STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365155	A. Building B. Wing	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avon Place Healthcare Center	32900 Detroit Rd Avon, OH 44011

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident interview, staff interview, observation, and policy review, the facility failed to provide wound care per the physician's orders. Furthermore, the facility failed to initial and date wound dressings per the facility policy. This affected one (#44) of four residents reviewed for wound care and six (#32, #38, #39, #44, #64, #66) of six residents reviewed for wound dressings. The facility census was 73. Review of Resident #44's medical record revealed an admission date of 01/04/25. Diagnoses included multiple sclerosis, muscle weakness, severe protein calorie malnutrition, hyperlipidemia, and hypertension. Review of Resident #44's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #44 had intact cognition and required substantial or maximal assistance to roll from side to side. Furthermore, Resident #44 was dependent for toileting hygiene and personal hygiene. Resident #44 also had one stage three pressure ulcer, and two stage four pressure ulcers.Review of Resident #44's care plan with a last revision date of 09/17/25 revealed Resident #44 had an alteration in skin integrity as evidenced by pressure ulcers present on his sacrum, right and left gluteal fold, and right and left heel. Intervention listed in the care plan included to provide treatments per the physician's orders and to provide assistance with activities of daily living (ADL) and positioning as needed. Review of Resident #44's skin risk assessments dated 01/11/25 and 03/21/25 revealed Resident #44 was a very high risk for pressure ulcers. The skin risk assessment dated [DATE] revealed Resident #44 was a high risk for pressure ulcers. Review of Resident #44's current physician orders revealed the following wound care orders: - An order with a start date of 09/16/25 for the right gluteal fold wound to be cleansed with wound cleaner, patted dry, and collagen applied to the wound bed, followed by a clean dry dressing to cover. The dressing was to be changed every night shift and as needed. - An order with a start date of 08/12/25 for the left gluteal fold wound to be cleansed with wound cleaner, patted dry, and collagen applied to the wound bed, followed by a bordered gauze dressing. The dressing was to be changed daily on night shift and as needed. - An order with a start date of 09/10/25 for the sacrum wound to be cleansed the wound cleaner, patted dry, and collagen applied to the wound bed, followed by a bordered gauze dressing. The dressing was to be changed daily on night shift and as needed. - An order with a start date of 10/15/25 for the left and right heel wounds to have betadine applied, covered with a dry, clean pad dressing and wrapped with rolled gauze three times a week and as needed. Interview on 10/20/25 at 8:48 A.M. with Licensed Practical Nurse (LPN) #118 verified all wound dressings should be initialed and dated by the nurse completing the dressing change. Observation on 10/20/25 at 9:01 A.M. of Resident #39's wound dressing with concurrent interview with Licensed Practical Nurse Manager (LPNM) #121 verified Resident #39's wound dressing was not initialed or dated. Resident #39 stated the dressing was last changed the morning of 10/19/25.Observation on 10/20/25 at 9:10 A.M. of Resident #44's wounds with concurrent interview with LPNM #121 verified Resident #44 did not have any of the three wound dressings (sacrum, right gluteal fold, left gluteal fold) in place as per the physician order. The wounds were open, and Resident #44 was wearing a brief. Interview with Resident #44, at the time of the observation, revealed he could not recall when the last time the wound dressings were changed. Interview on 10/20/25 at 9:16 A.M. with LPN #118, verified she was not aware Resident #44 did not have wound dressings in place to his sacrum, right gluteal fold, or left gluteal fold. LPN #118 stated third shift was supposed to apply the dressings. Observation on 10/20/25 at 9:19 A.M. of Resident #32's wound vac dressings with concurrent interview with LPNM #121 verified the wound vac dressings were not initialed or dated, and the dressing was falling off. Interview with Resident #32 at the time of the observation revealed the wound vac was last changed on 10/18/25 but it needed changed again as the wound vac was falling off. Observation on 10/20/25 at 10:39 A.M. of Resident #48's wound dressing with concurrent interview with LPNM #121 verified the wound dressing was not initialed or dated. Interview with Resident #48 at the time of the observation revealed the wound dressing was last completed 10/19/25. Observation on 10/20/25 at 10:45 A.M. of Resident #66's wound dressing with concurrent interview with Registered Nurse Manager (RNM) #193 verified the wound dressing was not initialed or dated. Resident #66 stated it had been a couple of days since it was last changed.Observation on 10/20/25 at 10:51 A.M. of Resident #64's wound dressing with concurrent interview with RNM #193 verified the wound dressing was not initialed or dated. Resident #64 stated he could not recall when the dressing was last changed.Observation on 10/22/25 at 9:27 A.M. of incontinence care for Resident #44 revealed the only dressing present on Resident #44's wounds was the

