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	06/02/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident record review, resident interview, and staff interview, the facility failed to ensure residents were treated with respect and dignity. This affected three residents (#30, #31, and #87) of three reviewed for respect and dignity. The facility census was 103. Findings include: 1. Review of the medical record for Resident #30 revealed she was admitted to the facility on [DATE] with diagnoses that included urinary tract infection, repeated falls, hypoxemia, cerebral palsy, and epilepsy. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #30 was alert and oriented to person, place, and time, impaired on both sides of her lower extremities, and required assistance from staff for Activities of Daily Living (ADLs). Review of the care plan dated 05/07/25 revealed Resident #30 had an ADL self-care deficit with interventions that included staff to assist with completion of needs throughout the day. Observation on 05/14/25 at 8:07 A.M. revealed Resident #30 laying in bed, uncovered and naked from the waist down and exposed, and able to be viewed from the hallway. Interview and observation on 05/14/25 at 8:09 A.M. with Certified Nurse Assistant (CNA) #826 revealed Resident #30 was able to be seen from the hallway naked from the waist down. CNA #826 revealed Resident #30 required assistance from staff for ADLs, however, she was not assigned to care for Resident #30 at the time. CNA #826 was observed looking at Resident #30 from the hallway, walked away, and stated, she isn't mine. CNA #826 confirmed and verified the findings at the time of the observation. Review of facility policy, Resident Rights, revised November 2016, revealed the facility was to ensure residents' personal dignity, well-being, and self-determination is maintained. 2. Review of the medical record for Resident #87 revealed she was admitted to the facility on [DATE] with diagnoses that included noninfective gastroenteritis and colitis, unspecified, respiratory failure, unspecified, unspecified whether with hypoxia or hypercapnia, and acquired absence of other specified parts of digestive tract. (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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the MDS assessment dated [DATE] revealed Resident #87 was alert and oriented with cognition impairment, was impaired on both sides of her upper and lower extremities, always incontinent of bowel and bladdr, and was dependent on staff for ADLs. Review of the physician orders dated 04/30/25 revealed an order to monitor Resident #87 chole drain, a drainage procedure, specifically a percutaneous cholecystostomy, where a thin tube (catheter) is inserted into the gallbladder to drain fluid, like bile, and relieve pressure. Observation and interview on 05/14/25 at 11:17 A.M. revealed Resident #87 sitting in her room with her chole drainage bag exposed and can be visually seen from the hallway. Resident #87 revealed her drainage bag was never covered. Interview and observation on 05/14/25 at 11:22 A.M. with Licensed Practical Nurse (LPN) #904 revealed Resident #87 had a history of colon cancer and utilized a gall bladder bag for elimination. LPN #904 observed Resident #87 elimination bag exposed and could be seen from the hallway. LPN #904 revealed all bowel and bladder bags were to be covered for dignity for the residents. LPN #904 confirmed and verified the above findings at the time of the observation. Review of facility policy, Resident Rights, revised November 2016, revealed the facility was to ensure residents' personal dignity, well-being, and self-determination is maintained. 3. Review of the medial record for Resident #31 revealed an admission date of 11/22/24 and diagnoses included but not limited to Guillain-Bare Syndrome, quadriplegia, and disease spinal cord. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #31 had intact cognition and required assistance from staff for Activities of Daily Living. Resident #31 was continent of bladder and bowel. Review of the care plan dated 11/25/24 revealed Resident #31 had ADL self-care performance deficit related to his diagnoses of Guillain-Barre, quadriplegia, spinal stenosis, osteoarthritis (OA), hypertension, pulmonary embolism and diabetes mellitus (DM) that impairs his ability to fully participate in completion of his tasks. Staff provides assistance with completions of his needs throughout the day. Interventions included staff assist of one (1) to two (2) for ADL's. Observation on 05/15/25 at 8:17 A.M. revealed CNA #619 delivered Resident #31's breakfast tray and placed it on the over-bed-tray (OBT) next to his urinal which was ¾ full of yellow urine. CNA #619 left the room without emptying the urinal full of urine. Interview and observation on 05/15/25 at 8:20 A.M. with CNA #619 verified she placed Resident #31's breakfast tray next to his urinal full of urine. CNA #619 was walking away and reported she saw the urinal full of urine and didn't empty the urinal because she had breakfast trays to pass. Interview on 05/15/25 at 8:28 A.M. with Resident #31 revealed he is bothered by the breakfast tray placed next to his urinal which is full of urine. Resident #31 reported he is not going to eat his breakfast because it was placed next to her urinal full of urine. Interview on 05/15/25 at 8:36 A.M. with LPN/Unit Manager #904 verified the full urinal should have been emptied before placing the breakfast tray next to it. LPN/Unit Manager #904 reported the expectation is for all staff to empty the urinal before placing the breakfast tray next to it. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy, Resident Rights, revised November 2016, revealed the facility was to ensure residents' personal dignity, well-being, and self-determination is maintained. This deficiency represents non-compliance investigation under Complaint Number OH00165080, Complaint Number OH00162845, and Complaint Number OH00162472.

