STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366488	A. Building B. Wing	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenue at Lyndhurst	5442 Rae Road Lyndhurst, OH 44124

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure Resident #12 and Resident #27 were treated in a dignified manner at all times. This affected two residents (Resident #12 and Resident #27) of 11 residents reviewed for dignity. The facility census was 88. Findings include: 1. A review of resident record for Resident #27 revealed the date of admission as 03/22/24 with diagnosis including hemiplegia and hemiparesis following a cerebral infarction affecting the left non dominant side, acute respiratory failure with low oxygen level, and type 2 diabetes mellitus without complications. Resident #27's physician orders included barrier cream to the bilateral buttocks after each incontinent episode and as needed. An annual Minimum Data Set (MDS) assessment dated [DATE] revealed a brief interview for mental status with a score of 12 indicating resident #27 was cognitively intact. The assessment further revealed resident #27 had impairment on one side of the upper extremity and lower extremity. Lastly the assessment revealed resident #34 was dependent on staff for completion of all activities of daily living. A care plan dated 06/05/26 revealed Resident #27 had a self-care deficit related to cerebral vascular accident and hemiplegia. Staff was to provide care throughout the day. The care plan further revealed resident #27 to need the assistance of one attendant for toilet use and that resident #27 was incontinent. Interventions included encourage resident to use the call light for assistance and praise the resident for all evidence of self-care. The care plan also revealed resident #34 had altered skin integrity due to impaired mobility, impaired cognition, and incontinence of bowel and bladder. Interventions included barrier cream as ordered. On 06/03/26 at 9:45 A.M. Resident #27 was receiving care from Certified Nurse Aide (CNA) #308. The door was closed and this surveyor was observing a medication pass with Registered Nurse (RN) # 419. CNA #308 then opened the door and hollered down the hall for someone to bring her barrier cream for Resident #34. RN #419 verified CNA #308 was hollering down the hall for a personal care item. CNA #308 then went back in the room and closed the door. This surveyor knocked on the door as it was observed CNA #308 was rendering care to Resident #27 without donning a gown to follow enhanced barrier precautions. As this surveyor opened the door and introduced myself, CNA #308 looked at this surveyor and stated. well, this is just great. The comments was made in front of the resident and able to be heard out in the hall by RN #419. RN #419 verified hearing the statement at the time it was said. (continued on next page)

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
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record for Resident #12 revealed he was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes, benign prostatic hyperplasia with lower urinary tract symptoms, and obstructive uropathy. Review of Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #12 had a Brief Interview for Mental Status (BIMS) score of 12 that indicated he was alerted and oriented with some cognition impairment. Review of the MDS assessment revealed Resident #12 had an indwelling catheter, had impairment on both upper and lower extremities and was dependent on staff for activities of daily living (ADLs). Review of the care plan dated 05/15/26 revealed Resident #12 had a foley catheter with interventions that included cover catheter bag for privacy bag and dignity. Review of the physician orders dated 03/31/26 revealed orders for a foley catheter due to obstructive uropathy, dignity privacy cover to catheter bag and foley catheter care per policy. Observation and interview on 06/11/26 at 8:49 A.M. revealed CNA #375 walking past Resident #12 who was sitting in his wheelchair in the common area adjacent to the nursing station. Resident #12 foley catheter bag was positioned on the right side of his wheelchair and uncovered. Observation revealed Resident #12 foley bag was filled with a yellowish liquid. CNA #375 identified the contents of Resident #12's foley bag as urine and continued to walk past him. CNA #375 stated It should be covered but I'm helping with a hoyer right now when asked should Resident #12 foley bag be covered. CNA #375 confirmed and verified the above findings at the time of the interview. Observation and interview on 06/11/26 at 8:54 A.M. with Human Resources (HR) #387 revealed all foley bags were to be covered for privacy and dignity. HR #387 revealed Resident #12 foley bag was exposed while he was seated in the common area. HR #387 confirmed and verified the above findings at the time of the interview. Interview on 06/03/26 at 11:00 A.M. with Corporate Registered Nurse (RN) #412 confirmed that the facility did not have a dignity policy, the facility follows the resident rights policy. Review of the undated facility policy called Catheter (Indwelling), Insertion and Removal of (Female and Male) revealed it did not mention covering the catheter bag. This deficiency represents non-compliance investigated under Complaint Number 272510, 2604622, 3035297, and 3037432.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and review of the facility policy, the facility failed to provide care conferences quarterly and upon request. This affected seven residents (#10, #14, #17, #34, #46, #65 and #87) of seven residents reviewed for care planning. Facility census was 88.Findings include: 1. Review of Resident #14's medical record revealed an admission date of 06/17/22 and diagnoses including hemiplegia and hemiparesis affecting right dominant side, depression, morbid obesity, spinal stenosis and hyperlipidemia. Review of a quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #14 was cognitively intact and did not reject care. Further review of Resident #14's medical record revealed no evidence of a care conference since the last recertification survey completed on 08/28/25. Interview on 06/10/26 at 12:00 P.M. with the Administrator and Corporate Registered Nurse (CRN) #412 verified they could not locate evidence of any care conferences held for Resident #14 since 08/28/25. 2. Review of the medical record for Resident #10 revealed he was admitted to the facility on [DATE] with diagnoses that included vascular dementia, pulmonary hypertension, and hemiplegia and hemiparesis following cerebral infraction affecting the left dominant side. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #10 had a Staff Assessment for Mental Status (SAMS) that indicated he had short- and long-term memory problem, was severely impaired regarding task of daily life, had inattention, disorganized thinking and altered level of consciousness. Review of the MDS assessment revealed Resident #10 had impairment on one side of both the upper and lower extremities and was dependent on staff for activities of daily living (ADLs). Review of the progress note dated 11/10/25 at 2:52 P.M. revealed Resident #10 had a quarterly care conference scheduled for 12/09/25 at 12:00 P.M. Review of the progress notes dated from 11/10/25 through 06/01/26 revealed no care conferences had taken place. Review of the assessments dated from Resident #10 admission, 06/19/25 through 06/01/26, revealed no care conferences documented. Interview on 06/02/26 at 3:30 P.M. with Resident #10's Power of Attorney (POA) revealed the facility did not provide care planning and/or care conferences. Resident #10's POA revealed the only person she was able to discuss anything with was the social service and activity departments. Resident #10's POA revealed she had not had a care conference despite her requests. Interview on 06/02/26 at 12:31 P.M. with Social Service Designee (SSD) #421 revealed she was responsible for completing admission care conferences and the after that, residents received (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	quarterly care conferences. SSD #421 revealed care conferences were scheduled mid-month, and notifications were sent to families. SSD #421 revealed all care conferences were documented in Point Click Care (PCC) under the plan of care summary listed under the assessments tab. SSD #421 revealed care conferences generated a progress note, therefore care conferences were documented in two different areas in the resident's medical record. SSD #421 after review of Resident #10's medical record confirmed and verified there were no documented care conferences or upcoming care conferences scheduled. Interview on 06/02/26 at 2:36 P.M. with Activity Director (AD) #316 revealed care conferences were scheduled to take place every 3 months and was documented in PCC. AD #316 revealed care conference forms were also uploaded in the miscellaneous section of the resident's medical record. AD #316 revealed if care conferences were not listed in PCC, then it did not happen. AD #316 after review of Resident #10's medical record confirmed and verified there were no documented care conferences or upcoming care conferences scheduled. Interview on 06/02/26 at 2:58 P.M. with Registered Nurse (RN) #418 revealed she assisted with scheduling care conferences and care conferences were scheduled upon admission and quarterly. RN #418 revealed care conferences were documented in PCC under the assessments tab. RN #418 after review of Resident #10's medical record confirmed and verified there were no documented care conferences or upcoming care conferences scheduled. 3. Review of the medical record for Resident #17 revealed she was admitted to the facility on [DATE] with diagnoses that included nontraumatic subarachnoid hemorrhage, hemiplegia affecting left nondominant side, functional quadriplegia and contracture of right hand. Review of the MDS assessment dated [DATE] revealed Resident #17 had a Brief Interview for Mental Status (BIMS) score of 7, that indicated she had short- and long-term cognition impairment. Review of the MDS assessment revealed Resident #17 had inattention, impairment on both sides of the upper and lower extremities and was dependent on staff for ADLs. Review of the care plan conference summary dated 09/04/25 revealed Resident #17 had a care conference requested by Resident #17's designated care conference person. Review of the care plan summaries dated from Resident #17's last care conference, 09/04/25 through 06/01/26, revealed no other care conferences documented. Interview on 06/01/26 at 2:45 P.M. with Resident #17's designated care conference person revealed she had not been offered a care conference since her last requested meeting dated 09/04/25. Resident #17's designated care conference person revealed due to state surveyors being in the building, the facility was canceling all care conferences at this time. Interview on 06/02/26 at 12:31 P.M. with SSD #421 revealed she was responsible for completing admission care conferences and the after that, residents received quarterly care conferences. SSD #421 revealed care conferences were scheduled mid-month, and notifications were sent to families. SSD #421 revealed all care conferences were documented in Point Click Care (PCC) under the plan of care summary listed under the assessments tab. SSD #421 revealed care conferences generated a progress note, therefore care conferences were documented in two different areas in the resident's medical record. SSD #421 after review of Resident #17's medical record confirmed and verified there were no documented care conferences or upcoming care conferences scheduled. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 06/02/26 at 2:36 P.M. with AD #316 revealed care conferences were scheduled to take place every 3 months and was documented in PCC. AD #316 revealed care conference forms were also uploaded in the miscellaneous section of the resident's medical record. AD #316 revealed if care conferences were not listed in PCC, then it did not happen. AD #316 after review of Resident #17's medical record confirmed and verified there were no documented care conferences or upcoming care conferences scheduled. Interview on 06/02/26 at 2:58 P.M. with RN #418 revealed she assisted with scheduling care conferences and care conferences were scheduled upon admission and quarterly. RN #418 revealed care conferences were documented in PCC under the assessments tab. RN #418 after review of Resident #17's medical record confirmed and verified there were no documented care conferences or upcoming care conferences scheduled. 4. Review of the medical record for Resident #34 revealed she was admitted to the facility on [DATE] with diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting the left dominant side, tremor, contracture, moderate protein calorie malnutrition, dysphagia and carpal tunnel syndrome. Review of the MDS assessment dated [DATE] revealed Resident #34 had a BIMS score of 12 that indicated she was alert and oriented with some cognition impairment. Review of the MDS assessment revealed Resident #34 had impairment on one side of both upper and lower extremities and was dependent on staff for ADLs. Review of the assessments dated august 2025 through 06/01/26, revealed no care conferences documented. Interview on 06/02/26 at 12:31 P.M. with SSD #421 revealed she was responsible for completing admission care conferences and the after that, residents received quarterly care conferences. SSD #421 revealed care conferences were scheduled mid-month, and notifications were sent to families. SSD #421 revealed all care conferences were documented in Point Click Care (PCC) under the plan of care summary listed under the assessments tab. SSD #421 revealed care conferences generated a progress note, therefore care conferences were documented in two different areas in the resident's medical record. SSD #421 after review of Resident #34's medical record confirmed and verified there were no documented care conferences or upcoming care conferences scheduled. Interview on 06/02/26 at 2:36 P.M. with AD #316 revealed care conferences were scheduled to take place every 3 months and was documented in PCC. AD #316 revealed care conference forms were also uploaded in the miscellaneous section of the resident's medical record. AD #316 revealed if care conferences were not listed in PCC, then it did not happen. AD #316 after review of Resident #34's medical record confirmed and verified there were no documented care conferences or upcoming care conferences scheduled. Interview on 06/02/26 at 2:58 P.M. with RN #418 revealed she assisted with scheduling care conferences and care conferences were scheduled upon admission and quarterly. RN #418 revealed care conferences were documented in PCC under the assessments tab. RN #418 after review of Resident #34's medical record confirmed and verified there were no documented care conferences or upcoming care conferences scheduled. 5. Review of the medical record for Resident #46 revealed an admission date of 08/30/25. Diagnoses (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	included but were not limited to idiopathic normal pressure hydrocephalus, morbid obesity, stage III chronic kidney disease and congestive heart failure. Review of the 03/06/26 quarterly MDS 3.0 for Resident #46 revealed moderate cognitive impairment. Resident #46 was noted to be dependent for toileting, bathing lower dressing and transfers. Review of the assessments tab in the electronic medical record for Resident #46 revealed care conferences were completed on 09/03/25, 12/02/25, and 06/08/25. Phone interview on 06/11/26 at 10:58 A.M. with interim SSD #421 confirmed the facility did not have a social worker in 03/26 and she did not start assisting till 04/26. SSD #421 confirmed she was unable to provide evidence a care conference was completed for Resident #46 following her MDS completed on 03/06/26. 6. Review of the medical record for Resident #65 revealed an admission date of 07/24/24. Diagnoses included but were not limited to Alzheimer's dementia, chronic obstructive pulmonary disease, osteoarthritis and repeated falls. Review of the 04/20/26 quarterly MDS 3.0 for Resident #65 revealed severe cognitive impairment. Resident #65 was noted to require supervision for most activities of daily living. Review of the assessments tab in the electronic medical record for Resident #65 revealed only one recorded care conference since admission on [DATE]. Interview on 06/10/26 at 2:12 P.M. with the Director of Nursing confirmed no care conference had been completed since 01/16/26 and should have done after the last quarterly MDS in 04/26. 7. A review of closed medical record for Resident #87 revealed the date of admission as 07/25/25. Resident #87 was discharged from the facility on 04/24/26. Resident #87's diagnoses included congestive heart failure, gout, gastroesophageal reflux disease, muscle weakness, and Parkinson's disease with dyskinesia. A quarterly MDS assessment dated [DATE] revealed a brief interview for mental status with a score of 13 indicating Resident #87 was cognitively intact. A care plan dated 01/30/26 revealed Resident #87 needed assistance with bathing, needed assistance to transfer and ambulate as needed and needed assistance for toileting. A review of care plan review dates revealed the care plan was reviewed and updated on 10/28/26, and 01/30/26. A review of a progress note dated 10/28/26 revealed the only care conference meeting. There were no other care conferences documented in the medical record of Resident #87. A review of a document titled; Care Plan Conference Summary dated 10/28/25 revealed one care conference attended by the daughter of Resident #87. On 06/15/26 at 10:26 A.M. an interview with Corporate Registered Nurse #412 verified the lack of care plan conferences for Resident #87. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility document titled Care Conference revised August 2025, revealed the facility had a policy in place that care conferences would be conducted routinely and as necessary to discuss and coordinate residents plans of care, care needs and to evaluate goals to determine whether the established goals were appropriate and/or being met. Review of the policy revealed the contents of the care conference, and the attendees would be documented and signatures would be provided. Review of the facility document revealed the facility did not implement the policy. This deficiency represents noncompliance investigated for Complaint Numbers 3035297, 2727510, and 2673907.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure call lights were in reach at all times to accommodate resident needs. This affected three residents (Resident #34, Resident #93, and Resident #100) out of 11 residents reviewed for resident rights. Findings include: 1. A review of medical record for Resident #93 revealed the date of admission as 05/28/26. Resident #93's diagnoses included lumbar stenosis, difficulty walking and history of falling. There were no orders for call light placement.A Medicare five-day MDS assessment dated [DATE] revealed a brief interview for mental status with a score of 14 indicating Resident #93 was cognitively intact. The MDS Resident #93 needed supervision and touching assistance with toileting, bathing, dressing, and all transfers including toilet transferring.A care plan dated 05/29/26 revealed Resident # 93 was at risk for falls related to impaired mobility, weakness, and impaired safety awareness. Interventions included encourage use of call light for assistance.On 06/01/26 at 10:47 A.M. an observation of Resident #93 revealed her sitting in a recliner chair with her legs elevated. The call light activation button for Resident #93 was noted to be tucked between the cushion and the arm of the couch next to Resident #93. The call light activation button could not be visualized or reached by Resident #93. Personnel Manager #387 verified the call light activation button could not be seen or reached by Resident #93 at the time of the observation.2. Review of the medical record for Resident #34 revealed she was admitted to the facility on [DATE] with diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting the left dominant side, tremor, contracture, moderate protein calorie malnutrition, dysphagia and carpal tunnel syndrome.Review of the MDS assessment dated [DATE] revealed Resident #34 had a BIMS score of 12 that indicated she was alert and oriented with some cognition impairment. Review of the MDS assessment revealed Resident #34 had impairment on one side of both upper and lower extremities and was dependent on staff for ADLs.Review of the care plan dated 02/25/26 revealed Resident #34 had a self-care deficit and was at risk for falls with interventions to provide assistance of one and keep call light within reach.Interview and observation on 06/01/26 at 10:42 A.M. with Resident #34 revealed facility staff left her in bed most days and ignored her. Resident #34 revealed staff did not help her and most staff responded to her by saying I'm not assigned to you. Resident #34 revealed most staff did not claim her as their assigned resident. Resident #34 revealed when she pressed her call light, it took staff over 30 minutes to respond or sometimes they didn't respond at all. Observation of Resident #34 call light revealed it was located on the floor underneath her bed. Resident #34 revealed she could not reach her call light.Interview on 06/01/26 at 10:52 A.M. with Registered Nurse (RN) #350 revealed Resident #34 did not need any help with much and she could voice her concerns. RN #350, after observation of Resident #34 call light, confirmed and verified it was not within reach.Review of the facility document titled Resident Call System revised March 2023, revealed the facility had a policy in place that call lights were to be within resident's reach to ensure an environment that supported and enhanced each resident's quality of life and maintain the highest practical physical, mental, and psychosocial wellbeing. Review of the document revealed the facility did not implement the policy.3. Review of the medical record for Resident #100 revealed an admission date of 03/13/26 with diagnoses included but were not limited to moderate protein calorie malnutrition autistic disorder and gastrostomy status.Review of the 03/13/26 nursing admission assessment revealed Resident #100 was a total assist. Resident #100 was noted to be alert and oriented to time and place. Mental function was noted to vary. Nothing was indicated for communicationReview of 03/15/26 care plan for Resident #100 revealed at risk for falls related to psych meds and dependent for all transfers. One of the interventions listed included to encourage the use of call light for assistance.Observation on 06/01/26 at 1:23 P.M. with Licensed Practical Nurse (LPN) #383 confirmed Resident #100's call pad was under his pillow and head and not within his reach.Review of the March 2023 revised facility policy called Resident Call System (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed the staff will provide and environment to assist in making the needs of the resident and to provide an environment which supports and enhances each resident's quality of life, providing the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being consistent with the resident's comprehensive assessment and plan of care. Under the procedure: respond to a resident's call light in a timely manner, do not turn the light off if you are unable to meet the resident's needs, when leaving the room, be sure the call light is placed within the resident reach.

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(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 - Few	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 record review, observation, interview and facility policy review, the facility failed to ensure a comfortable, homelike environment with equipment that was in good repair. This affected two residents (Residents #34 and #77) of 10 residents reviewed for environment and had the potential to affect all residents within the facility. The facility census was 88.Findings include: 1. Review of medical records for Resident #77 revealed the date of admission as 02/11/26 with diagnoses including congestive heart failure, protein calorie malnutrition, chronic obstructive pulmonary disease, chronic kidney disease, and dementia. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #77 had a severe cognitive impairment. Review of a progress note dated 04/23/26 revealed the sister of Resident #77 was in to visit and noted water under the heating unit in his room. A towel was placed under the unit, and the Administrator was notified. Review of a work order dated 05/11/26 revealed there was water all over the floor in room [ROOM NUMBER]. In the comment section of the work order stated, the water was gotten up off the floor and cleaned up. There was no indication on the work order of the source of the water on the floor or any repairs that were made. On 06/03/26 at 3:05 P.M. an observation and interview with the sister of Resident #77 revealed there was a large puddle of water under the heating unit in the room of Resident #77. The resident's sister stated she had been telling the facility for months there was a leak and they have yet to repair it. On 06/04/26 at 10:05 A.M. an observation and interview revealed a large puddle of water under heating unit in Resident #77's room. The puddle of water under the heating unit was verified by Licensed Practical Nurse (LPN) #324 at the time of the observation. On 06/10/26 at 12:55 P.M. an interview and observation with Maintenance Director (MD) #343 revealed a towel under the heating unit in Resident #77's room. MD #343 stated the facility uses the TELS system (Computerized Maintenance Management System (CMMS) designed specifically for senior living and skilled nursing facilities (SNFs) for repairs and any staff member can put a needed repair in the system. MD #343 verified the work order dated 05/11/26 and noted there were no repairs made to the heating unit in the room of Resident #77. MD #343 stated the heating unit in the room of Resident #77 needed cleaned and he would get to it. MD #343 stated he was not sure how long the unit had been leaking. On 06/16/26 at 2:00 P.M. an interview with Corporate Registered Nurse #412 revealed the facility did not have a policy on maintaining a comfortable environment. 2. Review of the medical record for Resident #34 revealed she was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting the left dominant side, tremor, contracture, moderate protein calorie malnutrition, dysphagia and carpal tunnel syndrome. (continued on next page)

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	366488	A. Building B. Wing	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenue at Lyndhurst	5442 Rae Road Lyndhurst, OH 44124

