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	01/15/2026

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and review of the facility policy, the facility failed to ensure Resident #11 received showers to her preference and in accordance with care planned interventions. This affected one resident (Resident #11) out of three reviewed for bathing. The facility census was 61.Findings include:Review of Resident #11's medical record revealed an admission date of 01/25/25 and diagnoses included cellulitis of left lower limb, peripheral vascular disease, and major depressive disorder. Review of Resident #11's care plan dated 03/06/25 included Resident #11 had an ADL self-care performance deficit related to impaired mobility, muscle weakness and other diagnoses. Resident #11 would improve her current level of function in ADL's through the review date. Interventions included to provide bathing, showering per shower schedule and as requested; provide a sponge bath when a full bath or shower cannot be tolerated. Review of Resident #11's physician orders dated 03/20/25 revealed Resident #11 was a two person assist using a mechanical lift.Review of Resident #11's Quarterly Minimum Data Set assessment dated [DATE] revealed Resident #11 was cognitively intact. Resident #11 required substantial to maximal assistance with toileting hygiene and bathing. Resident #11 used a wheelchair and was dependent for chair-to-bed-to-chair transfers and the ability to get in and out of a tub or shower. Resident #11 did not reject care during the seven-day assessment look-back period.Review of Resident #11's progress notes dated 12/08/25 through 01/08/26 did not reveal evidence Resident #11 refused showers or requested a bed bath instead of a shower. Review of Resident #11's shower sheets dated 12/09/25 through 01/08/26 revealed there was no shower sheet provided for 12/08/25 or 12/18/25. Resident #11 had bed baths on 12/22/25, 01/02/26 and 01/05/26. Resident #11 had showers on 12/11/25, 12/15/25, 12/25/25 and 12/29/25. Review of Resident #11's electronic medical record aide charting for bathing and showers dated 12/08/25 and 12/18/25 revealed there was no evidence Resident #11 received a shower or bed bath. Observation on 01/08/26 at 11:08 A.M. of Resident #11's room revealed a sign on the door to the bathroom stated to give Resident #11 showers on Monday and Thursday evenings.Observation on 01/08/25 at 11:08 A.M. of Resident #11 revealed she was lying in bed and Licensed Practical Nurse (LPN) #410 and Certified Nursing Assistant (CNA) #481 were providing care. Resident #11 sighed and stated she did not have a shower for three weeks and had only been given bed baths. Resident #11 sighed again and stated it is what it is and said she wanted showers and did not care what time it was when she got the shower. When asked why Resident #11 was not getting showers as requested LPN #410 and CNA #481 stated Resident #11 was scheduled for showers on Monday and Thursday in the evenings, and that was not their shift. CNA #481 and LPN #410 indicated they were not sure but thought she was not getting showers when she was scheduled because she used a mechanical lift and needed two staff to assist, and there might not have been enough staff available for a shower. Resident #11 stated she told the nurses and aides she preferred showers.Review of the facility policy titled Your Rights and Protections as a Nursing Home Resident undated included as a nursing home resident you have certain rights and (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
	366471	A. Building B. Wing	01/15/2026

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	protections under Federal and State law that help ensure you get the care and services you need. You have the right to be informed, make your own decisions, and have your personal information kept private. You have the right to be treated with dignity and respect, as well as to make your own schedule and participate in activities you choose. You have the right to decide when to go to bed, rise in the morning, and eat your meals. You have the right to take part in developing your care plan. You have the right to participate in the decisions that affected your care.This deficiency represents non-compliance investigated under Complaint Number 2683768.

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	01/15/2026

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 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 observation, interview, record review and review of the facility policy the facility failed to ensure Resident #21 received adequate oral care. This affected one resident (Resident #21) out of three residents reviewed for oral care. The facility census was 61.Findings include:Review of Resident #21's medical record revealed an admission date of 10/08/24 and diagnoses included spastic quadriplegic cerebral palsy, adult failure to thrive, and quadriplegia.Review of Resident #21's care plan dated 11/04/24 included Resident #21 had an activities of daily living (ADL) self-care performance deficit related to impaired mobility, spastic cerebral palsy, quadriplegia and other diagnoses. Resident #21 would improve his current level of function in ADL's through the review date. Interventions included oral care every shift and as needed per facility policy; Resident #21 required one staff member to assist with personal hygiene and oral care. Review of Resident #21's Annual Minimum Data Set assessment dated [DATE] revealed Resident #21 was cognitively intact. Resident #21 was dependent for eating, oral hygiene, toileting hygiene, bathing, dressing, personal hygiene and bed mobility. Resident #21 was always incontinent of urine and bowel. Resident #21 did not reject care during the seven-day assessment look-back period.Observation on 01/08/26 at 7:49 A.M. of Certified Nursing Assistant (CNA) #481 revealed she was in the hall outside Resident #21's room and stated she just arrived for work and was completing resident rounds. CNA #481 stated she was new to the facility and had not taken care of the residents on this hall before including Resident #21.Observation on 01/08/26 at 8:18 A.M. of Resident #21 revealed he was lying in bed and slightly turned onto his left side and his head was tilted towards the left. Resident #21 stated sometimes he saw bugs flying around the room, and just saw them a little while ago. No observations of bugs were noted during the interview with Resident #21. Resident #21 stated some of the aides did not take care of him and he would like someone to brush his teeth. Observation of Resident #21's teeth revealed a large build up of yellowish-brown food material and what appeared to be tartar (hardened dental plaque, crusty and often yellowish or brownish deposit that formed on teeth when plaque wasn't removed by regular brushing and flossing) was seen at the base of all his teeth where the teeth met the gums. Resident #21's hair was matted at the back of his head, and his hands were contracted and drawn up towards his chest. Resident #21 was pleasant and answered questions appropriately.Observation and interview on 01/08/25 at 1:10 P.M. with CNA #481 of Resident #21 confirmed Resident #21's teeth had a large amount of yellowish-brown material on his teeth where the teeth meet the gums. CNA #481 confirmed Resident #21's teeth had really bad food build up, and confirmed his hair was matted at the back of his head. CNA #481 stated she noticed Resident #21's teeth when she was feeding him and it looked like they had not been brushed for a long time.Review of the facility policy titled Your Rights and Protections as a Nursing Home Resident undated included as a nursing home resident you have certain rights and protections under Federal and State law that help ensure you get the care and services you need. You have the right to be treated with dignity and respect, as well as to make your own schedule and participate in activities you choose. You have the right to decide when to go to bed, rise in the morning, and eat your meals.This deficiency represents non-compliance investigated under Complaint Number 2683768.

