STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365757	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broadview Multi Care Center	5520 Broadview Rd Parma, OH 44134

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on medical record review, hospital documentation review, resident and staff interviews, review of the facility investigation, policy review and review of the facility initiated corrective action, the facility failed to ensure appropriate care and assistance was provided to prevent a resident fall during a mechanical (Hoyer) lift transfer. Actual Harm occurred on 06/05/25 when Resident #116 was transferred with a Hoyer lift using only one staff member and the incorrect Hoyer sling resulting in a fall approximately four feet to the floor causing extensive bruising, pain and abrasions. Resident #116 was transferred to the emergency room where he had multiple x-rays. This affected one resident (#116) of three residents reviewed for falls. The facility census was 152. Findings include: Review of the medical record for Resident #116 revealed an admission date 05/28/22 with diagnoses including Cuada Equina Syndrome (the bundle of nerves at the base of the spinal cord, becomes compressed), lumbar stenosis, morbid obesity and heart failure. Review of the annual Minimum Date Set (MDS) 3.0 assessment dated [DATE] revealed Resident #116 had intact cognition. The assessment revealed Resident #116 required substantial/maximal assistance for toileting, personal hygiene, and bed mobility, was dependent on staff for showers and transferring. Resident #116 was always incontinent of bladder and frequently incontinent of bowel. Review of the physician orders dated 01/30/25 revealed Resident #116 was to be transferred with a mechanical lift (Hoyer) transfers at all times with two assists. Review of the plan of care dated 02/11/25 for activities of daily living (ADL) revealed Resident #116 had a self-care performance deficit related to debility related to Cauda Equina Syndrome, lumbar and thoracic spinal stenosis, radiculopathy, morbid obesity, pain, self-limiting with participating in ADL and mobility in and out of bed. Interventions included mechanical lift (Hoyer) transfers with two assists, providing total assistance with transfers and providing total assistance with personal hygiene. Review of the progress note dated 06/05/25 at 6:33 P.M. revealed the nurse was called to Resident #116's room by the aide. The aide stated Resident #116 had fallen while being transferred into bed with the Hoyer lift; it appears both bottom straps broke during the transfer, and Resident #116 fell to the floor. Resident #116 denied hitting his head. He complained of right hip and foot pain. Resident #116 was immediately assessed and assisted back to bed by four staff. The right foot was bruised and swollen; abrasions were noted to the right ankle, right elbow and a skin tear was noted to the left ankle. The doctor was notified, and orders were given to send Resident #116 to the emergency room via 911. Resident #116's family was notified. Review of the fall investigation dated 06/05/25 revealed Licensed Practical Nurse (LPN) #499 was the floor nurse, Certified Nurse Assistant (CNA) #540 was assigned to Resident #116, and CNA #505 was the other CNA on the unit. When Resident #116 fell to the floor, it was witnessed (CNA #540) in the resident's room. Resident #116 requested to be put in bed for hygiene care and was assisted per the care plan. (However, the care plan stated the resident required two staff assistance for the Hoyer, and only one staff was in the room at the time of the fall). Review of the (hospital) MyChart record dated 06/05/25 revealed Resident #116 received a computed tomography scan (CT) cervical spine without contrast, CT of the head without contrast, CT of T-spine/L-spine without contrast, x-rays of the left ankle, right ankle, right elbow, right femur, left foot, right foot, right hip, right humerus, right knee, left tibia and right tibia. Wound care notes in the record included a right elbow abrasion measuring one centimeter by one centimeter, a left ankle skin tear measuring 1.5 centimeters by 1.9 centimeter and a right ankle abrasion measuring three centimeters by one centimeter. Review of the witness statement taken over the phone by the DON on 06/05/15 for CNA # 540 revealed she and another aide were in the room when she was transferring Resident #116 back into bed. CNA #540 stated that when the Hoyer lift was lifting Resident #116 off of his power chair, the straps broke. CNA #540 then went and got the LPN #499, while the other aide stayed with Resident #116. Review of the undated witness statement from LPN #499 revealed around 5:30 P.M. she was passing medications, and the CNA came to her and told her Resident #116 was on the floor. She immediately went into the room to find Resident #116 was lying on the floor partially on the legs of the Hoyer. Both aides stated that the Hoyer strap broke, and Resident #116 fell. LPN #499 stated Resident #116 was assessed and sent to hospital for evaluation. Resident #116 had right foot pain. Review of the fall review dated 06/05/25 at 6:33 P.M. revealed Resident #116 was confined to chair, unable to stand without physical assistance, right foot and ankle pain. Fall details revealed the nurse was called to Resident #116's

