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| 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 12/31/2024 |
| 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) |
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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48567</p> <p>Based on medical record review, interview, and review of the facility policy, the facility failed to ensure all intravenous (IV) antibiotics were administered to resident #6 as ordered by the physician. This affected one resident (#6) of three residents reviewed for medication administration. The facility census was 103.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #6 revealed an admitted [DATE] with diagnoses including osteomyelitis of vertebra, sacral and sacrococcygeal area, pressure ulcer of sacral region, cervical spinal cord injury, quadriplegia, protein-calorie malnutrition, type two diabetes mellitus, and neuromuscular dysfunction of the bladder.</p> <p>Review of the care plan dated 11/11/24 revealed Resident #6 was receiving antibiotic therapy for treatment of osteomyelitis. Interventions included the administration of antibiotics per the medical provider's orders.</p> <p>Review of the admission Minimum Data Set (MDS) 3.0 assessment completed on 11/15/24 revealed Resident #6 was cognitively intact and dependent for all activities of daily living (ADL). Further review of the MDS revealed Resident #6 received IV medications.</p> <p>Review of the physician orders for Resident #6 revealed the flowing IV antibiotic (IVAB) orders:</p> <p>Vancomycin HCl in Dextrose Intravenous Solution 750-5 milligrams (mg) per 150 milliliters (ml), order dated 11/12/24: Use 150 ml IV every 12 hours for osteomyelitis (discontinued on 12/03/24).</p> <p>Vancomycin HCl Intravenous Solution 1000 mg per 200ml, order dated 12/03/24: Administer 200 ml per hour IV in the morning for osteomyelitis/septic Arthritis (discontinued on 12/18/24); order dated 12/18/24: Use 200ml per hour IV in the morning for osteomyelitis/septic Arthritis until 01/15/2025 at 11:59 P.M. (discontinued on 12/21/24); order dated 12/21/24: Use 200ml per hour IV in the morning for osteomyelitis/septic Arthritis until 01/15/2025 at 11:59 P.M.</p> <p>Zosyn Intravenous Solution 3-0.375 grams (gm) per 50ml, order dated 11/07/24: Infuse IV four times a day for osteomyelitis; order dated 12/18/24: Infuse IV four times a day for osteomyelitis until 01/15/2025 at 11:59 P.M.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Review of the November 2024 medication administration record (MAR) for Resident #6 revealed:</p> <p>Vancomycin 750-5 mg IV was not documented as administered the morning of 11/30/24 and included the code 9 (9=Other / See Nurse Notes).</p> <p>Zosyn 3-0.37gm IV four times a day was not documented as administered the morning or afternoon of 11/30/24 and included the code 9.</p> <p>There was no documented evidence that Zosyn 3-0.37gm IV four times a day was administered on 11/13/24 at 6:00 P.M., 11/14/24 at 6:00 A.M., 11/18/24 at 6:00 P.M., 11/21/24 at 6:00 P.M., 11/22/24 at 6:00 A.M., 11/24/24 at 6:00 A.M., 11/28/24 at 6:00 P.M., or 11/29/24 at 6:00 A.M.</p> <p>Review of the progress notes from 11/07/24 through 11/30/24 revealed a note dated 11/30/2024 at 7:36 P.M. which stated Resident did not receive morning or afternoon antibiotics therapy on this shift. This nurse asked several times that antibiotics be administered by allotted nursing staff. There were no progress notes indicating the ordered IV doses of Zosyn were administered to Resident #6 on 11/13/24 at 6:00 P.M., 11/14/24 at 6:00 A.M., 11/18/24 at 6:00 P.M., 11/21/24 at 6:00 P.M., 11/22/24 at 6:00 A.M., 11/24/24 at 6:00 A.M., 11/28/24 at 6:00 P.M., or 11/29/24 at 6:00 A.M.</p> <p>Review of Resident #6's December 2024 MAR revealed:</p> <p>Zosyn 3-0.37gm IV four times a day was held on 12/05/24 for the scheduled 6:00 A.M. dose</p> <p>Zosyn 3-0.37gm IV four times a day was not documented as administered and included the code 9 to see the eMAR (electronic medication administration record) progress notes for doses scheduled for 12/20/24 at 6:00 A.M., 12:00 P.M., and 6:00 P.M. and the dose scheduled on 12/21/24 for 12:00 A.M. and 6:00 A.M. (there were no eMAR notes indicating this medication was administered between the scheduled 12/19/24 12:00 P.M. dose and 4:59 P.M. on 12/20/24 when a note was added the Assistant Director of Nursing (ADON) administered a dose of Zosyn 3-0.375 gm/ml IV).</p> <p>There was no documented evidence that Zosyn 3-0.37gm IV four times a day was administered on 12/02/24 at 12:00 P.M. and 6:00 P.M., 12/03/24 at 6:00 A.M., 12/04/24 at 12:00 P.M. and 6:00 P.M., 12/05/24 at 6:00 P.M., 12/19/24 at 6:00 P.M., 12/20/24 at 6:00 A.M., 12/22/24 at 6:00 P.M., or 12/23/24 at 6:00 A.M.