STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366495	A. Building B. Wing	04/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenue at Brooklyn	4700 Idlewood Drive Brooklyn, OH 44144

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on observation, medical record review, resident interview, family interview, staff interview, and review of the facility policy, the facility failed to treat Resident #24 with dignity and respect during an interview. This affected one resident (#24) of three residents reviewed for abuse. The facility census was 98. Findings include: Record review for Resident #24 revealed an admitted [DATE]. Diagnosis included hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side. Review of the Admission Minimal Data Set (MDS) assessment dated [DATE] revealed Resident #24 was cognitively intact. Resident #24 had clear speech and was usually understood and was able to understand others. Resident #24 had impairment on one side of the upper extremity and both sides of the lower extremities. Resident #24 used a wheelchair for mobility, required setup or clean up assist for eating, dependent for toileting, bed mobility, transfers, and substantial/maximum assist for personal hygiene. Review of the care plan for Resident #24 dated 03/21/24 revealed Resident #24 was usually understood. Interventions included encouraging the resident to continue stating thoughts even if the resident was having difficulty. Focus on a word or phrase that makes sense or responds to the feeling resident is trying to express. Encourage the resident to take her time expressing her wants and needs. Review of the nursing progress notes for Resident #24 revealed no documentation in the progress notes from 03/23/24 through 03/26/23. Observation on 03/27/24 at 4:29 P.M. revealed Resident #24's daughter was visiting. Resident #24 was sitting up in bed. Resident #24 revealed she was upset about an incident with staff that occurred, and no one talked to her about it. Resident #24's daughter revealed she was communicating with the Director of Nursing (DON) via text about their concern, and the DON never came to talk to her or Resident #24 after expressing her concern. Resident #24's daughter requested that the surveyor look at the communication via text between her and DON. Review of the phone text dated 03/26/24 at 3:42 P.M. text titled to DON revealed Nobody is doing their job my mom said she was fighting with an aid the other night, but it was never reported. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the response from the DON dated 03/26/24 at 3:56 P.M. included, I did not hear about any interaction with staff and your mom would you like to meet with [Administrator] and I? Review of the response to DON from Resident #24's daughter dated 03/26/24 at 3:56 P.M. included, I am here now if available. Review of the response to the DON from Resident #24's daughter dated 03/26/24 at 4:36 P.M. included, ok well I guess you're not available, I will be back tomorrow. Review of the response from the DON dated 03/26/24 at 3:57 P.M. included, tomorrow is good, what time is best. Interview on 03/27/24 at 4:31 P.M. with Resident #24's daughter revealed she was upset, she had been there on this day since 2:55 P.M., no one called her or came to talk to her mom to see what happened. Interview on 03/27/24 between 4:33 P.M. and 5:11 P.M. with Resident #24 (daughter was present) revealed on third shift, Sunday night (03/24/24) two State tested Nurse Aides (STNAs) came in her room to assist her. Resident #24 revealed one of the STNA's started fighting with her; the STNA had her bed remote control. Resident #24 revealed she told the STNA to give her control. The STNA refused, and both her and the STNA began wrestling over the remote control. Resident #24 revealed the STNA then threw the remote at her and said, Here you can have your little remote. The STNA then turned to the second STNA and stated, I am done with her ugly ass. The second STNA then began laughing and as they walked out, the first STNA turned to Resident #24, put her two fingers up to her chest making the peace sign and said peace out and exited the room. Resident #24 identified the second STNA's first name. Resident #24 became tearful while discussing the incident and revealed she was mad; it gets hard when some people act tough against old people who can't help themselves. Resident #24 revealed the DON still did not come to talk to her about the incident. Observation on 03/27/24 at 5:11 P.M. as the surveyor was talking with Resident #24 and her daughter, the DON and Unit Manager Licensed Practical Nurse (LPN) #309 entered Resident #24's room. The DON confirmed she was aware of the text messages on Resident #24's daughters' phone and confirmed the texts were between her and Resident #24's daughter on the previous day. The DON stated to Resident #24 that she came in this morning and asked how things were going. The DON told Resident #24 that she got her a donut and repeated, don't you remember, I got you a donut? Resident #24 revealed to