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	11/18/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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 0580 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 review of the medical record, staff interviews, and review of facility policy, the facility failed to ensure changes in resident condition were reported. This affected one resident (#77) of three residents reviewed for changes in condition. The facility census was 76. Review of the medical record for Resident #77 revealed an admission date of 01/11/24 and a discharge date of 09/26/25. Diagnoses included dementia, chronic obstructive pulmonary disease, difficulty walking, osteoporosis anxiety, hypertension, and atrial fibrillation. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severe cognitive impairment. The resident required supervision with toileting, bathing, and bed mobility. The resident was independent with ambulation. Review of Resident #77's care plan revealed the resident had respiratory deficiencies or abnormalities of pulmonary function related to chronic obstructive pulmonary disease. Interventions included to administer oxygen as ordered, monitor for signs and symptoms of impaired respiratory function, monitor lung sounds as ordered, monitor oxygen saturation level as ordered, and observe for signs and symptoms of dyspnea. Further review of the plan of care revealed for respiratory system observation, monitoring, and data collection of current respiratory deficiencies or abnormalities of pulmonary function and to update the physician with any abnormal or new findings for possible evaluation or further treatment as needed. Review of Resident #77's care plan revealed the resident had altered cognitive function due to dementia. Interventions included to allow resident time to remember/respond, be patient with resident and evaluate and respond to the residents attempts to communicate. Further review of the care plan revealed the resident was at risk for alteration in comfort related to the disease process. Interventions included to acknowledge presence of pain and discomfort and listen to the residents concerns, and monitor for increased levels of pain and notify the physician. Review of Resident #77's care plan also revealed the resident was receiving anticoagulant therapy and was at risk for bleeding, bruising, and abnormal laboratory values. Interventions included to monitor for and report abnormal bruising or other adverse side effects related to use of anticoagulants. Review of a physician order dated 12/27/24 revealed to monitor of signs and symptoms of bleeding every shift for anticoagulant use. Review of a physician order dated 01/11/24 revealed an orders for oxygen at three liters per nasal cannula as needed for shortness of breath. Review of a physician order dated 01/12/24 revealed an order for Apixaban (anticoagulant) 2.5 milligrams by mouth two times a day for atrial fibrillation. Observations during review of Surveillance Video #3 dated 09/22/25 at approximately one minute and 17 seconds from the start of the video and of Surveillance Video #4 approximately at 18 seconds from the beginning of the video and again at two minutes and 37 seconds from the beginning of the video revealed night shift Certified Nursing Assistant (CNA) #322 providing incontinence care for the resident and the resident had visible dark discoloration at the base of the first two fingers on the top of the right hand. The resident had been incontinent of a large amount of diarrhea. Observation during review of Surveillance Video #7 dated 09/22/25 revealed while day shift CNA #306 and CNA #308 were assisting the resident out of bed to take a shower after having emesis, the resident stated oh, my leg. and touched her left leg. Neither nursing assistant responded to the resident's voiced concern. Review of the nurses notes for 09/22/25 revealed no documentation of Resident #77 having bruising on her right hand or diarrhea during the early morning hours toward the end of the night shift. Further review of the nurses notes revealed no documentation of the resident voicing concerns about her left leg. Review of a late entry nurses note dated 09/22/25 at 7:50 A.M. revealed the unit manager observed discoloration to the resident's right hand. The physician was then notified. Review of a nurses note dated 09/22/25 at 2:40 P.M. revealed the resident had sipped fluid for lunch and had emesis along with diarrhea. The resident's oxygen saturation level was 93 percent on room air. The resident was given oxygen at two liters per nasal cannula. There was no documentation the resident's physician was notified the resident's oxygen level had declined and required oxygen administration. Further review of the nurses notes on 09/22/25 through 09/23/25 revealed no documentation regarding oxygen administration, respiratory assessments or monitoring for effectiveness or continued decline. Interview on 11/05/25 at 11:32 A.M., Licensed Practical Nurse (LPN) #368 revealed on 09/22/25 she had administered the resident's medications around 4:50 A.M. to 5:00 A.M. LPN #368 denied knowledge of the resident having bruising or injuries. LPN #368 also revealed staff had not notified her of Resident #77 having diarrhea or loose stools. Interview on 11/06/25 at 9:59 A.M., CNA #322 revealed he had provided incontinence care for the resident on 09/22/25 sometime after 4:00 A.M. CNA #322 revealed this

