STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365762	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER: Avon Oaks Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE: 37800 French Creek Rd Avon, OH 44011	

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident record review, resident interviews, staff interviews, and facility policy review, the facility failed to ensure call lights were within reach. This affected four residents (#6, #13, #73, and #95) of four residents reviewed for call lights. The facility census was 92.Findings include:1. Review of the medical record for Resident #6 revealed he was admitted to the facility on [DATE] with diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, contracture of the right hand, and contracture, left and right knee.Review of the physician orders dated 10/04/22 revealed an order for fall prevention per protocol.Review of the physician orders dated 08/16/24 revealed an order for Hoyer (mechanical lift) for transfers.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #6 had a Brief Interview for Mental Status (BIMS) score of six indicating severe cognitive impairment. Review of the MDS assessment revealed Resident #6 was impaired on both sides of his upper and lower extremities and was dependent on staff for activities of daily living (ADL).Review of the care plan dated 02/02/26 revealed Resident #6 had a self-care performance deficit related to stroke and hemiparesis of the right upper and lower extremities and was at risk for falls with interventions that included assistance with ADL and keep the call light within reach.Review of the progress notes dated 02/23/26 at 2:59 P.M. revealed Resident #6 had a care plan meeting that indicated he was at a moderate risk for falls.Observation and interview on 03/18/26 at 10:44 A.M. revealed Resident #6 lying in bed leaning and facing the left side wall. Resident #6's bed was against the wall. Resident #6's call light was observed to be located approximately three feet away and tucked inside the drawer of bedside nightstand. Resident #6 revealed he could not locate his call light, and he did not know where it was located.Interview and observation on 03/18/26 at 10:46 A.M. with Certified Nursing Assistant (CNA) #919 revealed Resident #6 was dependent on staff for ADL and his call light should be within reach. CNA #919 revealed she removed Resident #6's call light during his breakfast meal. CNA #919 was then observed removing Resident #6's call light from the nightstand drawer and placing it on the bed. CNA #919 confirmed and verified the above findings at the time of the interview.2. Review of the medical record for Resident #13 revealed he was admitted to the facility on [DATE] with diagnoses that included stiff-man syndrome, spinal stenosis and muscle weakness.Review of the physician orders dated 06/09/25 revealed an order for fall prevention protocol.Review of the MDS assessment dated [DATE] revealed Resident #13 had a BIMS score of 14 that indicated he was alert and oriented to person, place, and time. Review of the MDS assessment revealed Resident #13 had impairment on both sides of his upper and lower extremities and was dependent on staff for ADL.Review of the care plan dated 03/05/26 revealed Resident #13 had a limited functional range of motion related to stiff-man syndrome and was at risk for falls with interventions that included keep call light within reach.Review of the progress note dated 03/05/26 at 3:22 P.M. revealed Resident #13 had a care pan meeting that indicated he was at moderate risk for falls.Observation and interview on 03/18/26 at 10:29 A.M. revealed Resident #13 lying in bed. Resident #13's call light was not visible and not within reach. Resident #13 revealed he did not know where his call light was located and was observed moving his right arm in a back-and-forth motion attempting to locate the call light. Resident #13 (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated wherever it is, I can't reach it.Interview and observation on 03/18/26 at 10:40 A.M. with Rehabilitation Therapist (RT) #970 revealed he was familiar with Resident #13, and his call light should be within reach. RT #970 was observed unwrapping the call light from around the head of the bed frame, directly behind Resident #13 head, and placing it in the bed next to him. RT #970 confirmed and verified the above findings at the time of the interview.3. Review of the medical record for Resident #73 revealed she was admitted to the facility on [DATE] with diagnoses that included systematic lupus erythematosus, rheumatoid arthritis, fracture of nasal bones, injury of head, and history of falling.Review of the physician orders dated 03/17/23 revealed an order for fall prevention per protocol.Review of the physician orders dated 08/23/24 revealed an order for stand-up lift for transfers.Review of the progress note dated 11/26/25 at 1:29 P.M. revealed Resident #73 had a care plan meeting that indicated she was at high risk for falls.Review of the progress note dated 12/22/25 at 1:17 P.M. revealed Resident #73 was found lying on the floor in her room near doorway with a large hematoma on forehead and bilateral nostrils epistaxis. Resident #73 reported she was trying to move for the people behind her. Resident #73 was noted to only be in the room with her bedbound roommate. Resident #73 was sent to the