

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 07/30/2026
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.			
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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, Self-Reported Incident (SRI) investigation review, video surveillance review, police report review, Ohio Board of Nursing complaint information, interviews, and facility policy review, the facility failed to implement adequate interventions to prevent a fall, prevent accident hazards to prevent injury, conduct a safe resident transfer to prevent injury, provide appropriate assessment and care after a fall, and complete timely and accurate fall assessments, investigations and care plans. This affected five residents (Residents #6, #24, #56, #113 and #115) of seven residents reviewed for accidents. The facility census was 95. Actual harm occurred on 06/03/26 when Resident #56 who was cognitively impaired and dependent on staff for activities of daily living (ADLs), was observed to have bruising and a chest hematoma (pooling of blood that forms outside of broken blood vessels in the skin, soft tissue or organs). By 06/06/26 the hematoma worsened, and the resident had redness and edema to the right hand with increased pain. Subsequently, Resident #56 was admitted to the hospital and diagnosed with multiple right and left side rib fractures, a hematoma to the right chest wall, bruising to the chest across the breasts and on the right-side flank, back, and multiple bruising to both arms, right and left side ribs, and both legs. Additional Actual Harm occurred on 07/02/26 when Resident #113 who received hospice care, had severe cognitive impairment, and required two-person assistance and a mechanical lift for transfers, was in bed without physician ordered fall interventions in place and fell out of bed onto a floor mat adjacent to the bed. Without assessing for injury, Licensed Practical Nurse (LPN) #930 lifted Resident #113 by placing one hand in the middle of Resident #113's back near her neck and the other hand behind her left knee and threw her onto the bed. LPN #930 then exited the room and left the resident alone without providing any other assistance. Resident #113 developed a swollen right arm and hand and was hospitalized from [DATE] until 07/11/26 with a thoracic burst fracture (a severe spinal injury where a middle-back vertebra shatters under heavy vertical force, sending bone fragments into the spinal canal), and multiple ecchymoses (bruising) on bilateral hands, wrists, forearms and upper extremities. Findings include: 1. Review of the closed medical record for Resident #113 revealed an admission date of 02/06/26 and discharge date of 07/03/26 with diagnoses including unspecified dementia, anxiety disorder and spinal stenosis. Review of Resident #113's x-ray of the lumbosacral spine three-view dated 02/06/26 revealed no evidence of fracture or subluxation. Moderate to severe spondylotic changes were seen in the lumbar spine as described. (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 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #113's fall care plan dated 02/07/26 revealed the resident was at risk for falls with interventions dated 02/20/26 for bed bolsters (long, firm, cylindrical or wedge-shaped cushions used on beds for body positioning and support), an intervention dated 02/07/26 for the bed in the lowest position when occupied, and an intervention dated 02/07/26 for call light within reach. Review of Resident #113's physician orders revealed an order dated 02/13/26 for bilateral half side rails to bed for mobility and positioning; an order dated 02/17/26 for a perimeter mattress to properly identify bed borders and for comfort every shift; an order dated 02/17/26 for floor mats to exit side of bed; an order dated 02/20/26 to admit to hospice services with a diagnosis of protein malnutrition; an order dated 02/20/26 for bed bolsters every shift; an order dated 02/23/26 for two staff to assist at all times every shift; an order dated 06/19/26 for a mechanical lift with two staff assistance for all transfers; and an order dated 07/20/26 to admit to the secured unit. Review of Resident #113's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had severe cognitive impairment and was dependent to roll left and right. Review of Resident #113's fall risk assessment dated [DATE] revealed the resident was at risk for falls. Review of Resident #113's medication administration records (MARS) and treatment administration records (TARS) from 06/01/26 to 07/03/26 revealed documentation the fall interventions including bilateral half side rails, perimeter mattress, and bed bolsters were in place. Review of video surveillance dated 07/02/26 at 9:57 A.M. provided by Resident #113's daughter revealed the resident was on the floor with her head facing the bottom of the bed and her feet towards the top of the bed. The resident was on a floor mat. The nurse (LPN #930) was observed picking the resident up from the floor under her right shoulder and under the left knee. He then threw the resident in bed with her head towards the foot of the bed and her legs towards the top of the bed. Resident #113 was slightly sideways in bed and had no gown on. The video surveillance confirmed the resident did not have a perimeter mattress, bed bolsters, or bilateral half side rails in place per physician's orders. The resident did have a floor mat to the exit side of the bed. Twelve seconds into the video surveillance, the nurse was observed walking out of the room and leaving the resident alone. The video surveillance did not reveal evidence that the nurse had assessed the resident after the fall and prior to transferring her and did not assist in putting Resident #113's gown back on. Review of Resident #113's Self-Reported Incident (SRI) investigation for physical abuse dated 07/02/26 revealed on 07/02/26, Resident #113's daughter and hospice nurse reported to the Administrator about the nurse's (LPN #930) technique used for Resident #113's transfer to bed. The nurse in question was immediately pulled from the floor and suspended pending an investigation. A skin assessment was performed on the resident with no apparent injuries noted. Statements were gathered and interviews conducted. The SRI was unsubstantiated. Review of Resident #113's Un-Witnessed Fall investigation dated 07/02/26 at 11:00 A.M. revealed the resident was found on the floor mat next to her bed by the charge nurse. No injuries or pain were noted during the assessment. The power-of-attorney (POA) and physician were notified. The resident (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	was transferred back into bed. The resident was unable to give a description of the incident. Injuries reported post fall include hematomas to the right elbow and right forearm. Review of Resident #113's progress note dated 07/02/26 at 12:55 P.M. authored by LPN #930 revealed the resident rolled onto the floor mat off her bed and was found by the nurse and assisted back in bed with one assist. The nurse practitioner, Director of Nursing (DON) and power-of-attorney were made aware. No injuries were found. Review of Resident #113's police report dated 07/02/26 at 2:27 P.M. revealed the police were dispatched on an abuse complaint. Upon arrival, the police spoke with the facility Administrator who stated on 07/02/26, he received an abuse complaint about Resident #113. The Administrator stated Resident #113 was a resident in the memory care unit and that she was in the late stages of dementia. The Administrator received the complaint from the resident's daughter. The daughter had a motion activated camera in Resident #113's room and provided the Administrator with footage that showed a nurse throwing the resident in bed. The Administrator provided the police with a copy of the footage. The Administrator further stated he reported the incident to the health department and was provided with an intake number of #276364. On 07/02/26 at approximately 9:57 A.M., Resident #113 fell out of bed. The nurse that responded to help her was LPN #930. LPN #930 placed his right hand on the middle of Resident #113's back near her neck and his left hand behind her left knee. He then picked her up and threw her on the bed. Resident #113's feet were near the headboard and her head near the end of the bed. LPN #930 then left the room. Resident #113 was wearing what appeared to be a hospital gown that fell off the resident. LPN #930 then left the room without attempting to put the resident's gown back on. On 07/02/26 at approximately 3:50 P.M., LPN #930 responded to the police station. He stated that he had no intent to harm Resident #113. He stated that after he left the room, he went to get another aide to help rearrange the resident. He further stated that he did not follow some of the protocols that were in place and was fired from the facility. The police advised him that the investigation was not complete and the police were to contact him if further information was needed. The officer attempted to gather further information from Resident #113 regarding the incident, and she did not recall this incident due to her dementia. On 07/03/26 at approximately 12:51 P.M., the officers spoke to Resident #113's power-of-attorney who wanted an update and to provide the police with video footage of the incident. At approximately 1:50 P.M. the officer called the daughter and asked if the resident had any injuries. The daughter stated that a private ambulance was going to transport the resident to the hospital to assess for injuries. The daughter reviewed the footage and told the officer that the resident was thrown into bed at 9:57 A.M. and at 10:00 A.M., a different aide came in and correctly rearranged the resident in bed. On 07/15/26, the officer received discharge paperwork from the daughter. The paperwork showed Resident #113 was admitted to the hospital on [DATE] and that she was discharged on 07/11/26. The injuries listed on the discharge paperwork was a closed stable burst fracture of the seventh thoracic vertebrae. On 07/15/26, a follow-up with the daughter revealed the doctor said a vertebra in the resident's neck was also injured. Review of Resident #113's progress note authored by the DON as a late entry on 07/02/26 at 2:52 P.M. revealed the resident's range of motion (ROM) was assessed. No issues or concerns were noted. Resident #113 was able to move extremities without pain or discomfort. Review of Resident #113's progress note dated 07/03/26 at 1:41 P.M. authored by LPN #716 revealed (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #115's progress note dated 11/13/25 at 12:39 P.M. authored by LPN #710 revealed the resident got up for lunch and the nurse observed the resident standing at the door. A bruise was noted under the resident's right eye, and the resident was unable to tell the nurse what happened to her face. The Assistant Director of Nursing (ADON) and son were notified. Review of Resident #115's progress note dated 11/13/25 at 12:56 P.M. revealed the son reported the resident had said she fell on [DATE] but she did not remember how she fell. The son confirmed no staff had called him and staff usually called for falls. Review of Resident #115's progress note dated 11/13/25 at 2:01 P.M. revealed the resident fell within the last two hours with a time unknown. The CNP was notified and wanted the resident sent to the emergency department (ED). Family were made aware. Review of Resident #115's progress note dated 11/13/25 at 2:27 P.M. revealed the resident got up for lunch and the resident was standing at the doorway. A bruise was noted under the resident's eye, and the resident was unable to report what happened. The ADON and son were notified. Review of Resident #115's progress note authored by the DON dated 11/13/25 at 9:28 P.M. revealed the clarification note stated the resident had fallen the night before and told the staff that she did not tell anyone. The resident was in the doorway without an assistive device and unsteady. The CNP was notified of the unwitnessed fall, and the resident was sent to the emergency room. Review of Resident #115's progress note authored by LPN #605 dated 11/13/25 at 11:11 P.M. revealed the resident was transported to the hospital. A right eye bruise was noted and no complaints of pain. Review of Resident #115's Fall Risk assessment dated [DATE] revealed the resident was at risk for falls. Interview on 07/23/26 at 12:37 P.M. with RRN #935 confirmed the resident record showed a large black eye on the right eye. Interview on 07/27/26 at 3:00 P.M. with the Administrator confirmed Resident #115's unwitnessed fall did not have an adequate investigation to determine what caused the fall with injury, what interventions were in place prior to the fall and what new interventions were implemented following the fall. The investigation also did not contain staff statements to determine the events that led to the fall. Review of the Fall Management policy revised October 2022 revealed the facility will identify each resident who was at risk for falls and will develop a plan of care and implement interventions to manage falls. The facility will provide an environment free from potential hazards. The licensed nurse will perform a Fall Risk Assessment immediately if the resident was deemed to be at risk for falls. 4. Review of the medical record for Resident #6 revealed an admission date of 07/11/25. Diagnoses included but were not limited to stage IV chronic kidney disease, atrioventricular block, type II (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	diabetes mellitus, unspecified protein-calorie malnutrition, acquired absence of left great toe, partial traumatic amputation of left great toe, displaced fracture of proximal phalanx of left great toe, and osteoarthritis. Review of the 01/16/26 Quarterly MDS 3.0 assessment for Resident #6 revealed a moderate to severe cognitive impairment and was noted to be dependent on rolling left and right and ADLs. Review of the physician orders for Resident #6 revealed a 10/30/25 order to turn and reposition with care round and as needed. No additional orders were noted related to fall interventions prior to the 01/21/26 fall. Review of the 10/29/25 admission assessment for Resident #6 revealed his last fall was indicated as 10/19/25 and no fall risk score was noted. No evidence of a fall risk assessment was found prior to 01/21/26. Review of 07/22/26 care plan for Resident #6 revealed the fall care plan was initiated on 08/06/25 and indicated resident was at risk for falls related to impaired mobility and weakness. Interventions listed were call light within reach, encouraging resident to use call light, encouraging non-skid footwear when out of bed to minimum slipping as tolerated, following facility fall protocol, and therapy to evaluate and treat as ordered or as needed. Review of the nursing progress note dated 01/21/26 timed at 5:51 A.M. for Resident #6 revealed (unspecified) CNA called nurse to resident room, and she had found resident on the floor between his bed and the window. Resident #6 was lying face down parallel between the bed and the window, and his right leg was straight, and his left leg was bent at the knee under the right leg. Resident #6's bed was noted to b		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, record reviews of nursing staff schedules, timecards, facility assessment and Payroll Based Journal, the facility failed to maintain sufficient staffing levels to ensure residents received timely care and services. This affected eight residents (Resident #6, #12, #13, #16, #39, #40, #93 and #99) and had the potential to affect all 95 residents residing in the facility. Findings include: 1. Review of the Payroll Based Journal report revealed the facility had a one-star staffing rating and was identified with low weekend staffing for the second fiscal year quarter from 01/01/26 through 03/31/26. Interviews with residents during the survey revealed they had concerns with staffing. Residents stated they had to wait too long for their call lights to be answered and receive timely assistance with incontinence care and activities of daily living (ADLs). The interviews included the following: Interview on 07/20/26 at 9:14 A.M. with Resident #16 revealed call lights were not always answered timely. Interview on 07/20/26 at 9:49 A.M. with Resident #40 revealed there was not enough staff for her mechanical lift transfer and frequently had to wait to get up due to lack of staff to assist her. Interview on 07/20/26 at 10:23 A.M. with Resident #39 revealed on first shift and weekends there were not enough staff, and staff were not always timely with care. Interview on 07/20/26 at 10:41 A.M. with Resident #12 revealed the facility was short-staffed for aides on all shifts and call lights took at least an hour and a half for staff to answer. Interview on 07/20/26 at 11:01 A.M. with Resident #99's daughter revealed she had staffing concerns related to care not being provided timely. Interview on 07/20/26 at 2:30 P.M. with Resident #6 revealed that it took a long time for care to be given. Resident #6 stated staff say they will come back and they do not come back for a long time, sometimes several hours. Resident #6 also stated that night shift was really bad and took a long time and stated that the Director of Nursing stated they would get help but does not provide help. Interview on 07/21/26 at 5:43 A.M. with Certified Nursing Aide (CNA) #912 stated there was not enough staff scheduled for nights. There were typically four to five aides and five nurses, so they were not always able to finish assigned showers and tasks. Interview on 07/21/26 at 6:02 A.M. with CNA #625 stated there was not usually enough staff and did (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	not feel the facility always tried to cover call offs. CNA #625 also stated being not always able to complete showers due to staffing. CNA #625 tried to do checks and changes but was not always able to complete them every two hours if there was only three CNAs and not able to complete timely mechanical lift transfers with only three aides due to waiting for another aide to assist with the transfer. Interview on 07/21/26 at 6:31 A.M. with CNA #703 revealed there was not always enough staff scheduled and call-offs were not always covered. Interview on 07/23/26 at 6:43 A.M. with CNAs #631 and #807 stated when there were call-offs they were not always able to complete their two-hour checks and changes and not always able to complete all their scheduled showers, and management did not usually come in to assist staff. 