the DON, You did not tell me who you were. The DON revealed to Resident #24, I don't have to do that, I asked how things were going. Resident #24 repeated to the DON while crying, I did not know who you were. Resident #24 continued, So I did not tell you anything else because I did not know who you were. The DON stated to Resident #24, I said what are you upset about, and you said get out. The DON revealed she left the room. Resident #24 continued crying repeating, That's not fair, I didn't know she was the DON, you never said you were here to talk about me and my daughters' concerns. Resident #24 continued crying and repeating that was not fair then told the DON she was told by the staff she was the bad one and needed two staff on night shift to care for her. (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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Abuse Prohibition, revised October 2022, revealed types of abuse included physical assault - hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment. Mental/Emotional Abuse included humiliation, harassment, threats and punishment or deprivation or in any manner demean or humiliate the resident. Mental abuse may occur through verbal or non-verbal conduct which causes or has the potential to cause the resident to experience intimidation, fear, shame, humiliation, agitation, or degradation. Verbal Abuse included oral, written, or gestured language including but not limited to disparaging or derogatory terms directed to or within the residents hearing distance. This deficiency represents noncompliance investigated under Complaint Number OH00152016.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0562 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide immediate access to any resident. 37097 Based on observation, family interview, and staff interviews the facility failed to ensure phone calls were timely answered and addressed when transferred to nursing staff. This had the potential to affect all residents. The facility census was 81. Findings Include: Interview on 03/27/24 at 12:04 P.M. with Resident #42's daughter revealed when she calls the facility, she is transferred to the nurse's station. No staff answered her calls, so she leaves messages but never receives return calls. Observation on 03/27/24 at 12:44 P.M. revealed the facility's main phone number was called. Business Office Manager (BOM) #308, who had filled in as receptionist, answered and transferred the call to Resident #50's nursing station. At 12:48 P.M. BOM #308 came back on the line and transferred the call to a different station due to no answer. At 12:51 P.M. BOM #308 came back, said she would give the message to the nurse to return the call. The call was never returned. Interviews on 03/27/24 at 2:04 P.M. through 2:56 P.M. with Licensed Practical Nurse (LPN) #317, Registered Nurse (RN) #318, and RN #319 revealed they were with residents, in resident rooms, and on the hall. They were never at the nurses' station to answer calls. Families called all day. There was no time to take or answer phone calls. Interview on 04/01/24 at 3:29 P.M. with BOM #308 confirmed she had left a written message at the nurses' station to call back regarding Resident #50. BOM #30 verified the facility had received that complaint from families before. Interview on 04/01/24 at 3:33 P.M. with the Administrator verified the concern regarding nurses not answering or not responding to phone calls had been brought up before and discussed at staff meetings, and the facility was trying to address the issue. This deficiency represents non-compliance investigated under Complaint Number OH00152016.

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on medical record review, phone text review, resident interview, family interview, staff interview, review of the facility time sheets, and review of the policy, the facility failed to implement their abuse policy after allegations of staff-to-resident abuse. This affected one resident (#24) of three residents reviewed for abuse. The facility census was 98. Findings include: Record review for Resident #24 revealed an admitted [DATE]. Diagnosis included hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side. Review of the Admission Minimal Data Set (MDS) assessment dated [DATE] revealed Resident #24 was cognitively intact. Resident #24 had clear speech and was usually understood and was able to understand others. Resident #24 had impairment on one side of the upper extremity and both sides of the lower extremities. Resident #24 used a wheelchair for mobility, required setup or clean up assist for eating, dependent for toileting, bed mobility, transfers, and substantial/maximum assist for personal hygiene. Review of the care plan for Resident #24 dated 03/21/24 revealed Resident #24 was usually understood. Interventions included encouraging resident to continue stating thoughts even if resident was having difficulty. Focus on a word or phrase that makes sense or responds to the feeling the resident is trying to express. Encourage