

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366394	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/13/2025
NAME OF PROVIDER OR SUPPLIER Avenue Care and Rehabilitation Center, The		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on review of staffing schedules and staff interview, the facility failed to maintain the services of a registered nurse (RN) for at least eight consecutive hours a day, seven days a week as required. This had the potential to affect all 87 residents currently residing in the facility. The census was 87. Findings include: Review of the nursing staff information and staff schedules for 06/28/25 and 07/04/26 revealed no RNs were present working in the facility during those days. On 08/13/25 at 3:15 P.M., interview with Human Resources Director (HRD) #890 verified the facility did not have an RN on duty on 06/28/25 and 07/04/26. This deficiency represents non-compliance investigated under Complaint Number OH00161573 (1254625), Complaint Number OH00164532 (1254632), and Complaint Number OH00166711 (1254468).		

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, staff interview, and policy review, the facility failed to maintain a clean, sanitary, and safe environment. This deficient practice had the potential to affect all 87 residents residing in the facility. The facility census was 87. Findings included: Observation during an environmental tour conducted on 08/06/25 between 1:00 P.M. and 1:55 P.M. with Maintenance Supervisor (MS) #748 revealed carpeted areas throughout resident rooms and common areas were noted with stains and debris, the room occupied by Resident #59 had a two-inch long hole in the wall, the air conditioning cover in Resident #124's room was dislodged and on the floor, the wall trim on the bathroom door in Resident #31's room was half secured to the wall, the outlet for the telephone line in Resident #25's room was broken in half, the supplemental tube feeding poles used by Resident #19 and Resident #72 had residual dried tube feed on the pole and base, the private bathroom used by Resident #33 had multiple brown stains on the tub floor, the pillowcases and blankets on Resident #27's bed were stained brown, Resident #77's bathroom contained approximately ten to fifteen articles of wet clothing on the floor producing a strong musty odor, Resident #36, Resident #82, and Resident #83's rooms had multiple areas of water stains on the ceiling, the closed closet door in Resident #81's room had multiple brown spots, the walls in Resident #14 and Resident #83's rooms were severely scratched with chipped paint, the wall above the air conditioning unit in Resident #4 and Resident #13's rooms was starting to crumble, Resident #67's bed had a blanket with multiple brown and orange stains, and the fall mats used by Resident #14 and Resident #65 were dirty, torn, and tattered. Interview with MS #748 during the observations on 08/06/25 between 1:00 P.M. and 1:55 P.M. verified all the above findings at the time of discovery. Review of the facility policy titled, Environmental Services Cleaning Guidebook, dated 04/20/23, revealed the guidebook was provided to all housekeeping employees to maximize efficiency, outline preferred cleaning methods for infection control and presentation, and emphasize the proper use of chemicals as critical to the success of maintaining a safe and sanitary environment. This deficiency represents non-compliance investigated under Complaint Number OH00166853 (1254633) and Complaint Number OH00164532 (1254632).		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, medical record review, and policy review, the facility failed to revise the care plans as required and failed to ensure resident care planning conference were held as required. This affected four (#72, #25, #29, and #59) of seven residents reviewed for care plans and care planning conferences. The facility census was 87. Findings Include: 1. Review of the medical record revealed Resident #72 was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis affecting the right dominant side after a stroke, aphasia (the inability to speak) after a stroke, osteomyelitis of vertebrae of the sacral and sacrococcygeal region, diabetes, high blood pressure, obstructive and reflux uropathy, and Alzheimer's disease with early onset. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #72 was rarely/never understood, was dependent on staff for all aspects of care, had a Stage IV pressure ulcer (full-thickness skin and tissue loss) to her sacral area, was incontinent of both bowel and bladder, and received enteral nutrition through a feeding tube. Review of the care plans for Resident #72 revealed a care plan for pressure wounds to the left medial foot and coccyx and was last revised on 03/14/25. Review of the progress note dated 05/28/25 revealed the wound to the left foot had healed. Resident #72 had a care plan initiated 11/11/24 for being placed on antibiotics for a diagnosis of sepsis. No revisions were made. The care plan was not marked as resolved. Resident #72 had a care plan for a diagnosis of sepsis initiated on 12/31/24. The goal was to be free of infection by the review date (no date listed). The interventions were to administer antibiotics per the physician orders, monitor for signs and symptoms of a urinary tract infection, and to report any signs or symptoms of delirium to the physician. Resident #72 had a care plan for being at high risk for rehospitalizations. The care plan was initiated on 10/29/23 with no revisions made since it was initiated despite being hospitalized since initiation. The resident was recently hospitalized on [DATE]. Interview with Licensed Practical Nurse (LPN) #744 on 08/13/25 at 1:45 P.M. revealed she was the facility's MDS nurse and was responsible for initiating, revising, and resolving the care plans for residents. LPN #744 was unaware Resident #72's pressure wound to the left foot had resolved. She confirmed Resident #72 was no longer septic as of August 2025 and the care plan should have been revised/resolved. Regarding rehospitalizations, LPN #744 said she initiated the care plan as part of her baseline care plan but social services was responsible for revising the care plan with any hospitalizations and did not know why it had not been updated. LPN #744 was unable to explain why the care plans for Resident #72 had not been revised. Review of the facility policy titled, Care Plan and Advanced Care Plan Process, last revised in October 2017, revealed care plans would be reviewed quarterly, annually, and when a significant change in status occurred. The care plan should identify the date, problem, measurable and realistic goals, time frames for achievement, interventions specific to discipline and frequency, resolution, goal analysis, and discharge options. 2. Review of Resident #25's medical record revealed an admission date of 07/03/23, with diagnoses that included cerebral infarction, hemiplegia and hemiparesis, dysphagia, chronic respiratory failure, paranoid schizophrenia, bipolar disorder, anxiety disorder, and muscle weakness. The resident's son and daughter were both listed as emergency contact number one. Review of the most recent annual MDS assessment dated [DATE] revealed Resident #25 was not able to be understood and staff assessed the resident as severely cognitively impaired. Review of the electronic medical record found only one care conference dated 08/07/25 at 5:47 P.M. held with Resident #25 and the son. Further review of the medical record revealed no other documented care conferences. Interview on 08/08/25 at 9:59 A.M. with Social Service Designee (SSD) #805 revealed she had been at the facility since March 2025 and her first care planning conference with Resident #25 was held 08/07/25. SSD #805 did not know if any additional care conferences had been held for Resident #25 with the previous SSD. Interview with (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	08/12/25 at 11:03 A.M. Administrator verified there was no documentation for any additional care conferences for Resident #25. Review of Resident #25's medical record revealed an admission date of 07/03/23, with diagnoses that included cerebral infarction, hemiplegia and hemiparesis, dysphagia, chronic respiratory failure, paranoid schizophrenia, bipolar disorder, anxiety disorder, and muscle weakness. The Resident's son and daughter were both listed as emergency contact number one.3. Review of Resident #29's medical record revealed an admission date of 12/21/21 and a re-entry date of 08/15/22. Resident #29's diagnoses included senile degeneration of the brain, anxiety disorder, and embolism and thrombosis of unspecified parts of the aorta. Review of Resident #29's Annual MDS assessment dated [DATE] revealed Resident #29 had severe cognitive impairment. Review of Resident #29's social service progress notes dated 02/21/23 included the interdisciplinary team (IDT) met with Resident #29 and Resident #29's niece for a care plan conference. Review of Resident #29's social service progress notes dated 02/21/23 through 08/05/25 did not reveal evidence Resident #29 had additional care plan conferences. Review of the May 2025 care conference schedule revealed Resident #29 was scheduled for a care conference on 05/20/25. There was no documentation a care conference letter was mailed to the responsible party or family for this care conference.4. Review of Resident #59's medical record revealed an admission date of 10/20/17 and a re-entry date of 04/10/25. Resident #59's diagnoses included chronic obstructive pulmonary disease, asthma, and hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side. Review of Resident #59's quarterly MDS assessment dated [DATE] revealed Resident #59 was cognitively intact. Review of Resident #59's social service progress notes dated 04/11/23 included the IDT team met with Resident #59 and his son for a care plan conference. Review of Resident #59's social service progress notes dated 04/11/23 through 08/06/25 did not reveal a care conference was conducted during this time frame. Review of the May 2025 care conference schedule did not reveal evidence Resident #59 had a care conference scheduled. Interview on 08/06/25 at 10:56 A.M. of SSD #805 revealed she started working in the facility about five months ago. SSD #805 stated she arranged resident care conferences. Care conferences were conducted for new admissions within the first five days of admission then quarterly. SSD #805 stated notices were mailed to families and delivered by the receptionist to residents in the facility. SSD #805 stated she was up do date with care conferences and she documented the care conferences in the resident electronic record. SSD #805 stated Resident #29 was supposed to have a care conferences in May 2025, but that did not happen. SSD #805 confirmed Resident #29 did not have care conferences documented in her electronic records since 2023. SSD #805 stated Resident #29 had a care conference scheduled but a letter was not mailed to the family, responsible party and there was no evidence in Resident #29's medical record the family or the responsible party were contacted. SSD #805 further stated Resident #59 was supposed to have a care conference in May 2025 as well, but that did not happen. SSD #805 confirmed Resident's #59 did not have care conferences documented in his electronic records since 2023 and stated there was no evidence a letter was mailed to Resident #59's responsible party about a care conference.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview, the facility failed to ensure outdated drinks and food and beverage additives were stored in a manner to prevent spoilage. This had the potential to affect four (#3, #28, #70, and #77) of four residents identified by the facility as receiving on thickened liquids. The facility census was 87. Findings include: Observation during a tour of the facility on 08/06/25 from 8:40 A.M. to 9:35 A.M. revealed two 46 ounce containers of nectar thickened orange juice were found in the [NAME] pantries on the units. There was no date written on them to show when they had been opened. The use by date was June 2025. Further observation revealed eight individual thick and easy instant food and beverage thickener packets with a use by date of 10/29/23 found in the [NAME] pantries. On 08/06/25 at 9:41 A.M., Regional Director of Clinical Operations #808 verified the two containers of outdated nectar thickened orange juice and the eight outdated thick and easy instant food and beverage thickener packets. This deficiency represents non-compliance investigated under Complaint Number OH00166853 (1254633).		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and policy review, the facility failed to ensure medical records were accurate and complete. This affected five (#1, #6, #30, #105, and #112) of 33 resident records reviewed. The facility census was 87. Findings include: 1. Record review revealed Resident #1 was admitted [DATE] with diagnoses of sepsis, malignant neoplasm of left kidney, end stage renal disease, and dependence on renal dialysis. Review of the hospital admission referral packet dated [DATE] revealed Resident #1 was an end stage renal disease patient on a dialysis regimen with a Tuesday, Thursday, and Saturday schedule. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 had moderate cognitive impairment, required hemodialysis, and required maximal assistance with toileting hygiene, showers, dressing, and personal hygiene. Review of the physician orders for [DATE] revealed Resident #1 had orders for atorvastatin calcium 10 milligrams (mg), donepezil five (5) mg, tamsulosin 0.4 mg, apaxiban 5 mg two times a day, aspirin 81 mg, midodrine three times a day. The physician orders did not include an order for dialysis. Review of Resident #1's medication administration record (MAR) and the treatment administration record (TAR) for [DATE] revealed documentation was not completed on [DATE] and [DATE] for the administration of the aforementioned medications at bedtime and treatments during the shift including turning/repositioning rounds, monitoring for signs/symptoms of infection every shift, and pressure reducing mattress and wheelchair cushion every shift. The TAR was broken down into two shifts, 7:00 A.M. to 7:00 P.M. and 7:00 P.M. to 7:00 A.M. The documentation was not completed on the 7:00 P.M. to 7:00 A.M. shift. Interview on [DATE] at 9:56 A.M. with Licensed Practical Nurse (LPN) Unit Manager #745 confirmed there was no physician order for dialysis in the electronic record for Resident #1; however, dialysis was received at the facility Monday, Wednesday, and Friday. Interview on [DATE] at 3:50 P.M. with Resident #1 confirmed dialysis was received as scheduled and evening medications were received on [DATE] and [DATE]. Interview on [DATE] at 10:13 A.M. with the Director of Nursing (DON) confirmed there was no physician order for dialysis in the electronic record for Resident #1. Interview on [DATE] at 7:58 A.M. with LPN #732 confirmed she worked the evening of [DATE] but was unable to recall if the medications were administered or if documentation was completed. Interview on [DATE] at 8:02 A.M. with LPN #724 confirmed she worked the night shift on [DATE] and did administer Resident #1's evening medications but admitted to forgetting to complete documentation at times. 2. Review of the medical record revealed Resident #30 was admitted to the facility on [DATE] with diagnoses including emphysema, cerebral palsy, diabetes, and post traumatic stress syndrome. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the quarterly MDS assessment dated [DATE] revealed Resident #30 was cognitively intact and used a noninvasive ventilator (NIV). Review of the nurses notes for Resident #30 from June through [DATE] revealed respiratory therapy routinely documented the hours of use for the NIV. The pharmacist documented monthly regarding the review of the resident's medications. Registered Nurse (RN) Unit Manager #801 documented on [DATE] regarding an update on a computed tomography (CT) scan the resident was scheduled for of the abdomen and pelvis. No other documentation regarding the resident's care or the results of the CT scan and when it was completed were documented. Interview with the Director of Nursing (DON) on [DATE] at 1:10 P.M. confirmed the nurses should be documenting any changes regarding the resident and confirmed there was no documentation in Resident #30's medical record regarding results of the CT scan. 3. Review of the medical record revealed Resident #105 was admitted to the facility on [DATE] with diagnoses including senile degeneration of the brain, end stage renal disease dependent on hemodialysis, diabetes, a stroke, and vascular dementia without behavioral disturbance. The resident was admitted to hospice on [DATE] with a diagnosis of end stage renal disease after refusing to attend any further dialysis treatments. Resident #105 died on [DATE]. Review of the nurses notes for Resident #105 revealed on [DATE] the resident requested to be sent to the hospital for diarrhea. The nurse practitioner approved the transfer to the local emergency room (ER). The next note dated [DATE] revealed Resident #105 returned from the hospital positive for clostridium difficile. Review of the nursing admission assessment completed on [DATE] revealed Resident #105's vital signs were documented but the rest of the admission assessment was left blank. Interview with the DON on [DATE] at 2:00 P.M. revealed she does not know why Resident #105's admission assessment on [DATE] was blank, but stated there was probably a glitch in the facility's electronic health record that removed the assessment information. The DON said she was planning on in-servicing nursing on documentation. 4. Record review for Resident #6 revealed an admission date of [DATE]. Diagnoses included end stage renal disease, diabetes mellitus II, and paroxysmal atrial fibrillation. Review of Resident #6's electronic medical record (EMR) revealed a physician note dated [DATE] at 1:58 P.M. for Resident #112 and on [DATE] at 3:14 P.M. a physician note was found for Resident #112. On [DATE] at 8:00 A.M. the DON verified two physician notes for Resident #112 were found in the EMR for Resident #6. Review of the facility policy titled, "EHR Records and Documentation," dated 12/22, revealed the facility the facility must maintain medical records on each resident that are complete, accurately documented, readily accessible, and systematically organized. The medical record must reflect the resident's condition and the care and services provided across all disciplines to ensure information is available to facilitate communication among the interdisciplinary team. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	This deficiency represents non-compliance investigated under Master Complaint Number 2564323, Complaint Number OH00167217 (1254635), and Complaint Number OH00166806 (1254522).		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interview, medical record review, and review of the facility policy, the facility failed to ensure residents were provided with a dignified dining experience. This affected two (#25 and #95) out of three reviewed for respect and dignity. The facility census was 87. Findings include: 1. Review of Resident #95's medical record revealed an admission date of 06/18/24 and diagnoses included type two diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral, end stage renal disease (ESRD), and depression. Review of Resident #95's care plan revised 04/16/25 included Resident #95 had a self care deficit related to weakness, ESRD with hemodialysis, blindness to both eyes and limited mobility. Resident #95 would maintain the highest level of independence possible through the review date. Interventions included to provide eating set up and supervision. Observation on 08/05/25 at 8:44 A.M. of Certified Nurse Aide (CNA) #772 revealed she carried Resident #95's meal tray in his room and set the tray up but did not offer to assist Resident #95 and did not stay in the room to supervise him while he was eating. CNA #772 did not return to the room to check on Resident #95 after she set his tray up and left the room. Observation on 08/05/25 at 1:13 P.M. revealed CNA #772 delivered Resident #95's meal tray to his room, set the tray up and did not stay in the room to assist Resident #95. CNA #772 did not show Resident #95 where his silverware was and did not ensure a piece of meat with gravy on top was cut up before she left Resident #95's room. Further observation revealed there was no knife on the tray and no way to cut the piece of meat into bite size pieces. Resident #95 began eating his mashed potatoes with his fingers and interview with the resident during the observation confirmed he was using his fingers and stated no was assisting him. When asked about the whole piece of meat and no knife on the meal tray and Resident #95 eating his mashed potatoes with his fingers, interview with Licensed Practical Nurse (LPN) #733 during the observation confirmed there was no way to cut the meat up and left the room to find a knife. LPN #733 confirmed Resident #95 was eating mashed potatoes with his fingers and showed him where the spoon was. 2. Review of Resident #25's medical record revealed an admission date of 07/03/23 and diagnoses included cerebral infarction due to embolism of unspecified cerebral artery, hemiplegia (paralysis) and hemiparesis (weakness) following cerebral infarction affecting the right dominant side, and dysphagia following cerebral infarction. Review of Resident #25's annual Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status was not conducted due to Resident #25 being rarely or never understood. Resident #25 had impairment on both sides of her upper extremities and impairment on one side of her lower extremities. Resident #25 required substantial to maximal assistance with eating and was dependent for toileting hygiene, bathing, and oral hygiene. Resident #25 was always incontinent of urine and bowel. Review of Resident #25's care plan revised 08/06/25 included Resident #25 had a self-care deficit related to dementia, history of cerebrovascular accident with hemiplegia, impaired mobility, dysphagia. Resident #25's activities of daily living (ADL) needs would be met by staff while allowing her to participate as able. Interventions included the resident needed dependent assistance of one for eating and was dependent on the assistance of one for incontinence care. Observation on 08/05/25 at 8:47 A.M. of Resident #25 revealed she was lying in bed and the head of the bed was elevated at approximately a 30-degree angle. Interview during the observation with LPN #733 stated Resident #25 required assistance with feeding and if the nurse aides had enough time they assisted her out of bed into her wheelchair and took her to the dining room to eat, but otherwise she was fed in her room. Certified Nurse Aide (CNA) #772 carried Resident #25's meal tray in the room and stated she was going to feed her. CNA #772 set Resident #25's meal tray up, stood next to her, did not raise the height of Resident #25's bed and began feeding her while the head of her bed was still at a 30-degree angle. CNA #772 dropped food on Resident #25's gown (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and continued to feed her while Resident #25's head of the bed was at a 30-degree angle. After a few minutes, CNA #772 raised Resident #25's head of bed to about a 90-degree angle and continued to stand next to her while she was assisting her with eating. CNA #772 confirmed she was standing while feeding Resident #25 and dropped food on her gown. CNA #772 stated she always stood when she fed Resident #25 in the room and when she was in the dining room she sat while she fed her. Review of the facility policy titled, Resident Rights and Facility Responsibilities, dated 10/03/23, revealed the facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This deficiency represents non-compliance investigated under Complaint Number OH00167217 (1254635), Complaint Number OH00164532 (1254632) , and Complaint Number OH00162468 (1254628).		