2. Observation and interview on 07/22/26 at 7:37 A.M. revealed Resident #13 was lying in bed pointing to her brief. Resident #13 revealed she was wet and needed to be changed and cleaned up. Resident #13 stated she was last changed the night prior and it had been a long time. Observation and interview on 07/22/26 at 7:39 A.M. with Licensed Practical Nurse (LPN) #705 in Resident #13's room, revealed Resident #13 was lying in bed and informed LPN #705 she was wet, needed to be changed and had not been changed since the night before. LPN #705 checked Resident #13's brief and stated, she is wet. LPN #705 then was observed fastening Resident #13 brief back together, then pulled up her covers, washed her hands and exited the room. LPN #705 stated I'll be back. LPN #705 was then observed standing next to a medication cart watching a current medication pass by an alternate surveyor. LPN #705 was not the designated staff member for the medication pass and left Resident #13 unchanged. LPN #705 confirmed and verified she did not check and change Resident #13 at the time of the interview. 3. Observation and interview on 07/22/26 at 9:42 A.M. of Unit Manager (UM)/LPN #705 revealed she was gathering supplies to provide Resident #16's incontinence care. UM/LPN #705 gathered the supplies she needed and proceeded to Resident #16's room to provide his incontinence care. Resident #16 told UM/LPN #705 he had been waiting a long time to have his incontinence brief changed. Resident #16 stated he told other staff he needed changed, including UM/LPN #705 and he did not know why they did not come back to provide his care. Resident #16 indicated he frequently waited a long time to be changed, and he asked UM/LPN #705 to change him before he ate because he did not like to eat when his incontinence brief was soiled. UM/LPN #705 verified that it was true, but the staff were instructed not to change residents' soiled incontinence briefs when they had food in the room because it was an infection control issue and Resident #16's meal tray was in the room when he asked to be changed. Resident #16's incontinence brief was saturated with urine. Resident #16 stated he wanted changed before he ate and told staff about it, but no one came into his room to provide his care before the meal came. He said he waited about two to three hours before he was changed. Interview on 07/22/26 at 10:26 A.M. with CNA #900 and #717 revealed there were just two of them assigned to the nursing unit Resident #16 resided on and it was not enough to meet the care needs of the residents. CNA #900 indicated some residents required two staff assistance and call lights were going off at the same time they were providing care for those residents and it made it hard for them to get to everyone in a timely matter. Interview on 07/22/26 at 10:47 A.M. of CNA #717 revealed she had just found out about a half hour prior that her assignment changed and she now had resident rooms 119 through 129 and 135 through 145. CNA #717 indicated she was not told she had the residents in rooms 135 through 145, so she had not made rounds or (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	changed incontinence briefs for those residents including Resident #16 because she did not know she had them. CNA #717 stated communication was not always good when there was not enough staff, and it was stressful when there weren't enough aides. CNA #717 indicated she did not feel she could take breaks including a lunch break when there wasn't enough staff because she wanted to make sure the residents were taken care of. CNA #717 revealed she did not have enough time to sit with residents and listen to them. CNA #717 stated about half the time there was not enough staff to care for the residents. 4. Interview on 07/22/26 at 2:36 P.M. of Occupational Therapy Assistant (OTA) #944 revealed she just spoke with Resident #93, he was not feeling well enough for therapy today and he had his call light on to have his aide clean him up. Observation on 07/22/26 at 2:42 P.M. revealed Resident #93's light above the door to his room was blinking, indicating his call light was activated. Observation on 07/22/26 at 2:45 P.M. revealed Assistant Director of Nursing (ADON) #713 answered Resident #93's call light and walked out of the room without doing anything and left the call light blinking. Observation on 07/22/26 at 2:47 P.M. revealed Certified Nursing Assistant (CNA) #629 walked into Resident #93's room to answer his call light. Resident #93 indicated he was waiting an hour to an hour and a half to have his incontinence brief changed. Resident #93 revealed the staff came to his room to answer his call light and said they would come back if no one changed him, but no one came back. Resident #93 indicated the aides were busy and unable to change him when they answered his call light. CNA #629 provided incontinence care and observation of Resident #93's buttocks, upper thighs and hips revealed multiple healed open areas. Resident #93 indicated one of the healed areas by his left lower buttock still hurt and he could not sit very long because of it. Resident #93's incontinence brief was very wet with urine. Interview on 07/22/26 at 3:15 P.M. with CNA #629 revealed Resident #93's call light was activated and she answered it. CNA #629 indicated she was giving another resident a shower and was unable to change Resident #93's incontinence brief when she answered his call light but told him to activate his call light in 15 minutes if no one came in to change him. CNA #629 indicated about 25 minutes later when she was finished with the shower Resident #93's call light was on and that is when she went to his room to change him. CNA #629 revealed Resident #93 did not tell her how long his call light was on when she first answered it. 5. Review of the facility assessment dated [DATE] showed the assessment did not identify specific staffing numbers required per unit. During an interview on 07/28/26 at 9:48 A.M., the Administrator confirmed the facility assessment reflected only the minimum staffing levels and was based on patient per day (PPD) calculations. He stated CNA numbers were based on census, and the facility aimed to operate at a PPD of 3.0 (the amount of care time per resident in a 24 hour period). During an interview on 07/28/26 at 9:35 A.M., Unit Manager #827 stated staffing levels were dependent on census. She explained that assignment sheets generally showed between four and eight CNAs scheduled, and she assigned CNAs to their units when they arrived for their shift. She stated the facility tried to schedule five to six CNAs per day shift. The memory care unit was consistently staffed with one nurse and two aides per shift. Review of the daily assignment sheet for day shift on 07/22/26 showed: CNA #913 (Assignment 1) was responsible for rooms 101&ndash;118 and 130&ndash;134, totaling 18 residents. CNA #717 (Assignment 2) was responsible for rooms 119&ndash;129 and 135&ndash;145, totaling 19 (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	residents. CNA #911 (Assignment 3) was responsible for rooms 146&ndash;148 and 200&ndash;219, totaling 20 residents. CNA #900 (Assignment 4) was responsible for rooms 149&ndash;170, totaling 22 residents. Review of the assignment sheets and timecards confirmed CNA #911 was responsible for 20 residents on 07/22/26, and CNA #717 was responsible for 19 residents. Additional review showed CNA #909 arrived at 2:48 P.M. on 07/22/26 to assist when the census was 79 residents. During an interview on 07/28/26 at 11:32 A.M., the Administrator confirmed that the staffing records for 07/22/26 showed five aides scheduled on night shift and four aides scheduled on day shift. He stated these were the only dated assignment sheets he located. This deficiency represents non-compliance investigated under Complaint Numbers 2735166, 2715490 and 1405090 (OH00167146).		

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. Based on the nursing staffing schedule, staff time punches and staff interview, the facility failed to maintain 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 95 residents residing in the facility. Findings include: Review of the nursing staff schedule and staff time punches for 06/06/26 revealed there was no RN present working in the facility. Interview on 07/28/26 at 10:18 A.M. with Administrator confirmed he was unable to provide evidence that an RN was working for at least eight consecutive hours on 06/06/26. This deficiency represents non-compliance investigated under Complaint Numbers 2735166, 2715490 and 1405090 (OH00167146).		

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on record review, interview, and facility policy review, the facility failed to ensure effective administration staff. This affected 30 residents (Residents #6, #9, #12, #13, #16, #24, #25, #29, #30, #32, #39, #40, #45, #49, #56, #61, #72, #80, #82, #83, #86, #88, #93, #96, #99, #106, #110, #113, #115 and #117) and had the potential to affect all residents residing in the facility. The facility census was 95. Findings include: During review of the annual and complaint survey, the following concerns were identified which resulted from ineffective administration including: The facility failed to implement an effective system to prevent injuries from falls and accident hazards which included following fall interventions and facility smoking policy, and completing accurate fall assessments, investigations and care plans which affected Residents #6, #9, #24, #56, #113 and #115. Actual harm occurred to Resident #56 who sustained multiple right and left side rib fractures, a hematoma to the right chest wall, bruising to the chest across the breasts and on the right-side flank, back, and multiple bruising to both arms, right and left side ribs, and both legs with no actual determination as to the cause of injuries. Additional actual harm occurred to Resident #113 when after falling out of bed staff inappropriately transferred her and she was thrown onto the bed. The resident sustained a thoracic burst fracture (a severe spinal injury where a middle-back vertebra shatters under heavy vertical force, sending bone fragments into the spinal canal), and multiple ecchymoses (bruising) on bilateral hands, wrists, forearms and upper extremities. Residents #6, #9, #24 and #115 had falls with inadequate investigations to implement corrective measures, incomplete documentation and updated care plans, and inaccurate assessments. The facility failed to implement effective dietary services to ensure substantial snacks for the secured memory care unit, the honoring of food preferences, and providing necessary adaptive equipment which affected Residents #29, #49, #80, #83, #86, #96 and #99. Residents #49, #96 and #99 did not receive substantial nutritional evening snacks when mealtimes were greater than 14 hours. Resident #83 was served food listed as an allergy, and Residents #29, #80 and #86 did not receive adaptive equipment during meal service. The facility failed to implement effective nursing services to ensure adequate and appropriate staffing by not having registered nurse (RN) coverage at least eight hours daily and not providing sufficient staffing to meet resident needs which resulted in inadequate and untimely provision of activities of daily living care or assistance affecting Residents #6, #12, #13, #16, #39, #40, #45, #88, #93, #99 and #110. Nursing staff did not implement care planned interventions for Resident #45, follow discharge instructions and provide timely incontinence care for Resident #13, ensure transport to dialysis treatment for Resident #106, accurately and consistently document advance directives in the medical record for Resident #93, accurately transcribe a physician order to prevent a significant medication error for Resident #88, and refrain from falsifying bathing documentation for Resident #88. The facility failed to implement an effective immunization program to ensure residents or resident representatives received education regarding the benefits and potential side effects of the COVID-19, influenza and pneumococcal vaccinations affecting Residents #9, #24, #32 and #72. The facility failed to implement an effective program for abuse, neglect, misappropriation and exploitation by ensuring Resident #93 was free from staff-to-resident verbal abuse, Resident #61 was free from misappropriated resident funds, Resident #117 was free from misappropriated personal property, Residents #25 and #30 were free from unnecessary medications, and timely abuse reporting and investigations for Residents #56, #82, #93 and #117. Review of the undated Administrator job description revealed the primary purpose of the job position was to direct the overall operation of the facilities activities in accordance with current applicable Federal, State and local standards, guidelines and regulations and to assure that the (continued on next page)		

