STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366471	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenue at Broadview Heights	1201 Akins Road Broadview Heights, OH 44147

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 - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34297 Based on record review, interview, and facility policy review the facility failed to develop and implement a comprehensive and individualized pressure ulcer prevention program to prevent the development of pressure ulcers, to timely identify new pressure ulcers, and to ensure wound care was completed as ordered to ensure Resident #72 skin was maintained and the resident did not develop an in-house stage three pressure ulcer (full thickness tissue loss, subcutaneous fat may be visible but bone, tendon or muscle are not exposed, slough may be present but does not obscure the depth of tissue loss, may include undermining and tunneling) to the left buttock. Actual Harm occurred on [DATE] when Resident #72's, who was dependent for eating, shower/bathing, upper and lower body dressing, and personal hygiene, and was incontinent of bowel and bladder, developed an in-house pressure ulcer identified at a stage three. This finding affected one resident (#72) of three residents reviewed for pressure wounds. The facility census was 69. Findings include: Review of the medical record revealed Resident #72 was admitted to the facility on [DATE] and expired in the facility on [DATE] with diagnoses including metabolic encephalopathy, cerebral infarction, and dysphagia. Review of the nursing admission assessment form dated [DATE] authored by Registered Nurse (RN) Unit Manager (UM) #834 revealed Resident #72 had a skin tear to the left elbow, an abrasion on the right ankle, and an abrasion on the left ankle. Review of the progress note dated [DATE] at 7:47 P.M. authored by RN UM #834 revealed Resident #72 arrived at the facility at 3:40 P.M. via a stretcher. The resident was alert and oriented times one to two with multiple skin tears and bruising noted to the bilateral upper extremities and abrasions noted to the bilateral outer ankles. Bilateral heel protector boots were in place. There was no documented evidence of a pressure ulcer to Resident #72's left buttock. Review of the physician's orders revealed an order dated [DATE] for a pressure reducing cushion to wheelchair, a pressure reducing mattress to the bed, and to float the heels while in bed as tolerated. (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 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #72's care plans dated [DATE] revealed the resident was admitted with a stage three pressure ulcer to the sacrum. Interventions dated [DATE] included to administer medications, administer treatments as ordered and monitor for effectiveness, monitor/document/report changes, treat pain as ordered and weekly treatment documentation. (There were no treatment orders until [DATE]). Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #72 exhibited a memory impairment, was dependent on eating, oral hygiene, toileting, shower/bathing, upper and lower body dressing, and personal hygiene. Review of Resident #72's Braden Scale for Predicting Pressure Sore Risk form dated [DATE] revealed the resident was high risk for developing pressure ulcer wounds. Review of the initial pressure ulcer wound evaluation form dated [DATE] at 1:31 P.M. completed by Nurse Practitioner (NP) #908 indicated the [AGE] year-old male was a new admission who was incontinent of bowel and bladder. The resident had a left buttock stage three full-thickness pressure ulcer which was present upon admission and measured 4.4 centimeters (cm) length by 6.5 cm width by 0.1 cm depth with 30% granulation and 70% pink with scant bloody exudate. The peri wound was moist and excoriated, and new orders for zinc oxide cream and a clean dry dressing were ordered daily and as needed. Review of the physician's orders revealed an order dated [DATE] for ProHeal 30 milliliters (ml) two times a day for supplement (discontinued [DATE]); and an order dated [DATE] for an air mattress to the bed with bolsters. Review of Resident #72's progress note dated [DATE] at 5:21 P.M. authored by Dietitian #908 revealed she was made aware of a stage three pressure ulcer to the left buttocks. Review of Resident #72's physician's orders revealed an order dated [DATE] (discontinued [DATE]) to cleanse the left buttock with normal saline, pat dry, apply zinc oxide and cover with a foam dressing daily and as needed. Review of the medical record revealed no progress note regarding Resident #72 being sent to the hospital on [DATE]. Review of Resident #72's hospital Encounter Summary Note dated [DATE] from 10:25 A.M. to 2:43 P.M. revealed the [AGE] year-old male with a significant past medical history for a cerebrovascular accident (CVA) with a left hemiplegia/hemiparesis diagnosis was DNRCCA was evaluated at the bedside for anemia. The resident's hemoglobin was 6.7 at the SNF earlier in the day and was sent in for a transfusion. The resident's heart rate was 115 and the oxygen level was 100%. The resident only responded to pain. The daughter requested the resident receive fluids and be discharged back to the SNF. The resident had significantly deteriorated, and she was the POA and wanted the code status changed to DNRCC. Review of the progress note dated [DATE] at 2:00 P.M. authored by RN UM #817 indicated Resident #72's daughter requested to not send the resident to the emergency room (ER) going forward. She wanted to keep the resident comfortable. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #72's progress note dated [DATE] at 3:24 P.M. revealed the resident arrived back to the facility via an ambulette. Review of the progress note dated [DATE] at 3:38 A.M. authored by Licensed Practical Nurse (LPN) #851 revealed Resident #72 was in respiratory distress and was put on ten liters oxygen. The physician was notified, and the resident was sent out at 3:25 A.M. to the ER. The daughter was notified. Review of Resident #72's progress note dated [DATE] at 5:36 A.M. revealed authored by LPN #851 revealed the resident returned at 5:00 A.M. and the code status was updated. Review of the progress note dated [DATE] at 8:10 A.M. authored by LPN #816 revealed the nurse called Resident #72's daughter and gave the nurse an update from the hospital documentation (following the resident's return to the facility). The nurse also updated the daughter that the resident's fingers were cyanotic, and the nurse could not get an oxygen level on the resident. The daughter requested the resident remain comfortable. Review of the Pressure Ulcer/Wound Record form dated [DATE] at 8:52 A.M. revealed Resident #72 had a left buttock stage three pressure wound which measured 3.9 cm length by 4.7 cm width by 0.1 cm depth with moderate serosanguinous exudate with a wound bed of 60% granulation and 40% slough. The surrounding skin color and surrounding tissue/wound edges were excoriated, and the wound had deteriorated. A new order was placed to cleanse the wound with normal saline, pat dry, apply silver alginate (antibacterial absorbent wound dressing) and cover with a foam dressing daily and as needed. Review of the physician's orders revealed an order dated [DATE] (discontinued [DATE]) to cleanse Resident #72's left buttock with normal saline, pat dry, apply silver alginate, and cover with a foam dressing daily and as needed. Review of the progress note dated [DATE] at 7:35 A.M. authored by LPN #816 revealed Resident #72 was observed without a pulse which was verified with other staff members. The daughter was updated, and the administrative staff were updated. Interview on [DATE] at 11:51 A.M. with NP #908 stated she first assessed Resident #72's skin and determined the resident had a stage three left buttock pressure wound on [DATE] and placed orders for wound care at that time. NP #908 could not remember if the resident had a dressing on his left buttock when she went into assess the resident's left buttock pressure wound. Interviews on [DATE] at 12:22 P.M. with LPN UM #886 and the Administrator confirmed Resident #72's hospital documentation dated [DATE] did not contain evidence of a pressure wound to Resident #72's left buttock as documented in the [DATE] care plan. She confirmed she had placed pressure ulcer wound assessments in Resident #72's electronic health record (EHR) for the dates of [DATE] and [DATE] which documented the left buttock pressure wound as a stage three but could not remember what the left buttock pressure wound looked like on [DATE]. She stated she must have found out the left buttock pressure wound was a stage three from the report obtained from the hospital during Resident #72's nurse to nurse report as she did not stage pressure wounds, and the wound NP completed staging of resident pressure wounds. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interviews on [DATE] at 1:46 P.M. with RN UM #834 indicated she admitted Resident #72 on [DATE], and he did not have skin impairments to his left buttock. She stated the wound assessment dated [DATE] was placed in the resident's record in error. RN UM #834 confirmed the resident was on a every two hour turn and barrier cream as needed. She verified the first treatment order was implement on [DATE]. An additional interview on [DATE] at 2:40 P.M. with RN UM #834 confirmed Resident #72's left buttock pressure wound assessments dated [DATE] and [DATE] were documented in error and struck out of the resident's medical record. RN UM #834 confirmed the facility first identified Resident #72's left buttock stage three pressure wound on [DATE] when the wound NP assessed the resident. RN UM #834 stated wound NP #908 ordered zinc oxide for the left buttock pressure wound following identification on [DATE], and she did not agree with NP #908's determination that the left buttock pressure wound was identified at a stage three. Review of Resident #72's medication administration records (MARS) and treatment administration records (TARS) revealed documentation from [DATE] to [DATE] to encourage the resident to float heels while in bed as tolerated and encourage the resident to offload pressure while in bed or chair as tolerated every shift. The MARS and TARS indicated the wound care was completed from [DATE] to [DATE] (when the resident expired in the facility). Review of the Pressure Ulcer Prevention and Interventions policy, revised ,d+[DATE], revealed the policy was to implement preventative skin measures for all resident's based on the levels and areas of risk to include moisture, nutrition, activity, mobility, mental status, psychosocial status and general physical condition. This deficiency represents non-compliance investigated under Complaint Number OH00157185.

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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** 34297 Based on observation, record review, interview, and facility policy review the facility failed to ensure Resident #38's incontinence care was completed timely. This finding affected one resident (#38) of three residents reviewed for incontinence care. The facility census was 69. Findings include: Review of Resident #38's medical record revealed the resident was admitted on [DATE] with diagnoses including multiple sclerosis, varicose veins, and difficulty in walking. Review of Resident #38's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition, was always incontinent of urine and frequently incontinent of bowel. Review of Resident #38's physician orders revealed an order dated 03/18/24 for a mechanical lift for all transfers every shift. Observation on 09/10/24 at 5:15 A.M. with State tested Nursing Assistant (STNA) #832 and STNA #849 of Resident #38's transfer from the power wheelchair to the bed using a Hoyer mechanical lift did not reveal concerns. Further observations revealed the pad underneath the resident was soaked with urine and the resident's incontinence brief was soaked with urine. Interview on 09/10/24 at 5:20 A.M. with Resident #38 revealed the resident put her call light on at approximately 3:15 A.M. to be placed in bed for incontinence care, but the staff did not answer her call light. She confirmed her incontinence brief was soaked with urine. Interview on 09/10/24 at 5:29 A.M. with STNA #849 stated Resident #38 was not on his assignment, and he did not answer the call light because he did not see the call light was on. Interview on 09/10/24 at 5:33 A.M. with STNA #832 confirmed Resident #38 was not provided timely incontinence care. Further interview with STNA #832 confirmed her assignment was mixed up and she was not aware she had Resident #38 on her assignment, and she did not provide timely incontinence care. Review of the Incontinence Care policy, dated 12/22, revealed the purpose was to ensure a resident who was incontinent of bowel and/or bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. This deficiency represents non-compliance investigated under Master Complaint Number OH00157185 and Complaint Number OH00156930.