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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, resident and staff interview, medical record review, review of an invoice, and review of the facility policy, the facility failed to ensure a resident's bed was appropriate to accommodate his height and weight and failed to ensure call lights were within reach for resident use. This affected three (#76, #44, and #95) out of seven residents reviewed for appropriate accommodation of needs. The facility census was 87. Findings include: 1. Review of Resident #76's medical record revealed an admission date of 02/22/24 and diagnoses included paroxysmal atrial fibrillation, muscle weakness, difficulty walking, and pain. Review of Resident #76's height dated 02/22/24 revealed he was 81.0 inches (six (6) feet nine (9) inches) tall. Review of Resident #76's care plan dated 03/06/24 included Resident #76 had an alteration in musculoskeletal status related to muscle spasms, muscle weakness, and osteoarthritis. Resident #76 would remain free of complications related to fracture, such as contracture formation, embolism and immobility through the review date. Resident #76 would remain free from pain or at a level of discomfort acceptable to the resident. Interventions included to anticipate and meet needs and Resident #76 needed to change position every two hours and as needed. Review of Resident #76's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #76 was cognitively intact. Resident #76 used a motorized wheelchair. Resident #76 required substantial to maximal assistance for toileting hygiene, personal hygiene, bathing and upper body dressing. Resident #76 was dependent for lower body dressing and chair-to-bed-to-chair transfer. Review of Resident #76's weight dated 07/09/25 revealed Resident #76 weighed 387.2 pounds. Observation on 08/04/25 at 10:17 A.M. of Resident #76 revealed he was lying in bed, the head of the bed was elevated about 45-degrees and Resident #76's head was even with the top of the mattress. Resident #76's pillow was on the floor at the head of the bed. Interview during the observation with Resident #76 stated he was 6 feet 9 inches, he was too tall for the bed, and did not fit in the bed. Resident #76 confirmed his pillow fell off the bed and it happened often. Resident #76 stated he had been begging for a bigger bed and the nurses and aides say they would be back and they do not come back. Resident #76 stated it was hard for him to roll side-to-side in the bed because it was not wide enough. Resident #76 rolled from side-to-side to show how hard it was for him. Observation showed Resident #76 could not roll freely. Observation on 08/05/25 at 8:32 A.M. of Resident #76 with the Administrator revealed Resident #76 was lying in bed and the foot of the bed was extended. There was a gap of about eight to twelve inches between the end of the mattress and the footboard. A long vinyl wrapped foam piece was placed in the gap between the mattress and the footboard, but the foam piece did not fit the area and was not tall enough for Resident #76 to rest his heels on it. The foam piece did not fit across the width of the gap between the mattress and the footboard. The Administrator confirmed the foam piece did not fit the open area between the mattress and the footboard and was not helping in any way. Review of Resident #76's invoice dated 08/05/25 included a bed was ordered and shipped to the facility and would arrive to the facility on [DATE]. The bed description was multi-layered pressure reduction mattress with firm perimeter and fire barrier, 650 pound cap. The bed dimensions were 48 (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	inches by 84 inches. Interview on 08/06/25 at 11:11 A.M. of the Administrator revealed she ordered another bed for Resident #76. The Administrator stated Resident #76's current bed dimensions were 36 inches by 80 inches (three (3) feet by 6 feet eight (8) inches). The new bed dimensions were 48 inches (four (4) feet) by 84 inches (seven (7) feet). Review of the facility policy titled, Resident Rights and Facility Responsibilities, included the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. 2. Review of the medical record revealed Resident #44 was admitted to the facility on [DATE] with diagnoses that included depression, chronic obstructive pulmonary disease, and hemiplegia. Review of the most recent MDS assessment dated [DATE] revealed Resident #95 was moderately cognitively impaired and required extensive assistance of one staff person for completing his activities of daily living Observation of Resident #44 on 08/04/25 at 11:59 A.M. revealed Resident #44 was up in her wheelchair and his call light was on the floor and out of reach. Interview with Certified Nurse Aide (CNA) #764 verified the placement of the call light at the time of observation. 3. Review of the medical record revealed Resident #95 was admitted to the facility on [DATE] with diagnoses that included type two diabetes, end stage renal disease, and chronic pain. Review of the most recent MDS assessment dated [DATE] revealed Resident #95 was moderately cognitively impaired and required extensive assistance of one staff person for completing his activities of daily living. The assessment also noted Resident #95 as completely blind with zero visual perception noted. Observation of Resident #95 on 08/05/25 at 8:06 A.M. revealed Resident #95 was up in his wheelchair and his call light was on the floor and out of reach. Interview with Licensed Practical Nurse (LPN) #741 verified the placement of the call light at the time of observation. This deficiency represents non-compliance investigated under Complaint Number OH00167095 (1254634).		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and review of a facility policy, the facility failed to ensure a resident's family or responsible party were notified of changes in condition. This affected one (#6) of two residents reviewed for change in condition. The census was 87. Findings include: Record review for Resident #6 revealed admission to the facility on [DATE]. Diagnoses included end stage renal disease, gastrointestinal hemorrhage, diabetes mellitus II and paroxysmal atrial fibrillation. Review of Resident #6's electronic medical record (EMR) revealed a nurse note dated 02/14/25 at 6:57 P.M. that Resident #6 was ordered to be sent to the hospital. There was no indication the family was notified. Further review revealed a note dated 02/19/25 at 4:10 P.M. that Resident #6 returned to the facility. There is no indication the family was notified. Review of Resident #6's EMR revealed a nurse note dated 02/26/25 at 2:29 P.M. that Resident #6 was ordered to be sent to the hospital. There was no indication the family was notified. Review of Resident #6's EMR revealed a nurse note dated 03/05/25 at 4:04 P.M. that Resident #6 was sent to the hospital from dialysis. There was no indication the family was notified. Review of Resident #6's EMR revealed a nurse note dated 03/13/25 at 12:37 P.M. that Resident #6 went to the hospital from the doctor's office. There was no indication the family was notified. Further review revealed she was sent out again on 03/13/25 at 1:22 A.M. and returned same day at 4:49 A.M. There was no indication the family was notified when Resident #6 left or returned to the facility. Review of Resident #6's EMR revealed a nurse note dated 03/15/25 at 3:11 P.M. that Resident #6 was ordered to go to the hospital. There was no indication the family was notified. Further review revealed a physician note dated 03/21/25 that Resident #6 was readmitted. There was no documentation that the family was notified. Interview with the Unit Manager Licensed Practical Nurse (LPN) #745 on 08/13/25 at 11:29 A.M. verified there was no documentation informing Resident #6's family was notified of her being sent out of the facility and to the hospital on [DATE], 02/26/25, 03/05/25, 03/13/25, or 03/15/25. Review of the facility policy titled, Resident Change in Condition, dated 07/28/22, revealed the purpose was to ensure staff provided timely and appropriate care and services when residents experience a change in condition that had or was likely to cause adverse negative health outcomes. The facility would promptly notify the resident, his or her attending physician and responsible party of changes in the resident's condition and, or status. This deficiency represents non-compliance investigated under Complaint Number OH00163811 (1254630).		