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	01/15/2026

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 - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, closed record review, review of Emergency Medical Services report, review of hospital records, policy review and interview the facility failed to follow Resident #62's physician orders and implement care planned interventions to ensure Resident #62 was monitored appropriately and timely treated for an acute change of condition, and failed to ensure adequate skin monitoring was completed to timely identify and treat areas of Resident #62's skin breakdown. The facility also failed to ensure Resident #39's new medical diagnoses of type two diabetes was timely treated.Actual Harm occurred beginning on 02/18/25 at 7:47 P.M. when Resident #62 reported he had blood in his urine, a urine specimen for urinalysis and culture and sensitivity was ordered, but no further monitoring was completed from 02/18/25 through 02/22/25 including vital signs or monitoring of the resident's urinary status. On 02/22/25 at 7:40 A.M. Resident #62 was found in a stuporous state, was unable to make eye contact and answer questions appropriately, and his skin was pale, cool and clammy. Resident #62 had involuntary shaking of his right arm and was humming. Resident #62's blood pressure was 101/56 (hypotensive), heart rate 41 beats per minute (bradycardic) and blood sugar was 59 (hypoglycemic). The resident's temperature was not taken. Emergency medical services (EMS) were called. Resident #62 was transported to the local hospital emergency department (ED) where his temperature was found to be 90.0 degrees Fahrenheit (F) (hypothermic) and he was admitted to the hospital with altered mental status, urinary tract infection, sepsis, hypothermia, hypotension, and a newly identified right lower buttock pressure ulcer noted to be present at the time of admission to the hospital. This affected one resident (#62) of three residents reviewed for a change in condition, and one resident (Resident #39) out of three residents reviewed for blood sugar monitoring. The facility census was 61.Findings Include:1.Review of Resident #62's closed medical record revealed an initial admission date of 04/16/23 with diagnoses including type two diabetes mellitus with diabetic neuropathy, anxiety disorder, obstructive and reflux uropathy, acute osteomyelitis of the left ankle and foot. Resident #62 was transferred to the local hospital Emergency Department on 02/22/25 and did not return to the facility.Review of Resident #62's care plan dated 04/28/23 and revised on 03/13/25 included Resident #62 was at risk for bladder incontinence related to impaired mobility, impaired cognition and recent catheter use due to obstructive uropathy. The plan revealed Resident #62 had his catheter removed and was voiding without difficulty at this time. Resident #62 would be continent during waking hours through the review date. Interventions included monitor and document for signs and symptoms of a urinary tract infection (UTI) such as pain, burning, blood tinged urine, cloudiness, increased pulse, increased temperature, fever, chills, urinary frequency, foul smelling urine, altered mental status, change in behavior, or a change in eating patterns.Review of Resident #62's care plan dated 04/28/23 and revised on 03/13/25 included Resident #62 had the potential for skin integrity and pressure ulcer development related to diabetes mellitus, chronic venous insufficiency, impaired mobility and other diagnoses. The care plan included Resident #62 would pick at skin continuously despite education. Interventions included to administer treatments as ordered and monitor for effectiveness, follow facility policies, protocols for the prevention and treatment of skin breakdown, inform the resident, family, caregivers of any new area of skin breakdown, weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate.Review of Resident #62's care plan dated 02/28/24 and revised 03/13/25 included Resident #62 would refuse medications and lab work, was non-compliant with wound care, non-compliant with ambulation and weight bearing status and would transfer without staff assistance. Resident #62 would pick at his skin and smear blood on the walls. (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	01/15/2026

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 - Actual harm Residents Affected - Few	Resident #62 would refuse care at times. Resident #62 would urinate in the computer room trash can. The goal developed included Resident #62 would have fewer episodes of behaviors by the review date. Interventions included to anticipate and meet Resident #62's needs, intervene as necessary to protect the rights and safety of others, approach and speak in calm manner and remove from the situation and take to alternate location as needed.Review of Resident #62's physician orders dated 04/02/24 revealed the resident received Insulin Glargine Solostar Subcutaneous Solution Pen-Injector 300 units per milliliter, 32 units subcutaneously at bedtime for diabetes mellitus. The order was discontinued on 02/24/25.Review of Resident #62's physician's orders dated 04/03/24 revealed an order for Humalog KwikPen Subcutaneous Solution Pen-Injector 200 units per milliliter, per sliding scale. If the resident's blood sugar was 180 to 240 inject two units, if the blood sugar was 241 to 300 inject four units, if the blood sugar was 301 to 360 inject 6 units, if the blood sugar was 361 to 400 inject eight units, and if the blood sugar was greater than 400 inject 10 units and notify the physician, subcutaneously with meals for insulin. Review of Resident #62's physician orders dated 04/04/24 and revised 04/05/24 revealed the resident had an order for Enhanced Barrier Precautions due to a diagnosis of Candida Auris, every shift. The orders remained active until 02/24/25 (after the resident's discharge).Review of Resident #62's care plan dated 04/05/24 and revised on 03/13/25 included Resident #62 was on Enhanced Barrier Precautions related to Candida Auris. Enhanced Barrier Precautions would be maintained throughout the review period. Interventions included to educate the resident, family, and staff regarding Enhanced Barrier Precautions and wear gown and gloves when performing high contact resident care.Review of Resident #62's quarterly Minimum Data Set assessment dated [DATE] included Resident #62 was cognitively intact. The assessment revealed Resident #62 was dependent (on staff) for toileting hygiene and lower body dressing, required substantial to maximal (staff) assistance with bathing, and required partial to moderate (staff) assistance with personal hygiene. Resident #62 required substantial to maximal (staff) assistance for the ability to roll from lying on his back to the left and right side and return to lying on his back on the bed, for the ability to move from sitting on the side of the bed to lying flat on the bed, and the ability to move from lying on the back to sitting on the side of the bed and with no back support and the ability to transfer from a bed to a chair or wheelchair. Resident #62 used a wheelchair and required partial to moderate (staff) assistance for the ability to wheel at least 50 feet and make two turns. The assessment revealed Resident #62 did not reject care during the seven-day assessment look-back period.Record review revealed a wound care note dated 12/31/24 which reflected Resident #62 was receiving care for a left medial heel diabetic ulcer which showed complete epithelialization with no signs of infection or inflammation. Healing was complete and the wound was now closed. Resident #62 was discharged from the Wound Care service with a note to follow up as needed.Review of Resident #62's Braden Scale for Predicting Pressure Sore Risk dated 02/08/25 revealed Resident #62 was at mild risk for developing pressure ulcers, injuries.Review of Resident #62's progress note dated 02/08/25 at 2:04 P.M. included Resident #62 had a skin tear to the right middle knuckle. The area was cleansed with normal saline and a steri-strips was applied. The skin tear was reported to the Nurse Practitioner and staff were to continue to monitor Resident #62's knuckle for signs and symptoms of infection and to discontinue the order when the skin tear was resolved.Review of Resident #62's Weekly Skin Check dated 02/14/25 at 4:14 P.M. revealed no evidence of new skin problems.Review of Resident #62's Treatment Administration Record dated 02/09/25 through 02/22/25 when Resident #62 was transported to the local emergency room (ED) and admitted to the hospital revealed a treatment for Resident #62's right middle knuckle, steri-strip in place, monitor for signs and symptoms of infection, bleeding every shift for skin tear, (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	01/15/2026