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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** Based on closed medical record review, review of an Emergency Medical Services (EMS) report, facility policy review and interview, the facility failed to timely identify and provide adequate and necessary care for Resident #104, who experienced an acute change in condition. This resulted in Immediate Jeopardy and actual harm/death beginning on [DATE] when the facility failed to recognize and failed to timely and adequately respond to Resident #104's report of a low blood glucose level. On [DATE], at 12:18 A.M., Resident #104, who was known by staff to be a brittle diabetic, activated her call light and Certified Nursing Assistant (CNA) 636 responded. Resident #104 reported she needed a snack because her blood glucose level was low. CNA #636 reported she gave Resident #104 a snack and got side-tracked and did not report the change of condition to the nurse on duty, Licensed Practical Nurse (LPN) #637. CNA #636 did not round on Resident #104 after providing the snack. LPN #637 revealed she had last seen Resident #104 on [DATE] at approximately 9:50 P.M. when she administered her scheduled medications. Resident #104 had a Freestyle Libre System (continuous glucose monitoring (CGM) system that measures glucose levels through a small sensor worn on the arm, providing glucose readings without the need for finger pricks) and when administering her medications, LPN #637 based the amount of insulin administered on a verbal report (of the glucose level) from the resident. LPN #637 confirmed she did not make rounds on Resident #104 throughout the night, from 10:00 P.M. to 6:30 A.M. At approximately 6:30 A.M. Resident #104's husband arrived at the facility, found Resident #104 unresponsive, not breathing, and with no palpable pulse, and alerted the nurse. Resuscitative efforts began, Cardiopulmonary Resuscitation (CPR) was initiated, and Emergency Medical Services (EMS) were called. During resuscitative efforts, a blood glucose reading was obtained from the facility's glucometer which read registered low. Intramuscular (IM) glucagon (an emergency medicine used to treat severe hypoglycemia in diabetic patients, who cannot take some form of glucose by mouth) was administered during resuscitative measures with no noted effect. EMS arrived, determined Resident #104 had obvious signs of death including rigor and asystole (an arrythmia indicating the absence of electrical activity in the heart). Resident #104 was pronounced deceased at the facility. This affected one resident (#104) of three residents reviewed for changes in condition. The facility census was 103. On [DATE] at 11:39 A.M. the Administrator, Director of Nursing (DON), and Regional Clinical Nurse #640, were notified Immediate Jeopardy began on [DATE] at approximately 12:18 A.M. when Resident #104 reported her blood glucose was low, and the change of condition was not communicated to the nurse on duty for appropriate evaluation and timely intervention. Resident #104 received no further nursing care or monitoring from staff until Resident #104's spouse arrived at the facility at approximately 6:30 A.M. and was found Resident #104 unresponsive. Resident #104 was not breathing, and had no palpable pulse, and resuscitative efforts were attempted but unsuccessful. Resident #104 was pronounced deceased at the facility by EMS. The Immediate Jeopardy was removed on [DATE] when the facility implemented the following corrective actions: • On [DATE] CNA #636 and LPN #637 were removed from the schedule pending an investigation into the events involving Resident #104. The investigation included interviewing staff regarding Resident #104's condition and staff interactions and reviewing Resident #104's medical record. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	• On [DATE] between 4:30 P.M. to 6:30 P.M. all 103 current residents of the facility were assessed for any changes in condition. This was completed by LPN Unit Manager (UM) #816 and LPN UM #904. • On [DATE], all 48 diabetic residents (#2, #5, #6, #7, #10, #11, #12, #13, #14, #15, #20, #22, #24, #25, #26, #27, #29, #30, #31, #32, #36, #38, #39, #40, #43, #45, #47, #52, #55, #56, #57, #61, #63, #64, #65, #69, #70, #71, #74, #75, #76, #79, #85, #88, #89, #95, #98, and #102) were assessed for changes in condition and blood glucose levels evaluated and verified for all residents with orders for blood glucose monitoring. Six of these residents (#10, #11, #22, #29, #63, and #89) were identified to have continuous glucose monitoring devices. This was completed by the DON. • On [DATE] between 4:00 P.M. and 11:00 P.M., all licensed nurses and Certified Nursing Assistants (CNAs) were educated on the facility's change in condition policy and procedure, including what constituted as a change in condition, timely reporting of changes in condition, and steps to take once a change is