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to ensure Notices of Medicare Non-Coverage (NOMNCs) were provided to Medicare Part A beneficiaries prior to the discontinuation of skilled services in a timely manner. This deficient practice affected two (#110 and #111) out of three residents reviewed for beneficiary notices. The facility census was 87. Findings included:1. Review of the medical record revealed Resident #110 was admitted to the facility on [DATE] with diagnoses that included alcohol abuse, metabolic disorder, and high blood pressure. Review of the NOMNC presented to and signed by Resident #110 on 05/08/25 revealed the notice indicated his skilled physical therapy, occupational therapy, and speech therapy services would end on 05/08/25. This provided no advance notice.2. Review of the medical record revealed Resident #111 was admitted to the facility on [DATE] with diagnoses that included a right femur fracture, type II diabetes, and high blood pressure. Record review of the NOMNC presented to and signed by Resident #111 on 06/09/25 revealed the notice indicated his skilled physical therapy, occupational therapy, and speech therapy services would end on 06/09/25. This also provided no advance notice. Interview with Social Service Designee (SSD) #805 on 08/05/25 at 4:30 P.M. confirmed the NOMNCs for Resident #110 and Resident #111 were not provided at least 48 hours prior to the discontinuation of skilled services as required.		

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interviews, review of self-reported incidents, review of discharge notices, and review of a policy review, the facility failed to ensure residents were permitted to return to the facility following a hospitalization and failed to ensure documentation of the need for discharge was reflected in the medical record to establish the need for discharge from the facility. This affected three residents (#18, #26 and #89) out of five residents reviewed for discharge. The facility census was 87. Findings include: 1. Review of the medical record revealed Resident #18 was admitted to the facility on [DATE] with diagnoses that included Parkinson's disease, borderline intellectual functioning, and dementia. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #18 was severely cognitively impaired and required the assistance of one staff member for completing activities of daily living (ADLs). Review of the discharge notice issued on 07/31/25 revealed Resident #18 would be discharged to another nursing facility on 08/30/25 for, "violating the rights of others to have a homelike environment." 2. Review of the medical record revealed Resident #89 was admitted to the facility on [DATE] with diagnoses that included chronic kidney disease, cannabis use disorder, and high cholesterol. Review of the most recent MDS assessment dated [DATE] revealed Resident #89 was cognitively intact and required supervision to complete ADLs. Review of facility self-reported incidents (SRIs) revealed on 07/28/25 Resident #89 was found in possession of another resident's cell phone, which he promptly returned without incident. Further review of the SRIs revealed no prior incidents involving abuse, neglect, or misappropriation by Resident #89 since 08/21/08. Review of the discharge notice provided to Resident #89 on 07/31/25 revealed Resident #89 would be discharged to another nursing facility on 08/30/25, the resident is violating the rights of others to privacy/personal possessions, respect, and the right to be free from abuse. Interview with the Administrator on 08/06/25 at 10:15 A.M. confirmed the discharge notices issued for Resident #18 and Resident #89 were not supported by appropriate documentation. 3. Review of the medical record revealed Resident #26 was admitted to the facility on [DATE] with diagnoses including encephalopathy (any condition that affects the brain's structure or function, leading to impaired mental state), diabetes, dementia without behavioral disturbance, and anxiety disorder. Review of the comprehensive admission MDS assessment, dated 07/25/25, revealed Resident #26 was moderately cognitively impaired and had no behaviors during the assessment period. Review of the nurses' notes dated 08/08/25 at 7:58 P.M. revealed Resident #26 was restless and became extremely agitated after dinner. The resident unbuttoned his pants to urinate in a trash (continued on next page)		

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	can. Registered Nurse (RN) #799 attempted to redirect the resident to his room as the common area was not an appropriate place to urinate. The resident refused redirection and attempted to remove other residents dinner plates while they ate. Other attempts at redirection were ineffective. The resident started walking the halls heading toward the lobby stating he was going to get to his car as he needed to work on it. RN #799 and a certified nurse aide (CNA) continued to try and redirect the resident to his room. Resident #26 attempted to open the secured door to the main entrance. RN #799 held the door shut and the resident became more agitated and attempted to hit RN #799. A second nurse notified Nurse Practitioner (NP) #811 of the resident's aggressive behavior and gave an order to transport the resident to a local emergency room (ER) for evaluation. At 7:15 P.M. Resident #26 was transferred to the ER. No further documentation was noted regarding what occurred with the resident after transport. Interview with the Mobile Director of Nursing on 08/11/25 at 3:35 P.M. revealed Resident #26 was admitted to the hospital. When he was discharged he would be transferred to another facility with a secured unit. He will not be returning to the facility. Interview with the Director of Nursing (DON) on 08/11/25 at 5:10 P.M. revealed anyone who was sent to the ER for evaluation was considered discharged. The DON was unable to explain why no further documentation was in the chart regarding what happened to Resident #26 after his transfer. The DON was unable to provide any discharge paperwork regarding the resident or where he went. No immediate discharge documentation was provided regarding Resident #26 not being able to return to the facility. Review of the facility's policy titled, "Discharge Planning & Managing Length of Stay," dated 12/01/22, revealed discharge planning should involve identifying each resident's discharge goals and needs, implementing appropriate interventions, and regularly evaluating those interventions throughout the resident's stay. When a facility anticipates discharge, a discharge summary includes a recapitulation history will be completed. A final discharge summary will be completed upon discharge that should be given to the resident or responsible party including medication reconciliation, discharge medication orders, and a post discharge plan of care including where the resident plans to reside, any appointments made for follow up care and any post discharge medical services. This deficiency represents non-compliance investigated under Complaint Number OH00166711 (1254468) and Complaint Number OH00167217 (1254635).		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and review of an Ombudsman notification log, the facility failed to ensure the Ombudsman was notified of resident hospitalizations as required. This affected three (#6, #17, and #24) of five residents reviewed for discharges. The census was 87. Findings include: 1. Record review for Resident #6 revealed an admission to the facility on [DATE]. Diagnoses included end stage renal disease, gastrointestinal hemorrhage, diabetes mellitus II, and paroxysmal atrial fibrillation. Review of the electronic medical record (EMR) from 01/11/25 to present revealed Resident #6 was admitted to the hospital on [DATE] and returned to the facility on [DATE]. Review of the EMR revealed Resident #6 was admitted to the hospital on [DATE] and returned on 03/07/25. Resident #6 was admitted to the hospital on [DATE] and readmitted to the facility on [DATE]. Review of the EMR revealed Resident #6 was sent to the hospital 06/10/25 and returned 06/12/25. Review of the Ombudsman Notification Log of Community Transfer and Discharges revealed no transfers or discharges were documented for the whole months of February, March 2025, and no documentation of the Ombudsman being notified of Resident #6 discharging to the hospital the being readmitted to the facility in June 2025. Interview with the Social Service Designee (SSD) on 08/13/25 at 10:10 A.M. revealed the previous SSD did not document any transfer or discharges for the whole month of February 2025, including Resident #6's hospitalization. 2. Review of the medical record revealed Resident #17 was admitted to the facility on [DATE]. Diagnoses included chronic kidney disease stage III, cerebrovascular disease, hemiplegia affecting left non-dominant side, and acute respiratory failure with hypoxia. Review of the EMR revealed Resident #17 was admitted to the hospital 05/15/25 and returned to the facility on [DATE]. Resident #17 was also admitted to the hospital on [DATE] and returned to the facility on [DATE]. Review of the Ombudsman Notification Log of Community Transfer and Discharges revealed no documentation of Resident #17 discharging to the hospital and readmitting to the facility notification was sent to the Ombudsman. 3. Record review for Resident #24 revealed an admission date of 05/21/25. Diagnoses included acute respiratory failure with hypoxia, end stage renal disease, diabetes mellitus II with diabetes neuropathy, chronic diastolic congestive heart failure, and benign prostatic hyperplasia with lower urinary tract symptoms. Review of the EMR for Resident #24 revealed the resident was hospitalized on [DATE] and (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	readmitted to the facility on [DATE]. Resident #24 was also hospitalized in July 2025 and readmitted to the facility on [DATE]. Review of the Ombudsman Notification Log of Community Transfer and Discharges revealed no documentation of Resident #24's hospitalizations with notification sent to the Ombudsman. Interview with the SSD and the Business Office Manager (BOM) on 08/12/25 at 10:15 A.M. confirmed neither have send notice to the Ombudsman to providing notification of Resident #6, #17, and #24's hospitalizations and provided no evidence it was done by anyone with the facility for those three residents.		

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to ensure a significant change in condition Minimum Data Set (MDS) assessment was conducted for Resident #64 following a significant change as required. This affected one (#64) of one residents reviewed for hospice services. The census was 87. Findings included: Record review revealed Resident #64 was admitted to the facility on [DATE] with diagnoses including Parkinson's disease, seizures, and chronic obstructive pulmonary disease. Review of the hospice revocation form signed by Resident #64 on 04/24/24 revealed hospice services would be discontinued on 04/25/24 due to the resident's health improving and no longer meeting criteria to receive hospice services. Further review of Resident #64's medical record revealed the resident experienced a medical decline in 04/25/24 and was again receiving hospice services. Review of the MDS assessments for Resident #64 revealed no significant change assessment was completed following the resident's discontinuation from hospice on 04/25/24. In an interview on 08/12/25 at 2:22 P.M. MDS Nurse #800 verified the lack of a significant change in assessment completed when Resident #64 was discontinued from hospice services in April 2025. Review of the most recent version of the Resident Assessment Instrument (RAI) Manual, revised October 2024, revealed the nursing home is required to complete an SCSA (significant change status assessment) when the resident comes off the hospice benefit.		

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to notify the appropriate state agency, the Ohio Department of Mental Health (ODMH), of a significant change in a resident's mental health condition, as required. This deficient practice affected one (#38) of two residents reviewed for pre-admission screening and resident review (PASRR). The facility census was 87. Findings included: Medical record review revealed Resident #38 was admitted to the facility on [DATE] with diagnoses that included hemiplegia of the left side and aphasia. Review of the most recent psychiatric consult note dated 08/11/25 revealed Resident #38 had diagnoses of delusional disorder, dementia, and major depressive disorder. These diagnoses reflected onset dates of 06/29/23 and 07/02/23 respectively, as documented throughout the medical record. Review of PASRR records for Resident #38 revealed a PASRR was completed during the initial admission on [DATE]. No additional PASRR evaluations were completed during the resident's stay to address the new mental health diagnoses identified after admission. Interview with Social Services Designee #805 on 08/12/25 at 3:30 P.M. verified no PASRR was submitted to ODMH to address Resident #38's new mental health diagnoses.		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, record review, and policy review, the facility failed to ensure an initial baseline care plan was initiated within 48 hours of admission as required. This affected one (#105) of four residents reviewed for baseline care plans. The facility census was 87. Findings include: Review of the medical record revealed Resident #105 was admitted to the facility on [DATE] with diagnoses including senile degeneration of the brain, end stage renal disease dependent on hemodialysis, diabetes, a stroke, and vascular dementia without behavioral disturbance. The resident was admitted to hospice on [DATE] with a diagnosis of end stage renal disease after refusing to attend any further dialysis treatments. Resident #105 died on [DATE]. Review of Resident #105's comprehensive admission Minimum Data Set (MDS) assessment, dated [DATE], revealed the resident was moderately cognitively impaired and required dialysis treatments three times a week. Review of the admission assessment dated [DATE] for Resident #105 revealed an initial baseline care plan was not completed upon admission. Review of Resident #105's care plans revealed no care plans were initiated until [DATE]. Interview with the Director of Nursing (DON) on [DATE] at 2:00 P.M. revealed the nurses do not know what to do with initial care plans that are to be completed upon admission and confirmed Resident #105's admission care plan was not completed as required. She was planning on educating the nurses regarding care plans at their next staff meeting. Review of the facility policy titled, Care Plan and Advanced Care Plan Process, last revised in [DATE], revealed an interim care plan will be completed within 48 hours of admission. The interim care plan should include, at minimum, the necessary healthcare information necessary to properly care of a resident. This includes, but is not limited to, initial goals based on the admission orders; physician orders; dietary orders; therapy services; social services; and any Preadmission Screening and Resident Review (PASARR) recommendations.		

