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	11/25/2025

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 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)

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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on review of medical records, interviews, and review of facility policy, the facility failed to ensure appropriate and timely routine skin assessments were completed for two residents (#58 and #61) of three residents reviewed for appropriate care and treatment related to altered skin integrity. The facility census was 57.Findings include: 1. Review of the medical record for Resident #58 revealed an admission date of 05/19/25 and a discharge date of 07/29/25. Pertinent diagnoses included acute respiratory failure with hypoxia, headache syndrome, severe persistent asthma, type two diabetes mellitus with hyperglycemia, schizoaffective disorder, muscle weakness, acute kidney failure, and hypothyroidism.Review of the admission Minimum Data Set (MDS) assessment completed on 05/26/25 revealed Resident #58 had intact cognition and no rejection of care. Further review of the MDS revealed Resident #58 had an upper extremity impairment on one side, required moderate assistance rolling left and right in bed, sitting from a lying position, standing from a sitting position, and with all transfers. The MDS also indicated that Resident #58 was not at risk for pressure ulcers, had no unhealed pressure ulcers, and had no other skin alterations. Interventions listed included pressure reducing devices for the bed and chair and the application of ointments or medications other than to the feet.Review of Resident #58's physician orders revealed an order dated 05/19/25 for a Braden skin assessment on admission and every week for three weeks. Further review of the orders revealed medication or treatment orders related to various skin conditions, including:- Orders for Nystatin (an antifungal) powder, dated 05/19/25 to 06/14/25 and another order dated 06/14/25, to be applied to the groin, abdomen, and breast two times a day. - Orders for Temovate external ointment (a topical corticosteroid), 0.05 percent (%), dated 05/20/25 through 06/14/25 and 06/16/25 through facility discharge, to be applied topically to the hands every Monday, Tuesday, Wednesday, Thursday, and Friday to reduce inflammation. Listed instructions noted to avoid application of the ointment to the face, breasts, groin, or armpits. - An order dated 06/14/25 for MetroCream External 0.75% (an antimicrobial cream), to be applied to the face topically every morning and at bedtime for redness. - An order for ketoconazole (an antifungal) external shampoo, 2%, dated 06/16/25, to be applied to the scalp one time a day every Monday, Tuesday, Wednesday, Thursday, and Friday. Review of the Nursing: admission Assessment completed on 05/19/25 revealed Resident #58 had a red area on the right buttock. The assessment included no information related to size, etiology, or contributing factors, presence of drainage, or the state of the surrounding tissue. Furthermore, the assessment revealed no indication the resident's physician was notified of the skin area or indication that treatments or interventions were put into place at the time the reddened area was identified. Review of the Braden scale assessment (a tool used by healthcare professionals to assess a patient's risk of developing a pressure ulcer) revealed the facility completed a Braden Scale assessment for Resident #58 on 05/19/25. There was no evidence subsequent assessments were completed once a week for three weeks following the admission assessment, as ordered. Review of this Braden scale assessment further indicated that Resident #58 had no mobility limitations and had sufficient strength to lift herself up from a chair and move independently in the bed and the chair (The admission MDS listed a mobility impairment and the need for moderate assistance). The assessment notes did not account for the presence of the reddened area that was assessed this same date on Resident #58's right buttock.Review of all assessments completed between 05/19/25 and 07/29/25 revealed no non-pressure skin grid assessments or pressure skin grid assessments were completed throughout the duration of Resident #58's time at the facility, despite the reddened area to the right buttock being identified upon admission. There was no indication of ongoing assessment or resolution of the altered skin integrity. Review of the Weekly Skin Check assessment revealed only one weekly skin assessment was completed, dated 07/21/25, in which no new skin problems were identified. The medical record contained no