

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

Printed: 12/04/2024  
Form Approved OMB  
No. 0938-0391

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>365292                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                               | (X3) DATE SURVEY<br>COMPLETED<br><br>09/23/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Hanover Healthcare Center                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>435 Avis Avenue NW<br>Massillon, OH 44646 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                        |                                                 |
| F 0600<br><br>Level of Harm - Immediate<br>jeopardy to resident health or<br>safety<br><br>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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42015</p> <p>Based on observation, medical record reviews review of employee time clock punch reports, review of employee personnel files, review of facility Self-Reported Incidents (SRI), review of the facility assessment, facility policy review and interview, the facility failed to ensure all residents were free from staff to resident physical and/or emotional abuse. This resulted in Immediate Jeopardy and the potential for serious life-threatening harm/injuries and psychosocial harm beginning on 09/05/24 at approximately 3:15 P.M. when Activity Director (AD) #400 witnessed State tested Nursing Assistant (STNA) #300 grab and force Resident #78 to sit in her specialty tilt-in-space wheelchair (a specialty wheelchair that offers both a tilting function and a reclining function and should not be considered an independent mobility device due to their size and weight) while yelling at the resident to sit down. STNA #300 then positioned the tilt-in-space wheelchair with the resident's feet in the air and her head pointing toward the ground. The resident was observed to be tearful and crying out I'm scared of you while attempting to get out of the inverted specialty wheelchair. The resident remained in this position until approximately 3:30 P.M. when Activity Assistant (AA) #301 responded after hearing STNA #300 yelling at the resident. Following the incident, STNA #300 received education from Licensed Practical Nurse (LPN)/Unit Manager #105 regarding the use of restraints but was not removed from the facility or schedule despite the allegation of abuse reported.</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

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| <p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>               | <p>The Immediate Jeopardy and actual physical harm continued on 09/07/24 at approximately 11:00 A.M. when STNA #200 was physically abusive to Resident #71. On 09/07/24 while STNA #200 was assisting Resident #71 into the shower room for her scheduled shower, the resident became agitated. STNA #200 continued the shower despite the resident's reaction. Following the incident, Resident #71 reported to Licensed Practical Nurse (LPN) #102 that STNA #200 forcefully grabbed her, undressed her, and threw her in the shower. Resident #71 also reported the incident to her son who called the facility and reported the allegations to LPN #102, requesting no male staff provide further care to his mother. LPN #102 acknowledged to the resident's son there had been an altercation between the resident and staff; however, the LPN failed to report an allegation of physical abuse to leadership staff. On 09/10/24, Resident #71 was noted to have a 25 centimeter (cm) by 20 cm bruise covering the entirety of her right forearm, one dime size bruise to the right chest, one quarter sized bruise to her right chest, a scabbed area to her right arm, and a bruise to her right inferior upper arm the size of a thumb print. The resident's injuries were consistent with the resident's report of physical abuse. The resident was transported to the emergency room (ER) on 09/14/24 for lab work because of the incident. While in the ER, Resident #71 reported the shower incident to hospital staff. As a result of the report, x-rays of the resident's right arm were completed, and three fractures of the resident's right wrist were identified. This affected two residents (#78 and #71) of three residents reviewed for abuse. The facility census was 102.</p> <p>On 09/12/24 at 5:44 P.M. the Administrator, and Regional Director of Clinical Operations (RDCO) #320 were notified Immediate Jeopardy began on 09/05/24 at approximately 3:15 P.M., when AD #400 witnessed STNA #300 grab Resident #78 by the arm and force the resident into her tilt-in-space wheelchair and inverted the chair, so her head was positioned towards the floor and her feet in the air consistent with a situation of physical abuse. The resident was tearful and crying I'm scared of you and attempting to get out of the inverted chair. Although the incident was reported to Human Resource Manager (HRM) #600, STNA #300 continued to work at the facility, providing care to the residents on the secured dementia unit, including Resident #71. Additionally, on 09/07/24, Resident #71 alleged physical abuse involving STNA #200 when the STNA forced her to take a shower. The resident sustained multiple injuries as a result of the incident and was subsequently diagnosed with fractures to her wrist consistent with an incident of physical abuse. Although several staff were aware of the incident, STNA #200 was not immediately removed from the facility and the STNA was permitted to continue to provide care to the residents on the secured dementia unit, including Resident #71.</p> <p>The Immediate Jeopardy was removed on 09/16/2024 when the facility implemented the following corrective actions:</p> <p>On 9/10/24 at 10:30 P.M. Registered Nurse (RN) #315 assessed Resident #71 for pain. On 09/12/24 at 7:59 A.M. Unit Manager #105 completed a skin check for Resident #71. On 09/12/24 at 10:30 A.M. Resident #71 had an in-person assessment completed by the nurse practitioner of the facility psych services (Psych 360).</p> <p>On 9/11/24 at 9:30 A.M. State tested Nursing Assistant (STNA) #200 was suspended pending investigation by the Administrator/Executive Director.</p> <p>On 09/11/2024 at 9:35 A.M. the Administrator/ED notified the local police department of the incident that had occurred between Resident #71 and STNA #200 on 09/07/24.</p> <p>(continued on next page)</p> |                                                                                        |                                                 |