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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	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** Based on record review, staff interview, resident interview, and policy review, the facility failed to ensure suprapubic catheters were secured. This affected two (#15 and #44) of two residents reviewed for catheter securement devices. The facility census was 73.1. Review of Resident #44's medical record revealed an admission date of 01/04/25. Diagnoses included multiple sclerosis, muscle weakness, severe protein calorie malnutrition, hyperlipidemia, and hypertension. Review of Resident #44's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #44 had intact cognition and had an indwelling catheter.Review of Resident #44's care plan for alteration in elimination, revised date of 09/17/25 revealed Resident #44 had a supra pubic catheter. Interventions included for the catheter to change as ordered and as needed, to empty the catheter drainage bag every shift, use enhanced barrier precautions when providing catheter care, catheter care every shift, keep drainage bag below the level of the bladder to prevent backflow, and to secure the catheter tubing to prevent accidental dislodgement.Review of Resident #44's physician orders revealed an order dated 05/20/25 to replace the catheter securement device every seven days and as needed.Review of the treatment administration record for Resident #44 revealed for the month of October a catheter securement device was in place, including on 10/20/25. Observation on 10/20/25 at 9:10 A.M. of Resident #44's wounds with concurrent interview with Licensed Practical Nurse Manager (LPNM) #121 verified Resident #44 did not have a urinary catheter securement device in place. Interview on 10/22/25 at 8:57 A.M. with Resident #44 revealed he did not know how long he had not had a catheter securement device for. Interview on 10/22/25 at 8:58 A.M. with Certified Nursing Assistant (CNA) #229 verified Resident #44 did not have a catheter securement device in place. 2. Review of Resident #15's medical record revealed an admission date of 12/23/25. Diagnoses included paraplegia, diabetes mellitus due to underlying condition with diabetic neuropathy, morbid obesity, hyperlipidemia, hypothyroidism, chronic kidney disease stage four, anemia, and delusional disorders.Review of Resident #15's quarterly MDS assessment dated [DATE] revealed Resident #15 had intact cognition and had an indwelling catheter.Review of Resident #15's care plan for a urinary catheter, revised 09/08/25, revealed the resident was to have a securement device in place to prevent the urinary catheter from dislodgement.Review of Resident #15's physician orders revealed an order dated 10/16/25 to monitor the catheter stabilization device daily and every shift.Observation on 10/22/25 at 9:52 A.M. of Resident #15's suprapubic catheter revealed the catheter did not have a securement device in place.Concurrent interview with Resident #15 and her husband revealed neither one of them thought the resident ever had a catheter securement device while at the facility. Interview on 10/22/25 at 10:22 A.M. with CNA #229 verified Resident #15 did not have a catheter securement device on. Review of the facility policy titled Catheter Care, Urinary with a last revision date of September 2024 revealed catheters should be secured utilizing a securement device or a leg band.This violation represents non-compliance investigated under Complaint Number 2643404.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, staff interview, resident interview, and policy review, the facility failed to ensure the medical record was accurate and was not falsified. This affected one resident (#15) of three residents reviewed for an accurate medical record. The facility census was 73.Review of Resident #15 ' s medical record revealed an admission date of 12/23/25. Diagnoses included paraplegia, diabetes mellitus due to underlying condition with diabetic neuropathy, morbid obesity, hyperlipidemia, hypothyroidism, chronic kidney disease stage four, anemia, and delusional disorders.Review of Resident #15 ' s quarterly MDS assessment dated [DATE] revealed Resident #15 had intact cognition and had