skin assessments, other than the admission assessment completed on 05/19/25. There were no ongoing assessments to show the reddened area was reassessed, tracked, or treated. Additionally, there were no skin assessments to indicate the necessity for use of antifungal, antimicrobial, or corticosteroid creams, lotions, powders, or shampoos as ordered. Review of the care plan from 05/20/25 through 09/14/25 revealed Resident #58 had actual impairment of skin integrity related to the right buttocks being reddened. Interventions included administration of treatments as ordered, adding a pressure-reducing device to the mattress and the chair, and follow facility protocols for treatment of skin injury. The care plan for actual skin integrity impairment was not resolved at any time during the duration of Resident #58's facility stay. Further review of the care plan revealed the facility initiated a care plan focus for

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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. Based on record review, interview, and facility policy review, the facility failed to ensure physician orders for weights were completed as ordered for one resident (#58). This had the potential to affect all residents residing in the facility. The facility census was 57. Findings include: Review of the closed medical record for Resident #58 revealed an admission date of 05/19/25 and a discharge date of 07/29/25. Diagnoses included but were not limited to acute respiratory failure with hypoxia, severe persistent asthma, type II diabetes with hyperglycemia, long term use of insulin, congestive heart failure, hypertensive heart disease and schizoaffective disorder, and post bariatric surgery status. Review of the 07/29/25 discharge Minimum Data Set (MDS) 3.0 for Resident #58 revealed a Brief Interview of Mental Status (BIMS) of 15 which indicated intact cognition. Review of the activities of daily living (ADLs) revealed Resident #58 was independent for meals. No weight was recorded on the MDS.Review of Resident #58's care plan last reviewed on 05/20/25 revealed potential for altered nutrition and hydration related to diagnosis of acute hypoxic respiratory failure, type II diabetes mellitus and history of bariatric surgery. Resident #58 also had physician-directed weight loss through the use of diuretics. A listed intervention included to monitor and record weights as physician ordered.Review of Resident #58's physician orders revealed an order dated 05/23/25 for daily weights to be obtained. Review of the Medication Administration Record (MAR) for July 2025 revealed staff were signing of Resident #58's daily weights on the MAR as being complete with the exception of 07/11/25 which was blank and 07/26/25 where it noted the resident refused. There were no actual weights recorded on the MAR. Review of Resident #58's weights under the weights tab in the electronic medical record revealed the last recorded weight was 05/27/25 which listed Resident #58's weight at 260.2 pounds.Interview on 11/19/25 at 2:30 P.M. with Registered Dietitian #369 confirmed the actual daily weights were not recorded on the resident's MAR, rather they were just checked off as complete. Registered Dietician #369 stated the weights should have been completed and recorded daily. Interview on 11/19/25 at 2:45 P.M. with the Director of Nursing (DON) confirmed daily weights were signed off but no weights were recorded in Resident #58's medical record as ordered by the physician. Review of the October 2024 revised facility policy called; Weight Policy and Procedure revealed residents will be weight monthly unless ordered otherwise by a physician. Weights will be recorded in the resident's medical record.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview, review of the medical record, and review of facility policy, the facility failed to ensure resident drug regimens did not include the unnecessary use of opioids. This affected one resident (#13) of four residents reviewed for appropriate pain management. The facility census was 57. Findings include:Review of the medical record for Resident #13 revealed an admission date of 02/17/24. Pertinent diagnoses included nontraumatic subarachnoid hemorrhage, nontraumatic intracerebral hemorrhage in the cortical hemisphere, dysphagia, aphasia, epilepsy, chronic obstructive pulmonary disease (COPD), chronic respiratory failure with hypoxia, and type two diabetes mellitus. Review of the quarterly Minimum Data Set (MDS) assessment completed on 08/26/25 revealed Resident #13 had severe cognitive impairment but was usually able to make herself understood and usually understood others. Further review of the MDS revealed