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	08/06/2024

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on closed medical record review, review of a Prehospital Care Report Summary/EMS Run report, review of the American Heart Association Cardiopulmonary Resuscitation (CPR) guidelines, facility policy review, interview with Emergency Medical Service (EMS) staff, staff interview and family interview, the facility failed to ensure all staff provided effective cardiopulmonary resuscitation (CPR). Additionally, the facility failed to ensure crash carts (a cart that holds equipment and includes a backboard, a hard, flat surface to facilitate effective chest compressions and an ambu bag, used to provide mechanical ventilation) in emergency resuscitation efforts were readily available and accessible during a cardiac emergency. This resulted in Immediate Jeopardy and actual harm/subsequent death when staff failed to initiate effective CPR for Resident #101 who experienced a cardiac emergency on [DATE]. At the initiation of the cardiac emergency, Resident #101 ' s family was with the resident in her room and yelled for help. Responding staff, Licensed Practical Nurse (LPN) #206 and State tested Nursing Assistant (STNA) #310, entered Resident #101 ' s room and found the resident was vomiting. LPN #206 left the room, indicating she was calling 911, and STNA #310 left to have LPN #207 print transfer documents (for the resident to go to the hospital). LPN #207 then returned to Resident #101's room at which time the resident was noted to lose consciousness and pulse. LPN #207 directed STNA #310 to get the crash cart and LPN #207 initiated CPR, with Resident #101 remaining in bed on her mattress. STNA #310 was unable to immediately locate the crash cart and EMS staff had arrived to the resident by the time STNA #310 located a crash cart on the secured unit of the facility and returned to Resident #101 ' s room. Without the presence of a crash cart, LPN #207 provided CPR to Resident #101 for approximately four minutes on her mattress (which decreased the effectiveness of CPR) and failed to provide any type of mechanical ventilation (via ambu bag) during this time. Upon EMS arrival, Resident #101 remained without a pulse or respirations. Resident #101 was moved to the EMS cot, a LUCAS device (provides mechanical chest compressions) was applied, and CPR was continued. Resident #101 was transferred to the hospital and subsequently expired on [DATE]. This affected one resident (#101) of one resident reviewed for CPR. The facility census was 95. (continued on next page)

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

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 12:44 P.M., the Administrator, Director of Nursing (DON), and Regional Registered Nurse (RRN) #920 were notified Immediate Jeopardy began on [DATE] when Resident #101 experienced a cardiac emergency. Facility staff left Resident #101 in her room, with her son, while LPN #206 called 911 and STNA #310 had LPN #207 print transfer documents. Resident #101 subsequently went into cardiac arrest. LPN #207 initiated CPR on a mattress without necessary supplies, including a backboard for support to provide good quality/effective chest compressions and an ambu bag to provide ventilation. Additional staff did not respond to provide assistance with CPR and staff were unable to immediately locate the crash cart. EMS arrived and assumed care for Resident #101, who was without a pulse or respirations. Resident #101 was admitted to the hospital and subsequently expired on [DATE]. The Immediate Jeopardy was removed on [DATE] when the facility implemented the following corrective actions: Resident #101 was transferred to the hospital on [DATE] and expired on [DATE]. On [DATE], the Administrator, DON and RRN #920 conducted an investigation into the incident on [DATE] and determined the facility did not provide timely CPR. On [DATE], the DON provided education to all licensed nursing staff, including 10 Registered Nurses (RN) and 18 Licensed Practical Nurses (LPN), on crash cart locations and the Cardiopulmonary Resuscitation Policy and Procedure. This was completed in-person and via telephone. On [DATE], all residents with advance directives for a Full Code status had vital signs assessed by the DON or designee and found to be stable. Medical Director (MD) #500 was updated on resident status and no negative outcomes were identified. Further assessment on [DATE] by the DON of residents who expired in the past 60 days revealed no areas of concern related to CPR. On [DATE], the DON educated all non-licensed facility staff on the CPR policy and procedure and the location of crash carts. This education included 16 dietary staff, 12 housekeeping staff, two activities staff, five therapy staff, nine department heads and four receptionists. Beginning on [DATE], the DON or RRN #920 would ensure all agency staff were educated on the CPR policy and procedure and location of crash carts prior to working a shift. Beginning on [DATE], the DON or designee would audit all crash cart locations five times weekly, and with any use, for four weeks. Beginning on [DATE], the DON or designee would audit all residents who required CPR to ensure appropriate CPR procedures were followed per facility policy, five times weekly for four weeks. On [DATE], an Ad Hoc Quality Assurance Performance Improvement (QAPI) committee meeting was held to review the CPR policy and procedure, education to be provided to facility staff and the location of crash carts. In attendance were the Administrator, DON, RRN #920 and MD #500. All audit findings of concern would be immediately addressed and reported to the QAPI committee for further review and prompt response and resolution. The Administrator and/or designee would monitor this area for ongoing compliance. (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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interviews on [DATE] between 5:25 P.M. and 5:31 P.M. with LPN #207, LPN #289, LPN #940, LPN #942 and STNA #942 confirmed they each received re-education on the facility's CPR policy and procedure and the locations of crash carts. Although the Immediate Jeopardy was removed on [DATE], the facility remained out of compliance at a Severity Level 2 (no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy) as the facility was still in the process of implementing their corrective action plan and monitoring to ensure on-going compliance. Findings include: Review of Resident #101's closed medical record revealed the resident was admitted to the facility on [DATE] and discharged on [DATE]. Resident #101 had diagnoses including encounter for surgical aftercare following surgery on the digestive system and ileostomy. Review of the care plan dated [DATE] revealed Resident #101 had a Full Code status (advance directives). Interventions included performing CPR in the event of cardiopulmonary arrest. Review of the Medicare five-day Minimum Data Set (MDS) dated [DATE] revealed Resident #101 was cognitively intact. The assessment revealed Resident #101 was independent with eating, required substantial/maximum (staff) assistance with toileting, supervision or touch assistance with bed mobility and partial moderate assistance with sit to stand and chair transfers. The MDS identified Resident #101 had no condition or chronic disease that may result in a life expectancy of less than six months. Resident #101 had a recent surgery requiring active skilled nursing facility care. Review of the progress note dated [DATE] at 2:30 P.M. and created by LPN #206 revealed Resident #101's call light was ringing, staff member answered the light, resident stated she was okay and noted her son was present. This nurse was informed by another staff member that the resident was observed ambulating from the bathroom back to her bed at that time. Resident #101 was now sitting upright in bed. Review of the progress note dated [DATE], created at 7:17 P.M., with an effective time of 3:10 P.M. and