

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2025
NAME OF PROVIDER OR SUPPLIER Avenue at Lyndhurst		STREET ADDRESS, CITY, STATE, ZIP CODE 5442 Rae Road Lyndhurst, OH 44124	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews and facility policy review, the facility failed to ensure clean food service areas including opened food that was not labeled or dated. This had the potential to affect all residents who received meals from the kitchen. The facility identified four (Residents #4, #19, #49, and #60) as receiving nothing by mouth (NPO). The facility census was 86. Findings include: Initial tour of the kitchen on 08/18/25 from 8:24 A.M. through 8:40 A.M. revealed potato chips and white cake mix were not dated in the dry storage area. In the prep area, the slicer had dried food on the blade, and the mixer had dried batter on the back splash. In the reach-in refrigerator located under the prep table in the cook's area there was bacon, chicken noodle soup, and lima beans that were not labeled and dated. In the reach-in freezer, there was breaded chicken patties, chicken fingers, unbreaded chicken breasts, onion rings and French fries that were not labeled or dated. The findings were verified by the Administrator at the time of the observation. Review of the undated facility policy titled, Food and Sanitation revealed that open packages and leftovers will be labeled and dated. Review of the undated facility policy titled, General Sanitation of the Kitchen revealed that the food and nutrition will maintain the sanitation of the kitchen through compliance with a written cleaning schedule.		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, interviews and facility policy review, the facility failed to ensure all call lights were within reach for residents who were dependent for activities of daily living. This affected four (Residents #5, #54, #89, #102) of 17 residents observed for accommodation of needs. In addition, the facility failed to ensure Resident #14 's tray table was in reach. This affected one (Resident #14) of 17 residents reviewed for accommodation of needs. The facility census was 86. Findings include: 1. Review of the medical record for Resident #5 revealed an admission date of 06/23/23. Diagnoses included paranoid schizophrenia, muscle weakness, history of falls, and other abnormalities of gait and mobility. Review of the plan of care dated 12/22/24 noted Resident #5 was at risk for falls due to polyneuropathy, incontinent of bowel and bladder, and frequent falls. Interventions included encouraging use of the call light and keeping call light in reach. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #5 had intact cognition. Resident #5 was dependent for toileting and mobility. 2. Review of the medical record for Resident #54 revealed an admission date of 04/04/25. Diagnoses included hemiparesis following a cerebral infarction, dementia, repeated falls and need for assistance with personal care. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #54 had impaired cognition. Resident #54 was dependent on staff for toileting and mobility. Review of the plan of care dated 07/18/25 revealed Resident #54 was at risk for falls due to history of falls, dementia and hemiparesis. Interventions included assistance from one for transfers, bilateral grab bars, encouraging the use of the call light and keeping the call light within reach. 3. Review of the medical record for Resident #102 revealed an admission date of 08/13/25. Diagnoses included encounter for surgical aftercare following surgery on the digestive system, need for assistance with personal care, cognitive communication deficit and schizophrenia. Review of the plan of care dated 08/14/25 revealed Resident #102 was at risk for falls due to history of falls. Interventions included encouraging the use of the call light and keeping the call light within reach. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #102 had impaired cognition. Resident #102 was dependent on staff for mobility. Observations on 08/19/25 from 10:13 A.M. to 10:40 A.M. with the Administrator noted the call light for Resident #5 was under the bed and out of reach. The call light for Resident #54 was wrapped around the lower bed frame; Resident #54 was unable to access the button to activate the light. The call light button for Resident #102 was hanging over the bed frame out of reach. The Administrator verified all findings stating all call lights should be within reach of all residents. Review of the facility policy titled Resident Call Light, dated 2023, noted staff were to answer the call light in a timely manner, do not turn off the call light if staff were unable to meet the resident's needs, (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and complete the task the resident has requested. 4. Record review revealed Resident #89 was admitted to the facility on [DATE] with diagnoses including kidney failure, adjustment disorder with mixed anxiety and depressed mood, and diabetes mellitus. Review of the care plans dated 02/10/23 with a revision date of 03/25/25 revealed Resident #89 was at risk for falls related to diagnoses. Interventions included but not limited to call light within reach. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #89 was rarely understood and dependent on toileting. Observation of Resident #89 on 08/18/25 at 11:13 A.M. revealed Resident #89 was lying in bed, and his call light was lying on the floor next to the bed. The call light was noted to be out of reach of Resident #89. Interview with Registered Occupational Therapist (OTR) #507 on 08/18/25 at 11:13 A.M. verified that the call light was out of reach, and Resident #89 demonstrated to OTR #507 use of the call light if it was within reach. 5. Review of the medical record for Resident #14 revealed an admission date of 10/10/24. Diagnoses included cerebral infarction, hemiplegia affecting the right side, aphasia, muscle weakness, and obesity. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #14 had intact cognition and required substantial to maximum assistance for positioning and transfers. The resident had impairment to one side in the upper and lower extremities. Observation on 08/18/25 at 11:01 A.M. revealed Resident #14 was lying in bed and her tray table was next to her bed; however, it was out of reach. On the tray table was a large cup of water. Resident #14 stated she was thirsty and unable to reach her cup. Interview 08/18/25 at 11:10 A.M. with Certified Nursing Assistant (CNA) #600 verified the tray table was not in reach for Resident #14. CNA #600 stated she checked on Resident #14 when she started her shift at 7:30 A.M. and had not been able to return to the room. Review of the policy titled Activities of Daily Living (ADL), dated March 2023, revealed the facility will ensure a resident was given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 medical record review and staff interviews, the facility failed to develop and implement comprehensive care plans. This affected four (Residents #1, #6, #7, and #39) of 38 residents reviewed for care plans. The facility census was 86. Findings include:1. Review of the medical record for Resident #39 revealed an admission date of 06/09/25 with diagnoses including quadriplegia, Guillain-Barre syndrome, generalized muscle weakness, and bilateral hand contractures. Review of the physician's orders dated 06/09/25 revealed Resident #39 had order for universal cuff (an assistive device for users with limited grip strength and dexterity to have more control of utensils) to hand with meals as tolerated and bilateral palm protectors (a device used for contractures to help prevent skin breakdown of the palm) to hands at night as tolerated. Review of the comprehensive care plan revealed no evidence of care planning to address Resident #39's adaptive equipment (universal cuff and palm protectors) needs. Interview on 08/25/25 at 2:10 P.M. with Regional Director of Clinical Services (RDCS) #502 confirmed she was unable to locate any care planning to address adaptive equipment for Resident #39. 