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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, staff interview, medical record review, and review of the facility policy, the facility failed to ensure resident finger nail care was provided in an adequate manner. This affected one (#29) of six residents reviewed for activities of daily living (ADLs). The facility census was 87. Findings include: Review of Resident #29's medical record revealed an admission date of 12/21/21 and a re-entry date of 08/15/22. Resident #29's diagnoses included senile degeneration of the brain, anxiety disorder, and embolism and thrombosis of unspecified parts of the aorta. Review of Resident #29's care plan revised 03/25/25 included Resident #29 was resistive to care related to dementia and refused personal hygiene care and ADL management including showers. Resident #29 would cooperate with care through the next review date. Interventions included to give a clear explanation of all care activities prior to and as they occurred during each contact; if possible negotiate a time for ADLs so Resident #29 participated in the decision making process and return at the agreed upon time; if Resident #29 resisted with ADLs, reassure the resident, leave, and return five to ten minutes later and try again. Review of Resident #29's annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #29 had severe cognitive impairment. Resident #29 was dependent for toileting hygiene, bathing, dressing and personal hygiene. Resident #29 was always incontinent of urine and bowel. Resident #29 did not reject care during the seven-day assessment look-back period. Review of Resident #29's progress notes dated 07/15/25 through 08/07/25 did not reveal evidence Resident #29 refused to have her fingernails cleaned and trimmed. Review of Resident #29's shower sheets dated 07/29/25 and 08/01/25 revealed Resident #29 had a bed bath. There were no notes on the shower sheets indicating Resident #29's fingernails were long, dirty and needed trimmed. Observation on 08/04/25 at 10:26 A.M. of Resident #29 with Certified Nurse Aide (CNA) #764 revealed Resident #29 had long dirty fingernails. CNA #764 confirmed Resident #29's fingernails were long, about a half inch to three quarters of an inch, and had dark brown material underneath the nails. Review of Resident #29's shower sheet dated 08/05/25 revealed Resident #29 had a bed bath. There were no notes on the shower sheet indicating Resident #29 needed her fingernails trimmed and cleaned. Observation on 08/07/25 at 7:34 A.M. of Resident #29 revealed her fingernails were about a half inch to three quarters of an inch, and had dark brown material underneath the nails. Interview on 08/07/25 at 8:07 A.M. of the Director of Nursing (DON) revealed the nurse aides should check Resident #29's fingernails on bath days and it should be documented on the shower sheet if Resident #29's fingernails were long, dirty and needed trimmed. The DON stated the aides should also report it to the nurse. The DON indicated the nurse's cut resident fingernails. Observation on 08/07/25 at 11:38 A.M. of CNA #752 confirmed Resident #29's fingernails were about a half inch to three quarters of an inch, and had dark brown material underneath the nails. CNA #752 stated she was not sure if Resident #29's fingernails should be cleaned when she was bathed. CNA (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#752 indicated she was going to soak Resident #29's fingernails now to help clean them. Interview on 08/07/25 at 11:42 A.M. of Licensed Practical Nurse (LPN) #743 revealed he was not told Resident #29's fingernails needed trimmed, and he would make sure they were trimmed today. Interview on 08/11/25 at 10:31 A.M. of CNA #788 revealed she had no issues with Resident #29 refusing care, she did not refuse care, and it was all in the way Resident #29 was approached when care was provided. Review of the facility policy titled, Activities of Daily Living (ADLs), dated 03/2023, included the purpose was to specify the responsibility to create and sustain an environment that humanizes and individualizes each resident's quality of life by ensuring all staff, across all shifts and departments, understand the principles of quality of life, and honor and support these principles for each resident; and that the care and services provided were person-centered, and honor and support each resident's preferences, choices, values and beliefs. A resident who was unable to carry out activities of daily living would receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This deficiency represents non-compliance investigated under Master Complaint 2564323, Complaint Number OH00162468 (1254628), Complaint Number OH00164532 (1254632), and Complaint Number OH00167217 (1254635).		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, and resident and staff interview, the facility failed to initiated orders timely and timely implement interventions for treatment of edema. This affected one (#88) of two residents reviewed for quality of care. The facility census was 87. Findings include:Record review revealed Resident #88 was admitted to the facility on [DATE] and readmitted on [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD), acute upper respiratory infection, and shortness of breath (SOB).Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #88 was cognitively intact. She required partial to moderate assistance for toileting, upper body dressing, and personal hygiene. She required substantial to maximal assistance to shower, for lower body dressing, and donning and doffing footwear.Review of the current care plan for Resident #88 revealed a focus area of edema to bilateral lower extremities with interventions to apply ACE (compression) wraps to bilateral extremities from toes to knees with instructions to apply in the morning and remove at night, and elevate the resident's legs while at rest. Review of Resident #88's orders revealed ACE wraps to be applied to bilateral legs from toes to knees with instructions to apply every morning and remove at night for edema dated 11/22/22, discontinued 01/02/25, then made an active order again on 04/15/25. There was no current order for ACE wraps to be applied at any certain time. Resident #88 also had an order for leg elevation while at rest every shift for edema that was discontinued 01/02/25 when the resident went to the hospital. Review of Resident #88's electronic medication administration record (eMAR) note dated 07/28/25 at 7:04 A.M. revealed ACE wraps were to be applied to bilateral lower extremities with instructions to put on in the morning and take off at the hour of sleep twice daily for edema. Observation on 08/04/25 at 10:30 A.M. revealed Resident #88 was sitting in her wheelchair and her bilateral legs were not wrapped and not elevated. Observation and interview on 08/04/25 at 11:21 A.M. revealed Resident #88 was sitting in her wheelchair in her room and her legs were not wrapped and were not elevated. Resident #88 was observed wearing non-skid gripper socks that appeared tight on the resident and the resident stated the staff do not elevate her legs, the staff do not put her legs on the wheelchair foot pedals unless she is taken out of her room, and never refused to have her legs wrapped. Continued observation and interview revealed Certified Nurse Aide (CNA) #771 placed the resident leg rests on the wheelchair after verifying the legs rest were not on the wheelchair and were on the floor against the wall. Resident #88's legs continued to not be wrapped. Observation on 08/04/25 at 3:13 P.M. revealed Resident #88's bilateral legs were not wrapped and not elevated as she was sitting in wheelchair in her room watching television.Observation on 08/05/25 at 11:25 A.M. revealed Resident #88's bilateral legs were wrapped but not elevated. On 08/06/25 at 10:00 A.M. the resident's bilateral legs were wrapped but not elevated and the wheelchair pedals were not on the wheelchair.Observation on 08/07/25 at 9:17 A.M. and 11:00 A.M. revealed Resident #88's bilateral legs were wrapped but not elevated.Interview with Resident #88 on 08/07/25 at 9:17 A.M. revealed her legs were to be wrapped every day and supposed to be elevated above her heart.Observation on 08/08/25 at 11:25 A.M. revealed Resident #88's bilateral legs were wrapped but not elevated. Observation on 08/11/25 at 11:21 A.M. revealed ACE wraps were not applied to Resident #88 and her legs were not elevated as she was sitting in her wheelchair. Observation on 08/12/25 at 9:21 A.M. revealed Resident #88's bilateral legs were wrapped but were not elevated. Interview on 08/12/25 at 9:21 A.M. with Resident #88 revealed she was going to tell her nurse aide to put the leg rests on her wheelchair so her legs could be elevated.Interview on 08/12/25 at 11:40 A.M. with Licensed Practical Nurse (LPN) #738 revealed she normally looked to make sure the ACE wraps were in place as night shift was supposed to wrap Resident #88's bilateral lower extremities due to edema.Interview with Unit Manager (UM) #745 on 08/12/25 at 11:45 A.M. stated when residents go out to the hospital and return, sometimes orders are missed despite being triple checked. UM #745 confirmed Resident #88 should have an order (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for bilateral lower extremity leg wraps and her legs should be elevated due to her edema and diagnoses and confirmed the resident did not have an active order. UM #745 stated an order for bilateral leg wraps and elevate bilateral legs was not made active again until 08/11/25 after UM #745 verified the order was missed.Observation and interview on 08/12/25 at 1:45 P.M. with CNA #771 verified Resident #88's legs were not elevated.Observation on 08/13/25 at 11:13 A.M. revealed Resident #88's bilateral legs were wrapped but not elevated. Interview on 08/13/25 at 2:50 P.M. with CNA #771 and CNA #772 verified Resident #88's bilateral wheelchair leg rests were not on the wheelchair Resident #88 was sitting in and stated they were going to put the resident in bed as she was sleeping in her wheelchair.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility policy review, the facility failed to ensure Resident #31's unstageable pressure ulcer to the coccyx was accurately identified and treated timely. This affected one (Resident #31) of three residents reviewed for pressure ulcers. The facility census was 87. Findings include: Review of Resident #31's medical record revealed an admission date of 03/14/25 and diagnoses included heart failure, chronic kidney disease, and unspecified intellectual abilities. Review of Resident #31's admission Minimum Data Set assessment dated [DATE] revealed Resident #31 had severe cognitive impairment. Resident #31 required substantial to maximal assistance with toileting hygiene and bathing. Resident #31 required partial to moderate assistance for dressing and personal hygiene. Resident #31 had an indwelling catheter and was occasionally incontinent of bowel. Resident #31 did not reject care during the seven-day assessment look-back period. Review of Resident #31's admission assessment dated [DATE] included Resident #31 had a right arm skin tear. There was no evidence Resident #31 had an open area to the coccyx. Review of Resident #31's progress notes dated 03/14/25 through 03/25/25 did not reveal documentation related to Resident #31's unstageable pressure ulcer (obscured full-thickness skin and tissue loss) on the coccyx. Review of Resident #31's admission care plan dated 03/16/25 at 3:00 P.M. revealed it was not completed and did not have any documentation recorded. Review of Resident #31's Braden Scale for Predicting Pressure Sore Risk assessment dated [DATE] revealed Resident #31 was at mild risk for developing a pressure sore injury/ulcer. Review of Resident #31's late entry progress note dated 03/18/25 at 3:38 P.M. included on 03/18/25 at 12:54 P.M. Resident #31 arrived to the facility via stretcher (Resident #31 was admitted on [DATE]). Resident #31 was admitted to the facility for acute kidney failure, congestive heart failure (CHF), and other diagnoses. Resident #31 was a one assist for bed mobility, required two staff for transfers, and required a mechanical lift for transfers. Review of Resident #31's pressure ulcer and wound record dated 03/23/25 at 6:12 A.M. included Resident #31 had a pressure area first observed on 03/23/25. Resident #31 had a stage one pressure wound (non-blanchable erythema of intact skin) to the sacrum (coccyx). Measurements were 2.0 centimeters (cm) long by 1.0 cm wide. There was no description of the appearance of the open area. Review of Resident #31's physician orders dated 03/23/25 through 03/25/25 did not reveal treatment orders for Resident #31's stage one pressure ulcer. Review of Resident #31's wound care notes dated 03/25/25 completed by Wound Nurse Practitioner (WNP) #809 included Resident #31 was seen for an initial evaluation of his wound. Resident #31 had limited mobility, incontinence, relied on facility staff for repositioning and activities of daily living (ADLs). Resident #31 had an indwelling catheter. Resident #31 was alert, confused, calm, cooperative and agreeable to care. Resident #31 had an unstageable pressure ulcer of the coccyx, it was acquired in-house, was full thickness and had a length of 3.0 cm, width of 6.7 cm, and depth was unable to be determined. Treatment was to cleanse with normal saline, apply Medihoney and calcium alginate, and cover with a silicone super absorbent dressing daily and as needed. Education was provided to Resident #31 and the nursing staff including the importance of offloading to promote wound healing and the importance of keeping the wound site clean and dry, avoiding contamination and changing dressings as instructed. Review of Resident #31's skin and wound progress notes dated 03/25/25 at 2:23 P.M. included Resident #31 was seen for an initial visit for an unstageable pressure ulcer to the coccyx. Measurements were length of 3.0 cm, width of 6.7 cm, and depth was unable to be determined. There was 80 percent slough, 20 percent pink tissue, and moderate serosanguinous drainage. A new order was to cleanse with normal saline, apply Medihoney and calcium alginate, and cover with a silicone super absorbent dressing daily and as needed. Review of Resident #31's care plan dated 03/26/25 included a care plan for pressure sores, skin care risk related to decreased mobility, incontinence, and assistance needed with ADLs with a goal to prevent and heal pressure sores and skin breakdown. Interventions included treatments (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	as ordered and turn and reposition during care rounds and as needed. Review of Resident #31's care plan dated 03/14/25 through 03/26/25 did not reveal a care plan for pressure ulcer, injuries or risk for pressure ulcers, injuries. Review of Resident #31's treatment administration record (TAR) dated 03/31/25 revealed a physician treatment order to cleanse Resident #31's coccyx with normal saline, apply Medihoney and calcium alginate, and a silicone super absorbent dressing at bedtime and as needed was not completed as ordered. Review of Resident #31's progress notes dated 03/31/25 did not reveal evidence why Resident #31's coccyx treatment was not completed. Review of Resident #31's TAR dated 08/03/25 and 08/04/25 revealed a physician treatment order dated 07/22/25 to cleanse Resident #31's coccyx with normal saline, pat dry, apply collagen to wound bed, and cover with a clean dry dressing daily and as needed was marked, No, the treatment was not completed. Review of Resident #31's progress notes dated 08/03/25 and 08/04/25 did not reveal a reason why Resident #31's treatment was not completed on 08/03/25 and 08/04/25. Review of Resident #31's TAR dated 08/09/25 through 08/11/25 revealed an order dated 07/22/25 to check placement of Resident #31's wound dressing every shift and document findings was not completed. Review of Resident #31's progress notes dated 08/09/25 through 08/11/25 did not reveal a reason Resident #31's wound dressing placement was not checked every shift. Review of Resident #31's TAR dated 08/09/25, 08/10/25, and 08/11/25 revealed a physician treatment order dated 07/22/25 to cleanse Resident #31's coccyx with normal saline, pat dry, apply collagen to wound bed and cover with a clean dry dressing daily and as needed was not completed. Review of Resident #31's progress notes dated 08/09/25 through 08/11/25 did not reveal a reason Resident #31's treatment to his coccyx was not completed. Observation on 08/11/25 at 7:53 A.M. of Resident #31 with Unit Manager (UM) #801 revealed Resident #31 was laying on his back in bed with his eyes closed. Resident #31's head of the bed was elevated about thirty-degrees and he had a pillow under the left shoulder. UM #801 stated Resident #31 had a dislodged indwelling catheter and had to be transported to the local hospital on [DATE] to have it replaced. Resident #31 returned from the hospital on [DATE]. Observation of Resident #31's dressing on his coccyx revealed it did not have a date the treatment was completed written on it. UM #801 confirmed the dressing did not have a date on it and would check with Wound Nurse (WN) #802 about the treatment. Observation on 08/11/25 at 8:40 A.M. of UM #801 revealed she was at the nurses station working on a computer. UM #801 stated Resident #31 returned from the hospital on [DATE] and the treatment orders for his coccyx were not reordered. UM #801 confirmed there was no evidence Resident #31's treatment was completed on 08/09/25 and 08/10/25. UM #801 stated she was trying to fix it now. UM #801 indicated she thought Licensed Practical Nurse (LPN) #742 completed Resident #31's admission. Interview on 08/11/25 at 10:31 A.M. of Certified Nurse Aide (CNA) #788 revealed Resident #31 was very pleasant and did not refuse to be cared for. Observation on 08/11/25 at 10:37 A.M. of Resident #31 revealed he was laying in bed on his back with the head of his bed elevated about thirty-degrees and a pillow was under his left shoulder. Observation and interview on 08/11/25 at 1:31 P.M. of Resident #31 with CNA #788 revealed he was laying in bed on his back with the head of his bed elevated about thirty-degrees and a pillow was under his left shoulder. Resident #31 was watching television. CNA #788 stated Resident #31 did not get out bed and she had never seen him out of bed. CNA #788 did not attempt to reposition Resident #31, did not encourage Resident #31 to reposition and did not encourage him to allow her to assist him out of bed. CNA #788 stated she never asked Resident #31 if he wanted to get out of bed. Observation on 08/11/25 at 4:18 P.M. of Resident #31 revealed Resident #31 was laying in bed on his back with the head of the bed elevated about thirty degrees, his eyes were closed, and a pillow was under his left shoulder. CNA #788 was walking at a fast pace in the hall with a hurried expression on her face. CNA #788 stated it was a busy day and confirmed she had not attempted to reposition Resident #31 or encouraged him to reposition except when she provided incontinence care. After incontinence care CNA #788 confirmed Resident #31 was positioned on his back, head of the bed elevated and a pillow under his left shoulder. Interview on 08/12/25 at 6:53 A.M. of Assistant Director (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of Nursing (ADON) #704 revealed she initiated Resident #31's admission care plan on 03/16/25 and confirmed there was no information documented in the care plan. ADON #704 stated the admission care plan was automatically generated and it was a basic care plan. ADON #704 stated she did not know why Resident #31's care plan was completely blank, she usually reviewed the admission care plans to make sure they were pertinent to the resident and she did not know what happened with Resident #31's care plan. Interview on 08/12/25 at 8:46 A.M. of LPN #742 revealed on 08/09/25 she admitted Resident #31 when he returned to the facility from the hospital. LPN #742 indicated Resident #31 returned at the change of shift, she was getting ready to leave the facility and UM #801 was supposed to complete his admission paperwork and orders. LPN #742 stated she assisted Resident #31 into bed but did not do anything else for him including vital signs, confirming Resident #31's orders and the admission assessment. Observation on 08/12/25 at 9:37 A.M. of Resident #31 with WNP #809, Wound Nurse (WN) #802 and Registered Nurse (RN) #797 revealed Resident #31 was lying in bed on his back, the head of the bed was elevated about thirty-degrees and he had a pillow under his left shoulder. WNP #809 stated Resident #31 was receiving hospice services but she still treated his wound. WNP #809 indicated she was notified on 03/25/25 that Resident #31 had a coccyx wound and she evaluated the wound on that day. Resident #31 was compliant with his care and the pressure ulcer to his coccyx was responding to treatment and it was healing. WNP #809 stated Resident #31 did not like to get out of bed. When asked if staff attempted to get Resident #31 out of bed WNP #809 stated that was a nursing responsibility and she was not sure what the protocol at the facility was for assisting residents out of bed. Observation of Resident #31's coccyx wound revealed the wound bed was a reddish-pink color. WNP #809 stated the wound was 100 percent granulated and had a moderate amount of serosanguinous drainage. The measurements were length 1.1 cm, width of 0.8 cm, and depth 0.4 cm. WN #802 applied collagen then a gauze dressing. WNP #809 stated Resident #31 was compliant with his care all along. Interview on 08/12/25 at 10:57 A.M. of MDS Nurse #744 revealed when a resident was admitted the nurse completed the admission assessment and admission care plan. MDS Nurse #744 stated when an admission care plan was completed the nurse had to place a check mark next to pertinent areas for a care plan to be generated. MDS Nurse #744 confirmed Resident #31 did not have a care plan for pressure ulcers generated until 03/26/25 which was thirteen days after Resident #31 had a coccyx pressure ulcer identified. Interview on 08/12/25 at 2:30 P.M. of WN #802 revealed Resident #31 did not have an open area to his coccyx on 03/14/25 when he was admitted to the facility. Resident #31's open area was identified on 03/23/25 and was documented as a stage one pressure ulcer. WN #802 stated she did not see the wound until 03/24/25. WN #802 confirmed there was no evidence on 03/23/25 of a new treatment order when the pressure ulcer was identified. WN #802 stated on 03/23/25 it was documented that Resident #31's physician was notified of the pressure ulcer but there was nothing in the notes specifying the name of the physician or if a treatment was ordered. WN #802 stated because Resident #31's pressure ulcer was documented as a stage one pressure ulcer she continued the barrier cream ordered on 03/17/25. WN #802 stated she was a new wound nurse and did not know what to put in place and she waited until WNP #809 could evaluate the area and order a treatment. WN #802 indicated Resident #31's wound was not staged appropriately on 03/23/25. WN #802 stated when she saw the wound on 03/24/25 it looked pink and there was no death. WN #802 stated Resident #31 was delayed cognitively, did not get out of bed and did not complain. Resident #31 was very compliant with his care and confirmed he lays in the same position all the time. Interview on 08/14/25 at 11:42 A.M. of WN #802 revealed Resident #31 was admitted to hospice services on 04/16/25. WN #802 confirmed Resident #31's treatments to the coccyx were not always documented by the nurses they were completed, but that was because sometimes the hospice nurse completed the treatments. WN #802 was unable to provide evidence the hospice nurses completed the undocumented treatments. Review of the facility policy titled, Pressure Ulcer Prevention and Interventions, revised 01/2023, included the purpose was to implement preventative skin measures for all residents based on the levels and areas of risk to (continued on next page)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366394	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/13/2025