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	highest degree of quality resident care was maintained at all times. Major duties and responsibilities included but were not limited to help to establish and direct the implementation of written policies and procedures that reflect the goals and objectives of the facility. Review of the Director of Nursing (DON) job description signed on 09/12/24 revealed the purpose of the position was to provide complete supervision and management of the nursing department through the implementation of policies and procedures and adherence to quality standards. Review of the Assistant Director of Nursing (ADON) job description signed on 11/03/25 revealed the ADON supports the DON in supervising and managing the nursing department to ensure high-quality resident care. This position helps implement policies and procedures, maintains compliance with federal and state regulations and ensure staffing levels meet resident needs. Interview on 07/28/26 at 1:46 P.M. with Administrator confirmed during the quality assurance (QA) meetings, the department heads meet every other month with the Medical Director, and the ancillary services send reports quarterly. Administrator confirmed the facility had concerns with the above findings. Review of facility policy for the Quality Assurance Performance Improvement (QAPI) Guidelines dated 03/2024 revealed a process that allowed for continuous identification of opportunities for enhancement and improvement by addressing gaps in the systems through planned interventions to improve overall quality of patient care and facility services. This deficiency represents non-compliance investigated under Complaint Number 1405090 (OH00167146).		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, staff interview, video surveillance review, police report review, and review of the facility's policies, the facility failed to implement care planned interventions and provide required assistance for multiple activities of daily living (ADL). Specifically, the facility failed to provide timely incontinence care for Residents #16, #45, #93, and #110; failed to ensure Resident #45's fingernails were trimmed appropriately; failed to ensure Resident #16's mattress remained properly positioned; failed to ensure Resident #110 received needed meal assistance; and failed to ensure scheduled showers were provided for Residents #45 and #88. This deficient practice affected five residents (#16, #45, #88, #93, and #110) out of seven residents reviewed for ADL. The facility census was 95. Findings include: 1. Review of Resident #45's medical record revealed an admission date of 06/17/26 with diagnoses including cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebellar artery, unspecified protein-calorie malnutrition, and adult failure to thrive. Review of Resident #45's care plan dated 06/18/26 included Resident #45 had an alteration in elimination of bowel and bladder. Resident #45 would continue to remain clean, dry, and free of odors on a daily basis through the review date of 09/28/26. Interventions included assisting with toileting needs throughout the day; checking and changing as required for incontinence, washing, rinsing and drying perineum, changing clothing as needed after incontinence episodes, and providing incontinence care with care rounds. Review of Resident #45's care plan dated 06/18/26 included Resident #45 had an ADL self-care performance deficit related to diagnoses. Staff assisted with completion of Resident #45's needs throughout the day. Resident #45 would continue to have needs met daily; remaining clean, dry, dressed, groomed and free of odors through the review date of 09/28/26. Interventions included checking fingernail length and trimming and cleaning on bath days and as necessary. Review of Resident #45's admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] included Resident #45 had severe cognitive impairment. Resident #45 required substantial to maximal assistance with toileting hygiene, bathing, upper and lower body dressing and personal hygiene. Resident #45 was occasionally incontinent of urine and bowel. Resident #45 did not reject care during the seven-day assessment look-back period. Observation on 07/20/26 at 9:24 A.M. of Resident #45 revealed there was a large area of dried urine on his sheet and a large area of dried urine on his bedspread. Resident #45 was unable to verbalize when he was last changed. Observation revealed a large puddle of what appeared to be spilled water on the floor under Resident #45's bedside table, near the foot of his bed. A communication board was lying in the puddle of liquid on the floor. An interview on 07/20/26 at 9:24 A.M. of Unit Manager/Licensed Practical Nurse (UM/LPN) #705 confirmed Resident #45 had large, dried urine areas on his sheet and bedspread, and there was a large puddle of what appeared to be spilled water on the floor with a communication board lying in the (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	middle of the puddle. UM/LPN #705 revealed it looked like the sheets and bedspread had not been changed in quite a while. UM/LPN #705 had housekeeping mop the floor to clean the spilled liquid. Observation on 07/20/26 at 9:36 A.M. of UM/LPN #705 revealed she gathered incontinence supplies to provide Resident #45's incontinence care and found UM/LPN #827 to assist her. UM/LPN's #705 and #827 proceeded to provide Resident #45's incontinence care and his sleep pants were wet with urine; the fitted sheet and regular sheet were wet with urine, and the sheets and bedspread had large areas of dried urine on them. Resident #45 had a moderate bowel movement of formed brown stool, and his incontinence brief was wet with urine. Further observation revealed Resident #45's fingernails on both hands were about a half inch long, yellow and had brownish-black colored material under the nails. UM/LPN #705 confirmed Resident #45's fingernails were long, dirty, needed cut, and the aides were supposed to cut the residents fingernails when they had showers. UM/LPN #705 indicated Resident #45 did not talk but would nod his head or shake his head when asked questions. An interview on 07/20/26 at 10:19 A.M. of Certified Nursing Assistant (CNA) #801 revealed he was assigned to Resident #45 but had not changed his incontinence brief or provided care this morning. An interview on 07/22/26 at 8:13 A.M. with the Director of Nursing (DON) revealed shower sheets were completed and were used for logging showers. After the showers were completed, the shower sheets were given to the Unit Managers. The DON indicated showers could be documented in the electronic record, but the paper shower sheets were what was used to ensure showers were completed. An interview on 07/23/26 at 2:40 P.M. with the DON confirmed not all showers were completed, and she did not have shower sheets for Resident #45 for 06/17/26 through 07/20/26. An interview on 07/27/26 at 9:36 A.M. of Regional Director of Clinical Operations (RDCO) #940 revealed shower sheets were expected to be filled out when residents had showers, and the facility was working on getting into compliance with the aide documentation in the electronic record. RDCO #940 indicated both were supposed to be completed, but it did not always happen. RDCO #940 revealed hair washing and clipping fingernails should be done by the aides as needed and per resident preference. 2. Review of Resident 16's medical record revealed an admission date of 11/29/23 with diagnoses including hemiplegia (paralysis) and hemiparesis (weakness) following cerebral infarction affecting the right non-dominant side, HIV (human immunodeficiency virus), neuromuscular dysfunction of the bladder, and neurogenic bowel. Review of Resident #16's care plan revised 07/08/24 included Resident #16 was incontinent of bladder and bowel due to diagnoses. Staff assisted with completion of his toileting and incontinence care needs. Resident #16 would remain clean, dry, and free of odors through the review date. Interventions included checking and changing during care rounds and as required/needed for incontinence. Washing, rinsing, and drying perineum, applying an adult brief or pad with each incontinence episode and as needed, and changing clothing as needed after incontinence episodes. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #16's Quarterly MDS 3.0 assessment dated [DATE] revealed Resident #16 was cognitively intact. Resident #16 required supervision or touching assistance with eating, and substantial to maximal assistance with toileting hygiene, bathing, and personal hygiene. Resident #16 was frequently incontinent of urine and occasionally incontinent of bowel. Resident #16 did not reject care during the seven-day assessment look-back period. Review of Resident #16's nurse aide charting on 07/22/26 revealed his incontinence brief was changed at 5:20 A.M. There was no evidence Resident #16's incontinence brief was changed on 07/22/26 between 5:20 A.M. and 9:42 A.M. Observation on 07/22/26 at 8:43 A.M. revealed Resident #16's call light was activated, and UM/LPN #705 answered the call light. Resident #16 told UM/LPN #705 his incontinence brief needed changed. An interview on 07/22/26 at 8:43 A.M. with UM/LPN #705 indicated Resident #16 said he needed changed, and she told him when he was done eating, he would have his incontinence brief changed. UM/LPN #705 indicated she told Certified Nursing Assistant (CNA) #629 to change Resident #16's incontinence brief when he finished eating. An interview on 07/22/26 at 9:19 A.M. of CNA #717 revealed her resident assignment included rooms 119 through 134 (which did not include Resident #16's room), and she did not know who was assigned to Resident #16's room. CNA #717 indicated CNA #629 was in the dining room assisting residents with their breakfast meal. Observation on 07/22/26 at 9:38 A.M. revealed Resident #16's call light was activated, and it was answered by UM/LPN #705. Resident #16 said he needed changed. Resident #16 was lying in bed, and his pillow had fallen into an open area between the headboard and the mattress, and there was a gap of about 12 inches where the pillow was laying. Resident #16 kept pulling up on the pillow and fluffing it to make it high enough to be comfortable for his head to lay on. Resident #16 stated the mattress slid every day like this, and the mattress could be seen hanging over the foot of the bed by at least 12 inches. UM/LPN #705 indicated she would have maintenance fix the bed, so it did not do that anymore. Observation on 07/22/26 at 9:42 A.M. of UM/LPN #705 revealed she was gathering supplies to provide Resident #16's incontinence care. UM/LPN #705 gathered the supplies she needed and proceeded to Resident #16's room to provide his incontinence care. Resident #16 told UM/LPN #705 he had been waiting a long time to have his incontinence brief changed. Resident #16 stated he told other staff he needed to be changed, including UM/LPN #705, and he did not know why they did not come back to provide his care. Resident #16 indicated he frequently waited a long time to be changed, and he asked UM/LPN #705 to change him before he ate because he did not like to eat when his incontinence brief was soiled. UM/LPN #705 revealed that was true, but the staff were instructed not to change the residents soiled incontinence briefs when they had food in the room because it was an infection control issue, and Resident #16's meal tray was in the room when he asked to be changed. Resident #16's incontinence brief was saturated with urine. Resident #16 stated he wanted to be changed before he ate and told staff about it, but no one came in his room to provide his care before the meal came. He said he waited about two to three hours before he was changed. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 07/22/26 at 10:26 A.M. with CNAs #900 and #717 revealed there were just two of them assigned to the nursing unit Resident #16 resided on, and it was not enough to meet the care needs of the residents. CNA #900 indicated some residents required two-staff assistance, and call lights were going off at the same time they were providing care for those residents, and it made it hard for them to get to everyone in a timely matter. An interview on 07/22/26 at 10:47 A.M. of CNA #717 revealed she just found out a half an hour ago that her assignment changed, and she now had resident rooms 119 through 129 and 135 through 145 (this included resident #16's room). CNA #717 indicated she was not told she had the residents in rooms 135 through 145 until a half an hour ago, and she had not made rounds or changed incontinence briefs for those residents, including Resident #16, because she did not know she had them on her assignment. CNA #717 stated communication was not always good when there were not enough staff, and it was stressful when there weren't enough aides. CNA #717 indicated she did not feel she could take breaks including a lunch break when there wasn't enough staff because she wanted to make sure the residents were taken care of. CNA #717 revealed she did not have enough time to sit with residents and listen to them. CNA #717 stated there was not enough staff to care for the residents about half of the time. An interview on 07/28/26 at 8:32 A.M. with Resident #16 confirmed no one had been in to fix the gap between his mattress and the headboard since he reported it last week. An interview on 07/28/26 at 8:37 A.M. with Maintenance Director #707 confirmed no one had informed him of the repair needed for Resident #16's bed until the surveyor pointed it out to him. He stated the bed bolsters need to be moved up closer to the head of the bed to keep it from sliding. He stated a work order was not created, and he had not been made aware of it prior to this morning. An interview on 07/28/26 at 10:56 A.M. of RDCO #940 revealed there was no written policy stating residents were not to have soiled incontinence briefs changed during mealtimes. RDCO #940 indicated the facility did not want the resident's food sitting in the room not attended to, but the residents could have their soiled incontinence briefs changed around mealtimes. RDCO #940 indicated there was no infection control issue preventing residents from having their incontinence briefs changed around mealtimes. 3. Review of Resident #93's medical record revealed an admission date of 09/19/25 with diagnoses including acute and chronic respiratory failure with hypoxia and hypercapnia, heart failure, acquired absence of the right leg above the knee, and peripheral vascular disease. Review of Resident #93's care plan revised 04/21/26 included Resident #93 had an alteration in elimination related to incontinence of bowels. Staff assisted with completion of Resident #93's toileting and incontinence needs throughout the day. Resident #93 would continue to remain clean, dry, and free of odors through the review date of 09/07/26. Interventions included assisting with toileting needs throughout the day, disposable briefs, checking and changing as required for incontinence, washing, rinsing, and drying perineum, and changing clothing as needed after incontinence episodes. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #93's Quarterly MDS 3.0 assessment dated [DATE] revealed Resident #93 was cognitively intact. Resident #93 had upper and lower extremity impairment on both sides. Resident #93 used a wheelchair and was dependent on staff for toileting hygiene, bathing, dressing and personal hygiene. Resident #93 was always incontinent of urine and bowel. Resident #93 did not reject care during the seven-day assessment look-back period. An interview on 07/21/2026 at 10:36 A.M. with Resident #93 revealed the physician told him his skin was fragile and to make sure he was changed as soon as had a bowel movement or urinated. An interview on 07/22/26 at 2:36 P.M. of Occupational Therapy Assistant (OTA) #944 revealed she just spoke with Resident #93, he was not feeling well enough for therapy today, and he had his call light on to have his aide clean him up. Observation on 07/22/26 at 2:42 P.M. revealed Resident #93's light above the door to his room was blinking, indicating his call light was activated. Observation on 07/22/26 at 2:45 P.M. revealed Assistant Director of Nursing (ADON) #713 answered Resident #93's call light and walked out of the room without doing anything and left the call light blinking. Observation on 07/22/26 at 2:47 P.M. revealed CNA #629 walked into Resident #93's room to answer his call light. Resident #93 indicated he was waiting an hour to an hour and a half to have his incontinence brief changed. Resident #93 revealed the staff came to his room to answer his call light and said they would come back if no one changed him, but no one came back. Resident #93 indicated the aides were busy and unable to change him when they answered his call light. CNA #629 provided incontinence care. Observation of Resident #93's buttocks, upper thighs and hips revealed multiple healed sites from prior breakdown. Resident #93 indicated one of the healed areas by his left lower buttock still hurt, and he could not sit very long because of it. Resident #93's incontinence brief was very wet with urine. An interview on 07/22/26 at 3:15 P.M. with CNA #629 revealed Resident #93's call light was activated and she answered it. CNA #629 indicated she was giving another resident a shower and was unable to change Resident #93's incontinence brief when she answered his call light but told him to activate his call light in 15 minutes if no one came in to change him. CNA #629 indicated about 25 minutes later when she was finished with the shower, Resident #93's call light was on and that was when she went to his room to change him. CNA #629 revealed Resident #93 did not tell her how long his call light was on when she first answered it. 4. Review of the medical record for Resident #88 revealed an admission of 02/13/24 with diagnoses including Cerebral Palsy, morbid obesity, type II diabetes, paraplegia, and scoliosis. Review of the MDS 3.0 assessment dated [DATE] Resident #88 revealed a BIMS of 15/15 indicating intact cognition. Resident #88 was noted to require moderate assistance of staff with bathing. Review of the shower sheets provided by the facility for the past three months revealed out of 18 (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	shower opportunities, shower sheets were only provided for 05/06/26, 05/19/26, 05/20/26, 06/13/26, 06/17/26, and 06/27/26 which revealed evidence of six out of 18 bathing opportunities. An interview on 07/23/26 at 2:40 P.M. with the DON confirmed not all shower sheets were completed as required for Resident #88. 