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| F 0600<br><br>Level of Harm - Immediate<br>jeopardy to resident health or<br>safety<br><br>Residents Affected - Few                | <p>On 9/11/24 at 1:00 P.M. ADON #100 notified Medical Director #800 of the incident with Resident #71 and STNA #200 (that occurred on 09/07/24) and of the incident with Resident #78 and STNA #300 (that occurred on 09/05/24).</p> <p>On 09/11/2024 at 1:15 P.M. the ED notified the local police department of the incident that had occurred between Resident #78 and STNA #300 on 09/05/24.</p> <p>On 09/11/24 at 3:00 P.M. STNA #300 was suspended pending investigation by the Executive Director.</p> <p>On 09/12/24 at 11:00 A.M. Resident #78 had an in-person assessment completed by the nurse practitioner of the facility psych services (Psych 360). On 09/12/24 at 8:06 P.M. LPN #226 reassessed Resident #78 for skin issues. On 09/13/24 at 1:48 P.M. Resident #78 had pain assessment completed by LPN #105.</p> <p>On 9/12/2024 beginning at 6:00 P.M. 61 residents with a Brief Interview for Mental Status Score (BIMS) score of 10 (out of a possible 15) and higher were interviewed by ADON# 100, Clinical Manager #101, and RDCO #320 to identify any additional occurrences of abuse. Beginning at 7:00 P.M. skin assessments were performed by LPN #430, ADON #100, Clinical Manager #101 and RDCO #320 on all other residents who had a BIMS under 10 or were not interviewable. All 102 residents were interviewed and/or assessed at this time.</p> <p>On 9/12/2024 at 4:44 P.M. the Administrator/ED sent a text message to all 121 staff members, to notify them of required in-service education that was being completed by RDCO #320. The education included a quiz. Elements of the education included: Using a tilt-and-space (chair) as a restraint, dementia care, de-escalating a catastrophic reaction, abuse, securing resident safety in cases of suspected abuse, staff removing perpetrators from the facility, reporting an incident to a supervisor immediately, phone numbers of department heads, including abuse coordinator, and proper steps/timelines in abuse investigation. Seventeen employees completed the education on this day.</p> <p>On 09/12/24 at 4:30 P.M., Regional Director of Operations (RDO) #750 educated HRM #600 on the policy and procedure for appropriate pre-employment checks to be completed prior to hire. On 9/13/2024 at 10:45 A.M. RDCO #320 educated HRM #600 verbally via telephone on proper policies and procedures for the use of Restraints, Dementia Care, Aggressive/Combative Behavior, Abuse Policy, Abuse Reporting, and Abuse Investigation. HRM #600 was educated that if an employee reported abuse to her, she should first make sure the resident was safe and the perpetrator was out of the facility, and then report the incident to the facility Abuse Coordinator, who was the Administrator/Executive Director.</p> <p>(continued on next page)</p> |                                                                                        |                                                 |

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| <p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>               | <p>On 09/13/24 at 9:30 A.M. Unit Manager #105 along with the interdisciplinary team who included the ED, ADON #100, Clinical Manager #101, Electronic Health Records Manager #751, LSW #753, Housekeeping Director #754, Maintenance Director #755, Culinary Manager #390, Activities Director #400, LPN #338, Business Office Manager #756, Mobile BOM #757, and Therapy Director #705 were educated by RDO #750. Education was in-person and included a review of proper policy and procedures on the use of Restraints, Dementia Care, Aggressive/Combative Behavior, Abuse Policy, Abuse Reporting, and Abuse Investigation. At 10:00 am, RDCO #320 educated Unit Manger #105 on Abuse Prevention, the use of restraints, and aggressive/combative behavior with emphasis on de-escalating catastrophic reactions, abuse investigation (including resident assessments &amp; documentation) and reporting, and use of restraints. At 1:00 P.M., RDCO #320 educated LPN #102 on abuse reporting, including the identity of the abuse coordinator, timelines, and proper notifications in instances of abuse allegations. Elements of these policies that were emphasized include: Using a tilt-and-space (chair) as a restraint, dementia care, de-escalating a catastrophic reaction, abuse, securing resident safety in cases of suspected abuse</p> <p>On 9/13/2024 at 10:45 A.M. RDCO #320 educated the Director of Nursing (DON) verbally via telephone on proper policies and procedures for the use of Restraints, Dementia Care, Aggressive/Combative Behavior, Abuse Policy, Abuse Reporting, and Abuse Investigation.</p> <p>On 09/13/24 between at 1:00 P.M. and 4:45 P.M. the remaining 104 staff including LPN #102 and Unit Manager #105 were educated in person or via telephone on the use of restraints, Dementia Care, Aggressive/Combative Behavior, Abuse Policy, Abuse Reporting, and Abuse Investigation by RDCO#320/designee. The facility indicated all new hires would be educated on the first day of orientation by social service staff.</p> <p>On 9/13/24 at 1:30 P.M. the facility Quality Assessment and Performance Improvement (QAPI) committee met to conduct a root cause analysis of the incidents involving Resident #78 and Resident #71. The QAPI committee included ED, RDO #750, RDCO #320, Medical Director (MD) #800, and the DON via telephone. The QAPI committee determined the root causes of the incidents included staff working in the memory care unit without proper training in Dementia Care and Aggressive/Combative Behavior, staff needed education on the Use of Restraints in terms of tilt-and-space chairs, and staff were unaware of the facility identified Abuse Coordinator, proper reporting protocols, and proper steps/requirements of an abuse investigation.</p> <p>On 9/14/2024 at 11:33 A.M. Resident #71 went to the hospital to have labs performed. While in the hospital, Resident #71 reported the incident of abuse to hospital staff. The hospital performed x-rays and found three fractures in Resident #71's right wrist. Resident #71 returned to facility with an order for a splint to the right wrist. An appointment was set for the resident to see an orthopedist on 09/24/24 at 8:25 A.M.</p> <p>On 9/16/2024 at 11:00 A.M. the DON/designees reviewed care plans for additional residents, Resident #2, #3, #7, #8, #9, #12, #17, #18, #19, #22, #24, #30, #41, #43, #44, #49, #50, #51, #54, #55, #56, #60, #62, #63, #65, #66, #69, #75, #76, #84, #85, #86, #87, #91, #96, #98, and #102 with history of catastrophic reactions.</p> <p>(continued on next page)</p> |                                                                                        |                                                 |