NAME OF PROVIDER OR SUPPLIER Avenue Care and Rehabilitation Center, The		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	include moisture, nutrition, activity, mobility, mental status, psychosocial status and general physical condition. Guidance for suggested and recommended assessment, documentation, interventions and treatment types included for non-blanchable erythema, Stage One to assess the location, measurement and color of the area, to assess the resident's skin daily and pay particular attention to bony prominences. This deficiency represents non-compliance investigated under Complaint Number OH00161573 (1254625) and Complaint Number OH00166806 (1254522).		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, resident and staff interview, review of fall investigations, review of an incident log, and review of facility policies, the facility failed to ensure thorough fall investigations were completed, resident care plans were revised to reflect current fall interventions, and fall interventions were in place as ordered. This affected three (#20, #24, and #25) of three residents reviewed for falls. The facility census was 87. Findings include: 1. Review of Resident #25's medical record revealed an admission date of 07/03/23 with diagnoses that included cerebral infarction, hemiplegia and hemiparesis, dysphagia, chronic respiratory failure, paranoid schizophrenia, bipolar disorder, anxiety disorder, and muscle weakness. Review of the most recent annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #25 was assessed by staff as severely cognitively impaired. The resident had a functional limitation in range of motion (ROM) to both sides of the upper extremities and impairment on one side of the lower extremities. The resident required maximal assistance to roll left and right, was dependent on staff for transferring from the chair to the bed, and moving from lying to sitting on the side of the bed was not attempted due to medical or safety concerns. The resident required a mechanical (Hoyer) lift for transfers. Review of the nurse's notes dated 05/31/25 at 6:55 A.M. revealed Resident #25 was found on the floor as Licensed Practical Nurse (LPN) #734 walked into the resident's room to give morning medication. An assessment and neurological checks were done before putting the resident back in bed. No injuries were noted at that time. Resident #25 was put back in bed, the bed lowered, the call light was within reach, and the resident was educated to call for help before getting out of bed. The physician and family were notified about her fall. Review of the fall investigation dated 05/31/25 at 5:40 A.M. revealed Resident #88's fall was unwitnessed. Resident #25 was observed on the floor as the nurse walked into resident room to give morning medication. An assessment and neurological checks were done and no injuries were noted at the time. The resident was she was trying to get out of bed when she fell to the floor and denied hitting her head. Resident #88 was oriented to person and place and no predisposing factors were noted. On 06/02/25 the interdisciplinary team (IDT) met in regard to the fall on 05/31/25. Immediate intervention was for Resident #88 to be brought out to the common area; and a long-term intervention was for bilateral floor mats. The physician and family were made aware and the facility would continue to monitor. Review of the fall risk assessment dated [DATE] revealed Resident #25 was at risk for falls and had one to two falls in the last 90 days. Review of the plan of care dated 06/05/25, and reviewed on 08/06/25, revealed Resident #25 was at risk for falls related to impaired cognition, poor safety awareness and psychotropic medications daily. Interventions included bilateral grab bars to the bed for mobility and positioning (initiated 06/05/25), call light within reach and encourage the resident to use it for assistance as needed (initiated 06/05/25), Hoyer lift times two staff for all transfers (initiated 06/05/25), review information on past falls and attempt to determine cause of falls; record possible root causes and alter/remove any potential causes if possible; educate resident/family/caregivers/interdisciplinary team (IDT) as to causes (initiated 06/05/25), and therapy to evaluate and treat as ordered or as needed (initiated (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	06/05/25). Further review of the care plan revealed no interventions related to the resident's bed being in low position, the resident being in the common area, or fall mats. Review of the plan of care dated 06/05/25, and reviewed on 08/11/25, revealed Resident #25 was at risk for falls related to impaired cognition, poor safety awareness and psychotropic medications daily. Interventions included keep the bed in lowest position when occupied (06/02/25), bilateral floor mats when the resident was in bed (06/02/25), bilateral grab bars to the bed for mobility and positioning (06/05/25), keep the call light within reach and encourage the resident to use it for assistance as needed (06/05/25), Hoyer lift times two staff for all transfers (06/05/25), review information on past falls and attempt to determine cause of falls; record possible root causes and alter/remove any potential causes if possible; educate resident/family/caregivers/IDT as to causes (06/05/25), and therapy to evaluate and treat as ordered or as needed (06/05/25). Review of the nurse's notes dated 06/13/25 at 8:01 P.M. revealed LPN #742 was notified by a certified nurse aide (CNA) at 2:50 P.M. that Resident #25 was on the floor lying on her stomach with her legs extended alongside her bed. LPN #742 obtained the resident's vital signs then assisted the resident to bed. Resident #25 was not able to recall how she fell out of bed. The resident's range of motion was assessed and the resident complained of pain all over. LPN #742 contacted emergency medical services (EMS) and Resident #25 was transported to the hospital at 3:52 P.M. The Assistant Director of Nursing (ADON), the resident's son, and the physician were notified. An intervention was implemented for floor mats and the resident was educated on the use of the call light. Review of the fall risk assessments dated 06/13/25 and 07/23/25 revealed Resident #25 was not at risk for falls and had no falls in the last 90 days. Review of the fall investigation for the fall dated 06/13/25 at 2:50 P.M. revealed the fall was unwitnessed in Resident #25's room Resident #25 was on the floor lying on her stomach with her legs extended, lying alongside her bed. Resident #25's vital signs were obtained and staff assisted the resident back to bed. The resident's range of motion was assessed and the resident complained of pain. Resident #25 was transported to the hospital and notifications were made. Resident #25 was oriented to person and situation and predisposing factors included incontinence and gait imbalance. On 06/16/25, the IDT team met to discuss the fall from 06/13/25. A long-term intervention was implemented to encourage Resident #25 to be in the common area when awake and the facility would continue to monitor and follow up. Review of Resident #25's current physician orders for August 2025 on 08/06/25 revealed no orders for fall prevention. Further review of the physician orders revealed on 08/08/25, order were added to Resident #25's physician orders to include use of a Hoyer lift for all transfers and bilateral floor mats. Observation on 08/07/25 at 7:29 A.M. revealed Resident #25 had fall mats in place, the bed was in low position, and the resident was lying in the middle of the bed. An interview on 08/07/25 at 4:33 P.M. with the Director of Nursing (DON), regarding falls, revealed after a fall the nurse should go to the Risk Management tab and the form will prompt them to do a fall assessment and a pain assessment as part of the fall report. The DON stated the facility had a road map book located on each unit with interventions that could be used and falls were reviewed every morning in the morning meeting. The DON stated the majority of the time the MDS assessment updated the care plan immediately or when the IDT note was done. The DON verified the fall notes did not include what interventions were in place during either of Resident #25's falls. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/07/25 at 4:42 P.M. the DON verified the fall intervention in the current care plan did not include low bed or fall mats; however, she was sure those interventions had been added to the care plan after Resident #25's fall on 05/31/25. On 08/07/25 at 4:58 P.M., the DON verified there were no orders for a low bed or fall mats for Resident #25 and she would have them re-entered. Observation on 08/08/25 at 10:44 A.M. revealed Resident #25 was in the common area with four other residents. On 08/08/25 at 11:03 A.M., LPN #742 and ADON #704 looked through Resident #25's electronic medical record and could not find the fall interventions of fall mats, low beds, or encouraging Resident #25 to be in the common room when out of bed. They looked under risk management, orders, and on the medication administration record (MAR) and treatment administration record (TAR). On 08/11/25 at 4:51 P.M., the DON revealed Resident #25's fall care plan was marked Resolved by accident for all the intervention added on 06/02/25 after Resident #25's fall on 05/31/25, and believe it happened on 06/06/25, but were not sure how it happened. On 08/11/25 at 4:57 P.M., the DON verified the Resident #25's fall risk assessments for 06/13/25 and 07/23/25 were not accurate as the resident had falls in the previous 90 days at the time the assessments were completed. On 08/12/25 at 10:48 A.M., the DON revealed the fall care plan had been accidentally marked resolved. The issue had been corrected after the surveyor pointed out the interventions were not in the current care plan. On 08/12/25 at 11:09 A.M., an interview with LPN MDS Nurse #744 revealed after the IDT meeting on 06/02/25 the interventions including bilateral floor mats were added to the care plan. A new MDS nurse went in and resolved the care plans a few days later so, when the care plan was opened it would not show the resolved interventions. 2. Review of Resident #20's medical record revealed an admission date of 06/05/25 and diagnoses included unspecified behavioral and emotional disorders with onset usually occurring in childhood and adolescence, major depressive disorder, anxiety disorder, and congestive heart failure. Review of Resident #20's care plan dated 06/06/25 included Resident #20 was a fall/safety risk related to decreased mobility and behavioral disturbance. Resident #20 would remain free of injuries and falls. Interventions included to keep call bell in reach and encourage use of call light, and instruct Resident #20 on safety measures. Review of Resident #20's annual MDS assessment dated [DATE] revealed Resident #20 had moderate cognitive impairment. Resident #20 did not reject care during the seven-day assessment look-back period. Resident #20 used a manual wheelchair. Resident #20 required partial to moderate assistance for toileting hygiene, bathing, dressing, and personal hygiene. Resident #20 required supervision or touching assistance for the ability to transfer to and from a bed to a chair or wheelchair and toilet transfers. Resident #20 had a fall in the last month prior to admission to the facility. Resident #20 had an indwelling catheter and was always continent of bowel. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #20's fall risk assessment dated [DATE] revealed Resident #20 was at risk for falls. Review of the facility incident log dated 07/28/25 at 11:30 A.M. revealed Resident #20 experienced a fall. Review of Resident #20's progress notes dated 07/28/25 did not reveal evidence Resident #20 experienced a fall at 11:30 A.M. Review of Resident #20's pain assessment dated [DATE] revealed the pain assessment was not completed and did not have anything documented regarding Resident #20's fall and if he had pain. Review of Resident #20's medical record did not reveal a fall risk assessment was completed on 07/28/25. Review of Resident #20's progress notes dated 07/28/25 at 11:48 A.M. revealed the pain medication Tylenol tablet 325 milligrams with instructions to given two tablets by mouth every six hours as needed for pain was administered for complaints of pain to bilateral shoulders. Review of Resident #20's incident report dated 07/28/25 at 11:30 A.M. included Resident #20 had a fall and was found sitting on the floor between his bed and the wheelchair in his room. Resident #20 was wearing non-skid slippers to his feet and was seated on his buttocks with his bilateral lower extremities and feet on the floor mat. There were no visible signs of injury. Resident #20 reported he was trying to use his cane to get into his wheelchair and transfer into the bathroom and complained of pain to his bilateral shoulders and bilateral knees. Resident #20 reported it was chronic pain and denied hitting his head. Resident #20's pain level was reported as a three out of ten, zero being no pain and ten being the worst pain. The report did not reveal if Resident #20's call light was in reach when he fell or if it was activated. Resident #20 was assisted into his wheelchair, vital signs were obtained, and Resident #20 was toileted and assisted back into his wheelchair. There were no vital signs documented in the incident report or progress notes or vital sign record. Resident #20 had a gait imbalance and impaired memory. There were no witness statements provided. The incident report revealed Nurse Practitioner (NP) #811 was notified of Resident #20's fall on 07/28/25 at 12:00 P.M. and Family Member (FM) #812 was notified of Resident #20's fall on 07/28/25 at 2:00 P.M. Review of Resident #20's progress notes dated 07/28/25 at 5:10 P.M. revealed Resident #20's follow-up pain was zero. This was documented more than five hours after the Tylenol was administered. Review of Resident #20's progress notes dated 07/29/25 at 5:01 A.M. included Resident #20 refused neurological checks and would not allow vital signs to be checked throughout the night. Review of Resident #20's incident report dated 07/29/25 revealed the IDT met regarding the fall on 07/28/25 at 11:30 A.M. and the notes included Resident #20 was observed on the floor on his buttocks with legs extended and Resident #20 stated, I was trying to go to the bathroom. Resident #20 was educated on the importance of using the call light for help. The notes did not indicate Resident #20's call light was in reach when he experienced a fall. The long term intervention was for Resident #20 to be toileted prior to lunch. Review of Resident #20's fall risk assessment dated [DATE] revealed Resident #20 was at risk for (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	falls. Observation and interview on 08/06/25 at 9:00 A.M. of Resident #20 revealed he was laying in bed with his eyes closed. Fall mats were observed on each side of his bed. Resident #20 stated he was trying to get his thoughts together and would talk later. Interview on 08/07/25 at 4:31 P.M. of the DON revealed after a fall, a fall risk management form was completed by the nurses. When an incident report was initiated the nurses were prompted to do a pain assessment, fall assessment, and notes were written regarding the fall incident. The DON stated the IDT note was not placed in the resident's medical record, but was found at the bottom of the Risk Management form. The DON stated she would have to print IDT notes for the surveyors because they did not have access to the Risk Management form. The DON stated she would have to print witness statements as well. The DON stated the IDT team met every morning to review things like falls and the residents care plan was updated when the fall was reviewed. The DON indicated when Resident #20 had the fall on 07/28/25 the fall and pain assessments should have been done right after the fall. A reasonable amount of time would be the assessments should be completed up to 72 hours after a fall. The DON said she preferred the fall and pain assessments to be completed immediately. The DON stated post fall assessments used to be completed after a resident fall, but they were not required to be completed at the time Resident #20 had his fall on 07/28/25. Interview on 08/11/25 at 10:31 A.M. of Certified Nurse Aide (CNA) #788 revealed she had no issues caring for Resident #20. CNA #788 stated Resident #20 was not difficult to care for, and it was all in the way a resident was approached. Interview on 08/13/25 at 10:53 A.M. of Unit Manager/Fall Nurse (UM/FN) #745 revealed she was the Fall Nurse. UM/FN #745 confirmed Resident #20 had a fall on 07/28/25 and there was no progress note documenting the fall. UM/FN #745 stated the nurse filled out a progress note on Resident #20's Risk Management form, but the progress note did not automatically transfer to the his electronic health record (EHR). UM/FN #745 stated the nurse would have to manually transfer the progress note from the Risk Management form to Resident #20's progress notes. UM/FN #745 stated Resident #20's fall was unwitnessed and neurological checks were initiated. UM/FN #745 stated she would expect to see a pain assessment and a fall assessment completed after Resident #20's fall and confirmed there was no pain or fall assessment completed on 07/28/25. UM/FN #745 stated Resident #20's pain must have progressed and confirmed there should have been a comprehensive pain assessment completed. UM/FN #745 confirmed there was no fall risk assessment completed until 08/05/25. UM/FN #745 indicated, I was closing out my falls and I completed a post fall assessment on 08/05/25 and that was from the 07/28/25 fall. UM/FN #745 stated vital signs should be taken and documented at the time of the fall and confirmed Resident #20 did not have vital signs documented in his EHR or on the Fall Risk Management form. UM/FN #745 stated, I think the nurse probably did a pain assessment but did not fill out the form. UM/FN #745 indicated she interviewed the staff involved in a fall and took verbal witness statements, but did not write anything down. UM/FN #745 confirmed she could not provide witness statements for Resident #20's fall on 07/28/25. UM/FN #745 indicated, I do not document verbal statements except for what the nurse says and what the nurse aide says. The IDT reviewed falls the next day and an intervention was put in place. UM/FN #745 revealed she did not always have interviews with the nurse and nurse aides involved in falls before the IDT clinical meeting, but followed up after and made sure everything lined up. 3. Record review revealed Resident #24 was most recently admitted to the facility on [DATE]. Diagnoses include acute respiratory failure with hypoxia, syncope and collapse, and end stage renal (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	disease. Review of the MDS assessment dated [DATE] revealed Resident #24 had moderately impaired cognitive deficit. He required substantial to maximal assistance from staff for toileting hygiene, shower, upper and lower body dressing, and donning and doffing footwear. Review of Resident #24's care plan dated 06/24/25 revealed he was at risk for falls related to gait/balance problems and history of falls. An interventions included bilateral floor mats, ensure the call light was within reach and encourage to use it for assistance as needed, and sit in the common area when out of bed. Observation on 08/06/25 at 10:13 A.M. revealed a fall mat to one side of Resident #24's bed that was situated in the middle of the wall leaving the other side of the bed with no fall mat. Observation on 08/07/25 at 11:15 A.M. revealed Resident #24 had one fall mat on one side of his bed and no fall mat on the other side of the bed. His bed was not against the wall but was situated in the middle of the wall. Observation and interview on 08/11/25 at 2:25 P.M. revealed Resident #24 was going to take a nap and the bed was situated in the middle of the wall with one fall mat on one side of the bed and no fall mat on the other side of the bed. Observation on 08/12/25 at 9:15 A.M. revealed one fall mat by one side of the bed and no fall mat on the other side of the bed. Resident #24 was in bed resting. Observation on 08/12/25 at 10:18 A.M. revealed Resident #24 had only one fall mat on one side of bed with no fall mat on the other side of his bed. Interview on 08/12/25 at 10:18 A.M. with LPN #738 and Registered Nurse (RN) #799 verified there was only one fall mat on one of Resident #24's bed and no fall mat on the other side of the bed. Review of the facility policy titled, Fall Management, revised 12/2022, revealed if a fall occurred the licensed nurse would assess the resident for injury from the fall immediately and initiate an investigation of the reason for the fall and implement an immediate intervention to attempt in preventing future falls. The licensed nurse would update the Fall Risk and Pain Assessment at the time of the fall. Review of the facility policy titled, Accidents and Hazards, revised 11/2022, included when an unusual occurrence or accident/hazard occurred within the facility, the licensed nurse would immediately assess the resident for injury. The licensed nurse would open a risk management report and gather interview statements from the appropriate facility staff, resident and, or family, visitor. The licensed nurse would document a brief description of the accident, incident in the medical record. The licensed nurse would notify the physician and the resident, responsible party and document the notification in the medical record. This deficiency represents non-compliance investigated under Master Complaint Number 2564323, Complaint Number OH00166853 (1254633), and Complaint Number OH00166806 (1254522).		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and policy review, the facility failed to ensure residents were provided with timely incontinence care. This affected two (#5 and #77) of four residents reviewed for bowel and bladder incontinence. The census was 87. Findings include:1. Review of Resident #5's medical record revealed an admission date of 08/19/22 and diagnoses included cerebral infarction, hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side, and type two diabetes mellitus without complications. Review of Resident #5's care plan revised 06/19/24 included Resident #5 had bowel and bladder incontinence related to decreased mobility, use of diuretic therapy, and cognitive impairment. Resident #5 would establish an individual bowel and bladder routine. Interventions included bowel protocol as ordered; briefs, depends or pantliners when out of bed; check for incontinence every two hours and as needed; and toileting per request and as needed. Review of Resident #5's care plan revised 11/25/22 included Resident #5 had a behavior problem related to aggression and verbal threatening of nursing staff. Resident #5 would have fewer episodes by the review date of 10/18/25. Interventions included to anticipate and meet needs; educate family and caregivers on successful coping and interaction strategies; explain all procedures before starting; and allow Resident #5 to adjust to changes. Review of Resident #5's annual Minimum Data Set (MDS) assessment dated [DATE] included Resident #5 had severe cognitive impairment. Resident #5 had upper and lower extremity impairment on one side. Resident #5 used a wheelchair. Resident #5 required substantial to maximal assistance for toileting hygiene, upper body dressing, and personal hygiene. Resident #5 was dependent for lower body dressing, bathing and the ability to transfer to and from a bed to a chair or wheelchair. Resident #5 was always incontinent of urine and bowel. Resident #5 did not reject care during the seven-day assessment look-back period. Observation on 08/06/25 at 9:49 A.M. of Registered Nurse (RN) #798 revealed she was standing at the medication cart in the hall of the lower level nursing unit and was preparing resident medications for administration. Resident #5 was heard yelling out for help and RN #798 was in the middle of a resident medication administration and did not indicate she heard Resident #5 yelling for help. Continued observation for the next ten minutes revealed Resident #5 periodically yelled for help. During the ten minutes, Certified Nurse Aide (CNA) #785 walked by Resident #5's room several times, and he yelled for help when CNA #785 walked by the room, but CNA #785 did not enter his room to find out why he was yelling. CNA #785 did not find RN #798 to let her know Resident #5 was yelling for help. Interview with RN #798 during the observation on 08/06/25 at 9:49 A.M. RN #798 stated Resident #5 probably needed changed, and the nurse walked into Resident #5's room and asked Resident #5 what she could do to help him. Resident #5 stated he had a bowel movement and needed his incontinence brief changed. Resident #5 was very upset and angry, and stated he needed changed and had been asking for awhile to get changed. Resident #5 stated he had been waiting since last night for someone to help him. RN #798 stated she would provide his incontinence care right now and proceeded to gather supplies to change his brief. Further observation revealed Resident #5 had a moderate sized formed bowel movement and his buttocks were excoriated and reddened. RN #798 provided appropriate incontinence care and applied barrier cream to his buttocks including the reddened and excoriated areas. Interview on 08/06/25 at 10:17 A.M. of CNA #785 revealed Resident #5 had behaviors if something did not go his way. CNA #785 stated she heard Resident #5 yelling for help but Resident #5 did not want her in his room and she did not go in his room. CNA #785 indicated the nurse took care of him or someone from the other side. CNA #785 confirmed no nurse aide went in Resident #5's room since she arrived for work at 7:00 A.M. CNA #785 stated she walked by his room that morning and did not go in even when he was yelling. Interview on 08/06/25 at 4:27 P.M. of RN #798 revealed when she was asked about CNA #785 walking by Resident #5's room without going in (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to see what he needed RN #798 stated the young nurse aides a lot of the time do not have patience and try to hurry the resident along and it upset him. Interview on 08/07/25 at 8:07 A.M. of the Director of Nursing (DON) revealed if Resident #5 was rude to a nurse aide it was not okay for the aide to not provide care for him. The DON stated it was not okay for CNA #785 to walk by his room, and not go in to see what he needed if he was screaming for help. The DON indicated at that point CNA #785 should find the nurse. The DON stated someone should have gone in Resident #5's room to see what he needed and make sure he was safe. The DON stated CNA #785 should not walk past someone yelling for help. Review of Resident #5's nurse aide charting dated 08/05/25 at 6:59 P.M. revealed Resident #5 was provided care for urinary and bowel incontinence and there was no additional documentation until 08/07/25 at 6:59 A.M. when Resident #5 was provided care for urinary incontinence. There was no evidence of aide documentation on 08/06/25.2. Review of Resident #77's medical record revealed an admission date of 05/04/22 and diagnoses included other sequelae of cerebral infarction, hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side, and vascular dementia. Review of Resident #77's care plan revised 04/08/25 included Resident #77 was incontinent of bowel and bladder. Resident #77's skin would remain intact through the review date. Interventions included to check Resident #77 every two hours and assist with toileting as needed and provide peri-care after each incontinent episode. Review of Resident #77's MDS assessment dated [DATE] revealed Resident #77 had severe cognitive impairment. Resident #77 was dependent for toileting hygiene, personal hygiene, bathing and lower body dressing. Resident #77 used a manual wheelchair. Resident #77 was always incontinent of urine and bowel. Resident #77 did not reject care during the seven-day assessment look-back period. Observation on 08/07/25 at 7:29 A.M. revealed Resident #77 was sitting in a wheelchair in the common area. Observation on 08/07/25 at 11:34 A.M. revealed Resident #77 was sitting in a wheelchair in the common area and her head was down and almost touching her legs. Observation and interview on 08/07/25 at 2:51 P.M. of Resident #77 revealed she was sitting in a wheelchair in the common area, her head was down and touching her lap. CNA #752 pushed Resident #77's wheelchair to her room and stated Resident #77 looked tired. CNA #752 stated Resident #77 was assisted out of bed into her wheelchair by the night shift nurse aides and she usually went back to bed around 3:00 P.M. CNA #752 indicated this was the first time Resident #77's incontinence brief was changed today and was the first time she was in bed. Resident #77 was wearing a yellow incontinence brief and when it was removed it was very wet and CNA #752 stated Resident #77 probably urinated two times in it. A green incontinence brief was in Resident #77's room and CNA #752 picked it up and started putting it on Resident #77. The brief appeared too big for Resident #77 and when asked CNA #752 stated the green brief was too big for Resident #77. CNA #752 found a yellow brief in Resident #77's room and stated it seemed like the right size for the resident. Review of the facility policy titled, Incontinence Care, dated 12/2022, revealed staff were to ensure a resident who was incontinent of bowel and/or bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. Review of the facility policy titled, Activities of Daily Living (ADLs), dated 03/2023, revealed the purpose was to specify the responsibility to create and sustain an environment that humanizes and individualizes each resident's quality of life by ensuring all staff, across all shifts and departments, understand the principles of quality of life, and honor and support these principles for each resident; and that the care and services provided were person-centered, and honor and support each resident's preferences, choices, values and beliefs. A resident who was unable to carry out activities of daily living would receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This deficiency represents non-compliance investigated under Master Complaint 2564323, Complaint Number OH00167095 (1253634), Complaint Number OH00166806 (1254522), Complaint Number OH00166853 (1254633), Complaint Number OH00167217 (1254635), Complaint Number OH00164532 (1254632), and Complaint Number OH00162468 (1254628).		