Resident #13 was on a scheduled pain regimen, received as needed analgesics (pain medications), and reported pain occurred almost constantly but rarely affected sleep or day-to-day activities. The MDS indicated that Resident #13 received medications from high-risk categories, including antidepressant, anticoagulant, antibiotic, anticonvulsant, and opioid. Review of the orders revealed Resident #13 had one routine order for control of neuropathy that included an order dated 01/21/25 for Gabapentin, 300 milligrams (mg), one capsule by mouth three times a day for neuropathic pain. The orders also included two PRN (as needed) analgesics (pain-relief medications): 1) orders dated 02/28/25 to 10/09/25 and 10/09/25 for acetaminophen oral tablet, 325 mg, give two tablets (650 mg) by mouth every six hours as needed for pain, and 2) orders dated 12/17/24 to 10/09/25 and 10/09/25 for oxycodone hydrochloride (an opioid typically prescribed to treat moderate to severe pain), five milligram tablet, give 5 mg by mouth every eight hours as needed for pain. Further review of the orders revealed consecutive orders, dated 02/17/24 to 10/09/25 and 10/09/25 through current, for staff to assess Resident #61 for pain every shift. The order specified that if pain was present, documentation was required and non-pharmacological interventions were to be attempted prior to administration of analgesics. Review of the care plan from 02/18/24 to 12/14/25 revealed Resident #13 was at risk for pain. Interventions included anticipating need for pain relief and responding immediately to any complaints of pain, documenting non-pharmacological intervention attempts prior to administration of pharmacological intervention, documenting probable cause of pain and removing or limiting causes where possible. The interventions further specify that non-pharmacological techniques to offer prior to administration of analgesics included relaxation techniques, meditation, guided imagery, soft music, dim lights, repositioning for comfort, offering a back rub, providing a quiet atmosphere, and instructing in deep breathing exercises.Review of the Medication Administration Record (MAR) from July 2025 revealed Resident #13 was administered oxycodone on 07/03/25 at 7:36 A.M. and 5:06 P.M., on 07/09/25 at 3:28 P.M. , on 07/15/25 at 8:31 A.M. and 4:46 P.M., on 07/19/25 at 9:49 P.M. and on 07/20/25 at 5:51 A.M. with a pain assessment documented with the oxycodone administration as NA. No non-pharmacological interventions were noted on the MAR as being attempted prior to the administration of oxycodone during the corresponding shifts on 07/03/25, 07/09/25, 07/15/25, and 07/19/25 to 07/20/25 and the overall pain rating for the shifts was documented as zero for each of the corresponding shifts. Furthermore, Resident #13 did not receive acetaminophen, a non-opioid analgesic, prior to receiving acetaminophen. Review of the MAR also revealed that only two (07/13/25 at 11:23 P.M. and 07/26/25 at 9:36 P.M.) of the total 22 doses of oxycodone administered to Resident #13 in July 2022 had documentation of attempted non-pharmacological interventions prior to medication administration. Review of the linked electronic MAR (eMAR) progress notes dated 07/03/25 at 7:36 A.M., 07/09/25 at 3:28 P.M., 07/15/25 at 8:31 A.M. and at 4:46 P.M., 07/19/25 at 9:49 P.M., and 07/20/25 at 5:51 A.M. revealed no assessments that indicated Resident #13 experienced moderate to severe pain or requested to receive oxycodone. Further review of the notes revealed no non-pharmacological intervention attempts were made prior to medication administration. Review of the MAR from August 2025 revealed Resident #13 was administered 5 mg of oxycodone by mouth on 08/11/125 at 7:35 P.M., on 08/12/25 at 11:12 A.M., and on 08/26/25 at 1:18 P.M. with the corresponding pain scale rated as NA. No non-pharmacological interventions were noted on the MAR as being attempted prior to the administration of oxycodone during the corresponding shifts on 08/11/25, 08/12/25, or 08/26/25 with an overall pain assessment for the shift rated as zero on 08/11/25 and 08/12/25 and as NA on 08/26/25. Further review of the MAR revealed that out of the total of 13 doses of oxycodone administered to Resident #13 in August 2025, only three doses, the doses administered on 08/01/25 at 7:07 A.M. and 7:17 P.M., and on