the resident to take her time expressing her wants and needs. Review of the nursing progress notes for Resident #24 revealed no documentation from 03/23/24 through 03/26/23. Observation on 03/27/24 at 4:29 P.M. revealed Resident #24's daughter was visiting. Resident #24 was sitting up in bed. Resident #24 revealed she was upset about an incident with staff that occurred, and no one talked to her about it. Resident #24's daughter revealed she was communicating with the Director of Nursing (DON) via text about their concern, and the DON never came to talk to her or Resident #24 after expressing her concern to the DON. Resident #24's daughter requested surveyor to look at the communication via text between her and DON. Review of the phone text dated 03/26/24 at 3:42 P.M. to the DON revealed Nobody is doing their job my mom said she was fighting with an aid the other night, but it was never reported. Review of the response from the DON dated 03/26/24 at 3:56 P.M. included, I did not here about any interaction with staff and your mom would you like to meet with {Administrator] and I? Review of the response to the DON from Resident #24's daughter dated 03/26/24 at 3:56 P.M. included, I am here now if available. Review of the response to the DON from Resident #24's daughter dated 03/26/24 at 4:36 P.M. included, ok well I guess you're not available, I will be back tomorrow. (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the response from the DON dated 03/26/24 at 4:37 P.M. included, tomorrow is good, what time is best. Interview on 03/27/24 at 4:31 P.M. with Resident #24's daughter revealed she was upset. She had been there on this day since 2:55 P.M., no one called her or came to talk to her mom to see what happened. Interview on 03/27/24 between 4:33 P.M. and 5:11 P.M. with Resident #24 (daughter was present) revealed on third shift Sunday night (03/24/24) two state tested nurse aides (STNAs) came in her room to assist her. Resident #24 revealed one of the STNA's started fighting with her. The STNA had her bed remote control. Resident #24 revealed she told the STNA to give her the control. The STNA refused and both her and the STNA began wrestling over the remote control. Resident #24 revealed the STNA then threw the remote at her and said, Here you can have your little remote. The STNA then turned to the second STNA and stated, I am done with her ugly ass. The second STNA then began laughing and as they walked out, the first STNA turned to Resident #24, put her two fingers up to her chest making the peace sign and said, peace out and exited the room. Resident #24 identified the second STNA's first name. Resident #24 became tearful while discussing the incident and revealed she was mad; it gets hard when some people act tough against old people who can't help themselves. Resident #24 revealed the DON still did not come to talk to her about the incident. Observation on 03/27/24 at 5:11 P.M. and 6:00 P.M. revealed as the surveyor was talking with Resident #24 and her daughter, the DON and Unit Manager Licensed Practical Nurse (LPN) #309 entered Resident #24's room. The DON confirmed she was aware of the text messages on Resident #24's daughter's phone and confirmed the texts were between her and Resident #24's daughter from the previous day. The DON confirmed the text message included an allegation of Resident #24 fighting with an aide the other night. The DON verified she did not talk to Resident #24 or Resident #24's daughter on 03/26/24 after receiving the text message regarding Resident #24 fighting with an aide. The DON confirmed an investigation was not initiated on 03/26/24, and she did not attempt to talk to Resident #24 regarding the allegation until 03/27/24 around 7:45 A.M. to 8:00 A.M. Interviews on 03/28/24 between 9:40 A.M. and 2:00 P.M. with the DON confirmed the two STNA's that worked Sunday night, 03/24/24, with Resident #24 were STNA #327 and STNA #328. The DON confirmed STNA #327 also worked 03/26/24. STNA #327 was the STNA Resident #24 identified by her first name. The facility failed to timely report the allegation to the state agency, failed to immediately suspend the alleged perpetrators, and failed to start an immediate investigation. Record review of the facility time sheets revealed STNA #327 punched in on 03/24/24 (Sunday night) from 5:45 P.M. until 6:00 A.M. and on 03/26/24 from 6:30 P.M. until 6:45 A.M. Record review of the facility time sheets revealed STNA #328 punched in on 03/24/24 (Sunday night) from 6:00 P.M. until 6:15 A.M. (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Abuse Prohibition, revised October 2022, revealed types of abuse included physical assault - hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment. Mental/Emotional Abuse included humiliation, harassment, threats and punishment or deprivation or in any manner demean or humiliate the resident. Mental abuse may occur through verbal or non-verbal conduct which causes or has the potential to cause the resident to experience intimidation, fear, shame, humiliation, agitation, or