5. Review of Resident #110's medical record revealed the resident was admitted on [DATE] with diagnoses including quadriplegia, diabetes and depression. Review of Resident #110's Quarterly MDS 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition, was dependent on staff for eating, oral hygiene, toileting, bathing, and personal hygiene. Review of Resident #110's physician orders revealed an order dated 02/25/26 for regular diet, regular texture, thin liquids consistency. Review of Resident #110's video surveillance dated 02/27/26 at 3:24 P.M. provided by the resident's daughter revealed Registered Nurse (RN) #818 came into the room at 3:24 P.M. and asked the resident if he was hungry. The food was sitting on the overbed tray. Per the video surveillance, it was unable to be determined the resident's response to the question. The nurse picked up the lid of the meal tray, sat the lid back down and told Resident #110 that you don't want to eat that now fine, hang tight let me talk to them. The food tray was sitting on an overbed table away from the resident. The nurse walked out of the room. Review of Resident #110's video surveillance dated 02/27/26 at 7:13 P.M. revealed staff, who appeared to be the nighttime receptionist, came into the room with food and left it on the overbed table. The staff asked the resident if he wanted the nurse. The tray from 3:24 P.M. appeared to be sitting on the overbed table. Review of Resident #110's Police Incident/Offense Report form 20-26204735 revealed the allegation was received on 02/27/26 at 8:12 P.M., the police were dispatched on 02/27/26 at 8:14 P.M., and the police arrived at the facility on 02/27/26 at 8:22 P.M. The narrative revealed on 02/27/26 a report was taken at the facility for suspected adult neglect. A report was forwarded to Adult Protective Services. An email interview on 07/27/26 at 5:19 A.M. with Resident #110's daughter revealed the video surveillance camera was event based and would activate if anyone entered the resident's room. The daughter confirmed the nurse was in the room at 3:24 P.M. and then no one came back into the room until the nighttime receptionist brought food into the resident's room at 7:13 P.M. An interview on 07/27/26 at 7:02 A.M. with the Administrator confirmed RN #818 was the nurse in the video surveillance who went into Resident #110's room on 02/27/26 at 3:24 P.M. The Administrator stated he was not aware the police department was looking into this resident's care on 02/27/26. The Administrator stated he was aware the resident's daughter demanded to talk to the administrative staff on 02/27/26 although he said he was not aware of the police coming in for a welfare check on (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the resident based on a report of neglect. The Administrator confirmed he did not initiate a self-reported incident (SRI) for abuse per the daughter's report of neglect or the police report of not providing timely resident care and neglect. The Administrator confirmed the video surveillance showed the resident in bed with the meal tray on the table against the wall in both video surveillance clips, and no staff were assisting the resident with the meal. A telephone interview on 07/27/26 at 7:42 A.M. with RN #818 revealed he did not remember the specific incident on 02/27/26. A telephone interview on 07/27/26 at 3:55 P.M. with Officer #942 revealed he came into the facility on [DATE] based on an allegation of neglect for Resident #110. Officer #942 stated the resident was supposed to be fed lunch and dinner, and that never happened and confirmed he had reviewed the video surveillance supplied by the resident's daughter. Officer #942 revealed Resident #110 was hard to understand, but he was pretty sure the resident had reported to him that he had not been fed his meal. He could not remember if it was the lunch meal or the dinner meal. Officer #942 confirmed he spoke to RN Assistant Director of Nursing (ADON) #713 on the phone concerning Resident #110's allegation of neglect. Review of the facility policy called Bathing-Personal Care, revised 08/2022, revealed resident will receive personal care in the facility according to the resident's plan of care to promote dignity, cleanliness and general well-being. Under procedure; shower bath or tub will be offered to the resident twice a week, as needed and as often as the resident would like per choice. The resident's care plan will be updated to document the resident's bathing needs. Review of the facility policy titled Activities of Daily Living, dated 03/2023, included a resident who was unable to carry out ADL would receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Review of the facility policy titled Incontinence Care dated 12/2022 included the purpose was to ensure a resident who was incontinent of bowel and/or bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. This deficiency represents non-compliance investigated under Complaint Numbers 3021865, 2799196, 2742587, 2735166, 2656594, and 2582257.		

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interview, and facility policy review, the facility failed to ensure residents were provided with adaptive equipment to maintain independence. This affected three residents (Residents #29, #80 and #86) of four residents who received adaptive equipment for drinking. The facility census was 95. Findings include: 1. Review of the medical record for Resident #86 revealed an admission date of 10/15/25. Diagnoses included but not limited to unspecified protein-calorie malnutrition, depression, and diverticulitis of intestine. Review of the Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #86 had severely impaired cognition and required supervision or touching for eating. Review of Resident #86's physician orders for July 2026 revealed a diet order for regular diet, regular texture with thin consistency liquids and disposable silverware for resident safety. Review of the daily diet ticket for Resident #86 revealed that Resident #86 was supposed to receive disposable silverware. Observation and interview on 07/21/26 at 4:16 P.M. revealed Resident #86's tray was prepared and placed into the food cart for delivery and then Dietary Aide (DA) #910 started preparing the next resident's tray. Resident #86's tray had regular silverware on it and not the plastic silverware per her diet order. This was verified by DA #910 at the time of the observation. 2. Review of the medical record for Resident #80 revealed an admission date of 07/18/24. Diagnoses included but not limited to Parkinson's Disease, Alzheimer's Disease, and anxiety disorder. Review of the comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #80 had severely impaired cognition and required supervision or touching for eating. Review of Resident #80's physician orders for July 2026 revealed a diet order for regular diet, regular texture with thin consistency liquids. Review of the daily diet ticket for Resident #80 revealed that Resident #80 was supposed to receive her meals on a divided plate. Observation and interview on 07/21/26 at 4:17 P.M. revealed Resident #80's meal was plated and placed inside the food cart, then DA #910 started preparing the next resident's tray. DA #910 was asked to remove Resident #80's tray from the food cart which revealed Resident #80's diet ticket which stated that she should have her food on a divided plate. Resident #80's entree was on a regular plate with no dividers. This was verified by DA #910 at the time of the observation. 3. Review of the medical record for Resident #29 revealed an admission date of 07/18/24. Diagnoses included but not limited to bipolar disorder, unspecified protein-calorie malnutrition, and Alzheimer's Disease. Review of the comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #29 had severely impaired cognition and required moderate assistance for eating. Review of Resident #29's physician orders for July 2026 revealed a diet order for regular diet, and mechanical soft (minced and moist) texture with thin consistency liquids. Review of the daily diet ticket for Resident #29 revealed that Resident #29 was supposed to receive no butter knife. Observation and interview on 07/21/26 at 4:22 P.M. revealed Resident #29's meal was plated and placed inside the food cart, then DA #910 started preparing the next resident's tray. Resident #29's diet ticket stated that he should have not have a butter knife. Resident #29's tray had a butter knife on it. This was verified by DA #910 at the time of the observation. Review of the undated facility policy titled, Assistive Devices revealed that adaptive assistive eating devices shall be provided to residents who need them for all meals.		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview, review of a concern form, and review of the facility policy, the facility failed to ensure Resident #93 was free from staff-to-resident verbal abuse. This affected one resident (Resident #93) out of four residents reviewed for abuse. The facility census was 95. Findings include: Review of Resident #93's medical record revealed an admission date of 09/19/25 and diagnoses included acute and chronic respiratory failure with hypoxia and hypercapnia, heart failure, acquired absence of right leg above the knee, and peripheral vascular disease. Review of Resident #93's care plan revised 04/21/26 included Resident #93 had an alteration in elimination related to incontinence of bowels. Staff assisted with completion of Resident #93's toileting and incontinence needs throughout the day. Resident #93 would continue to remain clean, dry and free of odors through the review date of 09/07/26. Interventions included assisting with toileting needs throughout the day; Resident #93 used disposable briefs; checking and changing as required for incontinence, washing, rinsing, drying perineum and changing clothing as needed after incontinence episodes. Review of Resident #93's Braden Scale for Predicting Pressure Sore Risk dated 06/02/26 included Resident #15 was at mild risk for developing a pressure sore. Review of Resident #93's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #93 was cognitively intact. Resident #93 had upper and lower extremity impairment on both sides. Resident #93 used a wheelchair and was dependent on staff for toileting hygiene, bathing, dressing and personal hygiene. He was always incontinent of urine and bowel and did not reject care during the seven-day assessment look-back period. Review of Resident #93's Grievance/Concern form dated 07/21/26 written by Central Supply Clerk #803 included the concern occurred on 07/20/26 and no time was documented. The Concern form stated Resident #93 did not like the way Certified Nursing Assistant (CNA) #801 speaks to him, and CNA #801 made comments about the smell of his bowel movements. CNA #801 also made a comment that Resident #93 was lucky to stay in bed, soiled himself and have someone like CNA #801 take care of him. Resident #93 did not want CNA #801 caring for him any longer. Observation on 07/21/26 at 9:30 A.M. of Resident #93 revealed he was lying in bed, did not have a shirt on, and the room was on the cool side. Resident #93 indicated his preference was for the room to be cool because he was always hot, and he did not want to wear a shirt. An interview on 07/21/26 at 9:30 A.M. with Resident #93 revealed CNA #801 had a smart mouth and doesn't know when to shut up. Resident #93 indicated it was his turn to have his incontinence brief changed and he told CNA #801 the doctor told him he should be changed as soon as possible after he was incontinent of urine or bowel. Resident #93 revealed CNA #801 said it must be nice to be lying in bed [expletive] yourself and waiting for me to clean you up. Resident #93 indicated if he could have got out of bed he would have wrung his neck and stated emphatically he felt like okay [NAME] you don't know how bad I feel about that, I already feel bad enough and you are making me feel worse. Resident #93 stated CNA #801 was always in a hurry, did not do a good job and wanted him to use a urinal or a bedpan, but Resident #93 stated he always wore a brief and did not know when he was going to have a bowel movement. Resident #93 stated CNA #801 used paper towels and even took the pillowcase off his pillow to use for incontinence care when Resident #93 had a bowel movement. Resident #93 revealed CNA #801 was always commenting on how much he goes and how bad it smelled. Resident #93 indicated he told Activity Director (AD) #711 and Central Supply Clerk #803 what happened. Resident #93 revealed the situation happened on 07/20/26. An interview on 07/21/26 at 9:45 A.M. of AD #711 confirmed (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #93 told her about his concerns with CNA #801, but as soon as he started telling her what happened, she told him he needed to speak with Social Worker Designee (SWD) #903. An interview on 07/21/26 at 12:44 P.M. with the Administrator revealed it was brought to his attention that Resident #93 was upset by CNA #801 who provided care for him. CNA #801 openly complained about the smell of Resident #93's bowel movement. The Administrator indicated he discussed the situation with the Director of Nursing (DON), and CNA #801 was sent home while the concern was looked into. The Administrator revealed he talked to staff including Unit Manager/Licensed Practical Nurse (UM/LPN) #705 who brought the concern to him and told him what CNA #801 said to Resident #93. The Administrator stated it sounded like CNA #801 was rude to Resident #93. The Administrator revealed he was not given a concern form on 07/20/26 when the incident happened but had notes given to him today about the interaction. The Administrator indicated he had not interviewed Resident #93 about the situation. An interview on 07/22/26 at 8:07 A.M. of SWD #903 revealed Resident #93 came to her, and he was upset. SWD #903 indicated Resident #93 told her CNA #801 said he [expletive] a lot, it smelled and he could lay there and [expletive] and [expletive] all day and have someone like CNA #801 clean him up all day. SWD #903 revealed as soon as Resident #93 told her this, she reported it to the Administrator, and CNA #801 had to go. SWD #903 revealed CNA #801 talking to Resident #93 that way set him over the edge. SWD #903 indicated it hurt her heart that CNA #801 would treat Resident #93 that way and stated, why was CNA #801 in health care if he was going to treat residents like that? An interview on 07/22/26 at 9:30 A.M. of UM/LPN #705 revealed she did not have complaints about CNA #801 until 07/21/26 when he was sent home. An interview on 07/22/26 at 4:07 P.M. with the Administrator and DON revealed the Administrator spoke with Resident #93 about the situation and Resident #93 was informed CNA #801 was suspended, and at the minimum, he would receive discipline for customer service. The Administrator revealed he had not initiated an investigation with CNA #801 or other residents. The DON indicated she spoke briefly with CNA #801 the day he went home, and CNA #801 was told there were customer service issues, and the facility would follow up for next steps. The DON revealed up to this point the facility had not followed up with residents. The DON indicated she spoke with Resident #93, and he told her the same thing about CNA #801 commenting on the smell, he did not care for Resident #93 properly, and Resident #93 told her he would have wrung CNA #801's neck if he could have reached him. Resident #93 told the DON that CNA #801 used paper towels and a pillowcase to clean him up. The Administrator revealed he did not think the situation was abusive, but it was definitely rude behavior and poor customer service. Review of the undated facility policy titled Abuse Prohibition included abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also included the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. This deficiency represents non-compliance investigated under Complaint Numbers 3069997, 3031303, 3021865, 2670307, 2582257, and 1405090 (OH00167146).		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 07/30/2026