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, medical record review, and review of facility policy, the facility failed to ensure a medication error rate of less than five percent (%). This affected two residents (Residents #12 and #39) of five residents (Residents #5, #12, #13, #30, and #39) observed during medication administration when the observation resulted in an error rate of 8.33%. The facility census was 57.1. Review of the medical record for Resident #12 revealed an admission date of 12/06/23 with pertinent diagnoses including spinal stenosis, depression, type two diabetes mellitus, repeated falls, polyarthritis, nonexudative age-related macular degeneration, hyperlipidemia, obstructive reflux uropathy, essential (primary) hypertension, benign prostatic hyperplasia without lower urinary tract symptoms and gastro-esophageal reflux disease. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment completed on 09/02/25 revealed Resident #12 had intact cognition with no observed behaviors. Further review of the MDS revealed Resident #12 required setup or clean-up assistance for eating, oral care, and personal hygiene. High-risk medications included drugs from the antibiotic category. Review of the care plan dated 09/16/25 revealed Resident #12 had the potential for impaired skin integrity. Interventions included administration of medications and treatments as ordered. Further review of the care plan revealed Resident #12 had impaired cognitive function and impaired visual function with interventions including administration of medications as ordered and monitoring for side effects of medications. Review of the medication orders revealed the following medications were to be administered to Resident #12 in the mornings:- Acidophilus oral capsule, give one capsule by mouth two times daily for supplement, dated 02/10/25, scheduled for 7:00 A.M. to be administered by a clinician- Cipro 500 milligram (mg) oral tablet, give one tablet by mouth two times daily for seven days for urinary tract infection (UTI), dated 11/16/25 and scheduled for administration by a clinician in the mornings between 7:00 A.M. and 11:00 A.M.- PreserVision AREDS2 oral capsule, give one capsule by mouth two times a day related to macular degeneration, dated 07/10/24, scheduled for morning administration by a clinician, which included tome span between 7:00 A.M. and 11:00 A.M.- Oyster calcium with vitamin D3 tablet, 500 mg - five micrograms (mcg), give one tablet by mouth in the morning for supplement, dated 07/10/24, to be administered by a clinician between 7:00 A.M. and 11:00 A.M. - Atenolol 25 mg oral tablet, give one tablet by mouth each morning for hypertension, dated 07/10/24, to be clinician-administered between 7:00 A.M. and 11:00 A.M. - Senna 8.6 mg tablet, give one tablet by mouth in the morning for constipation, dated 08/28/25, to be clinician-administered between 7:00 A.M. and 11:00 A.M.- Lac-Hydrin five external lotion five percent (%) to be applied topically to bilateral lower extremities twice a day for dry skin, dated 04/18/25 in the morning at 8:00 A.M. by the clinician- Multivitamin with minerals oral tablet, give one tablet by mouth in the morning for supplement, dated 07/20/24 to be administered daily at 8:00 A.M. by the clinician- Vitamin D3 tablet 1,000 units, give one tablet by mouth in the morning for health maintenance, dated 07/16/24, scheduled for 8:00 A.M. for clinician administration- Fish oil 1,000 mg oral capsule by mouth two times a day for supplement, dated 06/27/25, scheduled for clinician administration at 8:00 A.M. Observation on 11/20/25 of Licensed Practical Nurse (LPN) #303 preparing and administering medications for Resident #12 revealed, after checking Resident #12's blood pressure and pulse, LPN #303 dispensed the following medications into a clear plastic medicine cup between 9:03 A.M. and 9:08 A.M.:- Acidophilus 1billion units, one capsule- Multivitamin with minerals, one tablet- Atenolol 25 mg, one tablet- Vitamin D, 25 micrograms (mcg) (1,000 units), one tablet- Ciprofloxacin 500mg, one tablet- ProSight with zinc (the facility substitute for PresserVision AREDS2), one capsule- Oystershell 500-5mg plus D, one tabletInterview on 11/20/25 at 9:08 A.M. with LPN #303 revealed the ordered Senna, 8.6 mg, was not in the medication cart. Observation at this time revealed LPN #303 locking the prepared medication in the cart and leaving the unit at 9:09 A.M until returning at 9:15 A.M. Continued observation at that time revealed the new bottle of Senna was opened, dated, then one tablet was dispensed into the same medicine cup as the other seven pills. At 9:18 A.M., LPN #303 confirmed a total of eight pills were in the medication cup. Continued observation on 11/20/25 at 9:18 A.M. revealed LPN #303 entered the room of Resident #12, handed Resident #12 the medicine cup with the eight pills, verified Resident #12 had water, then left the room. Interview on 11/20/25 at 12:51 P.M. with Resident #12 revealed only pills were given at the time of the observation (at 9:19 A.M.) and Resident #12 was usure if lotion was applied to the legs that morning, stating I really can't remember getting it put on this morning. Interview on 11/20/25 at 3:29 P.M. with LPN #303 confirmed that Resident #12 had an order for Fish Oil that was supposed to be given twice daily, at 8:00 A.M. and at 8:00 P.M. Review of the progress note dated

