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	06/29/2026

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 0562 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide immediate access to any resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interview, family interview, and employee handbook review, the facility failed to ensure resident family members and other individuals were able to contact facility staff members via telephone. This directly affected one resident (Resident #93) of one resident reviewed for resident access. The facility census was 89.Findings include:Review of the medical record revealed Resident #93 was initially admitted to the facility on [DATE]. Diagnoses included Parkinson's disease, bipolar disorder, insomnia, anxiety, depression, other hallucinations, lack of coordination, panic disorder, tremors, and muscle weakness.Review of the quarterly Minimum Data Set assessment dated [DATE], revealed the resident was cognitively intact. The resident was dependent on assistance from staff for the activities of daily living.During an interview on 06/23/26 at 3:00 P.M., Resident #93's family member reported that when attempting to contact the facility in the evening or at night via telephone, it rings forever. The family member reported it was very difficult to reach someone by telephone and that this issue had been brought to the facility's attention multiple times. The family member also reported that Resident #93 received a medication that was time-sensitive and had a camera in their room. The family member saw that the resident had not received their medication in a timely manner on multiple occasions and attempted to call the facility via telephone to ask that the resident receive their medication. The family member reported they were often unable to reach a staff member when calling into the facility.Interview on 06/24/26 at 4:53 A.M. with Licensed Practical Nurse (LPN) #915 revealed nurses and aides were responsible for answering telephones on the night shift. LPN #915 reported the telephones were located in the nursing stations and that there were no cordless telephones available. LPN #915 reported that when administering medications, the nurses were unable to answer the phones and individuals attempting to contact the facility via telephone would get upset that they could not get ahold of anyone.Interview on 06/24/26 at 5:01 A.M. with Certified Nursing Assistant (CNA) #919 revealed the CNAs did not answer telephones at the facility and the nurses answered the telephones on the night shift if they were at the nursing station. CNA #919 reported if the nurse was administering medications or was not at the nursing station, no one answered the telephone.Interview on 06/24/26 at 5:25 A.M. with CNA #838 revealed the nurses were responsible for answering incoming calls to the facility on the night shift. CNA #838 reported they had never been trained or instructed to answer telephones at the facility. CNA #838 reported staff could barely hear the telephones ringing past the nursing station.Interview on 06/24/26 at 5:37 A.M. with LPN #834 revealed during the night shift, incoming calls went to a telephone located at every nursing station. LPN #834 reported there was not always someone at the nursing station and if nurses were passing medications, the odds of the telephone being answered were very slim. LPN #834 reported that during medication administration, nurses could not hear the phones ringing from the nursing station.Interviews on 06/25/26 at 8:47 A.M. with Receptionist #738 and Receptionist #857 revealed there was a receptionist present and working in the facility from 8:30 A.M. to 8:00 P.M. seven days per week. During these times, the receptionist was responsible for answering incoming calls to the facility. Outside of these times, the phone system was placed on night life, and all calls were instead routed to the nursing stations. The nurses were then responsible (continued on next page)

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

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F 0562 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for answering telephones between 8:00 P.M. and 8:30 A.M.Review of the employee handbook, page 30, revealed when answering the facility's phone, staff were to do so promptly.This deficiency represents non-compliance investigated under Complaint Number 2701315.

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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 medical record review, staff interviews, review of hospital paperwork, review of Emergency Medical Service (EMS) run report, and review of facility policy, the facility failed to ensure timely care and services following Resident #105's change in condition and failed to implement Resident #4's skin treatments as ordered. Actual harm occurred on 05/30/26 when Resident #105, who had a history of stroke and mild cognitive impairment, was observed to have a change in his cognitive and physical status without prompt assessment and response to Resident #105's change in condition. Facility staff noted possible slurred speech earlier on 05/30/26, but the resident was not assessed or treated until a left facial droop was identified at 11:00 A.M. Resident #105 was hospitalized with an acute stroke experiencing severe dysphagia requiring nothing by mouth (NPO) status and a nasogastric (NG) tube placement, loss of alertness and orientation, and new neurological deficits. This affected two residents (Resident #4 and Resident #105) of three residents reviewed for quality of care. The facility census was 89.Findings include: 1. Review of the medical record for Resident #105 revealed he was admitted to the facility on [DATE] with diagnoses that included cerebral infarction due to embolism of left middle cerebral artery, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, and Parkinson's disease. Review of the care plan dated 03/15/25 revealed Resident #105 had a cognitive and activities of daily living (ADL) self-care performance deficit related to general weakness, hemiplegia, and history of cerebrovascular accident with interventions that included assistance of two staff members for ADLs and monitor for changes in behavior and cognitive status. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #105 had a Brief Interview for Mental Status (BIMS) score of 10 that indicated he was alert and oriented with cognitive impairment with no signs of delirium, inattention, disorganized thinking or altered level of consciousness. Review of the MDS assessment revealed Resident #105 was dependent on staff for activities of daily living (ADLs). Review of the skilled nursing note assessment dated [DATE] revealed Resident #105 was alert and oriented to person, place, and time with some forgetfulness. Resident #105 was working with physical therapy for unsteady gait and balance and was able to feed himself with reliable hand grasp and supervision and was able to stand and pivot with standby guidance and verbal cues. Review of the late entry progress note dated 05/30/26 at 7:09 A.M. but entered on 06/02/26 at 7:54 A.M. (3 days later) by Licensed Practical Nurse (LPN) #924, revealed Resident #105 was able to be directed with statements of confusion, was at baseline, with diminished adventitious lung sounds (Unexpected, abnormal sounds superimposed over the breathing which are categorized by how they sound such as crackles, wheezing, and/or rhonchi. This typically indicates restricted airflow, fluid buildup, or trapped air in the lungs) without shortness of breath but repeated coughing. Resident #105 was not observed out of bed. Review of the progress note dated 05/30/26 at 12:11 P.M. revealed Resident #105 was sent to the Emergency Department (ED) for evaluation at 11:55 A.M. Review of the progress note dated 05/30/26 at 1:15 P.M. entered by Registered Nurse (RN) #827, (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	revealed she was called in by Certified Nurse Assistant (CNA) #878 to assess Resident #105 due to a change that she noticed in confusion at 7:09 A.M. RN #827 observed Resident #105 sitting up in bed with his arms extended at his side. RN #827 noted no visible abnormalities in Resident #105's appearance; however, he seemed confused but at baseline. Resident #105 was able to state his name, his location, and was able to report he had previously been at the hospital for two days. RN #827 asked Resident #105 if he was experiencing any signs or symptoms related to urinary tract infection. Resident #105 denied urgency, frequency, burning sensation, and pain while voiding. RN #827 verified that Resident #105 was feeling a little tired. RN #827 noted that Resident #105 had been coughing when CNA #878 attempted to feed him and that was the reason, she initially informed RN #827. RN #827 revealed Resident #105's vital signs were within normal limits with regular arrythmias, lungs diminished throughout, and bowel sounds present in all four quadrants with no palpable pain or tenderness noted. RN #827 went into Resident #105's room at approximately 8:25 A.M. to administer medications and he was able to take them as usual without coughing and able to hold a double handed cup with cranberry juice with no tremors when handed to his left hand; however, Resident #105 was weak and needed assistance to place the cup back on the table. Resident #105 answered questions again appropriately with no facial droop noted. RN #827 went back into the room to administer Bactrim that was pulled from the emergency medication kit (E-Kit) approximately 15 minutes later. Resident #105 was still observed to notably tired but had no facial droop. Resident #105's call light was answered but uncertain of time. Prior to entering Resident #105's room, other staff informed RN #827 that he consistently used his call light, and other staff had been in and out of his room but reported no facial droop to the left side of his face. The squad was called and arrived at approximately 11:45 A.M. and Resident #105 was observed being assessed. Resident #105's Power of Attorney (POA) requested he get out of bed and showered without mentioning facial droop and continued to insist staff get him up despite observed right-sided weakness. Review of the progress note dated 05/30/26 at 1:35 P.M. revealed the Certified Nurse Practitioner (CNP) on call was notified Resident #105 was sent out. Review of the progress note dated 05/30/26 at 7:01 P.M. revealed Resident #105 was in the emergency room (ER) and noted the resident had a stroke. Review of the progress note dated 05/30/26 at 10:13 P.M. revealed Resident #105 was admitted to the hospital. Review of a handwritten witness statement by CNA #907, undated, revealed a scratched-out sentence that read I tried helping Resident #105 get up for his shower. Further review of the witness statement revealed CNA #907 helped Resident #105 get in the shower as his daughter insisted on him getting one. Resident #105 appeared weak but was able to get him in the shower. CNA #907 went to make Resident #105's bed afterwards. Once CNA #907 finished, she grabbed clean clothes and went inside the bathroom to help CNA #878 get Resident #105 dressed. Resident #105 was not up straight and was tilting to his right. Resident #105's daughter came in after and took a picture of him and called the ER. Review of the handwritten witness statement by CNA #878, dated 05/30/26, revealed during her morning rounds, she observed Resident #105 appearing weak, fatigued, and having difficulty eating breakfast, including choking episodes. CNA #878 immediately notified RN #827 of her concerns. CNA #878 revealed RN #827 assessed Resident #105 and reported normal vital signs. CNA #878 revealed she changed Resident #105 and at that point, he stated he would like to rest. CNA #878 revealed RN #827 stated Resident #105 typically was tired in the mornings and to let him rest and get him up (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	closer to lunchtime. CNA #878 revealed once Resident #105's daughter arrived, she explained that she had concerns regarding his weakness and fatigue and at that time the daughter insisted he be showered and dressed. CNA #878 revealed Resident #105's daughter forced his clothes off and told her and CNA #907 they couldn't transfer him and proceeded to do it herself. CNA #878 revealed she expressed concern that she felt it was not best for him to be showered. CNA #878 revealed throughout the shower, Resident #105 continued to remain weak, unsteady and leaning heavily. CNA #878 revealed she continuously had to support Resident #105 and stabilize the shower chair to prevent him from falling. CNA #878 revealed she observed throughout the morning Resident #105 to be significantly weaker