emergency room (ER). Review of the progress note dated 12/22/25 at 9:24 P.M. revealed Resident #73 returned from the ER with a diagnosis of nasal fracture.Review of the MDS assessment dated [DATE] revealed Resident #73 had a BIMS score of eight, indicating moderate cognitive impairment. Review of the MDS assessment revealed Resident #73 was dependent on staff for ADL.Review of the care plan dated 01/01/26 revealed Resident #73 was at risk for falls with interventions that included keep call light within reach.Review of the physician orders dated 02/25/26 revealed an order for occupational therapy (OT) evaluation and treatment for wheelchair positioning.Interview and observation on 03/18/26 at 10:21 A.M. revealed Resident #73 sitting in her wheelchair with her back to the entrance of the room. Resident #73's call light was not visible and was not within reach. Resident #73 revealed she had a history of falling and recalled a fall that resulted in her hitting her head. Resident #73 revealed she did not know where her call light was located and would have to yell for help.Interview and observation on 03/18/26 at 10:25 A.M. with Licensed Practical Nurse (LPN) #805 revealed Resident #73 was at a high risk for falls and was dependent on staff for total care. LPN #805 revealed Resident #73 had a history of falls in which one resulted in a broken nose. LPN #805 revealed Resident #73's fall was a result of confusion and sitting in her wheelchair. LPN #805 revealed Resident #73 was required to have all fall interventions in place including call light within reach. Observation revealed LPN #805 attempting to locate Resident #73 call light by following the cord from the wall to the nightstand directly behind Resident #73. Resident #73 call light was approximately five feet away and out of reach. LPN #805 confirmed and verified the above findings at the time of interview.4. Review of the medical record for Resident #95 revealed he was admitted to the facility on [DATE] with diagnoses of peripheral vascular disease, acquired absence of the right leg above the knee, type II diabetes, and need for assistance with personal care.Review of the physician orders dated 08/05/25 revealed an order for fall prevention per protocol.Review of the physician orders dated 09/14/25 revealed an order for bed pad alarm every day and night shift.Review of the physician orders dated 12/05/25 revealed an order to remind Resident #95 to use call light for assistance for fall intervention.Review of the physician orders dated 01/31/26 revealed an order for floor mat to floor while in bed for fall intervention.Review of the care plan dated 02/08/26 revealed Resident #95 was at risk for falls and had decreased ability to perform ADL with interventions that included keeping the call light within reach.Review of the MDS assessment dated [DATE] revealed Resident #95 had a BIMS score of six, indicating severe cognitive impairment. Review of the MDS assessment revealed Resident #95 had impairment on one side of lower extremity and was dependent on staff for ADL.Review of the progress note dated 02/19/26 at 4:37 P.M. revealed Resident #95 had a care plan meeting that indicated he was at high risk for falls.Review of the physician orders dated 02/25/26 revealed an order for body pillow to edge of bed for safety for fall intervention.Review of the progress note dated 02/25/26 at 1:44 A.M. revealed (continued on next page)

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Avon Oaks Nursing Home	37800 French Creek Rd Avon, OH 44011

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #95 was found on the floor, lying face down adjacent to the bed stating he was trying to get out of there.Review of the progress note dated 03/05/26 at 9:58 P.M. revealed Resident #95 was found on the floor stating that he was trying to crawl out of bed. Resident #95 was placed back in bed with call light in reach.Observation and interview on 03/18/26 at 10:33 A.M. revealed Resident #95 lying in bed screaming for help. Resident #95 revealed he needed help to be repositioned in bed and needed help with eating his breakfast meal and a drink of water. Resident #95 was observed to be slouched down beneath his over the bed table with his breakfast tray untouched. Resident #95's call light was not visible or within reach.Interview and observation on 03/18/26 at 10:40 A.M. with RT #970 revealed he was familiar with Resident #95, and his call light should be within reach. RT #970 was observed grabbing Resident #95's call light from his recliner which was approximately five feet away from the bed and placed it next to Resident #95. RT #970 confirmed and verified the above findings at the time of the interview.Review of the facility document titled Falls/Safety Program, reviewed May 2025, revealed the facility had a policy in place to prevent or minimize injuries caused by accidental falls. Review of the policy revealed residents would be assessed for fall risk, call lights would be left within reach, and interventions would be put in place to prevent future falls. Review of the facility document titled Call Light/Bell Policy, revised May 2025, revealed the facility had a policy in place to provide transmission of call alerts from resident rooms to alert staff a resident may require assistance. Review of the policy revealed each resident would have a means of calling for assistance.