2. Review of the medical record for Resident #6 revealed an admission date of 07/26/25. Diagnoses included severe sepsis with septic shock and chronic obstructive pulmonary disease (COPD). Review of the admission /Medicare - 5 Day Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #6 had impaired cognition. Review of the physician orders for August 2025 identified an order for Do Not Resuscitate, Comfort Care (DNR CC- Arrest) dated 07/26/25. Review of Resident #6's plan of care initiated 07/26/25 revealed no care plan for DNR CC- Arrest. On 08/22/25 at 1:48 PM. RDCS #502 verified there was no care plan for DNR CC- Arrest for Resident #6 3. Review of the medical record for Resident #7 revealed an admission date of 07/16/25. Diagnoses included malignant neoplasm of connective and soft tissue and ileostomy status. Review of Resident #7's plan of care dated 07/17/25 revealed no ostomy care plan. Review of the Medicare - 5 Day MDS 3.0 assessment dated [DATE] revealed Resident #7 had intact cognition. On 08/22/25 at 1:48 PM. RDCS #502 verified there was no ostomy care plan for Resident #7. 4. Review of the medical record for Resident #1 revealed an admission date of 01/03/23. Diagnoses included dementia, malnutrition, fibromyalgia, dysphagia encephalopathy, and depression. Review of the occupational therapy Discharge summary dated [DATE] revealed a recommendation for (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a palm protector donned and placed on the right hand for up to seven hours. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #1 had impaired cognition. The resident was dependent on staff for eating, toileting, showering and transferring. Review of the physician order for August 2025 revealed a recommendation to wear right palm protector daily for six to seven hours. There was an additional order to wear a brace to the hand at all times. Review of Resident #1's plan of care dated 04/03/25 revealed the resident had a self-care deficit related to dementia. Intervention included encouraging the resident to wear a brace to left hand as tolerated. The resident required assistance for bathing, showering, toileting and transfers. The care plan was not updated to include the right palm protector. Review of the Kardex dated 08/25/25 revealed to encourage Resident #1 to wear brace to left hand as tolerated per family request. The Kardex did not address the right palm protector. Observation on 08/22/25 at 9:05 A.M. revealed Resident #1 was in the dining room sitting in a Broda chair. Resident #1 had a palm protector to the right hand and a green brace applied to her left hand. Interview on 08/25/25 at 11:30 A.M. with Therapy Program Director (TPD) #504 revealed therapy recommended the right palm protector. Therapy did not recommend a brace to left hand. TPD #504 stated the family was worried Resident #1's left hand would develop a contracture and wanted to prevent this from happening. The family has requested nursing ensure the resident wear the brace to the left hand at all times. Interview on 08/25/25 at 1:25 P.M. with RDSCS #502 verified the right palm protector was not care planned.		

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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 record reviews, observations, interviews and facility policy review, the facility failed to provide timely incontinence care for dependent residents. This affected five (Residents #9, #15, #41, #69 and #84) of ten residents observed for incontinence care. The facility census was 86. Findings include:1. Review of the medical record for Resident #84 revealed an admission date of 01/06/24. Diagnoses included chronic kidney disease, encephalopathy, repeated falls and mild cognitive impairment. Review of the plan of care dated 03/01/25 noted Resident #84 was incontinent of bowel and bladder. Interventions included checking and changing on care rounds and as needed. Review of the plan of care dated 03/28/25 noted Resident #84 had a self-care deficit, limited mobility, and impaired cognition. Interventions included toileting assistance of one staff and transferring assistance of two staff with a mechanical lift. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #84 had impaired cognition. Resident #84 required moderate assistance for toileting and mobility. Observation on 08/18/25 at 3:28 P.M. noted Resident #84 activated his call light and yelling "they won't change me." Continued observations noted Certified Nurse Assistant (CNA) #304 entered Resident #84's room at 3:50 P.M. and asked what Resident #84 needed. Resident #84 stated "I need to be changed," CNA #304 stated she would be back, turned off the call light and left the room. CNA #304 was observed walking across the hall to take another resident to the activities room. Observation at 3:58 P.M., Licensed Practical Nurse (LPN) #301 walked down the hall past Resident #84's room. LPN #301 was not aware of Resident #84's need because the call light was turned off. Observation at 3:58 P.M., Resident #84 yelling "hello, hello," no staff were observed working in the three halls that came together outside Resident #84's room. Observation at 4:07 P.M. and 4:10 P.M., Resident #84 yelling "hello, hello, anyone help me?" Observation at 4:12 P.M., Resident #84 activated the call light again, again. No staff were observed working in the three halls. The Administrator was walking down the hall and observed Resident #84's light on. The Administrator asked Resident #84 what he needed, Resident #84 stated "I need to be changed," the Administrator left the room. Interview on 08/18/25 at 4:15 P.M., the Administrator stated the procedure for call lights was that call lights were not shut off until the need of the resident was met. The Administrator was informed that observations made in the three halls indicated one aide and one nurse were observed in one hall from 3:28 P.M. to 4:15 P.M. The Administrator stated she would find a staff member, Resident #84's received care at 4:17 P.M. Interview on 08/18/25 at 4:18 P.M., CNA #304 was unable to provide a valid reason why she shut Resident #84's call light out without providing care and stated she told the nurse about the call (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	being activated. CNA#304 stated she made a mistake by turning off the light without providing care. Review of the facility electronic call light audits for 1275 call light responses noted the facility had a significant number of call lights that were activated for one to two hours. Review of the facility policy titled "Resident Call Light," dated 2023, noted staff were to answer the call light in a timely manner, do not turn off the call light if staff were unable to meet the resident's needs, and complete the task the resident has requested. 2. Review of the medical record for Resident #9 noted an admission date of 07/25/25. Diagnoses included bilateral primary osteoarthritis of the hip, pain in the right and left hip, and personality disorder. Review of the plan of care dated 03/28/25 noted Resident #9 had a self-care deficit, limited mobility, and impaired cognition. Interventions included toileting assistance of one staff and transferring assistance of two staff with a mechanical lift. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #9 had intact cognition. Resident #9 required moderate assistance for toileting and mobility. Review of medical record for Resident #15 noted an admission date of 06/25/25. Diagnoses included traumatic amputation of the right foot and chronic kidney disease. Review of care plan dated 07/01/25 noted Resident #15 was at risk for falls related to assistance needed with toileting and transfers. Interventions included keeping the call light within reach. Review of the comprehensive MDS 3.0 assessment dated [DATE] revealed Resident #15 had impaired cognition. Resident #15 required moderate assistance for toileting and mobility. Review of the medical record for Resident #41 noted an admission date of 05/30/25. Diagnoses included seizures, hemiplegia and hemiparesis. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #41 had impaired cognition. Resident #41 required moderate assistance for toileting and mobility. Review of the care plan dated 07/01/25 noted Resident #41 was at risk for falls related to assistance needed with toileting and transfers. Interventions included keeping call light within reach, encouraging the resident to use call light, and required a mechanical lift for transfers. Observations on 08/20/25 at 3:19 P.M. noted Residents #9, #15, and #41 activated their call lights. CNA #59 was the only staff working on the floor at that time and was in a room with another resident. Further observations noted LPN #346 walk down the hall and enter Residents #9, #15, and #41's rooms, turned off the call lights and returned to the nurse's desk. CNA #359 walked out of the other resident's room and was unaware of the needs of the three residents whose light was turned off. Interview on 08/20/25 at 3:19 P.M., Resident #41 stated she needed to be changed, and the nurse said she would be right back. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 08/20/25 at 3:24 P.M., Resident #15 stated she needed to be in bed, and the nurse said she would be right back. Interview on 08/20/25 at 3:25 P.M., Resident #9 stated she needed to be changed, and the nurse said she would be right back. Resident #9 stated staff always come in, turn the light off and then leave and never return. Interview on 08/20/25 at 3:37 P.M., LPNs #303 and #346 were observed sitting at the nurse's desk from 3:10 P.M. to 3:37 P.M. Both staff stated CNA #359 was working on the unit. Both staff were asked why they were sitting at the desk with three call light activated. Both staff stated they were doing training. 3. Review of the medical record for Resident #69 revealed an admission date of 09/19/23. Diagnoses included type II diabetes, Alzheimer's disease, encephalopathy, morbid obesity, overactive bladder and depression. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #69 had impaired cognition. The resident was dependent on staff for eating, toileting, showering and dressing. Resident #69 was incontinent of bowel and bladder. Review of the progress note dated 06/27/25 at 5:02 A.M. written by LPN #398 stated Resident #69's power of attorney (POA) contacted the facility to inform nursing that Resident #69 had not been checked and changed for a while. The resident was laid down for bed at 9:30 P.M. The CNA reported back to the nurse and stated the last time she checked on the resident was at 1:00 A.M. LPN #389 educated the CNA on the facility policy to check and change resident every two hours. Resident #69's POA called back ten minutes later to inquire again about care. LPN #398 checked on the CNA, and she was providing care to another resident. The CNA then went into Resident's #69 room and provided care, and the brief was mildly saturated. The resident was now in bed, resting comfortably and the POA was satisfied. Interview on 08/21/25 at 9:30 A.M. with LPN #389 stated Resident #69's POA was very strict about times when the resident was changed. LPN #389 verified Resident #69 was not changed every two hours per facility policy. LPN #389 educated the CNA on the facilities policy. Interview on 08/25/25 at 5:00 P.M. with the Director of Nursing (DON) stated she directed LPN #389 to document the incident. Review of the facility policy titled Incontinence Care, revised March 2022, revealed 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 noncompliance investigated under Master Complaint Number 2589262 and Complaint Numbers 2579574 1401332 (OH00167486), 1401404 (OH00167479), 1401399 (OH00165474), 1401397 (OH00163878), and 1401393 (OH00162964).		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 record review, observation, interview and facility policy review, the facility failed to ensure residents at risk for falls were safe by implementing interventions written in the plan of care, appropriate call light response, and timely intermittent observations of residents. This affected one (Resident #65) of five residents reviewed for falls. The facility failed to ensure all residents requiring a mechanical lift for transfers were transferred safely. This affected one (Resident #65) of 34 residents who required a mechanical lift for transfers. The facility failed to provide care and services to prevent falls related to level of assistance. This affected two (Residents #18 and #39) of five residents reviewed for falls. The facility failed to ensure Resident #99 had a fall assessment and a pain assessment after a fall with minor injury. This affected one (Resident #99) of five residents reviewed for falls. The facility census was 86. Findings include: 1. Review of the medical record for Resident #65 noted an admission date of 08/21/24. Diagnoses included unspecified dementia, encounter for palliative care, and repeated falls. Review of the plan of care dated 04/29/25 noted Resident #65 had continuous video monitoring. Review of the plan of care dated 05/02/24 noted Resident #65 was at risk for cognition decline due to dementia and senile degeneration of the brain. Review of the plan of care dated 05/02/24 noted Resident #65 had impaired visual function. Review of the facility siderail assessment dated [DATE] noted Resident #65 had no visual deficits, was not able to get out of bed, had a history of falls and had no desire to get out of bed. The assessment also indicated a recommendation of bilateral half rails to prevent further falls. No other siderails assessments were completed after 05/13/25. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #65 had impaired cognition. Resident #65 was dependent on staff for mobility. Review of the plan of care initiated on 03/31/25 (updated on 07/07/25 and 07/28/25) noted Resident #65 was at risk for falls due to incontinence of bowel and daily use of psychotropic medications. Interventions included the use of bilateral grab bars, Dycem (non-slip material) to the mattress, a perimeter overlay to the mattress dated 07/07/25, a sitter at night and a mechanical lift for all transfers both dated 07/28/25. Review of the nursing fall risk assessments dated 03/19/25 through 07/30/25 indicated Resident #65 was at risk for falls. Review of the incident log dated 11/24/24 through 08/18/25 noted Resident #65 had a fall on 02/01/25 at 8:01 P.M., 07/06/25 at 10:00 P.M., 07/25/25 at 1:35 A.M., and 07/28/25 at 1:30 A.M. Review of the videos sent in by the family from 07/06/25 through 07/28/25 noted Resident #65 was restless during the late evening and early morning hours. The videos showed Resident #65 fidgeting, removing his blankets and wiggling toward the right side of the bed several times. Review of the video dated 07/06/25 at 10:57 P.M. revealed Resident #65 sitting on the floor. Licensed (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Practical Nurse (LPN) #400 and Certified Nurse Assistant (CNA) #401 lifted Resident #65 under his arms to place him back in bed. Review of the video dated 07/13/25 from 8:24 P.M. to 11:47 P.M. revealed Resident #65's call light was activated at 8:40 P.M. Further review revealed Resident #65's call light was still activated at 11:00 P.M., no staff had checked on Resident #65 since 8:40 P.M. Resident #65 began calling out to the nurse for help from 11:00 P.M. to 11:49 P.M. when LPN #334 entered the room. The staff member observed Resident #65 positioned from the top right of bed to the left bottom of the bed, no repositioning was provided. The call light times were observed by the videos provided, a review of the facility electric call light responses