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 - Actual harm Residents Affected - Few	discontinue when resolved was marked it was completed two times a day (except for during the night shift on 02/11/25) during this time period.Review of Resident #62's progress note dated 02/17/25 at 1:12 P.M. included the nurse collected a wound culture to confirm C. Auris (Candida Auris). The progress note did not specify where the wound was located or where the wound culture was taken from. Review of Resident #62's progress note dated 02/18/25 at 7:47 P.M. included Resident #62 stated he had blood in his urine, and an order was given by the Nurse Practitioner (NP) to collect a urine specimen for urinalysis and culture and sensitivity. Resident #62's progress note did not indicate if the urine was observed by an aide or a nurse and there was no description of the urine including amount or odor. The note only included Resident #62 told the staff he had blood in his urine.Review of Resident #62's medical record including progress notes and documentation revealed no evidence Nurse Practitioner #470 or Physician Assistant #471 evaluated Resident #62 following this complaint of blood in his urine.Review of Resident #62's progress notes dated 02/18/25 at 7:47 P.M. through 02/22/25 at 7:30 A.M. revealed no documented evidence Resident #62 was monitored for a change of condition or for urinary status. There was no staff assessments/documentation for blood in the resident's urine, vital signs including temperature, or mental status changes during this time period. There was no documented evidence as to whether or not Resident #62 voiced additional concerns about his urine including if there was blood in it during this time period.Review of Resident #62's progress note dated 02/19/25 at 4:27 A.M. revealed Resident #62's urinalysis (UA) was collected and sitting in the refrigerator for the lab. There was no documentation revealing why Resident #62's urine specimen was not picked up by the lab on 02/19/25. Review of Resident #62's progress note dated 02/19/25 at 1:02 P.M. included Resident #62 continued to be on enhanced barrier precautions due to scratching and picking at the skin of his arms and hands.Review of Resident #62's urine culture Lab Results Report included the resident's urine was collected on 02/20/25 at 12:00 A.M. and reported on 02/22/25 at 7:46 P.M. (Note: Resident #62 was transported to the hospital ED on 02/22/25 at 8:20 A.M.) Proteus Mirabilis was present at greater than 100,000 CFU (colony forming units) per milliliter. The results identified Extended-Spectrum Lactamases (ESBL) enzymes that showed resistance to Extended-Spectrum (third generation) cephalosporins) producing organism but did not affect carbapenems and meropenem or imipenem. Proteus Mirabilis was resistant greater than two to Ciprofloxicin (Cipro).Review of Resident #62's progress note dated 02/20/25 at 3:48 P.M. included lab results were reported to Physician Assistant (PA) #471 and a new order for Cipro 500 milligrams (mg) by mouth was ordered two times a day for seven days for elevated white blood cells.Review of Resident #62's Treatment Administration Record dated 02/21/25 revealed a Weekly Skin Check every Friday to be completed under the assessment tab was initiated it was completed. However, there was no evidence of a Weekly Skin Check form dated 02/21/25 in the assessment tab documenting Resident #62's skin was evaluated and/or details of an actual skin check/assessment.Review of Resident #62's blood sugars checked with each meal dated 02/21/25 revealed at 8:00 A.M. his blood sugar was 222 and two units of Humalog insulin was administered, at 12:00 P.M. his blood sugar was 147 and no insulin was administered, at 5:00 P.M. his blood sugar was 93 and no insulin was administered.Review of Resident #62's Treatment Administration Record dated 02/21/25 from 6:00 P.M. to 6:00 A.M. revealed observe Resident #62 for signs and symptoms of hyperglycemia and hypoglycemia related to diabetes mellitus every shift. The record was initiated as completed, but the time was not recorded.Review of Resident #62's progress note dated 02/22/25 at 7:30 A.M. revealed Resident #62 was resting in bed and when he was awakened he was making a humming noise while shaking his right arm involuntarily. The note revealed Resident #62's name was called repeatedly, and he kept humming and his arm was shaking. Resident #62's blood pressure was 101/56 (hypotensive), (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	01/15/2026

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 - Actual harm Residents Affected - Few	heart rate 41 (bradycardic) and blood sugar 59 (hypoglycemic). There was no evidence the resident's temperature or oxygen saturation level were checked. Resident #61 was asked what day it was, what the nurse's name was and he repeated Friday. Resident #62's physician and Power of Attorney were notified, and the POA stated to send the resident out.Review of Resident #62's progress note dated 02/22/25 at 7:40 A.M. revealed the nurse was called to Resident #62's room and noted Resident #62 to be pale with cool, clammy skin. Resident #62 was in a stuporous state and unable to make eye contact or answer questions appropriately. The note revealed staff initiated neuro checks and continuous monitoring of vital signs. Review of Resident #62's [NAME] Review report from the local Fire Department included a call was received on 02/22/25 at 7:50 A.M., EMS was dispatched at 7:51 A.M. and arrived to the facility and had contact with Resident #62 at 7:57 A.M. Resident #62's blood pressure was 91/62, pulse was 40, respirations 16 and oxygen saturation was 95 percent. Resident #62 was confused, somnolent and had slowness and poor responsiveness. EMS was dispatched for a chief complaint of altered mental status (AMS) and diabetic issue. EMS were told by the facility staff that Resident #62's blood sugar was low, and he was not acting normal. An intravenous line (IV) was established and 10 percent dextrose solution (D10) ran to keep open (TKO). Resident #62's initial blood glucose was 47 and a repeat blood sugar revealed 180. Resident #62 denied chest pain, shortness of breath, nausea and dizziness. However, Resident #62 unable to sign (paperwork) due to his AMS, was transported to the local hospital ED and care was transferred at 8:32 A.M. Review of Resident #62's progress note dated 02/22/25 at 8:00 A.M. revealed EMS arrived and stated they would start an IV and administer dextrose solution. If the intervention was unsuccessful EMS would transport Resident #62 to the ER.Review of Resident #62's progress note dated 02/22/25 at 8:20 A.M. revealed Resident #62's blood glucose was 180, but he continued to slur his words and answer questions inappropriately. Resident #62 was transported by EMS to the local ED.Review of Resident #62's Acute Care Hospital Transfer Form dated 02/22/25 at 8:24 A.M. included Resident #62 was lethargic and had seizure like activities. There was no evidence Resident #62's temperature was checked and the last time his temperature was checked on 02/15/25 at 1:34 P.M. it was documented to be 97.8 degrees F. There was no documentation on the form to indicate Resident #62 had skin tears on his bilateral upper extremities, any type of pressure ulcer to the right lower buttock, a right foot non-pressure ulcer or a left foot non-pressure ulcer. (Please note, the resident had orders for weekly skin checks which should have been completed on 02/21/25. However, there was no documented evidence this was actually completed).Review of Resident #62's Emergency Department Visit Note dated 02/22/25 at 8:35 A.M. included EMS was called to the facility where Resident #62 resided due to Resident #62's altered mental status and Resident #62 was found to be hypoglycemic with a blood sugar to 46. Resident #62 was administered D10, his blood sugar improved to 180, but facility staff stated Resident #62 was not acting like himself and was normally alert and feisty. Resident #62 did not recognize his nurse at the facility, which was very abnormal for him. Resident #62 stated he felt a little short of breath with a cough, he had chest pain with the cough and reported diffuse abdominal pain. Resident #62 thought he might be having diarrhea, had no nausea or vomiting, and believed his lower extremity edema was new (Resident #62 had bilateral two plus nonpitting edema to the mid shin). Resident #62 did not know how long he had felt unwell. Resident #62's blood pressure was 102/55, pulse 58, temperature 90.0 degrees Fahrenheit (hypothermic), respirations 14 and oxygen saturation was 96 percent. Resident #62 was hypotensive, hypothermic and bradycardic. Resident #62's core body temperature was 86.4 Fahrenheit and he was placed on a Bair Hugger (used forced-air warming to maintain a patient's normal body temperature). Recommend ED to ED transfer for Emergency General Surgery (EGS)- a critical field focused on urgent, non-trauma surgical (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	01/15/2026