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, medical record review, and review of facility policy, the facility failed to ensure medications were not left with a resident to take independently who was not approved to safely store or self-administer medications. This affected one resident (#12) of five residents observed and reviewed for medication administration. The facility census was 57.Findings include: Review of the medical record for Resident #12 revealed an admission date of 12/06/23 with pertinent diagnoses including spinal stenosis, depression, type two diabetes mellitus, repeated falls, polyarthritis, nonexudative age-related macular degeneration, hyperlipidemia, obstructive reflux uropathy, essential (primary) hypertension, benign prostatic hyperplasia without lower urinary tract symptoms and gastro-esophageal reflux disease.Review of the assessments revealed a Nursing: Self-Administration of Medications evaluation completed on 01/26/25 indicated Resident #12 could not safely administer all medications but could safely administer Pantoprazole and Synthroid only. The assessment did not indicate the ability to safely store medications at the bedside. Further review of the assessments revealed no follow-up evaluation was completed with the quarterly assessments.Review of the quarterly Minimum Data Set (MDS) 3.0 assessment completed on 09/02/25 revealed Resident #12 had intact cognition with no observed behaviors. Further review of the MDS revealed Resident #12 required setup or clean-up assistance for eating, oral care, and personal hygiene. High-risk medications included drugs from the antibiotic category. Review of the active medication orders revealed the following medications were to be administered to Resident #12 by a clinician with the morning medication pass:- Acidophilus oral capsule, give one capsule by mouth two times daily for supplement, dated 02/10/25, scheduled for 7:00 A.M. to be administered by a clinician- Cipro 500 milligram (mg) oral tablet, give one tablet by mouth two times daily for seven days for urinary tract infection (UTI), dated 11/16/25 and scheduled for administration by a clinician in the mornings between 7:00 A.M. and 11:00 A.M.- Preservision AREDS2 oral capsule, give one capsule by mouth two times a day related to macular degeneration, dated 07/10/24, scheduled for morning administration by a clinician, which included tome span between 7:00 A.M. and 11:00 A.M.- Oyster calcium with vitamin D3 tablet, 500 mg - five micrograms (mcg), give one tablet by mouth in the morning for supplement, dated 07/10/24, to be administered by a clinician between 7:00 A.M. and 11:00 A.M. - Atenolol 25 mg oral tablet, give one tablet by mouth each morning for hypertension, dated 07/10/24, to be clinician-administered between 7:00 A.M. and 11:00 A.M.- Senna 8.6 mg tablet, give one tablet by mouth in the morning for constipation, dated 08/28/25, to be clinician-administered between 7:00 A.M. and 11:00 A.M. - Lac-Hydrin five external lotion five percent (%) to be applied topically to bilateral lower extremities twice a day for dry skin, dated 04/18/25 in the morning at 8:00 A.M. by the clinician- Multivitamin with minerals oral tablet, give one tablet by mouth in the morning for supplement, dated 07/20/24 to be administered daily at 8:00 A.M. by the clinician- Vitamin D3 tablet 1,000 units, give one tablet by mouth in the morning for health maintenance, dated 07/16/24, scheduled for 8:00 A.M. for clinician administration- Fish oil 1,000 mg oral capsule by mouth two times a day for supplement, dated 06/27/25, scheduled for clinician administration at 8:00 A.M.Observation on 11/20/25 from 9:03 A.M. to 9:18 A.M. of Licensed Practical Nurse (LPN) #303 preparing and administering medications for Resident #12 revealed the following medications were placed in a clear plastic medication cup: Acidophilus 1 billion units, one capsule; multivitamin with minerals, one tablet; Atenolol 25 mg, one tablet; vitamin D, 25 micrograms (mcg) or 1,000 units, one tablet; Ciprofloxacin 500 mg, one tablet; ProSight with zinc (the facility substitute for Preservision AREDS2), one capsule; and Oystershell 500-5 mg plus D, one tablet. Interview with LPN #303 at the time of observation confirmed a total of eight pills were in the medicine cup for Resident #12. Observation on 