degradation. Verbal Abuse included oral, written, or gestured language including but not limited to disparaging or derogatory terms directed to or within the residents hearing distance. Guidelines for an Investigation included to immediately assess the resident at the time of discovery of the alleged abuse. Maintain resident's protection during the investigation. An allegation toward any staff member or visitor will result in immediate removal from facility pending investigation. Notify the Attending Physician and resident's legal responsible party. Interview all staff, family members, or visitors that were involved with the incident or may have knowledge of the incident. Document and obtain written, signed, and dated statements. Social Services will provide support services and implement an interdisciplinary plan of care. All alleged violations are reported immediately but no later than two hours if the alleged violation involves abuse or results in serious bodily injury. No later than 24 hours if the alleged violation involves neglect, exploitation, mistreatment, or misappropriation of resident property, and does not result in serious bodily injury. Required to report Bullying - aggressive behavior in which someone intentionally and repeatedly causes another resident mental anguish or discomfort. This deficiency is an incidental finding identified during the complaint investigation.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on medical record review, phone text review, resident interview, family interview, staff interview, and review of the policy, the facility failed to timely report an allegation of staff-to-resident abuse to the state agency. This affected one resident (#24) of three residents reviewed for abuse. The facility census was 98. Findings include: Record review for Resident #24 revealed an admitted [DATE]. Diagnosis included hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side. Review of the Admission Minimal Data Set (MDS) assessment dated [DATE] revealed Resident #24 was cognitively intact. Resident #24 had clear speech and was usually understood and was able to understand others. Resident #24 had impairment on one side of the upper extremity and both sides of the lower extremities. Resident #24 used a wheelchair for mobility, required setup or clean up assist for eating, dependent for toileting, bed mobility, transfers, and substantial/maximum assist for personal hygiene. Review of the care plan for Resident #24 dated 03/21/24 revealed Resident #24 was usually understood. Interventions included encouraging resident to continue stating thoughts even if resident was having difficulty. Focus on a word or phrase that makes sense or responds to the feeling the resident is trying to express. Encourage the resident to take her time expressing her wants and needs. Review of the nursing progress notes for Resident #24 revealed no documentation from 03/23/24 through 03/26/23. Observation on 03/27/24 at 4:29 P.M. revealed Resident #24's daughter was visiting. Resident #24 was sitting up in bed. Resident #24 revealed she was upset about an incident with staff that occurred, and no one talked to her about it. Resident #24's daughter revealed she was communicating with the Director of Nursing (DON) via text about their concern, and the DON never came to talk to her or Resident #24 after expressing her concern to the DON. Resident #24's daughter requested surveyor to look at the communication via text between her and DON. Review of the phone text dated 03/26/24 at 3:42 P.M. to the DON revealed Nobody is doing their job my mom said she was fighting with an aid the other night, but it was never reported. Review of the response from the DON dated 03/26/24 at 3:56 P.M. included, I did not here about any interaction with staff and your mom would you like to meet with {Administrator] and I? Review of the response to the DON from Resident #24's daughter dated 03/26/24 at 3:56 P.M. included, I am here now if available. Review of the response to the DON from Resident #24's daughter dated 03/26/24 at 4:36 P.M. included, ok well I guess you're not available, I will be back tomorrow. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the response from the DON dated 03/26/24 at 4:37 P.M. included, tomorrow is good, what time is best. Interview on 03/27/24 at 4:31 P.M. with Resident #24's daughter revealed she was upset. She had been there on this day since 2:55 P.M., no one called her or came to talk to her mom to see what happened. Interview on 03/27/24 between 4:33 P.M. and 5:11 P.M. with Resident #24 (daughter was present) revealed on third shift Sunday night (03/24/24) two state tested nurse aides (STNAs) came in her room to assist her. Resident #24 revealed one of the STNA's started fighting with her. The STNA had her bed remote control. Resident #24 revealed she told the STNA to give her the control. The STNA refused and both her and the STNA began wrestling over the remote control. Resident #24 revealed the STNA then threw the remote at her and said, Here you can have