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 - Actual harm Residents Affected - Few	needs of patients such as severe infections and complications requiring immediate attention) evaluation and admission to the intensive care unit. Review of Resident #62's Change in Condition assessment dated [DATE] at 8:39 A.M. included Resident #62 most recent blood pressure was 101/51 at 8:38 A.M., respirations 20 at 8:39 A.M., blood sugar was 51 at 8:36 A.M. Resident #62's most recent temperature was taken on 02/15/25 at 1:34 P.M. There was no evidence Resident #62's temperature was checked at this time. Staff noted a significant change in mental status and Resident #62 was unable to answer questions appropriately or follow commands. Resident #62 had cool, clammy skin. There was no documented evidence Resident #62 was assessed for or that staff identified skin tears on his bilateral upper extremities, an unstageable pressure ulcer of the right lower buttock, a right foot non-pressure ulcer or a left foot non-pressure ulcer.Review of Resident #62's progress notes dated 02/22/25 at 10:52 A.M. included the ED was contacted and the nurse was told Resident #62 was being admitted to the Intensive Care Unit related to atypical vital signs and mental status.Review of Resident #62's ED to Hospital admission dated 02/22/25 at 2:00 P.M. included Resident #62 had a change in mental status and was transported from the local ED to the main hospital ED for altered mental status, UTI, sepsis, hypothermia and hypotension. Resident #62's blood pressure was 98/61, pulse 66, temperature 90.9 Fahrenheit, respirations 18, and his oxygen saturation was 91 percent. Resident #62's visit diagnoses included sepsis with encephalopathy and septic shock due to unspecified organism, hypothermia, acute kidney injury, acute cystitis without hematuria, and type two diabetes with diabetic polyneuropathy. Resident #62 had prior left foot OM (osteomyelitis) s/o calcanectomy in 03/2024 (subtotal or total calcanectomy, a surgery removing part or all of the heel bone to treat severe, non-healing ulcers, often from diabetes), and was growing rare candida auris in March 2024. Resident #62 was admitted to the Medical Intensive Care Unit (MICU) with concerns for septic shock 2/2 urinary tract infection (UTI) (likely referring to experiencing two urinary tract infections in a short timeframe), Resident #62 had positive leukocyte esterases (white blood cells present signaling inflammation or infection) and nitrates (usually a sign of urinary tract infection) on UA (urinalysis). Resident #62 endorsed hematuria prior to arrival and had fevers, chills, excessive sweating. Resident #62 was treated empirically with antibiotics (Vancomycin, Zosyn, and then changed to ceftriaxone). Resident #62 had a high probability of sudden, clinically significant deterioration which required the highest level of physician preparedness to intervene urgently. Resident #62 had multiple wounds and had various skin tears to his bilateral upper extremities (BUE) and the dressings were left in place to avoid further trauma to the area. Resident #62 had an unstageable pressure injury to his right lower buttock area that was present on admission (to the hospital). When asked Resident #62 reported a two year history of wounds to his buttocks. Resident #62 had ulcerations to his left inner foot that appeared to be diabetic versus venous in nature. Resident #62 was unable to say how they originated, but believed it was after his amputation surgery. On 02/23/25 at 12:33 A.M. documentation revealed an unstageable pressure injury to Resident #62's right lower buttock which was present on admission. On 02/24/25 at 1:05 P.M. measurements revealed the length was 3.5 centimeters (cm), width was 2.4 cm and depth was 0.05 cm. The wound bed was moist, pink, yellow and had eschar, and a scant amount of serosanguineous and yellow drainage was noted. The wound was cleansed and a dressing was placed. On 02/23/25 at 12:33 A.M. documentation revealed a left foot non-pressure ulcer which was present on admission. On 02/24/25 at 1:05 P.M. the wound bed was described as moist, pink, slough, and yellow and there was a moderate amount of yellow drainage. The wound was cleansed and Aquacel AG (antimicrobial wound dressing) was applied. On 02/23/25 at 12:33 A.M. documentation revealed a right foot non-pressure ulcer which was present on admission. On 02/24/25 at 1:05 P.M. the wound bed was described as dry, (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	01/15/2026

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 - Actual harm Residents Affected - Few	burgundy/maroon, and black. There was no drainage. The wound was cleansed and a dressing was applied.Review of Resident #62's progress note dated 02/23/25 at 1:31 P.M. included Resident #62 was admitted to the hospital for urinary tract infection, sepsis and was receiving pressors, vancomycin and zosyn IV, had some confusion, and was sleepy. The resident did not return to the facility.Interview on 01/07/26 at 3:35 P.M. with the Director of Nursing (DON) and the Administrator revealed the lab the facility used picked up specimens on Monday, Tuesday, Thursday and Friday. The DON stated the lab would pick up STAT specimens on Wednesday, Saturday and Sunday, and would only do a STAT urinalysis, not a culture and sensitivity on those days. Lab results were faxed to the facility, and if there were critical lab results the lab would call and notify the facility. Lab results could also be obtained by checking the computer for lab results. The DON stated Resident #62 had wounds on his heels, he had diabetic foot ulcers, he had no toes, was non-compliant and would often get up and stand on his feet. The DON and Administrator verified (on 02/22/25) Resident #62 was transported and admitted to the local hospital. The resident did not return to the facility and had been subsequently transferred from the initial hospital to another hospital and then he passed away. Interview on 01/12/26 at 4:55 P.M. with Nurse Practitioner (NP) #470 revealed he worked with Medical Director #473, and Medical Director #473 was Resident #62's Primary Care Provider until 11/21/24 when Resident #62 and his family requested Physician #474 to be his Primary Care Provider. NP #470 stated sometimes the nurses incorrectly called him about Physician #474's residents. NP #470 stated he did not know why and could not speak to Resident #62's body temperature being 90.0 Fahrenheit, but in general septic shock could cause the body temperature to be lowered. Interview on 01/12/26 at 4:20 P.M. with Physician Assistant (PA) #471 revealed he worked with Physician #474 and Physician #474 had been Resident #62's Primary Care Physician since 11/21/24. PA #471 stated the Wound Care service was following Resident #62 in February 2025 for his wounds, and PA #471 stated he did not give an order for a wound culture. PA #471 stated Resident #62 had increased confusion, and he started antibiotics when his lab work was reported. Interview on 01/13/26 at 8:58 A.M. with Licensed Practical Nurse (LPN) #442 revealed she took care of Resident #62 on 02/22/25 when he was transported to the local hospital ED. LPN #442 stated on 02/22/25 Resident #62 seemed different when she went in his room and said good morning, and when she asked him what year it was he said 2025. LPN #442 asked Resident #62 a few questions, he seemed confused, and his response to each question was Friday. LPN #442 thought Resident #62 had wounds on his heels, but stated she could not remember for sure, and could not remember if he had other wounds.Interview on 01/13/26 at 8:22 A.M. with Registered Nurse (RN) #476 revealed on 02/17/25 she collected the wound culture for Candida Auris from an open area on Resident #62's arm where he was scratching. RN #476 stated Resident #62 was a one person assist, needed assistance with showers and was dependent on staff for hygiene. RN #476 stated Resident #62 had grab bars on his bed to help with mobility.Interview on 01/14/26 at 9:58 A.M. with RN #451 revealed Resident #62 needed more help around the time he went to the hospital on [DATE]. RN #451 indicated Resident #62 scratched his arms and had open areas. Interview on 01/14/26 at 12:43 P.M. with the DON revealed if Resident #62 had blood in his urine the physician should be notified and orders obtained. The DON stated after Resident #62 reported blood in his urine (on 02/18/25) he should have been monitored for things like additional blood in his urine and his vital signs should have been checked.Interview on 01/15/26 at 9:58 A.M. with the DON, RDCO #472 and Social Services Designee (SSD) #477 revealed SSD #477 confirmed Resident #62 had dressings on his arms from scratching and picking. RDCO #472 stated she thought the areas from scratching and picking were scratches and not gaping wounds. RDCO #472 confirmed she did not see an indication the staff were putting dressings on Resident #62's arms and any indication (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	01/15/2026