than usual and was concerned about his safety. Review of the handwritten witness statement by RN #815, dated 05/30/26, revealed CNA #878 approached her about concerns regarding Resident #105. CNA #878 informed RN #815 that Resident #105 kept pressing his call light but was unable to state what he wanted. CNA #878 revealed she tried to feed Resident #105 when he began choking a little. RN #815 revealed Resident #105's call light was sensitive to touch, and he had confusion sometimes and was currently being treated for a urinary tract infection. RN #815 informed CNA #878 that Resident #105 sometimes was sleepy in the morning and didn't finish his breakfast. CNA #878 reported Resident #105 declined to get out of bed and was told to try again before lunch. RN #815 revealed she went into Resident #105's room and observed him sitting upright in bed in front of his breakfast tray and did not observe any abnormalities. RN #815 revealed RN #827 informed her Resident #105's vitals were within normal limits. RN #815 revealed she observed Resident #105's call light on, time unknown, and entered his room and observed him sitting upright in bed wanting to get out of bed. RN #827 informed CNA #878 and shortly after, CNA #878 informed her that Resident #105's daughter was in the room wanting him to get up and showered. RN #815 revealed shortly after, CNA #878 approached her and reported Resident #105's daughter was calling 911 to send him to the hospital. RN #815 revealed she approached Resident #105's daughter and asked if she wanted to send him to the hospital and she yelled Yes, his face is drooping. Why didn't you call me? RN #815 revealed she informed Resident #105's daughter that she would call 911. RN #815 revealed she called 911 and let Resident #105's daughter know and observed her to be on the phone crying saying, They did nothing, they just let him lay here. RN #815 revealed she informed Resident #105's daughter that staff had been in the room helping him eat, checking his vital signs and answering his call light. Review of the vitals summary dated 05/30/26 revealed Resident #105 had one blood pressure reading (138/57mmHg), one oxygen saturation reading (94%), one temperature reading (97.7 degrees Fahrenheit) and one pulse oximetry reading (60 bpm) documented at 1:54 A.M. and another blood pressure reading (129/57mmHg), oxygen saturation readings (96%), temperature reading (97.1 degrees Fahrenheit), a pulse oximetry reading (60 bpm) and only one set of respirations (18 breaths/min) documented at 8:23 A.M. Review of the vital summary revealed Resident #105 only had one set of vitals taken after the first onset of symptoms were identified (7:09 A.M.) and no other assessments were documented from 7:00 A.M. to 11:00 A.M until his transfer to the hospital. Review of the call light audit report dated 05/30/26 revealed the following for Resident #105:-Call light activated at 12:49 A.M. and answered at 12:49 A.M.-Call light activated at 12:49 A.M. and answered at 12:50 A.M.-Call light activated at 5:14 A.M. and answered at 5:15 A.M.-Call light activated at 5:16 A.M. and answered at 5:18 A.M.-Call light activated at 7:26 A.M. and answered at 7:41 A.M.-Call light activated at 7:45 A.M. and answered at 7:46 A.M.-Call light activated at 8:02 A.M. and answered at 8:04 A.M.-Call light activated at 8:35 A.M. and answered at 8:46 A.M.-Call light activated at 8:46 A.M. and answered at 8:47 A.M.-Call light activated at 8:50 A.M. and answered at 8:53 A.M.-Call light activated at 8:59 A.M. and answered at 9:05 A.M.-Call light activated at 10:03 A.M. and (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	answered at 10:23 A.M.-Call light activated at 10:50 A.M. and answered at 10:59 A.M.-Call light activated at 11:03 A.M. and answered at 11:13 A.M.-Call light activated at 11:17 A.M. and answered at 11:25 A.M.-Call light activated at 11:40 A.M. and answered at 11:50 A.M. Review of the prehospital care report summary dated 05/30/26 by the Fire Department revealed they received a call and were dispatched to the facility at 11:44 A.M., arrived on scene at 11:49 A.M., made contact with Resident #105 at 11:51 A.M., and left the scene at 12:01 P.M. on 05/30/26. Further review of the report summary revealed they received a call for Resident #105 experiencing left-sided drooping and garbled speech. Upon arrival, Resident #105 had notable left-sided facial droop while lying in bed. Resident #105's family member revealed he was last seen normal the previous day, 05/29/26 at approximately 1:00 P.M., talking and acting normally, after visiting with him. Staff reported Resident #105 had a decrease in his mental status that morning at 9:00 A.M. Review of the report summary revealed Resident #105 had a history of stroke, was able to speak and understand some questions, and noted to have left-sided facial droop, slurred speech and appeared confused. Resident #105 was transported to the hospital without incident. Review of Resident #105's hospital patient health summary progress note dated 05/30/26 revealed he arrived at the ED presenting with slurred speech, aphasia, and left facial droop. Resident #105, per Emergency Medical Services (EMS) per Resident #105's family member, was last known well at 6:00 P.M. on 05/29/26 after a visit at the facility. Resident #105's facial droop was observed on 05/30/26 at approximately 11:00 A.M., when staff went to bathe him. Facility staff revealed Resident #105 may have had slurred speech that morning, but EMS was not activated until after his facial droop was observed. Review of the document revealed Resident #105, as a result of a stroke, was now consuming no food, beverages, or oral medications (NPO) by mouth, was placed on a NG tube for medications, intravenous hydration, had severe oropharyngeal dysphagia with plans for Percutaneous Endoscopic Gastrostomy (PEG) tube placement, was no longer alert and oriented with partial facial paralysis and a drifting right leg. Interview on 06/24/26 at 9:27 A.M. with RN #815 revealed she was the supervising nurse at the time Resident #105 had a change in condition. RN #815 revealed CNA #878 told them to go see Resident #105 due to him acting differently and coughing when eating his breakfast. RN #815 revealed Resident #105 was sitting up in bed, and she had not observed anything strange. RN #815 revealed she proceeded to put Resident #105's glasses on him and asked