</p> <p>Review of the progress notes revealed an eMAR note dated 12/05/24 at 5:19 A.M. indicating the scheduled 12:00 A.M. dose of IV Zosyn was not administered until 3:00 A.M., so the 6:00 A.M. dose on 12/05/24 was held. Further review of the progress notes revealed a note dated 12/20/24 at 11:36 A.M. indicating IV Zosyn was not administered due to it being out of scope of practice for the nurse entering the note (Licensed Practical Nurse, LPN #316), the ordering provider was notified, and the facility was ordered to extend the medication by one dose. (There were no order entries or order modifications found to support the Zosyn order was created to extend the stop date by one dose). An additional progress note entered on 12/20/24 at 4:59 P.M. revealed the ADON was present to administer the Vancomycin, which was scheduled to have been administered at 8:00 A.M. There were no progress notes indicating Zosyn 3-0.37gm IV four times a day was administered by anyone to Resident #6 on 12/02/24 at 12:00 P.M. and 6:00 P.M., 12/03/24 at 6:00 A.M., 12/04/24 at 12:00 P.M. and 6:00 P.M., 12/05/24 at 6:00 P.M., 12/19/24 at 6:00 P.M., 12/20/24 at 6:00 A.M., 12/22/24 at 6:00 P.M., or 12/23/24 at 6:00 A.M.</p> <p>(continued on next page)</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Interview on 12/30/24 at 4:13 P.M. with LPN #316 confirmed there was no registered nurse (RN) on day shift that she was made aware of on 12/20/24 to administer the IV antibiotic for Resident #6 that was scheduled at 12:00 P.M. and 6:00 P.M. or the other IV antibiotic that was scheduled for 8:00 A.M. She also verbalized that she thought the night shift RN was responsible for administering the 6:00 A.M. dose that day but could not say for certain by looking at the documentation it had been given. During the interview, LPN #316 voiced concern regarding other IV antibiotics not being given as ordered due to no RN coming to the unit to administer the IV's, though she could not specify any other dates, times, or other resident related specifics.</p> <p>Interview via telephone on 12/30/24 at 5:15 P.M. with LPN #421 confirmed Resident #6 received his first dose of IV antibiotics when the night shift nurse came on duty on 11/30/24, and that he had not received the IV antibiotic scheduled for 8:00 A.M. or the afternoon dose of the IV antibiotic he was supposed to receive every six hours. She further confirmed there was one RN on duty and another that was a trainee and that RN # 444 was informed by her that Resident #6 needed the IV antibiotics, and RN #444 told her the trainee could give the medication. LPN #421 verbalized she later informed RN #444 the IV antibiotic had not been given by the nurse in training and Resident #6 still needed them, but the RN never came to that unit to give them to Resident #6.</p> <p>Interview on 12/30/24 at 5:33 P.M. with the Director of Nursing (DON) confirmed there was an RN in the building on 11/30/24 and 12/20/24 when Resident #6 had documentation of missed IV antibiotic doses and voiced concern there was a communication problem amongst staff regarding RN availability for IV administration. The DON further revealed she or the ADON would come into the facility to cover IV administrations when notified of the need.</p> <p>A follow-up interview on 12/31/24 at 10:00 A.M. with the DON confirmed the November and December MARs contained multiple doses of Zosyn that had no documented evidence of administration. During the interview, the DON revealed it was possible the doses were administered by an RN, and that the administering nurse forgot to sign off medication administration in the MAR and the LPN did not document in the progress notes that the medication was administered by a facility RN. During the interview, the DON confirmed she could not guarantee each of the undocumented doses had been given because she was not present at the time to verify that they were. The DON confirmed there was an RN in the building on 11/30/24 and 12/20/24 when Resident #6 missed IV antibiotic doses, confirmed the progress note reflects the Vancomycin was administered late afternoon on 12/20/24 instead of in the morning as ordered, and reiterated communication being a possible factor in any omitted medications.</p> <p>Review of the Daily Attendance Report for 11/30/24, 12/20/24, and 12/21/24 revealed RNs were on duty within the facility except for 12/20/24 and 12/21/24 from 6:30 P.M. to 10:00 P.M. at which time Resident #6 had no scheduled antibiotics.