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	09/03/2025

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 Note: The nursing home is disputing this citation.	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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of a facility Self-Reported Incident (SRI), hospital record review and interview, the facility failed to provide adequate supervision to Resident #25, who required placement on the facility secured unit, frequent monitoring, and had a history of verbal, physical and/or combative aggressive behaviors, to prevent an avoidable resident injury.Actual Harm occurred on 08/22/25 at approximately 6:00 A. M when Resident #25 was found on the floor with two bruised and swollen eyes, reported pain rated a nine (out of ten with ten being the worst possible pain) and stated someone hit her. Resident #25 was transferred to a local hospital and found to have a subdural hematoma (bleeding the subdural space between the arachnoid membrane and dura mater of the brain), subarachnoid bleed (bleeding in the subarachnoid space between the brain and the arachnoid membrane), and intraparenchymal hematoma (a collection of blood within the brain tissue) of the brain, with unknown loss of consciousness and was admitted to the intensive care unit (ICU). This affected one (Resident #25) of three residents reviewed for abuse. The facility census was 160.Findings include:Review of the medical record for Resident #25 revealed the resident was admitted to the facility on [DATE] with diagnoses that included urinary tract infection, dementia, and anxiety. Resident #25 discharged to the hospital on [DATE]. As of 08/26/25 the resident had not returned to the facility. Review of the physician orders dated 05/20/25 revealed Resident #25 had an order to reside on the secured unit to stabilize medical symptoms of psychiatric illness and/or dementia. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #25 had a Brief Interview for Mental Status (BIMS) score of two indicating the resident had severely impaired cognition. Resident #25 was noted to have both short- and long-term memory impairment. Review of the MDS assessment revealed Resident #25 required supervision or touching assistance from staff for activities of daily living (ADLs). Review of the care plan dated 05/29/25 revealed Resident #25 was at risk for falls due to a history of falls, impaired balance, impaired mobility, dementia, and restlessness, required special care unit related to dementia with behaviors, wandered aimlessly and/or elopement risk. Interventions included, but were not limited to, assist with all transfers, locomotion, mobility, call light within reach, and reminders, and provide one-on-one supervision as needed and that Resident #25 required frequent monitoring. The care plan did not define what frequent monitoring required. Further review of the care plan revealed Resident #25 displayed resistive behaviors and was hard to direct related to verbal and physical aggression toward staff and other residents with interventions that included, but were not limited to, administering medications as ordered, monitor and document, allowing to make decisions to provide a sense of control, and encourage interaction and participation during care. Review of the progress note dated 08/02/25 at 12:31 P.M. revealed Resident #25 and an unknown resident were noted to be arguing over the restroom and were able to be redirected and the situation diffused. Resident #25 reported the other resident hit her, but staff were present the whole time and no physical contact was made. Review of the progress note dated 08/05/25 at 6:45 P.M. revealed Resident #25 was yelling, cursing and agitated with another unknown resident. Resident #25 was redirected, separated, and calm. Review of the notes revealed Resident #25's son was left a message. Review of the progress note dated 08/0825 at 7:58 P.M. revealed Resident #25 was getting into it with another unknown resident about the bathroom. Resident #25 refused to go into the room and was arguing with other residents. Review of the progress note dated 08/19/25 at 11:08 A.M, revealed Resident #25 yelled at staff, was redirected, and was resting at the table. The note referenced Resident #25 would continue to be monitored. Review of the progress note dated 08/20/25 at 10:54 A.M. revealed Resident #25 was having behaviors. Resident #25 was standing in the doorway talking about other residents and saying stuff to them. Resident #25 started getting loud with staff and going back and forth. Resident #25 was asked to return to her room and after a few moments of being mouthy and loud, Resident #25 returned to her room. An hour and a half later, Resident #25 was observed resting in her room with no more issues noted during the shift. Review of the progress notes revealed no documented notes from 08/20/25 at 10:54 A.M. to 08/22/25 at 6:00 A.M. regarding frequent monitoring and/or behaviors. Review of the progress note dated 08/22/25 at 6:00 A.M revealed Resident #25 had a transfer to a local hospital related to a trauma (fall-related or other) with bruising of the eyes. Review of the progress note dated 08/22/25 at 6:02 A.M. revealed Resident #25 had an unwitnessed fall with bilateral eye bruising and was swollen shut with a treatment plan to be sent emergently sent to the emergency room (ER) of a local hospital. Review of the progress note dated 08/22/25 at 7:14 A.M. revealed