noted. This education was provided by the DON. • On [DATE] between 4:00 P.M. and 11:00 P.M., all licensed nurses and CNAs were educated on the facility's call light response policy which included answering call lights timely and routine resident rounding frequently during work shifts were provided. This education was provided by the DON. • On [DATE] between 4:00 P.M. and 11:00 P.M., all licensed nurses were educated on the facility's blood glucose monitoring policy, with specific components including following physician's orders for glucose testing and monitoring for signs and symptoms of hypoglycemia (low blood glucose level) and hyperglycemia (high blood glucose level). This education was provided by the DON. • On [DATE] LPN #637's employment was terminated for failing to meet performance standards related to attendance and frequent rounding on all residents, including Resident #104. • On [DATE] a Quality Assurance Performance Improvement (QAPI) meeting was held to discuss the events and investigation into the [DATE] incident with Resident #104. Present at the QAPI meeting were the Administrator, Director of Nursing, Medical Director #639, LPN UM #816, Human Resources Manager (HRM) #730, Rehabilitation Manager #643, and Activities Director #913. All findings, including incidental, were shared and discussed, as well as the facilities plan of action to correct any deficient practice. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	• Beginning on [DATE], an audit including visual observation of three licensed nurses performing glucose checks accurately, including the use of continuous glucose monitoring systems, began and would be completed weekly for four (4) weeks duration. This would be completed by the DON or designee. • On [DATE], CNA #636 was terminated for falsification of documentation related to her conflicting statements provided during the incident with Resident #104. • Beginning on [DATE], an audit was implemented to review blood glucose readings of five (5) diabetic residents three (3) times a week for four (4) weeks to ensure any readings outside of ordered parameters had physician notification. This audit would be completed by the DON or designee. • Beginning on [DATE], an audit was implemented to interview three CNA'S three times a week for four weeks regarding changes in condition with notification of nurse and physician. This would be completed by the DON or designee. • On [DATE], all licensed nurses were re-educated on blood glucose monitoring to include the continuous glucose monitoring system and that the nurse must verify the blood glucose reading by either visualizing the screen with the result or by utilizing the facility glucometer. This education was provided by the DON. • Beginning on [DATE], an audit was implemented to ensure staff were rounding and making visual observation of residents every two to four hours. The audit would include interviewing five residents and making visual observations of three staff members. The audit would be completed three times a week for four weeks and would include including both day and night shift. The Administrator would monitor the audits for ongoing compliance. • The results of all audits would be reviewed by the Administrator and the facility's QAPI committee for further review and prompt response and resolution. Although the Immediate Jeopardy was removed on [DATE], the facility remained out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was still in the process of implementing their corrective actions and monitoring to ensure on-going compliance. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Findings include: Review of Resident #104's closed medical record revealed the resident was admitted to the facility on [DATE]. Resident #104 had medical diagnoses including type one diabetes mellitus (DM) with neuropathy and retinopathy, chronic pancreatitis, chronic kidney disease and dependence on renal dialysis and systolic congestive heart failure. Resident #104 was pronounced deceased at the facility on [DATE] at 6:52 A.M. Review of Resident #104's physician's orders revealed an order dated [DATE] for insulin glargine (long-acting insulin) 10 units subcutaneous in the morning for diabetes. Resident #104 also had an order dated [DATE] for insulin lispro (short-acting insulin) three units subcutaneous before meals in addition to sliding scale coverage. Resident #104's sliding scale insulin coverage included for a blood glucose of 151 to 200, give one unit of insulin. For a blood glucose result of 201 to 250, give 2 units. For a blood glucose result of 251 to 300, give 3 units. For a blood glucose result of 301 to 350, give 4 units. For a blood glucose result of 351 to 400, give five units. If blood glucose was less than 70 or greater than 401, notify the provider immediately. Review of the care plan initiated on [DATE] revealed the resident had a diagnosis of diabetes with hyperglycemia and hypoglycemia. The