STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366407	A. Building B. Wing	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenue at Medina	699 East Smith Road Medina, OH 44256

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based on record reviews, interviews, review of the State Board of Pharmacy investigation and facility policy review, the facility failed to ensure medications were safeguarded in accordance with accepted professional standards of practice when a licensed nurse diverted (stole) non-narcotic medications belonging to 10 residents without knowledge of facility administration. This affected 10 (Residents #6, #39, #43, #78, #79, #80, #81, #82, #83, #84) of 65 residents reviewed for medications.Findings include:1. Review of medical record for Resident #6 noted an admission date of 04/25/25. Diagnoses included generalized anxiety disorder and major depressive disorder. Resident #6 had impaired cognition.Review of the medication administration record (MAR) noted Resident #6 was receiving hydroxyzine (antianxiety) 12.5 milligrams (mg) dated 04/16/25 through 04/22/25 three times a day. 2. Review of medical record for Resident #39 noted an admission date of 12/04/24. Diagnosis included low back pain. Resident #39 had impaired cognition.Review of the MAR noted Resident #39 was receiving Macrobid (antibiotic) 100 mg dated 04/18/25 twice a day for seven days.3. Review of medical record for Resident #43 noted an admission date of 03/19/19. Diagnosis included unspecified dementia. Resident #43 had impaired cognition.Review of the MAR noted Resident #43 was receiving cephalexin (antibiotic) 250 mg dated 04/14/25 one time a day for three days.4. Review of medical record for Resident #78 noted an admission date of 12/04/24 and a discharge date of 01/21/25. Diagnoses included acute kidney failure, cerebral infarction due to unspecified occlusion or stenosis of precerebral arteries. Resident #78 had impaired cognition.Review of the MAR noted Resident #78 was receiving Levsin (antispasmodic) 0.125 mg dated 01/15/25 as needed.5. Review of medical record for Resident #79 noted an admission date of 06/06/26 and a discharge date of 06/15/25. Diagnoses included acute embolism and thrombosis of unspecified deep veins of the right-lower extremity. Resident #79 had impaired cognition.Review of the MAR noted Resident #79 was receiving prednisone (steroid) 7.5 mg dated 06/07/25 daily.6. Review of medical record for Resident #80 noted an admission date of 05/24/25 and discharge date of 05/28/25. Diagnoses included metabolic encephalopathy and adult failure to thrive. Resident #80 had impaired cognition.Review of the MAR noted Resident #80 was receiving hydroxyzine (antihistamine) 12.5 mg as needed dated 05/25/25 through 06/03/25 for anxiety.7. Review of medical record for Resident #81 noted an admission date of 05/12/25 and a discharge date of 08/25/25. Diagnoses included chronic obstructive pulmonary disease and type two diabetes mellitus. Resident #81 had impaired cognition.Review of the MAR noted Resident #81 was receiving Macrobid (antibiotic) 50 mg dated 12/28/24 through 05/07/25 at bedtime for prophylaxis.8. Review of medical record for Resident #82 noted an admission date of 03/27/25 and a discharge date of 04/11/25. Diagnoses included cerebral infarction and neoplasm of the trachea and thyroid gland. Resident #82 had impaired cognition.Review of the MAR noted Resident #82 was receiving cephalexin (antibiotic) 250 mg dated 02/20/25 three times a day.9. Review of medical record for Resident #83 noted an admission date of 08/09/25 and a discharge date of 08/17/25. Diagnoses included acute and chronic respiratory failure and type two diabetes mellitus. Resident #83 had (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366407	A. Building B. Wing	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenue at Medina	699 East Smith Road Medina, OH 44256

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	intact cognition.Review of the MAR noted Resident #83 was receiving scopolamine (antiemetic) patch dated 07/05/25 through 07/07/25 in the morning every three days.10. Review of medical record for Resident #84 noted an admission date of 02/14/25 and a discharge date of 02/22/25. Diagnoses included fracture of left femur, chronic kidney disease and artificial hip joint. Resident #84 had impaired cognition.Review of the MAR noted Resident #84 was receiving cefadroxil (antibiotic) 500 mg dated 02/14/25 through 02/24/25 two times day for prophylaxis.Review of investigation dated 07/21/25 noted the State Pharmacy Board was informed by the local law enforcement agency of a probable drug diversion by Licensed Practical Nurse (LPN) #201. The local law enforcement agency stated LPN #201 was found with 31 blister packs of various medications belonging to 20 different residents, two pill bottles containing white powder, and one transdermal patch. Further review noted medications belonged to 10 residents (#6, #39, #43, #78, #79, #80, #81, #82, #83, #84) who resided or were currently residing at the facility.Interview on 02/11/26 at 8:15 A.M., the Administrator stated the State Board of Pharmacy came in on 10/20/25 to investigate medications and medication storage. The Administrator stated the investigator did not provide names of the residents or medications taken from the facility. The Administrator stated she did not complete a self-reported incident (SRI) to the State agency due to lack of information.Interview on 02/18/26 at 8:34 A.M., the Director of Nursing (DON) could not provide adequate information related to the diversion of medications. This was observed when the DON first stated she was not the DON at the time of investigation. The DON then stated she was kept in the dark about the investigation for a while and could not provide information. The DON stated she was hired in August of 2025.Interview on 02/18/26 the Administrator stated Pharmacy Investigator (PI) #302 met with her and did not provide any resident names or medications taken. The Administrator stated she left the meeting thinking the diversion happened at another facility. Interview on 02/18/26 at 9:05 A.M., PI #302 stated she completed an investigation on 10/20/25 related to possible diversion of medications form the facility. PI #302 stated she sat with the DON and Regional Quality Assurance Nurse (RQAN) #304 and confirmed a list of residents residing at the specific facility. Review of an email sent to the DON from the Pharmacy Board dated 10/20/25 indicated a former employee was found in possession of numerous patient specific medications. The medications were able to be removed from the facility without anyone noticing or reporting the theft to the Board of Pharmacy.Review of the facility policy titled Abuse Prohibition, revised in 2022, noted allegations of misappropriation of resident property must be reported, thoroughly investigated and actions taken including diversion of resident medications. This deficiency represents non-compliance investigated under Complaint Number 2692061.