STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365044	A. Building B. Wing	04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hyde Park Health Center	4001 Rosslyn Drive Cincinnati, OH 45209

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39967 THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NONCOMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on medical record review, review of a facility self-reported incident (SRI), review of a incident report, review of a facility investigation, review of personnel files, observations, resident and staff interviews, and facility policy review, the facility failed to ensure a resident was free from a physical restraint. This affected one (#01) of three residents reviewed for physical restraints. The census was 85. Findings include: Review of the Resident #01's chart revealed the resident was admitted to the facility on [DATE] with diagnoses including cerebral infarction due to occlusion or stenosis of left middle cerebral artery, brain stem stroke syndrome, dysphagia, cognitive communication deficit, need for assistance with personal care, muscle weakness, other abnormalities of gait and mobility, age related physical debility, hypertension and hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side. Review of Resident #01's admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severe cognitive impairment and Resident #01 was dependent with oral hygiene, toilet hygiene, showering, upper body dressing, lower body dressing, putting on and taking off footwear, personal hygiene, sitting to lying, lying to sitting, sitting to standing, and chair transfers. Resident #01 required maximal assistance with rolling left and right and eating, tub transfers, toilet transfers, and walking ten feet were not attempted. Review of Resident #01's chart from 02/21/24 to 04/16/24 revealed no physical restraint assessments had been completed and there were no orders for physical restraints. Review of Resident #01's late entry progress note dated 04/03/24 at 2:36 P.M. revealed the resident was sitting in the common area by the nurse's station. Resident #01 continued being aggressive, combative, trying to scoot out of the wheelchair and stand up. State tested Nurse Aide (STNA) #32 put a sheet around the resident's waist to prevent him from another fall and hurting himself. The progress note was signed by Licensed Practical Nurse (LPN) #04. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #01's late entry progress note dated 04/03/24 at 2:40 P.M. reveal the STNA #32 came and got LPN #04 and stated that Resident #01 was being combative and was down the hall by the double doors refusing to come back to his room. LPN #04 went to ask the resident to come back to his room so he could eat breakfast. Resident #01 was combative with LPN #04. LPN #04 explained to Resident #01 that LPN #04 was concerned for his safety. Resident #01 was grabbing on the bars in the hallway trying to stand up and Resident #01 continued to try to hit staff. Resident #01 then pushed his wheelchair back and fell . Resident #01 did not hit his head. Resident #01 was lifted back to a sitting position by staff and Resident #01 was trying to get out of his wheelchair and trying to scoot out of the wheelchair. Resident #01 was brought to the common area by the nurse's station. Resident #01 continued with aggression. Resident #01 was assessed, and vital signs were completed. No injuries were noted. Review of the facility's SRI dated 04/03/24 revealed on 04/03/24 at 7:30 A.M., Resident #01 was noted to be exit seeking and aggressive. Resident #01 was trying to hit staff as he attempted to get up out of his wheelchair. After the resident fell out of the chair, STNA #32 loosely tied a sheet around the resident's waist in an attempt to keep the resident from getting up. The allegation of physical abuse was substantiated. Review of the facility's incident report dated 04/03/24 at 7:30 A.M. revealed Resident #01 was sitting in the common area by the nurse's station. Resident #01 continued being aggressive, combative and was trying to scoot out of his wheelchair and stand up. STNA #32 put a sheet around the resident's waist to prevent him from falling and hurting himself. Immediate actions taken were listed as one on one for aggressive behavior. The incident report was completed by LPN #04. Review of the facility's fall incident report dated 04/03/24 at 7:31 A.M. revealed Resident #01 was being aggressive and combative with staff. Resident #01 was trying to get out of his wheelchair by himself and was trying to stand up without assistance. Resident #01 was trying to scoot out of his wheelchair. Staff tried to prevent the resident from hurting himself. Resident #01 pushed back and tilted the wheelchair and fell . No injuries were noted. Resident #01 was brought to the common area by the nurse's station so he could be watched. Vital signs were taken, and Resident #01's temperature was 98 degrees Fahrenheit, pulse was 61, respirations were 18 and blood pressure was 193 over 90. No pain was noted. Resident #01's physician was contacted on 04/03/24 at 1:00 A.M. and Resident #01's family was notified on 04/03/24 at 1:01 A.M. The incident report was prepared by LPN #04. Review of Resident #01's skin assessment dated [DATE] revealed Resident #01 had old skin abrasions on both knees. Review of Physical Therapist (PT) #500's witness statement dated 04/03/24 revealed PT #500 arrived at the unit at about 7:45 A.M. and saw Resident #01 dressed and sitting up in his wheelchair by the nursing station. Resident #01 had a sheet tied around his trunk and tied in the back of the wheelchair. PT #500 asked staff what was going on and was told that Resident #01 was exit seeking and was very agitated. PT #500 put her things down and told the nurse that she was going to look for a wheelchair that might be better for Resident #01. When PT #500 came back about 20 minutes later, the sheet was removed. PT #500 told Assistant Director of Nursing (ADON) #119 when she came in and ADON #119 went to look at Resident #01 and called PT #500 over to see that Resident #01 had transferred himself to the couch. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of LPN #04's witness statement dated 04/03/24 revealed STNA #32 came and got LPN #04 and stated that Resident #01 was being combative and was down the hall by the double doors and was refusing to come back to his room. LPN #04 went to ask Resident #01 to come back to his room so he could eat breakfast. Resident #01 was combative with LPN #04. LPN #04 explained to the resident that LPN #04 was concerned for his safety. Resident #01 was grabbing on the bars in the hallway trying to stand up and Resident #01 continued to try to hit the staff. Resident #01 then pushed his wheelchair back and fell . Resident #01 did not hit his head and Resident #01 was lifted back to a sitting position by staff. Resident #01 continued to try to get out of the wheelchair and try to scoot out of the wheelchair. Resident #01 was brought to the common area by the nurse's station. Resident #01 continued with aggression. Vital signs were completed, and Resident #01 was assessed. Resident #01 was sitting in the common areas by the nurse's station. Resident #01 continued with being aggressive, combative, trying to scoot out of his wheelchair and stand up. STNA #32 put a sheet around the resident's waist to prevent him from another fall and hurting himself. LPN #04 did not tell STNA #32 to put a sheet around the resident's waist. Once the resident calmed down, he remained seated in his wheelchair. Review of STNA #32's witness statement dated 04/03/24 revealed Resident #01 was trying to get out of the chair so STNA #32 tied him in the chair. Review of STNA #43's witness statement dated 04/03/24 revealed STNA #43 had no knowledge of Resident #01's fall on 04/03/24. Review of STNA #43's second witness statement dated 04/03/24 revealed STNA #43 had no knowledge of Resident #01 being restrained on 04/03/24. Review of STNA #32's personnel file revealed STNA #32 was hired at the facility on 04/13/11. STNA #32 was educated on the employee handbook on 09/30/19. STNA #32 was checked on the abuse registry on 07/11/23 and 01/08/24 and was in good standing. STNA #32 had a Bureau of Criminal Investigation background check completed on 11/07/19. STNA #32 was also educated on the types of abuse and reporting abuse on 01/23/24. Further review of STNA #32's corrective action form dated 04/11/24 revealed STNA #32 restrained a resident in his wheelchair with a sheet on 04/03/24. STNA #32 violated the company employee standards of conduct as well as the companies about policy (physical abuse and physical restraint) by her own testament of tying a resident to his wheelchair with a bedsheet on 04/03/24. Therefore, due to having to substantiate the allegation of resident abuse concluding the investigation, the facility will have to terminate the employee. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN #04 on 04/16/24 at 9:29 A.M. revealed she could not remember the date of the incident but stated Resident #01 was down the hallway and STNA #32 was trying to get him to go back to his room. LPN #04 reported Resident #01 was trying to get out of his chair and STNA #32 called LPN #04 to help her get Resident #01 back to his room. LPN #04 stated Resident #01 was combative and was punching and hitting at the staff and he flipped his wheelchair backwards and fell . LPN #04 reported she assessed Resident #01, and he did not have any injuries from the fall. LPN #04 stated she and STNA #32 rolled Resident #01 backwards and set him at a table in the common area and Resident #01 continued to attempt to get out of the chair. LPN #04 stated she went back to her medication pass and she noticed Resident #01 had a sheet loosely laced around his waist when she came back to the common area. LPN #04 reported the sheet was not tied and STNA #32 told LPN #04 that she needed to take the bedsheet off Resident #01 and LPN #04 responded yes to STNA #32's statement about removing the bedsheet. LPN #04 reported Resident #01 was not in distress when he had the bedsheet laced around him and LPN #04 stated STNA #32 placed the bedsheet around the resident to protect him and to keep him from falling. LPN #04 stated a physical therapist, and the Director of Nursing (DON) were notified of the incident. Observation of Resident #01 on 04/16/24 at 9:36 A.M. revealed Resident #01 was lying in a low bed with a fall mat to the side of the bed. Resident #01's tube feed was noted to be running. No signs of distress were noted. Attempted to interview Resident #01 on 04/16/24 at 9:36 A.M. and Resident #01 was unable to provide his name. Resident #01 was asked if he used a wheelchair, and he nodded no. Interview with PT #500 on 04/16/24 at 9:42 A.M. revealed she arrived at the facility around 7:45 A.M. on 04/03/24 and she saw Resident #01 sitting up in a wheelchair in the common area near the nurse's station. PT #500 stated Resident #01 was dressed and he had a bed sheet tied around his chest and the wheelchair. PT #500 stated she asked STNA #32 and LPN #04 what was going on and they stated, the resident was all over the place and they were trying to keep him safe. PT #500 stated she went to the therapy room to look for another wheelchair for Resident #01 that might be safer for the resident and when she came back Resident #01 was still sitting in the common area, but the sheet had been removed. PT #500 stated she was not sure how long the sheet was wrapped around the resident and stated the resident did not seem combative or agitated. PT #500 stated Resident #01 was awake but was just sitting in the chair. PT #500 reported she informed ADON #119 immediately and reported the incident to the DON during morning meeting. Interview with ADON #119 on 04/16/24 at 9:49 A.M. revealed she did not witness Resident #01 being restrained in the facility and stated she was not notified by PT #500 of the restraint incident. Interview with the DON on 04/16/24 at 10:22 A.M. revealed all departments were educated on the abuse policy, use of restraints and reporting abuse on 04/03/24. The DON also stated the facility conducted skin assessments on all non interviewable residents that resident on the same unit as Resident #01 on 04/03/24 and the facility interviewed all interviewable residents on unit on 04/03/24 regarding abuse/restraints with no findings. Attempted to call STNA #32 by telephone on 04/16/24 at 10:35 A.M. with no response. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DON on 04/16/24 at 11:35 A.M. verified Resident #01 did not have any restraint assessments completed and the DON reporting tying a bed sheet around Resident #01's waist and wheelchair was not an appropriate restraint. The DON also confirmed Resident #01 had no orders for physical restraints. Interview with the Administrator on 04/16/24 at 12:25 P.M. revealed the facility implemented daily rounds to identify inappropriate restraints three times per day five days a week on 04/03/24. The Administrator reported the daily rounds remained ongoing. Observation of Resident #01 on 04/16/24 at 1:00 P.M. revealed Resident #01 was lying in a low bed with a fall mat to the side of the bed. Interview with the Administrator on 04/19/24 at 1:21 P.M. revealed there were no cameras on the unit in view of where Resident #01 was restrained in his wheelchair by STNA #32 using a flat bed sheet. Review of the facility's undated abuse, mistreatment, neglect, exploitation, and misappropriation of resident property policy revealed residents have a right to be free from abuse, neglect, exploitation, and misappropriation of resident property. This includes but is not limited to freedom from corporal punishment, involuntary seclusion or any physical or chemical restraint that is not required to treat a resident's medical symptoms. As a result of the incident, the facility took the following actions to correct the deficient practice by 04/11/24: On 04/03/24, Resident #01 was assessed by facility nursing with no new injuries or health declines noted. On 04/03/24, the facility educated all staff on the abuse policy, use of physical restraints and reporting abuse. On 04/03/24, the facility interviewed all interviewable residents that resided on Resident #01's unit with no findings. On 04/03/24, the facility completed skin assessments on all non interviewable residents that resided on Resident #01's unit with no findings. On 04/03/24, the facility implemented daily checks three times a daily for five days a week to check for inappropriate restraints. As of 04/11/24 there were no other concerns regarding inappropriate physical restraints. This deficiency represents non-compliance investigated under Complaint Number OH00152855.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39967 Based on medical record review, observations, staff interviews and policy review, the facility failed to ensure a resident's fall care plan was updated with current interventions. This affected one (#01) of three residents reviewed for falls. The census was 85. Findings include: Review of the Resident #01's chart revealed Resident #01 admitted to the facility on [DATE] with diagnoses including cerebral infarction due to occlusion or stenosis of left middle cerebral artery, brain stem stroke syndrome, dysphagia, cognitive communication deficit, need for assistance with personal care, muscle weakness, other abnormalities of gait and mobility, age related physical debility, hypertension and hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side. Review of Resident #01's admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severe cognitive impairment and Resident #01 was dependent with oral hygiene, toilet hygiene, showering, upper body dressing, lower body dressing, putting on and taking off footwear, personal hygiene, sitting to lying, lying to sitting, sitting to standing, and chair transfers. Resident #01 required maximal assistance with rolling left and right and eating, tub transfers, toilet transfers, and walking ten feet were not attempted. Review of Resident #01's fall risk care plan dated 02/21/24 revealed Resident #01 was at risk for falls related to generalized weakness. Resident #01 required extensive assistance with transfers and would transfer himself without asking for assistance due to cognition. Approaches included anticipate and meet the resident's needs, be sure call light is within reach and encourage the resident to use the call light for assistance as needed, keep personal items within reach, monitor behavior changes, monitor for side effects from medications and ongoing evaluation to ensure interventions match current needs. Resident #01's fall care plan did not include any information related to Resident #01's low bed or fall mats. Observation of Resident #01 on 04/16/24 at 9:36 A.M. revealed Resident #01 was lying in a low bed with a fall mat to the side of the bed. Observation of Resident #01 on 04/16/24 at 1:00 P.M. revealed Resident #01 was lying in a low bed with a fall mat to the side of the bed. Interview with the Director of Nursing (DON) and Licensed Practical Nurse (LPN) #139 on 04/16/24 at 2:58 P. M. verified Resident #01's fall mat and low bed were not updated on Resident #01's fall care plan. Review of the facility's managing falls and fall risk policy dated March 2018 revealed staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents non-compliance investigated under Complaint Number OH00152855.