STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366477	A. Building B. Wing	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenue at North Ridgeville	6200 Lear Nagle Road North Ridgeville, OH 44039

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 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 review of the medical record, staff interview, and policy review, the facility failed to ensure resident representatives were notified of medication changes. This affected two (#95, #43) of three residents reviewed for changes in condition. The facility census was 100. 1.Review of the medical record for Resident #95 revealed an admission date of 05/06/21. Diagnoses included type two diabetes mellitus, schizoaffective disorder, bipolar disorder, atrial fibrillation, hypertension, and dysphagia.Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had impaired cognition. Review of a physician order dated 05/05/25 revealed the resident had an order for metformin 500 milligrams (mg), give one tablet daily for type two diabetes mellitus. Review of the nurses' notes dated 05/05/25 through 05/28/25 revealed no documentation the resident's representative was notified of the new orders for the metformin.Interview on 12/15/25 at 3:30 P.M., the Director of Nursing (DON) verified the nurses should have notified the resident's representative when the new medication was ordered. 2. Review of the medical record for Resident #43 revealed a readmission date of 06/26/25. Diagnoses included chronic obstructive pulmonary disease, hypertension, dementia, osteoarthritis, and gastroesophageal reflux disease (GERD). Review of the quarterly MDS assessment dated [DATE] revealed the resident had intact cognition. Review of a physician order dated 06/25/25 revealed the resident was ordered lansoprazole 30 milligrams by mouth in the morning for GERD. Review of a physician order dated 08/11/25 revealed the resident was ordered omeprazole 10 mg by mouth in the morning for GERD.Review of the nurses' notes dated 08/11/25 through 08/30/25 revealed no documentation the resident's representative was notified of the new medication order. Interview on 12/17/25 at 8:13 A.M., the DON revealed a therapeutic interchange for the resident's GERD medication had been completed. The DON revealed the resident's representative should have been notified of the change in GERD medications. Review of the facility policy Resident Change in Condition, dated 07/28/22, revealed the facility would notify the resident's responsible party of changes in the resident's condition or status. This deficiency represents non-compliance investigated under Complaint Number 2602463 and Complaint Number 1401649.

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
	366477	A. Building B. Wing	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenue at North Ridgeville	6200 Lear Nagle Road North Ridgeville, OH 44039

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview and review of manufacturer's instructions for use, the facility failed to ensure mechanical lift (Hoyer) devices were properly maintained to promote safe transfers. This had the potential to affect 31 residents (#3, #4, #6, #8, #10, #12, #13, #26, #27, #30, #33, #35, #36, #37, #38, #43, #44, #46, #47, #61, #65, #68, #70, #73, #80, #82, #84, #85, #87, #91, and #96) who were identified to require a mechanical lift for transferring. The facility census was 100.Review of the medical record for Resident #84 revealed an admission date of 08/10/21 with diagnoses to include quadriplegia, anxiety disorder and hypothyroidism. Review of the comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #84 was cognitively intact and was dependent for activities of daily living. Observation and interview of three Hoyer lifts on 12/16/25 at 6:01 A.M. with Certified Nursing Assistant (CNA) #359 verified that the right wheel did not move to allow the legs of Hoyer #1, with the weight scale, to open. There were several strings in the wheel, which made it stick. Interview on 12/15/25 at 10:49 A.M. with Resident #84 stated that the Hoyer lift does not work properly.Interview on 12/16/25 at 5:22 A.M. with CNA #359 revealed that Hoyer lifts were not working properly. The Hoyer lift with the scale is not working, the spotter must kick the wheels to get the legs to come apart and be able to move. Interview on 12/16/25 at 5:13 A.M. with CNA #256 revealed that Hoyer lifts were not working properly. Interview on 12/16/25 at 6:04 A.M. with Maintenance Director (MD) #230 revealed that he did not service the Hoyer lift with the scale but will fix it right away. Interview on 12/16/25 at 8:15 A.M. with Administrator revealed that the Former Maintenance Director #600 ordered wheels for the Hoyer lifts and did not put them on. Interview of 12/17/25 at 2:28 P.M. with Director of Nursing identified 31 residents (#3, #4, #6, #8, #10, #12, #13, #26, #27, #30, #33, #35, #36, #37, #38, #43, #44, #46, #47, #61, #65, #68, #70, #73, #80, #82, #84, #85, #87, #91, and #96) who required the use of a mechanical (Hoyer) lift for transferring.Review of the undated manufacturer's instruction for Hoyer lifts revealed that casters and axle bolts require inspections. The legs of the lift must be in maximum open position for optimum stability and safety. This deficiency represents non-compliance investigated under Complaint Number 2659063 and Complaint Number 2589091.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366477	A. Building B. Wing	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenue at North Ridgeville	6200 Lear Nagle Road North Ridgeville, OH 44039