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 - Actual harm Residents Affected - Few	treatment was done.Interview on 01/15/26 at 1:16 P.M. with RDCO #472 and the Administrator confirmed Resident #62's record did not reveal evidence bilateral upper extremity skin tears or scratches were treated and had dressings applied during the time period above even though a culture of an area on his arm was obtained. RDCO #472 stated she could not refute that Resident #62's Treatment Administration Record stated his right middle knuckle skin tear was being monitored for signs and symptoms of infection, bleeding every shift from 02/09/25 through 02/22/25 when he was transported to the local ED. RDCO #472 stated after two weeks it was unlikely that the skin tear would still be on his hand. Review of the facility policy titled Resident Change in Condition dated 07/28/22 included the purpose was ensuring staff provided timely and appropriate care and services when residents experience a change in condition that had or was likely to cause serious life-threatening harm or injuries and/or adverse negative health outcomes. The licensed nurse would take immediate action to ensure timely and appropriate care and services were met when a resident change in condition was identified. The appropriate level of care and treatment would be delivered as required to best manage a resident's change in condition and the effort to treat a residents physical or emotional status such as an illness or injury based on the outcome of severity during assessment. Change of condition might included but was not limited to urination and bowel patterns, confusion, lethargy, disorientation, unusual or strange behavior. The licensed nurse would document any changes in the resident's medical condition or status in the resident's medical record.Review of the facility policy titled Pressure Ulcer Prevention and Risk Identification revised 01/2023 included the licensed nurse would perform a head-to-toe skin assessment upon admission and every seven days thereafter to identify any new skin areas. The licensed nurse would document her findings in the medical record. The licensed nurse would assess for redness, rashes, ecchymosis, shearing and open areas with attention to surfaces of the skin that come in contact with the bed or chair, bony prominences, surfaces of the skin that come in contact with orthotic devices and skin folds. The physician and responsible party would be notified by the licensed nurse promptly of the newly identified skin area and a treatment would be initiated according to the physician order. 2. Review of Resident #39's medical record revealed an admission date of 05/10/22 and diagnoses included type two diabetes mellitus without complications, other specified muscular dystrophies, and primary progressive multiple sclerosis.Review of Resident #39's physician orders dated 10/05/23 revealed Resident #39 was able to self-medicate and narcotics and Interferon Beta Auto pen given by nursing. Review of Resident #39's lab report dated 09/05/25 revealed Resident #39's glycohemoglobin-HGBA1C was 7.2 and the reference range was 4.1 through 6.1. Review of Resident #39's progress notes dated 09/23/25 at 5:42 P.M. included Nurse Practitioner (NP) #470 was notified that Resident #39 refused Metformin (treatment for type two diabetes to help control high blood sugar levels). Resident #39 stated she wanted to try a diet for three months before taking another medication.Review of Resident #39's progress notes dated 09/23/25 at 6:03 P.M. revealed the dietician recommended Resident #39 obtain a Libre for glucose checks due to Resident #39 did not want to be pricked with lancets. NP #470 agreed and a new order was placed. Review of Resident #39's physician orders dated 09/23/25 revealed FreeStyle Libre 2 sensor (continuous glucose system sensor), inject one unit subcutaneously at bedtime every fourteen days for assist resident with ac (before meals) TID (three times a day) related to type two diabetes mellitus without complications.Review of Resident #39's medical record dated 09/23/25 through 01/08/26 including blood sugar summary, progress notes and Medication Administration Records and Treatment Administration records did not reveal evidence Resident #39's blood sugars were checked.Review of Resident #39's Medication Administration Record (MAR) dated 09/24/25 revealed FreeStyle Libre 2 Sensor, inject one unit subcutaneously at bedtime every (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	01/15/2026

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 - Actual harm Residents Affected - Few	fourteen days for assist resident with ac TID was not marked it was completed and the MAR stated to see nurses notes, but review of the progress notes did not reveal evidence why the order was not completed.Review of Resident #39's progress notes dated 10/09/25 at 5:43 A.M. included FreeStyle Libre 2 Sensor was on order and the physician was aware.Review of Resident #39's Quarterly Minimum Data Set assessment dated [DATE] revealed Resident #39 was cognitively intact. Resident #39 was dependent for toileting hygiene, bathing. Resident #39 required substantial to moderate assistance with dressing and partial to moderate assistance with personal hygiene. Review of Resident #39's Medication Administration Record (MAR) dated 12/03/25 and 12/31/25 revealed FreeStyle Libre 2 Sensor, inject one unit subcutaneously at bedtime every fourteen days for assist resident with ac TID was not marked it was completed and the MAR stated to see nurses notes. Review of the MAR progress notes regarding the Libre dated 12/03/25 stated Resident #39 doesn't have one, and there were no MAR progress notes dated 12/31/25 revealing a reason why the order was not completed. Resident #39's MAR dated 12/17/25 was not marked off it was completed and did not have the reason why the order was not completed.Observation on 01/07/26 at 2:32 P.M. of Resident #39 revealed she was in a motorized, padded wheelchair, her hair was brushed back from her face, and her clothes were clean. Resident #39 stated she was told she was a diabetic, but was given no education about diabetes, and no staff nurse checked her blood sugars. Resident #39 stated she didn't know what she was supposed to do about her diabetes.Interview on 01/14/26 at 10:50 A.M. with Medical Director #473 revealed when he was asked about Resident #39's FreeStyle Libre 2 sensor that was ordered on 09/23/25 not being available Medical Director #473 stated the Libre usually went through the insurance company and might not have been approved. Me[TRUNCATED]

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	01/15/2026

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 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 interview and record review the facility failed to ensure Resident #62's nutritional care planned interventions, including record of meal intakes were implemented. This affected one resident (Resident #62) out of three residents reviewed for nutrition. The facility census was 61.Findings include:Review of Resident #62's closed medical record revealed an initial admission date of 04/16/23 and diagnoses included type two diabetes mellitus with diabetic neuropathy, anxiety disorder, obstructive and reflux uropathy, acute osteomyelitis of the left ankle and foot and Candida Auris. Resident #62 was transferred to the local hospital Emergency Department on 02/22/25 and did not return to the facility. Review of Resident #62's care plan dated 04/19/23 and revised on 03/13/25 included Resident #62 had the potential for altered nutrition, hydration related to type two diabetes mellitus, AMS, tremors, anxiety dysphagia, mechanically altered diet and other diagnoses. Resident #62 would not have unplanned significant weight changes through the next review. Resident #62 would consume more than 75 percent of two meals daily. Interventions included to monitor meal intakes and record on the STNA (CNA) flow record. Review of Resident #62's Quarterly Minimum Data Set assessment dated [DATE] included Resident #62 was cognitively intact. Resident #62 was dependent for toileting hygiene and lower body dressing, required substantial to maximal assistance with bathing, and required partial to moderate assistance with personal hygiene. Resident #62 required substantial to maximal assistance for the ability to roll from lying on his back to the left and right side and return to lying on his back on the bed, for the ability to move from sitting on the side of the bed to lying flat on the bed, and the ability to move from lying on the back to sitting on the side of the bed and with no back support and the ability to transfer from a bed to a chair or wheelchair. Resident #62 used a wheelchair and required partial to moderate assistance for the ability to wheel at least 50 feet and make two turns. Resident #62 did not reject care during the seven-day assessment look-back period. Review of Resident #62's aide charting dated 02/07/25 through 02/22/25 did not reveal evidence Resident #62 was eating and did not reveal evidence of monitoring Resident #62's meal intake and recording the percentage of his meals that were eaten. Review of Resident #62's progress notes dated 02/07/25 through 02/22/25 did not reveal evidence Resident #62 was eating, what his meal intake was or that he refused his meals. Interview on 01/15/25 at 9:58 A.M. with the Director of Nursing (DON), Regional Director of Clinical Operations (RDCO) #472 and Social Services Designee (SSD) #477 confirmed there was no evidence in Resident #62's medical record including aide charting that he was eating or his meal percentage intakes were recorded. RDCO #472 stated Resident #62's weights were stable and that was a good indicator he was eating, and the cafe was open when Resident #62 resided in the facility and he would often eat there.This deficiency represents non-compliance investigated under Complaint Number 2709129.