for 07/13/25 noted Resident #65's call was activated from 5:09 P.M. to 11:47 P.M. This was verified by Corporate Director of Operation (CDO) #505 during the observation of videos. Review of a video dated from 07/27/25 at 9:53 P.M. to 07/28/25 at 6:29 A.M. revealed Resident #65 activated the call light at 9:53 P.M. LPN #334 entered the room at 10:29 P.M. Resident #65 was positioned at the right edge of the bed at that time. LPN #334 straightened Resident #65's covers and left the room without repositioning the resident. At 12:47 A.M. Resident #65 was observed with his legs hanging over the right side of the bed. At 1:19 A.M. on 07/28/25 Resident #65 was observed on the floor next to the right side of the bed. No staff had checked on Resident #65 since 10:29 P.M. on 07/27/25. At 1:20 A.M., another resident entered the room after hearing a loud thud and hollering to find Resident #65 lying on the floor. Resident #26 left the room to call for help. Staff entered the room stating "why does he not have full side bed rails and discussed a way to transfer Resident #65 back into bed by lifting or by using the mechanical lift. Staff used the mechanical lift and positioned Resident #65 to the right side of the bed, covered him and left the room. From 1:37 A.M. to 6:09 A.M., no staff entered the room to check on Resident #65. From 3:19 A.M. to 3:31 A.M. Resident #65 was observed with both legs hanging off the right side of the bed. LPN #334 entered Resident #65's room at 6:09 A.M. and stated that she could not pull the resident by herself. The nurse picked up Resident #65's legs and placed them on the edge of right side of the bed, covered him up, took vital signs and left the room. Observation on 08/22/25 at 7:59 A.M. noted Resident #65 lying on his back in the center of the bed. LPN #385 was asked if Resident #65 had Dycem under him as written in the care plan. LPN #385 stated she did not think so as she had never observed it before. Continued observations noted Unit Manager (LPN #405) and Unit Manager Registered Nurse (RN) #307 turned Resident #65 to see if the Dycem was utilized. Both staff verified that no Dycem was placed under the resident to prevent sliding. LPN #405 stated the Dycem should be placed under the mattress to prevent the mattress from sliding. Unit Manager RN #307 stated the Dycem would be placed under Resident #65 after care was provided. Interview and observation on 08/22/25 at 11:39 A.M., CDO #404 and Regional Director of Clinical Services (RDCS) #502 observed the videos provided and verified all findings. Review of the facility policy titled "Resident Call Light," dated 2023, noted staff were to answer the call light in a timely manner, do not turn off the call light if staff were unable to meet the resident's needs, and complete the task the resident has requested. 2. Review of the medical record for Resident #65 noted an admission date of 08/21/24. Diagnoses included unspecified dementia, encounter for palliative care, and repeated falls. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the plan of care dated 03/31/25 noted Resident #65 was at risk for falls due to incontinence of bowel and daily use of psychotropic medications. Resident #65 required a mechanical lift for all transfers. Interventions included the use of bilateral grab bars, Dycem to the mattress dated 07/07/25, and a mechanical lift for all transfers dated 07/28/25. Review of the quarterly MDS 3.0 assessment dated [DATE], revealed Resident #65 had impaired cognition. Resident #65 was dependent on staff for mobility. Observation on 08/18/25 at 11:25 A.M. noted Hospice Aide (HA) #505 transferring Resident #65 via a mechanical lift without staff assistance. Resident #65 was observed in the lift sling parallel to the bed approximately four feet in the air. Interview immediately after the observation, HA#505 stated there were no staff to assist her. HA#505 stated she looked for staff but was on a tight schedule and needed to get her assignments completed. Interview on 08/18/25 at 11:50 A.M., the Administrator stated the facility policy required at least two staff members when transferring a resident via a mechanical lift. Review of the physician order dated 08/20/25 indicated Resident #65 required a mechanical lift of two staff assistance for transfers. Review of the facility policy titled "Hoyer Lift," dated 2022, noted the procedure required two staff members present at all times. 3. Review of the medical record for Resident #18 revealed an admission date of 06/24/25 and diagnoses including quadriplegia, convulsions, and aphasia. Review of the plan of care dated 06/24/25 revealed Resident #18 had activities of daily living (ADL) needs. Interventions included dressing and grooming assistance of two staff and toileting assistance of two staff. Review of the MDS 3.0 admission assessment dated [DATE] revealed Resident #18 had severely impaired cognition. Resident #18 required partial/moderate assist to roll left and right and was dependent on staff for toileting hygiene, lower body dressing, and transfers. Resident #18 was unable to complete the toileting transfer task. Resident #39 was always incontinent of bowel and bladder. Review of the fall investigation dated 08/02/25 at 6:10 A.M. revealed CNA #391 reported to LPN #398 that Resident #18 was lying on the floor. CNA #391 told LPN #398 that she just left the room for something to finish care and when she returned, the resident was on the floor. LPN # 398 assessed the resident and found her to have no injuries. Proper notification was given to physicians, Power of Attorney (POA) and Director of Nursing (DON). Review of CNA #391's witness statement revealed that Resident #18 was menstruating and had a bowel movement. CNA #391 left the room to get more supplies in the bathroom, and when she went back to the resident, Resident #18 was on the floor. Review of the fall risk assessment dated [DATE] revealed Resident #18 was not at risk for falls. Resident #18 was noted to require assistance with elimination, was confined to chair, and required physical help for balance. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the pain assessment dated [DATE] revealed Resident #18 did not verbalize pain. Review of the nursing progress note dated 08/02/25 revealed the POA of Resident #19 requested that her daughter be sent to the hospital. The physician was called, and a new order was received for Resident #18 to be sent to the hospital. Review of the progress note dated 08/03/25 at 2:19 A.M. revealed Resident #18 returned from the hospital with no new orders. Resident #18 denied pain. Review of the current nursing aide Kardex revealed Resident #18 required assistance of two for mobility and toileting. Review of the Interdisciplinary Team (IDT) note dated 08/12/25 at 5:51 P.M. revealed CNA #391 reported to LPN #398 that Resident #18 was lying on the floor. CNA #391 told LPN #398 that she just left the room for something to finish care and when she returned, the resident was on the floor. LPN #398 assessed the resident and found her to have no injuries. A new intervention was for two staff with all care and a perimeter mattress Interview on 08/21/25 at 2:01 P.M. with CNA #391 revealed she had worked night shift and was assigned to Resident #18 on 08/02/25. CNA #391 stated she was changing Resident #18 and turned her on her side. CNA #391 stated Resident #18 was holding the bed rail when she left the room to get supplies out of the bathroom because Resident #18 was menstruating. CNA #391 stated upon her return Resident #18 had already fallen out of bed. CNA #391 stated she checked on Resident #18 and went to get help from the nurse. CNA #391 stated Resident #18 was dependent on staff for care related to quadriplegia. Interview on 08/20/25 at 3:38 P.M. with LPN #398 revealed that there was only one aide in the room. She stated that she normally was in the skilled section but picked up that night. LPN #398 stated that there should have been two staff in the room at the time of the fall. 4. Review of the medical record for Resident #39 revealed an admission date of 06/09/25 with diagnoses including quadriplegia, Guillain-Barre syndrome, bilateral hand contractures, osteoarthritis of hips, osteopenia, and left knee osteoarthritis. Review of the MDS 3.0 admission assessment dated [DATE] revealed Resident #39 had intact cognition. Resident #39 had range of motion (ROM) impairments to bilateral upper and lower extremities. Resident #39 required partial/moderate assist to roll left and right and was dependent on staff for toileting hygiene, lower body dressing, and transfers. Resident #39 was unable to complete the toileting transfer task. Resident #39 was always incontinent of bowel and bladder. Review of the plan of care dated 06/17/25 revealed Resident #39 had ADL needs. Interventions included dressing and grooming assistance of two staff and toileting assistance of two staff. Review of the physician's order dated 07/17/25 revealed Resident #39 had an order for grab bar to the left side of the bed for mobility and positioning. Review of an unwitnessed fall incident report dated 08/10/25 revealed the CNA informed the nurse while she was changing Resident #39, she rolled out of bed. Resident #39 was seen on the floor near her nightstand with legs extended in front of her, lying on her left side. Resident #39 stated she (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bumped her head and was having pain in her left hip and knee. There were no visible injuries, and ROM was within normal limits (WNL) for Resident #39. Resident #39 stated she rolled out of bed while the CNA was changing her. Factors contributing to fall were listed as: during check and change resident rolled out of bed on the right side of the bed in which there was no railing. A side rail to the right side of bed was added for safety precautions and neurological checks were initiated. Review of the fall risk assessment dated [DATE] revealed Resident #39 was not at risk for falls. Resident #39 was noted to require assistance with elimination, was confined to chair, and required physical help for balance. Review of pain assessment dated [DATE] revealed Resident #39 complained of seven out of 10 throbbing pain to front of her left knee. There was no bleeding, bruising, or injury noted. Resident #39 was medicated with 50 milligrams (mg) of Tramadol (opioid pain medication) and 650 mg of Tylenol (analgesic) for pain. Review of the nursing progress note dated 08/10/25 revealed Resident #39 was post-fall and had complaints of pain to left hip and knee. The nurse practitioner (NP) was notified and gave an order for an x-ray of left knee and hip to rule out fracture. Review of the physician's order dated 08/10/25 revealed Resident #39 had an order for a left hip with pelvis and left knee x-ray. Review of the x-ray results dated 08/10/25 revealed no evidence of dislocation or fracture. There was noted mild osteoarthritis of both hip joints and the left knee joint. Review of the physician's order dated 08/10/25 revealed Resident #39 had order for a grab bar to the right side of the bed for safety. Review of the employee corrective action form dated 08/11/25 revealed CNA #331 was disciplined with a verbal warning. CNA #331 was educated on always checking the Kardex (a summary tool that provides an overview of a resident's care information) to see the level of assistance a resident needed as well as other resident specific information. It was noted "when in doubt always take another staff member to assist you." Review of the current nursing aide Kardex revealed Resident #39 required assistance of two staff for mobility and toileting. Review of the progress note dated 08/12/25 revealed an IDT review of Resident #39's fall on 08/10/25. The IDT added new intervention of a perimeter overlay to the mattress. Interview on 08/18/25 at 10:12 A.M. with Resident #39 revealed she had a recent fall out of bed. Resident #39 stated a nursing aide had come in to change her and rolled her onto her side. Resident #39 stated the nurse aide then stepped out of the room and she had fallen out of bed before the nurse aide had returned. Resident #39 stated she could help rolling onto her side but she had never been left alone rolled onto her side before. Resident #39 stated the bed was in a high position and she fell out of bed on the right side. Resident #39 stated she was still having pain in her knee since the fall. Resident #39 stated she was being medicated for pain and rubbing her knee helped. Resident #39 stated she had an x-ray of her knee, and it was not broken. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 08/21/25 at 8:36 A.M. with CNA #331 revealed she had worked night shift and was assigned to Resident #39 on 08/10/25. CNA #331 stated it was early in the morning, and she was doing check and change rounds. CNA #331 stated she was changing Resident #39 and turned her on her right side. CNA #331 stated there was no bed rail on the right side for Resident #39 to hold onto. CNA #331 stated while Resident #39 was turned onto her side she went to the bathroom to get wash cloths from the sink in the bathroom. CNA #331 stated upon her return Resident #39 was already falling out of bed. CNA #331 stated she checked on Resident #39 and got her into a comfortable position then went to get help from the nurse. CNA #331 stated Resident #39 was dependent on staff for care related to quadriplegia. CNA #331 stated it would have been more appropriate to have two people in room while changing Resident #39. Interview on 08/26/25 at 8:42 A.M. with RN #306 revealed she had worked night shift and was assigned to Resident #39. RN #306 stated CNA #331 came to her and indicated Resident #39 fell out of bed. RN #306 stated CNA #331 had changed her story of what happened several times and the way Resident #39 fell was not making sense. RN #306 indicated when she questioned Resident #39, she reported CNA #331 left her turned on her side when she fell. RN #306 stated Resident #39 did not have a side rail on the right side of her bed. RN #306 stated Resident #39 should not have been turned onto her right side and left without support. 5. Review of the closed medical record for Resident #99 revealed an admission date of 02/13/25. Diagnoses included pneumonia, malignant neoplasm of esophagus, encephalopathy, attention deficit hyperactivity disorder, anxiety disorder, and bipolar disorder. The resident was discharged to another facility on 03/11/25. Review of the fall risk assessment dated [DATE] revealed Resident #99 was not at risk for falls. Review of the Modification of admission MDS 3.0 assessment dated [DATE] revealed Resident #99 had intact cognition. Resident #99 required supervision or touching assistance for sit-to-stand, chair-to-bed transfers, and walking. Medications received: antipsychotic, antianxiety, antidepressant, antiplatelet, hypoglycemic, anticonvulsant. Antipsychotics received on an as needed (PRN) basis only. Review of the nurse's note dated 03/04/25 at 5:15 P.M. Resident #99 was returning to the facility from a radiation therapy appointment, when resident fell on the walkway outside of the building. The fall was witnessed by the receptionist and the person transporting the resident. Resident #99 had a right index finger skin tear, a minor right knee scrape, and minor left pinky finger scrape. The nurse cleaned the area and notified all parties. The resident did not have any injuries to the head. Vital signs were taken. Pain was three on scale of zero to ten. Review of the fall investigation dated 03/04/25 revealed the fall was unwitnessed (although nursing note stated it was witnessed by the receptionist and the transporter). Nursing assessed the resident. Vital signs were taken. The resident had a right index finger skin tear, a minor right knee scrape, and minor left pinky finger scrape. The pain assessment form and the fall assessment form were not completed. Interview on 08/22/25 at 1:48 P.M. RDCS #502 verified the pain assessment form and the fall assessment form were not completed. This deficiency represents noncompliance investigated under Master Complaint Number 2589262, and Complaint Numbers 2579574, 1401332 (OH00167486), 1401397 (OH00163878), 1401396 (OH00163306), and 1401401 (OH00162944).		