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 interview and record review, the facility failed to ensure that care plans were revised to reflect Resident #95's allergies and Resident #103's morning arise time. This affected two residents #95 and # 103. The facility's census was 100. 1. Review of the medical record for Resident #103 revealed an admission date of 04/01/22 and readmission date of 01/08/24 with a discharge date of 07/10/25. Diagnoses included type Alzheimer's disease, atrial fibrillation, and major depressive disorder. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severely impaired cognition and required moderate assistance for activities of daily living. Review of the concern dated 05/22/25 revealed that Resident #103's daughter requested that she stay in bed longer before getting resident up for the day. Review of Resident #103's care plan dated 04/30/25 revealed Resident #103 was an early morning get up for increased safety. The care plan was not revised regarding Resident #103's daughter's request. Interview on 12/17/25 at 10:13 P.M. with Administrator verified that Resident #103's care plan was not revised as per conversation with Administrator on 05/22/25. Review of the facility policy dated 11/16 with a revision date of 12/22 titled, Care Plan -Advance Care Plan Process, revealed the interdisciplinary team with the resident and/or their responsible party, an appropriate plan of care for the resident's needs or wishes specific to person centered care based on the assessment and reassessment process within the required timeframes. 2. Review of the medical record for Resident #95 revealed an admission date of 05/06/21. Diagnoses included type two diabetes mellitus, schizoaffective disorder, bipolar disorder, atrial fibrillation, hypertension, and dysphagia. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had impaired cognition. Review of Resident #95's allergy alert profile dated 05/26/21 revealed the resident had allergies to metformin, Depakote, Geodon, Lexapro, Pravachol, Seroquel, and Zetia. On 08/27/24 an allergy to Ativan was added. The allergy to metformin was noted as unknown severity. Review of Resident #95's care plan revealed the resident had allergies to Abilify, Depakote, Geodon, Lexapro, Pravachol, Seroquel, and Zetia. Intervention included to review allergies quarterly, flag chart, notify all disciplines of allergy and known reactions, and notify pharmacy of known allergies. The allergies to metformin and Ativan were not noted on the care plan. Interview on 12/17/25 at 11:10 A.M., MDS Coordinator #229 revealed everything for the resident including allergies should be reviewed quarterly. MDS Coordinator #229 verified Resident #95's allergies to metformin and Ativan had not been updated on the care plan. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366477	A. Building B. Wing	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenue at North Ridgeville	6200 Lear Nagle Road North Ridgeville, OH 44039

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy Care Plan Advanced Care Plan Process, revised 12/2022, revealed the interdisciplinary team in collaboration with the resident, would meet and review the care plan upon admission, quarterly, and annually. The plan of care identifies the date, problem, measurable and realistic goals, and time frames. This deficiency represents non-compliance investigated under Complaint Number 1401651, Complaint Number 1401649 and Complaint Number 1401647.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366477	A. Building B. Wing	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenue at North Ridgeville	6200 Lear Nagle Road North Ridgeville, OH 44039

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 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. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366477	A. Building B. Wing	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenue at North Ridgeville	6200 Lear Nagle Road North Ridgeville, OH 44039

