

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 09/16/2024
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 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>43063</p> <p>Based on record review and interview, the facility failed to use the services of a registered nurse (RN) for at least eight consecutive hours a day, seven days a week. This had the potential to affect all 96 residents residing in the facility.</p> <p>Findings include:</p> <p>Review of the nursing schedules from 08/28/24 to 09/03/24 revealed there was no RN coverage for eight consecutive hours on 08/31/24 and 09/01/24 as required.</p> <p>Interview on 09/11/24 at 3:33 P.M. with the Human Resources Director #203 verified there was no RN coverage for 08/31/24 and 09/01/24.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00157047.</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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