11/20/25 between 9:18 A.M. and 9:19 A.M. revealed LPN #303 entered the room of Resident #12, handed Resident #12 the medicine cup containing eight pills, verified Resident #12 had water, and then left the room as Resident #12 was picking up the first pill from the medicine cup and placing it into his mouth. Continued observation revealed LPN #303 returned to the medication cart and began preparing medications for another resident in the hallway, with no view of Resident #12, from 9:19 A.M. to 9:20 A.M. LPN #303 then locked the medications cart and left the unit, stating a needed medication was not on the cart and needed picked up from the pharmacy. As LPN #303 was observed walking away from the unit at 9:20 A.M., Resident #12 was observed continuing to independently take the medications handed to him, one by one, until the last one was swallowed at 9:22 A. M. (LPN #303 was not on the unit at that time). Interview on 11/20/25 at 9:23 A.M. with Resident #12 confirmed the medicine cup with pills is sometimes left in the room for him and reported that some nurses did

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, interview, and facility policy review, the facility failed to ensure a resident's admission was timely completed and failed to ensure routine assessments were completed as required. This affected three residents (#60, #2, and #61) of six residents reviewed for accuracy of medical records. The facility census was 57. Findings include: 1. Review of the closed medical record for Resident #60 revealed an admission date of 07/12/25 and a discharge date of 07/24/25. Diagnoses included but were not limited to rhabdomyolysis, sepsis, hydronephrosis, dysfunction of bladder, and elevated white blood cell count. Review of the hospital discharge instructions dated 07/11/25 for Resident #60 revealed medication orders for Albuterol 90 micrograms (mcg) inhaler as needed, Amlodipine 5 milligram (mg) oral tablet to be taken by mouth twice a day, Ceftriaxone 500 mg oral tablet to be given by mouth twice daily for ten days. Doxazosin 2 mg oral tablet to be given by mouth twice daily, finasteride 5 mg oral tablet to be given by mouth daily, Metoprolol tartrate 50 mg oral tablet to be given by mouth twice daily, multivitamin one tablet by mouth once daily, Protonix 40 mg delayed release tablet to be given by mouth daily, Xarelto 20 mg tablet by mouth daily with evening meal, Zocor 40 mg tablet to be given by mouth at bedtime, Spironolactone 50 mg oral tablet to be given by mouth at breakfast, tamsulosin 0.4 mg oral capsule to be given by mouth twice daily, and Spiriva Respimat 60 mcg per inhalation aerosol two puffs to be given daily as needed for shortness of breath. Review of the admission assessment dated [DATE] timed at 10:07 A.M. opened by Licensed Practical Nurse (LPN) #319 for Resident #60 revealed the assessment was not complete. The information contained in the assessment was populated from a previous admission in 2023 and did not contain current information. Review of the physician orders for Resident #60 revealed an order dated 07/12/25 timed at 7:09 P.M. had been entered for Amlodipine Besylate tablet 10 mg by mouth one time a day for hypertension, Pantoprazole sodium tablet delayed release 40 mg by mouth one time a day for acid reflux, Simvastatin tablet 40 mg tablet by mouth at bedtime for hyperlipidemia, and Tamsulosin hydrochloride capsule 0.4 mg by mouth one time a day for benign prostatic hyperplasia (BPH). Review of the physician orders for Resident #60 revealed an order dated 07/12/25 timed at 7:29 P.M. entered for Doxazosin Mesylate 4 mg oral tablet by mouth two times a day for blood pressure. Review of the physician order for Resident #60 revealed an order dated 07/12/25 timed at 7:31 P.M. for Finasteride 5 mg oral tablet by mouth in the evening for BPH. Review of the physician order for Resident #60 revealed an order dated 07/12/25 timed at 7:41 P.M. for Rivaroxaban 20 mg oral tablet by mouth in the evening for anticoagulation. Review of the nursing progress note dated 07/12/25 timed at 8:08 P.M. written by LPN #319 for Resident #60 revealed he was admitted to the facility at 10:00 A.M. Vitals and a head-to-toe assessment were noted to be completed and documented. (continued on next page)

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	11/25/2025