your little remote. The STNA then turned to the second STNA and stated, I am done with her ugly ass. The second STNA then began laughing and as they walked out, the first STNA turned to Resident #24, put her two fingers up to her chest making the peace sign and said, peace out and exited the room. Resident #24 identified the second STNA's first name. Resident #24 became tearful while discussing the incident and revealed she was mad; it gets hard when some people act tough against old people who can't help themselves. Resident #24 revealed the DON still did not come to talk to her about the incident. Observation on 03/27/24 at 5:11 P.M. and 6:00 P.M. revealed as the surveyor was talking with Resident #24 and her daughter, the DON and Unit Manager Licensed Practical Nurse (LPN) #309 entered Resident #24's room. The DON confirmed she was aware of the text messages on Resident #24's daughter's phone and confirmed the texts were between her and Resident #24's daughter from the previous day. The DON confirmed the text message included an allegation of Resident #24 fighting with an aide the other night. The DON verified she did not talk to Resident #24 or Resident #24's daughter on 03/26/24 after receiving the text message regarding Resident #24 fighting with an aide. The DON confirmed an investigation was not initiated on 03/26/24, and she did not attempt to talk to Resident #24 regarding the allegation until 03/27/24 around 7:45 A.M. to 8:00 A.M. Review of the facility self-reported incident (SRI) tracking ID: 245693 revealed a creation date of 3/27/2024 at 6:27:38 P.M. Record review revealed the SRI was not submitted until after surveyor intervention. Interviews on 03/28/24 between 9:40 A.M. and 2:00 P.M. with the DON confirmed the two STNA's that worked Sunday night, 03/24/24, with Resident #24 were STNA #327 and STNA #328. The DON confirmed STNA #327 also worked 03/26/24. STNA #327 was the STNA Resident #24 identified by her first name. The facility failed to timely report the allegation to the state agency. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Abuse Prohibition revised October 2022 revealed types of abuse included physical assault - hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment. Mental/Emotional Abuse included humiliation, harassment, threats and punishment or deprivation or in any manner demean or humiliate the resident. Mental abuse may occur through verbal or non-verbal conduct which causes or has the potential to cause the resident to experience intimidation, fear, shame, humiliation, agitation, or degradation. Verbal Abuse included oral, written, or gestured language including but not limited to disparaging or derogatory terms directed to or within the residents hearing distance. Reporting requirements included all alleged violations of abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property. All alleged violations are reported immediately but no later than two hours if the alleged violation involves abuse or results in serious bodily injury. No later than 24 hours if the alleged violation involves neglect, exploitation, mistreatment, or misappropriation of resident property, and does not result in serious bodily injury. Required to report Bullying - aggressive behavior in which someone intentionally and repeatedly causes another resident mental anguish or discomfort. This deficiency is an incidental finding identified during the complaint investigation.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on medical record review, phone text review, resident interview, family interview, staff interview, and review of the policy, the facility failed to timely investigate an allegation of staff-to-resident abuse. This affected one resident (#24) of three residents reviewed for abuse. The facility census was 98. Findings include: Record review for Resident #24 revealed an admitted [DATE]. Diagnosis included hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side. Review of the Admission Minimal Data Set (MDS) assessment dated [DATE] revealed Resident #24 was cognitively intact. Resident #24 had clear speech and was usually understood and was able to understand others. Resident #24 had impairment on one side of the upper extremity and both sides of the lower extremities. Resident #24 used a wheelchair for mobility, required setup or clean up assist for eating, dependent for toileting, bed mobility, transfers, and substantial/maximum assist for personal hygiene. Review of the care plan for Resident #24 dated 03/21/24 revealed Resident #24 was usually understood. Interventions included encouraging resident to continue stating thoughts even if resident was having difficulty. Focus on a word or phrase that makes sense or responds to the feeling the resident is trying to express. Encourage the resident to take her time expressing her wants and needs. Review of the nursing progress notes for Resident #24 revealed no documentation from 03/23/24 through 03/26/23. Observation on 03/27/24 at 4:29 P.M. revealed Resident #24's daughter was visiting. Resident #24 was sitting up in bed. Resident #24 revealed she was upset about an incident with staff that occurred, and no one talked to her about it. Resident #24's daughter revealed she was communicating with the Director of Nursing (DON) via text about their concern, and the DON never came to talk to her or Resident #24 after expressing her concern to the DON. Resident #24's daughter requested surveyor to look at the communication via text between her and DON. Review of the phone text dated 03/26/24 at 3:42 P.M. to the DON revealed Nobody is doing their job my mom said she was fighting with an aid the other night, but it was never reported. Review of the response from the DON dated 03/26/24 at 3:56 P.M. included, I did not here about any interaction with staff and your mom would you like to meet with {Administrator] and I? Review of the response to the DON from Resident #24's daughter dated 03/26/24 at 3:56 P.M. included, I am here now if available. Review of the response to the DON from Resident #24's daughter dated 03/26/24 at 4:36 P.M. included, ok well I guess you're not available, I will be back tomorrow. (continued on next page)

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	366495	A. Building B. Wing	04/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenue at Brooklyn	4700 Idlewood Drive Brooklyn, OH 44144

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the response from the DON dated 03/26/24 at 4:37 P.M. included, tomorrow is good, what time is best. Interview on 03/27/24 at 4:31 P.M. with Resident #24's daughter revealed she was upset. She had been there on this day since 2:55 P.M., no one called her or came to talk to her mom to see what happened. Interview on 03/27/24 between 4:33 P.M. and 5:11 P.M. with Resident #24 (daughter was present) revealed on third shift Sunday night (03/24/24) two state tested nurse aides (STNAs) came in her room to assist her. Resident #24 revealed one of the STNA's started fighting with her. The STNA had her bed remote control. Resident #24 revealed she told the STNA to give her the control. The STNA refused and both her and the STNA began wrestling over the remote control. Resident #24 revealed the STNA then threw the remote at her and said, Here you can have your little remote. The STNA then turned to the second STNA and stated, I am done with her ugly ass. The second STNA then began laughing and as they walked out, the first STNA turned to Resident #24, put her two fingers up to her chest making the peace sign and said, peace out and exited the room. Resident #24 identified the second STNA's first name. Resident #24 became tearful while discussing the incident and revealed she was mad; it gets hard when some people act tough against old people who can't help themselves. Resident #24 revealed the DON still did not come to talk to her about the incident. Observation on 03/27/24 at 5:11 P.M. and 6:00 P.M. revealed as the surveyor was talking with Resident #24 and her daughter, the DON and Unit Manager Licensed Practical Nurse (LPN) #309 entered Resident #24's room. The DON confirmed she was aware of the text messages on Resident #24's daughter's phone and confirmed the texts were between her and Resident #24's daughter from the previous day. The DON confirmed the text message included an allegation of Resident #24 fighting with an aide the other night. The DON verified she did not talk to Resident #24 or Resident #24's daughter on 03/26/24 after receiving the text message regarding Resident #24 fighting with an aide. The DON confirmed an investigation was not initiated on 03/26/24, and she did not attempt to talk to Resident #24 regarding the allegation until 03/27/24 around 7:45 A.M. to 8:00 A.M. Interviews on 03/28/24 between 9:40 A.M. and 2:00 P.M. with the DON confirmed the two STNA's that worked Sunday night, 03/24/24, with Resident #24 were STNA #327 and STNA #328. The DON confirmed STNA #327 also worked 03/26/24. STNA #327 was the STNA Resident #24 identified by her first name. The failed to immediately suspend the alleged perpetrators and failed to start an immediate investigation. Review of the facility policy titled, Abuse Prohibition, revised October 2022, revealed types of abuse included physical assault - hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment. Mental/Emotional Abuse includes humiliation, harassment, threats and punishment or deprivation or in any manner demean or humiliate the resident. Guidelines for an Investigation included to immediately assess the resident at the time of discovery of the alleged abuse. Maintain resident's protection during the investigation. Notify the Attending Physician and resident's legal responsible party. Interview all staff, family members, or visitors that were involved with the incident or may have knowledge of the incident. Document and obtain written, signed, and dated statements. Social Services will provide support services and implement an interdisciplinary plan of care. This deficiency is an incidental finding identified during the complaint investigation.