completed by LPN #206 revealed Resident #101 emptied her ileostomy with no apparent issues. Around 3:25 P.M., Resident #101 was back in bed when the nurse heard yelling coming from the room. Resident #101's son was screaming. The nurse and another staff member ran into the room to assess the situation. Resident #101's son was holding the trash can up to the resident's mouth. Resident #101 was vomiting at this time. Resident #101 looked pale, so this nurse felt for a pulse. The note indicated the resident's pulse was weak and thready. LPN #206 sent another staff member out to get assistance. Other nurses assisted by placing a call to 911 and obtaining proper paperwork for EMS. The note indicated the resident lost consciousness, there was no pulse and CPR was initiated. EMS arrived and continued with CPR. Resident #101's pulse was restored as paramedics were leaving the facility. Physician (MD) notified of events. Review of the progress note dated [DATE] at 10:12 A.M. and completed by LPN #213, revealed a call was placed to the hospital and Resident #101 was admitted to telemetry unit (provides continuous cardiac monitoring). (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the draft progress note dated [DATE] at 6:31 P.M. and completed by LPN #207, revealed an STNA came to the nursing desk and asked this nurse to print out paperwork and face sheet for a hospital transfer. After printing out papers, this nurse went to see if assistance could be provided. Upon entering Resident #101's room, the resident was found with her eyes closed and had a faint pulse. Resident #101 began to dry heave and the nurse placed the garbage can in front of the resident. After putting the garbage can in front of Resident #101, the resident became unresponsive, with no pulse. This nurse immediately put the head of the bed down and immediately started CPR, while another nurse called 911. This nurse, after starting CPR, yelled for the crash cart while CPR continued. Another nurse walked in the room for assistance while CPR continued. The crash cart arrived in the room. As the crash cart was in the room, EMS arrived at the facility. The draft progress note documented after paramedics assessed the resident for a pulse, Resident #101 had a faint pulse and no respirations. While this nurse and paramedics moved resident from the bed to the gurney, Resident #101 had no pulse. CPR continued on the gurney until paramedics put the LUCAS machine on and was doing compressions. Resident #101 left the facility with EMS and was transported to the hospital. Review of the Prehospital Care Report/EMS Run Report summary revealed EMS was called on [DATE] at 3:24 P.M. for Resident #101. The dispatch reason indicated provider impression was cardiac arrest. EMS was onsite at 3:32 P.M. Additional information indicated the healthcare provider (non 911 responder) first initiated CPR, manual compressions provided. The estimated time of arrest was 3:24 P.M. and the time of first CPR was 3:25 P.M. EMS left the scene at 3:45 P.M. and Resident #101 was receiving ongoing resuscitation in the Emergency Department (ED). Further review revealed EMS was dispatched for an unresponsive female who was vomiting. Upon arrival, nursing staff were performing CPR only on the resident. Resident #101 was apneic (a condition where a person involuntarily stops breathing) and pulseless. CPR with bag mask ventilation (BMV) was taken over by EMS. The resident's son stated the resident hit the call light an hour ago and complained of dizziness and nausea. As time went on, the resident became worse and started to vomit. Once Resident #101 vomited, she arrested per nursing staff. Nursing staff witnessed the arrest and started performing CPR. Resident #101 was moved over to the cot and the [NAME] device and monitor was applied to the resident. Resident #101 showed agonal breathing (when someone is not getting enough oxygen, not true breathing, natural reflex that happens when your brain is not getting needed oxygen to survive). CPR resumed. Resident #101 was loaded into the ambulance, CPR still in progress, intravenous (IV) access obtained, and Resident #101 was given epinephrine (epi) IV. Resident #101 was intubated (tube inserted through mouth or nose then down into trachea, allows air to get through), at pulse check the resident was in pulseless electrical activity (pea - no pulse), resident was given a second epi, CPR resumed, resident was given a third epi at the next pulse check and resident was in pea and CPR resumed. At the next pulse check, the resident had a pulse. As Resident #101 was taken in the ED room, the resident became pulseless, and CPR resumed. A telephone interview on [DATE] at 11:11 A.M. with Resident #101's husband revealed Resident #101 had passed away at the hospital on [DATE]. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A telephone interview on [DATE] at 3:13 P.M. with Resident #101's son revealed he visited the resident the morning of [DATE] and when he left, around 11:30 A.M., he had no concerns. At approximately 3:00 P.M., Resident #101 called him, crying and asking for help because she told him her call light was not being answered. Resident #101's son stated he left home and arrived to the facility approximately five minutes later. Resident #101's son stated the resident complained of nausea. He assisted her with emptying her ostomy bag and going back to bed. Resident #101's son stated the resident was white as a ghost and very pale. Resident #101's son stated he gave the resident a few small sips of cranberry juice, she stated she was going to be sick, he picked up the trash can, and the resident began to vomit. Resident #101's son stated her head fell back, her eyes were very wide, and her breathing was rigid. Resident #101's son stated he began yelling for help. An STNA entered the room and the resident's son stated his mother needed help. Resident #101's son stated the STNA did not move. A nurse came in, touched Resident #101, stated she was ice cold and told the STNA to call 911. The STNA still did not move. The nurse was attending to Resident #101 and pulled a phone out of her pocket and called 911. After three to four minutes, a male nurse came in and began performing CPR on Resident #101. Resident #101's son stated the nurse performed CPR on the mattress, with no backboard, and yelled for a crash cart four or five times. Resident #101's son stated the crash cart got to the room at the same time as EMS. Resident #101's son stated he believed had staff checked on the resident, they would have seen how pale she was and could have done something sooner. Telephone interviews between [DATE] at 3:59 P.M. and [DATE] at 2:56 P.M. with First Responder Captain (FRC) #208 with the local fire department revealed upon EMS arrival on [DATE], facility staff were administering chest compressions only to Resident #101. FRC #208 stated there was no evidence the resident was breathing. During the interviews, FRC #208 voiced concerns related to how staff were performing CPR in that CPR was being administered on the resident's mattress and there was no backboard (or hard surface) under Resident #101. FRC #208 stated the crash cart arrived at Resident #101's room as EMS were coming up the hall. FRC #208 confirmed the facility staff did not have an ambu bag present to provide ventilation to the resident while performing chest compressions. While the facility nurse stated he felt a pulse, FRC #208 stated EMS never felt or observed a pulse or respirations prior to transferring Resident #101 to the cot, further stating that was why EMS needed to continue CPR. FRC #208 stated a hard surface provided better quality chest compressions, adding if chest compressions were provided on a bed, the energy was going into the bed instead of the chest. As a result of not having a backboard under Resident #101, the chest compressions administered were not as good of quality or effective CPR. Interview on [DATE] at 8:59 A.M. with STNA #310 revealed on [DATE], Resident #101's call light was on. STNA #310 stated she entered the resident's room and the resident's son stated he did not need her. STNA #310 stated she went to the nurse's station then heard loud screaming coming from Resident #101's room. STNA #310 stated she entered the resident's room and asked what was happening. Resident #101 was projectile vomiting. She stated she sat the resident up and LPN #206 entered the room. LPN #206 realized Resident #101 wasn ' t with it and walked out to call 911. STNA #310 stated Resident #101 was cold, blue, and in and out of consciousness. STNA #310 stated she left Resident #101's room to have LPN #207 print transfer documents. STNA #310 stated LPN #207 asked what was going on and after STNA #310 explained, he stated LPN #206 should have called a Code Blue. STNA #310 stated LPN #207 went to Resident #101's room and the resident was not breathing. STNA #310 stated LPN #207 began chest compressions and asked for a crash cart. STNA #310 stated she ran all over the building looking for a crash cart, including three nurse's stations, before locating one on the secured memory care unit. By that time, STNA #310 stated EMS were onsite. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A telephone interview on [DATE] at 9:14 A.M. with LPN #207 revealed on [DATE], STNA #310 asked him to print papers to send Resident #101 out to the hospital. LPN #207 stated he went (to the resident ' s room) to see if he could help. LPN #207 stated when he entered Resident #101's room, the resident was breathing, with her head down. LPN #207 stated Resident #101 began to dry heave and he placed a trash can in front of her. LPN #207 stated Resident #101 then went limp, stopped breathing and had no pulse. The LPN stated he began chest compressions immediately and called for help. LPN #207 stated LPN #206 was there but then she went to call 911. LPN #207 stated he yelled for the crash cart, but it arrived at the room at the same time as EMS. LPN #207 verified Resident #101 was lying on a regular bed mattress, staff did not provide ventilation to Resident #101 during CPR and there was no backboard or hard surface used while he administered chest compressions. LPN #207 stated he believed he felt a faint pulse prior to EMS transferring Resident #101 but once transferred to the cot, Resident #101 lost the pulse again. While LPN #207 stated LPN #206 initially froze during the event, she (LPN #206) called 911. A telephone interview on [DATE] at 9:28 A.M. with LPN #206 revealed on [DATE] she heard Resident #101's son yelling. She was at the medication cart and went to see what was happening. LPN #206 stated Resident #101 was vomiting, her color was off, so she sent STNA #310 to get transfer paperwork, and she left to call 911. LPN #206 stated she checked Resident #101's vital signs and her pulse was weak. (The nurse did not document the vital signs in the resident's medical record). LPN #206 stated she was at the nurse's station calling 911 when LPN #207 went to Resident #101's room. LPN #206 stated, after calling 911, she went back to Resident #101's room and LPN #207 was doing chest compressions. Someone yelled to get the crash cart. LPN #206 confirmed the crash cart arrived at the room at the same time as EMS. Review of the American Heart Association (AHA) 2024 guidance for adult CPR included the following: Check for breathing, if the person is not breathing or only gasping, begin CPR; Chest compressions included to push down hard and fast at a rate of 100 to 120 compressions per minute; After every 30 compressions, give two rescue breaths; and make sure the person is on a firm surface. In 2008, after the publication of several studies looking at the rates of bystander CPR and public attitudes toward it, the AHA updated their guidance and decided to take out rescue breathing (mouth to mouth) for untrained or lay responders as a way to encourage and focus on hands only CPR. This updated guidance did not apply to trained healthcare professionals. Review of the facility policy titled Emergency Care/Code Management, revised [DATE], revealed the purpose was to ensure preparation for resident-specific emergency situations as they occur to promote the greatest optimal resident outcomes. The policy indicated CPR would be provided in accordance with the AHA guidelines. Review of the procedure included a crash cart would be maintained at each nursing unit and in the dining room. This deficiency is an incidental finding discovered during the course of 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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on closed medical record review, review of an Emergency Medical Services (EMS) Run report, review of the Health Care Summary, facility policy review, staff interview, physician interview and nurse practitioner (NP) interview, the facility failed to timely identify and provide adequate and necessary care for Resident #100, who experienced an acute change in condition. This resulted in Immediate Jeopardy and actual harm/serious health outcomes and potential for death beginning on 06/20/24 when the facility failed to recognize and adequately and timely respond to a decline in Resident #100's condition. Beginning on 06/20/24, Resident #100 was observed to have difficulty swallowing and his diet was downgraded to pureed. The physician was not notified of this change in condition. On 06/21/24 and 06/22/24, Resident #100 had poor oral intakes with no nursing assessments or monitoring completed and no evidence the physician was notified. On 06/22/24, at approximately 7:30 A.M., State tested Nursing Assistant (STNA) #202 identified Resident #100 was unresponsive to any stimuli. Licensed Practical Nurse (LPN) #203 was notified; however, failed to assess or notify the physician and took no action to address Resident #100's decline. Although Resident #100 was unresponsive, LPN #203 proceeded to place crushed medications mixed with chocolate pudding into the resident's mouth. At approximately 6:00 P.M., STNA #204 began her shift and found Resident #100 unresponsive to stimuli. STNA #204 notified LPN #203 of Resident #100's condition. LPN #203 stated Resident #100 had been that way all day and LPN #203 again took no action to address Resident #100's condition. Consequently, at approximately 9:00 P.M., STNA #204 returned to Resident #100's room and found the resident continued to be unresponsive. STNA #204 notified LPN #201, who assessed Resident #100 and found his vital signs to be unstable and the resident had a large amount of chocolate pudding and crushed medications in his mouth. On 06/23/24 EMS were called, and Resident #100 was sent to the hospital. Subsequently, Resident #100 was admitted to the hospital on 06/23/24 and admitted to hospice services on 07/01/24. The resident did not return to the facility. In addition, a concern that did not rise to Immediate Jeopardy occurred when the facility failed to timely respond to a change in condition for Resident #45, who experienced high blood pressure, rapid respirations, felt short of breath and received oxygen therapy outside of physician ordered parameters. This affected two residents (#100 and #45) of two residents reviewed for change in condition. The facility census was 95. On 07/30/24 at 12:54 P.M., the Administrator, Director of Nursing (DON), and Regional Registered Nurse (RRN) #920 were notified Immediate Jeopardy began on 06/20/24 when Resident #100 began experiencing a change in condition without adequate care/intervention. While the dietitian assessed the resident's diet texture, no nursing assessments were completed, and the physician was not notified. Resident #100's condition continued to decline throughout 06/21/24 and 06/22/24, without any nursing assessment, monitoring of vital signs or notification to the physician. Resident #100 was subsequently admitted to the hospital on 06/23/24 with a diagnosis of sepsis and transferred to hospice care on 07/01/24. The Immediate Jeopardy was removed on 07/30/24 when the facility implemented the following corrective actions: Resident #100 was admitted to the hospital on 06/23/24 and did not return to the facility. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 07/30/24, the Administrator, DON and RRN #920 conducted an investigation and determined the facility did not follow the Change in Condition Policy and Procedure for Resident #100. On 07/30/24, the DON issued disciplinary action to LPN #203 for failing to follow the Change in Condition Policy and Procedure. On 07/30/24, the DON and RRN #920 re-educated all licensed nursing staff on the Change in Condition Policy and Procedure, including ensuring staff provide timely and appropriate care and services when residents experience a change in condition that has or was likely to cause serious life-threatening harm or injuries and/or adverse negative health outcomes. On 07/30/24, Unit Manager LPN #213, LPN #263, LPN #239 and Registered Nurse (RN) #302 completed a head-to-toe assessment of all residents for a change in condition. All residents were assessed to be at baseline and no changes in condition were identified. All assessments were documented in the Electronic Medical Record (EMR) and Medical Director (MD) #500 was notified of the outcome of resident assessments. Beginning on 07/31/24, the DON or designee would conduct an audit of four random residents on each unit weekly for four weeks, then bi-weekly for two weeks, and then monthly. The audit would include compliance with providing timely and appropriate care and services when a resident experienced a change in condition. The audit tool would be used to validate resident status and appropriateness of care and included all pertinent information and actions needed to meet a residents medical, nursing, and mental and psychosocial needs if a change of condition was identified. On 07/30/24, an Ad Hoc Quality Assurance Performance Improvement (QAPI) committee meeting was held to review the policy and procedures for change in condition, education to be provided to nursing staff and a plan to complete assessments for all in facility residents for change in condition. All audit findings of concern would be immediately addressed and reported to the QAPI committee for further review and prompt response and resolution. The Administrator and/or designee will monitor this area for ongoing compliance. Interviews on 08/01/24 between 5:25 P.M. and 5:31 P.M. with LPN #207, LPN #289, LPN #940 and LPN #942 confirmed each received education on the facility ' s change in condition policy and procedures. Review of three (#8, #63 and #95) additional resident records revealed no additional related concerns. Although the Immediate Jeopardy was removed on 07/30/24, the facility remained out of compliance at a Severity Level 2 (no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy) as the facility was still in the process of implementing their corrective action plan and monitoring to ensure on-going compliance. Findings include: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. Review of Resident #100's closed medical record revealed the resident was admitted to the facility on [DATE] and discharged on [DATE]. Resident #100 had diagnoses including type two diabetes mellitus, unspecified dementia, aneurism of the ascending aorta without rupture and hypertension. Review of the admission Minimum Data Set (MDS) dated [DATE] revealed Resident #100 was severely cognitively impaired. The assessment revealed the resident had impairment to one side of the upper extremity, no impairment to the lower extremity, used a wheelchair for mobility, required supervision with eating, partial moderate assistance with personal hygiene and bed mobility and substantial maximum assistance with transfers. Review of the care plan initiated 05/22/24 revealed Resident #100 had functional bladder incontinence related to activity intolerance, dementia, and impaired mobility. Interventions included to monitor and document signs and symptoms of a urinary tract infection (UTI) to include increased pulse, increased temperature, altered mental status, change in behavior and change in eating patterns. Review of the progress note dated 06/07/24 at 12:39 P.M. and completed by LPN #213 revealed Resident #100 was alert and awake sitting at the dining table with lunch in front of him. Resident #100 was bent forward in the chair almost to where his head was touching his knees. He was eating lunch, but not using utensils. The resident was eating with his fingers at first then attempted to put his mouth on the table and food tray and eat his meal that way. The note documented, unable to get the resident to sit up in his chair. Further review revealed a Nurse Practitioner (NP) was notified and Resident #100 received an order for a urinalysis with culture and sensitivity. Further review of the medical record revealed no progress notes were completed on Resident #100 from 06/07/24 until 06/12/24. Review of the progress note dated 06/12/24 at 4:02 P.M. revealed Resident #100's urinalysis results came back positive and the resident was started on and antibiotic for a UTI. Review of the physician order/Medication Administration Record (MAR) revealed Resident #100 received Amoxicillin oral tablet 875-124 milligram (mg), one tablet by mouth two times a day for a UTI for seven days. Further review revealed Amoxicillin was initiated on 06/11/24 and completed 06/17/24. Additional review of the medical record revealed no evidence any assessments or monitoring was completed for Resident #100 during the course of treatment for the UTI. Review of the dietary note dated 06/20/24 at 3:19 P.M. completed by Registered Dietitian (RD) #501 revealed diet downgraded to puree per discussion with nursing, Resident #100 was pocketing and coughing with meals. Liberated therapeutic diet to aid with oral intakes. Discussed with the Interdisciplinary Team (IDT). Boost HVC eight ounces daily for added nutritional support. Will continue to monitor and coordinate for need of further intervention. Review of a nursing progress note dated 06/20/24 at 3:26 P.M. and completed by RN #224 revealed Resident #100 observed pocketing food and coughing during the breakfast meal. Diet downgraded to mechanical soft. Resident #100 continued to cough when fed during lunch. Resident did well with mashed potatoes. Resident #100's diet further downgraded to pureed. (continued on next page)

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	366495	A. Building B. Wing	08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the physician's orders revealed on 06/20/24, RD #501 created an order for a regular diet, pureed texture, and thin liquids. Review of the State tested Nurse Aide (STNA) tasks sheets revealed Resident #100 consumed 0% of his dinner meal on 06/20/24. On 06/21/24 the documentation indicated Resident #100 consumed 0 to 25% of breakfast and lunch and 0% for dinner. On 06/22/24 Resident #100 consumed 0 to 25% of breakfast and lunch and 0% of dinner. Further review of the medical record revealed no evidence of any assessments, monitoring of vital signs, or physician notification related to Resident #100's downgraded diet or change in condition during this time period. Review of an EMS run report revealed on 06/23/24 at 12:27 A.M., EMS received a call from the facility for Resident #100. EMS arrived on the scene at 12:35 A.M. Resident #100 was unresponsive and was placed on non-re-breather at 15 liters per minute (LPM) of oxygen. Resident #100 had unstable tachyarrhythmia and was cardioverted (shocks to restore heart rhythm) at 50 joules, then 100 then 200 joules. Resident #100 was taken to the trauma bay at the local hospital. Review of the progress note dated 06/23/24 1:39 A.M. and completed by LPN #201 revealed Resident #100 was observed unresponsive with blood pressure (BP) of 72/46 (hypotensive), blood sugar (BS) of 196, pulse of 115 (tachycardic), temperature of 99.6, respiration rate (RR) of 10 and oxygen saturation of 83% on room air. The note included Resident #100 had pudding residue in his mouth, unresponsive