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident record review, resident interviews, staff interviews, and facility document review, the facility failed to honor Resident #51's preferences. This affected one resident (#51) of one reviewed for preferences. The facility census was 92.Findings include:Review of the medical record for Resident #51 revealed he was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease, cerebral infarction, muscle weakness and difficulty in walking.Review of the physician orders dated 10/24/24 revealed an order for fall prevention per protocol.Review of the physician orders dated 01/22/25 revealed an order for perimeter mattress and floor mat for fall prevention.Review of the progress note dated 01/21/26 at 4:16 P.M. revealed Resident #51 had a care plan meeting that indicated he was at risk of wandering and was at high risk for falls.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #51 had a Brief Interview for Mental Status (BIMS) score of seven that indicated he had cognition impairment. Review of the MDS assessment revealed Resident #51 was dependent on staff for activities of daily living (ADL).Review of the fall risk assessment dated [DATE] revealed Resident #51 was at high risk for falls.Review of the progress note dated 03/09/26 at 5:23 P.M. revealed the Administrator would be replacing Resident #51's body pillow and made Resident #51's spouse aware.Review of the concern log dated 03/10/26 revealed Resident #51's spouse had a documented concern regarding Resident #51's body pillow missing. Review of the concern log revealed a resolution of the body pillow being replaced.Review of the care plan dated 03/12/26 revealed Resident #51 had a decreased ability to perform ADL and was at risk for falls with interventions that included assistance from staff for ADL including bed positioning and/or mobility, transfers and the need for a bolstered mattress to define perimeter with mat on the floor.Observation on 03/18/26 at 11:16 A.M. revealed Resident #51 lying in bed. Observation of Resident #51's recliner located adjacent to his bed revealed a sign that read No pillows, blankets, sheets on this chair. Observation revealed there were three regular pillows and one body pillow piled on top of the recliner.Interview and observation on 03/18/26 at 11:18 A.M. with Licensed Practical Nurse (LPN) #835 revealed Resident #51 was confused at times, required some assistance from staff with ADL and always tried to climb out of bed. LPN #835 revealed Resident #51's bed should be in the lowest position, and his body pillow should be placed in the bed and tucked under the sheet around the perimeter to stop him from falling out of the bed. LPN #835 revealed the body pillow was a preference of Resident #51's spouse, and it helped him not fall out of bed because he liked to roll back and forth while in bed. LPN #835 revealed the signs posted in Resident #51's room were reminders for staff to implement Resident #51's spouse preferences. LPN #835 was observed stating she doesn't want these pillows here, but we put them there to keep out of the way. LPN #835 confirmed and verified Resident #51's spouse preferences were not honored to decrease the risk of falls.Interview on 03/19/26 at 8:38 A.M with Resident #51's spouse revealed the facility rarely honored her preferences when it came to Resident #51's care. Resident #51's spouse revealed Resident #51 had a history of falls and the body pillow helped eliminate the risk.Interview on 03/19/26 at 3:22 P.M. with the Administrator and Director of Nursing (DON) confirmed and verified they were aware of Resident #51's spouse preference for the body pillow to decrease the risk of falls and have replaced it in the past.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident record review, resident and staff interviews, the facility failed to ensure Resident #95, who was dependent on staff for care, was assisted with activities of daily living (ADL). This affected one resident (#95) of one reviewed for ADL. The facility census was 92.Findings include:Review of the medical record for Resident #95 revealed he was admitted to the facility on [DATE] with diagnoses of peripheral vascular disease, acquired absence of the right leg above the knee, type 2 diabetes, dysphagia oral phase and oropharyngeal phase and need for assistance with personal care.Review of the physician orders dated 08/05/25 revealed an order for fall prevention per protocol.Review of the physician orders dated 09/22/25 revealed an order for a no added sugar and no concentrated sweets diet, mechanical soft texture and regular and/or thin consistency.Review of the nutritional risk assessment dated [DATE] revealed Resident #95 remained malnourished.Review of the care plan dated 02/08/26 revealed Resident #95 was at risk for falls and had decreased ability to perform ADL, had a history of dehydration, and was at nutrition and/or hydration risk due to diagnosis of severe protein calorie malnutrition with interventions that included keeping the call light within reach, nutritional support as appropriate, and providing feeding assistance as needed.