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| <p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>               | <p>On 09/16/24 at 2:00 P.M. Resident #71's care plan was reviewed by LPN #105. The care plan was updated for the resident to have two staff members during showers, and no males were to provide care during all showers. Additionally, the residents care plan was updated related to her fracture. Changes were communicated to staff through the resident's Kardex in Point Click Care (electronic medical record/documentation system).</p> <p>Beginning on 09/16/24 the Administrator or designee would interview two staff and three residents once a week for four weeks to ensure that no incidents of abuse had occurred.</p> <p>Beginning on 09/16/24 the DON/designee would perform two random skin assessments daily for four weeks to ensure care is being provided appropriately.</p> <p>Beginning on 09/16/24 the DON/Designee would audit the Connections (memory care) Unit five days a week for four weeks. Audits would include observation of activity of daily living assistance and meal service to ensure residents were receiving proper care.</p> <p>Beginning on 09/16/24 the ED/designee would audit Human Resources (HR) once a week for four weeks to ensure new hires were properly screened with Bureau of Criminal Investigations (BCI) (background checks) checks and reference checks. Audits would also ensure new hires were properly signed up for Relias for in-service training and receive proper abuse and dementia care training upon hire.</p> <p>Beginning on 09/16/24 the ED/designee would audit employee evaluations once a week for four weeks to ensure any issues mentioned in employee evaluations were followed with proper education or discipline by DON/designee.</p> <p>The results of all audits would be submitted to the QAPI committee for review upon completion and quarterly thereafter.</p> <p>STNA #300 was terminated on 09/17/24 at 3:45 P.M.</p> <p>STNA #200 was terminated on 09/17/24 at 3:50 P.M.</p> <p>Although the Immediate Jeopardy was removed on 09/16/24, the facility remained out of compliance at a Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was in the process of implementing their corrective action plan and monitoring to ensure on-going compliance.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #78 revealed an admitted [DATE] with diagnoses including unspecified dementia, generalized anxiety disorder, hypertension, and diabetes mellitus type two. The resident resided on the secured memory care unit in the facility.</p> <p>(continued on next page)</p> |                                                                                        |                                                 |

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| <p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>               | <p>Review of Resident #78's care plan, initiated on 02/02/24, revealed she had a self-care deficit requiring staff assistance with activities of daily living (ADL) related to functional decline, impaired mobility, and impaired cognition. Interventions included the resident was allowed up ad lib (out of bed/chair whenever they prefer). Further review revealed Resident #78 had a care plan initiated on 04/10/2024 that indicated the resident is at risk for elopement and required a secured unit related to her diagnosis of dementia. Interventions included for staff to assess for hunger, thirst, ambulation, toileting needs, observe whereabouts every two hours and as needed due to elopement risk, provide diversionary activities as needed, redirect when appropriate, and provide structured activities at times of increased elopement risk.</p> <p>Review of Resident #78's Secure Care Unit Evaluation-Initial, dated 02/03/2024, revealed the resident exhibited the following: gait disturbance, cognitive impairment, lack of safety awareness. An order was in place for the secured unit and the resident's guardian was notified of the need for the secured care unit.</p> <p>Review of Resident #78's Wandering Observation Tool, dated 05/02/24, revealed the resident had expressed anxiety/apprehension to leave the facility, packed personal belongings, pacing with no course of action or direction, or attempted to exit doors. The assessment determined the resident was at risk for elopement or unsafe wandering.</p> <p>Review of Resident #78's quarterly Minimum Data Set 3.0 (MDS) assessment, dated 07/10/24, revealed the resident had a moderate cognitive impairment. The assessment indicated the resident did not have an impairment to her upper or lower extremities and utilized a wheelchair. The resident was not assessed to have any behaviors.</p> <p>Review of Resident #78's Occupational Therapy (OT) progress note from 08/15/24 revealed the resident can stand up from wheelchair and walk. The resident was noted to be moderately independent with mobility with functional mobility throughout hallways at a slow pace without a device with fair tolerance. On 08/23/24 a progress note revealed the resident demonstrated good wheelchair positioning in custom tilt-in-space wheelchair while provided with set up for bilateral upper extremity activities in all planes with fair activity tolerance, occasional rest breaks, and good safety to improve strength, activity tolerance, wheelchair positioning, and safely to reduce fall risk and improve self-care, mobility, and functional daily activities within her environment.</p> <p>Review of Resident #78's OT Discharge Summary, dated 08/26/24, revealed the resident met her goal to sit upright in a new custom tilt-in-space wheelchair to facilitate correct anatomical alignment for two hours without sliding or complaint of discomfort.</p> <p>Further review of the medical record revealed no physician order for the tilt-in-space wheelchair, any use of physical restraints and no care plan regarding the tilt-in-space wheelchair.</p> <p>Review of Resident #78's progress notes revealed no documentation of restraint use, allegations of abuse, or resident assessments on 09/05/24 or 09/06/24.</p> <p>(continued on next page)</p> |                                                                                        |                                                 |