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, staff interview, resident interview, and policy review, the facility failed to ensure an external catheter system for incontinence care was provided per physician orders. This affected one (#43) of three residents reviewed for incontinence care. The facility census was 100. Review of the medical record revealed Resident #43 had an admission date of 01/23/25. Diagnoses included chronic obstructive pulmonary disease, hypertension, gastroesophageal reflux disease, and dementia.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition. The resident was frequently incontinent of bladder and always incontinent of bowel. The resident was dependent for transfers and required substantial/maximal assistance for toileting.Review of Resident #43's admission referral and admission physician orders revealed the resident was admitted directly from another nursing facility. Further review of the referral admission orders current as of 01/22/25 revealed the resident had orders for an external urinary catheter to be applied every night shift, one time a day.Review of the resident's incontinence care plan last revised 06/19/25 revealed the resident was incontinent of bowel and bladder due to weakness, decreased mobility, limited range of motion, and diuretic use. Interventions included incontinence briefs or pantiliners when out of bed, call light within easy reach, toileting per request and as needed, and check and change on care rounds and as needed. There were no interventions for the use of the external catheter system. Review of a urology consult progress note dated 02/24/25 revealed the facility refused to use the external urinary catheter per the resident's representative and was told it was against facility policy. Review of a urology consult progress note dated 05/01/25 revealed the resident required the external urinary catheter due to urinary incontinence. The resident would benefit in reducing skin breakdown and infection using the external urinary catheter daily. Review of a nurse's note dated 05/02/25 at 3:48 P.M. revealed the Director of Nursing (DON) spoke with the urology provider regarding the use of the external urinary catheter. The provider expressed the device had been recommended for the resident at home prior to being in a facility. The provider revealed all the risks and benefits were reviewed with the family. The provider agreed that prompted toileting would help with deficits but also the resident was difficult to transfer to the commode. The DON noted the resident was currently on a toileting program. Review of a nursing progress note dated 05/08/25 at 3:06 P.M. revealed a care conference was held with the resident, resident representative, Unit Manager, Director of Nursing, Ombudsman, and Administrator. The external urinary catheter system was discussed and the facility was unable to meet the request of the use of this system. Review of a nurse's note dated 05/19/25 at 11:20 A.M. revealed the resident was requesting to be checked and changed in bed and does not want put on the toilet, as getting on the toilet was too much. The resident requested to be changed every four hours. The staff would continue to encourage two-hour toileting. Review of a nurse's note dated 11/10/25 revealed the nurse spoke with the resident regarding the external urinary catheter. The resident stated she had used one at home. The resident stated she knew the facility would not allow the external urinary catheter, so she was okay with getting checked and changed.Review of the Treatment Administration Record dated 01/23/25 through 12/15/25 revealed no documentation the external urinary catheter system was implemented per physician orders. Interview on 12/16/25 at 8:32 A.M., the DON revealed the facility had no policy for the use of the external urinary catheter system. The DON revealed the facility also had no policy stating the system could not be utilized in the facility. The DON verified the resident had not been provided the external urinary catheter. The DON revealed the facility could not use the external urinary catheter system. The DON revealed the urinary catheter system was contraindicated for residents with bowel incontinence. Interview on 12/16/25 at 9:05 A.M., Resident #43 revealed the facility told her the external urinary catheter system was not allowed in the facility. Resident #43 revealed she would like to use the external urinary catheter. Resident #43 revealed the facility had asked her if she was okay with the check and change. Resident #43 revealed she agreed only because the external urinary catheter was not allowed. Interview on 12/17/25 at 10:55 A.M., the Administrator verified there was no information documented in the admission agreement or admission packet stating the external urinary catheter was not allowed in the facility. Review of a facility admission agreement and information packet provided to residents upon admission to the facility revealed no notice the external urinary incontinence care system was not allowed. This deficiency represents non-compliance investigated under Complaint Number 2602463 and Complaint Number 1401651.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366477	A. Building B. Wing	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenue at North Ridgeville	6200 Lear Nagle Road North Ridgeville, OH 44039

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366477	A. Building B. Wing	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenue at North Ridgeville	6200 Lear Nagle Road North Ridgeville, OH 44039