care plan noted Resident #104 utilized a FreeStyle Libre Continuous Glucose System. Listed interventions included utilizing the FreeStyle Libre per physician's orders, administer diabetes medication as ordered by the doctor, and to observe for side effects and effectiveness. Additional interventions included to observe as needed (PRN) for any signs or symptoms of hypoglycemia, including sweating, tremor, tachycardia (increased heart rate), pallor, nervousness, confusion, slurred speech, lack of coordination, and a staggering gait. Review of the Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #104 had intact cognition. The assessment revealed Resident #104 was independent with all activities of daily living (ADL'S). Review of the facility's Alarm Event Report dated [DATE] to [DATE] revealed Resident #104's call light was activated on [DATE] at 12:18 A.M. The alarm was cleared by staff on [DATE] at 12:21 A.M. Record review revealed no corresponding nursing progress note completed at this time or at any time until a note entered by LPN Unit Manager (UM) #815 on [DATE] at 07:45 A.M. (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 local EMS Prehospital Care Report Summary, dated [DATE] at 06:40 A.M. revealed EMS received a call from the facility and arrived at facility at 06:46 A.M. Review of the narrative history revealed Resident #104 was a full arrest. EMS providers asked facility staff when Resident #104 had last been seen normal, to which staff reported Resident #104 was found by the husband. Resident #104 was noted in her room with an automated external defibrillator (AED, a medical device used to treat cardiac arrest by delivering an electric shock to the heart, restoring a normal heart rhythm) applied. Manual Cardiopulmonary Resuscitation (CPR) was in progress, and manual respirations were being administered. The AED did not call for a shock. The EMS provider requested again when the resident was last seen normal, with staff reporting the resident was last observed normal the night prior, and Resident #104 was found unresponsive when the husband arrived to the facility and found her approximately 20-30 minutes prior. Resident #104 was noted with no pulse, she was not breathing, and the report noted Resident #104 was cold to the touch with rigor (condition that causes the muscles in the body to stiffen after death and typically begins two (2) to six (6) hours after death) noted in the resident's right arm. The EMS provider took over CPR, stopped for a rhythm check and again noted rigor was present. The EMS providers placed Resident #104 on the monitor with asystole (an arrythmia indicating the absence of electrical activity in the heart) noted in multiple leads. CPR was taken over by the fire department, stopped for rhythm check and rigor was noted. The EMS providers communicated with a physician at a local hospital, provided a report, and Resident #104's time of death was called as [DATE] at 6:52 A.M. Review of the death certificate dated [DATE] and signed by Physician #639 revealed Resident #104's causes of death to include End Stage Renal Disease (ESRD) on hemodialysis (HD), heart failure (HF) related to Ejection Fraction (EF), and diabetes mellitus Type 1. Review of the progress note dated [DATE] at 07:45 A.M. and authored by LPN UM #816 revealed Resident #104 was found unresponsive lying in bed. Resident #104 was a full code and a code was called. CPR was initiated and EMS was called. The AED machine was utilized, pads were placed, the AED machine indicated no shock was advised and to continue with CPR. CPR was continued. During resuscitative efforts, Resident #104's blood glucose was checked and read low on the machine. One dose (strength and amount not noted) of intramuscular glucagon was given. EMS arrived on scene at approximately 6:50 A.M. and took over CPR. Resident #104's heart rhythm was assessed by the EMS's monitor and showed asystole. The EMS providers contacted a local hospital and Resident #104 was pronounced at 6:52 A.M. by Physician #638. Resident #104's husband was present at the facility and notified of Resident #104's death. The DON was made aware of Resident #104's death. (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 [DATE] at 1:12 P.M. with the DON revealed during the facility investigation of Resident #104's death, the facility determined CNA #636 responded to Resident #104's call light (on [DATE]) between 3:00 A. M. and 4:00 A.M. based on a telephone interview with CNA #636 the afternoon following Resident #104's death. (This was subsequently noted to be inaccurate during the State agency investigation as per the facility call light audit report and interview with CNA #636 the resident's call light had been activated at 12:18 A.M.). The DON reported when CNA #636 answered the light, Resident #104 reported she needed a snack because her blood glucose was low. The DON reported CNA #636 gave Resident #104 a snack but did not