an indwelling catheter.Review of Resident #15 ' s care plan for a urinary catheter, revised 09/08/25, revealed the resident was to have a securement device in place to prevent the urinary catheter from dislodgement.Review of Resident #15 ' s physician orders revealed an order dated 10/16/25 to monitor the catheter stabilization device daily and every shift.Review of Resident #15's Treatment Administration Record (TAR) for the month of October revealed the nurses documented every shift that the foley securement device was in place.Observation on 10/22/25 at 9:52 A.M. of Resident #15's suprapubic catheter revealed the catheter did not have a securement device. Concurrent interview with Resident #15 and her husband revealed neither one of them thought she had ever had a catheter securement device while in the facility.Interview on 10/22/25 at 10:22 A. M. with Certified Nursing Assistant (CNA) #229 verified Resident #15 did not have a catheter securement device on. Interview on 10/23/25 at 12:17 P.M. with Licensed Practical Nurse (LPN) #233 revealed she worked third shift with Resident #15 on 10/16/25 and 10/17/25 and did not recall Resident #15 having a catheter securement device present. LPN #233 stated she knew Resident #15 did not have one on because when they roll Resident #15 to the side, they always place the catheter on the bed. Further interview revealed LPN #233 stated she probably just marked on the TAR that the securement device was in place even though LPN #233 knew it was not. LPN #233 verified that she falsified the medical record by clicking in the electronic medical record that she monitored the securement device that was not in place. Review of the facility policy titled Charting and Documentation with a last revision date of July 2017 revealed documentation in the medical record will be objective, complete, and accurate. This violation represents non-compliance investigated under Complaint Number 2643404.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and policy review, the facility failed to post the required Enhanced Barrier Precautions (EBP) signage outside of one resident's room who required EBP, and further the facility failed to ensure staff wore the appropriate personal protective equipment (PPE) when caring for residents requiring EBP. This affected two (#32 and #44) of four residents reviewed for infection control. The facility census was 73. 1. Review of the medical record for Resident #32 revealed an admission date of 08/05/25. Diagnoses included cerebral infarction due to unspecified occlusion or stenosis of the left middle cerebral artery, unspecified protein-calorie malnutrition, type II diabetes mellitus, and hypertension. Review of Resident #32's admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #32 had intact cognition and two stage four pressure wounds.Review of Resident #32's care plan with a revision date of 08/14/25 revealed Resident #32 admitted to the facility with pressure ulcers and an intervention included to follow EBP when providing care.Review of Resident #32's physician orders revealed an order dated 08/07/25 for EBP when providing wound care.Observation on 10/20/25 at 9:43 A.M. of Resident #32's dressing change completed by Licensed Practical Nurse (LPN) #121 revealed LPN #121 washed hands and applied gloves, then proceeded to remove the first wound vac outer dressing from Resident #32's mid back. Upon taking the mid back wound vac dressing off, the skin around the wound appeared inflamed and red. LPN #121 stated she would report the inflammation and redness to the wound Nurse Practitioner (NP) and the physician. Without changing her gloves, LPN #121 removed the second wound vac outer dressing from Resident #32's sacrum. Following removal of both wounds outer dressing, LPN #121 began to slowly and gently remove the mid back wounds black sponge. The black sponge was sticking to Resident #32's wound and LPN #121 grabbed a bottle of normal saline with her gloved hand, poured the normal saline on the sponge to loosen the black sponge from the wound. LPN #121 then removed her gloves, washed hands, and donned a new pair of clean gloves. With clean gloves, LPN #121 grabbed the same bottle of normal saline grabbed with dirty gloves, poured normal saline onto a gauze sponge and proceeded to clean the sacral wound bed. LPN #121 disposed of the gauze into the trash can, grabbed another gauze sponge, and again grab the normal saline bottle with her gloved hand, wet the gauze sponge with the normal saline and proceeded to cleanse the mid back wound. Without changing gloves LPN #121 applied foam to the wound beds and covered the wounds with a dressing before connecting the wound vac.Interview with LPN #121 following the treatment verified she did use proper technique when completing the dressing change and further verified only gloves were worn during the dressing change. 