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #95 had a Brief Interview for Mental Status (BIMS) score of six, indicating severe cognitive impairment. Review of the MDS assessment revealed Resident #95 had impairment on one side of lower extremity and was dependent on staff for ADL.Observation and interview on 03/18/26 at 10:33 A.M. revealed Resident #95 lying in bed screaming for help. Resident #95 revealed he needed help to be repositioned in bed and needed help with eating his breakfast meal and a drink of water. Resident #95 was observed to be slouched down beneath his over the bed table with his breakfast tray untouched. Resident #95's breakfast tray consisted of bacon, eggs, a bowl of unknown white substance, a cup of coffee and a glass of water. Resident #95's call light was not visible or within reach.Interview and observation on 03/18/26 at 10:40 A.M. with Rehabilitation Therapist (RT) #970 revealed he was familiar with Resident #95, and he required some assistance from staff. RT #970 was observed repositioning Resident #95 in bed and proceeded to grab Resident #95's glass of water and provided a drink. RT #970 verified Resident #95's need for assistance and above findings at the time of the interview.Interview and observation on 03/18/26 at 10:42 A.M. with Certified Nurse Assistant (CNA) #868 outside of Resident #95's room, revealed he was aware of Resident #95's care needs and him yelling out for help. CNA #868 was observed walking away from Resident #95's room without entering and stated He doesn't need any help. He just having a bad day. CNA #868 verified, despite Resident #95's yelling out for help, he did not need any assistance, and he was not going into the room. CNA #868 was then observed walking away.Interview on 03/19/26 at 9:59 A.M. with Registered Dietician (RD) #858 revealed Resident #95 was at high risk for malnutrition, had wounds, required some assistance and had a poor appetite. RD #858 revealed Resident #95 required set-up assistance with prompting and reminders during his meals. RD #858 revealed Resident #95 also required the need for high calorie supplements due to his intake amounts and was monitored for changes in his condition. RD #858 verified the above finding at the time of the interview.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident record review, resident and staff interviews, and facility policy review, the facility failed to ensure weight loss prevention interventions were completed as ordered. This affected two residents (#11 and #65) of two residents reviewed for nutrition. The facility census was 92.Findings include:1. Review of the medical record for Resident #11 revealed she was admitted to the facility on [DATE] with diagnoses that included moderate protein-calorie malnutrition, paraplegia, and dysphagia oropharyngeal phase.Review of the physician orders dated 09/26/25 revealed an order for a regular diet, regular texture and regular consistency with a Greek yogurt daily at breakfast.Review of the physician orders dated 01/25/26 revealed an order to weigh Resident #11 every Sunday.Review of the care plan dated 02/14/26 revealed Resident #11 had potential fluid deficit related to sepsis and had a nutrition and/or hydration risk due to moderate protein calorie malnutrition with interventions that included monitoring vital signs as ordered per protocol and recording and monitoring weights.Review of the physician orders dated 02/14/26 revealed an order for Ensure Plus (nutritional supplement) two times a day and Pro-Stat (protein supplement)30 milliliters (ml) two times a day.Review of the nutritional risk assessment dated [DATE] revealed Resident #11 was at high risk and had a weight loss of 7% in less than 30 days. Review of the assessment revealed interventions were in place for Resident #11 to not have further weight loss.