family who verified Resident #100 did fall at the facility. An additional phone call made by the hospital to the facility to discuss the circumstances and details of the fall was made, with the hospital records questioning why Resident #100 was not immediately sent into the hospital as she had a fall on 03/03/24 on blood thinners and had a notable head injury. The facility staff communicated to the hospital Resident #100 fell at home on 03/02/24 prior to arriving to the facility, which was a noted contraindication to what the family had reported to the hospital. The hospital records noted a report was filed with local adult protective services. An interview conducted on 03/27/24 at 3:46 P.M. with a family member of Resident #100 revealed a concern related to Resident #100's care while at the facility. The family member stated Resident #100 fell on [DATE] shortly after admission and hit her head. They had requested for Resident #100 to be sent to the hospital for evaluation but was unsure why she was not sent. Resident #100's family member stated they visited her at the facility on 03/05/24 and assisted her in removing a sweater she was wearing, and Resident #100 winced in pain. The family member identified the arm looked obviously broken and was bruised. The family reported to the nurse on duty a concern related to her arm and were told the nurse would contact the physician and order an x-ray examination. The family denied that the nurse physically examined Resident #100 and they never heard any x-ray results until they phoned the facility on 03/07/24. There was a different nurse on duty who told them the x-ray never came and there was no results to report and she would check on it. Later that day, the family was notified that an x-ray was completed at the facility indicating a left upper arm fracture and Resident #100 would be going to the hospital. Resident #100's family member denied any communication or involvement in a plan of care for Resident #100 and denied that a summary of Resident #100's care needs had been provided to them. An interview on 03/28/24 at 11:09 A.M. with the Director of Nursing (DON) indicated Resident #100 did not return to the facility post-hospitalization . She was unsure of the reason Resident #100 chose not to return to the facility. An interview on 03/28/24 at 3:50 P.M. with State tested Nurse Aide (STNA) #432 revealed she cared for Resident #100 while at the facility and recalled her having bruising to her arms. She additionally recalled Resident #100 being very frail and weak. An interview on 04/01/24 at 11:02 A.M. with Unit Manager (UM) #373 revealed she did not know Resident #100 as she was responsible for covering a different unit. UM #373 stated the facility is down a unit manager, and right now there is no unit manager for the memory care unit. UM #373 stated everyone tries to help out but there is not one designated manager overseeing or coordinating care on the memory care unit. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	An interview on 04/01/24 at 1:57 P.M. with STNA #350 revealed she cared for Resident #100 on multiple dates. She recalled her being in pain when her arms were moved while getting dressed. She specifically recalled the left arm appeared to hurt more than the right, she remembered Resident #100's left arm being stiff, difficult to move, and painful during activities of daily living. STNA #350 stated she had been told by an unnamed nurse on duty that stiff and painful was Resident #100's baseline. An interview on 04/01/24 at 2:05 P.M. with STNA #361 revealed she recalled caring for Resident #100 on multiple days. She recalled on the day Resident #100 went to the hospital, she was told to be careful while dressing her, and she dressed her slow and easy. When she went to move her left arm, she called out in pain. The nurse on duty, Registered Nurse (RN) #306, was already aware. Later that day, she went to the hospital because the left arm was broken. An interview on 04/02/24 at 9:42 A.M. with RN #306 revealed she admitted Resident #100 to the facility, and cared for her on the day she went to the hospital. She stated she received a call on that day from a family member of Resident #100 who stated they thought her arm was broken. RN #306 stated she looked at Resident #100's arm and it did not look purple or bruised, but when she went to move it the resident winced in pain. RN #306 stated the arm did not really look deformed, but she was guarding and cradling her left arm to protect it. RN #306 stated Resident #100 was still new, the staff didn't know her baseline or mannerisms yet and Resident #100 was aphasic (difficulty formulating language or speech) status post stroke. RN #306 stated she communicated with the hospital the best she could, but she was not in the facility when Resident #100 fell earlier in the week and did not have many details around the circumstances of Resident #100's fall. Attempts to reach RN #409 during the survey were unsuccessful. An interview on 04/02/24 at 11:29 A.M. with the DON revealed RN #409 did transcribe an order for Resident #100 to have arm x-rays on 03/05/24. The DON identified there was a delay in getting the x-ray completed as RN #409 was new and unfamiliar with the facility's process for ordering x-ray examinations. RN #409 attempted to call to order the examination, but the company only accepts online orders for STAT (urgent) examinations. The x-ray provider from the contracted company happened to be in the building on one of the next days providing in-servicing to staff and updated that they could not place orders that way. The DON indicated when RN #306 returned, she placed an order for the x-ray examination for Resident #100's arm and once the report came back the resident was sent to the hospital. The DON stated she was not aware of the delay in x-ray examinations until she happened upon the x-ray provider in the following days. The DON additionally identified that the nurse's should have been completing a 72-hour post-fall assessment each shift for 72 hours post fall and verified there was no post-fall assessments completed. Review of the policy titled, Fall Management, revised in December 2022 revealed the facility will provide an environment that is free from potential hazards. The Interdisciplinary Team will review falls routinely and reports of falls are monitored through the Quality Care Assurance process and routine meetings. The policy did not address what type of monitoring and for what duration residents require post-fall. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the policy titled, Resident Change in Condition, dated 07/28/22, revealed the facility will ensure staff provide timely and appropriate care and services when residents are experiencing a change in condition. The licensed nurse will take immediate action to ensure timely and appropriate care and services are met when a resident change in condition is identified. This deficiency represents non-compliance investigated under Complaint Numbers OH00152447, OH00152167, OH00152100, and OH00151975.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47990 Based on observation, staff interview, resident interview, and policy review, the facility failed to remove an indwelling urinary catheter as ordered and failed to provide justification for the continued use of the indwelling urinary catheter. This affected one (Resident #20) of one resident reviewed for urinary catheters. The facility census was 96. Findings include: Review of the medical record for Resident #20 revealed an admitted [DATE]. Medical diagnoses included Sjogren syndrome, lack of coordination, muscle weakness, and a displaced fracture of the surgical neck of the left humerus. The resident sustained a fall with a left humerus fracture at the facility on 02/22/24. Review of an incident report dated 02/22/24 at 5:35 P.M. revealed Resident #20 had a hospitalization for pneumonia from 02/27/24 to 03/03/24. The resident returned to the facility on [DATE]. Review of Resident #20's interdisciplinary progress notes revealed a noted dated 03/03/24 at 12:30 P.M. indicating Resident #20 had an indwelling urinary catheter that was to remain in place until 03/05/24 due to urinary retention. Review of Resident #20's physician's orders revealed an order dated 03/03/24 to remove Resident #20's indwelling urinary catheter on the night shift of 03/04/24 between 6 P.M. and 6 A.M. Resident #20 had two separate orders, one dated 03/03/24 and one dated 03/10/24 to provide urinary catheter care every shift. Review of Resident #20's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for March 2024 revealed the task of removing the indwelling urinary catheter was signed off and marked completed on the evening shift of 03/04/24 as scheduled by Licensed Practical Nurse (LPN) #429. The records also indicated beginning on 03/10/24, urinary catheter output was documented daily through the month of March 2024. Review of Resident #20's interdisciplinary progress notes referenced narrative notes on 03/12/24 and 03/26/24 stating Resident #20 had an indwelling urinary catheter to continuous drainage. There was no indication in the progress notes that the catheter was ever removed as ordered and re-inserted. There was no notation per nursing or the physician on why Resident #20 required the continued use of an indwelling urinary catheter. Resident #20 had an additional care planned focus initiated on 06/03/22 and revised on 06/28/22, of being frequently incontinent of bowel and bladder. Care planned interventions included wearing briefs, toileting per request and as needed, and maintaining the call light in easy reach. The care plan contained no indication that Resident #20 had an indwelling urinary catheter. (continued on next page)

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation and interview on 03/27/24 at 3:08 P.M. with Resident #20 and a visitor of Resident #20, revealed the resident had an indwelling urinary catheter since she returned back from the hospital. Both Resident #20 and her visitor denied the catheter having been removed and re-inserted. Subsequent observations on 03/28/24 at 9:15 A.M. and 04/02/24 at 6:22 A.M. revealed Resident #20 continued to have an indwelling urinary catheter in place. An interview conducted on 04/02/24 at 8:41 A.M. with STNA #418 verified Resident #20 had her indwelling urinary catheter since her return from the hospital in early March. An interview conducted on 04/02/24 at 8:47 A.M. with LPN #421 verified Resident #20 has had the indwelling catheter since her return to the facility earlier in the month of March and it had not been removed. An interview on 04/02/24 at 9:51 A.M. with Unit Manager (UM) #373 revealed she had transcribed the order for Resident #20's catheter to be removed upon her return from the hospital. UM #373 stated she was unsure why she still had the urinary catheter and would have to check, as she thought it had been discontinued. UM #373 verified there should be orders and a care plan for the indwelling urinary catheter. An interview on 04/02/24 at 3:01 P.M. with MDS Nurse #345 revealed clarification had been received regarding Resident #20's urinary catheter, with the physician ordering the removal of the indwelling urinary catheter on 04/02/24, providing instruction to monitor the resident for her ability to void and provided instructions on re-insertion if unable to void for more than 24 hours. This deficiency represents non-compliance investigated under Complaint Number OH00152447 and Complaint Number OH00151140.