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	01/15/2026

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 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 observation, interview, record review and review of the local fire department report, the facility failed to ensure Resident #24's respiratory status was properly treated and monitored. This affected one resident (Resident #24) out of three residents reviewed for oxygen therapy. The facility census was 61.Findings include:Review of Resident #24's medical record revealed an admission date of 02/17/24 and diagnoses included nontraumatic subarachnoid hemorrhage, nontraumatic intracerebral hemorrhage in hemisphere, cortical, vascular dementia, and aphasia.Review of Resident #24's care plan dated 02/20/24 and revised 11/10/25 included Resident #24 had altered respiratory status, difficulty breathing related to respiratory failure, history of PE (pulmonary embolism), morbid obesity and history of trach. Resident #24 would have no symptoms of poor oxygen absorption and would have no complications related to SOB (shortness of breath) through the review date. Interventions included to monitor and document changes in orientation, increased restlessness, anxiety and air hunger; to monitor for signs and symptoms of respiratory distress and report to the physician as needed such as increased respirations, decreased pulse oximetry, increased heart rate, diaphoresis, headaches, lethargy, confusion and skin color changes; to administer medication, puffers as ordered and monitor for effectiveness and side effects.Review of Resident #24's Quarterly Minimum Data Set assessment dated [DATE] included Resident #24 had severe cognitive impairment. Resident #24 had impairments on both sides of her upper and lower extremities, was dependent for toileting hygiene and required substantial to moderate assistance with bathing, dressing and personal hygiene. Resident #24 did not reject care during the seven-day assessment look-back period. Resident #24 used oxygen therapy.Review of Resident #24's progress notes dated 11/11/25 at 11:45 A.M. revealed Resident #24 had new orders to discontinue oxygen due to continued refusals with oxygen saturations maintaining in the 90's. The power of attorney (POA) was notified.Review of Resident #24's medical record, including progress notes, blood pressures, pulse, and oxygen saturations on 11/12/25 and from 11/14/25 through 11/25/25 did not reveal evidence Resident #24 was monitored for respiratory distress including decreased pulse oximetry, increased heart rate, diaphoresis, headaches, lethargy, confusion and skin color changes.Review of Resident #24's progress notes dated 11/25/25 at 6:28 A.M. revealed Resident #24 was ordered a chest X-ray to rule out possible pneumonia. Findings show pneumothorax or pleural effusion which demonstrated much better depth of inspiration since prior exam. No new orders at this time. Resident #24 was updated and in agreement with plan of care. There was no evidence Resident #25 had vital signs checked including oxygen saturation level.Review of Resident #24's [NAME] Review dated 11/25/25 from the local fire department included a call was received from the facility at 9:01 A.M., EMS had patient contact at 9:04 A.M. and Resident #24 was transported to the local ED at 9:29 A.M. EMS was dispatched for an altered level of consciousness and shortness of breath. Upon arrival Resident #24 was found awaiting EMS. Resident #24 was conscious, and alert and oriented times three (time, place, person). Audible crackles could be heard from Resident #24. Resident #24's nurse stated Resident #24 was normally on continuous oxygen at two to four liters per minute via nasal cannula, and during her rounds she noticed Resident #24 did not have oxygen in the room. Resident #24's nurse indicated Resident #24 was normally more alert and today was presenting a little confused. Resident #24 stated she had been off her oxygen since last night. Resident #24's oxygen saturation level was 90 percent on room air and improved to 96 percent following oxygen administration of six liters per minute via nasal cannula. Resident #24's augmentation continued to improve following oxygen administration, and continued to improve during the transport. Resident #24 was given a DuoNeb treatment and her lung sounds cleared following the treatment. Resident #24's (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	01/15/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care was transferred to the receiving nurse and the receiving nurse and doctor were made aware of the incident at the nursing home pertaining to staff not giving Resident #24 her oxygen and Resident #24 wishes not to return there. Review of Resident #24's progress notes dated 11/25/25 at 9:10 A.M. included Resident #24's daughter was contacted to be notified Resident #24 was being sent to the ED, there was no answer and a voicemail was left. There was no evidence Resident #24's vital signs were checked or events leading up to the decision to send Resident #24 to the ED.Review of Resident #24's progress notes dated 11/25/25 at 9:38 A.M. revealed Resident #24 was sent to the ED for evaluation due to shortness of breath.Review of Resident #24's progress notes dated 11/25/25 at 4:53 P.M. included Resident #24 returned back from the ED. Resident #24 was diagnosed with chronic bronchitis and respiratory tract infection. Resident #24 returned to the facility and was receiving two liters of oxygen per minute due to oxygen levels were dropping and for comfort. New orders for Doxycycline (antibiotic) 100 mg to be given two times a day for ten days. Resident #24 had orders for Prednisone 50 mg every day for five days. Blood pressure was 160/60, 60 pulse, respirations 20 and Resident #24's oxygen saturation was 96 percent on oxygen at two liters per minute via nasal cannula, temperature 97.8 Fahrenheit.Review of Resident #24's physician orders dated 11/25/25 through 01/07/26 did not reveal orders for oxygen via nasal cannula.Review of Resident #24's oxygen saturation levels dated 11/27/25 at 7:45 P.M. revealed Resident #24's oxygen saturation level was 97 percent on oxygen via nasal cannula. It did not specify how many liters of oxygen per minute Resident #24 was receiving. Review of Resident #24's oxygen saturation levels dated 11/29/25 and oxygen saturation was 95 percent, 11/30/25 and oxygen saturation was 97 percent, 12/04/25 and oxygen saturation level was 98 percent and 12/30/25 and oxygen saturation level was 96 percent revealed Resident #24 was receiving oxygen via nasal cannula and it did not specify how many liters per minute she was receiving. On 11/28/25 at 7:26 P.M. the oxygen saturation level was 97 percent and Resident #24 was receiving oxygen at three liters per minute via nasal cannula. On 12/18/25 Resident #24's oxygen saturation level was 96 percent and she was receiving oxygen at two liters per minute via nasal cannula.Observation on 01/07/26 at 1:33 P.M. of Resident #24 revealed she was lying in her bed watching television. Resident #24 was well groomed and her room was clean and neat. When asked questions Resident #24's speech was somewhat garbled and it was hard to understand what she was saying. Observation of the room revealed an oxygen concentrator with a nasal cannula and tubing attached. The tubing and nasal cannula were lying on the floor with the oxygen being administered to the air and was running at three liters per minute nasal cannula.Observation on 01/07/26 at 1:43 P.M. of Resident #24 with Licensed Practical Nurse (LPN) #420 confirmed Resident #24 was not wearing her nasal cannula and the oxygen tubing and nasal cannula was lying on the floor with the oxygen being administered to the air. LPN #420 confirmed the oxygen was set to administer oxygen at three liters per minute via nasal cannula. When asked what it should be set at Resident #24 stated it should stay at two. LPN #420 checked Resident #24's physician orders and stated there were no physician orders for oxygen, and there had not been any orders since she went to the hospital on [DATE]. LPN #420 confirmed Resident #24 was administered oxygen without physician orders.Interview on 01/07/26 at 3:35 P.M. of the Director of Nursing (DON) and the Administrator revealed the DON stated Resident #24's oxygen was discontinued because she refused to wear it. The DON confirmed Resident #24 was not monitored for respiratory distress after the oxygen was discontinued, including oxygen saturation levels, blood pressures, respirations and was transported to the ED on 11/25/25 for shortness of breath. The DON confirmed there was no evidence Resident #24 had her vital signs checked on 11/25/25 when EMS was called for Resident #24's shortness of breath. The DON confirmed Resident #24 did not have a physician order for oxygen administration but that (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	01/15/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was corrected today. Review of the facility policy titled Oxygen Therapy revised 12/2022 included oxygen would be provided as needed and prescribed in a safe manner ensuring each resident received necessary respiratory care and services that were in accordance with professional standards of practice, the resident's care plan, and the resident's choice. Oxygen would be administered and titrated per physician orders. This deficiency represents non-compliance investigated under Complaint Number 2679739.