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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 - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37097 Based on observation, interview, and record review the facility failed to ensure Resident #57 was consistently gotten out of bed. This affected one resident (#57) of three residents reviewed for activities of daily living provided for dependent residents. The Facility census was 81. Findings included: Review of the medical record for Resident #57 revealed an admitted [DATE] with diagnoses including encephalopathy, gastrostomy, dysphagia, pneumonia, blindness left eye, and genetic related intellectual disability. Review of the modification of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #57 was rarely or never understood. Resident #57's cognitive skills for daily decision making were severely impaired. Review of the social services progress note dated 11/14/23 revealed Resident #57's previous facility stated the resident loved music, joking around, and tried to be sociable. It was stated he does not like to be touched because it caused irritability and discomfort. Review of the social service progress notes dated 02/01/24 at 11:57 A.M. revealed at the care meeting with the guardian, social worker, and administrative nurse, Resident #57 being up in his chair frequently was discussed. Multiple observations on 03/26/24 and 03/27/24 revealed Resident #57 lying in bed, his head was slightly tilted upwards, his eyes were open and looking at the ceiling. The television was on, but the resident was not paying attention to it. The only movement Resident #57 had was to move his head towards the speaker when his name was mentioned. No attempts to communicate either with sound or gestures were observed. Interview on 03/27/24 at 10:46 A.M. with State tested Nurse Aide (STNA) #320 revealed Resident #57 was lying in bed. The STNA stated she sometimes got him out of bed. It depended on which STNA was working if the resident got up or not. STNA #320 stated some STNA's did not want to get him up. STNA #320 revealed Resident #57 never refused to get up, he never went to any activities and when he did get up, he was never taken out of his room. Interview on 03/28/24 at 11:43 A.M. with the Unit Manager, Licensed Practical Nurse (LPN) #309 revealed she was not sure when Resident #57 was last out of bed. Interview on 03/28/24 at 4:21 PM. with LPN #313 revealed Resident #57 was gotten out of bed occasionally. Maybe once or twice a week. Interview on 03/28/24 at 4:31 P.M. with STNA #314 revealed on shower days Resident #57 was gotten up into his chair. After his shower, he remained up in his room for a couple of hours. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents non-compliance investigated under Master Complaint Number OH00152261 and Complaint Number OH00152016.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37097 Based on observation, interview, and record review the facility failed to ensure Resident #57 was consistently provided with activities that met his needs. This affected one resident (#57) of three residents reviewed activities. The facility census was 81. Findings include: Review of the medical record for Resident #57 revealed an admitted [DATE] with diagnoses including encephalopathy, gastrostomy, dysphagia, pneumonia, blindness left eye, and genetic related intellectual disability. Review of the modification of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #57 was rarely or never understood. Resident #57's cognitive skills for daily decision making were severely impaired. Review of the plan of care for Resident #57 revealed plan of care for activities. Review of the social services progress note dated 11/14/23 revealed Resident #57's previous facility stated the resident loved music, joking around, and tried to be sociable. It was stated he does not like to be touched because it caused irritability and discomfort. Review of the social service progress notes for 02/01/24 at 11:57 A.M. revealed at the care meeting with the guardian, social worker, and administrative nurse the resident being up in his chair frequently was discussed. The guardian expressed she would like the resident to join in group activities for socialization. The activities director was notified for a room visit. Multiple observations on 03/26/24 and 03/27/24 revealed Resident #57 lying in bed, his head was slightly tilted upwards, his eyes were open and looking at the ceiling. The television was on, but the resident was not paying attention to it. The only movement Resident #57 had was to move his head towards the speaker when his name was mentioned. No attempts to communicate either with sound or gestures were observed. Observation on 03/26/24 of Resident #57's room revealed a sign posted on the wall stating: Resident #57 enjoys listening to music (old school, rap, gospel, country, sports radio, current R&B). Resident #57 enjoys books read to him (3 Little Pigs, Hungry Caterpillar, [NAME] Gat Gruff, Little Red [NAME]). Observation on 03/26/24 of Resident #57's room revealed the books mentioned were available in a basket in the resident's room. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/27/24 at 10:46 A.M. with State tested Nurse Aide (STNA) #320 revealed Resident #57 was lying in bed. The STNA stated she sometimes got him out of bed. It depended on which STNA was working if the resident got up or not. STNA #320 stated some STNA's did not want to get him up. STNA #320 revealed Resident #57 never refused to get up, he never went to any activities and when he did get up, he was never taken out of his room. Interview on 03/28/24 at 11:43 A.M. with the Unit Manager, Licensed Practical Nurse (LPN) #309 revealed she was not sure when Resident #57 was last out of bed. Interview on 03/28/24 at 11:52 A.M. with Activities Director #310 revealed she had tried doing music with Resident #57. He didn't like headphones and had rolled away from the radio. Activities had tried bringing him to activities, but the resident didn't like it. Now they would go in and put music on the television. The resident was on the room visits list. Activities Director #310 had not tried reading the books to the resident. Review of the Room Visit Schedule revealed Resident #57's room was scheduled for Monday visits. This deficiency is an incidental finding identified during the complaint investigation.