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the care plan dated 02/25/26 revealed Resident #34 had a self-care deficit with interventions to provide assistance with activities of daily living (ADL). Review of the MDS 3.0 assessment dated [DATE] revealed Resident #34 was alert and oriented with some cognitive impairment. Resident #34 had impairment on one side of both upper and lower extremities and was dependent on staff for ADL. Interview and observation on 06/01/26 at 10:42 A.M. with Resident #34 revealed facility staff left her in bed most days and ignored her. Resident #34 revealed staff did not help her, and most staff responded to her by saying I'm not assigned to you. Resident #34 revealed most staff did not claim her as their assigned resident. Resident #34 revealed the facility was responsible for doing her laundry, but they had not done it in a while. Resident #34 revealed her granddaughter would often have to come to the facility to put away her laundry. Observation of Resident #34 room revealed three chairs and a laundry basket with various piles of overflowing clothing, linen, and other various unknown items. During an interview on 06/01/26 at 10:52 A.M., Registered Nurse (RN) #350 stated the facility was responsible for doing Resident #34's laundry. RN #350, after observation of Resident #34 piles of clothing, confirmed and verified it was not done and stated, I will let laundry know. Review of the facility document titled Personal Clothing, revised September 2022, revealed the facility had a policy in place that personal clothing was removed and laundered before leaving the work area. Review of the document revealed the facility did not implement the policy. This deficiency represents non-compliance investigated under Complaint Number 2616202.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure Resident #100 was free from neglect of necessary care and services to allow the resident to reach the highest practicable, physical and emotional well-being. This affected one resident (Resident #100) of five residents reviewed for abuse and neglect. The facility census was 88. Findings include:Review of Resident #100's medical record revealed Resident #100 was admitted on [DATE] with severe cognitive impairment, autistic disorder, moderate proteinˆcalorie malnutrition, immobility, bowel and bladder incontinence, and a history of skin issues.Review of Resident #100's admission Braden revealed a score was 9, indicating very high risk for pressure injuries. The resident required continuous enteral feeding via PEG tube and total assistance for all ADLs, including feeding, oral care, bathing, hygiene, and mobility.Review of Resident #100's medical record revealed a fungal rash to the right groin documented beginning 03/13/26, with Certified Nurse Practitioner (CNP) #441 repeatedly directing staff to place a pillow between the legs to offload pressure; however, there was no physician order for pillow placement, and staff documentation did not show this intervention in place. Weekly skin assessments required by order and policy were missing except for one documented on 03/25/26. On 03/26/26, CNP #441 identified a new inˆhouse acquired Stage 3 pressure ulcer to the right groin. Treatment ordered on 03/26/26 was not initiated until 04/01/26. Through April and May 2026, required wound treatments were repeatedly missed, not documented, or incorrectly transcribed, with no nursing notes explaining omissions. Review of Resident #100's behavioral notes throughout April and May 2026 revealed repeated episodes of selfˆinjury (hitting self with hands or objects). The care plan dated 04/02/26 lacked autismˆspecific interventions addressing communication, sensory needs, triggers, or deˆescalation.Review of Resident #100's medical record revealed the resident required continuous enteral nutrition and consumed food by mouth. Enteral feeding orders were not consistently followed, with multiple long gaps in documented enteral intake. The facility ran out of Isosource 1.5 during the weekend of 05/29/26 through 05/31/26 without timely physician orders for substitution. The resident was totally dependent for feeding yet was not on the feedingˆassistance list and feeding documentation showed large gaps where no meal assistance was recorded.Review of Resident #100's bathing record revealed only about half of scheduled opportunities during March through May 2026 were completed, and oral care was documented only 4 times out of 30 days where twice daily care was required.On 06/01/26 at 12:39 P.M., interview with Resident #100's mother revealed she received a text from facility staff stating they had run out of Isosource 1.5. She stated when she left at 11:30 P.M. on 05/31/26 the enteral feeding bag was almost empty, and when she returned at 11:40 A.M. on 06/01/26 there was no tube feeding running. She stated he has had weight loss and was concerned.On 06/01/26 at 12:50 P.M., interview with Licensed Practical Nurse (LPN) #347 revealed the resident had knocked the feeding bag down, and she had not had a chance to get back to hang another one up, and she was unable to locate additional Isosource. LPN #347 could not provide evidence of the discarded bag.On 06/01/26 at 1:10 P.M., interview with Maintenance #414 revealed she changed the garbage bag at 10:07 A.M. and the enteral feeding was in the trash, and she showed a picture of a clean trash container.On 06/01/26 at 1:11 P.M., interview with Unit Manager #350 confirmed the enteral feeding had not been hung since at least 10:07 A.M.On 06/01/26 at 2:07 P.M., interview with Resident #100's mother revealed staff do not brush his teeth and do not bathe him consistently.On 06/03/26 at 12:46 P.M., observation revealed Resident #100's enteral feeding was not running.On 06/03/26 at 1:17 P.M., interview with LPN #356 confirmed Resident #100's lunch tray was on the table, untouched and out of reach.On 06/03/26 at 1:46 P.M., observation revealed the lunch tray remained untouched on the bedside table.On 06/03/26 at 2:21 P.M., interview with LPN #323 revealed she fed three residents in the dining room and was in the dining room away from her (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unit for about one and a half hours, and could not monitor the resident's tube feeding.On 06/03/26 at 3:10 P.M., observation of a skin check revealed a slightly reddened groin with no pillow in place. RN #350 and LPN #353 verified there was no pillow in place.On 06/04/26 at 8:32 A.M., observation revealed the resident's breakfast tray was on the counter across from his bed, untouched and not in reach.On 06/04/26 at 9:23 A.M., observation revealed the tray remained untouched.On 06/04/26 at 9:28 A.M., interview with CNA #342 confirmed staff take Resident #100's tray into the room and leave it for his mom and do not try to feed him.On 06/04/26 at 11:06 A.M., interview with the Director of Nursing (DON) confirmed the resident was dependent for feeding but was not listed on the feedingˆassistance list.On 06/04/26 at 12:33 P.M., interview with Resident #100's mother revealed she often found trays untouched from previous meals and staff had told her they would attempt to feed him when she was not present.On 06/08/26 at 8:52 A.M., observation revealed Resident #100's breakfast tray was still on the hall cart and untouched; CNA #316 confirmed it had not been offered.On 06/08/26 at 9:19 A.M., interview with the Administrator confirmed the breakfast tray was still on the cart in the hallway and had not been offered.On 06/08/26 at 1:15 P.M., observation revealed Resident #100's lunch tray was out of reach at the foot of the bed, untouched, with melted ice cream.On 06/08/26 at 1:50 P.M., interview with Registered Dietitian (RD) #420 revealed Resident #100 does not have a good oral intake and is reliant on his tube feeding.On 06/09/26 at 3:12 P.M., interview with Resident #100's mother revealed when she arrived on this day the enteral feeding bag was on the floor and not running.On 06/09/26 at 4:06 P.M., observation and interview with LPN #323 and Maintenance #343 confirmed the feeding bag was on the floor and the pole needed to be tightened.On 06/09/26 at 4:09 P.M., interview with LPN #323 revealed she was not aware the feeding was off and the pole was broken this morning.On 06/10/26 at 7:53 A.M., interview with Registered Nurse (RN) #419 confirmed staff could not find Isosource on 05/31/26 and LPN #323 called the onˆcall manager and let the resident's mother know and obtained permission to use Nutren 1.5, but the order was not written until 06/01/26.On 06/10/26 at 8:39 A.M., interview with Central Supply Clerk #359 confirmed he placed orders on 05/21/26 and 05/28/26 but Isosource was not on either, and they did run out. during the weekend of 05/29/26.On 06/10/26 at 9:47 A.M., observation of Resident #100's incontinence care showed no pillow in place before or after care; CNAs #366 and #400 verified no pillow was used.On 06/10/26 at 10:14 A.M., interview with RD #420 revealed three residents were on Isosource and required six oneˆliter bags for a 24ˆhour period; she became aware the facility was out on 06/01/26.On 06/11/26 at 11:10 A.M., interview with CNP #441 revealed she was not made aware that treatments ordered on 03/26/26 were delayed until 04/01/26.On 06/11/26 at 3:06 P.M., interview with the DON verified the wound care order dated 03/26/26 was not started and that weekly skin checks were not documented.On 06/11/26 at 3:07 P.M., interview with DON verified that wound treatments were not completed as ordered and there was no documentation explaining why.On 06/16/26 at 7:23 A.M., interview with the Administrator confirmed she received Resident #100's mother's emails about missed care and was unaware staff asked the mother to check another facility for formula.On 06/16/26 at 8:36 A.M., interview with Unit Manager #353 revealed she was not aware of enteral feeding shortages and could not provide evidence of physician substitution orders.On 06/16/26 at 9:22 A.M., interview with DON confirmed feeding assistance, oral care, and bathing were not provided and documented daily as required.Review of the policy titled, Abuse Prohibition, revised October 2022, revealed each resident has the right to be free from abuse, neglect, mental or physical abuse. Neglect is defined as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. All new and present employees will receive initial and continuous education, training, and reinforcement that identifies all aspects of abuse prohibition. On-going staff training will be provided in the areas of assessment, care planning and monitoring, and appropriate interventions/actions for those resident with special needs that may lad to neglect/abuse such as aggressive behaviors, catastrophic behaviors, behaviors during care ., history of self-injury, (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	communication disorders, and resident's requiring excessive nursing care or staff attention.This deficiency represents non-compliance investigated under Complaint Number 2616202, 3014007, and 272510.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of the facility self-reported incident (SRI), policy review, and interviews, the facility failed to prevent the diversion of narcotics by staff. This affected one resident (Resident #73) of one resident reviewed for misappropriation. The facility census was 88.Findings include: Review of the medical record for Resident #73 revealed readmission to the facility on [DATE] with diagnosis including encounter for surgical aftercare following surgery on the digestive system. The resident had a physician's order for oxycodone (a narcotic given for pain control) 5 milligrams (mg) give one tablet by mouth every six hours as needed (PRN) for pain.Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #73 was cognitively intact. Resident #73 received scheduled and PRN pain medications. The pain was described as almost constant, and frequently affected sleep with a level of eight on a zero to 10 pain scale with 10 being the worst.Review of the care plan dated 04/22/26 revealed Resident #73 was at risk for alteration in comfort related to pain related to recent abdominal surgery. Interventions included administering pain medication per physician orders.Review of the facility SRI tracking number 266924 for misappropriation of narcotics revealed Registered Nurse (RN) #443 removed six oxycodone 5 mg pills from the facility stock system on 10/27/26 under Resident #73's name. The six tablets of oxycodone were never placed in the narcotic drawer for Resident #73's use. Review of the narcotic count sheet for Resident #73's oxycodone narcotic count sheet revealed the six tablets removed on 10/27/26 were not added to the overall count of oxycodone pills. RN #443 removed six oxycodone 5 mg pills from the facility stock system on 10/28/26 under Resident #73's name. The six tablets of oxycodone were never placed in the narcotic drawer for Resident #73's use. A review of the narcotic count sheet for Resident #73's oxycodone narcotic count sheet revealed that the six tablets removed on 10/28/26 were not added to the overall count of oxycodone pills. Review of a witness statement by RN #444 revealed RN #443 came to her about 6:30 P.M. on 10/28/25 and asked for the narcotic keys; RN #443 was in her uniform, so she did not question it as she was busy doing an admission. Review of time punches for RN #443 revealed she was not clocked in on 10/27/25 and 10/28/25. The report stated that the local police were called. There was no police report to review as part of the investigation.Review of a document titled: Theft and Significant Loss Report, dated 02/25/26, created by the Ohio Board of Pharmacy revealed the date of the theft was 10/28/25 and the Lyndhurst police were notified. The report further revealed RN #443 was employed by the facility at the time of the incident. RN #443 came into the facility and removed six oxycodone pills from the Alixa machine (a machine at the facility for stock medications).During an interview on 06/16/26 at 3:00 P.M, the Administrator stated that RN #443 came into the facility when she was not working and retrieved the narcotic keys from RN #444. RN #444 did not question handing over the narcotic keys as RN #443 was in her uniform and she thought she was working. During an interview on 06/16/26 at 4:00 P.M., Corporate RN #414 revealed RN #443 was not on the schedule 10/27/25 and 10/28/25 and retrieved the narcotic keys from RN #444 and removed oxycodone tablets under Resident #73's name.A review of the facility policy titled; Medication Storage in the Facility-Controlled Substance Storage, dated 06/15, revealed controlled substances are not surrendered to anyone, including the residence physician, other than releasing controlled medication for a resident on pass or therapeutic leave, to a resident or responsible party upon discharge from the facility, or to the Drug Enforcement Agency (DEA) or other law enforcement officials functioning in a professional capacity in exchange for a receipt documenting the transaction.A review of the undated facility policy titled; Abuse Prohibition revealed the definition of misappropriation of resident property is defined as the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a residence belonging or money without the residents consent. The policy further stated the healthcare center's management will conduct a prompt investigation of any allegation received of suspected abuse, neglect, or misappropriation of (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	property and or funds. If warranted the health care centers management will provide notification to the proper authorities and when required, release the information to those agencies.This deficiency represents non-compliance investigated under Complaint Number 2703783 and 2609064.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. Based on record review, interview and review of the facility policy, the facility failed to employ staff free of disqualifying offenses. This had the potential to affect all 88 residents residing in the facility. Findings include: 1. Review of Human Resource Manager (HRM) #439's personnel file revealed a date of hire of 10/08/25. The file included a employee corrective action form dated 04/02/26 for termination as HRM #438 had been charged/convicted of an exclusionary offense. Review of undated Cuyahoga County Clerk of Courts docket information included in HRM #439's personnel file revealed she was indicted on 12/10/25 with pre-trials held on 01/06/26, 02/25/26 and 03/05/26. Charges listed included 2913.05 (telecommunications fraud) and 2913.02 (grand theft). Bail was posted on 12/24/25. Review of an e-mailed statement from HRM #439 to the Administrator on 04/01/26 revealed HRM #439 worked at another nursing facility for three years and put her notice in but the owners were upset so she did not work out her notice as she resigned. A month after starting employment at this facility, HRM #439's previous facility contacted her saying she owed $8000.00 and stated she had paid her son for time he was not employed there and if she did not pay the money back, the police would be called. A few months later, HRM #439 received a summons to appear in court and did not know what was going on. On 12/24/25 HRM #439 went to court and was told to plead guilty and be on probation because it was either that or going to trial. HRM #439 now had to pay restitution of $12000.00 and be on probation until it was paid. HRM #439 claimed her previous employer had it out for her and her son. Interview on 06/15/26 at 9:08 A.M. with the Administrator and Corporate Registered Nurse (CRN) #412 revealed on hire, HRM #439 did not have any disqualifying offenses on her background check. On 04/01/26, the facility received an anonymous tip that HRM #439 had a grand theft charge, so she was suspended that date. The Administrator confirmed 04/01/26 was the last date HRM #430 worked in the facility and shared when HRM #439 had been asked about the charges verbally, she denied them which contradicted the email above she provided the same date on 04/01/26. The Administrator verified staff were to notify them of any changes in legal status, including being charged of disqualifying offenses, which HRM #439 did not do. Phone interview on 06/15/26 at 1:14 P.M. with HRM #439 revealed she worked at the facility from 10/06/25 (wrong date) to 04/02/26 and confirmed she no longer worked at the facility as a previous employer said she did bad things, I did not, I had to go to court and the previous employer contacted the facility. HRM #439 stated she was notified mid-December 2025 of the charges of which she was arraigned for on 12/24/25 and confirmed she did not notify the Administrator of the charges at this time. HRM #439 stated on 03/30/26 she was sentenced for telecommunication fraud and grand theft and again confirmed she did not notify the Administrator of the charges as the facility had nothing to do with this. 2. Review of the employee file for Previous Director of Nursing (DON) #442 revealed an employment application dated 11/30/23 for Previous Director of Nursing (DON) #442 revealed an application for a registered nurse. On page two under the question which stated have you ever been convicted or pled guilty to a criminal offense, Previous DON #442 wrote expungement. No further details were noted. (continued on next page)

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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility's Bureau of Criminal Investigation (BCI) log revealed Previous DON #442 was listed as having an application date of 11/30/23, a date or hire and date of application submitted of 12/07/23. The date received back was listed as 12/19/23 with a 30-day cut off of 01/07/24 and indicated Previous DON #442 was hired on 12/07/23. Review of the employment offer for Director of Nursing for Previous DON #442 revealed a hire date of 05/22/25. Interview on 06/15/26 at 9:34 A.M. with Regional Registered Nurse (RN) #412 revealed Previous DON #442 was the ADON and became the assisting DON when there was a vacancy. The facility offered her the DON position. Regional RN #412 stated she was aware of staff reported concern related to her management style. Observation at the time of the interview opening Previous DON #442's BCI log results revealed the criminal history record check BCI convictions on file check dated 12/19/23 for Previous DON #442 revealed an arrest on 07/10/25 for a theft misdemeanor. The petty theft charge was sealed on 08/03/10. Interview on 06/15/26 at 11:15 A.M. with Regional RN #412 confirmed she was unable to provide evidence of personal care standards following being made aware of the background check results for Previous DON #442. Phone interview on 06/15/26 at 1:43 P.M. with Previous DON #445 stated she started as a as needed (prn) nurse and after three to four months she was asked to be a unit manager. Previous DON #445 stated she was out on medical leave for three weeks and then came back in June 2024 as the Assistant Director of Nursing (ADON). Previous DON #445 stated she was the interim DON for five to six months and then was offered the DON position. Previous DON #445 stated she had a theft violation that was expunged about 15 years ago. Previous DON #445 stated the facility did not request any further information or additional paperwork prior to being hired and stated they did not ask for any further character references. Interview on 06/15/26 at 2:59 P.M. with the Administrator confirmed Previous DON #442 quit the facility via text message on 10/06/25 and stated she was quitting effective immediately. Review of the facility policy, Abuse Prohibition, revised October 2022 revealed the facility will not proceed with hiring any professional that have been found guilty or who have active disciplinary action in effect against them by a state licensing body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property covered individuals will receive education annually of their obligations to report reasonable suspicion of crimes in the facility and on the facility's abuse policy and procedures. the facility will maintain a completed training/orientation attendance sheet documenting the individual completing training on reporting obligations. Facilities will work with law enforcement annually to determine which crimes are reported and provide periodic drills across all levels of staff and across all shifts to assure that covered individuals understand the reporting requirements examples of situations that would likely be considered crimes in all subdivisions would include but not limited to murder, manslaughter, rape, assault and battery, sexual abuse, theft/robbery, drug diversion for personal use/gain, identity theft, fraud and forgery. This deficiency represents non-compliance investigated under Complaint Number 2970354, 2604622, 2673907.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident record reviews, staff interviews, and facility policy review, facility failed to implement personˆcentered fall prevention interventions as outlined in the comprehensive care plans for Residents #10 and #82. This affected two residents (Residents #10 and #82) of 45 residents reviewed for care plans. The facility census was 88.Findings include: 1. Review of the medical record revealed Resident #10 was admitted to the facility on [DATE] with diagnoses including vascular dementia, pulmonary hypertension, and hemiplegia and hemiparesis following cerebral infraction affecting the left dominant side.Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #10 had a Staff Assessment for Mental Status (SAMS) that indicated he had short- and long-term memory problems, was severely impaired regarding tasks of daily life, had inattention, disorganized thinking and altered level of consciousness. Resident #10 had an impairment on one side of both the upper and lower extremities and was dependent on staff for activities of daily living (ADL).Review of the incident log dated 05/17/26 revealed Resident #10 had an unwitnessed fall at approximately 5:45 A.M.Review of the incident note dated 05/17/26 at 5:45 A.M. revealed Resident #10 was found on the floor on the side of his bed. Resident #10 was positioned on the left side of the bed with his bilateral left extremities bent, sitting on his bottom, slightly leaning up near the windowsill. Resident #10 was unable to communicate what happened but denied hitting his head and pain with no injuries noted. Resident #10 was assessed, transferred into bed to be changed, and then transferred to his wheelchair and placed in the dining room. Resident #10's family and physician were notified.Review of the fall investigation dated 05/17/26 revealed Resident #10 was found on the floor in his room on the left side of his bed near the windowsill after an unwitnessed fall. Resident #10 was alone and unattended when he rolled out of bed. Resident #10 was unable to say what occurred but denied hitting his head. Resident #10 was sitting on his bottom with his bilateral lower extremities bent. Resident #10 was then placed in his wheelchair and put in the dining room. Resident #10 neurological checks were initiated and his family and physician were notified. Further review of the fall investigation revealed the witness statement written by Certified Nursing Assistant (CNA) #390 who stated Resident #10 moved around a lot while in bed and that's why he slid out of bed. CNA #390 revealed Resident #10's bed should be in the lowest position to prevent falls.Review of the physician orders dated 05/18/26 revealed an order for bilateral floor mats next to the bed for safety every shift.Review of the interdisciplinary team note dated 05/18/26 at 10:02 A.M. revealed Resident #10's fall was reviewed. Resident #10 was often restless and moved around with impaired positioning due to contracted extremities. Resident #10 had a low air mattress with a perimeter overlay with a new intervention of bilateral floor mats to be implemented to reduce the risk of injury if a fall occurred.Review of the care plan dated 05/18/26 revealed Resident #10 had an ADL function potential and was at risk for falls with interventions including assistance with ADL, floor mats to both sides of the bed and mechanical lift with assistance of two staff for transfers.Interview on 06/02/26 at 3:30 P.M. with Resident #10's Power of Attorney (POA) revealed he was at risk for falls, his bed was always too high from the floor, and the bilateral floor mats were never in place. Resident #10's POA revealed Resident #10 had a recent fall and was found on the floor. Resident #10's POA revealed Resident #10 moved a lot while in bed and floor mats were needed for safety.Observation on 06/02/26 at 3:30 P.M. revealed Resident #10's bed was not in the lowest position, and no floor mats were located the room.During an interview on 06/02/26 at 3:34 P.M., CNAs #337 and #384, while in Resident #10's room, revealed Resident #10 was a fall risk and he moved around a lot while in bed. CNA #384 revealed he recently had a fall and was unsure of his fall interventions. CNAs #337 and #384 confirmed and verified, at the time of the interview, the position of Resident #10's bed was not in the lowest position and there was no floor mats located in the room.During an interview on (continued on next page)

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	366488	A. Building B. Wing	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenue at Lyndhurst	5442 Rae Road Lyndhurst, OH 44124

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	06/09/26 at 7:38 A.M., Licensed Practical Nurse (LPN) #351 stated Resident #10 was a high fall risk but did not have many falls. Resident #10 had a recent fall where he was found on the floor in his room near his windowsill. He moved around a lot while lying in bed and had a new fall intervention for fall mats to be placed on each side of his bed. LPN #351 revealed Resident #10's bilateral floor mats should always be in place. LPN #351 confirmed and verified the above findings at the time of the interview.2. Review of the medical record revealed Resident #82 was admitted to the facility on [DATE] with diagnoses including hemiparesis and hemiplegia following infarction affecting the dominant right side, dementia, and contracture of the right hand. Review of Resident #82 medical record revealed she was discharged from the facility on 05/09/26.Review of the care plan initiated upon admission, dated 04/06/25, revealed Resident #82 was a fall risk with interventions including assessing footwear for proper fit and non-skid soles and if unable to use call light, assess every 30-60 minutes.Review of the updated care plan dated 04/28/25 revealed Resident #82 had impaired cognitive function and/or dementia and a history of actual falls with interventions that included keeping her routine consistent, engaging in simple structured tasks, accommodating needs, assisting with decision making, and anticipating needs. Review of the care plan revealed fall interventions were in place with designated initiated dates as follows: determine and address causative factors of falls and monitor and document falls implemented on 05/01/25, to be in common area at all times when not in bed implemented on 06/07/25 and take to activities between meals implemented on 06/24/25.Review of the incident log dated 11/16/25 revealed Resident #82 had an unwitnessed fall at approximately 11:10 P.M.Review of the progress note dated 11/16/25 at 11:10 P.M. revealed Resident #82 was found on the floor in her room in front of her wheelchair. Resident #82 was assessed with no injuries. A new intervention of Dycem (non-slip material) to the wheelchair when out of bed to prevent falls.Review of the incident log dated 12/14/25 revealed Resident #82 had an unwitnessed fall at approximately 1:15 A.M.Review of the progress note dated 12/14/25 at 12:11 A.M. revealed Resident #82 was seated in her wheelchair in the dining area folding towels. Resident #82, after two attempts to administer medications, was noted to be agitated and trying to self-propel in her wheelchair down the hallway. Resident #82 became more agitated after staff attempts for redirection. Resident #82 was placed on frequent checks for safety. Resident #82 refused to be toileted and was brought back to the hallway to be monitored. Resident #82 was placed on one-on-one supervision and being monitored for safety.Review of the progress note dated 12/14/25 at 1:15 A.M. revealed Resident #82 was found on the floor of her bathroom underneath her walker. Resident #82 walker was in the standing potion with her bilateral legs extended in front of her. Resident #82 denied pain and hitting her head. Resident #82's vital signs were assessed, and there were no bruising or injuries noted. Resident #82's range of motion was intact, and her family and physician were notified.Review of the progress note dated 12/14/25 at 3:40 P.M. revealed the interdisciplinary team reviewed Resident #82's fall with a new intervention for standby assist when ADL care was needed.Review of the physician orders dated 12/14/25 revealed an order that Resident #82 may not be left unattended.Review of the incident log dated 04/08/26 revealed Resident #82 had an unwitnessed fall at approximately 9:10 P.M.Review of the progress note dated 04/08/26 at 9:48 P.M. revealed Resident #82 was heard yelling out during medication pass. Resident #82 slipped out of her chair while attempting to get up without assistance. Resident #82 revealed she needed to get her jacket. Resident #82 was assisted back into chair, skin was checked and okay, vital signs were normal and stable with no complaints of pain. Resident #82's family and physician were notified.Review of the incident log dated 04/18/26 revealed Resident #82 had a fall at approximately 5:30 P.M.Review of the progress note dated 04/18/26 at 5:32 P.M. revealed Resident #82 was found sitting on the floor in front of her wheelchair. Resident #82 had no complaints of pain or discomfort. Resident #82's vital signs were assed and neurological checks were initiated. Resident #82's family and physician were notified.Review of the progress note dated 04/18/26 at 6:17 P.M. revealed Resident #82 was found sitting on the floor in front of her wheelchair. Resident #82 had no complaints of pain or discomfort. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #82 was unable to communicate the situation. Resident #82's vital signs were assed and neurological checks were initiated. Resident #82's family and physician were notified.Review of the progress note dated 04/18/26 at 6:27 P.M. revealed Resident #82 had a fall and her family and physician were notified. Resident #82's medications were tolerated well with no complaints of pain before or after the fall. Resident #82 was currently up in her wheelchair in the common area.Review of the progress note dated 04/18/26 at 6:53 P.M. revealed Resident #82's family member came to the facility to show the camera clip of Resident #82's fall. Resident #82 received orders to be sent to the emergency department (ED) for further evaluation after review of the video showing the fall.Review of the physician orders dated 04/18/26 revealed an order for Resident #82 to be sent to the ED for scans of her head post fall.Review of the video clip dated 04/18/26 of Resident #82's fall revealed she was sitting in her room in her wheelchair adjacent to the left side of her bed. Resident #82 was alone and unattended when she fell out of her wheelchair and onto the floor.Review of the progress note dated 04/19/26 at 11:28 A.M. revealed Resident #82 was sent out to the hospital. Review of the progress note dated 04/20/26 at 12:16 A.M. revealed Resident #82 was admitted to the hospital with a diagnosis of an unwitnessed fall with all scans normal with no injuries noted. Resident #82 was being kept for observation.Review of the fall risk assessment dated [DATE] revealed Resident #82 was at high risk for falls with a history of three or more falls within the last 90 days.Resident #82 had a history of cognitive impairment and ambulated with problems and with devices.Review of the MDS 3.0 assessment dated [DATE] revealed Resident #82 had a memory problem, was moderately impaired regarding task of daily life, and was dependent on staff for ADL.Review of the incident log dated 05/09/26 revealed Resident #82 had a fall at approximately 5:30 A.M.Review of the progress note dated 05/09/26 at 5:30 A.M. revealed Resident #82 had been noncompliant all shift, refused her night medications, was combative and using profanity at staff. Resident #82 refused several attempts to be toileted, provided a snack and refused divergent items. Resident #82's family was notified twice of her behaviors. Resident #82, during morning medication pass, was sitting in wheelchair in the hallway after attempts to bring her near staff nurse to be monitored but she refused. Resident #82 was then observed leaning forward in wheelchair and then repositioned with her back against the wheelchair and tolerated well. Resident #82, a few minutes later, was heard screaming and observed on the floor in the hallway positioned on her right side with her bilateral lower extremities bent. Resident #82 was placed back into the wheelchair with the wheelchair noted to be soaked with urine. Resident #82 was then taken to her bathroom and placed on the toilet seat. Resident #82 complained of pain to her right lateral hip and/or thigh. Resident #82's right hip and/or thigh were assessed with no bruising, bleeding, or injuries noted. Resident #82 was given Tylenol (analgesic) which was tolerated. Resident #82's family and physician were notified with a new order for STAT (immediate) x-ray of the right hip and pelvis, and lab tests were ordered.Review of the progress note dated 05/09/26 at 5:32 A.M. revealed Resident #82 was administered Tylenol for pain.Review of the progress note dated 05/09/26 at 11:09 A.M. revealed Resident #82's STAT x-ray was completed, and results were reported to her physician. Resident #82 received new orders to be sent out to the ED for evaluation, and her family was notified.Review of the physician orders dated 05/09/26 revealed orders for STAT x-ray of Resident #82's right hip and pelvis due to fall and to send to the ED for evaluation due to an abnormal x-ray.Review of the progress note dated 05/09/26 at 12:10 P.M. revealed Resident #82 was picked up and transported to the ED.Review of the radiology results report dated 05/09/26 at 2:09 P.M. revealed Resident #82 had an x-ray of her right hip, unilateral with pelvis performed that indicated she had an acute fracture of the neck of the femur.During an interview on 06/01/26 at 11:00 A.M., Certified Nursing Assistant (CNA) #379 stated Resident #82 was currently out of the building due to being admitted to the hospital. Resident #82 was at high risk for falls and could not be left alone or she would attempt to get out of her wheelchair and fall. Resident #82 pushed herself around in her wheelchair in the hallway and always appeared agitated. During an interview on 06/08/26 at 9:39 A.M., LPN #323 stated Resident #82 was a high fall risk, confused, delirious, had (continued on next page)

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	366488	A. Building B. Wing	06/18/2026

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dementia and was often combative. Resident #82 was to be toileted every two hours, kept within eyesight, and placed at the nursing station or common area for monitoring and safety. She was not to be left alone or unattended. On 04/18/26, Resident #82 sustained a fall from her wheelchair and was sent to the hospital due to CNA #337, who was assigned to her, placed her in her room and left to do something else. LPN #323 revealed she was the nurse at the time of the fall and verified Resident #82 sustained a fall due to the fall interventions not being in place and followed, per the care plan.During an interview on 06/08/26 at 10:24 A.M., the Director of nursing (DON) and Corporate Registered Nurse (RN) #412 revealed residents could be left alone despite their care plan indicating not to be left alone. RN #412 stated No one wants to be watched while using the bathroom. My mother would have a fit. RN #412 acknowledged Resident #82's care plan and fall intervention of assistance of one staff member. RN #412 revealed CNA #337 left to grab incontinence care supplies and within seconds the fall occurred. Review of the fall investigation dated 04/18/26 related to the fall in question with RN #412, revealed Resident #82 was left on the toilet while CNA #337 went to read the checklist left in the room by Resident #82's family, not grab incontinence care supplies. RN #412 and the DON verified the above findings at the time of the interview.During an interview on 06/09/26 at 7:38 A.M., LPN #351 stated she was assigned to Resident #82 when she sustained a fall and was subsequently sent to the hospital on [DATE]. Resident #82 was combative and refused care throughout the night. Resident #82 was unable to be redirected after attempts to be seated in her wheelchair near the nursing station and put in bed. LPN #351 revealed Resident #82, after tending to other residents, was found on the floor in the hallway in front of her wheelchair. Resident #82 was assessed and placed back into her wheelchair and then toileted after being soaked in urine. Resident #82, after being placed on the toilet, complained of pain and kept tapping on her hip. Resident #82 received Tylenol for pain and her physician was notified. Resident #82 received new orders for an x-ray and was subsequently sent to the hospital. Resident #82 had a broken hip and never returned to the facility. LPN #351 verified Resident #82 was to not be left unattended and was to be kept in the common area for monitoring while out of bed. LPN #351 revealed staffing levels made it difficult to keep eyes on Resident #82 and like-residents due to completing other tasks throughout the shift. LPN #351 verified the above findings at the time of the interview.Review of Resident #82 medical record revealed she sustained five falls, with one resulting in a broken hip and hospitalization, related to being left unattended and not placed in the common area for monitoring and safety checks after her care plan and fall interventions dated 06/07/25 identified steps to be taken to decrease and prevent the chance of falls.Review of the facility document titled Care Plan-Advanced Care Plan Process, revised December 2022, revealed the facility had a policy in place to work towards achieving and maintaining the highest attainable physical and functional status of a resident by identifying a problem, the dates, time frames and measurable and realistic goals and document in the care plan. Review of the document revealed the facility did not implement the policy.