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Centers for Medicare & Medicaid Services

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NAME OF PROVIDER OR SUPPLIER Avenue Care and Rehabilitation Center, The		STREET ADDRESS, CITY, STATE, ZIP CODE 4120 Interchange Corporate Center Road Warrensville Heights, OH 44128	
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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, staff interview, and policy review, the facility failed to ensure resident oxygen tanks were stored in a secured manner. This affected three (#57, #75, and #30) of 45 residents who resided on the first floor of the facility. The facility census was 87. Findings include: 1. On 08/06/25 at 1:25 P.M., observation with Maintenance Supervisor (MS) #748 revealed one free standing oxygen tank not properly chained or supported in a proper cylinder stand or cart in Resident #57's room [ROOM NUMBER]. On 08/07/25 at 12:34 P.M., observation made during the tour of the facility with MS #748 revealed one free standing oxygen tank not properly chained or supported in a proper cylinder stand or cart in Resident #75's room. 3. On 08/07/25 at 12:54 P.M., observation made during the tour of the facility with the MS #748 revealed one free standing oxygen tank not properly chained or supported in a proper cylinder stand or cart in Resident #30's room. Interview with MS #748 verified the unsecured oxygen tanks in Resident #57, Resident #75, and Resident #30's room at the times of discovery. Review of the policy titled, Oxygen Storage, revealed units must be stored upright and not wrapped in plastic or other material. Portable units should be stored off the floor. E-tanks must be stored in a cart rack or chained to a wall.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on medical record review and staff interview, the facility failed to ensure an antibiotic medication was administered as ordered. This affected one (#102) of two residents reviewed for urinary tract infections. The census was 87. Findings include: Review of the medical record for Resident #102 revealed an admission date of 05/01/25. Diagnoses included cellulitis of the left lower limb, pain in the left and right legs, anxiety disorder, and glaucoma. The resident discharged against medical advice (AMA) to an independent living facility on 07/22/25. Review of the Minimum Data Set (MDS) assessment, dated 05/08/25, revealed Resident #102 had intact cognition. The resident required supervision or touching assistance for dressing and mobility, used a walker and a wheelchair, and was occasionally incontinent. Review of Resident #102's physician orders for June 2025 revealed the resident was ordered a urinary analysis (UA) collection one time only for possible urinary tract infection (UTI) on 06/07/25 at 8:00 P.M.; the medication to treat UTI symptoms Pyridium oral tablet 100 milligrams (mg) with instructions to take by mouth two times a day for urinary urgency for two days on 06/13/25 at 8:00 P.M.; and the antibiotic Fosfomycin tromethamine oral packet three (3) grams (gm) with instructions to give one packet by mouth in the morning every Tuesday, Friday, and Sunday for three admissions ordered on 06/13/25 at 7:00 A.M. and discontinued on 06/16/25. The Fosfomycin tromethamine 3 gm oral packet was reordered on 06/16/25 and started 06/17/25. Review of Resident #102's laboratory report revealed a urine sample was collected on 06/07/25 and received on 06/10/25. Further review of the a report revealed on 06/12/25 the resident's urine was positive for a UTI and antibiotic recommendations were given. Review of the nurse's notes dated 06/12/25 at 3:17 P.M. revealed Resident #102 was educated on the new order for an antibiotic and the medication would be in that night. Review of Resident #102's nurse's notes dated 06/15/25 at 12:07 P.M. noted Fosfomycin tromethamine 3 gm oral packet was not available. Review of Resident #102's medication administration record (MAR) for June 2025 revealed Fosfomycin tromethamine 3 gm oral packet was marked as See nurse notes on Friday 06/13/25 and Sunday 06/15/25. The medication was not available and the resident did not receive the medication until 06/17/25. On 08/11/25 at 10:21 A.M. Assistant Director of Nursing (ADON) #704 revealed on Friday, 06/13/25 Resident #102's Fosfomycin tromethamine was to be started and given Tuesday, Friday, and Sunday and stated it was not available. ADON #704 confirmed the medication was given Friday, 06/13/25 or Sunday, 6/15/25. On Monday, 6/16/25 ADON #704 caught the problem, contacted the nurse practitioner (NP), had the medication reordered, and the first dose was given on Tuesday, 06/17/25. On 08/11/25 at 4:51 P.M. the Director of Nursing (DON) verified the antibiotic for Resident #102 had not been given until 06/17/25. This deficiency represents non-compliance investigated under Complaint Number OH00166711 (1254468), Complaint Number OH00164532 (1254632), Complaint Number OH00163811 (1254630), and Complaint Number OH00166806 (1254522).		

