

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365152	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Schoenbrunn Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 2594 East High Avenue New Philadelphia, OH 44663	

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 0600 Level of Harm - Actual harm Residents Affected - Few	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34298</p> <p>Based on medical record review, review of a facility self-reported incident (SRI) and investigation, review of a personnel records, review of staff schedules and time punches, facility policy review and interviews, the facility failed to ensure Resident #03 was free from an incident of staff to resident abuse which included intimidation, verbal and emotional abuse.</p> <p>Actual psychosocial harm occurred on 09/30/24 to Resident #03 when State tested Nursing Assistant (STNA) #174, while providing care for the resident, yelled, used profanity and punched/hit the wall above the resident's bed. Resident #03 believed STNA #174's actions were directed toward her. Following the incident, STNA #174 worked additional shifts, providing care for Resident #03, before he was suspended on 10/06/24, and subsequently terminated. Resident #03 reported being fearful, afraid of retaliation and not wanting to eat or do anything as a result of the incident. This affected one resident (#03) of three residents reviewed for abuse. The facility census was 65.</p> <p>Findings include:</p> <p>Review of Resident #03's medical record revealed an admitted [DATE]. Diagnoses included acute and chronic respiratory failure with hypoxia, myocardial infarction, anxiety disorder and major depressive disorder.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment, dated 10/09/24, revealed Resident #3 was cognitively intact.</p> <p>Review of the facility SRI, tracking number 252690 dated 10/06/24, revealed on 09/30/24 Resident #03 alleged that a staff person (STNA #174) was angry and punched a nearby wall. On Sunday, 10/06/24, at approximately 6:13 A.M., the Administrator was notified by a facility nurse that STNA #174 became frustrated in Resident #03's room and punched/hit the wall. Although this incident took place on 09/30/24 at 10:10 A.M. it was not reported to facility management until 10/06/24.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365152	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Schoenbrunn Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 2594 East High Avenue New Philadelphia, OH 44663	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a facility investigation written statement, completed by STNA #100 and dated 10/09/24, revealed around 09/30/24, STNA #174 and STNA #100 were putting Resident #03 to bed. STNA #174 was frustrated about something and punched the wall in Resident #03's room. STNA #174 had been getting frustrated easily lately. At times, the nurses would get STNA #100 when they needed something so STNA #174 did not get upset. STNA #100 asked STNA #174 if he had been going to counseling lately and taking antianxiety medications. STNA #100 stated STNA #174's actions startled her and Resident #03. Three or five days later, Resident #64 (Resident #03's spouse) asked STNA #100 if she heard about the incident with STNA #174. Resident #64 stated Resident #03 was fearful because of the incident.</p> <p>Review of a facility investigation written statements, completed by STNA #114 and STNA #152, revealed they had witnessed STNA #174 express frustration and anger in front of residents and staff. Review of an undated written statement, completed by STNA #181, revealed on 09/27/24, STNA #181 asked STNA #174 to help put a resident in bed using a mechanical lift. STNA #174 got angry and started punching the shower book and throwing things.</p> <p>Review of an undated written statement, completed by STNA #174, revealed on 09/30/24 it was a rough day and due to last minute appointments, therapy, call lights going off and demands, STNA #174 got frustrated and snapped. STNA #174 slapped the wall and yelled out comments, which STNA #174 realized scared Resident #03.</p> <p>Interview on 10/18/24 at 10:44 A.M. with Resident #03 revealed on 09/30/24, she had her call light on and STNA #174 came in the room. Resident #03 stated STNA #174 hit the wall above her head and stated, you [explicative] people. Resident #03 stated STNA #100 reported the incident to a nurse and stated the nurse would talk to STNA #174. During the interview with Resident #03, her husband, Resident #64, entered the room. Resident #64 stated he resided in another room and was not aware of the incident with STNA #174 until STNA #181 told him about it. Resident #64 stated he went to the nurse to make sure it was reported, and the nurse stated the incident could not be reported until Monday because the Administrator was not in the facility on the weekend. Resident #03 and Resident #64 stated STNA #174 continued to work after the incident. Resident #03 confirmed STNA #174 was assigned to provide care for her following the incident and stated he kept telling her it was okay; he had just been frustrated with her. Resident #03 stated she told LPN #202 she was afraid of retaliation by STNA #174. Additionally, Resident #03 stated she was upset and did not want to eat or do anything for three days following the incident. Resident #03 revealed none of the nurses came to ask her about what happened with STNA #174.</p> <p>Interview on 10/18/24 at 10:48 A.M. with STNA #181 revealed she did not witness the incident with STNA #174 (and Resident #03) but had heard about it. STNA #181 stated STNA #174 was upset prior to going to Resident #03's room and had been throwing binders at the nurse's station. STNA #181 stated LPN #214 witnessed STNA #174 getting upset. STNA #181 stated she thought STNA #100 reported witnessing STNA #174 punch the wall in Resident #03's room.