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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 medical record review, interviews, and policy review, the facility failed to ensure required care conferences were conducted and failed to verify resident and/or representative participation for Resident #77. This affected one resident (Resident #77) of 45 residents reviewed for care plans. The facility census was 88.Findings include: Medical record review for Resident #77 revealed an admission date of 02/11/26. Diagnoses included congestive heart failure, protein calorie malnutrition, chronic obstructive pulmonary disease, chronic kidney disease, and dementia. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] identified Resident #77 as having severe cognitive impairment. Review of the care plan dated 05/20/26 showed Resident #77 had an alteration in bowel and bladder elimination, was at risk for falls, and required assistance with activities of daily living. The medical record did not contain any signed care conference attendance sheets or documentation verifying that Resident #77's representative was invited to or participated in required care planning conferences. During an interview on 06/03/26 at 3:05 P.M., the sister of Resident #77 stated she had not been invited to or participated in any care plan meetings. During an interview on 06/09/26 at 12:41 P.M., Social Service Designee (SSD) #421 confirmed there were no documented care plan conferences for Resident #77. SSD #421 reported she was serving as the interim SSD and only completed care plans on admission and discharge, not quarterly. During an interview on 06/09/26 at 1:49 P.M., the Administrator and the Director of Nursing (DON) stated care conferences were the responsibility of the MDS nurse. Both verified there was no documentation that the sister of Resident #77 was invited to or attended care conferences and acknowledged the lack of evidence to demonstrate required care planning participation.A review of the facility policy titled Care Plan – Advanced Care Plan Process, revised December 2022, revealed that the interdisciplinary team is responsible for coordinating with the resident and/or responsible party to develop an appropriate, person-centered plan of care based on ongoing assessment. The policy states residents and their sponsors will be invited to participate in the development of the comprehensive care plan upon admission, quarterly, annually, with significant change, and as needed. The interdisciplinary team, in collaboration with the resident and/or representative, is required to meet and review the care plan during these intervals. This deficiency represents non-compliance investigated under Complaint Number 2727510.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident record review, staff interviews, and facility policy review, the facility failed to implement adequate communication for non-English speaking residents. This affected two residents (Residents #50 and #65) of two residents reviewed for communication. The facility census was 88. Findings include: 1. Review of the medial record for Resident #50 revealed she was admitted to the facility on [DATE] with diagnoses that included dementia, asthma, type 2 diabetes, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #50 was sometimes understood and had a Brief Interview for Metal Status (BIMS) score of 0, that indicated short- and long-term condition impairment. Review of the MDS assessment revealed Resident #50 required some assistance from staff for activities of daily living (ADLs). Review of the care plan dated 05/20/26 revealed Resident #50 had a communication problem related to speaking Russian. Review of the care plan revealed Resident #50 preferred to speak Russian. Review of the activity assessment dated [DATE] revealed Resident #50 was born in Russia and spoke Russian as her primary language. Review of the progress note dated 04/28/26 at 2:42 P.M. revealed Resident #50 ambulated throughout the facility with a walker, but she was difficult to understand due to language barriers. Review of the progress note revealed Resident #50 watched and listened to Russian television and music stations. Observation on 06/01/26 at 10:30 A.M. revealed Resident #50 sitting in her room. Resident #50 was unable to communicate with the state surveyor, and observations revealed no communication devices, boards, or alternative options for understanding. Interview on 06/01/26 at 10:32 A.M. with Certified Nursing Assistant (CNA) #379 revealed Resident #50 did not speak or understand English. CNA #379 revealed she did not know if Resident #50 utilized a hearing device and if she did, staff would continue to not understand. CNA #379 revealed staff couldn't understand Resident #50, and Resident #50 could not understand staff. CNA #379 stated We just guess and that's bad. We don't have a communication board, and I think she speaks Russian. CNA #379 confirmed and verified the above findings at the time of the interview. Interview on 06/01/26 at 11:35 A.M. with Resident #50's Power of Attorney (POA) revealed Resident #50 was unable to participate in a lot of things due to the language barrier, so she often sat in her room watching a Russian television channel. Review of the facility document titled Non-Discrimination and Accessibility Notice undated, revealed the facility provided free services to residents such as aids and services to communicate effectively that included qualified sign language interpreters, written formats, and language services to residents whose primary language was noted English. Revie of the document revealed the facility did not implement the policy. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record for Resident #65 revealed an admission date of 07/24/24. Diagnoses included but were not limited to Alzheimer's dementia, repeated falls, chronic obstructive pulmonary disease, and hypertensive heart disease. Review of the 04/20/26 quarterly MDS 3.0 assessment for Resident #65 revealed severe cognitive impairment and not usually understood. Review of the 07/27/24 admission assessment for Resident #65 revealed she was alert, and oriented to place and person. Nothing was indicated under the communication as to whether Resident #65 spoke clearly, was aphasic or dysphasic. English language was not checked, and Russian was written in under other Language spoken. Review of the 11/06/25 re-admission assessment for Resident #65 revealed communication was clear. English language spoken not checked and Russian language indicated. Resident #65 was noted to answer questions readily. Under the communication section on page 13 no problem was identified. Review of the 08/05/24 care plan for Resident #65 revealed resident has a communication deficit related to hard of hearing, dementia, and a language barrier. Resident was noted to speak Russian. A goal initiated on 01/26/26 revealed Resident #65 will maintain current level of communication function by making sounds, using appropriate gesture, responding to yes/no questions appropriately using communication board and writing messages. Interventions listed included Resident #65 is able to communicate by vision board (02/28/25). Observation on 06/01/26 at 12:05 P.M. with Resident #65 revealed she did not speak English and appeared anxious or startled when spoke to. Communication was not able to be completed due to language barrier. Interview on 06/03/26 at 1:07 P.M. with Certified Nurse Aide (CNA) #316 stated staff use hand motions to communicate with Resident #65 and stated she understands some English but is unable to speak it. Interview on 06/08/26 at 3:28 P.M. with Licensed Practical Nurse (LPN) #353 confirmed Resident #65 understands some English and staff are able to ask questions and will respond with yes or no in Russian and also confirmed she has never seen a communication board for Resident #353. Interview on 06/09/26 at 8:26 A.M. with CNA #319 revealed she delivers trays to her and uses gestures to communicate with her and did not recall seeing a communication board in the room and had not seen Resident #65 using it. Interview on 06/09/26 at 11:30 A.M. with LPN #383 stated she watches facial expressions to monitor pain and was not aware of a communication board to use with Resident #65. LPN #383 stated Resident #65 had a fall on 05/28/26 and due to the language barriers, Resident #65 was unable to tell LPN #383 what had happened. Interview on 06/10/26 at 2:12 P.M. with the Director of Nursing (DON) revealed the staff use gestures to communicate with Resident #65. DON confirmed the care plan stated a communication board would be used and was unable to provide evidence of a communication board for Resident #65. Review of the March 2023 revised facility policy called Activities of Daily Living (ADLs) revealed the (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	purpose was to specify the responsibility to create and sustain an environment that humanizes and individualizes each resident's quality of life by ensuring all staff, across all shift and departments understand the principles of quality of life, and honor and support theses principles for each resident and that the care and services provided are person-centered and honor and support each resident's preferences, choices, values and beliefs. Under the procedure number #3 The facility will provide care and services for the following activities of daily living and letter f stated communication including speech, language and other functional communication systems. The facility will ensure that residents receive proper treatment and assistive devices Review of the undated facility policy called Non-Discrimination and Accessibility Notice revealed the facility complies with applicable Federal and State civil rights laws and does not discriminate on the basis of race, color, national origin, sex, age, disability or other protected classes. Facility does not exclude people or treat them differently because of race, color, religion, national origin, sex, age, disability, creed, ancestry, gender identity or expression, marital status, lawful source of income, familial status, learning disability or physical or mental disability or any other characteristic protected by applicable law. The facility will provide free aids and services to people with disabilities to communication effectively with us, such as: qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic format, Braille, other formats) and language services to people whose primary language is not English, such as : qualified interpreters, or information written in other languages. This deficiency represents non-compliance investigated under Complaint Number 2995079.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident record reviews, resident interviews, staff interviews, and facility policy review, the facility failed to provide routine activities of daily living (ADLs) for 12 residents (Residents #10, #17, #20, #34, #46, #66, #77, #82, #87, #99, #100 and #108) of 21 residents reviewed for ADLs. The facility census was 88. Findings include: 1. Review of the medical record for Resident #10 revealed he was admitted to the facility on [DATE] with diagnoses that included vascular dementia, pulmonary hypertension, and hemiplegia and hemiparesis following cerebral infraction affecting the left dominant side. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #10 had a Staff Assessment for Mental Status (SAMS) that indicated he had short- and long-term memory problem, was severely impaired regarding task of daily life, had inattention, disorganized thinking and altered level of consciousness. Review of the MDS assessment revealed Resident #10 had impairment on one side of both the upper and lower extremities and was dependent on staff for activities of daily living (ADLs). Review of the care plan dated 06/20/25 revealed Resident #10 had an ADL function potential and oral care deficit with interventions that required assistance of one for bathing and/or hygiene twice a day. Review of the oral care task dated 05/07/27 through 06/02/26, for a 30-day look back period, revealed Resident #10 received oral care 7 out of 30 days. Interview on 06/02/26 at 3:30 P.M. with Resident #10's family member revealed facility staff did not provide adequate mouth care. Interview on 06/02/26 at 3:34 P.M. with Certified Nursing Assistants (CNAs) #337 and #384 revealed they were assigned to different units but helped each other when necessary. CNA #337 revealed she was assigned to Resident #10 but did not provide oral care. CNA #337 confirmed and verified the above findings at the time of the interview. Interview on 06/02/26 at 4:00 P.M. with Licensed Practical Nurse (LPN) #356 revealed facility CNAs were responsible for doing resident's mouth care. LPN #356 revealed all mouth care completed was documented in Point Click Care (PCC) under the task list. LPN #356, after review of Resident #10's oral care task, stated If it's not there, it didn't get done. LPN #356 confirmed and verified oral care not being done at the time of the interview. Interview on 06/03/26 at 8:32 A.M. with LPN #356 revealed Resident #10 did not get his teeth brushed and stated, I don't do mouth care, the CNAs do. LPN #356 confirmed and verified the above findings at the time of the interview. 2.Review of the medical record for Resident #17 revealed she was admitted to the facility on [DATE] with diagnoses that included nontraumatic subarachnoid hemorrhage, hemiplegia affecting left nondominant side, functional quadriplegia and contracture of right hand. Review of the MDS assessment dated [DATE] revealed Resident #17 had a Brief Interview for Mental Status (BIMS) score of 7, that indicated she had short- and long-term cognition impairment. Review of (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366488	A. Building B. Wing	06/18/2026

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the MDS assessment revealed Resident #17 had inattention, impairment on both sides of the upper and lower extremities and was dependent on staff for ADLs. Review of the care plan dated 05/22/26 revealed Resident #17 had potential for dental and/or oral health problems, had natural teeth in poor condition, and had an ADL self-care performance deficit with interventions that required to provide mouth care every shift and as needed. Review of the oral care task dated 05/06/27 through 06/02/26, for a 30-day look back period, revealed Resident #17 received oral care 14 out of 30 days. Interview on 06/01/26 at 2:45 P.M. with Resident #17's family member revealed facility staff did not take care of Resident #17 teeth. Resident #17's family member revealed she had to visit the facility in order for care to take place. Interview on 06/02/26 at 4:00 P.M. with Licensed Practical Nurse (LPN) #356 revealed facility CNAs were responsible for doing resident's mouth care. LPN #356 revealed all mouth care completed was documented in Point Click Care (PCC) under the task list. LPN #356, after review of Resident #17's oral care task, stated If it's not there, it didn't get done. LPN #356 confirmed and verified oral care not being done at the time of the interview. Interview on 06/03/26 at 8:30 A.M. with Resident #17 revealed facility staff did not brush her teeth or do oral care. Interview on 06/03/26 at 9:30 A.M. with CNA #369 reveled oral care was documented in PCC when it was completed. CNA #369 revealed if it was not listed in PCC, it had not been done. CNA #369 revealed sometimes it could be documented late. CNA #369 revealed she was assigned Resident #17 and she had not brushed her teeth or provided any oral care. 3.Review of the medical record for Resident #34 revealed she was admitted to the facility on [DATE] with diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting the left dominant side, tremor, contracture, moderate protein calorie malnutrition, dysphagia and carpal tunnel syndrome. Review of the MDS assessment dated [DATE] revealed Resident #34 had a BIMS score of 12 that indicated she was alert and oriented with some cognition impairment. Review of the MDS assessment revealed Resident #34 had impairment on one side of both upper and lower extremities and was dependent on staff for ADLs. Review of the care plan dated 02/25/26 revealed Resident #34 had a self-care and oral care deficit, had potential for altered nutritional status, had missing teeth on both upper and lower levels, with interventions to provide oral care twice a day and assistance of one for personal hygiene and/or oral care and required assistance of one, and a divided plate, Kennedy cup, and built-up utensils. Review of the physician orders dated 04/27/26 revealed an order for a regular diet, pureed texture with thin liquids. Review of the physician orders dated 04/28/26 revealed an order to encourage adequate nutritional intake elated to protein calorie malnutrition. (continued on next page)

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	366488	A. Building B. Wing	06/18/2026

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the physician orders dated 05/28/26 revealed an order for Resident #34 to use a Kenndey cup for all beverages and weighted utensils with meals. Review of the dietary nutritional assessment dated [DATE] revealed Resident #34 was on a mechanically altered diet that required the use of a divided plate, Kennedy cup, and built-up utensils. Review of the oral care task dated 05/05/27 through 06/02/26, for a 30-day look back period, revealed Resident #34 received oral care 6 out of 30 days. Review of the adaptive equipment list provided by the facility revealed Resident #34 required the use of a Kennedy cup for all beverages and weighted utensils with meals. Interview and observation on 06/01/26 at 10:42 A.M. with Resident #34 revealed facility staff left her in bed most days and did not provide mouth care. Resident #34 revealed she did not remember the last time her teeth or mouth was cleaned. Resident #34 revealed her breakfast tray had already been delivered and taken away. Resident #34 revealed she had to feed herself, which she could not do because she needed help with her meals and drinks. Resident #34 revealed her hands shook a lot and made it difficult to do things on her own. Resident #34 revealed that without help with her meals, food would fall everywhere. Resident #34 was observed to have various unidentified food particles on her gown, over the bed tray and on her bed. Interview on 06/01/26 at 10:52 A.M. with Registered Nurse (RN) #350 revealed Resident #34 did not need any help. RN #350, after observation of Resident #34 laying in bed with food particles on her, revealed Resident #34 was just a messy eater. Interview on 06/02/26 at 4:00 P.M. with Licensed Practical Nurse (LPN) #356 revealed facility CNAs were responsible for doing resident's mouth care. LPN #356 revealed all mouth care completed was documented in Point Click Care (PCC) under the task list. LPN #356, after review of Resident #34's oral care task, stated If it's not there, it didn't get done. LPN #356 confirmed and verified oral care not being done at the time of the interview. Interview on 06/03/26 at 8:32 A.M. with LPN #356 revealed Resident #34 always needed help with ADLs including with her meals. L Interview on 06/03/26 at 9:36 A.M. with Resident #34, while sitting in the common area, revealed that facility staff did not brush her teeth or do any oral care. Resident #34 stated All they did was get me dressed and put me in my chair. Interview on 06/03/26 at 9:40 A.M. with CNA #379 revealed she was assigned Resident #34 for the day. CNA #379 confirmed and verified she provided morning care for Resident #34 but did not brush her teeth or provide any mouth care. Observation and interview on 06/08/26 at 9:50 A.M. revealed Resident #34 laying in bed with her breakfast tray in front of her on the over the bed table. Resident #34 hands were shaking as she attempted to feed herself breakfast. RN #322 entered Resident #34 room and revealed Resident #34 required assistance with her meals sometimes. RN #322 was observed asking Resident #34 if she needed help with her meal and Resident #34 stated yes. RN #322 stated I will get the CNA to help you. Observation of Resident #34 breakfast tray revealed a plastic cup with no straw with an unidentified liquid, a regular set of utensils that were not weighted utensils, and a second plastic cup with an (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	unidentified liquid. RN #322 revealed Resident #34 only used a straw sometimes. RN #322 confirmed and verified Resident #34 did not have the required assistance and adaptive equipment required for her meals. Interview on 06/08/26 at 9:56 A.M. with LPN #323 revealed Resident #34 required to be fed at all meals, utilized a Kennedy cup and weighted utensils due to her shaking and needed assistance. LPN #323 revealed Resident #34 did not eat well if she was not provided with assistance because she could not hold a cup to drink or without a straw. LPN #323 confirmed and verified the above findings at the time of the interview. Interview on 06/08/26 at 2:13 P.M. with the Registered Dietician (RD) #420 revealed Resident #34 required extensive help with meals due to her shaking a lot. RD#420 revealed Resident #34 required adaptive equipment that included a divided plate, a Kennedy cup, and weighted utensils. RD #420 revealed Resident #34 also required the use of a straw with her drinks and was currently utilizing a puree diet. RD #420 confirmed and verified the above findings at the time of the interview. 4.Review of the medical record for Resident #66 revealed she was admitted to the facility on [DATE] with diagnoses that included hemiplegia affecting the right dominate side, type 2 diabetes, and epilepsy. Review of the MDS assessment dated [DATE] revealed Resident #66 had a BIMS score of 7 that indicated she was alert and oriented with cognition impairment. Review of the MDS assessment revealed Resident #66 was impaired on one side of both her upper and lower extremities and was dependent on staff for ADLs. Review of the care plan dated 05/01/26 revealed Resident #66 had ADL self-care performance deficit with interventions that included assistance of two staff members with bathing and/or showering. Interview on 06/11/26 at 10:18 A.M. with the DON, while reviewing Resident #66 shower sheets, revealed for the month of May 2026, Resident #66 received only 4 showers and/or bed baths out 31 days. The DON revealed showers were to be offered at least twice a week. The DON confirmed and verified the information provided was complete and accurate at the time of the interview. 5. Review of the closed medical record for Resident #82 revealed she was admitted to the facility on [DATE] with diagnoses that included hemiparesis and hemiplegia following infarction affecting the right dominant side, dementia, and contracture of the right hand. Review of Resident #82 medical record revealed she was discharged from the facility on 05/09/26. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #82 had a memory problem, was moderately impaired regarding task of daily life, and was dependent on staff for activities of daily living (ADLs). Review of the care plan initiated upon admission, dated 04/06/25, revealed Resident #82 had a self-care deficit with interventions that included assisting with ADLs, and provide a bath and/or shower twice a week. Interview on 06/11/26 at 10:18 A.M. with the DON, while reviewing Resident #82 shower sheets, revealed from March 2026 through May 2026, Resident #82 was only offered13 showers and/or bed baths out 69 days. The DON revealed showers were to be offered at least twice a week. The DON (continued on next page)

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	366488	A. Building B. Wing	06/18/2026

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pulmonary disease, kidney disease, and unspecified dementia. Review of a quarterly MDS assessment dated [DATE] revealed Resident #77 had a brief interview for mental status with a score of 5 indicating a sever cognitive deficit. The MDS also revealed Resident #77 needed partial to moderate assistance with bathing. A care plan dated 05/20/26 revealed Resident #77 had an activity of daily living self-care performance deficit related to dementia, congestive heart failure, and chronic obstructive pulmonary disease. Interventions included staff to assist with completion of his needs throughout the day including and not limited to bathing or showering with the assistance of one person. A review of the facility shower schedule revealed Resident #77 was supposed to be bathed on Mondays and Thursdays. Review of the shower schedule for March 2026 revealed showers were supposed to occur 03/02/26, 03/05/26, 03/09/26, 03 12:26, 03/16/26, 03/19/26, 03/23/26, 03/26/26, and 03/30/26. A review of shower sheets for March 2026 revealed Resident #77 missed bathing on 03/02/26, 03/13/26, 03/23/26. 03/26/26 and 03/30/26. Review of the shower schedule for April 2026 revealed showers were supposed to be given on 04/02/26, 04/06/26, 04/09/26, 04/13/26, 04/16/26, 04/20/26, 04/23/26, 042726, and 04/30/26. A review of shower sheets for April 2026 revealed Resident #77 missed bathing on 04/02/26, 04/04/26, 04/06/26, 04/13/26, 04/16/26, 04/21/26, 04/27/26 and 04/30/26. Interview on 06/04/2026 at 11:51 AM with the Director of Nursing (DON) and Corporate RN #412 stated showers are supposed to be providing showers twice a week. They confirmed Resident #77's showers were not completed as required and evidence provided did not meet the two-time a week requirement. 8. A review of the closed medical record for Resident #87 revealed the date of admission as 07/25/25 with diagnoses including but were not limited to congestive heart failure, difficulty walking, and Parkinson's disease. Resident #87 was discharged on 04/24/26. A review of a quarterly MDS assessment revealed a brief interview for mental status with a score of 13 indicating Resident #87 was cognitively intact. The MDS also revealed Resident #87 was dependent on staff to complete bathing. A care plan dated 10/28/25 revealed Resident #87 had an activity of daily living self-care deficit. Interventions included assistance of one person for bathing. A review of the facility shower schedule revealed Resident #87 was supposed to be bathed on Tuesdays and Fridays. Review of the shower schedule for January 2026 revealed showers were supposed to be given 01/06/26, 01/09/26, 01/13/26, 01/16/26, 01/20/26, 01/23/26, 01/27/26, and 01/30/26. A review of shower sheets for January 2026 for Resident #87 revealed showers were not given on (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	given him a washcloth to wash his face and some mouthwash but did not assist him to brush his teeth and stated his teeth felt dirty. Observation at the time of the interview revealed his teeth appeared to have white food built up between his bottom teeth. Interview on 06/04/2026 at 11:51 A.M. with the DON and Corporate RN #412 stated showers are supposed to be providing showers twice a week. They confirmed Resident #99's showers were not completed as required and evidence provided did not meet the two-time a week requirement. Interview on 06/16/26 at 9:22 A.M. with the DON confirmed oral hygiene is to be provided twice daily and was unable to provided evidence that oral hygiene was provided for Resident #99 twice daily as required. 11. Review of the medical record for Resident #100 revealed an admission date of 03/13/26. Diagnoses included but were not limited to moderate protein-calorie malnutrition, autistic disorder, and a gastrostomy tube. Review of the 03/13/26 nursing admission assessment for Resident #100 revealed resident required total assistance for transfer and assistance of two for bathing and was a total assist of one for oral hygiene and feeding. Interview on 06/01/26 at 2:07 P.M. with Resident #100's mother revealed staff do not brush his teeth and do not bathe him consistently. Observation at the time of the interview revealed Resident #100's teeth appeared to have white build up of food in front of his lower teeth. Review of the facility provided list of residents who required feeding assistance revealed Resident #100 was not listed. Review of the oral hygiene task for Resident #100 for the past 30 days from 05/06/26 to 06/05/26 revealed oral care was indicated as provided once a day for 05/06/26, 05/08/26, 05/09/26, 05/12/26, 05/19/26, 05/24/26, 05/27/26, 06/01/26, 06/02/26, and 06/04/26. Oral care was indicated as provided twice a day on 05/07/26, 05/13/26, 05/16/26 and 05/21/26. Oral care was indicated as provided two times a day as required four out of 30 days. Review of the facility shower schedule indicated Resident #100's bathing was to be provided on Sundays and Wednesday during first shift. Review of the shower schedule for March 2026 for Resident #100 revealed bathing was supposed to be provided on 03/15/26, 03/18/26, 03/22/26, 03/25/26, and 03/29/26. Review of the facility provided shower sheets for March 2026 for Resident #100 revealed a bed bath on 03/18/26, 03/21/26, 03/30/26. Three out of five bathing opportunities provided. Review of the shower schedule for April 2026 for Resident #100 revealed bathing was supposed to be provided on 04/01/26, 04/05/26, 04/08/26, 04/12/26, 04/15/26, 04/19/26, 04/22/26, 04/26/26, and 04/29/26. Review of the facility provided shower sheets for April 2026 for Resident #100 revealed bed baths were provided on 04/25/26, 04/27/26, 04/29/26. A shower was provided on 04/15/26 and 04/20/26. An incomplete shower form was provided for 04/05/26 that only had a name and signature on it and (continued on next page)

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	366488	A. Building B. Wing	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenue at Lyndhurst	5442 Rae Road Lyndhurst, OH 44124

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	did not indicate whether a bed bath, shower or bathing was refused and did not indicate a skin check. Five out of nine bathing opportunities were provided. Review of the shower schedule for May 2026 for Resident #100 revealed bathing was supposed to be provided on 05/03/26, 05/06/26, 05/10/26, 05/13/26, 05/17/26, 05/20/26, 05/24/26 and 05/27/26. Review of the facility provided shower sheets for May 2026 for Resident #100 revealed bed baths were given on 05/02/26, 05/06/26, 05/09/26, 05/16/26, 05/27/26, and 05/30/26. An incomplete shower form was provided for 05/13/26 that only had a name and signature on it and did not indicate whether a bed bath, shower or bathing was refused and did not indicate a skin check. Six out of eight bathing opportunities were provided. Observation on 06/03/26 at 1:46 P.M. revealed Resident #100's lunch tray was sitting on the bedside table untouched. Cup was upside down with the lid on. Observation on 06/04/26 at 8:32 A.M. revealed Resident #100's breakfast tray was sitting in his room on the counter across from his bed untouched. Observation on 06/04/26 at 9:23 A.M. revealed Resident #100's breakfast tray was sitting in his room on the counter across from his bed untouched. Interview on 06/04/26 at 9:28 A.M. with Certified Nursing Assistant #342 revealed they are told to take the tray in Resident #100's room and leave it for his mom to feed him. Interview on 06/04/26 at 11:06 A.M. with the Director of Nursing (DON) confirmed the list was provided was a complete list of residents who required feeding assistance and confirmed Resident #100 was not on the list. Observation on 06/08/26 at 9:19 A.M. with the Administrator revealed Resident #100's breakfast tray was still on the cart in the hallway and resident had not been assisted with breakfast. Observation on 06/08/26 at 1:15 P.M. revealed Resident #100's lunch tray was sitting on the tray table out of reach at the foot of the bed. Tray was untouched and the unopened ice cream appeared to have melted. Phone interview on 06/08/26 at 1:50 P.M. with Registered Dietitian #420 confirmed staff are supposed to offer to feed Resident #100 each meal. Interview on 06/16/26 at 9:22 A.M. with the Director of Nursing (DON) revealed resident feeding assistance should be charting following every meal. DON confirmed staff are expected to attempt to feed Resident #100 if the mother is not present and provide oral care twice a day. DON confirmed oral care and feeding assistance was not provided and documented daily as required. DON confirmed bathing was not provided twice weekly as required for Resident #100. 12. Review of the closed medical record for Resident #108 revealed an admission date of 05/18/23 and a date of death of [DATE]. Diagnoses included but were not limited to Alzheimer's dementia, moderate protein-calorie malnutrition and stage III chronic kidney disease. Review of the 12/26/25 annual MDS assessment for Resident #108 revealed moderate cognitive (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	impairment. Resident #108 was noted to require supervision with bathing. Review of the facility shower schedule for Resident #108 revealed bathing was supposed to be provided on Wednesday and Saturday during the day shift. Review of the shower opportunities for November 2025 through February 13,2026 revealed 29 bathing opportunities: 11/05/25, 11/08/25, 11/12/25, 11/15/25, 11/19/25, 11/22/25, 11/26/25, 11/29/25, 12/03/25, 12/06/25, 12/10/25, 12/13/25, 12/17/25, 12/20/25, 12/24/25, 12/27/25, 12/31/25, 01/03/26, 0107/26, 01/10/26, 01/14/26, 01/17/26, 01/21/26, 01/24/26, 01/28/26, 01/31/26, 02/04/26, 02/07/26, and 02/11/26. Review of the shower sheets provided for Resident #108 revealed an incomplete form indicated nothing other than a signature for 11/14/25, a refusal on 11/17/25, 11/21/25, 11/24/25, an incomplete form indicating nothing other than a signature for 11/28/25, a refusal on 12/01/25, an incomplete form with nothing other than a signature for 12/05/25, 12/08/25, a refusal on 12/15/25, an incomplete form with nothing other than a signature for 12/19/25 and 12/22