report Resident #104's change of condition, her report of the low blood glucose, to LPN #637. The DON reported CNA #636 was later terminated due to not reporting the resident's change in condition to the nurse. The DON reported she interviewed LPN #637 who stated she did not see Resident #104 after [DATE] at approximately 10:00 P.M. The DON reported LPN #637 was terminated due to issues identified during the investigation, including LPN #637's failure to round or check on Resident #104 from [DATE] at 10:00 P.M. to [DATE] at approximately 6:30 A.M. The DON reported the investigation identified the last time LPN #637 saw Resident #104 was on [DATE] before 10:00 P.M. The DON reported it was the expectation of staff to round on patients at least every two hours. Interview on [DATE] at 7:58 A.M. via phone with Certified Nursing Assistant (CNA) #636 revealed (on [DATE]) between approximately 12:30 A.M. to 1:00 A.M. she answered Resident #104's call light. Resident #104 reported she needed a snack because her blood glucose was low. CNA #636 reported she gave the resident a cream-filled oatmeal cookie for a snack. CNA #636 reported she got side-tracked and never reported the change in condition to LPN #637 as she should have. CNA #636 reported she was terminated following the incident and indicated she was supposed to notify the nurse immediately of a change in resident condition and was supposed to round on residents every two hours. Interview on [DATE] at 8:26 A.M. with LPN #637 revealed she attempted to give Resident #104 her medications (on [DATE]) at approximately 9:00 P.M. However, Resident #104 was busy and wanted her to return at a later time. LPN #637 reported she returned between approximately 9:45 P.M and 9:50 P.M. and administered Resident #104 her medications. LPN #637 reported Resident #104 checked her CBG device and reported her blood glucose level was 229. LPN #637 stated she did not verify the resident's blood glucose reading (by reviewing the device), as she was required to do. LPN #637 reported she administered two units of insulin lispro solution pen-injector per sliding scale as ordered. LPN #637 reported she was terminated following the incident for not checking Resident #104's CBG monitor result and not rounding on residents every two hours (as well as an issue with attendance). Interview on [DATE] at 9:57 A.M. with the Administrator verified on [DATE] at 12:18 A.M. Resident #104's call light was activated and was answered at 12:21 A.M. by CNA #636. The Administrator reported Resident #104 reported her blood glucose was low, and she needed a snack. The Administrator reported CNA #636 provided a snack but failed to notify the nurse of a change in condition, as required. The Administrator revealed the next time the resident's call light was activated on [DATE] was at 6:39 A.M. by staff during code in progress. The Administrator confirmed CNA #636 failed to notify LPN #637 of a change in condition and LPN #637 failed to check Resident #104's blood glucose, do an assessment for change in condition, and round on resident. The Administrator revealed the expectation was for CNA and LPN staff to round every two hours on residents, nurses to check the blood glucose reading of continuous monitoring devices and not take the word of the resident and CNA staff to report a change in condition timely to the nurse. (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 [DATE] at 10:10 A.M. with Physician #639 revealed Resident #104 was a brittle diabetic and he expected nursing staff to check the continuous monitoring devices for blood glucose checks. Physician #639 reported Resident #104's diagnoses of ESRD and diabetes mellitus were major contributing factors in her death. Interview on [DATE] at 12:24 P.M. with LPN UM #816 revealed on [DATE] she overheard the nurse state Resident #104 was unresponsive and assisted with the code. LPN UM #816 reported CPR was initiated, and the resident's blood glucose level was checked. The blood glucose level read low on the glucometer. LPN UM #816 revealed if the result read low or lo on the glucometer, it meant the blood glucose level was 20 or below. LPN UM #816 reported intramuscular glucagon was administered, and CPR was continued. LPN UM #816 reported 911 arrived and took over CPR but Resident #104 was asystole on the monitor and was pronounced deceased by EMS at that time. LPN UM #816 confirmed the CNAs and LPNs were expected to round on residents every two hours. LPN UM #816 confirmed the expectation was for CNAs to notify the nurse immediately of a change in condition and the expectation was for the nurse to immediately assess any change in condition. LPN UM #816 confirmed LPN #637 should have confirmed the resident's evening blood glucose reading to verify accuracy and not take the residents verbal word before administering insulin. LPN UM #816 revealed she spoke with LPN #637 on [DATE] at approximately 7:30 A.M. to get a statement