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| <p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>               | <p>During an interview on 09/11/24 at 10:30 A.M. with Activity Assistant (AA) #301, the AA voiced concerns that some of the staff working on the memory care unit were not treating the residents right and management would not do anything about it. She reported two of her coworkers (AD #400 and AA #310) witnessed abuse last Thursday (09/05/24). She shared STNA #300 forced Resident #78 into her tilt-in-space wheelchair and positioned her with her head to the floor and her feet in the air. AA #301 stated it was reported to the facility and they continued to allow STNA #300 to care for residents on the unit. AA #301 went on to say last Thursday (09/05/24) around 3:15 P.M. she heard STNA #300 yelling at a resident (AA reported she was unable to hear what the STNA was saying due to being in another room with residents). She stated around 3:30 P.M. she was able to respond after she left a resident's room while passing snacks. At that time, she witnessed Resident #78 positioned all the way back in her tilt-in-space wheelchair with her head towards the ground and her feet in the air. The resident was crying and visibly upset. She stated she went to the resident and positioned her in an upright position and gave her a snack to help her calm down. AA #301 stated she has reported issues like this in the past to management, but nothing was done. Lastly, she stated, in her opinion, staff use this wheelchair often to keep Resident #78 from walking on the unit.</p> <p>Interview on 09/11/24 at 10:41 A.M. with AD #400 revealed on 09/05/24 she was doing her rounds on the memory care unit. Between 3:15 P.M. and 3:30 P.M. she was visiting with residents on the unit and heard some commotion. Resident #78 was observed to be walking around the unit, and she heard STNA #300, in a very loud voice, tell the resident to sit down. She then witnessed STNA #300 forcefully grab the resident's arm (she cannot recall which arm) and pull the resident down into the tilt-in-space wheelchair. AD #400 stated she intervened and asked STNA #300, is there anything I can do? STNA #300 then told the AD to back off. The resident then attempted to swing at STNA #300 and remove herself from the chair. STNA #300 stated, she done hit me and positioned the chair with the resident's head towards the floor and her feet in the air. The resident began to cry and stated, I'm scared of you. STNA #300 was then heard stating now you can't move. AD #400 stated she left right away and went to Human Resource Manager #600 (identified as Employee Life Cycle Manager by the facility but the employee identified herself as Human Resource Manager) and reported the incident. The HRM advised AD #400 to write a statement and give it to LPN/Unit Manager # 105. AD #400 reported she wrote a statement and placed the statement in the DON's mailbox. She stated she then returned to the unit and observed the resident in the same position but at that time, AA #301 was walking to the resident and repositioned her in an upright position and provided her a snack. AD #400 reported the resident stated to AA #301 I'm glad you came when you did. AD #400 went on to say the next day (09/06/24) she let everyone know in morning meeting, including Administration (AD #400 was unable to recall which administrative staff were present but did state the Administrator and UM #105 were present) about the incident. Unit Manager #105 reported you should have told her right away, and that she would deal with it. AD #400 reported she was detailed and clear about what she saw when she reported the observation to HRM #600, her written statement left in the DON's mailbox, and when she reported the incident again during the morning meeting.</p> <p>(continued on next page)</p> |                                                                                        |                                                 |

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| <p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>               | <p>Interview on 09/11/24 at 10:56 A.M. with AA #310 revealed on 09/05/24 around 3:30 P.M. she witnessed Resident #78 standing in the dining room when she heard STNA #300 come over to her and yell I told you to sit down. She continued that STNA #300 was yanking on the resident's arm (she was unable to recall which arm). AA #310 stated the resident who is a gentle soul was attempting to hit STNA #300 and crying out. AA #310 stated AD #400 went over to help with the situation and was told by STNA #300 basically to leave her alone and that she had this. AA #310 stated the resident was petrified as STNA #300 forced her into her tilt-in- space wheelchair and placed her with her head to the ground and her feet in the air. AA #310 stated she was shocked and didn't know what to do. She stated the resident was positioned in a way she could not get out of the chair. AA #310 stated STNA #300 told the resident Don't get up. She stated the resident was crying and terrified. AA #310 stated AD #400 left the floor and went straight to HRM #600 to report the incident. She went on to say STNA #300 was very loud and scary to the residents, and she wished the unit had cameras because she had never heard of so much abuse in a facility.</p> <p>Interview on 09/11/24 at 11:38 A.M. with HRM #600 revealed AD #400 reported to her on 09/05/24 (she was unsure of the time) that STNA #300 forcefully put Resident #78 into her tilt-in- space wheelchair and tilted it fully back so the resident could not move. HRM #600 reported she advised AD #400 to write a statement and get UM #105 involved. HRM #600 stated she did not further report the issue and did not obtain a statement from AD #400. The HRM reported she doesn't deal with abuse allegations and defers them to the management. She stated she was mostly there for the support of the staff. She confirmed she did not follow the facility abuse policy by not reporting it to the Administrator or other leadership staff.</p> <p>Interview on 09/11/24 at 12:47 P.M. with Therapy Manager #705 revealed Resident #78 had a custom tilt-in-space wheelchair that she utilized for positioning to help her sit up straight. She reported the resident did well with the wheelchair and while receiving therapy, the resident could get up independently from the wheelchair and walk with staff assistance.</p> <p>Interview on 09/11/24 at 1:13 P.M. with LPN/UM #105 revealed one day last week AA #310 came to her and mentioned that she thought Resident #78 was being restrained in her tilt-in- space wheelchair by STNA #300. UM #105 stated she checked on the resident and removed the leg rest from her tilt-in- space wheelchair. The resident was not tilted back all the way at that time. She shared she provided verbal education to STNA #300 (however, there was no documented evidence of the education) regarding how tipping the chair too far back could be considered a restraint. She stated the next day in morning meeting AD #400 reported to her that STNA #300 had restrained Resident #78 and UM #105 stated she told AD #400 that she had already taken care of it at the time of the incident (with the verbal education provided to STNA #300). UM #105 verified this was not further reported to Administration when she addressed physical restraint use with STNA #300.</p> <p>During a telephone interview on 09/11/24 at 2:50 P.M. STNA #300 denied the allegations but reported Unit Manager #105 did provide her verbal education to not place Resident #78 in her wheelchair with the head laid back because it could be considered a restraint.</p> <p>(continued on next page)</p> |                                                                                        |                                                 |