him a few questions but nothing out of the ordinary. RN #815 revealed Resident #105 was typically alert and oriented and sometimes forgetful. RN #815 revealed it was Resident #105's shower day and after he was showered, Resident #105's daughter said she was calling 911 due to him being unable to form words and his face drooping. RN #815 revealed she could not elaborate on his change in condition, as she was not the nurse that was doing assessments; however, she was informed that Resident #105 was able to take his medications, drink his potassium without issues and his vitals were within normal limits. RN #815 confirmed and verified the above findings at the time of the interview. Interview on 06/24/26 at 11:28 A.M. with LPN #924 revealed she was not in the facility on 05/30/26 and initially did not recognize the progress note she had written. LPN #924, after reviewing the progress note, revealed she had backdated the note to reflect Resident #105's current status and skilled notes were automatically generated to input a synopsis of resident's overall health and care. LPN #924 revealed Resident #105 was a long-term resident, required at least one staff member for ADLs and was able to feed himself. LPN #924 revealed if a resident had a change in his mental status or observed something abnormal, she would notify the physician to determine the next steps regarding resident's care. LPN #924 confirmed and verified her assessment was inaccurate due to her (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	was treated in the hospital and at the facility for a UTI and it had been at least 3 days since his return from the hospital and treatment had been started. RN #827 revealed Resident #105 had no signs or symptoms that he was still having residual effects of a UTI. RN #827 verified that Resident #105 being unable to grasp a cup, pressing his call light every 20 minutes without stating need, being confused, having choking and/or coughing episodes while eating and being tired and weak was not his baseline. RN #827 also confirmed and she had only documented one set of vitals from the time she was notified of a change in condition to the time he was transferred to the hospital, approximately a 4-hour timeframe. RN #827 confirmed the above findings at the time of the interview. Interview on 06/26/26 at 10:23 A.M. with Medical Director (MD) #901 revealed Resident #105 had a history of stroke and dementia. MD #901 revealed Resident #105 presented with weakness, was very confused and had a change in his behavior. MD #901 revealed the CNP was called and neuro checks and monitoring were put in place. MD #901 revealed residents with dementia can have confusion and it's not likely to send them to the hospital for simple things. MD #901 revealed most of the time, monitoring to watch for worsening symptoms was the first step. MD #901 revealed Resident #105, at the time, was currently being treated for a UTI and sometimes you can can't determine if you're treating the right issue. MD #901 confirmed and verified Resident #105 had a change in condition; however, the effects were not significant enough for Resident #105 to be sent to the ER. Review of the facility document titled Resident Change in Condition dated 07/28/22, revealed the facility had a policy in place to ensure timely and appropriate care and services when a resident experiences a change in condition or is likely to cause serious life-threatening harm or injuries and/or adverse negative health outcomes. Review of the policy revealed the facility would take immediate action to ensure timely and appropriate care and services were met when a resident change in condition is identified. Further review of the policy revealed a change in condition included, but not limited to, physical changes, non-physical changes and an alteration in mental status. 2. Review of the medical record for Resident #4 revealed an admission date of 06/20/25 with diagnoses including pneumonia, chronic obstructive pulmonary fibrosis, type II diabetes, anxiety, fracture of clavicle and dysuria. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had impaired cognition and was dependent on the staff for toileting. The resident was incontinent of bowel and bladder. Review of the physician orders dated June 2026 revealed two treatment orders to apply barrier cream to buttocks after each incontinent episode as needed and apply zinc oxide 20 % to buttocks three times a day and as needed for excoriation. There was no order to apply miconazole powder to groin area. Review of the wound nurse practitioner (NP) note dated 06/12/23 stated the resident had contact dermatitis to the groin, and buttocks that was improving. Treatment included zinc oxide cream and briefs off in bed. Observation on 06/25/26 at 12:00 P.M. with Registered Nurse (RN) #866 of Resident #4 stated she did not complete the zinc treatment to the buttocks for resident. RN #866 revealed staff just changed her and put miconazole powder on the resident. Resident #4 was not interviewable. Interview on 06/25/26 at 12:04 P.M. with RN #902, the Assistant Director of Nursing (ADON) (continued on next page)

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	366477	A. Building B. Wing	06/29/2026

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	confirmed staff applied for miconazole powder to the resident's buttocks without an order due to the resident requesting the miconazole power. This deficiency represents non-compliance investigated under Complaint Number 3005283, 2993232, 2711143, 2732611.