</p> <p>Review of the policy titled Medication Administration - General Guidelines, dated December 2017, revealed medications were to be administered in accordance with prescriber orders, within the facility's established drug administration times, in accordance with accepted nursing principles and practice, and only by licensed personnel within their laws and regulations per scope of practice. Review of the policy further revealed all administered medications must be signed-off in the MAR by the person who administered that medication and no staff who administered medications were permitted to end their work duty before first ensuring all medications they administered were documented.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00160880.</p> | | |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48567</p> <p>Based on observation, interview, review of the medical record and review of the facility policy, the facility failed to ensure appropriate handling and transport or soiled linens after providing incontinence care to Resident #37. This affected one resident (#37) and had the potential to affect an additional 12 residents (#20, #36, #40, #41, #49, #55, #72, #87, #88, #89, #90, and #92) who were to receive care and services from Certified Nurse Aide (CNA) #300. The facility census was 103.</p> <p>Findings include:</p> <p>Review of the medical record revealed Resident #37 had an admitted [DATE] with diagnoses including cerebral infarction, pure hypercholesterolemia, primary insomnia, atherosclerotic heart disease, vitamin D deficiency, slow transit constipation, essential hypertension, long term use of anticoagulants, poly-osteoarthritis, occlusion and stenosis of bilateral carotid arteries, flaccid hemiplegia affecting the right dominant side, neuralgia and neuritis, facial weakness following cerebral infarction, difficulty in walking, generalized muscle weakness, and chronic pain.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment 3.0 completed on 11/22/24 revealed Resident #37 was cognitively intact and had an upper and lower extremity range of motion impairment on one side. Further review of the MDS revealed Resident #37 was always incontinent of bowel and bladder and was dependent for toileting, hygiene, and bathing.</p> <p>Review of the care plan last reviewed on 12/04/24 revealed Resident #37 had a self-care performance deficit and an alteration in elimination related to cerebrovascular accident (CVA), impaired mobility, chronic pain, and weakness. Interventions included checking and changing for incontinence as required and providing perineal care with each episode of incontinence.</p> <p>Observation on 12/26/24 from 2:35 P.M. to 2:45 P.M. of incontinence care for Resident #37 by CNA #300 and CNA #359 revealed CNA #300 threw the urine-soaked brief containing a small smear of soft stool in the trash can lined with a plastic trash bag. Further observation revealed CNA #300 tossed each soiled washcloth, used towels, and dirty draw sheets into the trash can on top of the soiled brief. CNA #300 was then observed using gloved hands to pick up each piece of linen out of the trash bag/can, placing soiled linen into her cradled left bare arm (no gown or sleeves), holding the bundle of soiled linen near the left side of her chest/scrub top, and carrying the soiled, unbagged linen into the hall to the soiled utility room.</p> <p>Interview on 12/26/24 with CNA #300 at 2:50 P.M. confirmed she discarded the soiled linen in the same bag with the soiled brief, lifted the linen out of the trash can and cradled the linen into her arms near her chest, and carried the soiled linen into the hall to the soiled utility room unbagged. During the interview, CNA #300 stated there weren't enough plastic bags available to bag linen separately and staff were not allowed to bring the soiled linen barrels to the resident rooms. She also confirmed that soiled linen was supposed to be contained before leaving the resident's room.</p> <p>Interview on 12/26/24 at 2:55 P.M. with CNA #359 confirmed the soiled linen was carried in the hall without a bag or container by CNA #300 and that linen was supposed to be bagged before being taken out of the resident's rooms.</p> <p>(continued on next page)</p> | | |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Review of the policy titled Laundry and Bedding, Soiled, last revised September 2022, revealed contaminated laundry was to be bagged or contained at the point of collection and were not to be held close to the body during transport.</p> <p>This deficiency was an incidental finding identified during the complaint investigation.</p> | | |