

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  366495	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/18/2024
NAME OF PROVIDER OR SUPPLIER  Avenue at Brooklyn		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 37095</p> <p>Based on observation, record review, and interview, the facility failed to securely administer medications according to professional standards. This affected four (Resident #78, #18, #54, and #84) of seven residents reviewed for medication administration. The total census was 93.</p> <p>Findings include:</p> <p>1. Observation of Resident #78 on 06/18/24 at 8:29 A.M. revealed there was an unattended medication cup containing six pills on her bedside table. The resident was in bed. Interview with Resident #78 at this time revealed she was able to take medications on her own, but could not reach them where they were on her table.</p> <p>Record review of Resident #78 revealed an admitted [DATE] and diagnoses including anxiety disorder and depression. An active order dated 04/05/24 indicated the resident was not to self-administer medications.</p> <p>2. Observation of Resident #18 on 06/18/24 at 8:31 A.M. revealed there was an unattended medication cup containing six pills on her bedside table. The resident was asleep in bed.</p> <p>Record review of Resident #18 revealed an admitted [DATE] and diagnoses including spinal stenosis, anemia, and human immunodeficiency virus. Resident #18's orders did not reference self-administration of medication, and a self-administration assessment dated [DATE] Resident #18 could not safely self-administer medications.</p> <p>3. Observation of Resident #54 on 06/18/24 at 8:36 A.M. revealed there was an unattended medication cup containing two pills on her bedside table. The resident was asleep in bed.</p> <p>Record review of Resident #54 revealed an admitted [DATE] and diagnoses including Alzheimer's dementia, diabetes, and osteoporosis. An active order dated 02/12/24 indicated Resident #54 was not to self-administer medications.</p> <p>(continued on next page)</p>

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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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. Observation of Resident #84 on 06/18/24 at 8:38 A.M. revealed there was an unattended medication cup containing five pills on her bedside table. The resident was in bed. Interview with Resident #54 at this time revealed it was a common occurrence for nurses to leave medications on her table for her to take later. She noted that she needed applesauce to help take her pills due to difficulty swallowing. Observation at this time revealed no applesauce within reach of the resident.</p> <p>Record review of Resident #84 revealed an admitted [DATE] and diagnoses including anxiety disorder, dementia, and mild cognitive impairment. An order dated 12/15/23 indicated Resident #84 was not to self-administer medications.</p> <p>Interview with Registered Nurse (RN) #401 on 06/18/24 at 8:43 A.M. confirmed the above observations. RN #401 said when he was hired he was taught to leave medications at the bedside for residents, and that it was necessary because many residents would not accept their pills before breakfast. He was unsure if any of the observed residents had orders or assessments indicating they were safe to self-administer medications.</p> <p>Interview with the Director of Nursing on 06/18/24 at 1:53 P.M. confirmed the above record reviews. She confirmed nurses were supposed to monitor residents when administering medications.</p> <p>Record review of the facility's medication administration policy dated 08/2014 revealed it did not specifically mention a need for nurses to observe residents when administering medications.</p> <p>This deficiency represents noncompliance investigated under Complaint Number OH00154232 and OH00154160.</p>		