</p> <p>Interview on 10/18/24 at 11:06 A.M. with LPN #214 verified she witnessed STNA #174 upset at the nurse's station on 09/30/24. LPN #214 stated STNA #174 got frustrated when there was any change or if a lot of residents needed assistance. LPN #214 denied STNA #100 reported any concerns with STNA #174 and Resident #03 until the end of the week.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365152	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Schoenbrunn Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 2594 East High Avenue New Philadelphia, OH 44663	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 10/18/24 at 11:20 A.M. with the Administrator verified he was not notified about the incident with STNA #174 and Resident #03 until the morning of 10/06/24. The Administrator stated STNA #100 wrote a statement that it was not reported because she did not feel abuse occurred.</p> <p>Review of STNA #174's personnel file revealed a hire date of 02/27/19. STNA #174 was terminated on 10/10/24 due to creating a hostile work environment for co-workers on numerous occasions and had been witnessed expressing frustrations with aggressive, and at times, threatening behavior. On or around 09/30/24, STNA #174 punched/slapped a wall in a resident's room. As a result of the seriousness and frequency of his actions, termination was deemed appropriate and necessary.</p> <p>Review of the staff schedule and time punches revealed STNA #174 worked on 09/30/24 from 5:53 A.M. to 2:05 P.M., 10/01/24 from 5:53 A.M. to 2:00 P.M., 10/02/24 from 5:53 A.M. to 2:10 P.M., 10/03/24 from 5:53 A.M. to 2:02 P.M., 10/05/24 from 5:53 A.M. to 2:09 P.M. and 10/06/24 from 5:53 A.M. to 6:33 A.M.</p> <p>Review of the undated facility policy titled Abuse, Neglect and Exploitation revealed abuse was defined as willful infliction of injury, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Possible indicators of abuse included, but were not limited to, resident, staff, or family report of abuse, psychological abuse of a resident observed and sudden or unexplained changes in behaviors and/or activities such as fear of a person or place, or feelings of guilt or shame. The facility would make efforts to ensure all residents were protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples included, but were not limited to, responding immediately to protect the alleged victim and integrity of the investigation and providing emotional support and counseling to the resident during and after the investigation as needed.</p> <p>This was an incidental finding discovered during the complaint investigation.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365152	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Schoenbrunn Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 2594 East High Avenue New Philadelphia, OH 44663	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>34298</p> <p>Based on review of the facility self-report incident (SRI) and investigation, staff interview and review of facility policy, the facility failed to prevent misappropriation of resident medication. This affected 13 residents (#1, #5, #14, #20, #25, #28, #29, #70, #71, #72, #73, #74 and #75) of 13 residents reviewed for misappropriation. The facility census was 65.</p> <p>Findings include:</p> <p>Review of SRI #252381, dated 09/27/24, revealed local law enforcement notified the facility that during the search of a facility employee's vehicle, medication packages with residents' names were found. The employee was identified as Licensed Practical Nurse (LPN) #211. Residents #1, #5, #14, #20, #25, #28, #29, #70, #71, #72, #73, #74, and #75 were identified in the SRI as the residents with medications found in LPN #211's vehicle.</p> <p>Review of the facility investigation revealed a total of 70 medication packages for Residents #1, #5, #14, #20, #25, #28, #29, #70, #71, #72, #73, #74, and #75 were found in LPN #211's car. The medications included 22 packages of Mirtazapine, 23 packages of Metoprolol, one package of Hydralazine, four packages of Buspar (to treat anxiety), one package of Trazodone (antidepressant), six packages of Lasix (diuretic), one package of Celexa (antidepressant), seven packages of tizanidine (muscle relaxant), one package of Zolofl (antidepressant) and four packages of Seroquel. The medications were dated from 09/29/23 through 08/01/24. All medication packages were unopened, except for two packages of Metoprolol for Resident #5, and each package contained one pill.</p> <p>Interview on 10/18/24 at 8:30 A.M. with the Administrator verified medications were found in LPN #211's car but none of the medications were controlled medications. The Administrator stated LPN #211 was acting erratic at a local airport. The police were called and LPN #211 was taken to the hospital for further evaluation and treatment. LPN #211's family retrieved her car and discovered the medication packages in the center console. The family contacted the police about the medication and the police contacted the facility. The Administrator stated as far as he knew, LPN #211 was still receiving inpatient treatment.</p> <p>Interview on 10/18/24 at 9:15 A.M. with Police Officer (PO) #500 revealed he opened the case related to the medications in LPN #211's car. PO #500 stated LPN #211's family brought the car to the police station after discovering the medications. PO #500 verified all the medications were still in the unopened packages except for the two packages of Resident #5's Metoprolol. PO #500 stated he had not been able to interview LPN #211 because she was still receiving treatment and the physicians did not want her to be interviewed yet.