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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the nursing progress noted dated 07/13/25 timed at 8:40 A.M. revealed Licensed Practical Nurse (LPN) #371 assisted LPN #372 with Resident #60 who was found to be sideways wedged between the two head rails and there was noted blood on the floor. Resident #60 was able to be repositioned in the bed and was noted to have a dent on the top of his head with a small lump on the side of the dent. Resident #60 stated he had been hallucinating. LPN #371 called the physician and received an order to send Resident #60 out to a local hospital for evaluation. Review of the nursing progress note dated 07/13/25 timed at 10:38 A.M. revealed LPN #371 spoke with the emergency room physician who stated Resident #60 was sent to the hospital without paperwork. LPN #371 updated the physician on Resident #60's status. Review of the July 2025 Medication Administration Record (MAR) for Resident #60 revealed only three of the physician-ordered medications with a start date of 07/12/25 were listed. Two Amlodipine Besylate oral tablet 2.5 mg oral tablets were noted as being given at 8:00 P.M. on 07/12/25, Doxazosin Mesylate oral tablet 4 mg by mouth was noted as not being given and to see nurses notes, and Tamsulosin HCl oral capsule 0.4 mg was given at 8:00 P.M. Review of Resident #60's care plan revealed it was initiated on 07/12/25 but not completed. Review of the 07/18/25 admission Minimum Data Set (MDS) 3.0 for Resident #60 revealed he had intact cognition. Resident #60 was noted to require maximum assistance from staff for toileting, bathing, dressing and transfers and was also noted to have an indwelling catheter. Telephone interview on 11/24/25 at 11:10 A.M. with LPN #371 revealed on the night of 07/12/25, she was working on another unit and was approached by two other nurses for help. When she entered Resident #60's room, there was blood on the floor, Resident #60 was sideways in the bed with his head wedged against the bed rail and his feet pushing against the other bed rail. They were able to get Resident #60 turned in the bed and noticed an indentation on his head from being wedged against the bed rail. The blood was noted to be from his intravenous (IV) access site. LPN #371 stated she attempted to review the physician orders, but they were in the queue and not completed or activated. LPN #371 called the physician and received orders to send Resident #60 out for evaluation. LPN #371 told LPN #372 to call for transport. LPN #371 also confirmed she received a phone call from Resident #60's hospital physician later the same day stating he was sent without any paperwork and asked for information as to what had happened prior to being sent to the hospital. Telephone interview on 11/24/25 at 12:25 P.M. with LPN #372 revealed she worked on the night of 07/12/25, it was her first day at the facility and she was having difficulty with her computer access for medical records and had notified management. LPN #372 had flushed Resident #60's IV as ordered and left his room to assist another resident. An aide, whom she did not recall their name, stated she needed help. When she entered Resident #60's room, he had turned himself sideways in the bed and was wedged between the railings near the top of the bed and he was pushing with his feet which pushed his head further against the other railing. Resident #60 had torn his IV site cap off and it bled onto the floor. LPN #372 stated she called 911 due to him being confused, pulling out the IV cap, and due to the indentation on his head from being wedged in the bed railings. LPN #372 stated she tried to find his initial nursing assessment but was unable to and confirmed no paperwork was sent with Resident #60 when he was transported to the local hospital. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Telephone interview on 11/24/25 at 1:45 P.M. with LPN #319 confirmed when a resident is admitted they do a head-to-toe assessment, obtain vital signs, complete the admission assessment, and make a documentation note in the electronic medical record. LPN #319 confirmed the admission assessment should be completed within an hour of a resident's admission to the facility. LPN #319 did not recall Resident #60 and did not recall if admission paperwork or an assessment was completed. Interview on 11/24/25 at 2:02 P.M. with the Director of Nursing (DON) confirmed the admission assessment for Resident #60 was not completed and also confirmed physician orders for medications were not entered until at least 10 hours after admission and not all ordered medications were entered. Interview on 11/24/25 at 4:06 P.M. with Regional Director of Clinical #373 confirmed the admission assessment for Resident #60 was not completed and only had information from his previous admission in 2023. Regional Director of Clinical #373 also confirmed the admission assessment should have been completed within a couple hours of admission, medications should have been entered sooner than 10 hours after