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to administer medications to treat Parkinson's disease in a timely manner for Resident #87, and failed to ensure a timely orthopedic follow-up appointment was scheduled for Resident #99. This affected two residents (Resident #87 and Resident #99) of four residents reviewed for quality of care. The facility census was 88.Findings include: 1. A review of medical records for Resident #87 revealed the date of admission as 07/25/25 with diagnoses included Parkinson's disease with dyskinesia (difficulty moving). Resident #87's physician orders included Carbidopa-Levodopa (a prescription medication primarily used to treat Parkinson's disease and similar symptoms like tremors, stiffness, and slowness of movement) ER Oral Tablet Extended Release 50-200 MG (Carbidopa-Levodopa) give 1 tablet by mouth one time a day for tremors dated 12/03/25, Carbidopa-Levodopa Oral Tablet 25-250 Milligrams (MG), give 1 tablet by mouth in the morning for Parkinson's dated 02/06/26, Sinemet Oral Tablet 25-100 MG, Give 2 tablet orally at bedtime for Parkinson dated 02/06/26, and Sinemet Oral Tablet 25-100 MG, give 2 tablet orally two times a day for Parkinson dated 02/06/26. A review of a quarterly MDS dated [DATE] revealed a brief interview for mental status with a score of 13 indicating Resident #87 was cognitively intact. A review of a care plan dated 07/26/25 revealed Resident #87 was not care planned for Parkinson's with regards to the dyskinesia and medication administration. A review of a neurology visit note dated 12/01/25 revealed the residents medications to treat Parkinson's were to be given within 15 minutes of ordered time. A review of time stamped audits for April 2026 revealed the following: On 04/01/26 carbidopa levodopa 50-200 MG, one tablet by mouth one time a day was ordered for 10:00 P.M. The medication was distributed to Resident #87 on 04/02/26 at 2:43 AM.On 04/02/26 carbidopa levodopa 50-200 MG one tablet by mouth one time a day for tremors was ordered for 10:00 P.M. The medication was distributed for Resident #87 at 11:15 P.M.On 04/03/26 carbidopa levodopa 25-250 MG one tablet by mouth in the morning was ordered for 8:00 A,M. The medication was dispensed to Resident #87 at 9:56 A.M.On 04/03/26, carbidopa levodopa 25-100MG, 2 tablets by mouth two times a day was ordered for 4:00 P.M. The medication was dispensed to Resident #87 at 5:10 P.M.On 04/04/26, carbidopa levodopa 25-100 MG, 2 tablets by mouth two times a day was ordered for 12:00 P.M. The medication was dispensed to Resident #87 at 1:35 P.M.On 04/04/26, Carbidopa levodopa 25-100 MG, 2 tablets by mouth two times a day was ordered for 4:00 P.M. The medication was dispensed to Resident #87 at 5:03 P.M.On 04/05/26, Carbidopa levodopa 25-100 MG, 2 tablets by mouth two times a day was ordered for 12:00 P.M. The medication was dispensed to Resident #87 at 1:41 P.M.04/05/26 carbidopa levodopa 50-200 MG one tablet by mouth one time a day was ordered for 10:00 P.M. The medication for Resident #87 was distributed on 04/06/26 at 1:18 A.M.On 04/07/26 carbidopa levodopa 25-100MG, 2 tablets orally at bedtime was ordered for 8:00 P.M. The medication was distributed to Resident #87 at 8:33 P.M.on 04/07/26 carbidopa levodopa 50-200 MG one tablet by mouth at bedtime was ordered for 10:00 P.M. The medication was distributed to Resident #87 on 04/08/26 at 4:20 A.M.On 04/08/26, Carbidopa levodopa 25-100 MG, 2 tablets by mouth two times a day was ordered for 12:00 P.M. The medication was dispensed to Resident #87 at (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1:25 P.M.On 04/09/26 carbidopa levodopa 25-250 MG one tablet by mouth in the morning was ordered for 8:00 A.M. The medication was dispensed to Resident #87 at 8:32 A.M.On 04/09/26 carbidopa levodopa 25-100 MG 2 tablets by mouth two times a day was ordered for 12:00 P.M. The medication was dispensed to Resident #87 at 1:52 P.M.on 04/10/26 carbidopa levodopa 25-100 MG 2 tablets by mouth two times a day was ordered for 4:00 P.M. The medication was distributed to Resident #87 at 6:07 P.M.On 04/10/26 carbidopa levodopa 2 tablets orally at bedtime was ordered for 8:00 P.M. The medication was distributed to Resident #87 at 8:41 P.M.On 04/10/26 carbidopa levodopa 50-200 MG one tablet by mouth one time a day was ordered for 10:00 P.M. The medication was distributed to Resident #87 at 10:36 P.M.on 04/11/26 carbidopa levodopa 25-100 MG 2 tablets by mouth two times a day was ordered for 12:00 P.M. The medication was distributed to Resident #87 at 12:37 P.M.On 04/11/26 carbidopa levodopa 50-200 MG one tablet by mouth at bedtime was ordered for 10:00 P.M. The medication was distributed to Resident #87 d at 11:53 P.M.On 04/12/26 carbidopa levodopa 25-100 MG 2 tablets orally 2 times a day was ordered for 12:00 P.M. The medication was distributed to Resident #87 at 12:31 P.M.on 04/12/26 carbidopa levodopa 25-100MG 2 tablets by mouth at bedtime was ordered for 8:00 P.M. The medication for Resident #87 was distributed on 04/13/26 at 12:15 A.M.on 04/13/26, carbidopa levodopa 25-250 MG one tablet by mouth in the morning was ordered for 8:00 A.M. The medication was distributed to Resident #87 at 9:15 A.M.On 04/13/26 carbidopa levodopa 50-200 MG one tablet by mouth at bedtime was ordered for 10:00 P.M. The medication was distributed to Resident #87 on 04/14/26 at 2:00 A.M.on 04/15/26 carbidopa levodopa 25-250 MG one tablet by mouth in the morning was ordered for 8:00 A.M. The medication was distributed to Resident #87 at 8:49 A.M.On 04/16/26 carbidopa levodopa 25-100 MG 2 tablets by mouth two times a day was ordered for 12:00 P.M. The medication was distributed to Resident #87 at 2:42 P.M.On 04/16/26 carbidopa levodopa 25-100 MG 2 tablets by mouth two times a day was ordered for 4:00 P.M. The medication was distributed to Resident #87 at 5:27 P.M.On 04/16/26 carbidopa levodopa 50-200 MG 1 tablet by mouth at bedtime was ordered for 10:00 P.M. The medication was distributed to Resident #87 at 11:53 P.M.On 04/17/26 carbidopa levodopa 25-100 MG 2 tablets by mouth two times a day was ordered for 4:00 P.M. The medication was distributed to Resident #87 at 4:50 P.M.on 04/19/26 carbidopa levodopa 50-200 MG one tablet by mouth at bedtime was ordered for 10:00 P.M. The medication was distributed to Resident #87 at 10:45 P.M.On 04/20/26 carbidopa levodopa 50-200 MG one tablet by mouth one time a day was ordered for 10:00 P.M. The medication was distributed to Resident #87 on 04/21/26 at 12:22 A.M.on 04/24/26 carbidopa levodopa 25-250 MG one tablet by mouth in the morning was ordered for 8:00 A.M. The medication was distributed to Resident #87 at 8:33 A.M.on 04/24/26 carbidopa levodopa 25-100 MG 2 tablets by mouth two times a day was ordered for 4:00 P.M. The medication was distributed to Resident #87 at 1:23 P.M. On 06/09/26 at 1:49 P.M. an interview with the Administrator revealed the facility did not have a policy regarding following physician orders. On 06/15/26 at 10:20 A.M. an interview with Corporate Registered Nurse verified the time stamped medication administration records were correct as given. A review of the facility policy titled, Medication Administration Preparation and General Guidelines dated August 2014 revealed medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. The policy further stated medications are administered in accordance with written orders of the prescriber. 2. Review of the medical record for Resident #99 revealed an admission date of 03/13/26. Diagnoses included but were not limited to spastic hemiplegia affecting left nondominant side, moderate protein-calorie malnutrition, congestive heart failure, hemiplegia and hemiparesis, and stage IV (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	chronic kidney disease. Review of the 03/13/26 nursing admission assessment for Resident #99 revealed resident is oriented to person, place and time. Resident #99 was noted to be a two person assist for transfers and was non-weight bearing and on bedrest. Resident #99 was noted to have not had any falls in the past 90 days. Upon admission, Resident #99 was noted to be 267.6 pounds. Review of the 03/14/26 physician order for Resident #99 revealed an order for mechanical lift with two-person assist for transfers. Review of the 03/14/26 care plan for Resident #99 revealed resident required a mechanical lift for all transfers. Review of the 04/01/26 nursing progress note timed at 9:50 A.M. written by Licensed Practical Nurse (LPN) #373 revealed CNA called nurse into the room, upon arrival resident was still connected to the Hoyer lift but laying on the floor. The Hoyer at this time is tilted and stuck under the resident's bed. Upon questions the three CNAs, they stated that the Hoyer was tilted over and they lowered the resident to the floor. Assessment of the resident's condition was completed. Resident is at baseline, he denies hitting his head but he is complaining of lower back pain and pain in left leg. Vitals were elevated. Blood pressure was 206/107 with a heart rate of 75. Temperature was 98.2 Fahrenheit (F) with respirations of 20 and oxygen saturation at 97%. Certified Nurse Practitioner (CNP) notified and made aware of condition. Orders received for further evaluation. Family notified. Resident transported via ambulance to hospital. Review of the 04/01/26 nursing progress noted timed at 3:37 P.M. written by LPN #373 revealed resident returned to facility via ambulance. Resident now has a cast on his left arm. Paramedics stated the resident has a broken elbow. CNP here to evaluate resident. Review of the hospital notes for dated 04/01/26 timed at 10:01 A.M. revealed Resident #99 presented to the emergency department from the facility with concerns for a fall out of a Hoyer lift. Resident #99 was noted to be in the process of being transferred from his bed and there was no chair when the Hoyer lift broke off. Resident #99 fell landing on his back. Resident #99 complaining of left knee pain, elbow and back pain. Resident #99 denied hitting his head or change in conscientiousness. Review of the left knee x-ray revealed no acute bony abnormality identified. Review of the left elbow x-ray revealed elbow joint effusion. Suggest follow up radiographs in 10 days. Clinical impression as of 04/01/26 revealed a closed fracture of left elbow. Resident #99 was placed in a posterior long arm splint out of an abundance of caution. Explained the need to follow up with orthopedic surgery and patient was discharged in stable condition with outpatient follow up. Review of the nursing progress note dated 04/10/26 timed at 8:30 A.M. revealed the nurse practitioner ordered a consult for orthopedics for the left elbow trauma. Interview on 06/04/26 at 8:17 A.M. with Resident #99 stated he had an ortho appointment for his arm and had asked Unit Manager #353 previously to make sure it was on a gurney and not a van transport because he had gotten sick last time and spit up blood. Resident #99 stated it was too painful to ride in his wheelchair that long in his wheelchair and had asked to go by gurney. Interview on 06/15/26 at 1:54 P.M. with the Director of Nursing (DON) and Scheduler #375 confirmed the first orthopedic follow up appointment was made on 04/15/26 for 05/11/26 which was 14 days (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	after the accident. DON confirmed Resident #99 missed the appointment on 05/11/26 due to change in condition and was sent to the hospital. Resident #99 returned to the facility on [DATE]. The orthopedic follow up appointment was rescheduled on 05/15/26 (four days after coming back from the hospital) for 05/23/26. On 05/23/26 Resident #99 went out to the hospital after calling 911 himself stating his heart was racing and missed the 05/23/26 ortho appointment. The 05/23/26 ortho appointment was rescheduled on 05/26/26 for 06/04/26. DON stated on 06/04/26 Resident #99 refused to go to the appointment stating he wanted to go on a gurney and not in a wheelchair. DON stated he explained to Resident #99 that he could not go to the appointment due to limited space issues in the at the orthopedic doctors office and would need to go by wheelchair. DON stated the cost of sending a resident by gurney was $800-$1000 and Resident #99's mother had refused to pay the cost. DON stated he was unsure why the appointment had not been scheduled soon that 04/15/26 after the 04/01/26 fall, was not sure why the missed 05/11/26 appointment was not scheduled until 05/15/26 and stated he was unsure why the 05/23/26 missed appointment was not rescheduled till 05/26/26. Phone interview on 06/15/26 at 2:05 P.M. with Secretary #445 at the orthopedic physician's office revealed the first appointment scheduled following the 04/01/26 fall was on 04/15/26 for an appointment on 05/11/26. He was noted to be in the emergency room and missed appointments on 05/11/26 and 05/23/26. Secretary #445 stated Resident #99 also missed his 06/04/26 appointment, confirmed there was not another ortho consult scheduled following the missed appointment on 06/04/26 and also confirmed there is no space issue with residents who come on a gurney as it happens frequently. Secretary #445 confirmed usually if there is a consult recommended from the hospital they usually get residents in within the week. Interview on the 06/16/26 at 7:23 A.M. with the Administrator confirmed she was not aware Resident #99 had requested to go to his ortho appointment by gurney until the day of the 06/04/26 appointment and it was too late to get a gurney for transport. The Administrator confirmed they had talked to Resident #99's mother about the cost involved in gurney transport and she stated she was unable to pay for it. The Administrator confirmed the fall was due to the Hoyer not functioning properly and Resident #99 sustained a fracture due to the facility and was not caused by the resident. Interview on 06/16/26 at 10:41 A.M. with Unit Manager #353 confirmed Resident #99 had previously asked to go to his appointment by gurney stating it was too painful to be in a wheelchair that long and she had notified scheduling prior to the 04/06/26 appointment that he had requested a gurney for his ortho appointment. Email was sent to the Administrator and Director of Nursing (DON) on 06/18/26 at 11:05 A.M. requesting a policy for outside appointments or scheduling/transportation to appointments. Phone interview on 06/18/26 at 11:48 A.M. with the Administrator and DON confirmed the facility did not have a policy for outside appointments or scheduling transportation for outside appointments. This deficiency represents non-compliance investigated under Complaint Number 3014836, 3032216, 2673907, 2965630, 2727510, and 2604622.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, facility policy review and interview, the facility failed to develop and implement a comprehensive and individualized pressure ulcer prevention program to prevent and/or promote pressure ulcer healing for Resident #29, #83 and #100. This affected three residents (Resident #29, #83 and #100) of six residents reviewed for pressure ulcers. The facility census was 88.Actual harm occurred on 03/26/26 (13 days after admission) when Resident #100 who was severely cognitively impaired and high risk for pressure ulcer development with a history of pressure ulcers and skin disorders developed pressure ulcer, first identified to be Stage III (a severe wound featuring full-thickness skin loss where subcutaneous fat is visible) to the right groin. The facility failed to provide evidence Resident #100 was being adequately monitored and provided necessary interventions and treatments to prevent the ulcer from developing. Following the development, the facility failed to ensure treatments/interventions were provided as ordered to promote optimal and timely healing. Findings include:1. A review of medical record for Resident #100 revealed an admission date of 03/13/26 with diagnoses including atherosclerosis of native arteries of the right leg with ulceration of other part of the lower leg, autistic disorder, protein calorie malnutrition, unspecified intellectual disability, contracture of muscle of unspecified lower leg.A review of the Nursing admission assessment dated [DATE] revealed a Braden Scale for predicting pressure sores was completed. The assessment revealed Resident #100 was completely limited in the ability to meaningfully respond to pressure-related discomfort, skin was often very moist, and linen must be changed at least once a shift. The assessment revealed , Resident #100 was bedfast (confined to bed), completely immobile, required moderate to maximum assist in moving and had adequate nutrition. The score was nine indicating Resident #100 was very high risk for developing pressure ulcers.A review of a Minimum Data Set (MDS) assessment history revealed there was no MDS assessment completed for Resident #100 contained within the resident's medical record.A care plan dated 04/02/26 revealed Resident #100 had the potential for impaired skin integrity and pressure ulcer development related to moderate protein calorie malnutrition, impaired cognition, limited mobility and bowel and bladder incontinence. Interventions included administer treatments as ordered and evaluate for effectiveness. The care plan further revealed Resident #100 had altered skin integrity and was at risk for additional altered skin integrity related to being dependent for mobility, bowel and bladder incontinence, sacral fungal rash, right groin pressure and right knee pressure areas. Interventions included administer medications as ordered, administer treatments as ordered, continue current at-risk interventions, observe as needed dressings to ensure it is intact, observe any changes in skin status: appearance, color, wound healing, symptoms of infection, wound size and stage and notify provider of adverse findings and wound care nurse practitioner as scheduled and as needed.A review of weekly skin checks (a check of the resident's skin from head to toe) revealed they were not completed weekly. Skin checks were documented as completed by the facility nurse on 03/25/26, 04/21/26, 05/02/26, 05/23/26 and 06/07/26. The weekly skin check dated 03/25/26 stated Resident #100 had no new areas.A review of wound note dated 03/13/26 and authored by Certified Nurse Practitioner (CNP) #441 revealed Resident #100's had a wound identified as Wound #1. The area was identified as a fungal rash to the right groin next to the scrotum and inner thigh. The wound was described as macerated (The softening and breakdown of skin caused by prolonged exposure to moisture. It often occurs around cuts, burns, or ulcers due to excessive wound fluid, sweat, or urine), and erythematous (an abnormal reddening of the skin). The note further revealed to place a pillow between the legs of Resident #100 to offload pressure.A review of wound care notes authored by CNP #441 dated 03/20/26, 03/26/26, 04/02/26, 04/09/26, 04/16/26, 04/23/26, 05/07/26, 05/14/26 continued to identify Wound #1 as a fungal rash. The notes stated each time to place a pillow between the legs of Resident #100 to offload pressure.A review of physician orders from admission to current (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366488	A. Building B. Wing	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0686 Level of Harm - Actual harm Residents Affected - Few	for Resident #100 revealed no order to place a pillow between his knees to offload pressure.A review of a wound visit note dated 03/26/26 and authored by CNP #441 revealed a wound identified as Wound #3, with the location noted to the right groin. The wound type was documented as a Stage III pressure ulcer and documented as in-house acquired (An area that develops when sustained pressure cuts off blood circulation to the skin and tissue. These injuries are largely preventable and typically occur during long term bed rest when patients are not repositioned frequently). The area was measured at 3.7 centimeters (cm) in length by 0.8 cm width with 0.3 cm depth. The wound was documented as being seen for the first time and noted a treatment plan would be established. Orders included to cleanse the area with soap and water, apply silver alginate (An anti-microbial wound dressing made from natural seaweed fibers and silver ions. It absorbs heavy wound drainage to create a protective gel and the silver targets and kills bacteria to prevent or treat infections) and place an absorbent pad daily and as needed.A review of physician orders revealed the order to cleanse the area with soap and water, apply silver alginate and place an absorbent pad daily and as needed was not started on 03/26/26. The order was not implemented until 04/01/26 and was to be completed every night shift.A review of the Treatment Administration Record dated 04/01/26 through 04/30/26 revealed on 04/01/26 the completion of the treatment was documented with the code of 9 indicating the treatment was not completed and to see nurse's notes. A review of nurse's notes for 04/01/26 revealed no indication as to why the treatment was not completed. On 04/02/26 and 04/03/26 the treatment was not documented as completed. On 04/05/26 the completion of the treatment was documented with the code of 9 indicating the treatment was not completed and to see nurse's notes. A review of nurse's notes for 04/05/26 revealed no indication as to why the treatment was not completed. On 04/06/26 the completion of the treatment was documented with the code of 9 indicating the treatment was not completed and to see nurse's notes. A review of nurse's notes for 04/06/26 revealed no indication as to why the treatment was not completed. On 04/08/26 the completion of the treatment was documented with the code of 9 indicating the treatment was not completed and to see nurse's notes. A review of nurse's notes for 04/08/26 revealed no indication as to why the treatment was not completed.A review of a wound note dated 04/02/26 and authored by CNP #441 revealed a wound identified as Wound #3, with the location noted to the right groin. The wound type was documented as a Stage III pressure ulcer and documented as in-house acquired. The wound measured 8 cm by 1.3 cm by 0.5 cm (about the size of a baby carrot). The wound status was documented as declined. A new order to cleanse the wound with soap and water, apply calcium alginate (A highly absorbing seaweed derived wound pad that absorbs fluid. They react with wound drainage to form a protective moist gel that accelerates healing.), apply an absorbent pad two times daily and as needed. A review of physician orders dated 04/03/26 revealed the order to the right groin to cleanse the wound with soap and water, apply calcium alginate, apply an absorbent pad two times daily and as needed was transcribed to be complete only once daily.A review of the Treatment Administration record dated 04/03/26 through 04/09/26 revealed the treatment to cleanse the wound with soap and water, apply calcium alginate, apply an absorbent pad was only completed daily from 04/03/26 through 04/06/26. The treatment was not documented as completed at all on 04/07/26 or 04/09/26.A review of a wound note dated 04/09/26 and authored by CNP #441 revealed a wound identified as Wound #3, with the location noted to the right groin. The wound type was documented as a Stage III pressure ulcer and documented as in-house acquired. The wound measured 8 cm by 1.2 cm by 0.4 cm. The wound status was documented as unchanged. A new order to cleanse the wound with soap and water, apply collagen (A topical application for wound care that provides a natural framework that enables immune and skin cells to migrate and rebuild the wounded area) and apply an absorbent pad two times daily.A review of the Treatment Administration record dated 04/09/26 through 04/22/06 revealed the treatment to cleanse the wound with soap and water, apply collagen and apply an absorbent pad two times daily was not documented as completed on the mornings of 04/10/26, 04/11/26, 04/12/26, 04/13/26, 04/16/26. 04/17/26, or 04/22/26. The review further (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366488	A. Building B. Wing	06/18/2026

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F 0686 Level of Harm - Actual harm Residents Affected - Few	revealed the treatments not completed at bedtime on 04/15/26 or 04/22/26.A review of corresponding progress notes from 04/09/26 through 04/22/26 revealed no documented reasons why the treatment cleanse the wound with soap and water, apply collagen and apply an absorbent pad two times daily was not completed as ordered.A review of a wound note dated 04/16/26 and authored by CNP #441 revealed a wound identified as Wound #3, with the location noted to the right groin. The wound type was documented as a Stage III pressure ulcer and documented as in-house acquired. The wound measured 7.5 cm by 1.2 cm and 0.4 cm. The wound status was listed as unchanged. There were no new orders.A review of a wound care note dated 04/23/26 and authored by CNP #441 did not address the wound identified as Wound #3.Wound #3 was assessed by CNP #441 on 04/30/26 and 05/07/26. On 04/30/26 a new order was provided to cleanse the wound with soap and water and apply triad paste at the groin peri-wound every shift and as needed.A review of the Treatment Administration Record dated 05/01/26 through 05/07/26 revealed the treatment to cleanse the wound with soap and water, triad paste at the groin peri-wound every shift and as needed was not completed 05/06/26 on day shift or afternoon shift.A review of progress notes revealed no documentation as to why the treatments were not completed on 05/06/26 on day shift or afternoon shift.A review of a wound note dated 05/14/26 and authored by CNP #441 revealed a wound identified as Wound #3, with location noted to the right groin. The wound type was documented as a Stage III pressure ulcer and documented as in-house acquired. The wound measured 3.2 cm by 1 cm by 0.3 cm. The wound status was listed as declined. There were no new orders.A review of the Treatment Administration Record dated 05/07/26 through 05/13/26 revealed the treatment to cleanse the wound with soap and water, triad paste at the groin peri-wound every shift and as needed was not completed 05/10/26 on day shift or afternoon shift or on 05/11/26 on day shift or afternoon shift.A review of progress notes revealed no documentation as to why the treatments were not completed on 05/10/26 or 05/11/26 on day shift and afternoon shift.A review of a wound note dated 05/21/26 and authored by CNP #441 revealed a wound identified as Wound #3, with the location noted to the right groin. The wound type was documented as a Stage III pressure ulcer and documented as in-house acquired. The wound measured 3 cm by 1 cm by 0.3 cm. The wound status was documented as unchanged. New orders to cleanse the wound with soap and water, apply collagen and leave open to air were noted.A review of physician orders for May 2026 revealed the order for collagen was not implemented as ordered. A review of the Treatment Administration record dated 05/20/26 revealed the order to cleanse the wound with soap and water, triad paste at the groin peri-wound continued from previous wound orders until 06/02/26.There was no documentation in the progress notes to indicate why the order was changed and by whom.A wound care note dated 05/28/26 authored by CNP #441 revealed Wound #3 was resolved.Observation on 06/03/26 at 3:10 P.M. of a skin check for Resident #100 revealed there was no pillow between the resident's legs to off load/reduce pressure to the area. Registered Nurse #350 and Licensed Practical Nurse #353 verified there was no pillow in place at the time of the observation.Observation of incontinence care on 06/10/26 at 9:47 A.M. with Certified Nursing Assistant (CNA) #366 and CAN #400 revealed there was no pillow in place upon starting care. Care was rendered and no pillow was put in place upon completion of care. CNA #366 and CNA #400 verified there was no pillow between the legs of Resident #100 at the start of care and a pillow was not placed at the completion of care. Both stated they were unaware of Resident #100 needing a pillow between the knees.On 06/11/26 at 11:10 A.M. an interview with CNP #441 revealed she was not made aware the treatment ordered on 03/26/26 was not started until 04/01/26.On 06/11/26 at 3:06 P.M. an interview with Director of Nursing (DON) verified Resident #100's weekly skin checks were not documented as completed within the medical record. The DON also verified the weekly skin check dated 03/25/26 identified no pressure ulcers. The DON verified no orders for pillow placement between the knees was ever put in place for Resident #100. The DON stated the facility wound care nurse or the floor nurse was responsible for putting orders in for residents following a wound care visit. The DON verified the order to cleanse Resident #100's right groin area with soap and water, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366488	A. Building B. Wing	06/18/2026