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| <p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>               | <p>Review of STNA #300's personnel file on 09/12/24 at 9:04 A.M. with HRM #600 revealed STNA# 300 was hired on 07/26/23. There was no performance review or record of dementia care education/training despite routine assignment to the facility secure dementia unit. HRM #600 stated STNA #300 was never entered into the online training system and therefore did not receive education. HRM #600 stated the facility had attempted to contact STNA #300's references provided on the employee's application, but the facility never received calls back from the references, so the facility moved forward with hiring STNA #300. Lastly, HRM #600 denied any formal discipline in STNA #300's personnel file.</p> <p>Review of STNA #300's time clock punch reports revealed the STNA worked 09/05/24 from 6:54 A.M. until 6:54 P.M., 09/07/24 from 6:54 A.M. until 5:46 P.M., and 09/10/24 from 6:53 A.M. until 6:55 P.M. Review of the staff schedule dated 09/05/24 through 09/10/24 revealed STNA #300 was scheduled to work on the secured unit.</p> <p>Review of the facility Self-Reported Incidents in the Enhanced Information Dissemination Center (portal for reporting incidents of alleged abuse) from 09/05/24 through 09/11/24 revealed no reporting of the incident involving STNA #300 and Resident #78.</p> <p>The facility had no investigation related to the incident reported to the Unit Manager #105 or HR #600. The DON was out of the office at the time of the incident and UM #105 was unable to locate a statement from AD #400 in the mailbox of the DON.</p> <p>Interview on 09/12/24 at 1:06 P.M. with MD #800 revealed he was not notified until today (09/12/24) regarding the incident of alleged abuse involving Resident #78. MD #800 stated it would be his expectation for the facility to immediately report allegations of abuse to administration, remove the STNA from the area and start an immediate investigation.</p> <p>Interview on 09/12/24 at 1:43 PM with the Administrator revealed he was unaware of the abuse allegation involving Resident #78 until it was reported to the surveyor during survey activity on 09/11/24. The Administrator stated he would have initiated an immediate investigation and taken the appropriate steps had he been aware of the incident.</p> <p>2. Review of the medical record for Resident #71 revealed an admitted [DATE] with diagnoses including unspecified dementia with moderate behavioral disturbance, other sequelae of cerebral infarction, dysarthria following cerebral infarction, chronic kidney disease stage three, anxiety disorder, and major depressive disorder. The resident was noted to reside on the facility's secured dementia unit.</p> <p>Review of Resident #71's admission MDS 3.0 Assessment, dated 07/03/2024, revealed the resident was cognitively intact. The assessment indicated the resident had a lower extremity impairment to one side and utilized a wheelchair. The resident was dependent for showering and did have one to three days of behavioral symptoms towards others including hitting, kicking, pushing, scratching, and grabbing.</p> <p>(continued on next page)</p> |                                                                                        |                                                 |

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| <p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>               | <p>Review of Resident #71's care plan, dated 07/08/24, revealed the resident had behaviors including yelling, cussing at other residents, refusing care, yelling out, being tearful and having loud outbursts, which required nonpharmacological interventions including redirect, reapproach, calm environment, quiet environment, comfort, active listening. Interventions included administer medications as ordered, approach, speak in calm manor, encourage the resident to express feelings, encourage to maintain as much independence and control/decision making as possible, intervene as necessary to protect the rights and safety of others, minimize potential for disruptive behaviors by offering tasks that divert attention, monitor behavioral episodes, and attempt to determine underlying causes, and notify medical provider of increased episodes of behaviors.</p> <p>Review of Resident #71's shower sheet skin assessment, completed by STNA #200 and dated 09/07/24, documented the resident had a shower on this date. The only skin issue noted on the shower sheet was an old scab to her left arm. The form was also signed by LPN #102.</p> <p>Review of Resident #71's nursing progress notes for 09/07/24 revealed there were no progress notes regarding any allegation of abuse or issues/incidents related to the shower the resident received on this date.</p> <p>Review of Resident #71's nursing progress note dated 09/09/24 at 11:39 A.M. revealed UM #105 documented This nurse manager noted an aging bruise on the resident's left forearm. When speaking with the resident she stated that I think I bumped it on my bed when I fell . Resident did have an unwitnessed fall on 08/26/24.</p> <p>Review of Resident #71's nursing progress note, dated 09/10/2024 at 9:00 P.M. and created on 09/11/23 3:27 A.M. by Registered Nurse (RN) #315, revealed STNA (unidentified) reported that resident has a bruise on her entire right forearm. Resident was assessed by this nurse. She stated that a male aide, (STNA #200), with the blonde hair, grabbed her from behind, undressed her in front of everyone and twisted her arm. She said she grabbed his badge to check for his name and he grabbed it back. She said she fought back and screamed. According to her, this incident occurred on Saturday or Sunday between 2:00 P.M. to 4:00 P.M. She also stated that he called for a female aide, but it was only the male aide who was grabbing her arm. I was notified by an STNA (unidentified) that this resident told a similar story to another resident; manager-on-call (Assistant Director of Nursing #100) was notified; Family Member #701 updated via phone call at 10:45 P.M.</p> <p>Observation of Resident #71 on 09/11/23 at 11:10 A.M. revealed the resident had a large bruise with various shades of purple covering the entirety of her right forearm. Also noted was one dime size bruise to her right chest that was light red in color, one quarter sized bruise to the right chest that was light red in color, a scabbed area to her right arm, and a bruise to the right inferior upper arm the size of a thumb print which was light purple in color. The resident was seated in a wheelchair and had a contracture noted to her left hand. She presented to have minimal use of her left upper extremity.</p> <p>(continued on next page)</p> |                                                                                        |                                                 |