of what happened. LPN #637 confirmed the last time she saw Resident #104 was around [DATE] at 10:30 P.M. LPN UM #816 confirmed LPN #637 should have been checking on Resident #104 every two hours. LPN UM #816 revealed she spoke with CNA #636 on [DATE] at approximately 7:45 A.M. and confirmed last time CNA #636 saw the resident was on [DATE] between 12:00 A.M. and 1:00 A.M. LPN UM #816 reported she verbally notified the DON on [DATE] of the statement findings for CNA #636 and LPN #637. A telephone interview on [DATE] at 2:02 P.M. with Resident 104's husband revealed he arrived to the facility on [DATE] at 6:30 A.M. and found Resident #104 unresponsive. Resident 104's husband reported he last spoke with Resident #104 on [DATE] at 11:00 P.M. and stated the resident had reported at that time her blood glucose reading was in the 200's. Resident 104's husband reported Resident #104 was her normal self and there was nothing abnormal at that time. Resident 104's husband then stated he had concerns with the resident's care and how staff treated her. Resident 104's husband reported facility staff had not been very prompt and when the resident had blood glucose problems in the past, the resident would have to go and find staff to assist. Resident 104's husband reported he had concerns with staff not checking on Resident #104 frequently and if she needed medication or insulin she would have to find staff at time. Interview on [DATE] at 3:31 P.M. with LPN #717 revealed he did not receive education on continuous glucose monitoring (CGM) as part of the recent in-service on blood glucose checks. Interview on [DATE] at 3:41 P.M. with LPN #705 revealed she did not receive education on CGM as part of the recent in-service on blood glucose checks. An additional interview on [DATE] at 9:12 A.M. with Physician #639 revealed he was notified of the incident with Resident #104 at the facility's QAPI meeting when he was told of the low blood glucose which occurred on [DATE]. However, another physician was actually on-call at the time of the incident. Physician #639 reported he was unaware staff did not routinely round on Resident #104 on [DATE] and was unaware that CNA #636 had not reported a change in condition to the nurse on duty for a timely assessment of Resident #104 on [DATE]. (continued on next page)

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	366495	A. Building B. Wing	06/02/2025

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the MediVena One-Care PRO Blood Glucose Monitoring System Manufacturer Book, revealed on page 16, If a LO message appears on the display, your meter has detected your blood glucose level is lower than 20 milligrams per deciliter (mg/dl). It is suggested you review your testing procedure and test again with a new test strip to confirm the result. If the same result occurs, consult your healthcare professional immediately. Review of facility, Call Lights - Answering, revised [DATE], revealed staff would respond to resident's call light in a timely manner and throughout the shift nursing staff should periodically round the unit and visualize residents to ensure that the call light was in reach and needs were met. Review of facility policy, Blood Glucose Testing and Management revised [DATE], revealed the purpose was to determine a resident's blood glucose baseline, manage diabetes, prevention of complications and to identify variations in a resident's blood glucose levels. The licensed nurse would monitor the resident for signs or symptoms of hypoglycemia or hyperglycemia. Review of facility policy, Resident Change in Condition dated [DATE], revealed the purpose was to ensure 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. The facility would notify the resident physician and responsible party of changes in the residents' condition and/or status. Licensed nurse would take immediate action to ensure timely and appropriate care and services were met when a resident change in condition was identified. Licensed nurse would notify the attending physician regarding the change in condition once an assessment of the resident had been completed. This deficiency represents the non-compliance investigated under Complaint Number OH00165604.