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F 0686 Level of Harm - Actual harm Residents Affected - Few	apply silver alginate and place an absorbent pad daily and as needed was not started as ordered on 03/26/26, but rather initiated on 04/01/26. The DON verified the lack of documentation to indicate the treatment to the right groin was completed as ordered as noted above. The DON verified the new treatment dated 04/03/26 was supposed to be two times daily and was only completed once daily. The DON verified the documentation in the TAR to cleanse the wound with soap and water, apply collagen and apply an absorbent pad two times daily was not documented as completed on the mornings of 04/10/26, 04/11/26, 04/12/26, 04/13/26, 04/16/26, 04/17/26, or 04/22/26 and the treatments not completed at bedtime 04/15/26 and 04/22/26. The interview further verified the lack of documentation within the progress notes to explain why treatments did not occur. The DON verified the treatment to cleanse wound with soap and water, triad paste at the groin peri-wound every shift and as needed was not completed 05/06/26, 05/10/26, or 05/11/26 on day shift and afternoon shift. The DON verified the change in orders from NP #441 on 05/21/26 were not implemented.Observation on 06/03/26 at 3:10 P.M. of a skin check for Resident #100 revealed a slightly reddened groin with no open areas.A review of the facility policy titled, Pressure Ulcer Prevention and Risk Identification with a January 2023 revision date revealed the purpose was to establish measures to prevent the development of pressure ulcers within the facility and or to prevent further decline of existing pressure ulcers. The policy further revealed the licensed nurse will perform a head-to-toe skin assessment upon admission and every seven days thereafter to identify any new skin areas. The licensed nurse will document her findings in the medical record. The nurse will assess for redness, rashes, ecchymosis, sharing, and open areas with attention to surfaces of the skin that come in contact with the bed or chair, Bony prominences, surfaces of the skin that come in contact with orthotic devices and skin folds. If a new skin area is identified on the assessment or during any other type of care or service, the licensed nurse will initiate a skin grid measurement flow record. The skin grid will be updated every seven days until the area is resolved.A review of the facility policy titled, Pressure Ulcer Prevention and Interventions with a revision date of January 2023 revealed the purpose was to implement preventative skin measures for all residents based on levels and areas of risk to include moisture, nutrition, activity, mobility, mental status, psychosocial status and general physical condition. When the interdisciplinary team is considering interventions facility policy, standards of practice, and resident goals, preferences, and advanced directives should be reviewed and considered prior to implementation. Procedures involved included the resident skin will be assessed and monitored on a routine basis as is outlined in the skin assessment protocol. The policy also revealed the skin is to be assessed routinely, at bath time, and per facility policy. The skin is to be observed for changes and pain or irritation. Any changes were to be reported to the charge nurse or supervisor. Finally, the policy revealed to administer treatments, as ordered and evaluate the efficacy of the treatment.2. A review of the medical record for Resident #83 revealed an admission date of 03/17/26 and a discharge date of 05/16/26 with diagnoses including unspecified dementia, unspecified severity, with agitation, unspecified severe protein calorie malnutrition, and generalized anxiety disorder.Review of Resident #83's medical record revealed the resident did not have any MDS assessments completed.A care plan dated 03/17/26 revealed Resident #83 had the potential for impaired skin integrity and pressure ulcer development. Interventions included administer medications as ordered, assess the resident's risk for skin breakdown, administer treatments as ordered, observe skin during care as needed and report any abnormal findings to the nurse or provider as needed, and pressure reducing mattress to the bed. The care plan further revealed Resident # 83 had an activity of daily living deficit. Interventions included resident would have needs met on a daily basis including assistance of one person for toilet use and assistance of one person for transfers.A review of Nursing admission assessment dated [DATE] revealed a Braden Scale for predicting pressure sores was completed. The assessment revealed Resident #83 had no impairment with ability to respond to pressure related discomfort, skin was occasionally moist and Resident #83 was chairfast. The assessment further revealed Resident #83 was slightly limited with the ability to change position and (continued on next page)

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	366488	A. Building B. Wing	06/18/2026

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F 0686 Level of Harm - Actual harm Residents Affected - Few	probably had inadequate nutritional intakes. The total score was 16 indicating a mild risk for pressure ulcer development.A review of weekly skin assessments revealed they were completed on admission, and on 03/24/26, 03/31/26, and 04/16/26. Those assessments revealed no new skin areas. There were no documented weekly skin assessments on 04/07/26, 04/23/26, and 04/30/26.A review of resident shower sheets from admission revealed Resident #83 was to have showers on Wednesdays and Saturdays. There were no skin issues documented on the twice weekly shower sheets for March of 2026. Twice a week bed baths were documented in April 2026 with no skin issues until 04/29/26. Resident #83 did not have a shower completed on 04/29/26. Resident #83 had a documented shower on 05/01/26. Resident #83 did not have a shower or bed bath completed on 05/06/26. The missed showers were signed off by the nurse on duty. There were no skin assessments associated with the missed showers.Review of Resident #83's medical record was no documentation in the progress notes on Resident #83 by nursing staff from 04/08/26 through 05/07/26.A review of a progress note dated 05/07/26 at 8:40 P.M. revealed Resident #83 was sent to the emergency room for a change in mental status. There was not a skin assessment completed upon the transfer.A review of a hospital consult note dated 05/07/26 revealed Resident #83 had an ulcer to the left buttock approximately two inches in diameter with surrounding erythema (an abnormal reddening of the skin).A review of results of a hospital computed tomography scan (CAT) scan of the chest, abdomen, and pelvis dated 05/07/26 revealed a sacral decubitus (an area of damaged skin and tissue caused by constant, prolonged pressure) ulcer was present with underlying air. There was associated underlying soft tissue thickening which extends to the sacrum.On 06/04/26 at 11:54 A.M. an interview with Corporate Registered Nurse #414 and the DON verified the lack of weekly skin checks for Resident #83. The DON stated he was not aware Resident #83 had a decubitus ulcer on admission to the hospital.A review of the facility policy titled; Pressure Ulcer Prevention and Risk Identification with a January 2023 revision date revealed the purpose was to establish measures to prevent the development of pressure ulcers within the facility and or to prevent further decline of existing pressure ulcers. The policy further revealed the licensed nurse will perform a head-to-toe skin assessment upon admission and every seven days thereafter to identify any new skin areas. The licensed nurse will document her findings in the medical record. The nurse will assess for redness, rashes, ecchymosis, sharing, and open areas with attention to surfaces of the skin that come in contact with the bed or chair, Bony prominences, surfaces of the skin that come in contact with orthotic devices and skin folds. If a new skin area is identified on the assessment or during any other type of care or service, the licensed nurse will initiate a skin grid measurement flow record. The skin grid will be updated every seven days until the area is resolved.A review of the facility policy titled pressure ulcer prevention and interventions with a revision date of January 2023 revealed the purpose was to implement preventative skin measures for all residents based on levels and areas of risk to include moisture, nutrition, activity, mobility, mental status, psychosocial status and general physical condition. When the interdisciplinary team is considering interventions facility policy, standards of practice, and resident goals, preferences, and advanced directives should be reviewed and considered prior to implementation. Procedures involved included the resident skin will be assessed and monitored on a routine basis as is outlined in the skin assessment protocol. The policy also revealed the skin is to be assessed routinely, at bath time, and per facility policy. The skin is to be observed for changes and pain or irritation. Any changes were to be reported to the charge nurse or supervisor. Finally, the policy revealed to administer treatments, as ordered and evaluate the efficacy of the treatment.3. A review of medical records for Resident #29 revealed the date of admission as 05/07/26 with diagnosis included Parkinson's disease, and cerebral infarction.Resident #29's physician orders revealed orders for barrier cream to the bilateral buttocks with each incontinent episode and as needed, Braden skin assessment on admission and every week for three weeks, and on 06/10/26 pad and protect the buttocks area daily.Review of Resident #29's medical record revealed a Braden scale was completed one time on 05/07/26.A Medicare five-day Minimum Data Set (MDS) assessment (continued on next page)

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	366488	A. Building B. Wing	06/18/2026

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F 0686 Level of Harm - Actual harm Residents Affected - Few	dated [DATE] revealed a brief interview for mental status with a score of 15 indicating Resident #29 was cognitively intact. The assessment further revealed Resident #29 was at risk to develop pressure areas.A care plan dated 05/19/26 revealed Resident #29 had the potential for impaired skin integrity and pressure ulcer development related to impaired mobility and history of a cerebral vascular accident. Interventions included barrier cream as ordered and observe skin during care and as needed and report any abnormal findings to the nurse and provider as needed.A review of weekly skin checks revealed head to toe skin checks were completed on Resident #29 on 05/11/26 and 06/08/26. There were no other weekly skin checks documented within the medical record of resident #29.On 06/02/26 at 3:30 P.M. an interview with the daughter of Resident #29 revealed he had a history of open areas to the sacrum and had seen wound care in the past. The daughter further stated she had asked the facility for bandages for the area since Resident #29 had admitted three weeks ago.On 06/02/26 at 3:35 P.M. an observation of the sacral area of Resident #29 with Registered Nurse (RN) #350 and Licensed Practical Nurse (LPN) #353 revealed the sacral area was not padded or protected. The sacral area was closed but very tender to touch. RN #350 and LPN #353 verified the findings at the time of the observation.On 06/15/26 at 3:00 P.M. an interview with the Director of Nursing (DON) verified the lack of weekly skin checks and the lack of Braden scale completions for Resident #29 within the medical record. A review of the facility policy titled, Pressure Ulcer Prevention and Risk Identification revealed, the purpose of the policy is to establish measures to prevent the development of pressure ulcers within the facility and to prevent further decline of existing pressure of ulcers. The licensed nurse will perform a head-to-toe assessment upon admission and every seven days thereafter to identify any new skin areas. A licensed nurse will document her findings in the medical record.This deficiency represents non-compliance investigated under Complaint Number 3032216, 3014007, 2976056, and 2604622.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff and resident interviews, review of the facility investigation, review of staff witness statements, review of hospital documents, review of the manufacturers recommendations, and policy review, the facility failed to ensure Resident #99's was safely transferred in a Hoyer lift, failed to implement effective fall preventive measures to prevent multiple falls for Resident #82, failed to ensure fall interventions were implemented for Resident #10, and failed to ensure thorough fall investigations were completed to determine root cause of falls and proper fall interventions to implement. This affected four residents (Resident #65, #76, #82, and #99) of eight residents reviewed for falls. The facility census was 88.Actual Harm occurred on 04/01/26 when Certified Nursing Assistant (CNA) #320 and CNA #345 were unable to operate the Hoyer lift in a manner to prevent it from tipping over which caused Resident #99 to descend three feet to the floor and subsequently suffer a left elbow fracture. Actual harm occurred on 05/09/26 when Resident #82, who was assessed to be at a high risk for falls, had repeated falls when effective care planned interventions were not in place and the resident fell when left unattended in her wheelchair resulting in a broken hip and hospitalization. Findings include: 1. Review of the medical record for Resident #99 revealed an admission date of 03/13/26 with diagnoses including but not limited to spastic hemiplegia affecting left nondominant side, moderate protein-calorie malnutrition, congestive heart failure, hemiplegia and hemiparesis, and stage IV chronic kidney disease. Review of the 03/13/26 nursing admission assessment for Resident #99 revealed the resident was oriented to person, place and time. Resident #99 was noted to be a two person assist for transfers, was non-weight bearing and on bedrest. Upon admission, Resident #99 was noted to be 267.6 pounds. Review of the 03/14/26 physician order for Resident #99 revealed an order for a mechanical lift with two-person assistance for transfers. Review of the 03/14/26 care plan for Resident #99 revealed the resident required a mechanical lift for all transfers. Review of Resident #99's nursing progress note dated 04/01/26 at 9:50 A.M., written by Licensed Practical Nurse (LPN) #373, revealed a CNA called the nurse into the room. Upon arrival, the resident was still connected to the Hoyer lift but laying on the floor. The Hoyer lift at this time was tilted and stuck under the resident's bed. Upon questioning the three CNAs, they stated that the Hoyer lift was tilted over and they lowered the resident to the floor. Assessment of the resident's condition was completed. The resident was at baseline and denied hitting his head, but he was complaining of lower back pain and pain in his left leg. Resident #99's vital signs were elevated. His blood pressure was 206/107 with a heart rate of 75, his temperature was 98.2 Fahrenheit (F), and his respirations were 20 with an oxygen saturation at 97%. The Certified Nurse Practitioner (CNP) was notified and made aware of the residents' condition. Orders were received for further evaluation and the family was notified. Resident #99 was transported via ambulance to the hospital. Review of Resident #99's nursing progress note dated 04/01/26 at 3:37 P.M. written by LPN #373 revealed the resident returned to facility via ambulance. Resident #99 was now in a cast on his left arm. Paramedics stated the resident has a broken elbow and the CNP was there to evaluate resident. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #99's fall assessment dated [DATE] revealed LPN #373 was notified by the CNA (unspecified) that the resident was still connected to the Hoyer lift by laying on the floor. The Hoyer was tilted and stuck under the resident's bed. Upon questioning the three CNAs, they stated that the Hoyer lift was tilted over and they lowered the resident to the floor. Assessment of the resident's condition was completed. Resident #99 was noted to be at baseline and denied hitting his head but was complaining of lower back pain and pain in his leg. The resident's vitals were elevated with a blood pressure of 206/107, heart rate of 75, temperature of 98.2 F, respirations 20, and oxygen saturation of 97%. CNP was notified and made aware of the resident's condition. Orders for further evaluations were received and the family was notified. Nurse spoke with resident's mother and resident was transported to the hospital. Resident #99's pain level was noted to be a seven. A fracture of the left elbow was noted following the incident and the accident was noted to occur during transfer. Resident #99's family was notified on 04/01/26 at 9:45 A.M. Review of the facility Incident report checklist dated 04/01/26 at 9:30 A.M. for Resident #99 revealed employees involved were LPN #373, CNA #319, CNA #320 and CNA #345. Factors observed at the time of fall was equipment malfunction when Resident #99 was being assisted with transfer by staff at the time of the incident. Assisted with more help than care planned. Resident #99 was getting up to the power chair and had on gripper socks at the time of the fall. The resident was noted to be alert and oriented before and after the fall. Review of the charge nurse statement revealed the (unspecified) CNA called her to the room and upon arrival the resident was laying on the floor connected to the Hoyer lift that was tilted over and stuck under the bed. An assessment was completed, the CNP and family were notified and the resident left for the hospital. Neuro checks were completed at 3:30 PM, 7:30 PM and 11:30 PM. (No information was noted related to the last time Resident #99 was checked prior to incident.) Review of the witness statement from CNA #345 dated 04/01/26 revealed she was walking past the 300 hallway and saw two aides with the door open getting ready to Hoyer Resident #99. Resident #99 was already connected to the Hoyer ready to put him in the chair. CNA #345 grabbed the handles on the back. As soon as the other (unspecified) aide moved the Hoyer, it tipped as it's falling. CNA #345 stated she hit her face on the power chair and the Hoyer and Resident #99's bottom half was on her leg. CNA #345 got her leg free and went to get the nurse. Review of the witness statement dated 04/01/26 written by CNA #320 revealed CNA #320 and CNA #319 were told Resident #99 needed to be put in his wheelchair for therapy .got the Hoyer and there was a Hoyer pad on his wheelchair, so CNA #319 and #320 started and the other aide came in and insisted that she should help, so CNA #319 stepped back and CNA #320 and CNA #345 started the process Resident #99 was hooked to the Hoyer. CNA #320 started to raise Resident #99 with her foot on the machine and the aide (not specified) started to turn Resident #99 and the Hoyer tilted and the bed prevented Resident #99 from falling due to it being stuck. We (not specified) unhooked the Hoyer and CNA #320 and LPN #323 held the machine. Resident #99 did not fall and from CNA #320's sight no aide was hurt. Review of the witness statement dated 04/01/26 written by CNA #319 revealed we (not specified) were told Resident #99 needed to go to therapy now, so we had him hooked up. The other aide (not specified) came in and we switched spots while I (CNA #319) was going to change Resident #99's bed. The Hoyer started tilting. CNA #319 stated her concern was on Resident #99 so her focus was on the resident, so they lowered the Hoyer so they could make Resident #99 comfortable. CNA #319 stated she did not personally see her (not specified) get hit, but she couldn't imagine how the Hoyer legs were stuck under the bed. (continued on next page)

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	366488	A. Building B. Wing	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenue at Lyndhurst	5442 Rae Road Lyndhurst, OH 44124

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the hospital notes dated 04/01/26 at 10:01 A.M. revealed Resident #99 presented to the emergency department from the facility with concerns for a fall out of a Hoyer lift. Resident #99 was noted to be in the process of being transferred from his bed and there was no chair when the Hoyer lift broke off. Resident #99 fell landing on his back. Resident #99 complained of left knee pain, elbow and back pain. Resident #99 denied hitting his head or change in conscientiousness. Review of the left elbow x-ray revealed elbow joint effusion. Clinical impression as of 04/01/26 revealed a closed fracture of left elbow. Resident #99 was placed in a posterior long arm splint out of an abundance of caution. Explained the need to follow up with orthopedic surgery and the patient was discharged in stable condition with outpatient follow up. Interview on 06/01/26 at 4:25 P.M. with Resident #99 revealed he fell from the Hoyer lift, was sent to the hospital, and returned with a broken elbow. Interview on 06/08/26 at 9:40 A.M. with LPN #323 revealed there were three aides in Resident #99's room. LPN #323 stated she thought two of the aides (CNA #319 and CNA #320) were new CNAs and CNA #345 was also new to their facility. Therapy staff requested Resident #99 to be gotten up for therapy. LPN #323 was doing medication pass when CNA #345 came and said Resident #99 was on the floor. LPN #323 stated upon entering the room, the Hoyer legs were closed and the Hoyer lift was tilted over. LPN #323 stated the (unspecified) aide was underneath Resident #99, the other aide's shoe was stuck under the Hoyer lift, and the Hoyer lift was stuck under the bed. Resident #99 was lying on his back on the floor. The aides stated they lowered him to the floor, but Resident #99 stated they dropped him and his arm was hurting. LPN #323 stated based on what she saw, she did not think they were able to lower him to the floor and she thought he fell to the floor. LPN #323 got vitals and called the CNP and family. CNP gave the order to send Resident #99 out for evaluation. LPN #323 stated she did not think the Hoyer legs were fully open and may have caused the Hoyer to tip. Interview on 06/09/26 at 8:26 A.M. with CNA #319 revealed Resident #99 was a two-person assist and required a Hoyer mechanical lift. CNA #319 stated she went into the room with CNA #320 with the Hoyer lift. CNA #345 came into the room and said she would assist, so CNA #319 stepped out of the way and was leaving the room to go get sheets to change the bed. As she was walking out of the room, she heard WHOA! CNA #319 turned around and saw the Hoyer tilted and Resident #99 hanging over the foot of the bed and the Hoyer was stuck under the bed. CNA #319 stated she helped hook Resident #99 up to the Hoyer lift but was not there when they started to lift him from the bed. CNA #319 did not recall if the feet of the Hoyer were open or closed, just recalled one of the legs was wedged against the floor and the other one stuck under the bed. CNA #319 stated she did not see if Resident #99 hit the end of the bed. CNA #319 stated she suggested to lower the Hoyer to make him more comfortable. CNA #319 stated she did not know if Resident #99 hit his arm because her back was to them. CNA #319 stated she got a pillow and blanket to make him more comfortable on the floor at the foot of the bed. CNA #19 stated when the nurse arrived, she left the room. Phone interview on 06/09/26 at 10:53 A.M. with CNA #320 revealed Resident #99 required a Hoyer lift for transfers. CNA #320 stated she was helping two other CNAs and had just started at the facility. CNA #320 was helping CNA #319 hook Resident #99 up to the Hoyer lift and then CNA #345 stepped in and stated she would assist hooking the resident up the Hoyer lift . CNA #320 asked CNA #345 if she was doing it right and CNA #345 stated yes and stated since CNA #320 was new she would help her. CNA #320 stated she backed up. CNA #345 hooked Resident #99 up to the Hoyer and asked CNA #320 to help move him. CNA #320 stated she was standing in front of the Hoyer lift at the side of the bed. CNA #345 was at the back of the Hoyer where the legs came out. The legs of the Hoyer were under the bed and she stated they were open. When CNA #345 started to raise Resident #99, the Hoyer lift (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	tipped over towards the end of the bed. CNA #320 stated Resident #99 was hanging so they lowered him to the floor and stated Resident #99 did not hit the floor. CNA #320 and #345 unhooked Resident #99 from the Hoyer and tipped the Hoyer back upright. LPN #323 came to assess Resident #99. CNA #320 stated Resident #99 was laughing and was talking appropriately until the ambulance took him. Interview on 06/10/26 at 9:11 A.M. with Resident #99 revealed they were supposed to be getting him up to his new powerchair to work with therapy. They put the Hoyer pad on and attached the straps. Staff discussed which colors they needed to use. Resident #99 stated he asked them to raise him up because his knees hurt so he had to cross his legs to support his knee so it was not painful. When they lifted him up off the bed, the wheelchair was about four to six feet away from the bed by the far wall of his room. When they raised him up, they moved him over towards the wheelchair and he heard a pop and then the Hoyer lift tipped over. One of the aides fell backwards into the electric wheelchair and his leg was on top of her. The CNA had to push his leg off of her. Resident #99 stated he fell to the ground and was laying on the ground and was telling them to stop because it hurt. Resident #99 stated his shoulder hit the ground and he laid his head back. Resident #99 stated the Hoyer lift was not wedged under the bed, it was on top of him. Resident #99 stated he tried to push the Hoyer lift off of him, the aide put a pillow under his head and they called 911 to come. Resident #99 stated there were three to four people in the room and the nurse who came was LPN #323. Interview on 06/10/26 at 3:59 P.M. with CNA #345 revealed she was walking by Resident #99's room and saw two aides with the resident connected to the Hoyer lift. The Hoyer lift was on the side of the bed at his stomach level. CNA #345 stated she was standing behind the back of the Hoyer lift with the legs under the bed. CNA #345 stated the legs of the lift were slightly open but not fully open. CNA #320 and #345 lifted Resident #99 off the bed with CNA #345 using the remote to lift him. CNA #320 was next to her behind the Hoyer lift and CNA #320 was pulling back on the handles and was steering the Hoyer. Resident #99's chair was in the middle of the floor between the end of the bed and the wall. CNA #345 pulled the Hoyer out from underneath the bed. CNA #319 was holding one of the handles on the back of the Hoyer lift pad and CNA #345 was holding the handle close to her. CNA #320 went to turn the Hoyer lift and it started to tip. Resident #99 was turning as the Hoyer lift was tipping. CNA #345 put her foot down on the floor to brace herself. CNA #345 stated she fell to the ground and her right leg was underneath Resident #99, who fell to the ground. CNA #345 leaned onto the wheelchair and pulled her leg out from underneath the resident and ran to get LPN #323. When she came back with LPN #323, they unhooked the Hoyer lift hooks and CNA #345 left the room. Interview on 06/15/26 at 7:54 A.M. with the Administrator stated they thought that when the facility staff were transferring Resident #99, the Hoyer lift legs may not have been fully open, the weight of the resident shifted and the Hoyer and it tipped. Resident #99 stated he fell to the ground, but the aides stated he did not fall to the ground. Administrator verified Resident #99 was sent to the hospital and fractured the elbow. Review of the maintenance repair logs from 12/01/25 to 06/01/26 did not reveal any entries related to Hoyer lift repairs. Review of the facility work history revealed the mechanical lifts were last inspected on 03/06/26 and then next on 05/26/26. Observation on 06/10/26 at 12:31 P.M. with Maintenance #343 revealed two Hoyer lifts were indicated as out of service with a date of 04/02/26. Maintenance #343 stated the parts for the Hoyer lifts were ordered prior to his start date of 04/15/26. Maintenance #343 revealed the Hoyer lifts (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	should be inspected monthly and confirmed there were no recorded inspections of the remaining facility Hoyer lifts during the month of April 2026. Review of the July 2022 revised facility policy titled Hoyer Lift revealed to transfer a resident from a bed to a chair, after attaching hooks to the sling, position the lift over the resident. Position lift arm in low position. Attach the sling to the lift. Encourage resident to fold both arms across his/her chest, if possible. Communicate with resident and address the resident's fear. Raise the resident from the bed with the mechanical lift. Move the lift away from the bed. Turn the resident in a manner that he/she is facing you. Do not pull the resident backwards. Position the lift over the chair. Ensure the resident is comfortable. Remove the hooks from the lift. Remove the lift from the resident. Remove the hooks from the sling. The policy did not give any specifics about the positioning of the legs of Hoyer prior to lifting the resident. Review of the Invacare Reliant 450 Hoyer lift user manual revealed in section seven Lifting the Patient revealed Invacare recommend that two assistants be used for all lifting preparation and transferring to/from procedures. The legs of the lift must be in the maximum open position for optimum stability and safety. If it is necessary to close the legs of the lift to maneuver the lift under a bed, close the legs of the lift only as long as it takes to position the lift over the patient and lift the patient off the surface of the bed. When the legs of the lift are no longer under the bed, return the legs of the lift to the maximum open position and lock the shifter handle immediately. 2. Review of the closed medical record for Resident #82 revealed she was admitted to the facility on [DATE] with diagnoses that included hemiparesis and hemiplegia following infarction affecting the right dominant side, dementia, and contracture of the right hand. Review of Resident #82 medical record revealed she was discharged from the facility on 05/09/26. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #82 had a memory problem, was moderately impaired regarding task of daily life, and was dependent on staff for activities of daily living (ADLs). Review of Resident #82's care plan dated 04/06/25 revealed the resident was a fall risk with interventions that included assessing footwear for proper fit and non-skid soles and if unable to use call light, assess every 30-60 minutes. Review of Resident #82's updated care plan dated 04/28/25 revealed the resident had impaired cognitive function and/or dementia and a history of actual falls. Interventions included keeping her routine consistent, engaging in simple structured tasks, accommodating needs, assisting with decision making, and anticipating needs. Review of the care plan revealed fall interventions were in place with designated initiated dates as follows: determine and address causative factors of falls and monitor and document falls implemented on 05/01/25, to be in common area at all times when not in bed implemented on 06/07/25 and take to activities between meals implemented on 06/24/25. Review of Resident #82's medical record revealed the resident sustained five falls dated 11/16/25, 12/14/25, 04/08/26, 04/18/26, and 05/09/26. Review of the incident log dated 11/16/25 revealed Resident #82 had an unwitnessed fall at approximately 11:10 P.M. Review of Resident #82's progress note dated 11/16/25 at 11:10 P.M. revealed the resident was (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	found on the floor in her room in front of her wheelchair. Resident #82 was assessed with no injuries noted with a new intervention of dycem (a slip-resistant material) to the wheelchair when out of bed to prevent falls. Review of the fall investigation dated 11/16/25 revealed Resident #82 had an unwitnessed fall in her room from her wheelchair and was found on the floor. Resident #82 was assessed, her range of motion checked and intact with no injuries noted. Resident #82's vitals were checked and neurological checks were initiated. Resident #82's family and physician were notified. Resident #82 was unable to state what occurred due to cognition impairment. Resident #82 was placed back in her wheelchair and was to be monitored by staff. The investigation did not identify the root cause of the fall or address the intervention of being in common areas when out in bed, not being implemented. Review of the progress note dated 12/14/25 at 12:11 A.M. revealed Resident #82 was seated in her wheelchair in the dining area folding towels. Resident #82, after two attempts to administer medications, was noted to be agitated and trying to self-propel in her wheelchair down the hallway. Resident #82 became more agitated after staff attempts for redirection. Resident #82 was placed on frequent checks for safety. Resident #82 refused to be toileted and was brought back to the hallway to be monitored. Resident #82 was placed on one-on-one supervision and being monitored for safety. Review of Resident #82's medical record revealed no evidence the resident was one-on-one monitoring on 12/14/25. Review of the incident log dated 12/14/25 revealed Resident #82 had an unwitnessed fall at approximately 1:15 A.M. Review of the progress note dated 12/14/25 at 1:15 A.M. revealed Resident #82 was found on the floor of her bathroom underneath her walker. Resident #82 walker was in the standing potion with her bilateral legs extended in front of her. Resident #82 denied pain or hitting her head. Resident #82's vital signs were assessed with no bruising or injuries noted. Resident #82's range of motion was intact and her family and physician were notified. Review of the progress note dated 12/14/25 at 3:40 P.M. revealed the interdisciplinary team reviewed Resident #82 fall with a new intervention for standby assist when ADL care was needed. Review of the fall investigation dated 12/14/25 revealed Resident #82 had an unwitnessed fall in her bathroom and was found on the floor with her bilateral legs extended in front of her with her walker positioned above her body. Resident #82's family and physician were notified. Resident #82 was unable to state what occurred due to cognition impairment. Review of the fall investigation revealed Resident #82's fall occurred due to being left unattended in the bathroom for a short period of time without support or assistance. Resident #82's neurological checks were initiated, and the resident was not to be left by herself. Review of the physician orders dated 12/14/25 revealed an order that Resident #82 may not be left unattended. Review of the incident log dated 04/08/26 revealed Resident #82 had an unwitnessed fall at approximately 9:10 P.M. Review of the progress note dated 04/08/26 at 9:48 P.M. revealed Resident #82 was heard yelling out (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	during medication pass. Resident #82 slipped out of the chair while attempting to get up without assistance. Resident #82 revealed she needed to get her jacket. Resident #82 was assisted back into the chair, skin was checked and okay, vitals were normal and stable with no complaints of pain. Resident #82's family and physician were notified. Review of the fall investigation dated 04/08/26 revealed Resident #82 had an unwitnessed fall from her wheelchair and was found on the floor in her room during medication pass. Resident #82 was left alone and unattended and attempted to self-transfer. Resident #82 was assessed with no injuries noted and the family and physician were notified. The fall investigation did not address the intervention of Resident #82 being in common areas when out in bed, not being implemented. There was no evidence of new fall prevention interventions implemented after the fall. Review of the incident log dated 04/18/26 revealed Resident #82 had a fall at approximately 5:30 P.M. Review of the progress note dated 04/18/26 at 5:32 P.M. revealed Resident #82 was found sitting on the floor in front of her wheelchair. Resident #82 had no complaints of pain or discomfort. Resident #82's vital signs were assed and neurological checks were initiated. Resident #82's family and physician were notified. Review of the fall investigation dated 04/18/26 at 5:30 P.M. revealed Resident #82 had an unwitnessed fall in her room, was found sitting on the floor in front of her wheelchair and was unable to communicate what happened. Resident #82 was alone and unattended and attempting to self-transfer. Resident #82's neurological checks were initiated, the resident was assessed from head-to-toe, and the family and physician were notified. Resident #82 was not taken to the hospital. The facility did not address the intervention of being in common areas when out in bed not being implemented. There was no evidence of new fall prevention interventions implemented after the fall. Review of the progress note dated 04/18/26 at 6:53 P.M. revealed Resident #82's family member came to the facility to show the camera clip of Resident #82's fall. Resident #82 received orders to be sent to the ED for further evaluation after review of the video showing the fall. Review of the physician orders dated 04/18/26 revealed an order for Resident #82 to be sent to the emergency department (ED) for scans of her head post fall. Review of the hospital paperwork dated 04/19/26 revealed Resident #82 was admitted to the hospital on [DATE] with a known history of dementia after an unwitnessed fall. Review of the hospital paperwork revealed no noted injuries. Review of Resident's census information revealed the resident returned to the facility on [DATE], but there was no progress note addressing her return or new fall interventions as a result of the fall on 04/18/26. Review of the fall risk assessment dated [DATE] revealed Resident #82 was at high risk for falls with a history of 3 or more falls within the last 90 days. Resident #82 had a history of cognition impairment and ambulated with problems and with devices. Review of the incident log dated 05/09/26 revealed Resident #82 had a fall at approximately 5:30 A.M. Review of the fall investigation dated 05/09/26 revealed Resident #82 had an unwitnessed fall from (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	her wheelchair in the hallway. Resident #82 had been noted to be noncompliant, combative, and refusing medications and attempts for toileting throughout the night. Resident #82 was found on the floor with her bilateral lower extremities bent and soaked in urine. Resident #82 was placed back into her wheelchair and taken to her bathroom to be toileted. Resident #82 complained of pain to her right lateral hip and/or thigh area. Resident #82's family and physician were notified, and she received new orders for a stat (to be completed immediately or without delay) x-ray. Resident #82 received Tylenol for pain and tolerated it well. Resident #82 was not sent to the hospital at that time. Review of the progress note dated 05/09/26 at 5:30 A.M. revealed Resident #82 had been noncompliant all shift, refused her night medications, was combative and using profanity at staff. Resident #82 refused several attempts to be toileted, was provided with a snack and refused divergent items. Resident #82's family was notified twice of her behaviors. During morning medication pass, Resident #82 was sitting in her wheelchair in the hallway after the resident refused attempts to bring her near the staff nurse to be monitored. Resident #82 was then observed leaning forward in her wheelchair and was then repositioned with her back against the wheelchair. Resident #82, a few minutes later, was heard screaming and observed on the floor in the hallway positioned on her right side with her bilateral lower extremities bent. Resident #82 was placed back into the wheelchair with the wheelchair noted to be soaked with urine. Resident #82 was taken to her bathroom and placed on the toilet seat. Resident #82 complained of pain to her right lateral high and/or thigh. Resident #82's right hip and/or thigh were assessed with no bruising, bleeding, or injuries noted. Resident #82 was given Tylenol and tolerated the medicine. Resident #82's family and physician were notified with a new order for stat x-ray of right hip and pelvis and lab test ordered. Review of the progress note dated 05/09/26 at 11:09 A.M. revealed Resident #82's stat x-ray was completed, and the results were reported to her physician. Resident #82 received new orders to be sent out to the ER for evaluation and her family was notified. Review of the progress note dated 05/09/26 at 12:10 P.M. revealed Resident #82 was picked up and transported to the ER. Review of the radiology results report dated 05/09/26 at 2:09 P.M. revealed Resident #82 had an x-ray of her right hip, that indicated she had an acute fracture of the neck of the femur. Interview on 06/01/26 at 11:00 A.M. with Certified Nursing Assistant (CNA) #379 revealed Resident #82 was currently out of the building due to being admitted to the hospital. CNA #379 revealed Resident #82 was a high fall risk and could not be left alone or she would attempt to get out of her wheelchair and fall. CNA #379 revealed Resident #82 pushed herself around in her wheelchair in the hallway and always appeared agitated. CNA #379 confirmed and verified the above findings at the time of the interview. Interview on 06/02/26 at 4:20 P.M. with Director of Nursing (DON) revealed all fall-related documentation regarding investigations and follow-up related to Resident #82's falls were provided to the survey team. During review of the fall documentation, the DON confirmed and verified the lack of thorough investigations related to Resident #82's falls with missing interventions, lack of staff witness statements, no identified interventions before and after each fall, and whether staff education, training and/or discipline occurred. Interview on 06/08/26 at 9:39 A.M. with Licensed practical Nurse (LPN) #323 revealed Resident #82 was a high fall risk, confused, delirious, had dementia and was often combative. LPN #323 revealed Resident #82 was to be toileted every two hours, kept within eyesight, and placed at the nursing station or common area for monitoring and safety. LPN #323 revealed Resident #82 was not to be left (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	alone or unattended. LPN #323 revealed on 04/18/26, Resident #82 sustained a fall from her wheelchair and was sent to the hospital. LPN #323 stated CNA #337placed Resident #82 in her room and left to do something else. LPN #323 revealed she was the nurse at the time of the fall and confirmed and verified Resident #82 sustained a fall due to the fall interventions not being in place and followed, per the care plan. Interview on 06/08/26 at 10:24 A.M. with the DON and Corporate Registered Nurse (RN) #412 revealed residents could be left alone despite their care plan indicating not to be left alone. RN #412 stated No one wants to be watched while using the bathroom. My mother would have a fit. RN #412 acknowledged Resident #82's care plan and fall intervention of assistance of one staff member. RN #412 revealed CNA #337 left to grab incontinence care supplies and within seconds the fall occurred. Review of the fall investigation dated 04/18/26 related to the fall in question with RN #412, revealed Resident #82 was left on the toilet while CNA #337 went to read the checklist left in the room by Resident #82's family, not grab incontinence care supplies. RN #412 and the DON confirmed and verified the above findings at the time of the interview. Interview on 06/09/26 at 7:38 A.M. with LPN #351 revealed she was assigned t