to stimuli. NP and family notified. The family requested Resident #100 be sent to the hospital. EMS was called and resident was sent to the hospital. Review of the hospital Health Issue Summary revealed Resident #100 was admitted to the hospital on 06/23/24 with a diagnosis of sepsis and transferred to hospice care on 07/01/24. Interview on 07/25/24 at 2:56 P.M. with STNA #204 revealed she worked with Resident #100 on 06/22/24, with her shift beginning at 6:00 P.M. STNA #204 revealed at the start of her shift, she went into Resident #100's room. Resident #100 was unresponsive. STNA #204 stated she turned him and called his name, but he would not respond. STNA #204 stated she went to get the nurse, LPN #203, who was still there from day shift. STNA #204 revealed she reported her findings to LPN #203, who stated Resident #100 had been like that all day. LPN #203 went on to state even when she gave the resident his medications, she had to shove them in his mouth. STNA #204 stated she had to provide care to other residents and did not return to Resident #100 until approximately 9:00 P.M. STNA #204 stated Resident #100 was still unresponsive. STNA #204 informed LPN #201 of Resident #100's condition. Together, STNA #204 and LPN #201 went to Resident #100's room. The resident was unresponsive. STNA #204 stated she and LPN #201 turned Resident #100 on his side and a brown substance came out of his mouth. LPN #201 opened the resident's mouth and found a glob of pudding with crushed medications in the back of the resident's throat. STNA #204 stated they used an entire box of toothettes to scoop the dried pudding and crushed medications from the back of Resident #100's mouth. STNA #204 stated LPN #201 checked the resident's vital signs, and his oxygen level and BP were low. Resident #100 was still not responding. STNA #204 stated there was confusion about the resident's advance directives/code status, so the nurse called family and the doctor, and the resident was then sent out to the hospital. STNA #204 stated she was so upset that she reported the incident to Unit Manager (UM) #205. STNA #204 stated she told UM #205 that Resident #100 was unresponsive and LPN #203 shoved pudding in his mouth. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Medication Administration Record (MAR) for Resident #100 revealed on 06/22/24, LPN #203 administered the following morning medications to Resident #100: Eliquis tablet five milligrams (mg), Losartan 50 mg tablet, Metformin 750 mg tablet, Acidophilus one capsule, Depakote 125 mg tablet, Glimepiride two mg tablet, Quetiapine fumarate 25 mg and Risperidone one mg tablet. Interview on 07/25/24 at 3:15 P.M. with UM #205 confirmed STNA #204 reported (on 06/22/24) Resident #100 had a mouthful of pudding and medication and they sent him out. UM #205 further stated STNA #204 reported Resident #100 was not right when her shift began, and she tried telling the nurse. UM #205 stated there was not much she could do about it because Resident #100 was already sent to the hospital. UM #205 stated she was unsure if the DON was aware of the concern, and stated this DON was no longer employed by the facility. Interview on 07/25/24 at 3:36 P.M. with LPN #203 revealed Resident #100's diet texture was downgraded (in June) to pureed and he received his medications crushed in pudding. LPN #203 stated Resident #100 had been drinking fluids, but not much. LPN #203 stated she gave the resident his medications and she kept giving him fluids and he swallowed his medications. LPN #203 stated Resident #100 slept a lot on 06/22/24 but stated he did wake up a little bit. LPN #203 denied Resident #100 had a temperature and stated his vital signs were fine. LPN #203 verified she did not document any vital signs or assessments for Resident #100 on 06/22/24. LPN #203 also confirmed she did not notify the physician of a change in condition for the resident. LPN #203 stated Resident #100 had a UTI and denied anyone at the facility talked to her about Resident #100's condition. Interview on 07/29/24 at 11:25 A.M. with STNA #202 revealed she worked with Resident #100 on 06/22/24, beginning at 7:30 A.M. STNA #202 revealed she worked with Resident #100 many times and stated on 06/22/24, the resident had been knocked out all day. STNA #202 stated LPN #203 told her he had a UTI. STNA #202 stated she went to the resident's room at the start of her shift, and she could not wake Resident #100 up. STNA #202 stated she got LPN #203 and they both went back to the resident's room. STNA #202 stated LPN #203 tried to give Resident #100 his medication, but he would not swallow it and he already had pudding or some other substance in his mouth. STNA #202 stated Resident #100 would not wake up or respond to anything. STNA #202 stated she elevated the head of the resident's bed while LPN #203 put the medication crushed in pudding in his mouth and tried to get him to swallow. STNA #202 stated Resident #100 did not swallow his medications and was like that all day. STNA #202 stated Resident #100 usually moved around, would propel up and down the hall and feed himself. STNA #202 stated she was off for a few days and noticed a definite decline with the resident when she returned to work on 06/21/24. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 07/29/24 at 1:49 P.M. with Agency LPN #201 revealed she checked on Resident #100 during rounds when she first arrived on 06/22/24. LPN #201 revealed Resident #100 just looked like he was sleeping. LPN #201 revealed she did not recall getting anything alarming about Resident #100's condition that day from LPN #203 during the nurse change in shift report. LPN #201 revealed after checking on the residents, she began medication pass. While LPN #201 could not recall the time STNA #204 came to get her, she did recall STNA #204 stating she needed to check on Resident #100 because he was unresponsive. LPN #201 revealed this was the first time she worked with Resident #100. LPN #201 stated she opened Resident #100's mouth and noted there was a lot of chocolate in his mouth. LPN #201 stated Resident #100 was breathing but he did not arouse or respond. LPN #201 stated she assessed Resident #100's vital signs, documented they were off, looked for his code status and then called the resident's family. LPN #201 stated the family requested Resident #100 be sent to the hospital. LPN #201 then notified the physician. LPN #201 stated EMS arrived, and Resident #100 was transported to the hospital. Interview on 07/29/24 at 3:09 P.M. with LPN #213 revealed typically when a resident was on an antibiotic, the nurses would monitor every shift for vitals, temperatures, and checking on the resident and this would be documented in the medical record. Additionally, the nurse would be monitoring for adverse reactions from the antibiotic. The surveyor indicated no assessments could be found for Resident #100 and requested LPN #213 locate the information. LPN #213 did not return at any point with the requested assessments or monitoring for Resident #100. Interview on 07/29/24 at 4:13 P.M. with MD #500 revealed he expected nursing staff to monitor vital signs and document on a resident who was diagnosed with a UTI and receiving antibiotics. If a resident had a change in condition, non-urgent, he would expect to be notified within 24 hours, at most. MD #500 stated if a resident was unresponsive, he should be notified immediately. MD #500 stated he should have been notified when Resident #100's change first occurred as he would have done blood work, a urinalysis and chest x-ray to rule out potential complications. MD #500 confirmed he was not notified of changes that occurred with Resident #100. Interview on 07/30/24 at 3:08 P.M. with NP #502 revealed he was not notified or called regarding Resident #100 having difficulty swallowing, having his diet order changed to pureed and was not made aware Resident #100 was not eating or unresponsive. NP #502 stated there would have been interventions implemented had he been aware of Resident #100's decline. Review of the facility policy titled, Resident Change in Condition dated 07/28/22 revealed Purpose: Ensuring staff provide timely and appropriate care and services when residents experience a change in condition that has or is likely to cause serious life-threatening harm or injuries and or adverse negative outcomes. The facility will promptly notify the resident, his or her attending physician, and responsible party of changes in the resident ' s condition and or status. The licensed nurse will take immediate action to ensure timely and appropriate care and services are met when a resident change in condition is identified. When a significant or an acute change is identified in resident ' s physical, mental, or psychosocial status. the licensed nurse will notify the attending physician regarding the change in condition once an assessment of the resident has been completed. 