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

Printed: 12/04/2024  
Form Approved OMB  
No. 0938-0391

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| F 0600<br><br>Level of Harm - Immediate<br>jeopardy to resident health or<br>safety<br><br>Residents Affected - Few                | <p>An interview with Resident #71 at the time of the observation revealed she received these injuries the past weekend when a male STNA (identified through scheduling/interview/description as STNA #200) came up to her from behind, grabbed her right arm and started taking her clothes off. The resident stated the STNA forced her into the shower while she was screaming and yelling for him to stop. The STNA then placed her under hot water and then turned it to cold water. She reported he placed shampoo on her head and face, and she was yelling, screaming, and fighting him to stop but he would not. She then reported another STNA, identified as STNA #300, told Resident #71 she paid him a hundred dollars to do this to her. The resident continued that STNA #300 is not a nice person. She gets mad and vicious. She screams at the residents. The resident reported she received all the injuries from STNA #200 forcing her into the shower. The resident stated that she called her son and told him of the incident and additionally reported the incident to staff members working the day it happened.</p> <p>Interview on 09/11/24 at 11:20 A.M. with Family Member #704 revealed he received a phone call from his mother on Saturday (09/07/24) stating that a male STNA threw her in the shower. His mother said she was scared and wanted him to come and get her. Family Member #704 stated he then called the facility nurse (LPN #102) who was working the unit and reported what his mother had told him. He requested that male staff members no longer work with his mother. He stated [TRUNCATED]</p> |                                                                                        |                                                 |

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| <p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42015</b></p> <p>Based on observation, medical record reviews, review of facility Self-Reported Incidents (SRI), facility policy review and interview, the facility failed to ensure all allegations of physical and/or emotional abuse were reported immediately to the Administrator and State Survey Agency as required. This resulted in Immediate Jeopardy and the potential for serious life-threatening harm/injuries and psychosocial harm beginning on 09/05/24 at approximately 3:15 P.M. when Activity Director (AD) #400 witnessed State tested Nursing Assistant (STNA) #300 grab and force Resident #78 to sit in her specialty tilt-in-space wheelchair (a specialty wheelchair that offers both a tilting function and a reclining function and should not be considered an independent mobility device due to their size and weight) while yelling at the resident to sit down. STNA #300 then positioned the tilt-in-space wheelchair with the resident's feet in the air and her head pointing toward the ground. The resident was observed to be tearful and crying out I'm scared of you while attempting to get out of the inverted specialty wheelchair. The resident remained in this position until approximately 3:30 P.M. when Activity Assistant (AA) #301 responded after hearing STNA #300 yelling at the resident. The allegation was not immediately reported to the Administrator and the State Survey Agency therefore, STNA #300 continued to provide care to residents on the secure dementia unit, including Resident #78.</p> <p>The Immediate Jeopardy and actual physical harm continued on 09/07/24 at approximately 11:00 A.M. when STNA #200 was physically abusive to Resident #71. On 09/07/24 while STNA #200 was assisting Resident #71 into the shower room for her scheduled shower, the resident became agitated. STNA #200 continued the shower despite the resident's reaction. Following the incident, Resident #71 reported to Licensed Practical Nurse (LPN) #102 that STNA #200 forcefully grabbed her, undressed her, and threw her in the shower. Resident #71 also reported the incident to her son who called the facility and reported the allegations to LPN #102, requesting no male staff provide further care to his mother. LPN #102 acknowledged to the resident's son there had been an altercation between the resident and staff; however, the LPN failed to report an allegation of physical abuse to leadership staff. On 09/10/24, Resident #71 was noted to have a 25 centimeter (cm) by 20 cm bruise covering the entirety of her right forearm, one dime size bruise to the right chest, one quarter sized bruise to her right chest, a scabbed area to her right arm, and a bruise to her right inferior upper arm the size of a thumb print. The resident's injuries were consistent with the resident's report of physical abuse, and it was later identified the resident had three fractures to her right wrist. The allegation was not immediately reported to the Administrator and State Survey Agency therefore, STNA #200 continued to provide care to the residents on the secure dementia care including Resident #78. This affected two residents (#78 and #71) of three residents reviewed for abuse. The facility census was 102.</p> <p>On 09/12/24 at 5:44 P.M. the Administrator (also known as the Executive Director or ED), and Regional Director of Clinical Operations (RDCO) #320 were notified Immediate Jeopardy began on 09/05/24 at approximately 3:15 P.M., when AD #400 witnessed STNA #300 grab Resident #78 by the arm and force the resident into her tilt-in- space wheelchair and inverted the chair, so her head was positioned towards the floor and her feet in the air consistent with a situation of physical abuse. The resident was tearful and crying I'm scared of you and attempting to get out of the inverted chair. Although the incident was reported to Human Resource Manager #600, the allegation was not immediately reported to the Administrator and the State Survey Agency. STNA #300 continued to work at the facility, providing care to the residents on the secured dementia unit, including Resident #71.</p> <p>(continued on next page)</p> |                                                                                        |                                                 |