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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 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. (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 0684 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 review of the medical record, staff interviews, and policy review, the facility failed to ensure a resident was accurately assessed for additional injuries after being found with bruising with no known cause at the time of discovery. This affected one (#77) of three residents reviewed for abuse. The facility census was 76.Review of the medical record for Resident #77 revealed an admission date of 01/11/24 and a discharge date of 09/26/25. Diagnoses included dementia, chronic obstructive pulmonary disease, difficulty walking, osteoporosis anxiety, hypertension, and atrial fibrillation. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severe cognitive impairment. The resident required supervision with toileting, bathing, and bed mobility. The resident was independent with ambulation. Review of Resident #77's care plan revealed the resident had altered cognitive function due to dementia. Interventions included to allow resident time to remember/respond, be patient with resident and evaluate and respond to the residents attempts to communicate. Further review of the care plan revealed the resident was at risk for alteration in comfort related to the disease process. Interventions included to acknowledge presence of pain and discomfort and listen to the residents concerns, and monitor for increased levels of pain and notify the physician. Observations during review of Surveillance Video #3 dated 09/22/25 at approximately one minute and 17 seconds from the start of the video and of Surveillance Video #4 approximately at 18 seconds from the beginning of the video and again at two minutes and 37 seconds from the beginning of the video revealed night shift Certified Nursing Assistant (CNA) #322 providing incontinence care for the resident and the resident had visible dark discoloration at the base of the first two fingers on the top of the right hand. The resident had been incontinent of a large amount of diarrhea. Observation during review of Surveillance Video #7 dated 09/22/25 revealed while day shift CNA #306 and CNA #308 were assisting the resident out of bed to take a shower after having emesis, the resident was noted with bruising on the top of the right hand. The resident stated Oh, my leg. and touched her left leg. Neither nursing assistant responded to the resident's voiced concern. Review of a late entry nurses note dated 09/22/25 at 7:50 A.M. revealed the unit manager observed discoloration to the resident's right hand. The physician was then notified. There was no documentation in the nurses notes the resident was assessed for additional injuries or the resident's range of motion was assessed. Review of a sample body check form with a handwritten date of 09/22/25 at 7:50 A.M. revealed the resident was noted with bruising to the top of the right hand. No other skin area concerns were identified.Review of hospital documentation dated 09/23/25 revealed given the bruising/pain over the right hand, left hip pain, and anticoagulant use, scans were obtained due to possibility of unwitnessed fall. Imagining demonstrated first and second metacarpal fracture as well as possible femoral neck fracture with recommendation for a MRI (magnetic resonance imaging) of the left hip to better assess if there is a fracture. A medical records request was sent for Resident #77's hospital medical records on 11/06/25 requesting MRI results. As of 11/20/25 the medical records had not been provided. Interview on 11/05/25 at 2:46 P.M., Unit Manager Licensed Practical Nurse (LPN) #396 revealed on 09/22/25 she had noticed a dark spot of Resident #77's hand. LPN #306 revealed she tried to assess the resident's hand but the resident drew back the hand. LPN #396 revealed the physician was notified and new orders were received. LPN #396 revealed the resident had moved the left hand and could move her legs up and down a little. LPN #396 revealed she had not completed a range of motion assessment for the resident. Interview on 11/18/25 at 11:21 A.M., CNA #306 revealed after reviewing Surveillance Video #7 acknowledged the resident stated Oh, my leg. CNA #306 revealed she had not recalled the resident stating a concern with her leg. CNA #306 revealed the nurse should have been notified before getting the resident out of bed. Interview on 11/18/25 at 11:50 A.M., Registered Nurse (RN) #302 revealed after she was notified of Resident #77's bruising to the hand she looked at the resident's hand and visible skin. RN #302 revealed she had not removed the resident's gown to assess the resident's skin had not check the resident's range of motion for additional injuries. RN #302 revealed the nursing assistants had not reported the resident had indicated a concern with her leg. Interview on 11/18/25 at 1:04 P.M., LPN #402 revealed when a resident had an injury the resident should be asked how the injury occurred and also question staff who last worked with the resident. LPN #402 revealed the resident should have a complete head to toe assessment to check for additional injuries. LPN #402 revealed the resident's range of motion should be assessed if safe to do so and the physician should be notified. Interview on 11/18/25 at 4:25 P.M.