2. Record review for Resident #45 revealed an admitted [DATE] with diagnoses including orthostatic hypotension, syncope and collapse. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the admission Medicare five-day MDS revealed Resident #45 was cognitively intact. The assessment revealed Resident #45 required set up or clean up assist with meals, partial to moderate assist with personal hygiene, was independent with bed mobility, and required partial to moderate assistance with transfers. Resident #45 had occasional pain, had no shortness of breath or trouble breathing. Review of the care plan revealed Resident #45 had altered cardiovascular status related to hypertension, hyperlipidemia and congestive heart failure. Interventions included to monitor vital signs and lab work as ordered and notify the MD of significant abnormalities. Review of a physician order dated 07/25/24 revealed an order for oxygen at two liters via nasal cannula to keep oxygen saturation above 92% as needed. The order was dated 07/25/24. Observation on 07/29/24 at 8:37 A.M. with LPN #212 revealed Resident #45 complained of not feeling well. Continued observation revealed Resident #45 was breathing rapidly, was pale and his nose was dripping clear fluid. Resident #45 was receiving oxygen via nasal cannula at five LPM. Resident #45 stated again he was not feeling well, and he felt short of breath. Concurrent interview with LPN #212 revealed Resident #45's presentation was not typical. LPN #212 verified Resident #45's oxygen was set at five LPM and stated the resident was not able to adjust his own oxygen settings. LPN #212 assessed Resident #45's vital signs. Resident #45's oxygen saturation level was 95%. LPN #212 placed a wrist cuff on Resident #45 and obtained a blood pressure of 230/88. LPN #212 then obtained a manual blood pressure cuff and obtained a blood pressure in the right upper arm of 181/110. Resident #45 was afebrile and had a pulse of 81. Further observation revealed Resident #45 continued to have rapid respirations. LPN #212 revealed she counted respirations of 27 and stated she was not sure of the respiration count because she had to keep looking away to look at the clock on the wall while she was counting. LPN #212 stated this was a big change for Resident #45 and he was not usually like this. LPN #212 returned to the medication cart, reviewed the order for the oxygen and verified Resident #45 should be receiving oxygen at two LPM. LPN #212 then prepared and administered Resident #45's medications. LPN #45 left the room, did not adjust the oxygen level per the physician order, and continued going up the hall to administer additional residents' medications. Interview on 07/29/24 at 3:12 P.M. with LPN #212 revealed she rechecked Resident #45's vital signs at 1:00 P.M., nearly 4.5 hours after the initial assessment, and his blood pressure was 160/64. LPN #212 confirmed that was the only time she rechecked Resident #45's vital signs. LPN #212 confirmed she did not notify the physician of the change in condition and had only notified LPN #213. Interview on 07/29/24 at 3:40 P.M. with LPN #213 revealed the nurse on the floor would notify the physician of a residents change in condition. LPN #213 confirmed LPN #212 notified her of Resident #45's change in condition and revealed she did not notify Resident #45's physician or NP of Resident #45's change in condition, stating she was not asked to. LPN #213 confirmed the physician should have been notified of Resident #45's condition. Interview on 07/29/24 at 4:13 P.M. with MD #500 revealed he should have been notified of Resident #45's BP of 181/110. Additionally, MD #500 stated if Resident #500 required more oxygen than what was ordered, he should have also been notified of that. MD #500 verified he was not notified of concerns identified with Resident #45, but stated the NP may have been. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a progress note created on 07/30/24 at 8:07 A.M. with an effective date 07/29/24 at 3:30 P.M. by LPN #213 revealed NP #502 was notified of Resident #45's blood pressures. The documentation did not include notification of the oxygen level of five LPM. Interview on 07/30/34 at 3:08 P.M. with NP #502 confirmed he was notified on 07/29/24 of Resident #45's blood pressures. While NP #502 did not recall the exact time he ws notified, he confirmed it was sometime after 12:00 P.M. Review of the facility policy titled, Resident Change in Condition dated 07/28/22 revealed Purpose: Ensuring staff provide timely and appropriate care and services when residents experience a change in condition that has or is likely to cause serious life-threatening harm or injuries and or adverse negative outcomes. The facility will promptly notify the resident, his or her attending physician, and responsible party of changes in the resident ' s condition and or status. The licensed nurse will take immediate action to ensure timely and appropriate care and services are met when a resident change in condition is identified. When a significant or an acute change is identified in resident ' s physical, mental, or psychosocial status. the licensed nurse will notify the attending physician regarding the change in condition once an assessment of the resident has been completed. This deficiency represents the non-compliance investigated under Complaint Number OH00155297.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34297 Based on observations, resident interview, staff interview, medical record review and review of a local police department (LPD) report, the facility failed to ensure timely and appropriate toileting and incontinence care was provided. This affected three (Residents #80, #98, and #95) of four residents reviewed for incontinence care. The facility census was 95. Findings include: 1. Review of Resident #98's medical record revealed the resident was admitted on [DATE] and discharged on [DATE] with diagnoses including unilateral primary osteoarthritis, palmar facial fibromatosis and Raynaud's syndrome without gangrene. Review of Resident #98's Admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition. Telephone interview on 08/01/24 at 10:01 A.M. with Resident #98 revealed on the morning of 07/01/24 she had to wait about an hour for staff to take her to the bathroom. She stated her daughter called the facility to have someone come down and take her to the bathroom. During the nightshift (6:00 P.M. to 6:00 A.M.) on 07/01/24, Resident #98 stated she put the call light on and no one answered her call light for over an hour and a half to two hours. Resident #98 stated she ended up trying to go to the bathroom herself and soiled herself. Resident #98 stated she felt it was unacceptable that staff took so long to answer her call light and take her to the bathroom. Interview on 08/01/24 at 11:11 A.M. with STNA #246 confirmed she worked on 07/01/24 from 6:00 P.M. to 6:00 A.M. and she was assigned the Secured Memory Care Unit (SMCU). STNA #246 stated the nurse who was supposed to work on Resident #98's unit was a no call and no show. She stated Resident #98's unit did not have an STNA assigned, and