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and policy review, the facility failed to obtain laboratory values as ordered and failed to notify the physician of laboratory results as required. This affected one (#59) of two residents reviewed for urinary tract infections. The census was 87. Findings include: Review of Resident #59's medical record revealed an admission date of 10/20/17 and a re-entry date of 04/10/25. Resident #59's diagnoses included chronic obstructive pulmonary disease, asthma, hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side. Review of Resident #59's care plan dated 11/05/24 included Resident #59 had a suprapubic catheter related to obstructive uropathy diagnosis. Resident #59 would remain free from catheter related trauma through the review date. Interventions included to monitor, record, and report to the physician signs and symptoms of a urinary tract infection such as pain, burning, blood tinged urine, cloudiness etcetera; and monitor for signs and symptoms of discomfort on urination and frequency. Review of Resident #59's physician orders dated 11/22/24 revealed staff were to obtain Resident #59's urine and send it to the laboratory for a urinalysis with culture and sensitivity. Review of Resident #59's progress notes and medication and treatment administration record's dated 11/11/24 through 11/26/24 did not reveal evidence Resident #59 had a urine culture ordered and did not reveal evidence a urine specimen was collected and sent to the laboratory for a culture and sensitivity. Review of Resident #59's physician orders dated 11/26/24 revealed for staff to collect urine for a urinalysis and culture and sensitivity. Discontinue the order once the urine was collected. Review of Resident #59's progress notes dated 11/26/24 at 1:06 P.M. included, per the family request, a urine specimen for urinalysis and culture and sensitivity was ordered by an unidentified nurse practitioner. Review of Resident #59's laboratory report revealed a urine swab was collected on 11/27/24, received at the laboratory on 11/30/24 and the report dated was 12/01/24. Pathogens detected were enterococcus faecalis 1×10^7 copies per uL (10,000,000 copies per microliter). The first line medication recommended was the antibiotic doxycycline by mouth 100 milligrams (mg) every twelve hours for ten days. Review of Resident #59's progress notes dated 12/03/24 at 5:59 P.M. included Resident #59's urine culture and sensitivity results from 12/01/24 were reported to the nurse practitioner and new orders were given for doxycycline 100 mg with instructions give two times a day for ten days. Review of Resident #59's physician orders dated 12/03/24 revealed doxycycline hyclate oral tablet 100 mg with instructions to give one capsule by mouth two times a day for a urinary tract infection (UTI) for ten days until 12/13/24. Review of Resident #59's medication administration record (MAR) dated 12/03/24 revealed Resident #59's first tablet of doxycycline 100 mg (doxycycline hyclate) was administered at bedtime. Review of Resident #59's progress notes and physician orders dated 12/03/24 through 12/17/24 did not reveal evidence a urine specimen for urinalysis and culture and sensitivity was ordered and collected. There was no evidence the physician or nurse practitioner were notified of the laboratory results for Resident #59's urine culture reported on 12/06/24. Review of Resident #59's laboratory results report revealed a urine for urinalysis and culture and sensitivity was collected on 12/03/24, received at the laboratory on 12/03/24, and the report date was 12/06/24. The report included Resident #59's urine had greater than 100,000 CFU per ml (colony forming units) of enterococcus faecalis. Review of Resident #59's physician progress notes dated 12/07/24 and written by Nurse Practitioner (NP) #810 included Resident #59's urine culture was positive for a urinary tract infection and he was started on doxycycline. Resident #59 had an indwelling catheter. Review of Resident #59's quarterly Minimum Data Set (MDS) assessment dated [DATE] included Resident #59 was cognitively intact. Resident #59 did not reject care during the seven-day assessment look-back period. Resident #59 used a wheelchair. Resident #59 used a mechanical lift and was a two staff assist for transfers. Resident (continued on next page)		