2. Review of Resident #44's medical record revealed an admission date of 01/04/25. Diagnoses included multiple sclerosis, muscle weakness, severe protein calorie malnutrition, hyperlipidemia, and hypertension.Review of Resident #44's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #44 had intact cognition and required substantial or maximal assistance to roll from side to side. Furthermore, Resident #44 was dependent for toileting hygiene and personal hygiene. Resident #44 had one stage three pressure ulcer, and two stage four pressure ulcers. Review of Resident #44's care plan with a last revision date of 09/17/25 revealed Resident #44 had an alteration in skin integrity as evidenced by pressure ulcers present on his sacrum, right and left gluteal fold, and right and left heel. Interventions listed in the care plan included to provide treatments per the physician's orders, EBP. Observation on 10/20/25 at 11:56 A.M. of Resident #32's door, wall, and surrounding area outside of the resident room revealed no EBP signage. Interview on 10/20/25 at 11:57 A.M. with LPN #118 verified Resident #32 did not have an EBP sign posted on the door, wall, or surrounding area.Observation on 10/22/25 at 9:12 A.M. of incontinence, wound, and catheter care for Resident #44 completed by Certified Nursing Assistant (CNA) #211, CNA #229, and LPN #121 revealed the staff wore gloves when providing care.Interview with LPN #121 following the observation verified all three staff members providing care to Resident #44 were not wearing the required PPE. LPN #121 stated gowns should have also been worn. Review of the facility policy titled Enhanced Barrier Precautions with a last revision date of August 2022 revealed PPE including gown and gloves are required when providing care such as changing briefs, catheter care, and wound care. Furthermore, the policy states signs are to be posted in the door or wall outside the resident room indicating the type of precautions and PPE required.This violation represents non-compliance investigated under Complaint Number 2643404.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, resident interview, staff interview, and policy review, the facility failed to ensure Resident #44's call light was within reach to be able to call for assistance as needed. This affected one resident (#44) of three residents reviewed for call lights. The facility census was 73. Review of Resident #44's medical record revealed an admission date of 01/04/25. Diagnoses included multiple sclerosis, muscle weakness, severe protein calorie malnutrition, hyperlipidemia, and hypertension.Review of Resident #44's care plan with a last revision date of 09/17/25 revealed Resident #44 had an alteration in skin integrity as evidenced by pressure ulcers present on his sacrum, right and left gluteal fold, and right and left heel. Interventions listed in the care plan included to provide treatments per the physician's orders and to provide assistance with activities of daily living (ADL) and positioning as needed. Review of Resident #44's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #44 had intact cognition and required substantial or maximal assistance to roll from side to side. Furthermore, Resident #44 was dependent for toileting hygiene and personal hygiene. Resident #44 also had one stage three pressure ulcer, and two stage four pressure ulcers.Review of Resident #44's skin risk assessments dated 01/11/25 and 03/21/25 revealed Resident #44 was a very high risk for pressure ulcers. The skin risk assessment dated [DATE] revealed Resident #44 was a high risk for pressure ulcers. Observation on 10/22/25 at 8:33 A.M. of Resident #44 revealed his call light was hanging on his tube feeding pole. Concurrent interview with Resident #44, who was lying in bed crying revealed no staff members had come into his room throughout the night. Resident #44 stated no staff member attempted to turn and reposition him that night. He stated the last staff person that was in his room was the nurse who hung the tube feeding. Furthermore, Resident #44 stated he had an incontinence episode of bowel and could not call for assistance.Interview on 10/22/25 at 8:35 A.M. with Certified Nursing Assistant (CNA) #229 verified the call light was hanging on the tube feeding pole and was out of reach of Resident #44. CNA #229 also verified Resident #44 had been incontinent and was unable to call for assistance. CNA #229 was unable to report the last time Resident #44 was provided care. Review of the facility policy titled Answering the Call Light with a last revision date of March 2021 revealed when the resident is in bed or confined to a chair, be sure the call light is within reach per resident preference. This violation represents non-compliance investigated under Complaint Number 2643404.