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| <p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>               | <p>Additionally, on 09/07/24, Resident #71 alleged physical abuse involving STNA #200 when the STNA forced her to take a shower. The resident sustained multiple injuries as a result of the incident and was subsequently diagnosed with fractures to her right wrist consistent with an incident of physical abuse. Although several staff were aware of the incident, the incident was not immediately reported to the Administrator and the State Survey Agency. STNA #200 was not immediately removed from the facility and the STNA was permitted to continue to provide care to the residents on the secured dementia unit, including Resident #71.</p> <p>The Immediate Jeopardy was removed on 09/13/24 when the facility implemented the following corrective actions:</p> <p>On 09/11/24 at 9:26 A.M. the Administrator/Executive Director (ED) created Self-Reported Incident, tracking number 251754 regarding Resident #71's allegation of abuse. On 09/11/24 and 09/12/24 the Executive Director conducted interviews with Resident #71, STNA/Alleged perpetrator #200, Activities Aide #310, STNA #300, STNA #131, LPN#102 and RN# 315.</p> <p>On 09/11/24 at 9:35 A.M. the Administrator/ED notified the local police department of the incident with Resident #71 and STNA #200 that occurred on 09/07/24. The local police opened case #2024-12273.</p> <p>On 9/11/24 at 1:00 P.M. ADON #100 notified Medical Director #800 of the incident with Resident #71 and STNA #200 (that occurred on 09/07/24) and the incident with Resident #78 and STNA #300 (that occurred on 09/05/24).</p> <p>On 09/11/24 at 1:04 P.M. Regional Director of Clinical Operations (RDCO) #320 created Self-Reported Incident, tracking number 251771 regarding the incident that occurred between Resident #78 and STNA #300 on 09/05/24. On 09/11/24 and 09/12/24 the Executive Director conducted interviews with Activities Director #400, Activities Aide #310 Activities Aide #301, STNA/Alleged Perpetrator #300, STNA #131, Unit Manger #105, HRM #600, and STNA #340.</p> <p>On 09/11/2024 at 1:15 P.M. the ED notified the local police department of the incident involving Resident #78 and STNA #300 that occurred on 09/05/24. The local police opened case #2024-12336.</p> <p>On 9/12/2024 beginning at 6:00 P.M. 61 residents with a Brief Interview for Mental Status Score (BIMS) of 10 (out of a score of a possible score of 15) and higher were interviewed by ADON# 100, Clinical Manager #101, and RDCO #320 to identify any additional occurrences of abuse. Beginning at 7:00 P.M. skin assessments were performed by LPN #430, ADON #100, Clinical Manager #101 and RDCO #320 on all other residents who had a BIMS under 10 or were not interviewable. All 102 residents were interviewed and/or assessed at this time.</p> <p>On 9/12/2024 at 4:44 P.M. the ED sent a text message to all 121 staff members, to notify them of required in-service education that was being completed by RDCO #320. The education included a quiz. Elements of the education included: Using a tilt-and-space (chair) as a restraint, dementia care, de-escalating a catastrophic reaction, abuse, securing resident safety in cases of suspected abuse, staff removing perpetrators from facility, reporting incident to supervisor immediately, phone numbers of department heads, including abuse coordinator, and proper steps/timelines in abuse investigation. Seventeen employees completed the education on this day.</p> <p>(continued on next page)</p> |                                                                                        |                                                 |

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| NAME OF PROVIDER OR SUPPLIER<br><br>Hanover Healthcare Center                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>435 Avis Avenue NW<br>Massillon, OH 44646 |                                                 |
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| <p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>               | <p>On 09/13/24 at 9:30 A.M. Unit Manager #105 along with the interdisciplinary team who included the ED, ADON #100, Clinical Manager #101, Electronic Health Records Manager #751, LSW #753, Housekeeping Director #754, Maintenance Director #755, Culinary Manager #390, Activities Director #400, LPN #338, Business Office Manager #756, Mobile BOM #757, and Therapy Director #705 were educated by Regional Director of Operations (RDO) #750. Education was in-person and included a review of proper policy and procedures on the use of Restraints, Dementia Care, Aggressive/Combative Behavior, Abuse Policy, Abuse Reporting, and Abuse Investigation. At 10:00 am, RDCO #320 educated Unit Manger #105 on Abuse Prevention, the use of restraints, and aggressive/combative behavior with emphasis on de-escalating catastrophic reactions, abuse investigation (including resident assessments &amp; documentation) and reporting, and use of restraints. At 1:00 P.M., RDCO #320 educated LPN #102 on abuse reporting, including the identity of the abuse coordinator, timelines, and proper notifications in instances of abuse allegations. Elements of these policies that were emphasized include: Using a tilt-and-space (chair) as a restraint, dementia care, de-escalating a catastrophic reaction, abuse, securing resident safety in cases of suspected abuse</p> <p>On 9/13/2024 at 10:45 A.M. RDCO #320 educated the DON verbally via telephone on proper policies and procedures for the use of Restraints, Dementia Care, Aggressive/Combative Behavior, Abuse Policy, Abuse Reporting, and Abuse Investigation.</p> <p>On 09/13/24 between at 1:00 P.M. and 4:45 P.M. the remaining 104 staff including LPN #102 and Unit Manager #105 were educated in person or via telephone on the use of restraints, Dementia Care, Aggressive/Combative Behavior, Abuse Policy, Abuse Reporting, and Abuse Investigation by RDCO#320/designee. The facility indicated all new hires would be educated on the first day of orientation by social service staff.</p> <p>On 9/13/24 at 1:30 P.M. the facility Quality Assessment and Performance Improvement (QAPI) committee met to conduct a root cause analysis of the incidents involving Resident #78 and Resident #71. The QAPI committee included ED, RDO #750, RDCO #320, Medical Director (MD) #800, and the Director of Nursing (DON) via telephone. The QAPI committee determined the root causes of the incidents included staff working in memory care unit without proper training in Dementia Care and Aggressive/Combative Behavior, staff needed education on the Use of Restraints in terms of tilt-and-space chairs, and staff were unaware of the Abuse Coordinator, proper reporting protocols, and proper steps/requirements of abuse investigation.</p> <p>Beginning on 09/16/24 RDCO #320/designee would audit 24-hour reports daily for four weeks to see if any reportable incidents occurred. The RDCO/designee would also audit to ensure facility Self-Report Incidents (SRIs) were reported to the State (ODH) agency portal in a timely fashion.</p> <p>On 09/17/24 the facility completed and submitted their final Self-Reported Incident information for tracking number 251771 which substantiated the incident of abuse involving Resident #78.</p> <p>On 09/17/24 the facility completed and submitted their final Self-Reported Incident information for tracking number 251754 which substantiated the incident of abuse involving Resident #71.</p> <p>Although the Immediate Jeopardy was removed on 09/13/24, the facility remained out of compliance at a Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was in the process of implementing their corrective action plan and monitoring to ensure on-going compliance.</p> <p>(continued on next page)</p> |                                                                                        |                                                 |