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#59 required the assistance of one staff member for bathing and bed mobility. Interview on 08/12/25 at 10:19 A.M. of the Director of Nursing (DON) revealed Resident #59's physician should have been notified as soon as possible after his urine culture results were reported by the laboratory. The DON confirmed Resident #59's urine culture results were reported on 12/01/25, but the physician was not notified until 12/03/25. The DON did not know why there was a two day delay for Resident #59's urine culture results to be reported to the physician, and there should have been a progress note about it. The DON confirmed Resident #59 had a urine specimen for urinalysis and culture and sensitivity collected on 12/03/25 and there was no order in his record or progress note regarding the urine specimen. The DON was unable to explain why the urine specimen was collected on 12/03/25. The DON confirmed Resident #59 had a urine for urinalysis and culture and sensitivity ordered on 11/22/24, and there was no evidence the urine was collected and sent to the laboratory. Interview on 08/12/25 at 2:05 P.M. of NP #801 revealed if she ordered Resident #59's urine for urinalysis and culture and sensitivity she would expect it to be collected within 48 hours. NP #810 stated if she ordered Resident #59's urine specimen for urinalysis and culture and sensitivity twice it was probably because she was frustrated that she had not received the report and ordered it again. NP #810 stated she could not remember the details because it was awhile ago. NP #810 indicated she did not know there was a delay of two days for reporting Resident #59's urine culture results and hoped a member of the physician team would have been called with the results and would have responded on 12/01/25 with an antibiotic order if they felt it was appropriate. NP #810 stated she would have wanted to treat Resident #59's infection as soon as possible and did not have an explanation for the two delay from 12/01/25 through 12/03/25. Review of the facility policy titled, Resident Change in Condition, dated 07/28/22, included the purpose was to ensure staff provided timely and appropriate care and services when residents experience a change in condition that had or was likely to cause adverse negative health outcomes. The facility would promptly notify the resident, his or her attending physician and responsible party of changes in the resident's condition and, or status. 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. This deficiency represents non-compliance investigated under Complaint Number OH00166711 (1254468).		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, medical record review, interview, and policy review, the facility failed to ensure personal protective equipment (PPE) was utilized when providing care for residents on enhanced barrier precautions and failed to handle contaminated items in a safe manner. This affected one (#95) of two residents observed for infection control precautions. The facility census was 87. Findings include: Review of Resident #95's medical record revealed an admission date of 06/18/24 and diagnoses included type two diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral, end stage renal disease, and depression. Review of Resident #95's care plan revised 04/15/25 included Resident #95 required enhanced barrier precautions to reduce transmission of multidrug resistant organisms (MDROs) related to hemodialysis. Resident #95's enhanced barrier precautions would be maintained through the review period. Interventions included to use disposable gowns and gloves during high contact care activities. Observation on 08/05/25 at 10:00 A.M. of Resident #95's room revealed a sign posted outside his room which revealed enhanced barrier precautions were in place and indicated everyone must clean their hands, including before entering and when leaving the room. Providers and staff must also wear gloves and a gown for high-contact resident care activities including dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use including central line, urinary catheter, feeding tube, tracheostomy, wound care, and any skin opening requiring a dressing. Observation and interview on 08/05/25 at 10:00 A.M. of Certified Nurse Aide (CNA) #772 providing Resident #95's morning and incontinence care revealed CNA #772 did not put on an isolation gown before providing morning and incontinence care for Resident #95. CNA #772 picked up Resident #95's bed linens and dropped them directly on the floor without placing them in a plastic bag or other container. CNA #772 picked the bed linens off the floor and placed them directly on the foot of Resident #95's bed without using a plastic bag. CNA #772 picked the bed linens off the foot of the bed and placed them on top of a small trash can before placing bed linens in a plastic bag. CNA #772 confirmed she dropped Resident #95's bed linens on the floor without using a plastic bag and picked them up and placed them on his bed without using a plastic bag. When asked if she saw the enhanced barrier precaution sign outside Resident #95's door, CNA #772 stated she did not know where the supplies were and confirmed she did not don an isolation gown before providing care for Resident #95. CNA #772 showed the surveyor a closet where PPE supplies were kept. Interview on 08/05/25 at 10:05 A.M. of Assistant Director of Nursing (ADON) #704 revealed she was Infection Preventionist for the facility. ADON #704 stated she talked to CNA #772, and said the CNA was confused and did not understand what the surveyor was asking her. ADON #704 stated CNA #772 knew where PPE supplies inside the door of Resident #95's room. Review of the Isolation Categories of Transmission-Based Precautions policy, revised September 2022, revealed staff and visitors were to wear gloves and disposable gowns upon entering the room and remove before leaving the room and perform hand hygiene before leaving the room.		

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on medical record review and staff interview, the facility did not ensure residents received COVID immunizations as requested. This affected three (#66, #86, and #55) of the eight residents reviewed for COVID immunizations. The census was 87. Findings include:1. Review of the COVID-19 vaccine informed consent form for Resident #66 revealed the form was reviewed verbally and was dated 10/28/24; however, the form did not specify if Resident #66 consented or refused the vaccine. Review of the medical record for Resident #66 revealed a COVID-19 vaccine had not been given since 05/23/23.2. Review of the COVID-19 vaccine informed consent form dated 02/20/24 for Resident #86 revealed verbal consent to receive the vaccine was provided by the power of attorney (POA). Review of the medical record revealed Resident #86 never received a COVID-19 vaccine.3. Review of the COVID-19 vaccine informed consent form dated 10/28/24 for Resident #55 revealed verbal consent to receive the vaccine was provided by the resident. Review of the medical record for Resident #55 revealed a COVID-19 vaccine had not been given since 12/14/22. Interview on 08/11/25 at 12:57 P.M. with the Infection Preventionist revealed COVID-19 vaccines were only administered by her but was unable to provide any additional documentation related to Resident #66, Resident #86, and Resident #55's COVID-19 vaccine status. The Infection Preventionist was not able to provide any further information as to why Resident #66, Resident #86, and Resident #55's COVID-19 vaccine were not given when informed consent was provided. Interview on 08/13/25 at 2:12 P.M. with Resident #86 revealed she was unable to recall if the COVID-19 vaccine was received. Residents #55 and #66 were unable to confirm receipt of the COVID-19 vaccine due to cognitive impairment.		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation, staff interview, and review of manufacturer's instructions, the facility failed to ensure side rails were securely attached and in place to prevent resident entrapment or other accidents. This deficient practice affected three (#50, #55, and #79) of 22 residents who utilized side rails for safety. The census was 87. Findings included: Observation during an environmental tour conducted on 08/06/25 between 1:00 P.M. and 1:55 P.M. with Maintenance Supervisor (MS) #748 revealed the side rails on the beds of Resident #50, Resident #55, and Resident #79 were not secure, were extremely loose, and were not tightly affixed to the sides of the beds. Interview with MS #748 at the time of discovery confirmed the side rails were loose and not securely attached to Resident #50, Resident #55, and Resident #79's beds. Review of the undated manufacturer's instructions for the bed rails utilized by Resident #50, Resident #55, and Resident #79 revealed after any adjustments, repair or service and before use, make sure all attaching hardware is tightened securely.		

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation and staff interview, the facility failed to ensure the posted nursing staff information was up to date as required. This deficient practice had the potential to affect all 87 residents residing in the facility. The facility census was 87. Findings include: Observation of the posted nursing staff information on 08/11/25 at 6:20 A.M. revealed the posting was dated 08/08/25, three days prior to the date of observation. Interview with the Administrator on 08/11/25 at 6:25 A.M. confirmed the nursing staff posting was not current.		