NAME OF PROVIDER OR SUPPLIER Avenue at Brooklyn		STREET ADDRESS, CITY, STATE, ZIP CODE 4700 Idlewood Drive Brooklyn, OH 44144	
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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of the Medicaid Information Technology System (MITS), review of the Ohio Department of Medicaid Bureau of Long-Term Services and Supports application of Shared of Cost/Patient Liability for Nursing Facilities, review of Ohio Department of Health (ODH) documentation, review of a facility Self-Reported Incident (SRI), and interview, the facility failed to ensure Resident #61 was free from misappropriation of resident funds and Resident #117 was free from misappropriation of personal property. This finding affected two (Residents #61 and #117) of ten residents reviewed for abuse. The facility census was 95. Findings include: 1. Review of the medical record for Resident #61 revealed he was admitted to the facility on [DATE] with diagnoses including major depressive disorder, heart failure, and diabetes mellitus. Review of the resident fund management services (RFMS) authorization and agreement to handle resident funds document revealed Resident #61 opened a resident funded account on 09/12/23. Review of the document revealed Resident #61 opted to have direct deposit of income with a monthly allowance. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #61 had a Brief Interview for Mental Status (BIMS) score of 13/15 indicating he was alert and oriented to person, place, and time. Resident #61 was dependent on staff for activities of daily living (ADL). Review of the patient liability submitted in the MITS from the Ohio Department of Medicaid (ODM) revealed Resident #61 had a patient liability of \$672.00 for the period of 03/01/25 through 07/01/26. Review of the facility's trial balance dated 07/20/26 regarding resident funds accounts revealed Resident #61 had a current balance of \$34,245.19 with a designated established monthly allowance of \$75.00. Review of the quarterly statement dated 04/01/26 through 06/30/26 revealed Resident #61 had deposits from Social Security in the amount of \$2,169.00 on 04/03/26, 05/01/26, and 06/03/26 and a pension deposit of \$722.50 on 04/01/26, 05/01/26, and 06/01/26. Further review of the quarterly statement revealed care cost auto withdrawal of \$672.00 on 04/01/26, \$2169.00 on 05/01/26, \$647.50 on 05/01/26, \$647.50 on 06/01/26 and \$2,169.00 on 06/03/26. Further review of Resident #61's financial records revealed that she received spend-down letters monthly since 07/25/25. An interview on 07/21/26 at 9:14 A.M. with Business Office Manager (BOM) #622 revealed that Resident #61's RFMS account was very high because the county Medicaid Benefits Center (CMBC) did not get her income correctly. The CMBC received an email weekly, and you must inform them when a resident has a problem, so the problem can be resolved. Resident #61's MITS stated that her (continued on next page)		

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	monthly income was lower than it actually was, because Resident #61 gets a pension and social security, which increased when her husband passed away. BOM #622 stated that patient liability was determined by adding all income and subtracting \$75.00, which was an increased from \$50.00 in January 2026. An interview on 07/23/26 at 8:52 A.M. with Medicaid Supervisor (MS) #939 revealed that she spoke to the RBOM #938 on 07/21/26. MS #939 stated that the facility does not have the right to adjust the amount of patient liability submitted in the MITS. MS #939 stated that she spoke to the facility in December 2025 and sent a form and a checklist for them to fill out, but it was not returned. She stated she forwarded it to the facility on Tuesday, 07/21/26. Review of the Ohio Department of Medicaid Bureau of Long-Term Services and Supports application of Shared of Cost/Patient Liability for Nursing Facilities dated 05/11/22 revealed a Medicaid-certified nursing home in Ohio cannot charge more than your calculated patient liability. Under Ohio Medicaid rules, the nursing facility's reimbursement rate plus your required monthly patient liability (share of cost) constitutes payment-in-full. They are prohibited from seeking additional payments for covered services. 2. Review of Resident #117's medical record revealed the resident was admitted on [DATE] (discharged on 04/27/26) with diagnoses including chronic obstructive pulmonary disease, dependence on supplemental oxygen and heart failure. Review of employee files revealed Activity Aide (AA) #941's date of hire was on 07/12/23. The Employee Corrective Action Form (in the employee file) dated 02/19/25 revealed AA #941 was terminated for performance/policy violation. The violation statement indicated AA #941 was terminated for unauthorized possession or use of property belonging to the facility. Review of the facility SRI Investigation tracking number 257852 dated 03/04/25 revealed at 3:00 P.M., Resident #117 reported that he recently found out the private bank account he used was overdrawn. He had an account at an outside bank that he stated was used regularly. An SRI was initiated. Resident #117 was alert and oriented and able to make decisions. During the investigation, Resident #117 stated at times he would give money or the bank card to a former AA #941 to make purchases for him. Resident #117 stated in 04/20/24, the bank debit card was given to AA #941 to purchase a list of items the resident wanted that would also assist in the resident's spend-down to meet resource limits per Medicaid guidelines. On 03/04/25, the Administrator contacted the police department to report potential theft. The SRI was unsubstantiated. Review of Resident #117's MDS 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition. Review of the Ohio Department of Health (ODH) Journal Entry form dated 06/10/26 with Case Number M257852 revealed previously, on 12/18/25, a notification was issued to AA #941 advising the employee that an investigation was initiated for an allegation of misappropriation which had a reasonable basis. Specifically, the allegation was made that between 08/01/24 and 02/28/25, AA #941 had misappropriated personal property by wrongfully making fraudulent purchases with Resident (continued on next page)		

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#117's bankcard. After reviewing the Report and Recommendation, the recommendation was a Finding of Misappropriation against AA #941. The finding will be sent to the Attorney General's office, the prosecutor's office and the Ohio Nurse Aid Registry. Review of the ODH letter dated 07/09/26 to AA #941 for Case Number M257852 revealed the Director adopted the Hearing Officer's Report and Recommendation and found that you did misappropriate funds from a long-term care resident. Interview on 07/27/26 at 12:56 P.M. with Regional Registered Nurse (RRN) #940 confirmed the misappropriation of Resident #117's funds by AA #941. Review of the undated Abuse Prohibition policy revealed each resident had the right to be free from abuse, neglect, and corporal punishment of any type by anyone. The health care center's management prohibits neglect, mental or physical abuse, including mental abuse associated with the unauthorized use of photographs and recording that were used in a manner to demean or humiliate a resident including, but not limited to photographs and recordings uploaded to social media, involuntary seclusion, misappropriation of resident property and/or funds. This deficiency represents non-compliance investigated under Complaint Number 2656594.		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident record review, staff interviews, Self-Reported Incident (SRI) review, review of the police report, review of hospital paperwork, and facility policy review, the facility failed to implement the abuse policy related to an injury of unknown origin for Resident #56. This affected one (Resident #56) of one resident reviewed for injuries of unknown origins. The facility census was 95. Findings include: Review of the medical record for Resident #56 revealed she was admitted to the facility on [DATE] with diagnoses including dementia and transient cerebral ischemic attack. Review of the medical record revealed Resident #56 had new upgraded diagnoses of multiple fractures of the left side ribs and contusion of the right front wall of thorax dated 06/09/26. Review of the care plan dated 10/22/25 revealed Resident #56 had an activity of daily living (ADL) self-care performance deficit with interventions including two-staff assistance for ADL and a new care plan entry dated 06/18/26, after an injury of unknown origin, to have a fixed monitoring system put in her room per family request. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #56 had a Staff Assessment for Mental Status (SAMS) score that indicated she had a short term and long-term memory problem and was severely impaired regarding decisions of daily life. Review of the MDS assessment revealed she had impairment of the upper and lower bilateral extremities and was dependent on staff for ADL. Review of the progress notes dated 05/16/26 through 06/01/26 revealed no progress notes documented within that time frame. Review of the pain summary dated 05/25/26 through 06/12/26 revealed Resident #56 had a pain rating of zero except on 06/02/26, which she reported a pain level of five on a zero to 10 pain scale. Review of the weekly skin check assessment dated [DATE] revealed Resident #56 had a new skin problem of a hematoma to the chest. Review of the progress note dated 06/03/26 at 5:33 P.M. revealed Resident #56 had bruising under her right breast, right nipple and in the middle of her chest. Resident #56 received a new order for a STAT (immediate) x-ray of the chest for bruising. Review of the radiology report dated 06/03/26 revealed Resident #56 had a single view chest x-ray that revealed bruising of the chest, bilateral linear atelectasis (partial collapse of small areas in both lungs), tortuous of the aorta (main artery of your body has abnormal twists, loops, or sharp curves instead of a straight path) with no acute findings identified. Review of the progress note dated 06/04/26 at 6:10 A.M. revealed Resident #56's x-ray results were reported to the physician with no new orders. Review of the progress note dated 06/05/26 at 8:16 P.M. revealed Resident #56's bruising spread to her right upper extremities, shoulder and breast. Resident #56 displayed signs of pain and upon assessment, new edema was observed. Resident #56 received new orders to be sent to the hospital for further evaluation. Review of the progress note dated 06/05/26 at 8:29 P.M. revealed Resident #56's family was notified and she was being transported to the emergency room (ER) for further investigation. Review of the MDS 3.0 assessment dated [DATE] revealed Resident #56 discharged from the facility and was anticipated to return. Review of the nursing resident transfer form dated 06/06/26 revealed Resident #56 was transferred to the local ER for increased hematoma, redness, edema to the right hand, and increased pain. Review of the progress note dated 06/06/26 at 2:20 A.M. revealed Resident #56 was picked up and taken to the ER for evaluation. Review of the progress note dated 06/06/26 at 9:50 A.M. revealed Resident #56 had a change in condition. Review of the progress note dated 06/06/26 at 6:12 P.M. revealed Resident #56 was being admitted to the local hospital, but the hospital would not provide admitting diagnosis until she arrived in a different unit. Review of the SRI tracking number 275412 revealed on 06/06/26 Resident #56 was sent to the hospital due to a growing bruise on her chest. (continued on next page)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #56 emergency room x-ray revealed multiple bilateral rib fractures with no report of any recent falls or incidents to explain injuries. Reviews of the staff interviews revealed no explanation for injuries and were educated on mechanical lift transfers and transfers according to care plans. Review of the SRI revealed the facility unsubstantiated the allegation due to the evidence being inconclusive and reported the incident to the Local Police Department (LPD). Further review of the SRI revealed a timeline of events related to Resident #56's injury of unknown origin. Review of the timeline revealed on 06/03/26, at approximately 5:00 P.M., revealed Resident #56 had bruising under her right breast and mid chest and an x-ray was ordered. On 06/03/26, at approximately between 8:00 P.M. to 8:15 P.M., revealed the x-ray was completed with no new orders. On 06/05/26, at approximately 8:00 P.M. to 8:30 P.M., revealed Resident #56's bruising spread to her right upper extremity, shoulder and breast and was sent to the ER for evaluation. On 06/06/26, Resident #56 was admitted to the hospital with fractured ribs, an SRI was initiated, and audits and educated initiated. Review of the SRI tracking number 275412 dated 06/06/26, approximately three days after the first observed skin change, revealed the facility initiated an incident of injury of unknown origin due to a growing hematoma on Resident #56 arm and a fracture identified after being sent to the ER. Review of the progress note dated 06/07/26 at 2:00 P.M. revealed the hospital requested facility ordered x-rays to be faxed for review after speaking with Resident #56's daughter and informed of the x-ray. Review of the LPD incident report dated 06/08/26, five days after first observed skin change, revealed at 7:54 A.M., the LPD received a call and a unit was dispatched to the facility at 3:58 P.M. for a report of personal injury. Review of the incident report revealed the facility reported Resident #56 sustained broken ribs while in the care of the facility and were unsure of how the injuries occurred. Review of the incident revealed no other information documented. Review of the hospital paperwork dated 06/08/26 revealed Resident #56 presented to the trauma intensive care unit (TICU) for multiple rib fractures and large intramuscular hematoma. Resident #56 had multiple bilateral nondisplaced rib fractures including right third through fifth and left second, third, sixth and seventh ribs, possibly acute or subacute with concerns of neglect and/or abuse. Review of the hospital paperwork revealed Resident #56's bruising started 06/02/26, one day prior to what the facility documented, and worsened over the next few days until she was seen in the ER on [DATE]. Review of the nursing readmission assessment dated [DATE] revealed Resident #56 was admitted back to the facility with multiple fractures of the rib, right and left side, and a hematoma to the right chest wall. Further review of the assessment revealed Resident #56 had bruising to the chest across breasts and on the right-side flank, back, and right upper arm, multiple bruises of the arms, right and left side ribs and legs. Review of the progress note dated 06/09/26 