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #11 had a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. Review of the MDS assessment revealed Resident #11 required some assistance from staff for activities of daily living (ADL), had complaints of difficulty or pain when swallowing, and had a loss of 5% or more in the last month or loss of 10% or more in last six months.Review of the progress note dated 03/14/26 at 11:20 A.M. revealed Resident #11 had a weight change note warning that indicated she had a significant weight loss. Resident #11 revealed she didn't have much interest in food. Review of the progress note revealed Resident #11 will be continuously monitored.Interview on 03/18/26 at 8:40 A.M. with Resident #11 revealed she had a weight loss that was not on purpose, and she had been trying to eat her meals. Resident #11 revealed Registered Dietician (RD) #858 ordered her special drinks, but she had issues finishing her meals.Review of the weight summary revealed Resident #11 weighed 153.4 pounds (lbs.) on 02/01/26, 142.4 lbs. on 03/05/26, and 140 lbs. on 03/15/26 that indicated Resident #11 had a continuous steady weight loss.Further review of the weight summary revealed Resident #11 was not weighed on 02/08/26, 02/15/26, 02/22/26, 03/01/26 and 03/08/26 as required by the physician orders dated 01/25/26 to ensure no significant weight loss.Interview on 03/19/26 at 9:59 A.M. with RD #858 revealed Resident #11 was high-risk for nutrition due to significant weight loss, wounds, very little interest in food, depression and requiring a lot of encouraging. RD #858 revealed Resident #11 was being monitored for changes and was to be weighed according to the physician's orders. RD #858 verified the above findings at the time of the interview.2. Review of the medical record for Resident #65 revealed she was admitted to the facility on [DATE] with diagnoses of type II diabetes, dysphagia oropharyngeal phase and dementia.Review of the MDS assessment dated [DATE] revealed Resident #65 had a BIMS score of six, indicating severe cognitive impairment. Review of the MDS assessment revealed Resident #65 required supervision and/or touch assistance for eating.Review of the care plan dated 01/16/26 revealed Resident #65 was at nutrition and/or hydration risk due to suboptimal intakes with interventions that included steroids to increase appetite and monitoring dietary intake and weight.Review of the physician orders dated 01/16/26 revealed an order for no added salt, no added concentrated sweets, mechanical soft diet, soft texture and thin consistency and to weigh every Sunday. Further review of the weight summary revealed Resident #65 was not weighed on 01/25/26, 02/08/26, 02/22/26, 03/08/26, and 03/15/26 according to the physician's orders dated 01/16/26 to ensure no significant weight loss.Interview on 03/19/26 at 9:59 A.M. with (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RD #858 revealed residents who were high-risk for nutrition were to be monitored for changes and were to be weighed according to physician's orders. RD #858 verified the above findings at the time of the interview.Review of the facility document titled Weight Management, reviewed May 2025, revealed the facility had a policy in place that resident's weights would be monitored in an attempt to prevent unplanned significant weight changes. Review of the policy revealed residents would be weighed weekly for four weeks upon admission and monthly thereafter, if weights were stable and/or scheduled weights were required due to a decrease, increase in appetite or weight variance.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident record review, resident and staff interviews, and facility policy review, the facility failed to ensure respiratory care was implemented as ordered for Resident #65. This affected one resident (#65) of one reviewed for respiratory care. The facility census was 92.Findings include:Review of the medical record for Resident #65 revealed she was admitted to the facility on [DATE] with diagnoses of acute respiratory failure with hypercapnia, shortness of breath, dependence on supplemental oxygen, and chronic respiratory failure with hypercapnia.Review of the physician orders dated 01/15/26 revealed an order for 2 liters per minute (LPM) of oxygen as needed for shortness of breath and to maintain pulse oximetry over 92 percent (%) as needed and oxygen continuously via nasal cannula.