STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365155	A. Building B. Wing	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avon Place Healthcare Center	32900 Detroit Rd Avon, OH 44011

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility policy review the facility failed to release one former resident (#95) medical records timely to her family and their legal representative. This affected one (#95) of two Former Residents (#95, #96) reviewed for medical record release. The facility census was 84.Findings include:Review of Former Resident (FR) #95's medical record revealed an admission date of 01/11/24. The resident was discharged to the hospital on [DATE] after suffering a fall with hip fracture.Review of the medical record requests provided by FR #95's family Attorney #151 revealed on 10/30/25 an initial record request was faxed to the facility and also sent through the United States Postal Service (USPS). The request was printed on the attorney's professional letterhead. The request gave the resident's name, date of birth , social security number, a notarized affidavit of next of kin, a signed authorization for release of medical records, the resident's death certificate, and the request for a certified copy of FR #95's medical record dated 05/01/25 through 09/23/25. An email and phone number was also provided if the facility had any additional questions.Interview with the facility Medical Records Staff Member #150 on 03/16/26 at 1:02 P.M. revealed when a record request was received, the request is forwarded to the Administrator who then sends the request to corporate. The medical record is not released until an approval is received from corporate on what could be released. Medical Records Staff Member #150 was not familiar with the requests for FR #95 as she had only been in her position for approximately 30 days.Telephone interview with Attorney #151 on 03/16/26 at 11:12 A.M. revealed on 12/11/25 Attorney #151 received FR #95's consent to treat form for psychiatric therapy, the facility discharge form dated 09/24/25, the hospital history and physical dated 09/24/25, the facility diagnosis audit report, an allergy audit report, the immunization audit report, the order summary report, weight and vital summary, and the resident's care plan report. On 12/15/25 Attorney #151 alerted the facility through fax and the USPS that the medical record received was incomplete and requested the following: minimum data set, all assessments, nursing notes, doctor progress notes, therapy notes, medication administration records, treatment administration records, care giver notes, consultations, and activity of daily living logs. Attorney #151 stated on 12/29/25, 01/09/26, 02/04/26, and 03/11/26 additional record requests were sent to the facility via fax and USPS. Attorney #151 stated fax confirmations were received that the requests were received by the facility. Attorney #151 also stated on 12/29/25 she spoke with the Administrator who confirmed receiving the medical record request and stated she forwarded the information to the corporate office. Attorney #151 stated voice mail messages were left with the Administrator on 03/03/26, 03/06/26, and 03/11/26 regarding the medical record requests and there has been no response.Interview with the Administrator on 03/16/26 at 1:14 P.M. verified she had received record requests dated 10/30/25, 12/15/25, 12/29/25, 01/09/26, 02/04/26 and 03/11/26 for FR #95. The Administrator stated the requests with the information being requested were forwarded to the corporate office. The Administrator stated as far as she knew the complete record was sent. Upon asking for the phone number to speak to someone in the corporate office, the number was failed to be provided.Review of the facility policy titled Release of Information revised November 2009 (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	revealed all information contained in the resident's medical record is confidential and may only be released by the written consent of the resident or his/her legal representative (sponsor), consistent with state laws and regulations. Closed or thinned medical records are maintained by the Medical Records Department and are available only to authorized personnel. Authorized personnel include, but are not limited to nursing personnel, physicians, consultants, support services, administration, government agencies, and resident/representative (sponsor). A resident may obtain photocopies of his or her records by providing the facility with at least a forty-eight (48) hour (excluding weekends and holidays) advance notice of such request. A fee may be charged for copying services.This deficiency represents non-compliance investigated under Complaint Number 2719650.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and facility policy review the facility staff failed to ensure medications were administered as ordered and failed to ensure the medications were properly stored until administered. This affected one (#62) of one resident observed for medication storage and had the potential to affect Resident #64 who the facility identified as cognitively impaired and independently mobile. The facility census was 84.Findings include:Review of Resident #62's medical record revealed an admission date of 05/14/25. Diagnoses include paraplegia, ventilator dependent, and a stage four pressure ulcer.Review of Resident #62's quarterly Minimum Data Set (MDS) dated [DATE] revealed he had an intact cognitive function. The resident required set up for eating.Review of Resident #62's most recent care plan revealed he required assistance with activities of daily living due to weakness. Interventions were to administer medications as ordered.Review of Resident #62's medical record revealed a physician's order dated 03/06/26 for Xarelto (blood thinner) 10 milligrams (mg) by mouth in the morning. Further review revealed an order dated 02/04/26 for Ferrous Sulfate (iron) 325 mg to be administered by mouth once daily, and an order dated 02/28/26 for Fludrocortisone Acetate 0.1 mg, two tablets by mouth daily for blood pressure.Observation on 03/17/26 at 