at 10:54 P.M. revealed Resident #56 was readmitted to the facility at 10:20 P.M. An interview on 07/22/26 at 1:45 P.M. with Unit Manager Licensed Practical Nurse (LPN) #705 revealed she did not notice Resident #56's fractures until two days before she was sent out to the ER because of bruising to the side of her breast and underneath her arms. LPN #705 revealed she reported it to the Director of Nursing (DON) the following morning because she was working nights at the time. LPN #705 revealed Resident #56 received an x-ray the next morning with no findings. LPN #705 revealed a few days later, the bruising spread and she was sent to the ER and admitted with fractures. LPN #705 revealed the facility did not initiate an investigation until after receiving the admitting diagnosis. LPN #705 stated the facility staff were educated on transfers after Resident #56 became a mechanical lift of two staff for transfers after her hospital stay. LPN #705 revealed the facility believed that during repositioning, Resident #56 was transferred using the bear-hug technique from the back and was pulled upward. LPN #705 revealed the bear-hug technique was not a transfer technique utilized or taught to staff for transferring residents. LPN #705 revealed (continued on next page)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the facility reported Resident #56's injury of unknown origin on 06/06/26, approximately three days after the first sign of injury. LPN #705 confirmed and verified the above findings at the time of the interview. An interview on 07/23/26 at 12:18 P.M. with the Administrator revealed after investigating, the facility was unable to determine the cause of Resident #56's injuries. The Administrator revealed Resident #56 was unable to communicate what occurred and no one witnessed or knew of any incidents related to the injuries. The Administrator revealed staff were educated and audits performed of mechanical lift techniques. The Administrator revealed he did not report the incident to the Ohio Department of Health (ODH) until 06/06/26 and to the LPD until 06/08/26. The Administrator revealed there was no immediate reporting of Resident #56's injuries, and no investigation was started until after she was admitted to the hospital. The Administrator confirmed and verified the above findings at the time of the interview. Review of the facility document titled Abuse Prohibition, revised 2022, revealed the facility had a policy in place that each resident had a right to be free from abuse including injuries of unknown origin. Review of the policy revealed the facility failed to keep Resident #56 free from abuse, report within a two-hour timeframe and implement the policy in totality. Review of the document revealed the facility did not implement the policy. This deficiency represents non-compliance investigated under Complaint Number 3041303.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview, and facility policy review, the facility failed to report abuse allegations to the State Agency. This affected three residents (Residents #82, #93 and #117) of ten residents reviewed for abuse. The facility census was 95. Findings include: 1. Review of former Resident #117's medical record revealed the resident was admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), impulse disorder and major depressive disorder. Review of Resident #117's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition. Review of Resident #117's progress notes dated 04/11/26 at 5:26 A.M. revealed the resident was admitted to the hospital with COPD exacerbation. Resident #117 did not return to the facility. Review of Resident #82's medical record revealed the resident was admitted on [DATE] with diagnoses including COPD, essential hypertension and hyperlipidemia. Resident #82 still resides in the facility. Review of Resident #82's progress note dated 12/23/25 authored by Licensed Practical Nurse (LPN) Unit Manager (UM) #705 which was struck out as incorrect documentation indicated the nursing staff were notified that the resident stated an incident happened with another resident. Resident #82 stated another resident grazed her left foot. The nurse on staff along with the LPN UM #705 assessed the resident and no injuries were noted and no complaints of foot pain. The provider was notified and a new order for an x-ray was obtained. No bruising or redness was noted. The family was made aware. Review of Resident #82's radiology report dated 12/23/25 revealed the resident did not have a fracture, and a small plantar calcaneal spur was noted. Review of Resident #82's MDS 3.0 assessment dated [DATE] revealed the resident exhibited moderate cognitive impairment. Interview on 07/22/26 at 7:36 A.M. with Resident #82 revealed the resident reported to the administration that Resident #117 ran over her feet with a wheelchair. Resident #82 stated the facility investigated and told her it did not happen. Interview on 07/23/26 at 10:31 A.M. with the Administrator revealed Resident #82 had a feud with another resident and that was why she had reported that the other resident who no longer resides in the building had run over her feet with a wheelchair. The Administrator confirmed the facility conducted a complete investigation and determined the incident did not occur but could not find the investigation. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/23/26 at 10:49 A.M. with Social Service Designee (SSD) #903 confirmed Resident #82 had reported Resident #117 because the resident was a woman and she was black. SSD #903 revealed the facility did not find evidence that Resident #117 had run over Resident #82's feet with a wheelchair. An additional interview on 07/27/26 at 8:30 A.M. with the Administrator confirmed Residents #82 and #117's physical altercation was not reported to the State agency. 2. Review of Resident #93's medical record revealed an admission date of 09/19/25 and diagnoses included acute and chronic respiratory failure with hypoxia and hypercapnia, heart failure, acquired absence of right leg above the knee, and peripheral vascular disease. Review of Resident #93's care plan revised 04/21/26 included Resident #93 had an alteration in elimination related to incontinence of bowels. Staff assisted with completion of Resident #93's toileting and incontinence needs throughout the day. Resident #93 would continue to remain clean, dry and free of odors through the review date of 09/07/26. Interventions included assisting with toileting needs throughout the day; Resident #93 used disposable briefs; check and change as required for incontinence, wash, rinse, dry perineum and change clothing as needed after incontinence episodes. Review of Resident #93's Quarterly MDS 3.0 assessment dated [DATE] revealed Resident #93 was cognitively intact. Resident #93 had upper and lower extremity impairment on both sides. Resident #93 used a wheelchair. Resident #93 was dependent on toileting hygiene, bathing, dressing and personal hygiene. Resident #93 was always incontinent of urine and bowel. Resident #93 did not reject care during the seven-day assessment look-back period. Review of Resident #93's Grievance/Concern form dated 07/21/26 written by Central Supply Clerk #803 included the concern occurred on 07/20/26 and no time was documented. The Concern form stated Resident #93 did not like the way Certified Nursing Assistant (CNA) #801 speaks to him and CNA #801 made comments about the smell of his bowel movements. CNA #801 also made a comment that Resident #93 was lucky to stay in bed, soiled himself and have someone like CNA #801 take care of him. Resident #93 did not want CNA #801 caring for him any longer. Review of facility Self-Reported Incidents (SRI) dated 07/20/26 through 07/24/26 did not reveal evidence Resident #93 had reported the allegation of verbal abuse to the State Agency. Observation on 07/21/26 at 9:30 A.M. of Resident #93 revealed he was lying in bed, did not have a shirt on and the room was cool. Interview at the time of the observation with Resident #93 indicated his preference was for the room to be cool because he was always hot and he did not want to wear a shirt. Resident #93 stated CNA #801 had a smart mouth and doesn't know when to shut up. Resident #93 indicated it was his turn to have his incontinence brief changed and he told CNA #801 the doctor told him he should be changed as soon as possible after he was incontinent of urine or bowel. Resident #93 revealed CNA #801 said it must be nice to be laying in bed (expletive) yourself and waiting for me to clean you up. Resident #93 indicated if he could have got out of bed he would have wrung his neck and stated emphatically he felt like okay [NAME] you don't know how bad I feel about that, I already feel bad enough and you are making me feel worse. Resident #93 revealed CNA #801 (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was always in a hurry, did not do a good job and wanted him to use a urinal or a bedpan, but Resident #93 stated he always wore a brief and did not know when he was going to crap. Resident #93 stated CNA #801 used paper towels and even took the pillowcase off his pillow to use for incontinence care when Resident #93 had a bowel movement. Resident #93 revealed CNA #801 was always commenting on how much he goes and how bad it smelled. Resident #93 indicated he told Activity Director (AD) #711 and Central Supply Clerk #803 what happened. Resident #93 revealed the situation happened on 07/20/26. Interview on 07/21/26 at 9:45 A.M. of AD #711 confirmed Resident #93 told her about his concerns with CNA #801 but as soon as he started telling her what happened she told him he needed to speak with Social Worker Designee (SWD) #903. Interview on 07/21/26 at 12:44 P.M. with the Administrator revealed it was brought to his attention that Resident #93 was upset by CNA #801 who provided care for him. CNA #801 openly complained about the smell from Resident #93's bowel movement. The Administrator indicated he discussed the situation with the Director of Nursing (DON) and CNA #801 was sent home while the concern was looked into. The Administrator revealed he talked to staff including Unit Manager/Licensed Practical Nurse (UM/LPN) #705 who brought the concern to him and told him what CNA #801 said to Resident #93. The Administrator stated it sounded like CNA #801 was rude to Resident #93. The Administrator revealed he was not given a concern form on 07/20/26 when the incident happened but had notes given to him today about the interaction. The Administrator indicated he had not interviewed Resident #93 about the situation. Interview on 07/22/26 at 8:07 A.M. of SWD #903 revealed Resident #93 came to her and he was upset. SWD #903 indicated Resident #93 told her CNA #801 said he (expletive) a lot, it smelled and he could lay there and (expletive) and piss all day and have someone like CNA #801 clean him up all day. SWD #903 revealed as soon as Resident #93 told her this she reported it to the Administrator and CNA #801 had to go. SWD #903 revealed CNA #801 talking to Resident #93 that way set him over the edge. SWD #903 indicated it hurt her heart that CNA #801 would treat Resident #93 that way and why was CNA #801 in health care if he was going to treat residents like that. Interview on 07/22/26 at 9:30 A.M. of UM/LPN #705 revealed she did not have complaints about CNA #801 until 07/21/26 when he was sent home. Interview on 07/22/26 at 4:07 P.M. with the Administrator and Director of Nursing (DON) revealed the Administrator indicated he spoke with Resident #93 about the situation and Resident #93 was informed CNA #801 was suspended and at the minimum he would receive discipline for customer service. The Administrator revealed he had not initiated an investigation with CNA #801 or other residents. The DON indicated she spoke briefly with CNA #801 the day he went home and CNA #801 was told there were customer service issues and the facility would follow up for next steps. The DON revealed up to this point the facility had not followed up with residents. The DON indicated she spoke with Resident #93, and he told her the same thing about CNA #801 commenting on the smell, he did not care for Resident #93 properly and Resident #93 told her he would have wrung CNA #801's neck if he could have reached him. Resident #93 told the DON CNA #801 used paper towels and a pillowcase to clean him up. The Administrator revealed he did not think the situation was abuse, but it was (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	definitely rude behavior and poor customer service. The Administrator indicated he did not report the allegation to the required State Agency because he did not think it was abuse. Review of Resident #93's Self-Reported Incident (SRI) dated 07/24/26 at 4:15 P.M. included the category of allegation/suspicion was emotional/verbal abuse. The report stated there were no alleged perpetrators assigned to the case. The report was not completed. Review of the facility policy titled Abuse Prohibition undated included abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also included the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled using technology. The facility must ensure all alleged violations involving abuse, neglect, exploitation or mistreatment including injuries of unknown source and misappropriation of resident property were reported immediately but not later than two hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the Administrator of the facility and to the State Agency in accordance with state law through established procedures. This deficiency represents non-compliance investigated under Complaint Number 3041303.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm 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 medical record review, interview, and review of facility policy the facility failed to ensure physician orders were followed for appointments. This affected one resident (Resident #13) of three residents reviewed for coordination of care. The facility census was 95. Findings include: Review of the medical record for Resident #13 revealed she was admitted to the facility on [DATE] with diagnoses that included acute kidney failure, acute chronic diastolic congestive heart failure, and peripheral vascular disease. Review of the care plan dated 07/10/26 revealed Resident #13 had an altered cardiovascular status related to hypertension, peripheral vascular disease, and hyperlipidemia with interventions that included follow-up with cardiology as ordered. Review of the physician orders dated 07/10/26 revealed Resident #13 had a cardiology appointment scheduled for 07/14/26 at 8:00 A.M. Review of the progress note dated 07/10/26 at 12:03 P.M. revealed Resident #13's son contacted the facility regarding follow-up appointments, questions were answered and all needs were met. Review of the progress note dated 07/14/26 at 7:09 A.M. revealed Resident #13's son revealed he would not be able to go to the appointment and was in agreement to reschedule. Review of the progress note dated 07/14/26 at 8:11 A.M. revealed Resident #13's cardiology appointment on 07/14/26 at 8:00 A.M. was rescheduled. Interview on 07/20/26 at 11:48 A.M. with Resident's #13 son revealed being notified Resident #13 had missed the scheduled cardiology appointment for 07/14/26. The facility informed him that the follow-up appointment would be rescheduled but he was not provided with the new information. Interview on 07/21/26 at 3:30 P.M. with Registered Nurse (RN) #818, while actively reviewing Resident #13's medical record, revealed she had no upcoming follow-up appointments scheduled regarding cardiology. There was a progress note that stated the appointment was rescheduled; however, it was not rescheduled. RN #818 revealed the unit manager, Licensed Practical Nurse (LPN) #827 usually scheduled appointments, but at this time, there was nothing documented. RN #818 confirmed and verified the above findings at the time of the interview. Review of the facility document titled Bill of Rights effective 10/03/23, revealed the facility had a policy in place that all residents had a right to adequate and appropriate medical treatment and nursing care. This deficiency represents non-compliance investigated under Complaint Number 2656594.		