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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 record review and interview, the facility failed to ensure Resident #41's PureWick incontinence device was implemented per the physician's order. This finding affected one (Resident #41) of three residents reviewed for incontinence care. Findings include: Review of Resident #41's medical record revealed the resident was admitted on [DATE] with diagnoses including acute respiratory failure with hypoxia, chronic obstructive pulmonary disease and unspecified dementia.Review of the email to the hospital dated 01/19/26 at 4:02 P.M. revealed the Power-of-Attorney (POA) had concerns about returning and would like to address them at a care conference shortly after readmission. The concerns included the PureWick system which she was aware that the facility was unable to accommodate at any of the buildings and possibly not getting the proper medications at the proper times.Review of an email from the facility to Ombudsman #737 on 02/26/26 at 9:34 P.M. revealed the team shared that it was communicated to the facility that there was confusion regarding why the facility continued not to follow an order for which it had been cited. The clarification that the citation was not due to failure to follow the order itself, but rather due to a failure to communicate that they facility were unable to follow the order. Effectively, the facility failed to clearly communicate the inability to follow the order prior to admission or were ineffective by not reconciling the orders on the new admission timely. Although Resident #41's POA indicated she contacted several progressive quality care facilities and were told that four of them provided this type of care, a clarification was obtained that no facility within their company had PureWick system in place, nor was authorized to use this system. As a company, the facility does not use the PureWick system. Additionally, following the resident's most recent hospital stay, it was communicated to both the hospital and representative prior to re-admission that the facility does not use the PureWick system and therefore would not be able to accommodate the order. The facility specifically asked the hospital to educate the representative on this limitation, and they stated they had done so. Upon review of the resident's orders at re-admission, there was no order for the PureWick system.Review of Resident #41's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition.Review of Resident #41's Urology Visit note dated 04/14/26 revealed the resident with urinary incontinence presented for evaluation and worsening leakage. She is accompanied by a companion who provided additional history. The resident had urinary incontinence that was bothersome, with episodes most notable in the morning after she was dressed and seated, when she experienced sudden large-volume gushing leakage that can soak under her legs and sometimes up to her waist. The form indicated a letter of medical necessity was provided documenting clinical need and expected benefit for PureWick use. Caregiver to submit for facility and state review and appeals.Review of Resident #41's progress note dated 05/02/25 at 3:48 P.M. revealed the Director of Nursing (DON) spoke with the urology office regarding the use of the Pure wick system. The office expressed that her and her office had recommended this device to be used at home before the resident was in a facility. The office stated that all risks and benefits were reviewed with the family and the office agreed that prompted toileting should help with deficits, but also the resident was difficult to transfer to a commode. Resident #41 was currently on a toileting program.Review of Resident #41's progress note dated 05/08/25 at 3:06 P.M. documented as a late entry revealed a care conference was held with the POA, unit manager, DON, Administrator, and Ombudsman #737. The PureWick system was discussed, and the facility was unable to meet the request of the use of the system. Per the conversation with urology, a toileting program was implemented a few weeks back. The resident, at times, refused to allow staff to provide care or to check and change her. The resident did well during a transfer with therapy but did not trust nurse CNAs to complete transfer. Therapy to work with resident, but was recently cut due to no progress being made. Ombudsman and POA were (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	aware of current interventions and in agreement at this time.Telephone interview on 06/22/26 at 11:41 A.M. with Ombudsman #737 revealed Resident #41 used the PureWick system at home and the POA had reported that she wanted the system in the facility. Ombudsman #737 stated the POA had told her the resident had a current order for the PureWick system.Telephone interview on 06/22/26 at 12:23 P.M. with Resident #41's POA revealed she provided a letter of medical necessity for the resident's PureWick system that the facility would not honor.Interview on 06/22/26 at 1:47 P.M. with Resident #41 revealed she did not have a PureWick incontinence system in the facility and she wanted one. Resident #41 confirmed that the facility had educated her that the incontinence system was contraindicated and not permissible in the facility.Interview on 06/22/26 at 2:01 P.M. with the DON revealed Resident #41's PureWick system was contraindicated and Resident #41 was educated for contraindications for pure wick.Interview on 06/23/26 at 6:30 A.M. with the DON revealed Resident #41's PureWick incontinence system was contraindicated due to mobility issues, and the facility was unable to meet the Pure Wick needs of the resident. Interview on 06/23/26 at 7:44 A.M. with the Administrator revealed Resident #41's POA wanted the resident to have a PureWick system and was educated that the facility did not accommodate the incontinence system and the resident was not a candidate for the system.Interview on 06/23/26 at 7:47 A.M. with Admissions #867 revealed Resident #41 had known she was not to use the PureWick incontinence system in the facility prior to returning to the facility from the hospital. Admissions #867 confirmed the facility advised the resident and POA that they do not use the system in the facility and still wanted to come here. Stated had a verbal conversation with the hospital and the resident prior to her coming back from the hospital and she still wanted to come back to the facility. Interview on 06/24/26 at 8:25 a.m. with NP #734 confirmed she would order the PureWick system for Resident #41 if the resident wanted one.Telephone interview on 06/26/26 at 10:40 A.M. with Resident #41's urology office revealed the urology office placed an order for the PureWick system on 08/12/25 and then provided a letter of medical necessity on 04/14/26 for the use of the PureWick system.Telephone interview on 06/26/26 at 10:40 A.M. with Resident #41's urology office revealed the urology physician assistant provided a letter of medical necessity for the resident to use the PureWick incontinence system. The letter of necessity was provided to the POA to give to the facility for implementation of the PureWick incontinence system.Telephone interview on 06/26/26 at 2:50 P.M. with Resident #41's POA confirmed she gave the PureWick order and letter of necessity to the facility and discussed the order on 04/14/26 when the resident returned to the facility.Review of Incontinence Care policy dated 12/2022 revealed the purpose of the policy was 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.This deficiency represents non-compliance investigated under Complaint Numbers 2785497, 2732611, 2711583, 2711143.