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	01/15/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, review of facility policy and review of Centers for Disease Control and Prevention guidelines, after Resident #62 was found to be positive for Candida Auris (a fungal infection that can cause severe, often drug resistant infection, the facility failed to ensure the facility tracked the infection for signs/symptoms and control of the infection within their infection control program, and failed to ensure the resident and family were timely educated and knowledgeable of the treatment and/or precautionary mechanisms required for the infection. This affected one resident (Resident #62) out of three reviewed for infection control. The facility census was 61. Findings include: Review of Resident #62's closed medical record revealed an initial admission date of 04/16/23 and diagnoses included type two diabetes mellitus with diabetic neuropathy, anxiety disorder, obstructive and reflux uropathy, acute osteomyelitis of the left ankle and foot and Candida Auris. Resident #62 was transferred to the local hospital Emergency Department on 02/22/25 and did not return to the facility. Review of Resident #62's care plan dated 04/05/24 and revised on 03/13/25 revealed Resident #62 was on Enhanced Barrier Precautions related to Candida Auris. Enhanced Barrier Precautions would be maintained throughout the review period. Interventions included to educate the resident, family, and staff regarding Enhanced Barrier Precautions. Review of Resident #62's Quarterly Minimum Data Set assessment dated [DATE] included Resident #62 was cognitively intact. Resident #62 was dependent for toileting hygiene and lower body dressing, required substantial to maximal assistance with bathing, and required partial to moderate assistance with personal hygiene. Resident #62 required substantial to maximal assistance for the ability to roll from lying on his back to the left and right side and return to lying on his back on the bed, for the ability to move from sitting on the side of the bed to lying flat on the bed, and the ability to move from lying on the back to sitting on the side of the bed and with no back support and the ability to transfer from a bed to a chair or wheelchair. Resident #62 used a wheelchair and required partial to moderate assistance for the ability to wheel at least 50 feet and make two turns. Resident #62 did not reject care during the seven-day assessment look-back period. Review of Resident #62's physician orders revealed Enhanced Barrier Precautions due to Candida Auris was originally ordered on 04/04/24 and was an active order through 02/22/25 when Resident #62 was transported to the local ED. Review of Resident #62's medical record revealed Resident #62 was on lifelong precautions related to Candida Auris. The medical record contained no evidence the resident and/or resident representative received education on the infection, treatment for, and precautions necessary for the infection until 02/13/25. Review of Resident #62's medical record including progress notes dated 11/21/24 through 02/22/25 did not reveal evidence Resident #62 did not want his family to be including in his care and treatment. Attempted review of the facility infection control logs from 11/21/24 through 02/22/25 revealed the facility was unable to provide infection control logs for review. Review of Resident #62's Care Plan Conference Summary dated 12/11/24 revealed Resident #62's diagnoses and his plan of care was reviewed and there were no issues. The summary of the care plan discussion was blank and did not include information related to Candida Auris discussed. There was no evidence family members attended the care conference. Review of the facility Infection Control Detail Report dated 02/01/25 through 02/28/25 did not reveal evidence Resident #62 had Candida Auris.Review of Resident #62's physician orders dated 02/10/25 revealed orders Contact Precautions, all therapies, treatments, activities, to be completed in room at all times, every shift for Candida Auris.Review of Resident #62's medical record contained no evidence as to why the resident went from enhanced barrier precautions to contact precautions. Review of Resident #62's progress notes dated 02/13/25 at 5:25 P.M. (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	01/15/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed Resident #62's Power of Attorney (POA) #478 was contacted by telephone to address Contact isolation due to Candida Auris. POA #478 was verbally aggressive towards the nurse and Unit Manager and continued to talk over the nurse. When trying to educate and explain the plan of care for the order obtained to swab Resident #62's skin to recheck for Candida Auris, POA #478 remained verbally aggressive. The Unit Manager placed a follow-up call to POA #478 (the note did not explain what happened with the follow-up call). The nurse reached out to the Social Worker to schedule a care conference with the IDT (interdisciplinary team). Review of Resident #62's progress notes dated 02/13/25 at 5:43 P.M. included the nurse called to obtain an order to swab Resident #62 to recheck a culture previously obtained at the local hospital. The wound swab was to be obtained, and an order was placed in lab. All parties were notified. Review of Resident #62's progress notes dated 02/13/25 at 6:00 P.M. revealed the nurse contacted POA #478 to follow-up regarding the Candida Auris. POA #478 was immediately hostile, screaming at the top of her lungs and making it incredibly difficult for the nurse to effectively communicate and answer questions and address concerns. The nurse was unable to provide an explanation. POA #478 ended the call abruptly after 20 minutes and the nurse did not have an opportunity to address or report any circumstances related to this issue. Review of Resident #62's progress notes dated 02/16/25 at 1:27 A.M. revealed Resident #62's Contact precautions for Candida Auris were continued. Review of Resident #62's progress notes dated 02/17/25 at 1:12 P.M. included a wound culture was collected to confirm Candida Auris. The culture was placed for pick up and the facility was awaiting results. All parties were notified. Review of Resident #62's progress notes dated 02/19/25 at 1:02 P.M. included POA #478 was notified that lab results were negative, and Resident #62 was out of isolation. Resident #62 continued to be on Enhanced Barrier Precautions due to Resident #62 scratching and picking at skin of his arms and hands. Resident #62 was notified. Interview on 01/07/26 at 3:35 P.M. with the Director of Nursing (DON) and the Administrator revealed the DON confirmed Resident #62 had Candida Auris, she did not know where the Candida Auris was found on Resident #62, and she was not sure when the Candida Auris was first identified but thought it was in February 2025. Interview on 01/12/26 at 10:32 A.M. with Nurse Practitioner (NP) #470 revealed he worked with Medical Director #473 and on 11/21/24 Resident #62 requested that his Primary Care Physician be changed from Medical Director #473 to Physician 474. Interview on 01/12/26 at 4:55 P.M. with NP #470 revealed he was not sure why Resident #62 was on Enhanced Barrier Precautions and not sure when it was recommended that he stay on lifelong precautions related to Enhanced Barrier Precautions. Interview on 01/12/25 at 3:59 P.M. with Social Services Designee (SSD) #477 revealed she arranged Resident #62's care conferences, and on 12/11/24 the Administrator, the MDS Nurse and the Activity Director were present at the care conference meeting. Interview on 01/12/26 at 4:20 P.M. of Physician Assistant (PA) #471 revealed he worked with Physician #474 and on 11/21/24 Resident #62 requested a change and wanted Physician #474 to be his Primary Care Provider. PA #471 stated he was not informed of Resident #62's Candida Auris and was given no documentation about it when he started caring for Resident #62. PA #471 stated he did not see anything in the immediate chart when he took over and if he did see a past medical history for Candida Auris he would have documented it. PA #471 stated he was not aware of the Candida Auris and talked to Physician #474 when he found out Resident #62 had it and Physician #474 stated Resident #62 likely had a colonization. Interview on 01/12/26 at 5:39 P.M. with Regional Director of Clinical Operations (RDCO) #472 revealed a staff member, she didn't know which staff member but thought it was probably Registered Nurse (RN) #476 found that Resident #62 had Candida Auris while she was reviewing his medical record and contacted her. RDCO #472 stated the facility had private rooms and she told RN #476 to place Resident #62 in Contact isolation and to obtain an (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	01/15/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	order for a repeat culture for Candida Auris. The culture was negative. RDCO #472 confirmed there was no evidence in Resident #62's medical record stating the family was notified he had Candida Auris and stated Resident #62 was found to have Candida Auris while he had a hospital admission, and the facility would not necessarily inform the family about the Candida Auris when he returned to the facility. RDCO #472 indicated Resident #62 was his own person, Resident #62's daughter was his POA and the POA did not kick in until Resident #62 could not make his own decisions. Interview on 01/13/25 at 9:51 A.M. with RDCO #472 revealed if Resident #62 had an active Candida Auris infection he would need Contact Precautions and if he was colonized with Candida Auris then he would need Enhanced Barrier Precautions. RDCO #472 stated the facility was not sure if Resident #62 had an active infection and placed him on Contact isolation until they knew. RDCO #472 indicated the wound swab was taken from the skin of Resident #62's arms. Interview on 01/13/25 at 10:42 A.M. with the Administrator and DON confirmed facility infection control logs from 12/2024 through 03/2025 could not be located, and it could not be determined if Resident #62's Candida Auris was tracked during those dates. The Administrator stated the former Infection Preventionist was RN #476 and she no longer worked for the facility. Interview on 01/13/26 at 8:22 A.M. with RN #476 revealed she was not the Infection Preventionist for the facility when she worked there. RN #476 stated she did a little bit of everything, was the Unit Manager for the vent floor and the nursing unit on the other side of the building. RN #476 stated she did some Infection Control work, but the traveling DON handled infection control and when the current DON began working in the facility, she took over the infection control work. RN #476 indicated when she left the facility around 09/2025 all the infection control material was in a binder and kept in the DON's office. RN #476 stated she was reviewing Resident #62's chart, found he had Candida Auris, contacted the corporate office, and was advised to put Resident #62 on Contact precautions. RN #476 stated she huddled with her staff and told them Resident #62 was on Contact precautions. RN #476 indicated Resident #62's family was angry when she contacted them to tell them he was being retested for Candida Auris and said if he had Candida Auris so long why was he just now put on Contact precautions. RN #476 revealed she took the culture from an open area on Resident #62's arm where he was scratching. RN #476 revealed one of the biggest reasons she left the facility was poor care and safety of the residents. Interview on 01/14/26 at 10:50 A.M. with Medical Director #473 revealed Resident #62 was his patient for awhile but he switched primary care providers in November 2024. Medical Director #473 revealed he did not remember anything about Resident #62 having Candida Auris, he was followed by the Podiatry service and had a lot of physicians. Medical Director #473 revealed he did not know why Infectious Disease Physician (IDP) #479 said Resident #62 should be on lifelong precautions related to Candida Auris, and for the small amount of Candida Auris he had that would not be concerning. Medical Director #473 revealed he did not think a meeting was needed to discuss Resident #62's Candida Auris, as it was common on everyone. If Resident #62 was spiking fevers and it could be determined he was infected and if none of that was from other things, then it can be said it was from Candida Auris. Interview on 01/15/26 at 9:58 A.M. with the DON, RDCO #472 and SSD #477 revealed SSD #477 stated she arranged care conferences and Resident #62's POA (POA #478) lived out of town and only came to the initial care conference meeting. SSD #477 stated Resident #62 was his own person and she asked him if he wanted his family involved in the care conferences and he stated no they did not need to be involved. SSD #477 stated she did not document anywhere in Resident #62's medical record that he declined to have his family involved in his care conferences. Review of CDC (Centers for Disease Control and Prevention) guidance titled Preventing the Spread of C. auris) dated 12/15/25 included C. auris could cause severe illness and spreads easily in healthcare facilities. (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	01/15/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Some patients carry C. auris on their skin and other body sites without it causing symptoms (colonization). Both infected and colonized patients could spread C. auris. Patients who were colonized could spread C. auris the same way that patients who were infected could. C. auris spreads easily in healthcare facilities and could cause life-threatening infections in some patients. Patients who were infected and patients who were colonized could spread C. auris onto nearby surfaces or objects including doorknobs, bedrails and medical equipment used for multiple patients. Other patients could get C. auris through contact with these items. C. auris could survive on surfaces for a long time and not all disinfectants could kill it. Patients could remain colonized for weeks, months or longer even if they never had symptoms. Outbreaks often began when a patient who became infected or colonized in one facility was admitted or transferred to another. Healthcare facilities use the same IPC (infection prevention and control) measures for patients who were colonized and infected to help prevent them from spreading C. auris to others. Frequent hand-cleaning with ABHS (alcohol-based hand sanitizer) and soap and water if hands were soiled or ABHS was not available. Wear gloves and gowns to deliver care and ensure visitors clean hands with ABHS or soap and water. Patients infected or colonized with C. auris often continue to have it on their skin or other body sites for a very long time. Precautions were taken until they were discharged . For patients living in settings like nursing homes, long-term measures were taken based on the facility's policy. Healthcare facilities should be informed if an incoming patient has ever tested positive for C. auris with or without symptoms. Patients who were colonized or infected might have C. auris on their skin or body sites after discharge. Patients and close contacts should frequently clean their hands with ABHS or soap and water. Review of the facility policy titled Your Rights and Protections as a Nursing Home Resident undated included as a nursing home resident, you have certain rights and protections under Federal and State law that helped ensure you get the care and services you need. You have the right to be informed, make your own decisions, and have our personal information kept private. You have the right to be fully informed about your total health status in a language you understand. You have the right to be fully informed about your medical condition, to participate in the decisions that affect your care. The nursing home must notify your doctor and if known your legal representative or an interested family member when the following occurred, your physical, mental, or psychosocial status starts to get worse, you have medical complications, your treatment needed to change significantly. This deficiency represents non-compliance investigated under Complaint Number 2709129.