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, staff interview, and policy review, the facility failed to ensure a resident allergy was identified for a physician ordered medication during the monthly medication regimen review. This affected one (#95) of three residents reviewed for medication allergies. The facility census was 100.Review of the medical record for Resident #95 revealed an admission date of 05/06/21. Diagnoses included type two diabetes mellitus, schizoaffective disorder, bipolar disorder, atrial fibrillation, hypertension, and dysphagia. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had impaired cognition. Review of Resident #95's allergy alert profile dated 05/26/21 revealed the resident had allergies to metformin, Depakote, Geodon, Lexapro, Pravachol, Seroquel, and Zetia. On 08/27/24 an allergy to Ativan was added. The allergy to metformin was noted as unknown severity.Review of Resident #95's care plan revealed the resident had allergies to Abilify, Depakote, Geodon, Lexapro, Pravachol, Seroquel, and Zetia. Intervention included reviewing allergies quarterly, flag chart, notify all disciplines of allergy and known reactions, and notify pharmacy of known allergies. The allergies to metformin and Ativan were not noted on the care plan.Review of a physician order dated 09/29/24 revealed an order for metformin 500 milligrams (mg) daily for elevated blood sugar.Review of a progress orders note dated 10/01/24 at 3:57 A.M. revealed the system had identified a possible drug allergy for the following order: metformin oral tablet 500 mg, one time a day for type two diabetes mellitus and elevated blood glucose.Review of a progress note dated 10/01/24 at 11:32 A.M. noted the pharmacy was called as resident had an allergy to metformin. The Nurse Practitioner was notified for clarification.Review of a progress note dated 10/01/24 at 11:58 A.M., the nurse practitioner gave new order to hold metformin until the order could be reviewed and reassessed. Review of a physician order dated 10/08/24 revealed the metformin was discontinued. Review of the medication administration record for 09/29/24 through 10/08/24 revealed the metformin was not administered. Review of a nurse practitioner progress note dated 05/05/25 revealed the provider handwrote the resident's allergies on the top of the form. The provider noted the resident's elevated blood glucose levels and then ordered metformin 500 mg daily. Review of a physician order dated 05/05/25 revealed an order for metformin oral tablet 500 mg, give one tablet daily for type two diabetes mellitus. Further review of the electronic physician order revealed an alert on the side of the order noted the resident's allergy to metformin. Review of the pharmacy documentation dated 05/05/25 noted the resident had an allergy to metformin and noted a previous script was discontinued. Review of the nurse's notes dated 05/06/25 through 05/28/25 revealed no documentation the resident's representative was notified of the new orders for the medication metformin. Further review of the nurses' notes revealed no documentation the physician had been notified of the order for metformin and the resident's allergy to the medication. Also, there was no documentation the order had been reviewed or clarified.Further review of the electronic progress notes in the clinical record revealed no orders alert noting the resident's allergy to the metformin. Review of a pharmacy review progress note dated 05/17/25 at 2:56 P.M. revealed the pharmacist reviewed the resident's medication regimen and had noted any irregularities and/or observations on a separate report to the Director of Nursing and prescriber. Review of a monthly pharmacy review recommendation dated 05/17/25 revealed no documentation the consultant had noted the resident's order for metformin and allergy to the metformin. Review of the medication administration record (MAR) dated 05/01/25 through 05/29/25 revealed the resident was administered the medication daily for 24 days from 05/06/25 through 05/29/25 by four different nurses. Review of a nurses note dated 05/29/25 revealed the nurse had spoken with hospice regarding the resident's representative's request to discontinue the resident's metformin. The resident was noted as tolerating the medication well with no signs or symptoms of diarrhea at this time. The resident's representative was adamant the metformin be discontinued so hospice discontinued the medication.Review of the bowel task documentation from 05/01/25 through 05/30/25 revealed the resident had no diarrhea documented. Review of a nurse practitioner progress note dated 06/02/25 revealed the provider noted the resident had been started on metformin. After initiation of the medication, the resident's representative demanded the medication be discontinued due to an allergy. The resident's representative was educated the resident's side effect of diarrhea was no longer existent and it was not a true medication allergy. Interview on 12/15/25 at 3:30 P.M., the Director of Nursing (DON) revealed the allergy was addressed and the nurse practitioner was contacted regarding the allergy and the medication was discontinued. The DON was not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366477	A. Building B. Wing	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenue at North Ridgeville	6200 Lear Nagle Road North Ridgeville, OH 44039

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366477	A. Building B. Wing	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenue at North Ridgeville	6200 Lear Nagle Road North Ridgeville, OH 44039

