STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	36G266	a. building _____ b. wing _____	06/13/2019

name of provider or supplier	street address, city, state, zip code
NEW AVENUES-PRESSER	17608 EUCLID AVENUE CLEVELAND OH, 44112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETIO N
W 0000	INITIAL COMMENTS POST SURVEY REVISIT ADMINISTRATOR: Karen Knavel CERTIFIED BED CAPACITY: 16 CENSUS: 15 At the time of the Annual survey a Post Survey Revisit was conducted for all previously cited deficiencies. Previously cited deficiencies have been corrected as of 06/13/19. However, non-compliance was found at the time of the Annual survey.	W 0000		

laboratory director's or provider/supplier representative's signature | title | (x6) date

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.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	36G266	a. building _____ b. wing _____	06/13/2019

name of provider or supplier	street address, city, state, zip code
NEW AVENUES-PRESSER	17608 EUCLID AVENUE CLEVELAND OH, 44112

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W 0000	INITIAL COMMENTS FUNDAMENTAL SURVEY ADMINISTRATOR: Karen Knavel CERTIFIED BED CAPACITY: 16 CENSUS: 15 The following deficiencies are based on the Fundamental survey completed on 06/13/19.	W 0000		
W 0189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure dangerous chemicals were secured when unattended. This had the potential to affect the 11 (Individual #1, #3, #4, #5, #6, #9, #10, #11, #12, #14, #15) individuals who resided in the facility who were intellectually disabled and independently mobile. The facility census was 15 individuals. Findings include: On 06/12/19 at 4:10 P.M., the surveyor	W 0189	It is the practice and policy of NATI to ensure the safety of each individual at all times by providing a facility that is safe including during an unexpected emergency situation. The Deficiency: The facility failed to ensure dangerous chemicals were secured when unattended. The Correction: The Facility will complete a staff In-Service as to properly securing dangerous chemicals when unattended. Documented In-Service training will occur on 06-28-19. The Residential Coordinator will be responsible for the In-Service. To Monitor for Compliance: The Residential Coordinator will do weekly visual checks for 6 months for compliance. If the Residential Coordinator is not available the QIDP will be responsible for monitoring. Evidence of In-Service and compliance will be available for Surveyor review. Compliance Date: June 28th 2019	06/28/2019

laboratory director's or provider/supplier representative's signature | title | (x6) date

SAMANTHA.PAVONE | 07/01/2019

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA 36G266	(x2) multiple construction a. building _____ b. wing _____	(X3) DATE SURVEY COMPLETED 06/13/2019

name of provider or supplier	street address, city, state, zip code
NEW AVENUES-PRESSER	17606 EUCLID AVENUE CLEVELAND OH, 44112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICICIENCY MUST BEPRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETIO N
W 0189	Continued From page 1 observed a closet on the north hall of the facility. The closet door was open. The surveyor observed three bottles of different chemical toilet cleaners. The label of one of the bottles read may be fatal if swallowed. The other two bottles both read harmful of swallowed, seek medical attention, avoid contact with eyes. On 06/12/19 at 4:42 P.M., the above information was verified by the qualified intellectual disability professional.	W 0189		
W 0351	483.460(f)(1) COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE Comprehensive dental diagnostic services include a complete extraoral and intraoral examination, using all diagnostic aids necessary to properly evaluate the client's condition not later than one month after admission to the facility (unless the examination was completed within twelve months before admission). This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to provide dental services within one month of admission. This affected one (Individual #2) of three individuals reviewed for dental services. The facility census was 15 individuals. Findings include:	W 0351	It is the practice and policy of NATI to ensure the safety of each individual at all times by providing a facility that is safe including during an unexpected emergency situation. The deficiency: The facility failed to provide dental services within one month of admission To correct: the facility will ensure upon all admissions if the prior provider does not provide current medical assessments, nursing services will obtain all medical assessments within 30 days. Yes an audit for all 15 individuals will be completed by July 25th by our Nursing Manager. To monitor: All necessary assessments will be completed and submitted by the Clinical Services Coordinator to the Clinical Services Director or designee within 30 days and monitored annually. A documented training of this procedure will be completed by the Clinical Services Director by July 25th 2019 and be available upon request. Compliance Date: July 25th 2019	07/25/2019

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	368266	a. building _____ b. wing _____	06/13/2019

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W 0351	Continued From page 2 Clinical record review revealed Individual #2 was admitted to the facility on 01/29/19 with diagnoses that included profound mental retardation, cerebral palsy, hypertension, and seizure disorder. There was no documentation in the clinical record of any dental services provided, either after admission or within 12 months of admission to the facility. In a meeting on 06/13/19 at 11:15 A.M. Licensed Practical Nurse (LPN) #1 verified the above findings, and said Individual #1 had not seen a dentist since admission. On 06/13/19 at 11:25 A.M., LPN #1 said she had called Individual #2's guardian who told her Individual #2 had seen a dentist last year. The guardian said she would look for documentation and call the dental clinic for documentation of the visit. This documentation was not provided during the survey.	W 0351		