she was pulled from the SMCU to work on the hall with Resident #98 around 8:00 P.M. STNA #246 stated she provided care to Resident #98 around 8:15 P.M. STNA #246 confirmed the resident was distraught and stated her light had been on for two hours. She stated the resident was in the bathroom and urine was noted on the bathroom floor with towels on top of the urine. STNA #246 confirmed she had observed the police in the building because Resident #98's daughter had called them for a wellness check. Telephone interview on 08/01/24 at 11:52 A.M. with Registered Nurse (RN) #903 revealed she was late to her shift on 07/01/24, arriving at approximately 6:45 P.M. for the shift that began at 6:00 P.M. RN #903 stated she had trouble accessing the electronic health record system (EHR) prior to starting her shift and she had to wait for assistance from the manager. She stated she was unaware Resident #98's call light was ringing until she saw the police in the building. She stated she was not aware that Resident #98's unit did not have an STNA until STNA #246 came out of the SMCU around 8:00 P.M. and told her. RN #903 stated she did not feel like she was safe to work in the building due to what she felt was inadequate staffing and resigned after 07/01/24. Interview on 08/01/24 at 12:30 P.M. with the Administrator revealed the facility was unable to obtain Resident #98's call log audits for 07/01/24. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the actual working staff schedule for 07/01/24 for the 6:00 P.M. to 6:00 A.M. shift revealed the facility had sufficient staffing, including four licensed nurses and six STNAs. Review of the LPD Incident/Offense Report revealed on 07/01/24 at 8:19 P.M. a call was received to respond to the facility. At 8:23 P.M. the police were dispatched and arrived at the facility at 8:33 P.M. to respond to a welfare check request. Resident #98's daughter called the police and stated the resident pushed her call light button for assistance and had to wait over an hour for staff with no assistance. When the police arrived, the front doors were locked. Officer #901 spoke with Resident #98, who stated her daughter left at approximately 7:00 P.M. and she pushed the call light for assistance after her daughter left. Resident #98 stated she continuously pushed the call light for an hour with no assistance. The daughter stated she called the nursing desk several times with no answer. The daughter called the police for a wellness check. The police officer spoke with the daughter on the phone and in person and stated the staff were not answering the call lights. The daughter provided screen shots from her telephone which showed the daughter called the facility at 8:02 P.M., 8:06 P.M. and 8:11 P.M., before calling the police. The visitor log confirmed the daughter signed out of the facility at 7:07 P.M. on 07/01/24. The resident's nurse, Registered Nurse (RN) #903 was interviewed and stated she had been doing rounds with other residents and arrived at work at approximately 6:00 P.M. It should be noted RN #903 was doing rounds on another hallway than the one Resident #98 resided on. RN #903 confirmed she would not have observed the call light because she was not on that hall yet. RN #903 indicated there was an State tested Nursing Assistant (STNA) assigned to each hall, and she should have observed the call light. Interview with STNA #246 revealed she was assigned to the SMCU and was unsure if another STNA was assigned to Resident #98's hallway. The police had received 11 calls from residents or family members of the facility in which a member of the staff could not be reached via the call button or the phone. Two of those calls resulted in reports. 2. Review of Resident #80's medical record revealed the resident was admitted on [DATE] with diagnoses including Parkinsonism, chronic obstructive pulmonary disease and heart failure. Review of Resident #80's quarterly MDS 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition and was always incontinent of urine. Interview on 08/01/24 at 7:54 A.M. with Resident #80 revealed the facility did not use the correct size of incontinence briefs and put briefs on the resident which were too small. As a result, staff used multiple briefs, which Resident #80 stated were bulky and uncomfortable. Interview on 08/01/24 at 7:57 A.M. with STNA #261 confirmed Resident #80 required size 5x incontinence briefs but the facility did not provide enough of the appropriate size for the resident. STNA #261 stated staff had to piece meal briefs together, using the smaller size 3x briefs. Observation on 08/01/24 at 11:37 A.M. of incontinence care provided by STNA #261 and Licensed Practical Nurse (LPN) #255 revealed the resident had on four incontinence briefs, rolled into a fifth brief. STNA #261 and LPN #255 removed the five incontinence briefs and placed a size 5x incontinence brief, which fit properly, on the resident. Concurrent interview with LPN #255 revealed the resident sometimes requested multiple briefs and he was care planned for multiple briefs. LPN #255 confirmed the resident had multiple improperly fitted briefs placed on him at one time. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Record review for Resident #95 revealed an admitted [DATE]. Diagnosis included hypertensive heart disease, chronic diastolic congestive heart failure, repeated falls, difficulty in walking, muscle weakness and need for assistance with personal care. Review of the quarterly MDS dated [DATE] revealed Resident #95 was cognitively intact. Resident #95 required partial moderate assistance with toileting, set up or clean up assist with personal hygiene and Resident #95 was always continent of bowel. Review of the care plan dated 04/25/24 revealed Resident #95 had an Activities of Daily Living (ADLs) self-care performance deficit related to activity intolerance. Interventions included one staff for toileting. Observation on 07/29/24 at 10:00 A.M. revealed Resident #95 was sitting in the doorway of her room. The resident was repeatedly yelling in the hall Would someone please help me. I need help. Continued observation revealed STNA #202 entered Resident #95's room. The toilet seat in Resident #95's bathroom was covered with diarrhea/stool. The floor directly in front of the toilet had a large amount of diarrhea. Resident #95 informed STNA #202 she needed to use the bathroom now, she had diarrhea, and requested STNA #202 to please clean the toilet because she needed to use it. STNA #202 stated she was busy and she would get someone. Further observation revealed STNA #202 left Resident #95's room, entered another resident's room and closed the door. STNA #202 was not observed to request assistance for Resident #95 prior to entering another resident's room and closing the door. Resident #95 continued to sit in her doorway and asked the surveyor if anyone was coming because she needed to go to the bathroom now. Resident #95 stated she had been waiting and asking staff for about 30 minutes to assist her. Observation revealed no additional staff were present in Resident #95's hall. The surveyor left the hall to find assistance for Resident #95. Observation on 07/29/24 at 10:12 A.M., after returning to Resident #95's room and unsuccessfully finding an available staff member, revealed Resident #95 was standing in front of the toilet in her bathroom. Resident #95 was using her feet, with toilet paper under her slippers, to clean the diarrhea/stool off her floor in front of the toilet. The toilet seat was partially cleaned, with stool still smeared on the seat. Resident #95 stated she needed to use the bathroom. Observation on 07/29/24 at 10:14 P.M. revealed LPN #255 was walking up the hall. The surveyor requested LPN #255 assist Resident #95. Observation with LPN #255 confirmed Resident #95 was sitting on the toilet unassisted. LPN #255 stated she would wait with Resident #95 until she was done. This deficiency represents non-compliance investigated under Complaint Numbers OH00155416 and OH00155360.