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the medical record, staff interview, resident interview, and policy review, the facility failed to ensure medications were administered per physician orders resulting in a medication error exceeding five percent. 41 opportunities were observed with six medication errors, resulting in a medication error rate of 14 percent. This affected four (#37, #80, #84, #89) of four residents observed for medication administration. The facility census was 100. 1. Review of the medical record for Resident #89 revealed an admission date of 03/25/25. Diagnoses included chronic obstructive pulmonary disease, hypertension, dementia, and adjustment disorder.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition. Review of the 12/2025 physician orders revealed the resident had morning medication orders with a scheduled time of 7:00 A.M. for Spiriva Respimat Inhalation Solution 1.25 microgram (mcg)/actuation (act) one inhalation in morning, a multivitamin in the morning, Sertraline 50 milligrams (mg) 1.5 tablet in morning, potassium gluconate 595 mg one tablet in morning, Cholecalciferol 25 mcg in the morning, Anastrozole one milligram in the morning, levetiracetam 750 milligrams one tablet two times a day for seizures, cyanocobalamin 500 mcg in the morning, Memantine 5 mg one tablet two times a day for dementia, and ferrous sulfate 325 mg in the morning.Observation on 12/15/25 at 11:23 A.M. of medication administration for Resident #89 revealed Licensed Practical Nurse (LPN) #290 administered the resident the Spiriva Respimat Inhalation Solution 1.25 microgram (mcg)/actuation (act) one inhalation in morning, a multivitamin in the morning, Sertraline 50 milligrams (mg) 1. 5 tablet in morning, potassium gluconate 595 mg one tablet in morning, Cholecalciferol 25 mcg in the morning, Anastrozole one milligram in the morning, levetiracetam 750 milligrams one tablet two times a day for seizures, cyanocobalamin 500 mcg in the morning, Memantine 5 mg one tablet two times a day for dementia, and ferrous sulfate 325 mg in the morning. This resulted in two medication errors for the late administration of the levetiracetam and Memantine, both scheduled twice daily. Review of the medication administration record (MAR) dated 12/15/25 revealed LPN #290 documented the morning medications were administered at 11:25 A.M. Interview on 12/15/25 at 11:23 A.M., LPN #290 verified the medications were administered late. LPN #290 revealed morning medication should be administered between 7:00 A.M. and 11:00 A.M.Interview on 12/15/25 at 11:29 A.M., Resident #89 revealed the morning medications were late today. Resident #89 revealed the medications were usually administered around 9:00 A.M.2. Review of the medical record for Resident #84 revealed an admission date of 10/29/24. Diagnoses included neurogenic bowel, anxiety disorder, and iron deficiency anemia. Review of the annual MDS assessment dated [DATE] revealed the resident had intact cognition.Review of the 12/2025 physician orders revealed the resident had morning medications orders with a scheduled time of 7:00 A.M. for Cholecalciferol 25 mcg three capsules in the morning, Colace 100 mg two times a day, Levothyroxine 100 mcg in the morning, over the counter (OTC) hemp CBC gummy twice daily for appetite, multivitamin one tablet in the morning, pseudoephedrine 30 mg tablet daily in the morning, Gabapentin 300 mg one tablet three times a day for nerve pain, Senna 8.6 mg two tablets in the morning, and polyethylene powder 17 grams two times a day for constipation.Interview on 12/15/25 at 10:49 A.M., Resident #84 revealed he had not got his morning medications as of yet and they were supposed to be given between 7:00 A.M. and 9:00 A.M. Observation on 12/15/25 at 12:01 P.M. revealed LPN #290 administered Resident #84 the morning medication including Cholecalciferol 25 mcg three capsules in the morning, Colace 100 mg two times a day, Levothyroxine 100 mcg in the morning, multivitamin one tablet in the morning, OTC Hemp CBC gummy 20 mg, pseudoephedrine 30 mg tablet daily in the morning, Gabapentin 300 mg one tablet three times a day for nerve pain, Senna 8.6 mg two tablets in the morning, and polyethylene powder 17 grams two times a day for constipation. This resulted in one medication error for the late administration of the Gabapentin which was scheduled three times per day. Review of the MAR dated 12/15/25 revealed LPN #290 administered the morning medications at 12:02 P.M. Interview on 12/15/25 at 12:02 P.M., LPN #290 verified the morning medications had been administered late. 3. Review of the medical record for Resident #80 revealed an admission date of 07/01/24. Diagnoses included type two diabetes mellitus, congestive heart failure, hypertension, atrial fibrillation, and depressive disorder. Review of the quarterly MDS assessment dated [DATE] revealed the resident had intact cognition. Review of the 12/2025 physician orders revealed the resident had orders for morning medications with a scheduled time of 7:00 A.M. for aspirin enteric coated 81 mg in the morning, ascorbic acid 500 mg two times

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366477	A. Building B. Wing	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenue at North Ridgeville	6200 Lear Nagle Road North Ridgeville, OH 44039

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366477	A. Building B. Wing	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenue at North Ridgeville	6200 Lear Nagle Road North Ridgeville, OH 44039

