STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366394	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenue Care and Rehabilitation Center, The	4120 Interchange Corporate Center Road Warrensville Heights, OH 44128

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 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and review of photographs, the facility failed to ensure timely colostomy care was provided to residents. This affected one resident (#73) of one resident reviewed for colostomy care. The facility identified only one resident (#83) in-house with an ostomy. The facility census was 83.Findings include: Review of Resident #73's medical record revealed an admission date 11/03/25. Diagnoses included rectal cancer and enterostomy (surgical opening from the intestine through the abdominal wall to allow drainage of intestinal contents).Review of the care plan dated 11/10/25 revealed Resident #73 had an ileostomy related to colon cancer. Interventions included for staff to assist Resident #73 with toileting needs as needed, check and change on care rounds and as needed, and to complete ostomy care per orders. Review of Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #73 had intact cognition and had an ostomy for stool elimination. Review of Resident #73's current physician orders for December 2025 revealed an order for staff to empty the resident's ostomy every shift and as needed and change the ostomy appliance every week and as needed.Interview on 12/09/25 at 9:41 A.M. with Resident #73 revealed a few weeks ago she had put her call light on for assistance with her colostomy bag that had burst open. Resident #73 stated a nurse (unknown name) had come in and had turned her call light off and had not provided her with care. Resident #73 stated she had continued to be covered in stool from her colostomy and she had begun to yell out for help and no one had come in and she had called a family member at that time. Resident #73 stated her family member had come to the facility shortly after and had observed her covered in stool and had taken photos at that time. Resident #73 stated she had been covered in stool for at least two hours without receiving any assistance from staff. Resident #73 stated her colostomy bag burst open often because staff did not empty, burp (expel air from the colostomy drainage bag), or change it timely. Observation of Resident #73's colostomy bag at the time of interview revealed the bag was approximately half full of liquid stool. Telephone interview on 12/09/25 at 10:41 A.M. with Resident #73's family member revealed on 11/20/25 at approximately 5:00 P.M., she received a call from Resident #73 who had been upset and crying because she had been lying in her stool for several hours. Resident #73's family member stated she immediately arrived at the facility and observed Resident #73 covered in stool. The family member stated she had taken photos at that time before she cleaned Resident #73 up and then had proceeded to speak with the unit manager about what had occurred. Resident #73's family member reported the unit manager had stated she would address the concerns, however the issue had still been occurring. At time of the telephone interview Resident #73's family member had provided photos. Review of photograph dated 11/20/25 timed 5:06 P.M. revealed a large amount of dried, liquid stool on Resident #73's gown and bedding and the resident's colostomy bag was not attached to Resident #73's abdomen. The family member provided permission to share the photograph with facility leadership. Observation on 12/09/25 at 12:50 P.M. revealed Resident #73 had a large amount of liquid stool covering her abdomen, her back and legs. Resident #73 stated no one had come in to care for or empty her bag since the last interview. At the time of observation, Registered Nurse (RN) #215 and RN #236 had entered and Resident #73 had informed them of what occurred. RN #215 and #236 then proceeded to assist Resident #73 with care. Interview on 12/10/25 at 9:42 A.M. with Interim Director of Nursing (DON) revealed she had been aware that Resident #73's colostomy bag had needed to be changed often due to it had been leaking, however she was unaware of concerns related to the bag not being emptied timely. The Interim DON was made aware of photo provided by Resident #73's granddaughter and Interim DON confirmed the photograph had what appeared to be dried stool on Resident #73 gown and sheets that indicated she had not been provided ostomy care timely.This deficiency represents non-compliance investigated under Master Complaint Number 2684078 and Complaint Number 2675296.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ staff that are licensed, certified, or registered in accordance with state laws. Based on interview and review of the Ohio e-licensure verification website, the facility failed to ensure nursing staff had an active nursing license. This had the potential to affect all residents residing in the facility. The facility census was 83.Findings include: Interview on 12/09/25 at 9:12 A.M. with the Administrator revealed the former Director of Nursing (DON) had resigned and Registered Nurse (RN) #256 assumed the role of Interim DON in October 2025.Review of the Ohio e-licensure verification website (https://elicense.ohio.gov/oh_verifylicense) on 12/10/25 at 7:11 A.M. revealed Interim Director of Nursing (DON)/RN #256's license was inactive, it had lapsed, with a listed expiration date of 10/31/25. Interview on 12/10/25 at 9:42 A.M. with Interim DON/RN #256 revealed she had been the Interim DON since October 2025 following the previous DON's resignation. Interim DON #256 stated her nursing license was current and she exited the room. Review of the Ohio e-licensure verification website on 12/10/25 at 10:20 A.M. with the Administrator confirmed the Interim DON/RN #256's nursing license was inactive and had lapsed. The Administrator stated she was unaware her nursing license was inactive and stated she had posted a notice at the time clock a few months ago to remind Registered Nurses of the renewal deadline.Interview on 12/10/25 at 12:32 P.M. with Human Resources (HR) #226 revealed she had placed a renewal reminder for RN's at the time clock on 08/19/25. HR #226 stated approximately a week prior to the deadline of 10/31/25, she noted the Interim DON/RN #256 had not renewed her nursing license and stated she had called her into her office and had assisted her with completing the license application. HR #226 stated the Interim DON/RN #256 had completed the application and stated she had to obtain a credit card from her car to pay the required fee for the application. HR #226 stated she had not followed up with the Interim DON/RN #256 and had not been aware the application had not been completed. HR #226 confirmed the Ohio e-licensure verification website had indicated the Interim DON/RN #256's nursing license was inactive and had lapsed.Review of the Ohio Administrative Code Chapter 4723-7, effective 01/01/18, revealed a registered nurse who does not renew a license to practice nursing on or before October thirty-first of odd numbered years and who has not requested inactive status, shall have a lapsed license. A licensee who continues to practice nursing in Ohio with an inactive or lapsed license shall be subject to disciplinary action under the Ohio Revised Code. This deficiency represents an incidental finding identified during the complaint investigation.