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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, observations, staff and resident interviews, the facility failed to ensure incontinent care needs were met in a timely manner for Resident #6. This affected one (Resident #6) of three residents reviewed for incontinence care. The facility census was 154. Findings include: Review of the medical record for Resident #6 revealed an admission date 01/05/24. Diagnoses included type II diabetes, convulsions, chronic diastolic congestive heart failure, hypertension, presence of a cardiac pacemaker, and peripheral vascular disease. Review of the plan of care dated 01/09/24 revealed Resident #6 had bowel incontinence related to impaired mobility, physical limitations, no control and unformed stool. Interventions included checking if Resident #6 was continent, offer assistance with toileting, if incontinent, remove wet or soiled clothing, briefs, provide incontinent care, and apply protective barrier after each incontinent episode. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #6 had cognitive impairment and was dependent on staff for toileting. Resident #6 was always incontinent of bowel and had an indwelling suprapubic catheter (a soft tube placed through the lower abdomen directly into the bladder to drain urine) for urine output. Observation on 07/21/25 at 11:15 A.M. revealed Resident #6's call light was on. The call light was continuously monitored to see when staff were going to respond. Observation of multiply staff going down the hall, but no one entered Resident #6's room until 11:54 A.M. Licensed Practical Nurse (LPN) #395 entered the room to give Resident #6 medication. Interview on 07/21/25 at 11:56 A.M. with Resident #6 revealed the nurse came in to give medications and when he asked to be changed because he had waited all morning, the nurse stated she would go get his aide. Resident #6 stated he felt like she thought she was too good to change him. Resident #6 stated he had been waiting all morning for incontinence care. Observation on 07/21/25 at 11:58 A.M. revealed the interim Director of Nursing (DON) brought clean towels and washcloths to provide incontinence care to Resident #6. The interim DON and LPN #395 completed incontinence care. Interview on 07/21/25 at 12:07 P.M. with Certified Nurse Assistance (CNA) #514 stated she was the aide for Resident #6, and she was assisting other residents that had to get up for dialysis and was told that Resident #6 needed changed, but she had not gotten there yet. CNA #514 did not feel they were short staffed, just busy. CNA #514 stated call lights should be answered within ten minutes. Interview on 07/21/25 at 12:21 P.M. with LPN #395 verified call lights should be answered within ten minutes and that 40 minutes was too long. LPN #395 stated she assisted with cleaning Resident #6, and he had had a small bowel movement. Interview on 07/21/25 at 12:25 P.M. with the interim DON verified call lights should be answered within as soon as possible, it may take ten minutes if staff were busy. The interim DON stated any staff member could answer a call light, to see if they can assist the residents at that time. Staff were to work together to answer call lights timely. This deficiency represents non-compliance investigated under Complaint Number 1276733 (OH00167219) and 1276730 (OH00164488).

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and interview, the facility failed to provide the appropriate assistive device to enable residents to eat or drink independently. This affected two (Residents #19 and #25) of three residents reviewed for assistive devices and 19 residents reviewed for needing assistance with meals. This had the potential to affect three additional (Residents #64, #104, and #122) identified by the facility as also requiring adaptive equipment for eating and drinking. The facility census was 152. Findings include: 1. Review of the medical record for Resident #19 revealed an admission date of 06/21/22. Diagnoses included hemiplegia and hemiparesis, vascular dementia, dysphagia, and impulse disorder. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #19 was severely cognitively impaired and was dependent on staff for eating and drinking. Review of the physician's orders for Resident #19 revealed the resident was on a pureed texture, nectar thickened liquids, with double portion proteins, ordered 11/08/24. A Magic Cup (supplement) three times a day for dietary supplement to be provided with meals, with total assistance was ordered 02/10/25. Adaptive equipment required included a sippy cup with lid/spout and a divided plate. Review of the quarterly nutrition assessment completed on 07/11/25 revealed Resident #19 required a spouted cup with lid and handle at all meals to promote independence with beverages. Total assistance was to be provided at meals at this time with spouted cup. Observation of meal trays and assistance on 07/22/25 at 12:45 P.M. revealed Resident #19's tray ticket stated sippy cup with lid/spout and a divided plate. The resident did not have the sippy cup with lid/spout. The observation was verified with Certified Nursing Assistant (CNA) #430 and CNA #536. 2. Review of the medical record for Resident #25 revealed an admission date of 03/15/25. Diagnoses included drug induced Parkinson's, Alzheimer's, convulsions, and dementia with other behavioral disturbances. Review of the significant change MDS 3.0 assessment dated [DATE] revealed Resident #25 was severely cognitively impaired and was dependent on staff for eating and drinking. Review of the physician's orders for revealed Resident #25 was on a pureed diet with double portion of protein and vegetable, ordered 03/15/25. Adaptive equipment: scoop plate, built-up utensil(s), and a two handled sippy cup. Review of the nutrition assessment dated [DATE] at 4:24 P. M, revealed Resident #25 revealed a pureed diet, double portions were in place and tolerated well. Resident #25 needed extensive-to-total assistance to complete the meal. Preferences and alternative menu were reviewed with his wife who provided preferences. Observation of meal trays and assistance on 07/22/25 at 12:44 P.M. revealed Resident #25's tray ticket listed a 2-handle sippy cup, built-up utensils and scoop plates. The resident did not have the 2-handle sippy cup. Staff were assisting residents. The observation was verified with CNA #430 and CNA #536. This deficiency was an incidental finding identified during the complaint investigation.