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366488	A. Building B. Wing	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenue at Lyndhurst	5442 Rae Road Lyndhurst, OH 44124

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(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, observations, interviews and facility policy review, the facility failed to provide timely and appropriate incontinence care for Residents #22 and #31. This affected two residents (Residents #22 and #31) of seven residents reviewed for incontinence care. The facility census was 88.Findings include:1. Review of the medical record for Resident #22 revealed the initial date of admission as 10/07/25 and a readmission date of 12/23/25. Diagnoses included overactive bladder. Review of the quarterly minimum data set (MDS) 3.0 assessment dated [DATE] revealed a brief interview for mental status with a score of 10 indicating Resident #22 had a mild cognitive deficit. The MDS also revealed Resident #22 was dependent on staff for toileting and was always incontinent of bladder and bowel.Review of the care plan dated 04/02/26 revealed Resident #22 had bowel and bladder incontinence. Interventions included checking and changing during care rounds and as needed. The care plan also revealed Resident #22 had an activity of daily living deficit and needed assistance of two staff for toileting.Review of the physician's orders revealed an order dated 05/30/26 for Resident #22 to receive Cefdinir (an antibiotic for infection) 300 milligrams (mg) two times daily for two days for a urinary tract infection (UTI).On 06/02/26 at 3:04 P.M. an observation of incontinence care for Resident #22 revealed Resident #22 was wearing two briefs. Interview with Registered Nurse (RN) #350 and Licensed Practical Nurse (LPN) #353 verified the resident was wearing two briefs at the time of the observation.2. Review of medical records for Resident #31 revealed the date of admission as 07/04/21. Diagnoses included Parkinson's disease, dementia and anxiety. Review of the annual MDS 3.0 assessment dated [DATE] revealed Resident #31 had mild cognitive impairment and required supervision or touching assistance for toileting. The resident was occasionally incontinent of bladder and bowel.Review of the care plan dated 04/03/26 revealed Resident #31 had a self-care deficit. Interventions included one person assistance with toileting.On 06/02/26 at 9:32 A.M., an observation of incontinence care for Resident #31 was conducted. Resident #31 appeared visibly upset regarding the extent of his incontinence and stated he had not been changed throughout the night. He further stated, care around here is really going downhill. The Director of Nursing (DON) was present during the observation. When the bed linens were pulled back, Resident #31 was noted to have his pajama bottoms pulled down around his knees while lying in bed. The DON responded to the resident by asking, Don't you remember [name] came in to change you, and you refused stating you wanted to wait until after breakfast? Resident #31 again stated he wanted to be changed, reiterated he had not been changed all night, and repeated his concern that care was declining. The resident's brief was observed to be saturated, and there was a strong odor of urine. The DON declined to verify the saturation of the brief. A review of the facility policy titled; Incontinence Care, dated December 2022, revealed the purpose of the policy is to ensure a resident who is incontinent of bowel and or bladder receives 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 3032216, 3014836, 2616202, and 2604187.

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	366488	A. Building B. Wing	06/18/2026

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and facility policy review, the facility failed to provide necessary nutritional and hydration care and services for Residents #25, #46, #76, #77, #83, #99, and #100). This affected seven residents (Resident #25, #46, #76, #77, #83, #99, #100) out of 12 residents reviewed for nutrition. The facility census was 88. Actual harm occurred on 05/07/26 after Resident #83, who had cognitive impairment with a history of malnutrition, nutrition and hydration status was not properly monitored and poor oral intakes were not treated, resulting in the resident experiencing weight loss, significant dehydration and acute kidney injury. Resident #83 required hospitalization, intravenous (IV) fluids, and treatment for a urinary tract infection.Findings include: 1. A review of closed medical record for Resident #83 revealed the resident was admitted on [DATE] and discharged on 05/16/26. Resident #83's diagnoses included unspecified dementia, unspecified severity, with agitation, unspecified severe protein calorie malnutrition, tremor, and generalized anxiety disorder. Review of Resident #83's physician order revealed an order dated 03/17/26 for weekly weights, an order dated 03/17/26 for a regular diet, mechanical soft texture, thin liquid, with boost plus before meals and at bedtime, an order dated 05/06/26 for boost, very high calorie, give one supplement three times a day for nutrition related to unspecified severe protein calorie malnutrition, and an order dated 04/08/26 for a basic metabolic panel, complete blood count, thyroid stimulating hormone, lipid level, vitamin D level every three months. Review of Resident #83's medical record revealed no Minimum Data Set (MDS) assessments were completed. Review of Resident #83's care plan dated 03/17/26 revealed the resident had impaired cognitive function. Interventions included to observe for any changes in cognitive function specifically changes in decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, and mental status. The care plan also stated Resident #83 had an activity of daily living self-care performance deficit. Interventions included provide setup and supervision with meals for oral intake. Finally, the care plan revealed Resident #83 had the potential for altered nutrition and hydration related to dementia, anxiety, and low body mass index (BMI). A goal to improve fluid volume balance with no signs and symptoms of dehydration through the next review date was initiated on 03/20/26. Other interventions included to observe meal intakes and record on the certified nurse aid flow record, observe for signs and symptoms of dehydration such as dry mucous membranes, elevated temperature, dizziness withstanding, constipation, poor skin turgor, elevated sodium levels, elevated blood urea nitrogen level (BUN), obtain and record weights as ordered dated 03/20/26, obtain lab values as orders and report abnormal lab values to physician as indicated and refer to dietician as for evaluation and recommendations as needed. There were no interventions to offer fluids more frequently or monitor fluid intake related to the risk of dehydration. Weight loss was noted on 04/21/26 within the care plan related to poor oral intakes. Also, within the care plan it is noted on 05/06 26 that weight loss was confirmed and poor oral intakes continued. A review of weekly ordered weights revealed on 03/19/26 Resident #83 had a weight of 97.4 pounds via wheelchair scale and there were no further recorded weights for March 2026 within the medical record. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	A review of an admission nutrition assessment dated [DATE] and authored by Facility Registered Dietician (FRD) #420 revealed Resident #83 was on a mechanical soft diet with meal intake identified to be between 25 and 50 percent. Resident #83 was noted to be on Boost Plus, eight ounces, four times daily for nutritional support and needed limited assistance for eating. The nutritional plan was to continue current diet and interventions as they are appropriate and obtain weights per policy. A review of blood work results dated 04/08/26 revealed Resident #83 had an elevated sodium level of 148 (normal levels 136-145), an elevated BUN level of 33 (normal levels are 7-25), and BUN/Creatinine ration level of 41 (normal levels are 6-22). A review of weekly ordered weights revealed on 04/08/26 Resident #83 had a weight of 97.1 pounds via wheelchair scale, on 04/20/26 a weight of 82.6 pounds via sitting was recorded which indicated a 14.93 percent weight loss in 12 days. A progress note dated 04/20/26 revealed the labs were reviewed by the nurse practitioner with no new orders given. A review of significant change dietary assessment dated [DATE] revealed Resident #83 had a weight of 82.6 pounds. A BMI of 16 was noted indicating Resident #83 was underweight. Meal intakes were noted as less than 25 percent. Boost plus 8 ounces four times daily was noted with supplement intake at 75 to 100 percent. The weight of 82.6 pounds was questioned and a reweigh was requested to ensure accuracy. The plan was to continue to monitor per protocol and review re-weight to establish baseline. Coordinate with interdisciplinary team, resident, and family per plan of care. The note further stated Resident #83 continued with severe protein calorie malnutrition related to chronic illness, insufficient oral intake, decreased subcutaneous fat stores and loss of muscle mass. It was noted that the boost plus four times daily would provide 1440 calories and 56 grams of protein daily if 100% was consumed. It was noted that the residents does not want artificial feedings and continues taking fluids fairly well. The note further stated Resident #83 was at risk for altered hydration related to poor oral intake. Interventions were to continue to monitor per protocol and coordinate with interdisciplinary team, resident, and family for need for further interventions regarding hydration. A progress note dated 04/21/26 and authored by Facility Registered Dietician (FRD) #420 revealed a weight of 82.6 and a reweigh was requested. A review of weekly ordered weights revealed on 04/28/26 a weight of 80.4 pounds was recorded via mechanical lift scale, and on 05/02/26 a weight of 80.8 pounds was recorded via wheelchair scale. A review of meal intakes for April 2026 was as follows: -On 04/01/26 there was no documented food intake for breakfast lunch or dinner.-On 04/02/26 for breakfast lunch and dinner it was noted that Resident #83 was able to eat independently and required no setup or physical help from staff. The amount of food consumed was documented as 76 to 100%.-On 04/03/ 26 there was no documented food intake.-On 04 0426 there was a documented resident refusal of all meals.-On 04/05/26, 04/06/26, 04/07/26, 04/08/26, 04/09/26, 04/10/26, and 04/11/26 there was no documented food intake.-On 04/12/26 it was documented Resident #83 needed limited assistance for eating. The food intake was documented at zero to 25% for breakfast and lunch. There was no documentation of meal intake for dinner.-On 04/13/26 it is documented that Resident #83 refused all meals.-On 04/14/26 it was documented that Resident #83 was independent with set up four meal intakes of breakfast lunch and dinner. The amount of food consumed was (continued on next page)

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	366488	A. Building B. Wing	06/18/2026

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F 0692 Level of Harm - Actual harm Residents Affected - Few	documented at 51 to 75%.-On 04/15/26 it was documented that Resident #83 was dependent on staff for meal intake. Documented actual food intake was 0-25%. There is no documented food intake for breakfast or dinner.-On 04/16/26 it was documented that Resident #83 needed limited assistance for eating with setup. The amount consumed was 0-25%.-On 04/17/26 it was documented that Resident #83 needed limited assistance for eating with set up. The amount of food consumed was listed as zero to 25%.-On 04/18/26 and 04/19/26 there was no documented food intake for Resident #83.-On 04/20/26 it was documented that Resident #83 needed limited assistance for eating and set up. There was one meal documented at 2:29 PM with the consumption being zero to 25%.-On 04/21/26, 04/22/26, 04/23/26, 04/24/26, and 04/25/26 there was no documented food intake for Resident #83.-On 04/26 26 it was documented that Resident #83 could eat independently with set up. The amount of food consumed for breakfast was zero to 25%, 26-50% for lunch, and resident refusal was documented for dinner.-On 04/27/26 it was documented that Resident #83 needed staff assistance for meal intake and set up of meals. Food intake was documented at zero to 25% for lunch 26 to 50% for lunch and dinner.-On 04/28/26, 04/29/26, and 04/30/26, there was no documentation of assistance or meal intake for Resident #83.A review of a quarterly nutrition assessment dated [DATE] revealed Resident #83 was on a mechanical soft diet with a Boost plus supplement of eight ounces noted four times daily. The note further revealed Resident #83 to be totally dependent on staff for eating. Meal intakes were noted at less then 25 percent. Fluid intakes were noted as fair. A weight of 80.8 pounds was noted. The plan was to coordinate with the interdisciplinary team, resident, and family for a plan of care. It was noted that Resident #83 continued with severe protein calorie malnutrition related to chronic illness, insufficient oral intake, and decreased subcutaneous fat stores. There were no coughing or swallowing issues noted. The plan further stated to continue to encourage intakes to better meet nutritional needs. Per discussion with staff the resident was spending more time in the room. An adjustment to provide Resident #83 with boost very high calorie 8 oz three times a day for nutritional support was instituted. This would offer Resident #83 1590 calories per day and 66 grams of protein if it was consumed at 100%. It was also noted within the note that Resident #83 continued taking fluids fairly well. Resident #83 was noted to be at risk for altered hydration status related to poor oral intake. The note stated that the diet, snacks, and nutritional support supplement in fluids meat residents caloric and nutritional requirements. A review of documented meal intakes for May 2026 was as follows: -On 05/01/26 there was no documented meal intake.-On 05/02/25 it was documented Resident #83 was a dependent on staff for meal consumption. Refusals were documented for all three meals.-On 05/03/26 there were no documented meal intake.-On 05/04/26 there was documented refusal for all three meals.-On 05/05/26 there was no documented food intake-On 05/06/26 it was documented Resident #83 was able to eat independently. A meal intake of 76-100% is noted.-On 05/07/26 refusals were documented for all three meals.A review of physician notes authored by Certified Nurse Practitioner (CNP) #451 dated 03/19/26, 03/31/26, 04/21/26, and 05/06/26 revealed in each note that there was no height or weight within the medical record to calculate the BMI for Resident #83. There was nothing within the notes indicating notification of weight changes or resident decline in meal and fluid intakes including refusals. There was nothing within the notes indicating notification of Resident #83 going from needing limited assistance with meals to being totally dependent for meal intakes. A review of a progress note dated 05/07/26 at 8:40 P.M. revealed Resident #83 was sent to the emergency room for a change in mental status. A review of a hospital history of present illness dated 05/08/26 revealed Resident #83 presented to (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	the emergency room with poor oral intake and confusion. According to the emergency room note, the resident has had poor oral intake and confusion for the last month after changing long term care facilities. According to the emergency room note the resident does not feed herself, a tray was placed in front of her however no one was available to feed her. The son mentions there was no one present at the facility to feed her therefore she often goes without any oral intake. In the emergency room her sodium level was found to be elevated at 1:54, she has acute kidney injury with a creatinine of 1.49 and the prior level was 0.69 she had received a liter of normal saline and was started on Bactrim for urinary tract infection. Mucous membranes were noted to be dry and lips were very chapped. The assessment and plan within the history and physical revealed a urinary tract infection and the resident was started on Bactrim as prophylactic antibiotic treatment. The urine culture will be monitored in the antibiotic will be adjusted as needed. The resident was also admitted with acute kidney injury related to poor oral intake improvement was expected with IV fluids. The resident was admitted with hypernatremia likely due to poor intake of fluid, the resident has dementia and likely has an inability to ask for water. A nutritional note dated 05/11/26 within the hospital record revealed Resident #83 was not eating well and refusing liquids even with one-on-one assistance. A weight was listed at 87 pounds. A BMI was listed as 15.42 indicating Resident #83 was severely underweight. A significant weight loss was noted of greater then 7.5% in three months based on hospital recorded weights on 04/01/26 of 44.18 kilograms (97.4 pounds) and 39.5 kilograms (87 pounds) on 05/11/26. Mild to moderate muscle wasting was noted. The nutritional diagnosis within the nutritional note revealed mild malnutrition related to acute disease or injury. The note further revealed the malnutrition diagnosis is new. Mild malnutrition was related to acute disease or injury related to altered mental status, multifactorial as evidence of greater than 7.5% weight loss in three months, poor intake of less than 50% of estimated energy needs for greater than three days, and suspected prolonged poor oral intake prior to admission. On 06/03/26 at 3:30 P.M. an interview with FRD #420 acknowledged Resident #83's medical record identified a significant weight but there was a question if the weights obtained for Resident #83 were accurate. FRD #420 requested a re-weigh on 04/21/26 which was not completed. FRD #420 stated she did not track or follow-up with the facility as to the results of any re-weight obtained or lack thereof. FRD #420 stated obtaining weights and weekly weights within the facility have been an ongoing problem. FRD #420 further stated Resident #83 was noted to have a poor oral intake. FRD #420 stated she did not personally notify the physician of poor oral intake for Resident #83. On 06/16/26 at 11:30 A.M. an interview with Corporate Registered Nurse (CRN) #412 verified the lack of a re-weigh as indicated in the nutritional note dated 04/21/26. On 06/03/26 at 9:45 A.M. an interview with Registered Nurse (RN) #419 revealed she had taken care of Resident #83 at a sister facility. RN #419 stated Resident #83 had declined from being able to self-feed to needing to be fed. RN #419 stated there was no discussion with family or the physician in that she was aware of regarding the decline of Resident #83. On 06/04/26 at 11:15 A.M. an interview with the Director of Nursing (DON) verified there was nothing in Resident #83's medical record to indicate the decline in being dependent for feeding or how it was to be addressed and monitored. On 06/08/26 at 10:04 A.M. an interview with Licensed Practical Nurse (LPN) #323 revealed she had taken care of Resident #83 at different times. LPN #323 was aware Resident #83 needed to be fed and was not notified of refusals of food. LPN #323 stated that she saw a decline with the resident in (continued on next page)

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	366488	A. Building B. Wing	06/18/2026

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F 0692 Level of Harm - Actual harm Residents Affected - Few	the last two weeks because usually she was in the hall hollering and she was not doing that. On 06/09/26 at 10:05 A.M. an interview with Assistant Director of Nursing / Registered Nurse (ADON/RN) #322 revealed she had observed staff attempting to feed Resident #83. ADON/RN #322 stated fluids are given to dependent residents with meals, an additional two times daily and with medication administration. ADON/RN #322 stated Resident #83 was not discussed in interdisciplinary team meetings regarding food refusals, weight loss or hydration needs. On 06/09/26 at 1:49 P.M. an interview with DON and the Administrator revealed there was no policy for dehydration and dehydration needs are addressed and discussed in the nutrition assessments. Both stated there were no conversations with the son regarding the decline of Resident #83. On 06/16/26 at 11:30 A.M. an interview with CRN #412 verified there is a lack of meal intake documentation in the medical record for Resident #83. CRN #412 stated fluids are not monitored and documented on residents unless there is a physician order to do so. On 06/17/26 at 11:21 A.M., an interview with CNP #451 revealed if his documentation in his visit notes stated there were no weights to review in the medical record then there were no weights to review. CNP #451 further stated he was not notified of Resident #83 weight loss nor was he notified of any change in activity of daily living functions including refusals of food and fluids for Resident #83. CNP #451 stated the dietician addresses any weight issues with residents and there was nothing in the medical records or what he saw during his visits to indicate a change in his treatment plan. A review of the facility policy titled, Refusal of Care or Treatment with a revision date of December 2022 revealed while the resident has the right to refuse any treatment or services, the resident's refusal does not absolve the facility staff from providing other care that allows him or her to attain or maintain his or her highest practicable physical, mental, and cycle social well-being. A residence refusal of treatment does not absolve the healthcare facility from providing care that allows the resident to maintain his or her highest practical physical, mental, and psychological well-being in the context of making that refusal. After three consecutive incidents of refusals of care and treatment, refusal will be reported to the physician and documented in the nurse's notes. A review of the facility policy titled, Resident Change in Condition dated 07/28/22 revealed the purpose of the policies to ensure staff provide timely and appropriate care and services when residents experience a changing condition that has or is likely to cause serious life-threatening harm or injuries or adverse negative health outcomes. The policy further revealed when a significant or acute change is identified in the residence physical, mental, or psychosocial status the licensed nurse will notify the attending physician regarding the change in condition once an assessment of the resident has been completed. A change of condition may include but is not limited to a significant or acute change in the residence physical mental or psychosocial status including abnormal lab values level of weakness, demeanor, appetite, and alteration in mental status including confusion, lethargy, defects in judgment or thought and unusual or strange behavior. A changing condition may also include but is not limited to a need to alter the residence treatment significantly. The policy also stated that unless otherwise instructed by the resident, the licensed nurse will notify the residents responsible party when a change in condition is noted. The licensed nurse will document any changes in the residence medical condition or status in the resident's medical record. A review of the facility policy titled, Weight Policy and Procedure with the revision date of October 2024 revealed weights will be obtained at least monthly in order to identify those residents who may (continued on next page)

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	366488	A. Building B. Wing	06/18/2026