8:13 A.M. revealed Resident #62 had a small medication cup on his bedside table with four medications inside. The nurse was observed down the hall at the nurse's station. Resident #94 was sleeping in bed with a sheet over his head.Interview with Unit Manager #146 on 03/17/26 at 8:16 A.M. verified Resident #62's medications were left unattended in the resident's room while he was sleeping. Unit Manager #146 verified the four medications in the medication cup were Xarelto, Ferrous Sulfate, and Fludrocortisone Acetate.Review of the facility policy titled Administering Medications, revised April 2019 revealed medications are administered in a safe and timely manner, and as prescribed. Medication administration times are determined by resident need and benefit, not staff convenience. During medication administration medications are to be kept in the site of the nurse until they are administered to the resident. After administration the nurse records the day and time the medications were administered, the administration route, the dose and any observed complaints or symptoms observed during medication administration. This deficiency represents non-compliance investigated under Complaint Number 2734825.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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 record review, staff interview, and facility policy review the facility staff failed to accurately document on a resident's condition. This affected one resident (#94) of three medical records reviewed. The facility census was 84.Findings include:Review of Resident #94's medical record revealed an admission date of 11/20/25. Diagnoses included Parkinson's disease, Lewy Body dementia, diabetes mellitus, and congestive heart failure. Review of Resident #94's Minimum Data Set assessment dated [DATE] revealed the resident had an intact cognition. Review of Resident #94's nursing progress note dated 01/15/26 at 8:43 A.M. the resident was transferred to a local hospital following a fall overnight. An additional note dated 01/18/26 at 6:13 P.M. revealed the resident returned back to the facility via stretcher.Review of Resident #94's Skilled Progress Note completed by Licensed Practical Nurse (LPN) #147 on 01/15/26 at 7:38 P.M revealed the resident had no change in condition. Resident had no cognitive impairment and received skilled physical therapy services, skilled occupational therapy services, and skilled speech therapy services. Symptoms of back pain and musculoskeletal occurred. Observation of neurological musculoskeletal status with no new changes. A skilled skin assessment was completed and there were no changes that shift. Skilled cardiac and respiratory assessment was completed with no new changes. Skilled gastrointestinal and genitourinary assessment was completed with no negative findings. The resident was monitored for potential medication side effects and there were no adverse effects noted at that time. Pain status was monitor and the resident complained of all over pain. As needed, Percocet (narcotic pain reliever) was given as ordered.Review of Resident #94's Skilled Progress Note completed by LPN #147 on 01/16/26 at 7:39 P.M revealed the resident had no change in condition. Resident had no cognitive impairment and received skilled physical therapy services, skilled occupational therapy services, and skilled speech therapy services. Symptoms of back pain and musculoskeletal occurred. Observation of neurological musculoskeletal status with no new changes. A skilled skin assessment was completed and there were no changes that shift. Skilled gastrointestinal and genitourinary assessment was completed with no negative findings. The resident was monitored for potential medication side effects and there were no adverse effects noted at that time. Pain status was monitor and the resident complained of all over pain. As needed, Percocet was given as ordered.Review of Resident #94's Skilled Progress Note completed by LPN #147 on 01/17/26 at 7:40 P.M revealed the resident had no change in condition. Resident had no cognitive impairment and received skilled physical therapy services, skilled occupational therapy services, and skilled speech therapy services. Symptoms of back pain and musculoskeletal occurred with no new changes Observation of neuro musculoskeletal status with no new changes. A skilled skin assessment was completed and there were no changes that shift. Skilled cardiac and respiratory assessment was completed with no new changes. Skilled gastrointestinal and genitourinary assessment was completed with no negative findings. The resident was monitored for potential medication side effects and there were no adverse effects noted at that time. Pain status was monitor and the resident complained of all over pain. As needed, Percocet was given as ordered.Review of Resident #94's narcotic count sheets for Percocet and the Medication Administration Record (MAR) dated January 2026 revealed no Percocet was administered between 01/15/26 and 01/18/26. Interview on 03/18/26 at 7:17 A.M. with LPN #147 revealed no explanation for documenting on Resident #94 on 01/15/26, 01/16/26 and 01/17/26. LPN #147 verified Resident #94 was not in the facility and was in the hospital on [DATE], 01/16/26, and 01/17/26.Interview with LPN #141 on 03/18/26 at 11:10 A.M. verified Resident #94 was hospitalized from [DATE] through 01/18/26 and was not in the facility. LPN #141 could not explain why there was documentation completed on an absent resident.Interview with the Administrator on 03/18/26 at 12:05 P.M. revealed there were no discrepancies in the (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	narcotic count sheets pertaining to Resident #94.Review of the facility policy titled Charting and Documentation revised July 2017 revealed documentation in the medical record will be objective (not opinionated or speculative), complete and accurate. Entries may only be recorded in the resident's clinical record by licensed personnel in accordance with state law and facility policy.This deficiency is an incidental finding discovered during the course of a complaint investigation.