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, observations, interviews and facility policy review, the facility failed to ensure all insulin pens were documented with resident name, opened and expired dates. The facility also failed to remove expired insulin pens in a timely manner. This affected eight (Residents #10, #24, #33, #40, #73, #78, #81, and #82) of 19 residents who required insulin. The facility census was 86. Findings include: 1. Review of the medical record for Resident #10 revealed an admission date of [DATE]. Diagnoses included type two diabetes mellitus with ketoacidosis without coma and multiple sclerosis. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #10 had impaired cognition. Review of the current physician orders revealed Resident #10 had orders for insulin glargine solution pen-injector dated [DATE] and insulin lispro solution pen-injector dated [DATE] daily. 2. Review of the medical record for Resident #24 revealed an admission date of [DATE]. Diagnoses included type two diabetes mellitus. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #24 had impaired cognition. Review of the current physician orders revealed Resident #24 had orders for insulin glargine solution pen-injector dated [DATE] and Humalog solution pen-injector dated [DATE] daily. 3. Review of the medical record for Resident #33 revealed an admission date of [DATE]. Diagnoses included type two diabetes mellitus. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #33 had intact cognition. Review of the current physician orders revealed Resident #33 had an order for insulin lispro solution pen-injector dated [DATE] per sliding scale. 4. Review of the medical record for Resident #40 revealed an admission date of [DATE]. Diagnoses included type two diabetes mellitus with hyperglycemia. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #40 had impaired cognition. Review of the current physician orders revealed Resident #40 had orders for Humalog solution pen-injector dated [DATE] per sliding scale and Lantus solution pen-injector dated [DATE] at bedtime. 5. Review of the medical record for Resident #73 revealed an admission date of [DATE]. Diagnoses included type two diabetes mellitus. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #73 had intact cognition. Review of the current physician orders revealed Resident #73 had an order for insulin lispro solution pen-injector dated [DATE] per sliding scale. 6. Review of the medical record for Resident #78 revealed an admission date of [DATE]. Diagnoses included type two diabetes mellitus. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #78 had impaired cognition. Review of the current physician orders indicated Resident #78 had an order for Humalog solution pen-injector dated [DATE] per sliding scale. 7. Review of the medical record for Resident #81 revealed an admission date of [DATE]. Diagnoses included type two diabetes mellitus. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #81 had intact cognition. Review of the current physician orders revealed Resident #81 had orders for Humalog solution pen-injector dated [DATE] two times a day and insulin lispro solution pen-injector dated [DATE] per sliding scale. 8. Review of the medical record for Resident #82 revealed an admission date of [DATE]. Diagnoses included type two diabetes mellitus with foot ulcer. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #82 had impaired cognition. Review of the current physician orders revealed Resident #82 had orders for Humalog solution pen-injector dated [DATE] per sliding scale and Lantus solution pen-injector dated [DATE] daily. Observations of medication administration on [DATE] at 8:49 A.M. noted Licensed Practical Nurse (LPN) #385 administering medications to Resident #82. Resident #82 was receiving lispro solution via a pen-injector. The date on the pen indicated the insulin had expired on [DATE]. LPN #385 looked through the medication cart looking for another pen-injector. LPN #385 verified the expired pen was the only pen-injector for Resident #82. Observation of medication storage on [DATE] from 8:49 A.M. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to 8:57 A.M. revealed the following concerns: Resident #82- lispro pen-injector dated expired on [DATE]. Resident #33- lispro pen-injector not dated, lispro expired on [DATE]. Resident #40- Lantus pen-injector expired [DATE], two pens of Lantus not dated and a NovoLog pen-injector that expired on [DATE]. Resident #24- Humalog pen-injector expired on [DATE]. Interview with LPN #82 verified all findings at the time of the observation. Observation of medication storage on [DATE] from 9:05 A.M.to 9:12 A.M. revealed the following concerns: Resident #24- Lantus pen-injector not dated. Two pens of lispro pen-injector with no name or date. Resident #81- Humalog pen-injector not dated. Interview with LPN #400 verified all findings at the time of the observation. Observation of medication storage on [DATE] from 9:15 A.M. to 9:30 A.M. revealed the following concerns: Resident #78- Humalog pen-injector that expired on [DATE]. Resident #10- Lantus pen-injector that was not dated. Resident #73- lispro pen-injector not dated, another pen with the medication scratched off and expired on [DATE]. Interview with LPN #301 verified all findings at the time of the observation. Review of the facility policy titled Administering Medications, dated 2019, noted multi-dose containers were to be dated the day the container is opened and vials were to be clearly labeled with the resident's name or other identifying information.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, review of the meal spreadsheet, interview, and review of the facility policy, the facility failed to ensure accurate portions were served according to the menu diet spread sheet. This affected 22 (Residents #10, #14, #18, #29, #30, #37, #41, #42, #45, #46, #47, #51, #54, #56, #59, #66, #69, #73, #74, #78, #79, and #103) in the main dining room who were not on a pureed diet. The facility identified four (Residents #1, #48, #65, and #90) in the main dining room who received a pureed diet. This had the potential to affect all residents who received meals from the facility. The facility identified four (Residents #4, #19, #49, and #60) who received nothing by mouth (NPO). The facility census was 86. Findings include: Observation on 08/18/25 from 12:00 P.M. through 12:25 P.M. revealed residents were served by table. During the meal service, observation of the chicken and wild rice casserole revealed the portion appeared less than the spread sheet indicated. Interview on 08/18/25 at 12:23 P.M. with Resident #30 revealed that he was still hungry. Business Office Manager (BOM) #311 asked the kitchen for more food for Resident #30. Observation and interview of the lunch tray line on 08/18/25 at 12:24 P.M. revealed the utensil that was being used to serve the chicken and wild rice casserole was a #8 scoop. [NAME] #363 verified that she was giving one #8 scoop portion, which equaled four ounces. Review of the facility's spreadsheet for 08/18/25 lunch meal service revealed that the serving size for chicken and wild rice casserole was one cup, and the serving instructions stated to use either an eight-ounce spoodle or two four-ounce scoops. This was verified by Mobile Dietary Manager (MDM) #500 at time of observation. This deficiency represents noncompliance investigated under Complaint Numbers 1401399 (OH00165474) and 1401394 (OH00163002).		