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. (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 0695 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 review of the medical record, staff interview, and policy review, the facility failed to ensure a resident was assessed and monitored while administered oxygen after a change in condition. This affected one (#77) of three residents reviewed for change in condition. The facility identified nine residents receiving oxygen therapy. The facility census was 76.Review of the medical record for Resident #77 revealed an admission date of 01/11/24 and a discharge date of 09/26/25. Diagnoses included dementia, chronic obstructive pulmonary disease, difficulty walking, osteoporosis anxiety, hypertension, and atrial fibrillation. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severe cognitive impairment. The resident required supervision with toileting, bathing, and bed mobility. The resident was independent with ambulation. Review of Resident #77's care plan revealed the resident had respiratory deficiencies or abnormalities of pulmonary function related to chronic obstructive pulmonary disease. Interventions included to administer oxygen as ordered, aerosol treatments as ordered, cough and deep breath as ordered and as needed, elevated head of bed for shortness of breath, monitor for signs and symptoms of impaired respiratory function, monitor lung sounds as ordered, monitor oxygen saturation level as ordered, and observe for signs and symptoms of dyspnea. Further review of the plan of care revealed for respiratory system observation, monitoring, and data collection of current respiratory deficiencies or abnormalities of pulmonary function and to update the physician with any abnormal or new findings for possible evaluation or further treatment as needed. Review of a physician order dated 01/11/24 revealed an orders for oxygen at three liters per nasal cannula as needed for shortness of breath. Review of the residents vital sign report dated 09/01/25 through 09/30/25 revealed on 09/22/25 at 7:58 A.M. the residents oxygen saturation rate was 97 percent on room air with a respiratory rate of 18 breaths per minute. Further review of the vital sign report revealed no further monitoring of the resident's oxygen saturation rate, respiratory rate, and lung sounds. Review of a nurse's note dated 09/22/25 at 10:50 A.M. revealed the resident was observed vomiting during morning medication pass. The resident's medications were not administered and the physician was notified. Review of a nurses note dated 09/22/25 at 2:40 P.M. revealed the resident had sipped fluid for lunch and had emesis along with diarrhea. The resident's oxygen saturation level was 93 percent on room air. The resident was given oxygen at two liters per nasal cannula. There was no documentation the resident's physician was notified the resident's oxygen level had declined and required oxygen administration. Further review of the nurses notes on 09/22/25 through 09/23/25 revealed no documentation regarding oxygen administration, respiratory assessments or monitoring for effectiveness or continued decline. Review of the medication administration record (MAR) dated 09/01/25 through 09/30/25 revealed no documentation the resident had been administered oxygen. Review of a nurse's note dated 09/23/25 at 1:00 P.M. revealed the resident had an orthopedic appointment scheduled. The resident's representative was in the facility and informed staff the resident would be taken to the emergency room. The physician was notified and gave the okay to go to the hospital per family request. Interview on 11/06/25 at 1:10 P.M., Physician #316 revealed he could not recall the resident having emesis. Physician #316 revealed he could not recall the resident being administered oxygen. Physician #316 revealed if the resident needed oxygen then a protocol should have been followed including a chest x-ray and/or an evaluation in the emergency room. Interview on 11/18/25 at 11:50 A.M., Registered Nurse (RN) #302 revealed she could not recall what the resident's oxygen saturation level was or if the resident had received a respiratory assessment or continued monitoring. RN #302 revealed the physician was not notified the resident was administered oxygen as it was a nursing judgement. Interview on 11/18/25 at 12:12 P.M., the Director of Nursing (DON) verified there was no documentation of oxygen monitoring, respiratory assessments, and no documentation of the MAR of oxygen administration. Interview on 11/18/25 at 12:45 P.M., RN #500 revealed she was in charge of respiratory services. RN #500 revealed she recalled a day Resident #77 looked sick and believed staff had asked to bring the resident an oxygen concentrator. RN #500 revealed she was not monitoring the resident as the resident was not receiving respiratory services. Review of the facility policy Oxygen Administration, revised 10/2010, revealed the resident would be assessed during oxygen administration including lung sounds and oxygen saturation levels. Staff would document the rate of oxygen flow, route, and rationale, the frequency and duration of the treatment, the reason for as needed administration, all assessment data obtained before, during, and after the procedure, how the resident