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F 0692 Level of Harm - Actual harm Residents Affected - Few	be at nutritional risk and require further evaluation and monitoring. All new admissions and readmissions will be weighed by the facility within 24 hours of admission. Hospital and home weights are not accepted. In order to establish a baseline weight, all new admissions will be weighed weekly for the first four weeks after admission. If an unplanned significant weight loss has been identified, a nutrition referral form should be completed and forwarded to the dietitian. The resident will be referred to the nutrition risk committee for further discussion and intervention. The physician and responsible party will be notified of any significant weight changes. Any weight variance increase or decrease of 3 lbs. in a week or 5% in a month must be reweighed within 24 hours. There should be a documented clinical basis for any conclusion that nutritional status or significant weight change are unlikely to stabilize or improve. An example would be if the physician documentation indicated as to why weight loss is medically unavoidable. A care plan will be developed to address risk and identify causes of weight gain and or loss. 2. A review of medical records for Resident #77 revealed the date of admission as 02/11/26. Significant diagnosis included congestive heart failure, unspecified protein calorie malnutrition, chronic kidney disease, and unspecified dementia without behavioral disturbance. Significant orders included regular diet with thin liquids. A review of nutrition assessment dated [DATE] revealed Resident #77 required supervision for eating. A weight of 184.6 was noted in the hospital. An admission weight was requested the plan of completing weights per policy and continue diet as it remains appropriate. There were no nutritional recommendations at this time. A review of weights within the resident record revealed the initial weight was taken of Resident #77 on 03/18/26 which was noted to be 152 pounds via wheelchair scale. The next weight was on 03/25/26 at 153.7 pounds via standing scale. The last documented weight on the chart was 05/09/26 at 152.8 pounds via wheelchair scale. A review of a significant change nutrition assessment dated [DATE] revealed a weight of 152 pounds via wheelchair scale. The weight 30 days ago was listed as 184.6 pounds. Resident #83 was on a regular diet with thin liquid consistency, and it remained appropriate. The most recent weight was showing a loss in one month and present weight was stable. The plan was to continue to monitor per protocol to establish a baseline and coordinate with interdisciplinary team, resident, and family for plan of care. A quarterly minimum data set assessment dated [DATE] revealed a brief interview for mental status with a score of five indicating Resident #77 had severe cognitive deficit periods the assessment also revealed Resident #77 needed supervision with eating. A care plan dated 05/20/26 revealed Resident #77 had an activity of daily living self-care performance deficit related to dementia, congestive heart failure, and malnutrition. Interventions for eating included provide setup supervision with meals. The care plan further revealed Resident #77 had a potential for altered nutrition and hydration. Interventions included obtain and record weights as ordered. On 06/09/26 at 1:49 P.M. an interview with the DON and the Administrator verified no admission weight or weekly weights were completed on Resident #77. The DON stated he was not familiar with the facility weight policy but, it was a reasonable expectation weights be obtained on admission. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	3. Review of the medical record for Resident #25 revealed an admission date of 07/26/25. Diagnoses included but were not limited to moderate protein-calorie malnutrition, adult failure to thrive, schizoaffective disorder bipolar type, and paranoid schizophrenia. Review of the 08/12/25 physician order for Resident #25 revealed an order for monthly weights every four weeks on Tuesday for weight collection. Review of the 09/19/25 order physician order for Resident #25 revealed an order for weekly weight collection every day shift every seven days. The order was discontinued on 02/04/26. Review of the 01/2026 Medication Administration Record (MAR) for Resident #25 revealed no weight was recorded on 01/30/26 and no reason was given. Review of the 02/2026 MAR for Resident #25 indicated a weight was completed with a check mark with no weight listed. Review of weights recorded for Resident #25 revealed a monthly weight of 226.2 pounds (#) was recorded on 01/27/26. No weight was recorded for 0220/26 and the next weight recorded for Resident #25 was on 03/11/26 at 234.8# which indicated an 8.6# gain. Review of the 05/08/26 quarterly MDS assessment for Resident #25 revealed a Brief Interview of Mental Status (BIMS) of 13 which indicated intact cognition. Resident #25 was noted to be independent for eating and was on a regular diet. Interview on 06/08/26 at 1:23 P.M. with Regional Dietitian #427 confirmed monthly weights were not completed as ordered for Resident #25. 4. Review of the medical record for Resident #46 revealed an admission date of 08/30/25. Diagnoses included but were not limited to idiopathic normal pressure hydrocephalus, morbid obesity, stage III chronic kidney disease and congestive heart failure. Review of the 09/29/25 physician order for Resident #46 revealed an order for weekly weights in the morning every Monday. Review of the 03/06/26 quarterly MDS assessment for Resident #46 revealed moderate cognitive impairment. Resident #46 was noted to require supervision with eating and received a mechanically altered diet. Review of the 06/05/26 quarterly MDS assessment for Resident #46 revealed moderate cognitive impairment. Resident #46 was noted to require supervision with eating and was noted to have a significant weight that not was physician prescribed. Review of the 04/2026 MAR for Resident #46 revealed no weight was recorded for 04/27/26. Review of the 05/2026 MAR for Resident #46 revealed no weight was recorded for 05/04/26. Review of weights under the weights tab in the electronic medical record (EMR) revealed a weight of 251# recorded on 04/21/26 which was 251#, no weight recorded on 04/27/26. The next recorded weight was 05/14/26 which was 247.7#. A weight of 234.2# was recorded on 05/25/26, which (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366488	A. Building B. Wing	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenue at Lyndhurst	5442 Rae Road Lyndhurst, OH 44124

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F 0692 Level of Harm - Actual harm Residents Affected - Few	indicated a 13.5# (5%) loss. No reweight was recorded and the next weight of 234# was recorded on 06/01/26. Interview on 06/09/26 at 3:13 P.M. with Corporate Registered Nurse (RN) #214 confirmed the weekly weights were not completed as ordered and a reweight was not completed until 06/01/26 following the weight loss on 05/25/26. 5. Review of the medical record for Resident #76 revealed an admission date of 11/02/25. Diagnoses included but were not limited to congestive heart failure, morbid obesity, type II diabetes mellitus and stage IV chronic kidney disease. Review of the physician orders for Resident #76 revealed three weight orders. An 11/03/25 order for weight every day shift every four weeks. An 11/17/25 for weekly weights to be completed in the morning every Monday and a third order dated 11/22/26 order to monitor weight one time a day on Tuesday and Saturday. Review of the 04/2026 MAR for Resident #76 revealed Tues and Saturday weights were checked as complete but not weights were listed. The weekly weights were indicated as completed on 04/06/26 and 04/20/26 indicated a nine to see progress notes but no corresponding note was found and 04/17/26 and 04/27/26 were indicated as complete with no weight recorded. Review of the 05/2026 MAR for Resident #76 revealed Tuesday and Saturday weights were indicated as complete but no weight was recorded. There was no weekly weight recorded on 05/04/26 and no corresponding progress note. The weekly weight on 05/11/26 indicated a weight of 251#, the weekly weight on 05/18/26 indicated a weight of 247.7# and the weight on 05/25/26 was 234.2# which indicated a 13.5# (5%) loss in a week. Review of the weights tab in the EMR for Resident #76 revealed a weight recorded on 05/19/26 of 226.2# and 05/27/26 a weight of 224.2#. Review of the 05/08/26 quarterly MDS assessment for Resident #76 revealed a Brief Interview of Mental Status (BIMS) of 15 which indicated intact cognition. Resident #76 was noted to be independent for eating. Interview on 06/08/26 at 1:23 P.M. with Regional Dietitian #427 confirmed there were three weight orders for Resident #76 and were not completed as ordered. 6. Review of the medical record for Resident #99 revealed and admission date of 03/13/26. Diagnoses included but were not limited to spastic hemiplegia affecting left nondominant side, moderate protein-calorie malnutrition, bulimia nervosa and gastroesophageal reflux disease. Review of the 03/13/26 nursing admission assessment revealed Resident #99 requires set up for eating and is dependent for care. Review of the 03/17/26 nutrition assessment revealed Resident #99 was independent for feeding and recommended to monitor weight times four weeks. Review of the physician order for resident #99 dated 03/17/26 revealed an order to weigh monthly every day shift every four weeks on Tuesday. (continued on next page)

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	366488	A. Building B. Wing	06/18/2026

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of the 03/2026, 04/2026 and 05/2026 MARs for Resident #99 revealed no order for weekly weights. Review of the weights recorded under the weights tab in the EMR revealed a weight on 03/15/26 of 267.6#, a weight on 04/08;26 of 265.4#, a weight on 04/22/26 of 272.8#, and a weight on 05/09/26 of 270.1#. No additional weights were recorded. Interview on 06/08/26 at 1:50 P.M. with Registered Dietitian (RD) #420 confirmed the nutrition assessment stated weekly weights times four weeks and no order for weekly weights was found and weekly weights were not completed. 7. Review of the medical record for Resident #100 revealed an admission date of 03/13/26. Diagnoses included but were not limited to moderate protein calorie malnutrition autistic disorder and gastrostomy status. Review of the 03/13/26 nursing admission assessment revealed Resident #100 was a total assist. Review of the 03/17/26 nutrition assessment for Resident #100 revealed an admission weight of 114.8# on 03/15/26. Weights from the previous facility indicated stable weight but weights have been trending down over the past six months. Monitor weight weekly for four weeks. Review of the 03/2026 Medication Administration Record (MAR)for Resident #100 revealed they were indicated as complete with a check mark but no weight was recorded. Review of the weights tab in the EMR for Resident #100 revealed an admission weight on 03/15/26 of 114.8#, a weight on 04/02/26 of 114.2#, a weight on 04/22/26 of 119#, a weight on 04/28/26 of 116.6#, a weight on 05/09/26 of 116# and a weight on 05/21/26 of 113.4# Phone interview on 06/08/26 at 1:50 P.M. with Registered Dietitian #420 confirmed she recommended weekly weights but there was no order for weekly weights and therefore did not show up on the MAR to be completed. Review of the October 2024 revised facility policy called Weight Policy and Procedure revealed all new admission and readmissions will be weighed by the facility within 24 hours of admission. All new admissions will be weighed weekly for the first four weeks after admission. Weekly weights may be completed on the resident's scheduled bath day or other assigned day according to facility practice. Any weight variance (increase or decrease) of three pounds in a week or 5% in a month must be reweighed within 24 hours. Weights will be recorded in the resident's medical record. This deficiency represents non-compliance investigated under Complaint Number 3014007 and 2604622.

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	366488	A. Building B. Wing	06/18/2026

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, interviews, review of email and photographs provided by family, and policy review, the facility failed to ensure enteral tube feeding was provided as physician ordered for Resident #100 of two residents reviewed for enteral feedings. The affected one resident (Resident #100) of two residents reviewed for enteral feedings. The facility census was 88.Findings include:Review of the medical record for Resident #100 revealed an admission date of 03/13/26. Diagnoses included but were not limited to moderate protein-calorie malnutrition, autistic disorder, and gastrostomy status.Review of the 03/13/26 nursing admission assessment for Resident #100 revealed resident was a total assist for transfer, was non-weight bearing and nothing was indicated for communication. Resident #100 required total assistance of two staff for bathing, oral hygiene and transfers. Resident #100 was also noted to require one staff assistance for feeding.Review of the 03/20/26 physician order timed at 7:00 A.M. for Resident #100 revealed an order for Isosource 1.5 calorie enteral feeding to run continuously at 70 cubic centimeters (cc) per hour via the peg tube. Review of the care plan dated 03/17/26 for Resident #100 revealed the resident required a feeding tube to maintain nutritional status and hydration related to failure to thrive. Interventions were to administer tube feeding and flushes per physician order. Review of the electronic mail dated 04/02/26 provided by Resident #100's family member sent to the Administrator revealed Resident #100's tube feed was off again on 04/02/26 from 2:00 P.M. until approximately midnight. The email indicated it was the third time that happened within a week and Resident #100's family member was unable to find a nurse to ask.Review of the electronic mail from Resident #100's family member revealed a picture timestamped 05/17/26 timed at 8:38 P.M. The picture revealed a disposable enteral feeding bag dated 05/14/26 timed at 8:00 P.M. with Resident #100's name on it and Isosource 1.5 written on the bag hanging next to Resident #100's bed. Review of the electronic mail dated 05/17/26 from Resident #100's family member to the Administrator revealed she came into the facility on [DATE] at approximately noon. Resident #100 did not have his tube feed on again and the same bag was present from the following day and was dated 05/14/26 and approximately half full. She indicated his dinner was still present in the room from the evening prior and was concerned the resident had not received breakfast or lunch meals or fluids that day (05/17/26). The email indicated Resident #100's family member expected better and Resident #100 deserved better. Review of the facility invoice dated 05/18/26 for care supplies including enteral feedings revealed four cases of Isosource 1.5 calorie enteral feeding were ordered which would have provided six one-liter bags per case for a total of 24 liters of enteral feeding or four days' supply.Review of the facility invoice dated 05/21/26 for care supplies including enteral feeding revealed no cases of Isosource 1.5 calorie enteral feeding were ordered.Review of the facility invoice dated 05/28/26 for care supplies including enteral feeding revealed no cases of Isosource 1.5 calorie enteral feeding were ordered.Review of the email dated 06/04/26 timed at 8:17 P.M. received from Resident #100's family member revealed a screenshot of a text Resident #100's family member received from the facility nurse on 05/31/26 at 8:37 A.M. stating asking if the family member could go to a sister facility to obtain Resident #100's Isosource as the facility could not find any. Resident #100's family member responded and stated the sister facility did not have any. Review of the email dated 06/04/26 timed at 8:17 P.M. received from Resident #100's family member revealed a screenshot of a text message from the facility nurse dated 05/31/26 timed at 10:39 A.M. which stated the facility was going to use Nutren 1.5 cal solution and indicated the only difference was it did not contain fiber, unfortunately. The message indicated it was the closest thing the facility had and asked Resident #100's family member if that was okay. Interview on 06/01/26 at 12:39 P.M. with Resident #100's family member revealed she received a text from the facility nurse on 05/31/26 stating they had run out of Isosource 1.5 and were going to give him Nutren 1.5. When she (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366488	A. Building B. Wing	06/18/2026

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	left on 05/31/26 at 11:30 P.M., the enteral feeding bag was almost empty. When she came back today (06/01/26) at 11:40 A.M., there was no tube feed solution running when she arrived and it is supposed to be continuous enteral feeding. Resident #100's family member stated he has had weight loss and she remained concerned.Interview on 06/01/26 at 12:50 P.M. with Licensed Practical Nurse (LPN) #347 confirmed Resident #100 was supposed to receive a continuous enteral feeding of Isosource. LPN #347 stated the bag was hanged last night and Resident #100 had knocked the bag down and stated she had not had a chance to get back to hang another one up. LPN #347 stated she had thrown the enteral feeding bag away in the trash but was unable to provide evidence of the discarded bag. LPN #347 stated she was unsure what time that was but stated it was after a medication pass and was unable to recall an approximate time frame the tube feeding had been down. LPN #347 stated she was going to find a bag of Isosource 1.5 to hang. The State Surveyor accompanied LPN #347. Observation at the time of the interview revealed LPN #347 was unable to find Isosource 1.5 enteral feeding in any of the unit medication carts, unit supply rooms for the four nursing stations, or in the central supply room.Interview on 06/01/26 at 1:10 P.M. with Maintenance #414 stated she changed the garbage bag at 10:07 A.M. and stated the enteral feeding was in the trash and proceeded to show a picture taken at 10:07 A.M. of a clean trash container. When asked if she usually takes pictures of empty resident trash cans, she stated she did today.Interview on 06/01/26 at 1:11 P.M. with Unit Manager #350 confirmed Resident #100's enteral feeding was not hung for the continuous feeding and had not been hanged since at least 10:07 A.M. when the trash was taken out. Unit Manager #350 stated they were in the process of changing his enteral feeding to Nutren 1.5 since they were out of Isosource 1.5.Review of the nursing progress note dated 06/01/26 timed at 2:53 P.M. written by LPN #347 revealed this nurse notified the NP/Physician of tube feed being disconnected. No new order per NP. Resident resume tube feeding at this time. No additional nursing progress notes were found from 03/13/26 to 06/15/26 that indicated enteral feeding was held.Review of the 06/01/26 physician order timed at 7:00 P.M. for Resident #100 revealed an order for Nutren 1.5 calorie enteral feeding to run continuously at 70 cc per hour via the peg tube.Observation on 06/03/26 at 12:46 P.M. revealed Resident #100's enteral feeding was not running. Interview at the time of the observation with CNA #316 confirmed Resident #100's enteral feeding was not running.Interview on 06/03/26 at 1:17 P.M. with LPN #356 confirmed she hung another bag of Nutren 1.5 for Resident #100. LPN #356 stated LPN #323 was down in the dining room feeding another resident and LPN #356 was asked to hang the enteral feeding bag following surveyor intervention.Interview on 06/03/26 at 2:21 P.M. with LPN #323 revealed she checked on Resident #100 about 11:20 A.M. and then went down to assist with feeding residents in the dining room. LPN #323 stated they are told not to change the enteral feeding until it is completely out to not waste any tube feeding. LPN #323 stated she did not have time to run back to check Resident #100's enteral feeding while she was feeding residents and then run back again to the dining room. LPN #323 stated she fed three residents during lunch and was in the dining room away from her unit for about one and a half hours.Interview on 06/08/26 at 9:40 A.M. with LPN #323 confirmed Resident #100's enteral feeding was recently switched due to not having the enteral feeding available.Phone interview on 06/08/26 at 1:50 P.M. with Registered Dietitian (RD) #420 stated Resident #100 did not have good oral intake and relied on his tube feeding to meet his nutritional needs. RD #420 stated she became aware of enteral feeding issues on 06/01/26 and knew it was held for a time but was unsure how long it was held.Interview on 06/09/26 at 3:57 P.M. with Resident #100's family member revealed she stated when she arrived at 3:12 P.M., the enteral feeding bag was on the floor and not running. She stated she told CNA #409 earlier, but no one had returned to fix it.Observation and interview on 06/09/26 at 4:06 P.M. with LPN #323 and Maintenance #343 confirmed the enteral feeding was on the floor and stated the bolt for the enteral feeding pole needed to be tightened to be able to stand securely upright.Interview on 06/09/26 at 4:09 P.M. with LPN #323 confirmed she was not aware of a time when the enteral feeding was off for an extended period, other than on 05/30/26. LPN #323 stated she was not Resident #100's nurse on 05/30/26. LPN #323 stated (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366488	A. Building B. Wing	06/18/2026

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered Nurse (RN) #419 came to her on 05/30/26 before lunch and stated she could not find Isosource 1.5. LPN #323 and RN #419 checked the supply rooms and unit med carts but were unable to find more Isosource 1.5. RN #419 contacted Resident #100's family member to see if she could bring more enteral feeding from his previous facility. LPN #323 stated they notified the on-call manager about not having the enteral feeding but was unsure which one notified the on-call manager. LPN #323 reported that RN #419 hung Nutren 1.5 in the meantime. Interview on 06/09/26 at 4:26 A.M. with LPN #323 confirmed the enteral feeding was not running for Resident #100 when she and Maintenance #343 came into the room. LPN #323 stated she was not told the enteral feeding was not running and had just come back from break. LPN #323 stated the enteral feeding pole was broken this morning when she arrived and would not stand upright and had to be leaned against the wall. LPN #323 stated she went to another unit's medication room to get a new pole and carried it back to Resident #100's room.Interview on 06/10/26 at 10:14 A.M. with Registered Dietitian #420 stated there are three residents on Isosource 1.5 enteral feeding. RD #420 confirmed for a 24-hour period, the current residents on Isosource 1.5 would require six one-liter bags of Isosource. RD #420 stated she was made aware of on 06/01/26 the facility was out of Isosource 1.5 after arriving and gave an order to change all three residents receiving enteral nutrition to Nutren 1.5.Interview on 06/10/26 at 7:53 A.M. with RN #419 confirmed she was not Resident #100's nurse on 05/31/26 but was made aware the facility was out of Isosource 1.5 after checking all of the storage rooms and med carts. When RN #419 and LPN #323 couldn't find the enteral feeding, LPN #323 called the on-call manager and let Resident #100's family member know. They got permission to use Nutren 1.5 in the meantime. The order was not written until 06/01/26. RN #419 stated they let the central supply know and possibly they forgot to order more.Interview on 06/10/26 at 8:23 A.M. with LPN #323 stated on 05/30/26 a nurse had called off, and she and RN #419 were both covering additional residents due to the call off.Interview on 06/10/26 at 8:39 A.M. with Central Supply Clerk #359 revealed he placed supply orders twice a week on Mondays and Thursdays. He stated he placed an order on 05/21/26 and 05/28/26 but confirmed Isosource was not ordered on either of these orders. Central Supply Clerk #359 confirmed the last order with Isosource prior to 05/30/26 was placed on 05/18/26 and was unsure how many bags they had on hand when he placed the order on 05/18/26 but confirmed they did run out of Isosource sometime during the weekend of 05/29/26. Interview on 06/11/26 at 6:31 A.M. with LPN #351 stated she did not recall an extended period when Resident #100's enteral feeding was turned off and did not recall any concerns related to Resident #100's enteral feeding being off for a length of time on 05/15/26 or 05/16/26 when she worked. LPN #351 stated they would have documented if there were any issues with the enteral feeding being held. LPN #351 stated sometimes if they can't find the closed tube feeding bags, they will reuse the bag and pour in the bolus enteral feeding into the bag and maybe it didn't get redated.Interview on 06/16/26 at 6:23 A.M. with RN #303 revealed there had been a couple of times when Isosource was not available, but he got a one-time order to give another enteral feeding. RN #303 stated if they use the disposable bags for bolus feeding, they are supposed to change them every 24 hours and not supposed to reuse them. RN #303 stated he was not aware of any time when the enteral feeding was not running for more than an hour. Observation at the time of interview with RN #303 revealed the enteral empty enteral feeding bag was dated 06/15/26 timed at 12:00 P.M. RN #303 stated the bag ran out at 5:30 A.M. and he had not gotten a chance to hang the new bag.Interview on 06/16/26 at 7:23 A.M. with the Administrator confirmed she received the email dated 04/02/26 related to care concerns for Resident #100 and they met with Resident #100's family member the following day to address concerns. The Administrator also confirmed she did receive the email dated 05/17/26 stating Resident #100's enteral feeding was still dated 05/14/26 but had not seen the picture. The Administrator stated she was not aware of the enteral feeding being out for Resident #100 on 05/31/26 and was not aware a staff member asked Resident #100's family member to check an alternate facility to see if they had any to use.Interview on 06/16/26 at 8:36 A.M. with Unit Manager #353 confirmed she was not aware of any times when (continued on next page)

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	366488	A. Building B. Wing	06/18/2026

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #100's enteral feedings were out and did not receive a call or text on the weekend of 05/31/26. Unit Manager #353 stated she would have contacted the physician to get a one-time order until more enteral feeding was in stock. Unit Manager #353 confirmed she was unable to provide evidence that a one-time order was received to substitute the enteral feeding for Resident #100 until 06/01/26 at 7:00 P.M.Interview on 06/16/26 at 9:22 A.M. with the Director of Nursing (DON) confirmed he was not aware of a recent time when an enteral feeding was not available. If an enteral feeding was not available, staff are to reach out to the physician to get a one-time order to substitute the enteral feeding while waiting for more enteral feeding to arrive. The DON confirmed he could not provide evidence of a one-time order to use Nutren 1.5 in place of Isosource 1.5 on 05/31/26.Review of the May 2023 revised facility policy called Enteral Feeding revealed enteral feedings will be available for residents who have an intact gastrointestinal tract but are unable to consume adequate amounts of food. The nutritional status and needs of the resident receiving enteral nutrition is assessed by the Dietitian/Diet Technician. All enteral feeding products will be available 24 hours/day. Enteral feeding orders are determined by the physician with recommendations from the dietitian made as appropriate. All enteral feeding orders must include the following information: name of enteral feed, amount to be infused, rate of infusion, frequency of intermittent feedings, and amount to be flushed including medication administration. This deficiency represents non-compliance investigated under Complaint Number 2604622.

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	366488	A. Building B. Wing	06/18/2026

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, record review, and review of facility policy, the facility failed to change a nebulizer mask (a mask used to distribute breathing medications by machine) in a timely manner for infection prevention measures. This affected one resident (Resident #85) of one resident reviewed for respiratory care. The facility identified 17 residents as utilizing nebulizers (#1, #7, #19, #22, #30, #33, #34, #35, #46, #47, #53, #66, #75, #77, #85, #94, and #107). The facility census was 88.Findings include:A review of medical record for Resident #85 revealed a date of admission of 03/13/26. Significant diagnoses included quadriplegia, acute and chronic respiratory failure with a low oxygen level, and unspecified injury to the sacral spinal cord.Review of Resident #85's physician orders included order for sodium chloride inhalation solution 3% one inhalation orally via nebulizer every 8 hours as needed for shortness of breath, albuterol sulfate nebulization solution 2.5 milligrams to 3 milliliters of solution inhale orally via nebulizer every 8 hours as needed for shortness of breath, and Ipratropium-albuterol inhalation solution 0.5/2.5 milligrams per 3 milliliters of solution one inhalation every four hours as needed for shortness of breath. There were no orders identified related to the changing of the residents nebulizer tubing.A care plan dated 04/02/26 revealed Resident #85 had an altered respiratory status related to acute and chronic respiratory failure with low oxygen levels. Interventions included administer medication as ordered, administer oxygen as ordered and observe for signs and symptoms of respiratory distress.On 06/01/26 at 10:16 A.M. an observation revealed a nebulizer mask sitting on the bedside table of Resident #85 next to a nebulizer machine. The mask was dated as changed with a piece of tape dated 05/15/26. The mask was not in a bag.On 06/01/26 at 10:40 A.M. and interview with Licensed Practical Nurse (LPN) #304 verified the date on the unbagged nebulizer mask was 05/15/26. LPN #304 stated nebulizers were to be changed weekly and stored in a bag.A review of the facility policy titled; Oxygen Therapy with a revision date of December 2022 revealed respiratory supplies, including tubing, cannula, mask and humidification bottles will be dated with the last date changed and changed weekly and as needed. Equipment such as tubing, cannulas, and masks will be stored in a manner with regard to infection control.A review of the facility policy titled; Medication Administration-Small Volume Nebulizer with the revision date of 07/2013 revealed upon completion of breathing treatments place the nebulizer in a treatment bag.This deficiency represents non-compliance investigated under Complaint Number 2604622.