admission, and paperwork should have been sent with Resident #60 when he was sent to the hospital. Review of the November 2022 revised facility policy called; Admission, Discharge and Transfer revealed the facility will provide for a safe and appropriate admission, transfer and discharge as needed. Review of the December 2022 facility policy called; EHR Records and Documentation revealed the medical record shall reflect a resident's progress toward achieving their person-centered plan of care objectives and goals and the improvement and maintenance of their clinical, functional, mental and psychosocial status. The licensed nurse will document on all new admissions by documenting in the admission UDA (PCC) within 24 hours. The medical record should provide sufficient information for staff to respond to the changing status and needs of the resident. 2. Resident #2 was admitted on [DATE] and had a re-entry date of 12/11/24. Diagnoses included chronic obstructive pulmonary disease (COPD), respiratory failure, obstructive sleep apnea, anxiety disorder, cirrhosis of the liver, asthma, anemia, essential (primary) hypertension, personal history of neoplasm of the bladder, centrilobular emphysema, dependence on supplemental oxygen, gastrostomy status, and chronic pain syndrome. Review of the facility incident logs revealed Resident #2 had an unwitnessed fall on 07/05/25. Review of the clinical assessment history revealed the Nursing: Fall Risk Assessment - V 1 was completed on 09/22/24, 12/08/24, and 07/05/25 (Resident #2 was discharged and readmitted to the facility on [DATE]). There was no evidence that the fall risk assessment had been completed upon facility readmission or quarterly for Resident #2 for the current facility stay, until the fall that occurred on 07/05/25. Review of the quarterly MDS 3.0 assessment completed on 11/04/25 revealed Resident #2 had intact cognition, used a wheelchair for locomotion, and required moderate assistance with transfers. Further review of the MDS revealed Resident #2 had no history of falls since admission, re-entry, or completion of the previous comprehensive assessment. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/24/25 from 9:00 A.M. to 9:15 A.M. with the DON revealed uncertainty as to the frequency that the fall risk assessments were to be completed, but would be checking the policy to make that determination. A follow-up interview on 11/25/25 between 4:20 P.M. and 4:30 P.M. with the DON confirmed no admission or quarterly fall risk assessments had been completed since Resident #2's rea-entry date of 12/11/24 and that the only assessment completed since re-entry was on 07/05/25, after Resident #2's fall. 3. Review of the medical record for Resident #61 revealed an initial admission date of 03/07/25 and a discharge date of 11/12/25. Review of the Clinical Census revealed Resident #61 was out of the facility for greater than 24 hours, beginning on 10/13/25, with re-entry listed as 10/15/25. Pertinent diagnoses included multiple sclerosis, chronic obstructive pulmonary disease (COPD), neuromuscular dysfunction of the bladder, type two diabetes mellitus, hypertensive heart and chronic kidney disease with heart failure, Stage three chronic kidney disease, anxiety disorder, major depressive disorder, post laminectomy syndrome, and primary osteoarthritis of the right knee. Review of the incident logs revealed Resident #61 had an unwitnessed fall on 09/20/25. Review of the clinical assessment history revealed Resident #61 had a Nursing: Fall Risk Assessment - V 1 completed on 03/11/25 for the initial admission and did not have another fall risk assessment completed until 09/20/25 after sustaining an unwitnessed fall. There was no record of quarterly fall risk assessments or a fall risk assessment being completed with readmission on [DATE]. Review of the Discharge with Return Anticipated Minimum Data Set (MDS) 3.0 assessment completed on 10/13/25 revealed Resident #61 had moderate cognitive impairment and was dependent for transfers. Further review of the MDS revealed Resident #61 had one fall with injury since admission, re-entry or the last assessment. Interview on 11/25/25 between 4:20 P.M. and 4:30 P.M. with the DON confirmed there had been no quarterly or readmission fall risk assessments completed between Resident #61's initial admission date and the date of the fall (09/20/25). Review of the policy titled Fall Management last updated December 2022 revealed a licensed nurse was to assess each resident for fall risk through the Fall Risk Assessment on admission, quarterly, and with significant changes. This deficiency represents non-compliance investigated under Complaint Numbers 2560788 and 1401316.