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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** Based on observations, resident record review, staff interviews, and facility policy review, the facility failed to provide timely incontinence care Resident #13. This affected one (Resident #13) of one resident reviewed for incontinence care. The facility census was 95. Findings include: Review of the medical record for Resident #13 revealed she was admitted to the facility on [DATE] with diagnoses including acute kidney failure, acute chronic diastolic congestive heart failure, and peripheral vascular disease. Review of the care plan dated 07/10/26 revealed Resident #13 had an activities of daily living (ADL) self-care performance deficit related to impaired mobility, had an alteration in elimination of bowel and bladder related to incontinence, was incontinent, and was not toileted. Interventions included assisting with toileting needs throughout the day, checking and changing as required as needed. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #13 had a Brief Interview for Mental Status (BIMS) score of 15/15 indicating she was alert and oriented to person, place, and time. Resident #13 was impaired on both upper and lower bilateral extremities and was dependent on staff for ADL. An interview and observation on 07/22/26 at 7:37 A.M. revealed Resident #13 was lying in bed pointing to her brief. Resident #13 revealed she was wet and needed to be changed and cleaned up. Resident #13 revealed she was last changed the night prior, and it had been a long time. An interview and observation on 07/22/26 at 7:39 A.M. with Licensed Practical Nurse (LPN) #705 in Resident #13's room, revealed Resident #13 was lying in bed and informed LPN #705 she was wet, needed to be changed and had not been changed since the night before. LPN #705 checked Resident #13's brief and stated, she is wet. LPN #705 was then observed fastening Resident #13 brief back together, then pulled up her covers, washed her hands and exited the room. LPN #705 stated I'll be back. LPN #705 was then observed standing next to a medication cart watching a current medication pass by an alternate surveyor. LPN #705 was not the designated staff member for the medication pass and left Resident #13 unchanged. LPN #705 verified she did not check and change Resident #13 at the time of the interview. Review of the facility document titled Incontinence Care, dated December 2022, revealed the facility had a policy in place to ensure residents who were incontinent of bowel and/or bladder received appropriate treatment and services. This deficiency represents non-compliance investigated under Complaint Number 3021865, 2742587, 2735166, 2656594, and 2582257.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview, review of hospital records, review of therapy records, and review of the facility policy, the facility failed to ensure Resident #45's care planned interventions were implemented and physician orders were followed for eating assistance and adaptive equipment. This affected one (Resident #45) out of three residents reviewed for feeding assistance. The facility census was 95. Findings include: Review of Resident #45's After Visit Summary for a hospital stay from 06/15/26 through 06/17/26 included Resident #45's discharge diagnoses were failure to thrive, unsteady gait, and severe malnutrition. Resident #45's diet should be soft, bite sized, thin liquids. Aspiration precautions included placing medications whole, in puree (pudding/applesauce). Swallow strategy recommendations were one-to-one supervision, alternate bites and sips, feed/eat at a slow rate, maintain an upright position 20 to 30 minutes following all oral intake, no straws, sit upright 90 degrees. Review of Resident #45's medical record revealed an admission date of 06/17/26 with diagnoses including cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebellar artery, unspecified protein-calorie malnutrition, and adult failure to thrive. Review of Resident #45's physician orders dated 06/17/26 through 07/23/26 did not reveal orders to place Resident #45's medications whole, in applesauce or pudding. Review of Resident #45's physician orders dated 06/18/26 revealed Resident #45 needed assistance with all meals and no straws. Review of Resident #45's care plan dated 06/18/26 included Resident #45 had an activities of daily living (ADL) self-care performance deficit related to diagnoses. Staff assisted with completion of Resident #45's needs throughout the day. Resident #45 would continue to have needs met on a daily basis; remaining clean, dry, dressed, groomed and free of odors through the review date of 09/28/26. Interventions included checking fingernail length and trimming and cleaning on bath day and as necessary. Report changes to the nurse; eating, no straws; eating, assist with oral intake; therapy evaluation and treatment per physician orders. Review of Resident #45's care plan dated 06/23/26 included Resident #45 had the potential for altered nutrition/hydration related to diagnoses, mechanically altered diet and thick liquids. Resident #45 would safely consume meals without episodes of choking through the review date of 09/28/26. Interventions included encouraging Resident #45 to drink fluids provided at meals; observing as needed tolerance to diet and observing as needed for episodes of coughing/choking after trying to swallow, running nose during meals etcetera; refer to speech and language pathology (SLP) for evaluation/recommendations as needed. Review of Resident #45's Speech Therapy SLP Evaluation and Plan of Treatment dated 06/23/26 included Resident #45 was admitted to the facility on mechanical soft solids and thin liquids from the hospital. Resident #45 was referred to Speech Therapy for dysphagia service due to exacerbation of coughing/choking during oral intake, oral/pharyngeal function and signs/symptoms of dysphagia. Due to the documented physical impairments and associated functional deficit, without skilled therapeutic intervention Resident #45 was at risk for decreased leisure task participation and social isolation. Recommendations included nectar thick liquids and mechanical soft/ground textures. Review of Resident #45's admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] included Resident #45 had severe cognitive impairment. Resident #45 required supervision or touching assistance with eating. Resident #45 required substantial to maximal assistance with toileting hygiene, bathing, upper and lower body dressing and personal hygiene. Resident #45 was occasionally incontinent of urine and bowel. Resident #45 did not reject care during the seven-day assessment look-back period. Review of Resident #45's Speech Therapy Treatment Encounter Notes dated 07/08/26 (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	included Resident #45 was seen during the breakfast meal. Resident #45 had thin liquids (water) at the bedside table despite being on nectar-thick liquids. Education was provided to Resident #45 regarding following his diet/liquid recommendation in order to reduce the risk of aspiration. The thin liquid was removed, and education was provided to the nursing staff regarding liquid recommendation. Swallow dysfunction focused on body positioning to increase safety with intake, liquid delivery using small, controlled sips, intake, medication to bolus sizes and order, method of food, liquid presentation. Observation on 07/20/26 at 12:45 P.M. of Resident #45 revealed he was sitting upright in bed, and a meal tray was in front of him on the bedside table. There was no staff in the room assisting him with his meal. Observation on 07/21/26 at 4:57 P.M. of Resident #45 revealed he was sitting upright in his bed and his meal, a mechanical soft diet, was served to him. No staff stayed in the room to assist Resident #45 after Unit Manager/Licensed Practical Nurse (UM/LPN) #705 completed his meal set up. An interview on 07/21/26 at 4:58 P.M. with UM/LPN #705 revealed staff did not stay in the room to assist Resident #45 with eating after his meal was set up because he could feed himself. UM/LPN #705 indicated staff assisted Resident #45 with his meal set up then left the room. An interview on 07/22/26 at 11:12 A.M. with Director of Rehab (DOR) #945 revealed Resident #45 was currently receiving Speech Therapy for aphasia. An interview on 07/22/26 at 3:39 P.M. with DOR #945 revealed Resident #45 needed supervision at the time of the evaluation because he was not able to feed himself. DOR #945 indicated Resident #45 needed a lot of cueing for eating, needed to take small bites alternating with sips of liquid and it was not ideal to set up his meal tray and leave the room because he needed help. DOR #945 revealed Resident #45 was seen on 07/08/26 by therapy and when they entered his room, he had a straw and thin liquids. Observation on 07/22/26 at 4:10 P.M. revealed Resident #45 was sitting in a chair in his room. Resident #45 was holding a cup, and the cup had a lid with a straw in it and he took a sip of the drink with his straw. There were no staff in the room with Resident #45. Observation on 07/22/26 at 4:12 P.M. of Resident #45 with DOR #945 revealed Resident #45 was sitting in a chair in his room with an empty cup observed on the bedside table and the lid and straw were on the table next to the cup. DOR #945 confirmed Resident #45 had a straw, and he was not supposed to have straws. An interview on 07/22/26 at 4:21 P.M. with DOR #945 revealed DOR #945 reviewed Resident #45's notes and paperwork from the hospital and everything stated he should be supervised when eating. DOR #945 indicated Resident #45 could feed himself, but he needed nectar thick liquids, and he had trouble initiating and following through after his stroke. DOR #945 revealed staff should stay in Resident #45's room when he was eating his meals. DOR #945 indicated the straw put too much liquid back too quickly and increased the risk for aspiration. An interview on 07/22/26 at 4:30 P.M. with DOR #945 revealed Resident #45's care plan stated no straws and assist with oral intake. Resident #45's aide Kardex stated to assist with by mouth (po) intake and no straws. An interview on 07/23/26 at 9:18 A.M. of LPN #606 confirmed Resident #45's physician orders did not reveal an order to place whole pills in pudding or applesauce. LPN #606 indicated she admitted Resident #45 and knew his medications were supposed to be placed whole in applesauce or pudding and that was how she administered them. LPN #45 stated she must not have put the order in the system when she admitted Resident #45. Review of the facility policy titled Residents' Rights, effective 10/03/23, included residents upon admission and thereafter, had the right to adequate and appropriate medical treatment and nursing care and to other ancillary services that comprised necessary and appropriate care consistent with the program for which the resident contacted. This deficiency represents non-compliance investigated under Complaint Numbers 3021865, 2799196, and 2656594.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, interview, review of dialysis transfer agreement, and facility policy review, the facility failed to ensure residents were transported to dialysis treatments. This affected one resident (Resident #106) of one resident reviewed for dialysis services. The facility census was 95. Findings include: Review of the medical record for Resident #106 revealed he was admitted to the facility on [DATE] with diagnoses that included dependence on renal dialysis, end stage renal disease, type two diabetes mellitus with diabetic neuropathy, hypertensive heart and chronic kidney disease with heart failure and end stage renal disease. Review of the care plan dated 02/10/26 revealed Resident #106 was dependent on dialysis and received hemodialysis three times a week with interventions that included minimizing complications and follow physician orders. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #106 had a Brief Interview for Mental Status (BIMS) score of 13 that indicated he had no cognitive impairment. Resident #106 was impaired on both sides of upper and lower bilateral extremities, was dependent on staff for activities of living and was dependent on dialysis. Review of the nursing progress notes revealed on 07/05/26 Resident #106 was sent to the emergency room for an evaluation due to a change in condition and subsequently was admitted to the hospital and was re-admitted to the facility on [DATE]. Review of the physician orders dated 07/20/26 revealed Resident #106 was to receive hemodialysis three times a week, Monday, Wednesday, and Fridays with pick-up time of 6:15 A.M. Review of the order revealed Resident #106 was to be transported by local transport and to be in the facility lobby at 5:15 A.M. Observation and interview on 07/22/26 at 6:35 A.M. revealed Resident #106 was sitting in his wheelchair in the lobby located at the front entrance of the facility. Resident #106 stated I'm waiting for my dialysis transport. Observation and interview on 07/22/26 at 7:45 A.M. revealed Resident #106 in the hallway speaking with Social Services Designee (SSD) #903 discussing his dialysis transport not showing up. SSD #903 informed Resident #106 he missed his dialysis appointment due to not having transportation in place. SSD #903 revealed Resident #106 missed his dialysis transport because it was not set up due to his recent return from the hospital. Resident #106 asked SSD #903, What does that have to do with it? and SSD #903 replied that it did not matter whether he had just recently returned from a hospital stay, dialysis transport should be setup. Observation and interview on 07/22/26 at 7:52 A.M. revealed Resident #106 sitting near the entrance of the facility in his wheelchair, visibly upset. Resident #106 revealed something happened with his transportation to dialysis and now he had to sit in his wheelchair until 10:30 A.M. and he was very uncomfortable. Interview on 07/22/26 at 8:08 A.M. with SSD #903 revealed it was the facility's responsibility to call and alert the dialysis center of any updates regarding residents including hospitalizations. Interview on 07/22/26 at 8:09 A.M. with the Administrator revealed the facility had a transporter for residents needing transportation to and from appointments. Resident Transporter (RT) #629 was the facility driver and transporter. RT #629 set up transportation for all appointments including dialysis. Resident #106 was a long-standing dialysis resident with automatic transport in place, and he was unsure of what happened. Interview on 07/22/26 at 1:45 P.M. with unit manager Licensed Practical Nurse (LPN) #705 revealed Resident #106 was up and ready at 5:00 A.M. for his transport to dialysis. The staff thought he had already left the facility for his scheduled dialysis appointment and was not sure why transportation did not pick him up. Interview on 07/27/26 at 9:03 A.M. with RT #629 revealed she was responsible for setting up appointments for transportation to and from appointments for residents. Staff nurse's schedule appointments and then notified her to set up (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	transport. RT #629 revealed his dialysis transport was automatic and when he transferred to the hospital the facility did not update the dialysis center. The dialysis center continued to attempt to pick up Resident #106 and after not being successful, they stopped coming. The facility was responsible for notifying the dialysis center of the residents' changes to ensure consistent care to and from the facility. RT #629 confirmed and verified the facility failed to update the dialysis center to ensure transportation to and from the facility for Resident #106's dialysis appointments. Review of the facility nursing home dialysis transfer agreement dated November 2023, revealed the facility had an agreement in place with the dialysis provider to provide dialysis services. The facility was responsible for arranging transportation of designated residents to and from the dialysis center including the mode of transportation and qualified personnel to accompany the resident. Review of the facility document titled Dialysis Monitoring revised December 2022, revealed the facility had a policy in place that the facility would maintain the safety and health of resident receiving dialysis services on a routine basis by ensuring each resident received care and services for the revision of hemodialysis and/or peritoneal dialysis consistent with professional standards of practice. This deficiency represents non-compliance investigated under Complaint Numbers 2582257 and 1405092 (OH00167225).		