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	366488	A. Building B. Wing	06/18/2026

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Avenue at Lyndhurst	5442 Rae Road Lyndhurst, OH 44124

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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 observations, resident interviews, staff interviews, review of time punch details, daily staffing sheets and schedules, review of the facility assessment, and facility policy review, the facility failed to ensure adequate staffing levels to meet the needs of the residents. This affected all 88 residents residing in the facility.Findings include: 1. Review of the facility assessment dated [DATE] revealed for an average census of 87 residents, facility wide daily staffing needs for nursing services included for first shift: one Director of Nursing (DON), one staff Registered Nurse (RN), one licensed practical nurse (LPN), four Certified Nursing Assistants (CNAs), one minimum data set (MDS) coordinator (RN), one Assistant Director of Nursing (ADON) (RN), one wound nurse (RN, part-time) and one scheduling coordinator (part-time); for second shift: one LPN, four CNAs; and for third shift: one LPN, four CNAs.Interview on 06/03/26 at 8:36 A.M. with Scheduler/CNA #375 and the DON revealed the facility used hours per patient day (PPD) to determine amounts of staff to schedule. Currently, for a census of 88 residents, she was able to schedule five nurses and seven CNAs on both day shift and night shift.Review of facility schedules and time punches for the week preceding the survey revealed the following information:-On 05/25/26 night shift there were five nurses and six CNAs.-On 05/26/26 day shift there were four nurses and nine CNAs and on night shift there were three nurses and seven CNAs.-On 05/27/26 day shift there were four nurses and 11 CNAs and on night shift there were two nurses and five CNAs.-On 05/28/26 day shift there were four nurses and seven CNAs and on night shift there were three nurses and 7.5 CNAs.-On 05/29/26 day shift there were four nurses and 10.5 CNAs and on night shift there were three nurses and five CNAs.-On 05/30/26 day shift there were 2.5 nurses and nine CNAs and on night shift there were four nurses and 10 aides.-On 05/31/26 day shift there were three nurses and 11 CNAs and on night shift there were three nurses and five CNAs.Interview on 06/04/26 at 8:35 A.M. with the Administrator and Corporate Registered Nurse (CRN) #412 revealed for the staffing plan portion of the facility assessment, one RN, one LPN and four CNAs were the minimum staffing levels the facility had determined they could run with for a census of 87 residents on a shift as the facility did not take high acuity patients. The Administrator and CRN #412 were made aware during the interview the staffing plan in the facility assessment was not accurate nor complete, as for a like census of 88 residents as observed upon entering the survey on 06/01/26, five nurses and seven CNAs were able to be scheduled and determined to be needed for meeting resident needs on both shifts. The Administrator and CRN #412 were also made aware during the interview that the facility was not staffing per their stated PPD seven out of seven days reviewed (05/25/26 through 05/31/26) and that staff and resident interviews along with care observations showed inadequate staffing levels to which they would not confirm or deny.2. Review of resident council minutes dated 05/26/26 revealed some council members stated they feel the call light response is slower on the weekends and at times on shift changes. The Administrator and ADON/RN #322 stated they were looking at audits to see if there was a pattern established and then plan to be put into place to address.Completion of the resident council group interview on 06/01/26 at 2:00 P.M. with Residents #1, #17, #30 and #46 revealed call lights and staffing on all shifts was terrible especially with the amount of scheduled CNAs.3. Observation on 06/04/26 at 4:02 P.M. revealed Resident #22 was in bed and her call light was activated. Observation of the call light monitor at the nurses' station closest to Resident #22's room revealed her call light had been activated for 22 minutes at this point. No nursing staff could be found.Continued observation on 06/04/26 at 4:11 P.M. revealed LPN #347 was on the phone and approached the nurses' station. LPN #347 was made aware of Resident #22's call light being on now 31 minutes as of the time of observation. When LPN #347 was asked if this call light response time was acceptable, she stated, it depends, I just go with what they give me. LPN #347 shared the facility only had four nurses working this date as a nurse had (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	called off for her shift. CNA #342 was then observed entering Resident #22's room.Interview on 06/04/26 at 4:13 P.M. with CNA #342 revealed she did not have this room assigned to her as it was another aide's but she had answered Resident #22's call light and stated Resident #22 wanted a clip for her cereal. CNA #342 reported she was responsible for providing care for rooms 256, 257 and 314 to 323 and CNA #339 had been assigned to Resident #22 but she was nowhere to be found. CNA #342 then left the unit to attend to her assigned rooms.Interview on 06/04/26 at 4:17 P.M. with Resident #22 revealed her call light had been on a while and she had told CNA #342 she wanted to be changed into a gown as she got sick in the dining room and CNA #342 had told her she'd come back. Resident #22 confirmed CNA #342 had not provided the care she had requested when she had come in to deactivate her call light.Interview on 06/04/26 at 4:24 P.M. with the Administrator, DON and CRN #412 revealed while there was not a specified timeframe for staff to answer call lights, 31 minutes was not an acceptable response time and CRN #412 indicated that 15 minutes was the goal. The Administrator, DON and CRN #412 were made aware of Resident #22's unmet care needs during the interview and subsequently left to address her needs.Review of the facility policy, Resident Call System, revised March 2023 revealed staff were to respond to resident's call lights in a timely manner.4. The following concerns were identified related to insufficient staffing in the facility:Interview on 06/01/26 at 10:18 A.M. with Resident #46 revealed staff left her in bed and did not answer call lights for over 15 minutes.Interview on 06/01/26 at 10:26 A.M. with Resident #31 revealed staff barely checked on him, leaving him urinating on himself all day.Interview on 06/01/26 at 10:36 A.M. with Resident #6 revealed staffing was short on weekends and nights.Interview on 06/01/26 at 10:38 A.M. with Resident #66's family member revealed Resident #66 only got out of bed once a week and she was not bathed or provided incontinence care timely or routinely.Interview on 06/01/26 at 10:42 A.M. with Resident #34 revealed staff left her in bed all day and the CNA took a lot of time off the unit, leaving her to sit in her own urine. Many CNAs would say, I'm not your aide and no CNA would want to claim their assigned residents. Resident #34 stated she would sit and holler and staff would walk past her and not provide assistance.Interview on 06/01/26 at 11:35 A.M. with the family member of Resident #50 revealed the CNA turnover was high at the facility and they worked short-staffed as a result. The family member of Resident #50 stated many staff did not stay very long and there were only a few dedicated staff.Interview on 06/01/26 at 11:48 A.M. with Resident #99 revealed staff did not answer his call light so he would call his family to call the facility to obtain assistance.Interview on 06/01/26 at 11:56 A.M. with the Administrator revealed the facility did not use agency staffing to meet facility staffing needs.Interview on 06/01/26 at 12:30 P.M. with Resident #22 revealed she had not been checked or changed since 5:00 A.M. and reported she was soiled. Resident #22 stated staff did not answer the call light timely and she often had to wait 45 minutes or more to receive assistance when requested.Interview on 06/01/26 at 12:44 P.M. with Resident #100's family member revealed on 05/29/26 at 8:01 P.M. she had walked the entire facility and there was one nurse but she was unable to find a CNA. Resident #100's family member reported the nurses' stations were empty and she was not able to find any nurses to assist her. Interview on 06/01/26 at 3:11 P.M. with Resident #39 revealed when his call light was activated, staff would pass the room and not answer it and he would often have to wait an hour to receive assistance.Interview on 06/01/26 at 4:21 P.M. with Resident #52 revealed there were not enough CNAs and her bed would not be made, so the next shift would have to do it.Interview on 06/02/26 at 8:01 A.M. with Resident #20 revealed call light response times were slow and reported waiting a long time, often over 45 minutes, for staff to enter her room and see what she wanted.Interview on 06/02/26 at 8:41 A.M. with Resident #43 revealed there were not enough staff in the facility as there was not always a nurse on the premium unit and he received medications late on 05/31/26.Interview on 06/02/26 at 9:00 A.M. with Resident #14 revealed staffing had been bad on weekends as staff would not come in the room for a few hours or at all to get people out of bed.Interview on 06/02/26 at 9:58 A.M. with Resident #65's family member revealed she visits almost daily and there was frequently not enough staff to answer call (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	lights, especially on weekends. Interview on 06/02/26 at 1:37 P.M. with Resident #41's family member revealed several days a week, Resident #41 would sit until night shift came in without care being provided.Interview on 06/03/26 at 8:36 A.M. with Scheduler/CNA #375 and the DON revealed the facility had not used agency staffing to meet resident needs since 2024 and while the facility had discussed some personnel position changes, they had not yet implemented starting to have a designated shower CNA as of the time of the interview. This deficiency represents noncompliance investigated under Complaint Numbers 3032216, 2991771, 2965630, 2980463, 2727510, 2703783, 2616202, 2604187, and 2609064.

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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, record review, review of facility job descriptions, and interview, the facility failed to ensure effective administration to manage the facility and identify care concerns, implement appropriate and sustainable corrective actions to prevent reoccurrence, and attain or maintain the highest practicable physical, mental and psychosocial well-being. This had the potential to affect all 88 residents residing in the facility. Findings include:Review of the job description, Administrator, updated 05/15/25 and signed by the Administrator on 10/27/25 revealed the Administrator was responsible for overseeing the daily operations of the facility, ensuring compliance with all applicable federal, state and local regulations, and maintaining the highest standards of resident care. The Administrator leads facility staff in creating a positive, supportive environment that promotes the well-being of residents and fosters strong relationships with families, the medical community and regulatory agencies. The Administrator directs the implementation of policies/procedures that support the facility's mission and ensures high-quality resident care; ensures compliance with state and federal regulations, conducting regular reviews and updates to policies as needed; maintain a strong focus on resident rights, ensuring dignity, respect and individualized care; implement and oversee quality assurance programs to continuously improve care standards, address resident concerns promptly and effectively; conduct regular staff meetings and provide ongoing education and professional development; monitor employee performance, addressing any concerns through coaching and corrective action.Review of the job description, Director of Nursing (DON), updated 05/15/25 and signed by the DON on 02/23/26 revealed the DON was to provide complete supervision and management of the nursing department through the implementation of policies and procedures and adherence to quality standards. The DON has the authority to assess resident needs, set resident care standards in accordance with accepted standards to provide high quality care, develop and implement nursing care policies and procedures, supervise and manage all aspects of the nursing department, direct resident care based on individualized assessments, direct, evaluate and supervise all resident care, initiating corrective action as needed; assess resident care needs and assist in developing individualized care plans, ensure proper pre-admission and admission assessments for appropriate levels of care, review incident and accident reports, determine causes and develop corrective measures; develop and implement nursing service educational programs, including orientation and in-service training; ensure compliance with federal, state and local nursing regulations; ensure availability and economical use of nursing supplies and equipment, assess facility needs and make recommendations regarding equipment, staffing levels; oversee scheduling and staffing allocation for nursing personnel and conduct written employee performance evaluations.During onsite investigation, the following concerns were identified related to a lack of comprehensive and administrative oversight:1. Review of personnel files revealed the facility had retained Human Resource Manager (HRM) #439 on staff even after she had been indicted on 12/10/25 for charges including violations of Ohio Revised Code (ORC) 2913.05 (telecommunications fraud) and ORC 2913.02 (grand theft). HRM #439 was terminated on 04/02/26 for being charged and convicted of an exclusionary offense. Continued personnel file reviews revealed Former Director of Nursing (FDON) #442 had been hired on 12/07/23 with a petty theft charge without completion of personal care standards, continued to work for the facility minus a period of medical leave in 2024 and resigned without notice on 10/06/25.Interviews with the Administrator, Corporate Registered Nurse (CRN) #412, HRM #439, Assistant Director of Nursing (ADON)/Registered Nurse (RN) #322 and FDON #442 verified the personnel concerns identified during the survey.2. Observations of the kitchen environment and meal service on 06/01/26 and 06/02/26 revealed concerns with kitchen sanitation, honoring food preferences, garbage disposal, and palatable meals.Interviews with Dietary Manager (DM) #363, Regional Dietary Manager (RDM) #423, Registered Dietitian (RD) #427 and Regional Registered Dietitian (RRD) #427 verified the dietary service concerns identified during the survey.3. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observations, record reviews and interviews for Resident #100 revealed he developed a facility-acquired pressure ulcer found at a stage III (a severe wound featuring full-thickness skin loss where subcutaneous fat is visible) to the right groin on resulting in Actual Harm on 03/26/26. The facility failed to provide evidence Resident #100 was being adequately monitored and provided the necessary interventions and treatments to prevent the ulcer from being found as a Stage III pressure ulcer.Interviews with the DON, RN #350, LPN #353, CNA #366, CNA #400 and Certified Nurse Practitioner (CNP) #441 verified the pressure ulcer concerns identified during the survey.4. Record reviews and interviews for Resident #83 revealed a failure to complete weekly weights and continued monitoring of nutrition and fluids including notification to the physician for significant weight loss, resulting in Actual Harm and the resident's hospitalization on 05/07/26.Interviews with RD #420, CRN #412, RN #419, LPN #323, ADON/RN #322, the Administrator, CNP #451 and the DON verified the nutritional concerns identified during the survey.5. Record reviews and interviews for Resident #99 revealed a fall with major injury resulting in Actual Harm on 04/01/26. Additional record review for Resident #82 revealed a fall with major injury resulting in actual harm on 05/09/26.Interviews with CNA #379, LPN #323, the DON, CRN #412, LPN #351, CNA #337, CNA #384, Human Resources (HR) #387, LPN #351, X-ray Technician (XT) #437, LPN #356, CNA #319, the Administrator, CNA #345, CNA #320, Director of Maintenance (DOM) #343, Unit Manager (UM)/LPN #353 and Regional Director of Maintenance (RDOM) #416 verified the accidents concerns identified during the survey.6. Review of QAPI meeting minutes dated 12/10/25 revealed performance improvement plans (PIP) in place for check and changes, review on narcotic issues, staffing, human resources, hand hygiene and care conferences. The PIPs did not consistently identify a point person nor did the PIPs include measurable metrics, as many PIPs stated they were ongoing with no date(s) or had smaller goals to check back to as the facility worked towards improvement. There was no evidence that previous QAPI action items from the meeting on 08/12/25 (including monthly and weekly weights, dietary services, clinical admission assessments, in-house pressure ulcers and maintenance) were revisited, followed up with if needed, or determined to have corrective actions completed.During the current annual survey, deficiencies were identified related to incontinence care, medication misappropriation, staffing, personnel records, infection control, monthly and weekly weights, dietary services, medication storage, in-house pressure ulcers, care conferences and environment.7. Review of QAPI meeting minutes dated 03/19/26 revealed PIPs in place for hand hygiene, isolation precautions, incontinence care, care conferences, tray accuracy and narcotic counts. The PIPs did not consistently identify a point person did the PIPs include measurable metrics, as many PIPs stated they were ongoing with no date(s) listed or goals to check back to as the facility worked towards improvement. There was no evidence that previous QAPI action items from the meeting on 12/10/25 including staffing were revisited, followed up with if needed, or determined to have corrective actions completed.During the current annual survey, deficiencies were identified related to infection control, incontinence care, care conferences, tray accuracy, staffing and medication storage.8. Review of QAPI meeting minutes dated 04/10/26 revealed a PIP in place for staffing. The PIP was broken down into five focus areas and all five areas had ongoing under the ?date resolved' section. There was no evidence that previous QAPI action items from the meeting on 03/19/26 including hand hygiene, isolation precautions, incontinence care, care conferences, tray accuracy and narcotic counts were revisited, followed up with if needed, or determined to have corrective actions completed.During the current annual survey, deficiencies were identified related to staffing, infection control, incontinence care, care conferences, tray accuracy and medication storage.9. Review of the QAPI meeting minutes dated 05/21/26 revealed PIPs in place for staff competencies, human resources, family concerns regarding showers and fall with major injury. The PIP for staff competencies was marked as resolved on 05/21/26. The human resources PIP included a focus area for auditing employee files and listed no person responsible or date resolved. There was no evidence that previous QAPI action items from the meeting on 04/10/26 including staffing were revisited, followed up with if needed, or determined to (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	have corrective actions completed.During the current annual survey, deficiencies were identified related to staffing, staff training, performance evaluations, showers and falls.Interview on 06/16/26 at 12:51 P.M. with the Administrator, DON and CRN #214 revealed the facility met for QAPI monthly to discuss concerns but not all concerns became a QAPI PIP as they prioritized what they heard about the most. During the interview, the Administrator, DON and CRN #214 were made aware many of the PIPs completed did not have measurable goals with dates or point people assigned to track and revisit projects as the facility worked towards improvement and in turn, many of these issues were identified as deficiencies during the current annual survey as they had been incompletely brought through QAPI. CRN #214 acknowledged while she helped with some of the facility's PIPs, she did not routinely review all of the PIPs as that was the Administrator and DON's responsibility.This deficiency represents non-compliance investigated under Complaint Number 2673907 and 2604622.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on record review, interview, and review of the facility policy and procedure, the facility failed to ensure an effective Quality Assurance and Performance Improvement (QAPI) committee was in place to identify and address concerns timely and effectively. This had the potential to affect all 88 residents in the facility.Findings include: Review of the facility QAPI minutes and Performance Improvement Plan (PIP) documentation revealed the following plans without continued corrective action or evidence the plan was revised when necessary or changed once identified to be ineffective:1. Review of QAPI meeting minutes dated 12/10/25 revealed PIPs in place for check and changes, review on narcotic issues, staffing, human resources, hand hygiene and care conferences. The PIPs did not consistently identify a point person nor were they measurable, as many PIPs stated they were ongoing with no date(s) listed and/or no smaller goals to check back to as the facility worked towards improvement. There was no evidence that previous QAPI action items from the meeting on 08/12/25 (including monthly and weekly weights, dietary services, clinical admission assessments, in-house pressure ulcers and maintenance) were revisited, followed up with if needed, or determined to have corrective actions completed.During the current annual survey, deficiencies were identified related to incontinence care, medication misappropriation, staffing, personnel records, infection control, monthly and weekly weights, dietary services, medication storage, in-house pressure ulcers, care conferences and environment.2. Review of QAPI meeting minutes dated 03/19/26 revealed PIPs in place for hand hygiene, isolation precautions, incontinence care, care conferences, tray accuracy and narcotic counts. The PIPs did not consistently identify a point person nor were they measurable, as many PIPs stated they were ongoing with no date(s) listed and/or no goals to check back to as the facility worked towards improvement. There was no evidence that previous QAPI action items from the meeting on 12/10/25 including staffing were revisited, followed up with if needed, or determined to have corrective actions completed.During the current annual survey, deficiencies were identified related to infection control, incontinence care, care conferences, tray accuracy, staffing and medication storage.3. Review of QAPI meeting minutes dated 04/10/26 revealed a PIP in place for staffing. The PIP was broken down into five focus areas and all five areas had ongoing under the ?date resolved' section. There was no evidence that previous QAPI action items from the meeting on 03/19/26 including hand hygiene, isolation precautions, incontinence care, care conferences, tray accuracy and narcotic counts were revisited, followed up with if needed, or determined to have corrective actions completed.During the current annual survey, deficiencies were identified related to staffing, infection control, incontinence care, care conferences, tray accuracy and medication storage.4. Review of the QAPI meeting minutes dated 05/21/26 revealed PIPs in place for staff competencies, human resources, family concerns regarding showers and fall with major injury. The PIP for staff competencies was marked as resolved on 05/21/26. The human resources PIP included a focus area for auditing employee files and listed no person responsible or date resolved. There was no evidence that previous QAPI action items from the meeting on 04/10/26 including staffing were revisited, followed up with if needed, or determined to have corrective actions completed.During the current annual survey, deficiencies were identified related to staffing, staff training, performance evaluations, showers and falls.Interview on 06/16/26 at 12:51 P.M. with the Administrator, Director of Nursing (DON) and Corporate Registered Nurse (CRN) #214 revealed the facility met for QAPI monthly to discuss concerns but not all concerns became a QAPI PIP as they prioritized what they heard about the most. During the interview, the Administrator, DON and CRN #214 were made aware many of the PIPs completed did not have measurable goals with dates or point people assigned to track and revisit projects as the facility worked towards improvement and in turn, many of these issues were identified as deficiencies during the current annual survey as they had been incompletely brought through QAPI. CRN #214 acknowledged while she helped with some of the (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	facility's PIPs, she did not routinely review all of the PIPs as that was the Administrator and DON's responsibility. Review of the facility policy, QAPI Guidelines, revised March 2024 revealed QAPI was a process that allows for continuous identification of opportunities for enhancement and improvement by addressing gaps in the systems through planned interventions to improve overall quality of patient care and facility services.the Administrator has direct responsibility of the implementation oversight and resolution of all concerns identified by the committee.all performance improvement plans should be in writing. These plans should be preventative and in response to identified concerns. They should be actively worked through to completion and revised if needed. Performance improvement plans should be routinely re-evaluated to monitor their effectiveness and revisited if the same issue arises. Once an actual area of concern has been identified, the QAPI committee will determine what further assessments should be completed and each department will participate in the development and implementation of criteria relating to the care and services it provides. the QAPI committee will utilize various strategies and techniques for data collection. It is important the committee determines what area they want to measure and look for various sources of data as well as who will collect the data and how the data will be collected.This deficiency represents non-compliance investigated under Complaint Number 2673907 and 2604622.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and facility policy review, the facility failed to dispense medications in a manner to prevent the spread of infection. This affected three residents (#11, #34 and #53) of four residents observed for medication administration. Additionally, the facility also failed to ensure enhanced barrier precautions (an infection control measure used to prevent the spread of multi-drug resistant organisms) were followed for three residents (#27, #90 and #96) of 26 residents identified as being on enhanced barrier precautions. The facility census was 88. Findings include:1.On 06/03/26 at 9:05 A.M., an observation of medication administration for Resident #34 with Licensed Practical Nurse (LPN) #341 revealed the preparation of the following medications: Sertraline 50 milligrams (mg), Levetiracetam 500 mg, Baclofen 5 mg, Polyethylene Glycol 3350 17000 mg Powder, and Sennosides 8.6 mg. LPN #341 did not wash his hands prior to the preparation or after dispensing the medications for Resident #34.On 06/03/26 at 9:21 A.M., continued observation of medication administration for Resident #53 with LPN #341 revealed the preparation of the following medications: Aspirin 81 mg, Loratadine 10 mg, and Amlodipine 5 mg. LPN #341 did not wash his hands prior to the preparation or after dispensing the medications for Resident #53.On 06/03/26 at 9:32 A.M., continued observation of medication administration for Resident #11 with LPN #341 revealed the preparation of the following medications: Buspirone Hydrochloride 10 mg, Clopidogrel 75 mg, Farxiga 10 mg, Gabapentin 100 mg, Pantoprazole 40 mg, Sacubitril 49 MG-Valsartan 51 mg, Spironolactone 25 mg, and Acetaminophen 325 mg. While preparing the medications for administration, LPN #341 removed the Farxiga from the blister pack and the pill went onto the top of the medication cart. LPN #341 then picked up the Farxiga pill with his bare, unwashed hands and placed it in the medication cup that contained the rest of the medications to be distributed to Resident #11. Additionally, LPN #341 did not wash his hands prior to the preparation or after dispensing the medications for Resident #11.On 06/03/26 at 9:40 A.M., an interview with LPN #341 verified he did not wash his hands before, between, or after the medication administrations for Residents #11, #34 and #53. 2.A review of the medical record for Resident #90 revealed an admission date of 05/13/26. Significant diagnoses included cerebral infarction due to embolism of an unspecified cerebral artery. Significant orders included an order for a urinary catheter care per policy and enhanced barrier precautions (EBP). A care plan dated 05/14/26 revealed Resident #90 had an indwelling catheter. The care plan also revealed Resident #90 required enhanced barrier precautions to reduce transmission of multi-drug-resistant organisms related to a catheter.A Medicare five-day Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 00 indicating Resident #90 had a severe cognitive impairment. The assessment also revealed Resident #92 had a urinary catheter.On 06/01/26 at 10:32 A.M., an observation of Resident #90 revealed she received a bed bath from Certified Nurse Aide (CNA) #334. CNA #334 did not have a gown on while providing direct care. An interview with at the time of observation with CNA #334 verified she did not have a gown on while providing care. 3.A review of the medical record for Resident #96 revealed an admission date of 05/29/26. Significant diagnoses included sepsis due to unspecified staphylococcus and methicillin-susceptible staphylococcus aureus (a type of bacteria). Significant orders included Cefazolin (an antibiotic) 2-4 grams per 100 milliliters, infuse 800 milliliters (ml) intravenously four times a day for antibiotic therapy related to sepsis.A Medicare five-day MDS assessment dated [DATE] revealed a BIMS score of 15 indicating Resident #96 was cognitively intact.A care plan dated 06/04/26 revealed Resident #96 received intravenous (IV) therapy and had IV access for administration of IV antibiotics. The care plan also revealed Resident #96 required enhanced barrier precautions to reduce transmission of multi-drug resistant organisms related to IV access.On 06/01/26 at 11:03 A.M., an observation of Resident #96 revealed a central venous access line to the left upper extremity. There was not a sign on the door to indicate Resident #96 needed to have (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366488	A. Building B. Wing	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenue at Lyndhurst	5442 Rae Road Lyndhurst, OH 44124

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	enhanced barrier precautions practiced with direct care. On 06/03/26 at 11:57 A.M., an observation of Resident #96 revealed there was no sign on the door to indicate Resident #96 needed to have enhanced barrier precautions practiced with direct care. An interview with Registered Nurse (RN) #307 verified the lack of signage at the time of the observation. RN #307 stated she did not know Resident #96 needed enhanced barrier precautions.4.A review of the medical record for Resident #27 revealed an admission date of 02/09/23. Significant diagnoses included but were not limited to Type II Diabetes Mellitus, venous insufficiency and resistance to Vancomycin (an antibiotic). Significant orders included a wound care order to cleanse the sacrum with Vashe (wound cleansing) solution, pat dry, apply Silver Alginate (a type of wound dressing with antimicrobial properties) to the wound, and cover with an absorbent dressing daily and as needed. The resident additionally had orders for enhanced barrier precaution which specified for gloves and gowns to be worn when providing dressing, bathing, transferring, providing hygiene care, changing linens, changing briefs or assisting with toileting, and an order to cleanse the resident's bilateral lower extremities with soap and water, pat dry, and apply Ammonium Lactate lotion.A review of a Quarterly MDS assessment dated [DATE] revealed a BIMS score of 13 indicating Resident #27 was cognitively intact.A care plan dated 05/14/26 revealed Resident #27 required enhanced barrier precautions to reduce transmission of multi-drug resistant organisms related to wounds.On 06/03/26 at 9:45 A.M., an observation of morning care, including incontinence care, for Resident #27 revealed CNA #308 rendering care without a gown on. RN #419 verified CNA #308 did not have a gown on at the time of the observation.A review of the facility policy Medication Administration-Preparation and General Guidelines with a revision date of 08/2014 revealed hand washing and hand sanitation is to be completed. The person administering medication adheres to good hygiene which includes washing hands thoroughly before beginning a medication pass prior to handling any medication and after coming into direct contact with a resident.A review of the facility policy Hand Washing with the revision date of 07/2022 revealed the purpose was to maintain the highest standard of hygiene in patient care thorough hand-washing procedures. The policy further revealed these evidence-based practices are designed to protect healthcare staff and residents by preventing the spread of infections among residents, staff, and visitors in ensuring staff do not carry infectious pathogens on their hands or via equipment during resident care.A review of the facility policy Enhanced Barrier Precautions dated 08/2022 revealed enhanced barrier precautions are utilized to prevent the spread of multi-drug resistant organisms to residents. Enhanced barrier precautions employ targeted gown and glove use during high contact resident care activities when other contact precautions do not otherwise apply. Gloves and gowns are applied prior to performing high contact resident care activities including dressing, bathing and showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, and device care or use such as a central line, urinary catheter, feeding tube, tracheostomy/ventilator, and wound care. Enhanced barrier precautions are indicated for residents with wounds and or indwelling medical devices regardless of any multi-drug resistant organism colonization. Enhanced barrier precautions remain in place for the duration of the resident stay or until resolution of the wound or discontinuation of an indwelling medical device that places them at risk occurs.

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	366488	A. Building B. Wing	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenue at Lyndhurst	5442 Rae Road Lyndhurst, OH 44124

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview and review of the facility policy, the facility failed to ensure adequate hand hygiene supplies were routinely available. This affected two residents (#14 and #27) of ten rooms observed. Facility census was 88. Findings include:Observation on 06/02/26 from 12:13 P.M. to 12:43 P.M. with Assistant Director of Property Management (ADPM) #416, Director of Maintenance (DOM) #343, Account Manager (AM) #414 and Senior District Manager (SDM) #415 revealed Resident #14 and Resident #27's hand sanitizer dispensers in the entryway of their rooms were empty and would not dispense alcohol based hand rub.Interviews with AM #414 and SDM #415 verified the findings at the time of observation and shared hand sanitizer was to be checked daily during room cleaning.Review of the undated facility policy, Seven Step Daily Washroom Cleaning, revealed staff were to be sure toilet paper, paper towels and soap dispensers were filled. Review of the undated facility policy, Five-Step Daily Room Cleaning, did not address restocking of room supplies.This deficiency represents non-compliance investigated under Complaint Number 3032216 and 2616202.