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on observation, interview, and record review, the facility failed to ensure meals were served in a timely manner. This affected three (Residents #37, #666, and #103) and had the potential to affect all resident receiving food from the kitchen. The facility identified four (Residents #4, #19, #49, and #60) as receiving nothing by mouth (NPO). The facility census was 86. Findings include: Review of the undated facility mealtimes revealed breakfast was served from 7:00 A.M. to 8:45 A.M., lunch was served from 11:30 A.M. to 1:00 P.M., and dinner was served from 4:30 P.M. to 5:30 P.M. The identified order of serving was first dining room, assisted living, premium suites, front hall, middle hall and back hall. Observation of tray line on 08/18/25 at 12:25 P.M. revealed food was above 165 degrees Fahrenheit (F) on the tray line, preferences were honored, condiments were available, and every tray had appropriate silverware including adaptive equipment. Observation on 08/18/25 revealed the food cart left the kitchen at 1:24 P.M. and was delivered to the back hall. Interview on 08/18/25 at 1:24 P.M. with the Mobile Dietary Manager (MDM) #500 verified that the meal trays were delivered 24 minutes late according to the posted mealtimes. Observation during interview with Resident #63, who resided in the Middle Hall, on 08/18/25 at 1:55 P.M. revealed Corporate Registered Nurse (CRN) #410 delivered the lunch tray. Interview on 08/18/25 at 1:56 P.M. with CRN #410 confirmed he had delivered Resident #63's lunch meal tray. CRN #410 indicated he was unsure why the meal trays were late. CRN #410 reported he had been asked to help pass meal trays. During interviews with residents during the Resident Council meeting on 08/20/25 at 11:15 A.M., Residents #37, #666, and #103 voiced concerns that meals were often served late. Review of the posted mealtimes for lunch meal service revealed that the Middle Hall should have had their meal trays delivered at 12:45 P.M. and the Back Hall meal trays should have been delivered by 1:00 P.M. This deficiency represents noncompliance investigated under Complaint Numbers 1401399 (OH00165474) and 1401394 (OH00163002).		

Department of Health & Human Services
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NAME OF PROVIDER OR SUPPLIER Avenue at Lyndhurst		STREET ADDRESS, CITY, STATE, ZIP CODE 5442 Rae Road Lyndhurst, OH 44124	
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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide behavior health training consistent with the requirements and as determined by a facility assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the Facility Assessment, personnel record review, and interview, the facility failed to provide behavioral health training upon hire and/or annually to all staff who were employed at the facility. This had the potential to affect all 86 residents in the facility. Findings include: Review of the nursing in-service regarding behaviors on 05/06/25 revealed it included nursing staff but did not include housekeeping, dietary, or maintenance. Review of the facility's Facility assessment dated [DATE] included under staff training, education and competency training would be provided to all staff (beginning July 2023) about caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder. Training included review of competencies and skills to provide patient care services that reflect the resident's goals. Review of the personnel record for Housekeeper #418 revealed he was contract staff with a hire date of 05/27/25 with no documented evidence of behavioral training. Review of the personnel record for Floor Tech #415 revealed he was contract staff with a hire date of 11/03/24 with no documented evidence of behavioral training. Review of the personnel record for Certified Nursing Assistant (CNA) #329 revealed she had a hire date of 07/23/25 with no documented evidence of behavioral training. Review of the personnel record for CNA #313 revealed she had a hire date of 07/25/25 with no documented evidence of behavioral training. Review of the personnel record for CNA #323 revealed she had a hire date of 06/11/25 with no documented evidence of behavioral training. Interview on 08/20/25 at 10:10 A.M. with Corporate Human Resource Manager (CHR) #501 verified that new hires do not get behavioral training during orientation and it was not included on the company mandated 12 hours of annual in-services. Interview on 08/20/25 at 10:36 A.M. with Director of Nursing (DON) revealed that she did in-service staff on behaviors on 05/06/25 because she felt there was a need for staff to be trained on behaviors at the time. Interview on 08/20/25 at 2:56 P.M. with the contracted Regional Housekeeping Director (RHD) #423 verified that there was no documented behavioral training for housekeeping employees. This deficiency represents noncompliance investigated under Complaint Numbers 1401332 (OH00167486), 1401404 (OH00167479), and 14011397 (OH00163878).		

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F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. Based on medical record request review, email review, staff interview and facility policy review, the facility failed to fulfill a request for medical records in a timely manner. This affected one (Resident #100) of three residents reviewed for medical records requests. The facility census was 86. Findings include: Review of the medical record for former Resident #100 revealed an admission date of 10/07/24 and discharge date of 10/29/24. Resident #100 passed away while at the facility. Review of the medical records request dated 03/31/25 revealed a law firm representing Resident #100's personal representative requested a complete copy of all resident records in the possession of the facility for Resident #100. The request included a medical authorization form signed by Resident #100's administrator of estate and a court order for the release of the medical records and medical billing records. Review of the medical records request dated 05/12/25 revealed a second request was made for the medical records of Resident #100 by a law firm representing Resident #100's personal representative. Review of the email chain dated 08/20/25 between Medical Records #374 and the facility's corporate office revealed Medical Records #374 requested an update on sending the medical records as requested for Resident #100's administrator of estate. The corporate office responding indicating a secure link was sent to the law firm for access to the medical records on 08/20/25. Review of the uploads to the secure link revealed Resident #100's medical record from 08/01/24 to 07/31/25 was uploaded on 08/13/25. Interview on 08/25/25 at 8:48 A.M. with Medical Records #374 confirmed the requests on 03/31/25 and 05/12/25 were not fulfilled in a timely manner. Medical Records #374 confirmed the law firm was unable to access the medical records until 08/20/25 via a secure link. Interview on 08/25/25 at 8:58 A.M. with the Licensed Nursing Home Administrator (LNHA) revealed the former medical records employee had not fulfilled the medical record requests for Resident #100. LNHA indicated the former medical records employee had been terminated. Review of the facility policy Medical Records Request, dated January 2023, revealed record requests must be approved by the Corporate Clinical Director. A written consent from the resident or representative was required. Fees would be applied per page for medical records. This deficiency represents noncompliance investigated under Complaint Numbers 2581623, 1401397 (OH00163878) and 1401396 (OH00163306).		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the Ombudsman was notified of transfers for Residents #10 and #93, and the facility failed to ensure a transfer notice was issued for Resident #98. This affected three (Residents #10, #93, and #98) of three residents reviewed for hospitalization. The facility census was 86. Findings include:1. Review of the medical record revealed Resident #10 was admitted to the facility on [DATE] with diagnoses including acute kidney failure and multiple sclerosis. Review of the medical record revealed Resident #10 was sent to the hospital on [DATE] and was subsequently admitted to the hospital. Reviews of both the electronic and hard charts revealed no documented evidence that the Ombudsman was notified of the residents transfer to the hospital. Interview on 08/20/15 at 2:00 P.M. with Social Service Designee (SSD) #388 revealed that the Ombudsman was not notified that Resident #10 went to the hospital on [DATE]. 