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, medical record review, policy review and interview, the facility failed to have less than 5 percent (%) medication error rate. Three errors out of twenty-nine opportunities were observed resulting in an error rate of 10.34 %. This affected three residents (#5, #35, and #107) of five residents observed for medication administration. Findings include: 1. Review of the medical record for Resident #35 revealed an admission date of 02/16/23 with diagnoses including but not limited to Alzheimer's Disease, stage three chronic kidney disease (CKD), and hypertension (HTN). Review of the physician orders for May 2025 revealed an order for Aspirin 81 milligram (mg) delayed release (delayed release refers to medication designed to release the active ingredients at a time later than immediately after administration) to give 1 tablet in the morning for thrombosis and do not crush. Observation on 05/15/25 at 7:38 A.M. with Licensed Practical Nurse (LPN) #712 revealed she placed an Aspirin 81 mg chewable tablet in the medicine cups with other medications then proceeded to crush the medication and administered to Resident #35. LPN #712 held up the bottle up and confirmed Aspirin (ASA) 81 mg chewable tablet was crushed and administered to the resident. Interview on 05/27/25 at 8:03 A.M. with LPN/Unit Manager #904 confirmed medications are to be administered per physician orders and timely. LPN/Unit Manager #904 confirmed if the order is for ASA 81 mg delayed release Resident #35 should not receive ASA 81 mg chewable and the order stated do not crush. Review of facility policy, PQC Medication Pass Nursing Competency, revised November 2016, revealed medications are administered in accordance with written orders of the attending physician or physician extender. Review of facility policy, Medication Administration - General Guidelines, revised August 2014, revealed medications are administered in accordance with written orders of the prescriber, medications are administered according to established medication administration schedule for facility, 2. Review of the medical record for Resident #5 revealed an admission date of 04/20/25 and diagnoses included but not limited to fracture of left femur, type 2 diabetes mellitus (DM), epilepsy, and adult failure to thrive. Review of the physician orders for May 2025 revealed an order for Phenobarbital tablet 32.4 mg give 1 tablet in the morning for seizures and Phenobarbital 32/4 mg give 2 tablets at bedtime (HS). Review of the medication administration records for May 2025 for Resident #5 revealed on 05/15/25 it is coded #9, which meant to see nurses' note. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 05/15/25 at 7:45 A.M. of LPN #712 administering Resident #5's medications revealed she opened the locked narcotic drawer and there was no medication package for Phenobarbital 32.4 mg available to administer to Resident #5. LPN #712 reported she would need to order the medication from pharmacy. LPN #712 verified Phenobarbital was not available to administer to Resident #5 as ordered. Interview on 05/15/25 at 11:15 A.M. with LPN/Unit Manager #904 confirmed Resident #5's Phenobarbital was not available to administer per physician orders. Review of the nurse note dated 05/15/25 at 10:10 A.M. authored by LPN #712 revealed she spoke with pharmacy regarding Resident #5's medication Phenobarbital and per pharmacy a new prescription was needed. Nurse practitioner was notified of the missed dose and obtained a new script. The script was sent to pharmacy and pharmacy would deliver medication with next delivery. Resident #5 and family were made aware. Review of facility policy, PQC Medication Pass Nursing Competency, revised November 2016, revealed medications are administered in accordance with written orders of the attending physician or physician extender. Review of facility policy, Medication Administration - General Guidelines, revised August 2014, revealed medications are administered in accordance with written orders of the prescriber, medications are administered according to established medication administration schedule for facility, 3. Review of the medical record for Resident #107 revealed an admission date of 05/19/25 with diagnoses including but not limited to malignant neoplasm unspecified site of female breast, secondary neoplasm of bone, fibromyalgia, chronic kidney disease stage 4, and history of falls Review of physician orders dated May 2025 revealed an order for Aspirin 81 mg to give 81 mg by mouth (PO) in the morning. Observation on 05/27/25 at 8:35 A.M. of medication administration revealed Registered Nurse (RN) 727 administered Aspirin chewable 81 mg to Resident #107. Resident #107 swallowed all medications provided by RN #727. Interview on 05/27/25 at 8:44 A.M. with RN #727 confirmed he should not have administered chewable Aspirin to Resident #107. Interview on 05/27/25 at 8:03 A.M. with LPN/Unit Manager #904 confirmed medications are to be administered per physician orders and timely. Review of facility policy, PQC Medication Pass Nursing Competency, revised November 2016, revealed medications are administered in accordance with written orders of the attending physician or physician extender. Review of facility policy, Medication Administration - General Guidelines, revised August 2014, revealed medications are administered in accordance with written orders of the prescriber, medications are administered according to established medication administration schedule for facility, (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents non-compliance investigated under Complaint Number OH00162845.