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident and staff interview, review of facility call light tracking records, review of complaint intakes, and review of Resident Council meeting minutes, the facility failed to have adequate staffing to meet the care needs of all residents. This directly affected seven (#41, #14, #51, #93, #77, #101, #31) of seven residents reviewed for staffing and had the potential to affect all residents residing in the facility. The facility census was 89. Findings include:1. Review of Resident #41's medical record revealed the resident was admitted on [DATE] with diagnoses including acute respiratory failure with hypoxia, muscle weakness and unsteadiness on feet. Review of Resident #41's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition, was frequently incontinent of bladder and always incontinent of bowel. Review of Resident #41's care plans revealed an intervention revised on 09/04/25 for the resident would like to get up out of bed between 9:00 A.M. and 10:00 A.M. The care plans revealed an intervention revised on 01/27/26 which stated the resident was an extensive/total assist of one to two staff for toileting; and an intervention dated 01/23/25 to check and change on care rounds and as needed. Review of Resident #41's care plans revealed an intervention dated 05/26/26 that the resident had a right to make lifestyle choices and requested to stay in bed throughout the day at times. The resident would like to be check and changed every four hours (after the survey started). Interview on 06/24/26 at 10:38 A.M. with Resident #41 revealed she could not remember when the last time she was provided incontinence care. Observation on 06/24/26 at 10:43 A.M. with Certified Nursing Assistant (CNA) #870 and CNA #872 of Resident #41's incontinence care revealed the resident's brief appeared saturated. The bed was not wet. Interview on 06/24/26 at 10:42 A.M. with CNA #870 confirmed this was the first time she had been in Resident #41's room since she started for the day. She confirmed her shift was from 6:00 A.M. to 6:00 P.M. and the last time the resident was provided incontinence care was on nightshift. Review of the Incontinence Care policy dated 12/2022 revealed the purpose was to ensure a resident who was incontinent of bowel and/or bladder received appropriate treatment and services to prevent urinary tract infection and to restore continence to the extent possible. 2. Review of the medical record revealed Resident #14 was admitted to the facility on [DATE]. Diagnoses included respiratory failure, diabetes mellitus, anxiety, asthma, chronic kidney disease, tachycardia, depression, obstructive sleep apnea, muscle weakness, and need for assistance with personal care. Review of the Medicare five-day Minimum Data Set assessment dated [DATE] revealed Resident #14 was cognitively intact. The resident was dependent on assistance from staff for the activities of daily living, including transfers. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the plan of care, revised 04/10/26, revealed Resident #14 had an ADL self-care performance deficit. Interventions included encouraging the resident to use their call bell for assistance. Interview on 06/22/26 at 4:12 P.M. with Resident #14 revealed there were not enough staff to meet her needs in a timely manner. Resident #14 reported when she activated her call light, it sometimes took staff a prolonged period of time to respond. Review of the call light tracking logs for 06/01/26 through 06/24/26 for Resident #14 revealed there were 86 occurrences where call light response time was greater than 20 minutes, 22 of which were greater than 45 minutes and up to two hours and 29 minutes. Interview on 06/25/26 at 10:50 A.M. with the Administrator revealed the expectation for answering call lights was 15 to 20 minutes or less. 3. Review of the medical record revealed Resident #51 was initially admitted to the facility on [DATE]. Diagnoses included heart failure, type II diabetes mellitus, anemia, depression, hypertension, muscle weakness, need for assistance with personal care, history of falling, pain, repeated falls, and altered mental status. Review of the quarterly Minimum Data Set assessment dated [DATE], revealed the resident was cognitively intact. The resident was dependent on assistance from staff for the activities of daily living (ADLs). Review of the plan of care, revised 02/03/26, revealed Resident #51 had an ADL self-care performance deficit. Interventions included encouraging the resident to use their call bell for assistance. Interview on 06/22/26 at 10:07 A.M. with Resident #51 revealed the facility did not have enough staff to meet her needs. The resident reported when she activated her call light, it sometimes took staff between one and one and a half hours to respond. Review of the call light tracking logs for 06/01/26 through 06/24/26 for Resident #51 revealed there were 24 occurrences where call light response time was greater than 20 minutes, eight of which were greater than 45 minutes and up to one hour and 13 minutes. Interview on 06/25/26 at 10:50 A.M. with the Administrator revealed the expectation for answering call lights was 15 to 20 minutes or less. 4. Review of the medical record revealed Resident #93 was initially admitted to the facility on [DATE]. Diagnoses included Parkinson's disease, bipolar disorder, insomnia, anxiety, depression, other hallucinations, lack of coordination, panic disorder, tremors, and muscle weakness. Review of the quarterly Minimum Data Set assessment dated [DATE], revealed the resident was cognitively intact. The resident was dependent on assistance from staff for the activities of daily living (ADLs). Review of the plan of care dated 10/02/24 revealed Resident #93 had an ADL self-care performance deficit. Interventions included encouraging the resident to use their call bell for assistance. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 06/23/26 at 3:00 P.M. with Resident #93's family member revealed there were not enough staff to meet resident needs in a timely manner. Resident #93's family member reported that a CNA would often have an assignment where they would work on the secured memory care unit and would then cover the hallway that Resident #93 resided on, which was not on the secured unit. Resident #93's family member reported Resident #93 would wait for a prolonged period of time for staff assistance. Interview on 06/23/26 at 3:12 P.M. with Resident #93 revealed that when the resident activated their call light, staff often did not respond for a prolonged period of time. Review of call light tracking records for Resident #93 for 06/01/26 through 06/25/26 noted several days staff did not answer call lights in a timely manner. Response times noted 55 minutes on 06/01/26, 49 and 53 minutes on 06/03/26, 2.38 hours on 06/04/26, 39, 46, 51 and 59 minutes on 06/06/26, 1 hour and 30 minutes on 06/07/26, 40 and 48 minutes on 06/08/26, 1 hour and 48 minutes and 1 hour and 49 minutes on 06/09/26, 57 minutes on 06/11/26, 1 hour and eight minutes and 2 hours and 33 minutes on 06/16/26, 1 hour and five minutes on 06/18/26, 1 hour and 14 minutes and 1 hour and 35 minutes on 06/20/26, and 51 minutes on 06/21/26. Interview on 06/25/26 at 10:50 A.M. with the Administrator revealed the expectation for answering call lights was 15 to 20 minutes or less. 5. Interview on 06/22/26 at 10:11 A.M. revealed Resident #43 waited a prolonged period of time for their call light to be answered. Interview on 06/22/26 at 10:34 A.M. with Resident #40 revealed staffing was an issue at the facility. Interview on 06/22/26 at 11:37 A.M. with Resident #2 revealed the resident waited a long period of time for their call light to be answered. Interview on 06/22/26 at 12:11 P.M. with Resident #8 revealed the resident sometimes waited up to an hour for their call light to be answered when activated. Interview on 06/22/26 at 12:24 P.M. with Resident #32 revealed there were never enough staff working in the facility. Interview on 06/22/26 at 12:20 P.M. with Resident #46 revealed call lights were not answered in a timely manner. Interview on 06/22/26 at 4:35 P.M. with Resident #24 revealed the resident sometimes waited up to 45 minutes for their call light to be answered when activated. Interview on 06/24/26 at 5:25 A.M. with CNA #838 revealed there were not enough staff on night shift to be able to meet resident needs in a timely manner. Interview on 06/24/26 at 5:37 A.M. with LPN #834 revealed there were often not enough CNAs to meet resident needs in a timely manner. LPN #834 reported that an aide working on the secured memory care unit would often have to come off of the unit to care for residents on another hall and had difficulty answering call lights. LPN #834 reported night shift often did not receive help with covering vacancies when they were short staffed and that management never came in to cover shifts. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 06/24/26 at 6:03 A.M. with CNA #912 revealed the staff member was often assigned to work on the secured memory care unit and was also assigned residents who were not on the unit during the night shift. CNA #912 reported that residents often reported their call lights were not answered in a timely manner. CNA #912 reported she was going back and forth between the units, often did not know and could not see when call lights were activated, and was not able to get to residents in a timely manner to provide care. CNA #912 further reported they were unable to complete necessary work, including timely checks, answering call lights, and providing incontinence care. Review of complaint intakes for the facility revealed there were seven complaints that alleged concerns including not enough staff to timely meet resident needs, prolonged call light response time, and untimely assistance with ADLs. Review of the Resident Council meeting minutes dated 06/05/26 revealed that regarding the nursing department, one resident stated their call light response wasn't as prompt as usual. Residents were reminded about call light response monitoring and to see management immediately if any issues arose. This deficiency represents non-compliance investigated under Complaint Numbers 3005283, 2998572, 2732611, 2711583, 2707866, and 2701315.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure medications were administered as ordered. This affected three (#77, #93 and #101) of four residents reviewed for medication administration. The facility census was 89.Findings include: 1. Review of the medical record for Resident #101 revealed an admission date of 12/23/25 with diagnoses including cerebral infarction, chronic respiratory failure, chronic obstructive pulmonary disease (COPD), congestive heart failure, anxiety, atrial fibrillation, chronic kidney disease, Review of the admission MDS assessment dated [DATE] revealed the resident was cognitively intact and was dependent on staff for bathing, transfers, dressing and toileting. Review of the physician order revealed evening medication included Atorvastatin 80 milligrams (mg), Famotidine 20mg, Fluoxetine 20 mg, Topirate 100mg. Morning medications including Metoprol 25 mg and Omeprazole 40 mg. Review of the Medication Administration Record for December 2025 revealed evening medications on 12/23/25 included Atorvastatin 80 milligrams (mg), Famotidine 20mg, Fluoxetine 20 mg, Topirate 100mg were not administered. Morning medication including Metoprol 25 mg and Omeprazole 40 mg. were not administered. Review of the automatic medication dispensing system log revealed the system stocked the following medications: Atorvastatin 80 milligrams (mg), Famotidine 20mg, Fluoxetine 20 mg, Topirate 100mg, Metoprol 25 mg, and Omeprazole 40 mg. Interview on 06/23/24 at with the Director of Nursing (DON) verified the nurse did not administer the medications in the evening and morning. The DON stated the medication were stocked in the automatic medication dispensing system and she would expect the nurses to pull the medications from the automatic medication dispensing system. 