STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366463	A. Building B. Wing	05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenue at Wooster	1700 East Smithville Western Road Wooster, OH 44691

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 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 , medical record review, review of policy, staff interviews and resident interview, the facility failed to ensure a resident who required physical assitance to get out of bed waa provided timely assitance. This affected one (#34) of three residents observed for assitance. The facility census was 79.Findings include: Review of the medical record for Resident #34 revealed an admission date of 06/05/25. Diagnoses included traumatic subdural hemorrhage, major depressive disorder, and anxiety disorder. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #34 had moderately impaired cognition and was a substantial assistance for transfer. Observation and interview on 05/19/26 at 9:50 A.M. with Resident #34 revealed that he was lying in bed and had the call light being activated. Resident #34 stated that he just pressed the call light and he was ready to get out of bed. Resident #34 stated that he needed staff for transfers, but he was not a Hoyer lift anymore. Observation and interview on 05/19/26 at 9:52 A.M. revealed that Certified Nursing Assistant (CNA) #200 answered the call light, turned it off, and stated that she would have to get someone to assist her with the transfer. Observation on 05/19/26 at 10:25 A.M. revealed Resident #34's was lying in bed, and his call light was not activated. Resident #34 decided to activate the call light again. Observation on 05/19/26 at 10:28 A.M. revealed Licensed Practical Nurse (LPN) #201 revealed that she came into Resident #34's room and turned off the call light and stated that she was just asked to assist with transferring Resident #34 out of bed. LPN #201 stated that CNA #200 was just delivering water to the room next to Resident #34. Observation on 05/19/26 at 10:29 A.M. revealed Physical Therapy Aide (PTA) #202 entered the room and stated that he was asked to assist with a transfer. Observation on 05/19/26 at 10:33 A.M. revealed CNA #200 returned to the room and with the assistance of PTA #202, Resident #34 was transferred out of bed to his wheelchair. Interview on 05/19/26 at 11:10 A.M. with CNA #200 revealed that she had showers to do and there was another CNA and was probably doing a shower. CNA #200 stated that why she was late getting to Resident #34. Interview on 05/19/26 at 12:59 P.M. with Administrator revealed that he had not heard of call lights not being answered and can't say that this morning was acceptable. Review of the facility policy dated 11/2016 with a revision date of 03/2023 titled, Resident Call System, revealed that staff is to respond to resident's call light in a timely manner. This deficiency represents non-compliance investigated under Complaint Number 2992394.

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