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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. Based on interview, record review, and observation, the facility failed to ensure residents were free from significant medication errors. This affected one resident (#5) out of five residents reviewed for medication administration. The facility census was 103. Findings include: Review of the medical record for Resident #5 revealed an admission date of 04/20/25 and diagnoses included but not limited to epilepsy, fracture of left femur, type 2 diabetes mellitus (DM), and adult failure to thrive. Review of the physician orders for May 2025 revealed an order for Phenobarbital tablet 32.4 milligram (mg) give 1 tablet in the morning for seizures and Phenobarbital 32.4 mg give 2 tablets at bedtime (HS). a. Review of Resident #5's May 2025 medication administration records (MARS) revealed a total of nine missed morning doses for Phenobarbital 32.4 mg. On 05/02/25, 05/03/25, 05/04/25, 05/10/25, 05/11/25, 05/12/25, 05/15/15, 05/22/25, and 05/24/25 the MAR was coded #9, which means to see nurses' note. Review of Resident #5's medical record revealed there was not a nurses notes on 05/01/25. Nursing notes on 05/02/25, 05/03/25, and 05/04/25 revealed the Phenobarbital medication had not come in from pharmacy. The nurses note on 05/10/25 revealed the facility was awaiting delivery for the medication. The nurses note on 05/11/25 stated Phenobarbital 32.4 mg give 1 table by mouth in the A.M. for seizures with no indication as to why the medication was not administered. There was not a nurses note for 05/12/25. Review of the nurse note dated 05/15/25 at 10:10 A.M. authored by LPN #712 revealed she spoke with pharmacy regarding Resident #5's medication Phenobarbital and per pharmacy a new prescription was needed. The nurse practitioner was notified of the missed dose and obtained a new script. The script was sent to pharmacy, and pharmacy would deliver medication with next delivery. Resident #5 and family were made aware. Review of the nursing note dated 05/22/25 at 10:09 A.M. and 05/24/25 at 07:51 A.M. revealed the nurse practitioner (NP) notified of missing dose. Review of the nursing note dated 05/24/25 at 07:51 A.M. revealed NP notified of missed dose and pharmacy will supply medication on next delivery. b. Review of Resident #5's May 2025 MAR revealed a total of four missed doses of Phenobarbital 32.4 mg give two tablets at HS on 05/01/25, 05/02/25, and 05/24/25. The MAR was coded a #9 for the missed doses to see nurses note. On 05/03/25 the missed dose was coded a #4 on the MAR. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #5's nurses note dated 05/01/25 revealed the nurse did not document a reason the medication was not administered. The nurses note dated 05/02/25 revealed pharmacy had not delivered the medication, and the nurses note on 05/24/25 revealed the medication was unavailable and ordered. The nurses note on 05/03/25 revealed the resident's vitals were out of normal range, but the documented vital signs for blood pressure was 120/60, the pulse at 80 beats per minute, showing both vitals in normal range. The 05/03/25 note did indicate the reason the medication was not administered. Observation on 05/15/25 at 7:45 A.M. of LPN #712 administering Resident #5's medications revealed she opened the locked narcotic drawer and there was no medication package for Phenobarbital 32.4 mg available to administer to Resident #5. LPN #712 reported she would need to order the medication from pharmacy. LPN #712 verified Phenobarbital was not available to administer to Resident #5 as ordered. Interview on 05/15/25 at 11:15 A.M. with LPN/Unit Manager #904 confirmed Resident #5's Phenobarbital was not available to administer per physician orders. Interview on 05/28/25 at 1:24 P.M. with Regional Nurse #640 confirmed medications are to be administered per physician orders and timely. Regional Nurse #640 reported she did not know why Resident #5 had 13 missed doses of Phenobarbital as ordered and would need to check into it and get back with me. Interview on 05/28/25 at 2:13 P.M. with Nurse Practitioner #703 revealed he expects medication to be administered per his orders and timely. NP #703 reported he was not aware Resident #5 had 13 missed doses of Phenobarbital and that is a lot of medication to be missing. NP #703 reported Phenobarbital is a seizure medication, and Resident #5 is at risk for seizures. NP #703 asking what the issue was, why medication not administered per his orders. NP #703 reported he is in the building at least four days a week and can write the script at any time, if that is the issue. NP #703 reported he would be in the building today and follow up on Resident #5 and get some labs. NP #703 reported he was concerned Resident #5 hasn't received his medication as ordered, especially seizure medication. NP #703 reported ultimately it is the facility's responsibility to make sure the medication is available and administered per my orders. Interview on 05/28/25 at 2:26 P.M. with Regional Nurse #640 revealed after speaking with pharmacy, pharmacy indicated it was too soon to refill the prescription the way the script was written as it should be one script and not two. Interview on 05/28/25 at 2:29 P.M. with LPN/Unit Manager #904 revealed Phenobarbital 32.4 mg was in the facility AlixaRX and could have been pulled and administered instead of awaiting the evening delivery from pharmacy. Review of the lab for Phenobarbital level dated 05/28/25 revealed Resident #5's Phenobarbital level was 10. 1 micrograms per milliliter (mcg/ml), normal range 10 to 40. Phenobarbital level of 10.1 is at the lower end of the therapeutic range. Review of the facility AlixaRX medications available at the facility revealed Phenobarbital 32.4 mg was available in the system. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy, PQC Medication Pass Nursing Competency, revised November 2016, revealed medications are administered in accordance with written orders of the attending physician or physician extender. Review of facility policy, Medication Administration - General Guidelines, revised August 2014, revealed medications are administered in accordance with written orders of the prescriber, medications are administered according to established medication administration schedule for facility, This deficiency represents non-compliance investigated under Complaint Number OH00162845.