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 07/30/2026
NAME OF PROVIDER OR SUPPLIER Avenue at Brooklyn		STREET ADDRESS, CITY, STATE, ZIP CODE 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	Ensure that residents are free from significant medication errors. Based on medical record review, interviews, and facility policy review, the facility failed to ensure medication orders were transcribed accurately to prevent a significant medication error. This affected one resident (Resident #88) of six residents reviewed for medication administration. The facility census was 95. Findings include: Review of the medical record for Resident #88 revealed an admission date of 02/13/24. Diagnoses included but were not limited to cerebral palsy, morbid obesity, type II diabetes, paraplegia, scoliosis and post-traumatic stress disorder. Review of the 05/22/26 quarterly Minimum Data Set (MDS) 3.0 for Resident #88 revealed a Brief Interview of Mental Status (BIMS) of 15 which indicated intact cognition and was noted to require moderate to maximum assistance for activities of daily living (ADLs). Review of the nursing progress note for Resident #88 revealed a 06/26/26 order timed at 12:07 P.M. for 875 milligrams (mg) of Augmentin to be given orally two times a day for sinusitis. Review of the nursing progress note for Resident #88 dated 06/26/26 timed at 12:37 P.M. revealed the system has identified a possible drug allergy for the following order: Amoxicillin Oral tablet 875 mg, give 875 mg by mouth two times a day for sinusitis for seven days. Review of the physician order dated 06/26/25 timed at 6:00 P.M. for Resident #88 revealed an order for an 875 mg oral tablet of Amoxicillin to be given by mouth two times a day for sinusitis for seven days. The order was noted to be discontinued on 06/27/25. Review of the physician order dated 06/27/25 timed at 6:00 P.M. for Resident #88 revealed an order for an 875 mg oral tablet of Amoxicillin to be given by mouth two times a day for sinusitis until 07/04/25. The order was noted to be discontinued on 07/04/25. Review of the June 2025 and July 2025 Medication Administration Records for Resident #88 revealed 875 mg of Amoxicillin was given orally from 06/26/25 through 07/04/25. Phone interview on 07/23/26 at 11:27 A.M. with Certified Nurse Practitioner (CNP) #931 confirmed Augmentin was intended for the diagnosis of sinusitis for Resident #88 on 06/25/25 and if Amoxicillin was given, a medication error occurred. CNP #931 confirmed he was not made aware of the medication error. Interview on 07/28/26 at 11:45 A.M. with the Director of Nursing (DON) confirmed the order was intended for Augmentin and Amoxicillin was given in error for the full seven days. DON confirmed she was unaware and a significant medication error report was not completed. Review of the August 2014 revised facility policy called Medication Administration-General Guidelines revealed medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have been properly oriented to the facility's medication distribution system. Review of the undated facility policy called Incident/Accident/Medication Error Report revealed the purpose was to document and report any/all accidents, incident, medication errors or unusual occurrences that happen within the facility or on the facility's property. The procedure was to verbally report the incident, accident, error, etc. immediately to your supervisor and/or the Director of Nursing or Administrator. Obtain the appropriate report. Complete the report. Record the facts what you did immediately following the incident. Sign and date the report. Give the completed report to an individual identified in #1 above. The Administrator is responsible for oversight of all incident/accident/medication error reports as well as their follow up. This deficiency represents non-compliance investigated under Complaint Numbers 2715490, 1405089 (OH00167036) and 1405092 (OH00167225).		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on record review, observation, and interview, the facility failed to honor food preferences by not serving foods documented as an allergy. This affected one resident (Resident #83) of one resident reviewed for food preferences. The facility census was 95. Findings include: Review of the medical record for Resident #83 revealed an admission date of 05/31/25. Diagnoses included chronic obstructive pulmonary disease, obsessive-compulsive disorder, and anxiety disorder. Review of the comprehensive Minimum Data Set (MDS) assessment, dated 05/22/26, revealed Resident #83 had intact cognition. The resident required supervision with eating. Review of Resident #83's physician orders for July 2026 revealed regular diet with regular texture, thin consistency liquids and double portions. Resident #83 was allergic to carrots. Review of the care plan dated 06/02/25 revealed that Resident #83 had a potential for altered nutrition related to diagnoses with multi-food allergies and intolerances per resident. Interventions included but not limited to providing diet as ordered and monitor for signs and symptoms of allergic reactions to melons and carrots. Review of Resident #83's diet tray ticket revealed Resident #83 received a regular diet with regular texture, thin consistency liquids and double portions. Allergy to melons and carrots. Interview on 07/20/26 at 10:17 A.M. with Resident #83 revealed he had issues with receiving food items that he was allergic too including carrots and melon. Observation and interview on 07/21/26 at 4:26 P.M. revealed Resident #83's tray was prepared and placed into the food cart for delivery and Dietary Aide (DA) #910 started preparing the next resident's tray. Resident #83's diet ticket stated that he was allergic to carrots, and Resident #83's tray had carrots on the plate. This was verified by DA #910 at the time of the observation. This deficiency represents non-compliance investigated under Complaint Number 1405090 (OH00167146).		

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, observation, and facility policy review, the facility failed to provide substantial nutritional evening snacks when mealtimes were greater than 14 hours. This affected three residents (Residents #49, #96 and #99) of 20 residents (Residents #4, #25, #29, #30, #41, #48, #49, #59, #76, #78, #86, #89, #90, #92, #94, #96, #98, #99, #100 and #102) who reside on the memory care unit and receive meals from the kitchen. The facility census was 95. Findings include: 1. Review of the medical record for Resident #49 revealed an admission date of 12/23/21 with diagnoses including but not limited to dementia, major depressive disorder and mild protein-calorie malnutrition. Review of the comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #49 had severely impaired cognition and required moderate assistance with eating. Further review of Resident #49's electronic medical record revealed that there was no documentation of a substantial after dinner snack. 2. Review of the medical record for Resident #96 revealed an admission date of 11/22/24 and a readmission date of 08/26/25 with diagnoses including but not limited to vascular dementia, major depressive disorder and unspecified protein-calorie malnutrition. Review of the comprehensive MDS 3.0 assessment dated [DATE] revealed Resident #96 had severely impaired cognition and required supervision with eating. Further review of Resident #96's electronic medical record revealed that there was no documentation of a substantial after dinner snack. 3. Review of the medical record for Resident #99 revealed an admission date of 10/25/23 and a readmission date of 03/12/24 with diagnoses including but not limited to Alzheimer's Disease, major depressive disorder and mild protein-calorie malnutrition. Review of the comprehensive MDS 3.0 assessment dated [DATE] revealed Resident #99 had severely impaired cognition and was dependent on activities of daily living. Further review of Resident #99's electronic medical record revealed that there was no documentation of a substantial after dinner snack. Review of the posted mealtimes revealed that the breakfast memory care cart is delivered to the floor by 7:30 A.M. and the dinner memory care cart is delivered by 4:00 P.M. which reflected a 15.5-hour time frame between dinner and breakfast. Interview on 07/22/26 at 3:07 P.M. with Licensed Practical Nurse (LPN) #819 stated that there were snacks if residents asked for them but had no knowledge about a scheduled snack pass. Interview on 07/22/26 at 3:10 P.M. with Activity Assistant (AA) #723 revealed that she left at 4:30 P.M. and did not give refreshments at evening activities. Interview on 07/22/26 at 3:10 P.M. with Regional Registered Dietitian (RRD) #937 revealed that there was an open dining room which was why the facility met the 14-hour rule, but verified that Residents #49, #96, and #99 were residents who were dependent on staff. RRD #937 confirmed they received breakfast at 7:30 A.M. and dinner at 4:00 P.M. (15.5 hours) and there was no substantial after dinner snack tracking that was done for Residents #49, #96 and #99. Review of the facility's undated policy titled Meal Service Schedule revealed meals will be served according to a planned schedule that allows no more than 14 hours between dinner the previous evening and breakfast the next day. When an evening snack consisting of at least two food groups is offered to residents, the maximum time between meal and breakfast can be extended to 16 hours. This deficiency represents non-compliance investigated under Complaint Number 1405090 (OH00167146).		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on medical record review, observation, interview, and facility policy review, the facility failed to ensure shower sheets were not falsified for one resident (Resident #88) of five reviewed for showers. The facility census was 95. Findings include: Review of the medical record for Resident #88 revealed an admission date of 02/13/24. Diagnoses included but were not limited to cerebral palsy, morbid obesity, type II diabetes, paraplegia and scoliosis. Review of the 05/22/26 Minimum Data Set (MDS) 3.0 assessment for Resident #88 revealed a Brief Interview of Mental Status (BIMS) of 15 which indicated intact cognition. Resident #88 was noted to require moderate assistance of staff with bathing. Observation on 07/23/26 at 2:28 P.M. revealed the Director of Nursing (DON), Assistant Director of Nursing (ADON) #713, Licensed Practical Nurse (LPN) Unit Manager #705 and Certified Nursing Aide (CNA) #943 in a back office on the back 100 hall with the door closed. Following knocking on the door and the door being opened, various blank shower sheets as well as completed shower sheets were visible on the desk. LPN Unit Manager #705 was observed actively writing on a shower sheet with a pen. Interview at the time of the observation with LPN Unit Manager #705 confirmed she had her pen in her hand and was writing in the year on the date of the shower sheet for Resident #39 and also confirmed it was not a shower sheet for the current date and was a shower sheet from 05/13/26 which was not complete and was trying to complete it out before giving the requested shower sheets to the survey team. Interview on 07/23/26 at 2:40 P.M. with the DON confirmed not all shower sheets requested were completed and then provided the completed shower sheets for three additional requested residents. DON confirmed shower sheets should not be completed after the fact and should be completed on the same day. Interview on 07/23/26 at 3:17 P.M. with the Administrator confirmed Unit Manager #705 was suspended pending an investigation following being made aware of the shower sheets being falsified. Administrator confirmed the shower sheets should not have been completed after the fact and were not completed timely as required. Interview on 07/27/26 at 7:20 A.M. with the Administrator confirmed the DON and ADON were also suspended pending investigation related to the falsification of documents. Interview on 07/27/26 at 9:37 A.M. with Regional Director of Clinical Operations #940 confirmed shower sheets are part of the medical record and should be put in the medical record following completion. Review of the December 2022 revised facility policy labeled EHR Records and Documentation revealed the medical record shall reflect a resident's progress toward achieving their person-centered plan of care objectives and goals and the improvement and maintenance of their clinical, functional, mental, and psychosocial status. Under the procedure section number 10 revealed in accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are complete, accurately documented, readily accessible and systematically organized. Under #16 the medical record must contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress including his/her responses to treatment and/or services, and changes in his/her condition, plan of care goals, objectives and/or interventions. Under #26 maintain medical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible and systematically organized. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the August 2022 revised facility policy labeled, Bathing-Personal Care revealed residents will receive personal care in the facility according to the residents' plan of care to promote dignity, cleanliness and general well-being. A shower or bath will be offered to the resident twice a week, as needed, and as often as the resident would like per choice. This deficiency represents non-compliance investigated under Complaint Numbers 2656594, and 1405090 (OH00167146).		