2. Review of the medical record for Resident #77 revealed an admission date of 06/20/25 with diagnoses including quadriplegia, autonomic dysreflexia, neuromuscular dysfunction of bladder, neurogenic bowel, anxiety, contracture of the right and left knee. Review of the quarterly MDS assessment dated [DATE] revealed the resident was cognitively intact and was dependent on the staff for eating, dressing, bathing, transfers indwelling catheter and colostomy care. Review of the physician order for June 2026 revealed an order for Testosterone 200 milligram (mg) per milliliter (ml) to inject 0.5 ml intramuscular every Wednesday. Review of the Medication Administration Record (MAR) for June 2026 revealed testosterone was administered on 06/03/26, 06/10/26, 06/20/26 and 06/24/26. Interview on 06/24/26 at 5:33 P.M. with the DON verified the medication was not administered as ordered. The testosterone was backordered from the pharmacy and was not available for administration on 06/17/26. The testosterone was rescheduled for 6/20/25 and administered. The (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	testosterone was administered again four days later on 06/24/26 by mistake. 3. Review of the medical record revealed Resident #93 was initially admitted to the facility on [DATE]. Diagnoses included Parkinson's disease, bipolar disorder, insomnia, anxiety, depression, other hallucinations, lack of coordination, panic disorder, tremors, and muscle weakness. Review of the quarterly MDS assessment dated [DATE], revealed the resident was cognitively intact. The resident was dependent on assistance from staff for the activities of daily living. Review of the plan of care, revised 03/13/26, revealed Resident #93 had Parkinson's disease, affecting mobility, eating, and coordination. Interventions included giving medications as ordered by the physician. Review of Resident #93's physician orders for June 2026, identified an order for Carbidopa-Levodopa oral tablet 25-100 milligrams, give two tablets by mouth four times per day for Parkinson's disease. The medication was scheduled for 8:00 A.M., 11:00 A.M., 2:00 P.M., and 5:00 P.M. The resident also had an order for Carbidopa-Levodopa tablet 25-100 milligrams, give one tablet by mouth one time per day for Parkinson's disease, scheduled for 12:00 A.M. Review of the medication audits dated 06/01/26 through 06/21/26 revealed the medication was given at 12:07 P.M. instead of 11:00 A.M. on 06/05/26, at 12:17 P.M. instead of 11:00 A.M. on 06/08/26, 4:01 P.M. instead of 2:00 P.M. on 06/08/26, given again at 5:11 P.M. on 06/08/26 (one hour and 10 minutes after the last dose), 3:08 P.M. instead of 2:00 P.M. on 06/11/26, 3:09 P.M. instead of 2:00 P.M. on 06/14/26, 2:58 A.M. instead of 12:00 A.M. on 06/16/26, 9:09 A.M. instead of 8:00 A.M. on 06/17/26, 3:03 P.M. instead of 2:00 P.M. on 06/19/26, 4:08 A.M. instead of 12:00 A.M. on 06/21/26, and 11:45 P.M. instead of 8:00 P.M. on 06/21/26. Interview on 06/23/26 at 3:00 P.M. with Resident #93's family member revealed that Resident #93's medication for Parkinson's disease was not always administered timely. Resident #93's family member reported there was a camera in the resident's room and the family member would check to see if the resident received their midnight medications. When the resident had not received them in a timely manner, the family member would attempt to call the facility via telephone but often had trouble reaching anyone at the facility. Resident #93's family member reported that when the resident did not receive this medication on time, the resident would visibly slow down and was significantly physically affected. Interview on 06/25/26 at 7:29 A.M. with the DON verified the findings. This deficiency represents non-compliance investigated under Complaint Numbers 299572, 2732611 and 2707866.

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	06/29/2026

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on observation, resident interviews, staff interviews, review of Resident Council meeting minutes, and review of the facility handbook, the facility failed to ensure staff did not utilize their personal phones in resident care areas of the facility. This had the potential to affect all residents residing in the facility. The facility census was 89.Findings include:Interview on 06/22/26 at 10:01 A.M. with Resident #51 revealed staff were often utilizing their personal cell phones while working in the facility. Resident #51 reported that on one occasion, a staff member told the resident they were being rude by interrupting the staff member who was on the phone with their boyfriend at the time.Interview on 06/22/26 at 12:42 P.M. with Resident #66 revealed staff were often seen walking by the resident's room while on their cell phones.Interview on 06/22/26 at 12:57 P.M. with Resident #82 revealed staff members working in the facility were often seen using personal cell phones. Resident #82 reported staff often walked by their room while on their phone.Interview on 06/22/26 at 4:12 P.M. with Resident #14 revealed staff could often be seen on their personal cell phones while working in the facility.Observation on 06/24/26 at 5:25 A.M. revealed Certified Nursing Assistant (CNA) #838 was sitting in a darkened corner of a resident common area with a personal cell phone in hand and face illuminated by the light from the phone. Once the state surveyor approached CNA #838, the cell phone was dimmed and placed in the pocket of CNA #838's scrub pants.An interview at the time of observation with CNA #838 was unsure of what the facility's policy was for personal cell phones, although she was sure they were prohibited from using them during work hours. CNA #838 confirmed she did not have a work cell phone, only her personal one.Review of the Resident Council meeting minutes dated 05/07/26 revealed that regarding the nursing department, residents stated some aides were on their phones too much. Staff education regarding cell phone usage was provided.Review of the Resident Council meeting minutes dated 06/05/26 revealed that regarding the nursing department, residents stated some aides were on their phones too much. Review of the Resident Council departmental response forms for the nursing department 06/05/26 revealed numerous concerns were listed but did not address staff being on their cell phones.Review of the employee handbook, page 30, revealed the use of cell phones in resident areas may violate regulations and was prohibited in the work area.This deficiency represents non-compliance investigated under Complaint Number 3005283.