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 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 (continued on next page)

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

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident and staff interviews, the facility failed to code resident Minimum Data Set (MDS) assessments accurately. This affected three (Residents #2, #8, and #43) of 15 sampled residents reviewed for accuracy of MDS assessments. The facility census was 65.Findings include:1. Review of the medical record revealed Resident #2 was admitted to the facility on [DATE] with diagnoses that included major depressive disorder, anxiety disorder and hypotension. Review of the admission assessment of the MDS 3.0 assessment dated [DATE] revealed Resident #2 was moderately cognitively impaired and required moderate assistance with activities of daily living (ADL).Further review of the admission MDS section N revealed that Resident #2 received one shot injection and one dose of insulin.Further review of the medical record for Resident #2 revealed that he did not have any orders for insulin.Interview on 02/11/2026 at 1:31 P.M. with MDS Nurse #139 stated that the one injection that Resident #2 received was a one-time dose of an antibiotic and was accidentally marked as insulin. 2. Review of the medical record revealed Resident #8 was admitted to the facility on [DATE] with a readmit date of 01/03/25. Diagnoses that included major depressive disorder, anxiety disorder and Alzheimer's disease. Review of the admission assessment of the MDS 3.0 assessment dated [DATE] revealed Resident #8 was severely cognitively impaired and required substantial assistance with ADL.Further review of the admission MDS section N revealed that Resident #8 received a hypnotic.Further review of the medical record for Resident #2 revealed that he did not have any orders for hypotonic medication.Interview on 02/11/2026 at 2:11 P.M. with MDS Nurse #139 verified that Resident #8 did not receive a hypnotic at the time during the look back period.3. Review of the medical record revealed Resident #43 was admitted to the facility on [DATE] with diagnoses that included major depressive disorder, pruritus, and Alzheimer's disease. Review of the annual assessment of the MDS 3.0 assessment dated [DATE] revealed Resident #43 was severely cognitively impaired and required substantial assistance with ADL.Further review of the admission MDS section J revealed that a fall with major injury was not reflected in her MDS assessment.Further review of the medical record for Resident #43 revealed that she sustained a fall on 12/05/26.Interview on 02/17/26 at 11:04 A.M. MDS Nurse #139 verified that the annual MDS dated [DATE] should have reflected that Resident #43 had a fall with major injury on 12/05/25.

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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 record review and interview, the facility failed to ensure laboratory tests were obtained per physician's order. This affected one (Resident #2) of three residents reviewed for laboratory findings. The facility census was 65.Findings include:Review of the medical record revealed Resident #2 was admitted to the facility on [DATE] with diagnoses that included major depressive disorder, anxiety disorder and hypotension. Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #2 was moderately cognitively impaired and required moderate assistance with activities of daily living (ADL).Review of the progress note dated 02/07/26 at 5:42 A.M. revealed Resident #2 presented with amber colored urine. A urine sample was obtained and a dipstick performed with abnormal results. The physician was notified and ordered a urine analysis (UA) as well as a culture and sensitivity (C&S) for 02/09/26.Review of the physician's orders for February 2026 revealed that UA C&S were ordered for 02/09/26 and not completed until 02/10/26.Interview on 02/10/26 at 11:07 A.M. with Director of Nursing (DON) stated that the lab does not pick up urine on the weekend, so the physician put the order to be picked up on 02/09/26. The DON stated that the results usually come back within 24 to 48 hours, but she did not see any results yet. Interview on 02/17/26 at 10:00 A.M. with DON revealed that she spoke to physician on 02/11/26 to discontinue the order for the UA C& S because the hematuria stopped, so it was not completed.Interview on 02/17/26 at 10:51 A.M. with Regional Nurse #301 revealed that the order for UA C & S for Resident #2 was never completed. Interview on 02/17/26 at 12:37 P.M. with DON stated that there was no policy for obtaining labs.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility did not ensure residents received COVID immunizations as requested. This affected one (Resident #43) of the five residents reviewed for COVID immunizations. The facility census was 65.Findings include:Review of the medical record revealed Resident #43 was admitted to the facility on [DATE] with diagnoses that included major depressive disorder, pruritus, and Alzheimer's disease. Review of the annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #43 was severely cognitively impaired and required substantial assistance with activities of daily living (ADL).Review of the COVID consent form dated 10/13/25 for Resident #43 revealed that her power of attorney (POA) verbally gave consent for Resident #43 to receive the COVID vaccine, and it was witnessed by two nurses.Further review of the medical record for Resident #43 revealed that she did not get the COVID vaccine.Interview on 02/11/26 at 1:31 P.M. with MDS Nurse #139 verified that Resident #43 consented to the COVID vaccine, and there was no documented evidence that Resident #43 received the vaccine or that Resident #43 refused administration of the COVID vaccine.