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	08/06/2024

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on observation, staff interview, medical record review and review of facility policy, the facility failed to ensure residents were free from significant medication errors. This affected two (#6 and #8) of three residents reviewed for medication administration. The facility census was 95. Findings include: 1. Record review for Resident #6 revealed an admitted [DATE]. Diagnoses included epileptic spasms intractable with status epilepticus. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #6 was moderately cognitively impaired. Resident #6 required set up or clean up assistance with meals and was independent with personal hygiene. Resident #6 had a seizure disorder or epilepsy. Review of the care plan dated 03/14/24 revealed Resident #6 had a seizure disorder. Interventions included to give seizure medication as ordered by the doctor. Review of the current physician orders for Resident #6 revealed an order for vimpat oral tab give 200 milligrams (mg) two times a day for seizure disorder. Observation on 07/25/24 at 8:42 A.M. of medication administration with Licensed Practical Nurse (LPN) #239 revealed vimpat was not administered to Resident #6, as physician ordered. Concurrent interview with LPN #239 verified she did not administer vimpat to Resident #6 because the medication was not available for administration. LPN #239 stated did not know why the medication was unavailable. Review of the Medication Administration Record (MAR) for Resident #6 confirmed Resident #6 did not receive the morning dose of vimpat on 07/25/24. 2. Record review for Resident #8 revealed and admitted [DATE]. Diagnoses included diabetes mellitus. Review of the quarterly MDS dated [DATE] revealed Resident #8 was moderately cognitively impaired. Resident #8 had a diagnosis of diabetes mellitus. Review of the care plan dated 07/03/24 revealed Resident #8 had diabetes mellitus. Interventions included fasting serum blood sugar as ordered by the doctor. Review of the physician orders for Resident #8 revealed an order for humulog subcutaneous solution 100 units per milliliter (ml) (insulin lispro) inject as per sliding scale subcutaneously before meals and at bedtime for diabetes mellitus type two. The sliding scale included if the blood sugar result was 150 to 200, give two units. (continued on next page)

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Avenue at Brooklyn	4700 Idlewood Drive Brooklyn, OH 44144

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 07/25/24 at 9:06 A.M. of medication administration revealed Resident #8 was eating breakfast in the dining room. Resident #8 was served pancakes with syrup, cream of wheat, and sausage. Resident #8 had approximately 50% of her breakfast eaten. Continued observation revealed LPN #239 removed Resident #8 from the dining room and took her to the activity room to assess her blood sugar. LPN #239 checked Resident #8's blood sugar level with the glucometer and received a result of 199. LPN #239 proceeded to administer two units of lispro insulin to Resident #8 (physician order was to administer two units for a blood sugar level result between 150 to 200 before meals). Interview on 07/25/24 at 9:36 A.M. with LPN #239 revealed she checked residents' blood sugar during medication administration as she went down the list of residents. LPN #239 confirmed she may perform blood sugar checks, such as for Resident #8, during or after meals, which would be outside of the physician ordered parameters to administer sliding scale insulin based on blood sugar levels prior to meals. Review of the facility policy titled, Medication Administration, revised August 2014 revealed medications are administered as prescribed in accordance with good nursing principals and practices. The facility has sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions. This deficiency represents non-compliance investigated under Complaint Number OH00155297.

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	366495	A. Building B. Wing	08/06/2024

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Avenue at Brooklyn	4700 Idlewood Drive Brooklyn, OH 44144

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on observation, staff interview, medical record review and review of facility policy, the facility failed to ensure a shared blood glucose meter (glucometer) was cleaned and disinfected between use with residents. This affected three (#31, #8, and #63) of three residents observed for blood sugar assessment with use of a glucometer. This had the potential to affect two (#30 and #74) additional residents who received blood sugar checks via glucometer. The facility census was 95. Findings include: 1. Record review for Resident #31 revealed an admitted [DATE]. Diagnoses included type two diabetes mellitus. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #31 was moderately cognitively impaired. Resident #31 had a diagnosis of diabetes mellitus. Review of the care plan dated 03/21/24 revealed Resident #31 had a diagnosis of diabetes mellitus. Interventions included accu checks as ordered and as needed, diabetes medication as ordered by the doctor and monitor/document for side effects and effectiveness. Review of current physician orders for Resident #31 revealed an order for humulog kwikpen subcutaneous solution 100 units per milliliter (ml) subcutaneously before meals. Observation on 07/25/24 at 9:00 A.M. of medication administration with Licensed Practical Nurse (LPN) #239 revealed there was only one glucometer in the medication cart drawer. There was a piece of clear tape placed over the back of the glucometer holding the batteries in. Continued observation revealed LPN #239 removed the glucometer from the medication cart drawer, did not clean or disinfect the glucometer, and assessed Resident #31's blood sugar using the glucometer. LPN #239 returned to the medication cart, held the glucometer in her hand and confirmed she had more residents' blood sugars to assess. LPN #239 was not observed to clean and disinfect the glucometer after using it for Resident #31. 2. Record review for Resident #8 revealed and admitted [DATE]. Diagnoses included diabetes mellitus. Review of the quarterly MDS dated [DATE] revealed Resident #8 was moderately cognitively impaired. Resident #8 had a diagnosis of diabetes mellitus. Review of the care plan dated 07/03/24 revealed Resident #8 had diabetes mellitus. Interventions included fasting serum blood sugar as ordered by the doctor. Review of the physician orders for Resident #8 revealed an order for humulog subcutaneous solution 100 units per ml (insulin lispro) inject as per sliding scale subcutaneously before meals and at bedtime for diabetes mellitus type two. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 07/25/24 at 9:06 A.M. of medication administration revealed LPN #239 prepared to assess Resident #8's blood sugar via glucometer. Continuous observation revealed LPN #239 did not clean and disinfect the glucometer after it was used to assess Resident #31's blood sugar. LPN #239 assessed Resident #8's blood sugar, using the glucometer that was not cleaned and disinfected after use with Resident #31, then placed the glucometer in her pants pocket, which was bulging with other items including a large set of multiple keys. Further observation revealed LPN #239 returned to the medication cart, removed the glucometer from her pants pocket and placed it back in the medication cart drawer. LPN #239 did not clean and disinfect the glucometer. 3. Record review for Resident #63 revealed an admitted [DATE]. Diagnoses included type two diabetes mellitus. Review of the quarterly MDS dated [DATE] revealed Resident #63 was cognitively intact. Resident #63 had a diagnosis of diabetes mellitus. Review of the care plan dated 04/02/24 revealed Resident #63 had diabetes mellitus type two. Interventions included diabetes medication as ordered. Observation on 07/25/24 at 9:30 A.M. of medication administration revealed LPN #239 removed the same glucometer used for Resident #31 and Resident #8 from the medication cart drawer. Continuous observation revealed LPN #239 did not clean and disinfect the glucometer. LPN #239 proceeded to place the glucometer on Resident #63's nightstand then picked it back up and assessed Resident #63's blood sugar. LPN #239 returned to the medication cart, without washing her hands, after assessing Resident #63's blood sugar and placed the glucometer on the cart without cleaning and disinfecting the glucometer. Interview on 07/25/24 at 9:36 A.M. with LPN #239 confirmed she never cleaned and disinfected the glucometer before use, between residents or after use for Resident #31, Resident #8 and Resident #63. LPN #239 verified she used the same glucometer for all of the residents on her assignment and stated she would clean the glucometer at the end of her shift. Interview on 07/29/24 at 3:40 P.M. with LPN Unit Manager #213 revealed glucometers should be cleaned between each use with a sani wipe (disinfectant wipe) and allow the glucometer sit with the sani wipe on it for five minutes. Review of the facility policy titled Cleaning and Disinfecting of Blood Glucose Meter, revised July 2022, revealed it is the practice of the nursing facility to maintain appropriate infection control standards by cleaning and disinfecting a blood glucose meter prior to and after each use for individual resident care to prevent the transmission of infection. The deficiency represents an incidental finding during the investigation of the complaint survey.