</p> <p>Interview on 10/18/24 at 10:22 A.M. with the Director of Nursing (DON) verified the police brought the packages of medications to the facility and only two packages (Resident #5's metoprolol) were opened. The DON stated the medications were checked against the medication administration record (MAR). Some of the medications had been discontinued, some were from when residents were out of the facility, and some were marked as administered. The DON was unable to determine if any residents actually missed medications related to the incident.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365152	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Schoenbrunn Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 2594 East High Avenue New Philadelphia, OH 44663	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the undated facility policy titled Abuse, Neglect, and Exploitation revealed misappropriation of resident property was defined as the deliberate misplacement, exploitation or wrongful use of a resident's belongings without the resident's consent.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00158618.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365152	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Schoenbrunn Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 2594 East High Avenue New Philadelphia, OH 44663	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34298</p> <p>Based on resident interview, medical record review, review of a facility self-reported incident (SRI) and investigation, staff interview and review of facility policy, the facility failed to ensure allegations of staff to resident abuse were reported timely. This affected one resident (#03) of three residents reviewed for abuse. The facility census was 65.</p> <p>Findings include:</p> <p>Review of the medical record revealed Resident #03 was admitted on [DATE] with diagnoses that included acute and chronic respiratory failure with hypoxia, myocardial infarction, anxiety disorder and major depressive disorder.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment, dated 10/09/24, revealed Resident #03 was cognitively intact.</p> <p>Review of SRI #252690, dated 10/06/24, revealed Resident #03 alleged that on 09/30/24, State tested Nursing Assistant (STNA #174) was angry and punched a nearby wall. The SRI stated although the alleged incident occurred on 09/30/24, the Administrator was not notified until 10/06/24 at approximately 6:13 A.M. The allegation indicated STNA #174 became frustrated in Resident #03's room and punched/hit the wall.</p> <p>Review of a facility investigation written statement, completed by STNA #100 and dated 10/09/24, revealed around 09/30/24, STNA #174 and STNA #100 were putting Resident #03 to bed. STNA #174 was frustrated about something and punched the wall in Resident #03's room. STNA #174 had been getting frustrated easily lately. At times, the nurses would get STNA #100 when they needed something so STNA #174 did not get upset. STNA #100 asked STNA #174 if he had been going to counseling lately and taking antianxiety medications. STNA #100 stated STNA #174's actions startled her and Resident #03. Three or five days later, Resident #64 (Resident #03's spouse) asked STNA #100 if she heard about the incident with STNA #174. Resident #64 stated Resident #03 was fearful because of the incident.</p> <p>Review of an undated written statement, completed by STNA #174, revealed on 09/30/24 it was a rough day and due to last minute appointments, therapy, call lights going off and demands, STNA #174 got frustrated and snapped. STNA #174 slapped the wall and yelled out comments, which STNA #174 realized scared Resident #03.</p> <p>Interview on 10/18/24 at 10:44 A.M. with Resident #03 revealed on 09/30/24, there was an incident in which STNA #174 hit the wall above her head and stated, you [explicative] people. Resident #03 stated STNA #100 reported the incident to a nurse and stated the nurse would talk to STNA #174. During the interview with Resident #03, her husband, Resident #64, entered the room. Resident #64 stated he resided in another room and was not aware of the incident with STNA #174 until STNA #181 told him about it. Resident #64 stated he went to the nurse to make sure it was reported, and the nurse stated the incident could not be reported until Monday because the Administrator was not in the facility on the weekend. Resident #03 revealed none of the nurses came to ask her about what happened with STNA #174.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365152	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Schoenbrunn Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 2594 East High Avenue New Philadelphia, OH 44663	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 10/18/24 at 11:06 A.M. with LPN #214 verified she saw STNA #174 get upset at the nurses station. LPN #214 stated STNA #174 got frustrated when there was any change or a lot of residents needed assistance. LPN #214 denied STNA #100 reported any concerns with STNA #174 and Resident #03 until the end of the week.</p> <p>Interview on 10/18/24 at 11:20 A.M. with the Administrator verified he was not notified of the incident on 09/30/24 until the morning of 10/06/24. The Administrator stated STNA #100 wrote a statement indicating she did not report the incident because she did not feel abuse occurred.</p> <p>Review of the undated facility policy titled Abuse, Neglect and Exploitation revealed the facility will have written procedures that include reporting of all alleged violations to the Administrator, state agency, and all other required agencies within specified timeframe's. Reporting requirements included immediately, but not later than two hours after the allegation was made if the events that cause the allegation involve abuse or result 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.</p>