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, staff interview, pharmacist interviews, and policy review, the facility failed to ensure a resident was not administered a medication with a noted allergy without clarification from the physician. This affected one (#95) of three residents reviewed for medication allergies. The facility identified 67 residents with medication allergies. The facility census was 100.Review of the medical record for Resident #95 revealed an admission date of 05/06/21. Diagnoses included type two diabetes mellitus, schizoaffective disorder, bipolar disorder, atrial fibrillation, hypertension, and dysphagia.Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had impaired cognition. Review of Resident #95's allergy alert profile dated 05/26/21 revealed the resident had allergies to metformin, Depakote, Geodon, Lexapro, Pravachol, Seroquel, and Zetia. On 08/27/24 an allergy to Ativan was added. The allergy to metformin was noted as unknown severity.Review of Resident #95's care plan revealed the resident had allergies to Abilify, Depakote, Geodon, Lexapro, Pravachol, Seroquel, and Zetia. Intervention included reviewing allergies quarterly, flag chart, notify all disciplines of allergy and known reactions, and notify pharmacy of known allergies. The allergies to metformin and Ativan were not noted on the care plan. Review of a physician order dated 09/29/24 revealed an order for metformin 500 milligrams (mg) daily for elevated blood sugar.Review of a progress orders note dated 10/01/24 at 3:57 A.M. revealed the system had identified a possible drug allergy for the following order: metformin oral tablet 500 mg, one time a day for type two diabetes mellitus and elevated blood glucose.Review of a progress note dated 10/01/24 at 11:32 A.M. noted the pharmacy was called as resident had an allergy to metformin. The nurse practitioner was notified for clarification.Review of a progress note dated 10/01/24 at 11:58 A.M., the nurse practitioner gave new order to hold metformin until the order could be reviewed and reassessed. Review of a physician order dated 10/08/24 revealed the metformin was discontinued. Review of the medication administration record for 09/29/24 through 10/08/24 revealed the metformin was not administered. Review of a nurse practitioner progress note dated 05/05/25 revealed the provider handwrote the resident's allergies on the top of the form. The provider noted the resident's elevated blood glucose levels and then ordered metformin 500 mg daily. Review of a physician order dated 05/05/25 revealed an order for metformin oral tablet 500 mg, give one tablet daily for type two diabetes mellitus. Further review of the electronic physician order revealed an alert on the side of the order had noted the resident's allergy to metformin. Review of the pharmacy documentation dated 05/05/25 noted the resident had an allergy to metformin and noted a previous script was discontinued. Review of the nurse's notes dated 05/06/25 through 05/28/25 revealed no documentation the resident's representative was notified of the new orders for the medication metformin. Further review of the nurses' notes revealed no documentation the physician had been notified of the order for metformin and the resident's allergy to the medication. Also, there was no documentation the order had been reviewed or clarified.Further review of the electronic progress notes in the clinical record revealed no orders alert noting the resident's allergy to the metformin. Review of a pharmacy review progress note dated 05/17/25 at 2:56 P. M. revealed the pharmacist reviewed the resident's medication regimen and had noted any irregularities and/or observations on a separate report to the Director of Nursing and prescriber. Review of a monthly pharmacy review recommendation dated 05/17/25 revealed no documentation the consultant had noted the resident's order for metformin and allergy to metformin. Review of the medication administration record (MAR) dated 05/01/25 through 05/29/25 revealed the resident was administered the medication daily for 24 days from 05/06/25 through 05/29/25 by four different nurses. Review of a nurses note dated 05/29/25 revealed the nurse had spoken with hospice regarding the resident's representative's request to discontinue the resident's metformin. The resident was noted as tolerating the medication well with no signs or symptoms of diarrhea at this time. The resident's representative was adamant the metformin be discontinued so hospice discontinued the medication.Review of the bowel task documentation from 05/01/25 through 05/30/25 revealed the resident had no diarrhea documented. Review of a nurse practitioner progress note dated 06/02/25 revealed the provider noted the resident had been started on metformin. After initiation of the medication, the resident's representative demanded the medication be discontinued due to an allergy. The resident's representative was educated the resident's side effect of diarrhea was no longer existent and it was not a true medication allergy. Interview on 12/15/25 at 3:30 P.M., the Director of Nursing (DON) revealed the allergy was addressed and the nurse practitioner was contacted regarding the allergy and the