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #65 had a Brief Interview for Mental Status (BIMS) score of six, indicating severe cognitive impairment. Review of the MDS assessment revealed Resident #65 required oxygen therapy, the use of a non-invasive mechanical ventilator and/or Bilevel Positive Airway Pressure (BiPAP) machine and was dependent on staff for activities of daily living (ADL).Review of the care plan dated 01/16/26 revealed Resident #65 had decreased ability to perform ADL due to oxygen dependence and respiratory failure and had altered respiratory status and/or difficulty breathing with interventions that included supplemental oxygen use and monitoring for respiratory distress such as decreased pulse oximetry. Review of the physician orders dated 01/19/26 revealed an order to change oxygen tubing and label and date the tubing every Monday night. Observation and interview on 03/18/26 at 10:51 A.M. revealed Resident #65's spouse sitting on a rollator next to Resident #65 while she sat in a wheelchair outside of her room. Resident #65 was observed wearing a nasal cannula that was wrapped around her shoulders and attached to a portable oxygen tank positioned on the back of her wheelchair. Resident #65's nasal cannula and tubing were not dated. Resident #65's spouse appeared upset and approached surveyor with tears in his eyes and stated Can you help? Her oxygen tank is almost empty. Resident #65's spouse revealed the facility staff did not ensure her oxygen tank was always full, did not monitor her pulse oximetry to ensure she could breathe and did not keep her nasal cannula, tubing and nebulizer cleaned and sanitized. Observation of Resident #65's portable oxygen tank revealed the regulator gauge needle was near the red zone, indicating close to empty and requiring a refill. Resident #65 was observed repeatedly tilting her head back and opening her mouth and stated, I think I'm okay.Observation on 03/18/26 at 10:53 A.M. of Resident #65's oxygen equipment located in her room revealed her BiPAP machine tubing, oxygen tubing, and a partially filled bottle of clear liquid solution were not dated.Observation and interview on 03/18/26 at 10:57 A.M. with the Director of Nursing (DON) verified Resident #65's portable oxygen tank was near the red zone indicating a need for a refill or new tank, and her oxygen equipment not dated. The DON revealed Resident #65 was closely monitored for her oxygen needs and she was going to get a replacement tank. The DON returned without an oxygen tank and reported the nurse would bring it.Observation and interview on 03/18/26 at 11:03 A.M. revealed Resident #65's spouse reach into his coat pocket and place a portable pulse oximeter on Resident #65's finger to measure her blood oxygen saturation level. Observation of the pulse oximeter revealed Resident #65 had a pulse oximetry reading of 77% indicating severe hypoxemia. Resident #65's spouse stated see! She needs help, and no one cares or does anything.Interview and observation on 03/18/26 at 11:04 A.M. revealed Licensed Practical Nurse (LPN) #825 walking past Resident #65. LPN #825 was stopped, after surveyor intervention, and revealed she monitored Resident #65 pulse oximetry levels and oxygen tank levels frequently. LPN #825 revealed Resident #65 had a new portable oxygen tank in her room that she was going to switch out after tending to another resident. LPN #825 revealed Resident #65's spouse always intervened with Resident #65's care and she was currently okay with no need for intervention. LPN #825, after surveyor intervention, checked Resident #65's pulse oximetry levels and had a returned reading of (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365762	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avon Oaks Nursing Home	37800 French Creek 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.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	74%. LPN #825 was then observed removing Resident #65 from the hallway and escorting her into her room to provide care. LPN #825 revealed Resident #65 had an order in place to keep her pulse oximetry levels over 92%. LPN #825 verified Resident #85's oxygen equipment was not dated; her portable oxygen tank was in the red zone and a low pulse oximetry reading indicating a need for immediate intervention.Review of the facility document titled Oxygen Therapy, revised May 2025, revealed the facility had a policy in place that after a physician order was put in place residents would be assessed and monitored.