2. Review of the medical record revealed Resident #93 was admitted to the facility on [DATE] with a discharge date of 07/25/25. Diagnoses included diabetes mellitus, general anxiety disorder, and acute respiratory failure. Review of the medical record revealed Resident #93 was sent to the hospital on [DATE], 05/28/25, and 07/01/25 and was subsequently admitted to the hospital. Reviews of both the electronic and hard charts revealed no documented evidence that the Ombudsman was notified of the residents's transfers to the hospital. Interview on 08/20/15 at 2:00 P.M. with SSD #388 revealed the Ombudsman was not notified of Resident #93's transfers to the hospital on [DATE], 05/28/25, and 07/01/25. 3. Review of the medical record for Resident #98 revealed an admission date of 02/06/24. Diagnoses included cerebral infarction, pneumonia, hemiplegia and hemiparesis, sepsis, gastrostomy status, and dementia. The resident was discharged from the hospital on [DATE]. Review of the Discharge Return Anticipated Minimum Date Set (MDS) 3.0 dated 08/21/24 revealed Resident #98 had severely impaired cognition and required maximum assistance eating, oral hygiene, dressing, personal hygiene, and bathing/showers. Record review revealed there were no transfer notices for a hospitalization on 06/17/24 or a hospitalization on 08/08/24. The lack of the required transfer notices was verified Corporate Director of Operations #409 on 08/25/25 at 1:42 P.M.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to ensure medications were available for administration. This affected two (Residents #20 and #99) out of ten residents reviewed for medication administration. The facility census was 86. Findings include: 1. Review of the medical record for Resident #20 revealed an admission date of 08/01/22. Diagnoses included acute respiratory failure, visual loss of both eyes, dementia, peripheral vascular disease, osteoarthritis, and sarcoidosis of lung. Review of the comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #20 had intact cognition. The resident required partial assistance with toileting and transferring. Review of the laboratory result for urinary analysis final result dated 07/28/25 at 3:28 P.M. revealed a positive result for nitrites and Proetus Mirabilis, a bacterium. Review of the physician progress note dated 07/30/25 at 5:09 P.M. revealed the urinary tract infection (UTI) laboratory results and medications were reviewed. New orders were given for Cefdinir 300 milligrams (mg) (antibiotic) twice daily for seven days and saline nasal spray three times a day. Review of the physician order dated 07/30/25 at 6:30 P.M. for Cefdinir 300 mg, give one capsule twice daily for UTI. The order was started and discontinued on 07/30/25. An order dated 07/31/25 for Cefdinir 300 mg to give twice daily revealed a start date 07/31/25 and discontinue date of 08/07/25. Review of the Medication Administration Record (MAR) for July 2025 revealed on 07/30/25 at 8:00 P.M., Cefdinir was sign off with a number "9" indicating to see the nurse's note. On 07/31/24 at 8:00 A.M. and 8:00 P.M. Cefdinir was signed off as administered. Review of the nurse's progress note on 07/30/25 revealed no note regarding the Cefdinir. Interview on 08/25/25 at 1:43 P.M. with the Regional Director of Clinical Service (RDCS) #502 stated she believed on 07/30/25 the nurse did not have the medication from pharmacy and rescheduled it for the following day. RDCS #502 verified the UTI results on 07/28/25 at 3:28 P.M. the physician reviewed the results on 07/30/28, and there was a delay in starting the Cefdinir until 07/31/25 at 8:00 A.M. 2. Review of the closed medical record for Resident #99 revealed an admission date of 02/13/25. Diagnoses included pneumonia, malignant neoplasm of esophagus, encephalopathy, attention deficit hyperactivity disorder, anxiety disorder, and bipolar disorder. The resident was discharged to another facility on 03/11/25. Review of the modification of admission MDS 3.0 assessment dated [DATE] revealed Resident #99 had intact cognition. Review of the physician orders for Resident #99 revealed a medication order for Alprazolam oral tablet 0.5 mg (Xanax) (anxiety) give one tablet by mouth at bedtime for anxiety, ordered on 02/13/25 with a start date on 02/14/25. (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the MAR for Resident #99 for February 2025 revealed Alprazolam oral tablet 0.5 mg give one tablet by mouth at bedtime for anxiety was not given on 02/14/25, 02/15/25, and 02/17/25. It was noted to see nurse's note on 02/14/25, 02/15/25, and 02/17/25. Review of the nursing progress notes for Resident #99 for 02/14/25 revealed no notes regarding the missed dose of Alprazolam oral tablet 0.5 mg. Review of the nursing progress note dated 02/15/25 at 2:17 A.M. revealed the Alprazolam oral tablet 0.5 mg was pending delivery. There was no indication that any action had been taken regarding obtaining the medication. Review of the nursing progress note dated 02/15/2025 at 8:51 PM revealed Alprazolam oral tablet 0.5 mg: Provider notified about script for this medication by this nurse. Provider asked this nurse to call the pharmacy and gave them his cell phone number for pharmacy to call him. The nurse called the pharmacy as instructed and gave them provider's number. The medication was pending. Review of the nursing progress notes for Resident #99 for 02/17/25 revealed no notes regarding the dose missing for Alprazolam oral tablet 0.5 mg, give one tablet by mouth at bedtime for anxiety. Interviews on 08/22/25 at 1:48 P.M. RDCS #502 verified there was no nursing note regarding Alprazolam on 02/14/15 or 02/17/25. It appeared no action was taken until late 02/15/25. There was a delay in Resident #99 receiving Alprazolam. This deficiency represents noncompliance investigated under Complaint Numbers 1401397 (OH00163878) and 1401401 (OH00162944).		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **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 proper infection control with Resident #69 during incontinence care. This affected one (Resident #69) of one resident reviewed for incontinence care and had the potential to affect six additional (Residents #1, #22, #42, #55, #59, and #77) whom required incontinence care on the Certified Nursing Assistant's (CNA) #365's assignment. The facility census was 86. Findings include: Review of the medical record for Resident #69 revealed an admission date of 09/19/23. Diagnoses included type II diabetes, Alzheimer's disease, encephalopathy, morbid obesity, overactive bladder and depression. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #69 had impaired cognition. The resident was dependent on staff for eating, toileting, showering and dressing. Resident #69 was incontinent of bowel and bladder. Observation on 08/20/25 at 9:20 A.M. of incontinence care with Resident #69, with CNA #365, revealed she gathered the incontinence supplies, washed her hands and donned gloves. CNA #365 removed Resident #69's brief and began providing care. CNA# 365 finished cleaning Resident #69 applied a clean brief and continued to reposition and adjust the bed by touching the remote with the same soiled gloves. CNA #365 removed her gloves and washed her hands and left the room. Interview on 08/20/25 at 9:29 A.M. with CNA #369 stated since the gloves were not visibly dirty, she did not have to change them while repositioning Resident #69 or adjusting her bed. Review of the facility policy titled Incontinence Care, revised March 2022, revealed the procedure stated to clean and dry the resident, replace and drape the resident as requested, dispose of gloves, perform hand hygiene, and ensure call light is in place. This deficiency represents noncompliance identified under Complaint Number 1401393 (OH00162964) and 1401394 (OH00163002).		