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| F 0609<br><br>Level of Harm - Immediate<br>jeopardy to resident health or<br>safety<br><br>Residents Affected - Few                | <p>Findings Review of the medical record for Resident #78 revealed an admitted [DATE] with diagnoses including unspecified dementia, generalized anxiety disorder, hypertension, and diabetes mellitus type two. The resident resided on the secured memory care unit in the facility.</p> <p>Review of Resident #78's care plan, initiated on 02/02/24, revealed she had a self-care deficit requiring staff assistance with activities of daily living (ADL) related to functional decline, impaired mobility, and impaired cognition. Interventions included the resident was allowed up ad lib (out of bed/chair whenever they prefer).</p> <p>Review of Resident #78's quarterly Minimum Data Set 3.0 (MDS) assessment, dated 07/10/24, revealed the resident had a moderate cognitive impairment. The assessment indicated the resident did not have an impairment to her upper or lower extremities and utilized a wheelchair. The resident was not assessed to have any behaviors.</p> <p>Review of Resident #78's Occupational Therapy (OT) Discharge Summary, dated 08/26/24, revealed the resident met her goal to sit upright in a new custom tilt-in-space wheelchair to facilitate correct anatomical alignment for two hours without sliding or complaint of discomfort.</p> <p>Further review of the medical record revealed no physician order for the tilt-in-space wheelchair, any use of physical restraints and no care plan regarding the tilt-in-space wheelchair.</p> <p>Review of Resident #78's progress notes revealed no documentation of restraint use, allegations of abuse, or resident assessments on 09/05/24 or 09/06/24.</p> <p>During an interview on 09/11/24 at 10:30 A.M. with Activity Assistant (AA) #301, the AA voiced concerns that some of the staff working on the memory care unit were not treating the residents right and management would not do anything about it. She reported two of her coworkers (AD #400 and AA #310) witnessed abuse last Thursday (09/05/24). She shared STNA #300 forced Resident #78 into her tilt-in-space wheelchair and positioned her with her head to the floor and her feet in the air. AA #301 stated it was reported to the facility and they continued to allow STNA #300 to care for residents on the unit. AA #301 went on to say last Thursday (09/05/24) around 3:15 P.M. she heard STNA #300 yelling at a resident (AA reported she was unable to hear what the STNA was saying due to being in another room with residents). She stated around 3:30 P.M. she was able to respond, after she left a resident's room, while passing snacks. At that time, she witnessed Resident #78 positioned all the way back in her tilt-in-space wheelchair with her head towards the ground and her feet in the air. The resident was crying and visibly upset. She stated she went to the resident and positioned her in an upright position and gave her a snack to help her calm down.</p> <p>(continued on next page)</p> |                                                                                        |                                                 |

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| <p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>               | <p>Interview on 09/11/24 at 10:41 A.M. with AD #400 revealed on 09/05/24 she was doing her rounds on the memory care unit. Between 3:15 P.M. and 3:30 P.M. she was visiting with residents on the unit and heard some commotion. Resident #78 was observed to be walking around the unit, and she heard STNA #300, in a very loud voice, tell the resident to sit down. She then witnessed STNA #300 forcefully grab the resident's arm (she cannot recall which arm) and pull the resident down into the tilt-in-space wheelchair. AD #400 stated she intervened and asked STNA #300, is there anything I can do? STNA #300 then told the AD to back off. The resident then attempted to swing at STNA #300 and remove herself from the chair. STNA #300 stated, she done hit me and positioned the chair with the resident's head towards the floor and her feet in the air. The resident began to cry and stated, I'm scared of you. STNA #300 was then heard stating now you can't move. AD #400 stated she left right away and went to Human Resource Manager #600 (identified as Employee Life Cycle Manager by the facility but the employee identified herself as Human Resource Manager) and reported the incident. The HR manager advised AD #400 to write a statement and give it to LPN/Unit Manager #105. AD #400 reported she wrote a statement and placed the statement in the DON's mailbox. She stated she then returned to the unit and observed the resident in the same position but at that time, AA #301 was walking to the resident and repositioned her in an upright position and provided her a snack. AD #400 reported the resident stated to AA #301 I'm glad you came when you did. AD #400 went on to say the next day (09/06/24) she let everyone know in morning meeting, including Administration (AD #400 was unable to recall which administrative staff were present but did state the Administrator and UM #105 were present) about the incident. Unit Manager #105 reported she should have told her right away, and that she would deal with it. AD #400 reported she was detailed and clear about what she saw when she reported the observation to HRM #600, her written statement left in the DON's mailbox, and when she reported the incident again during the morning meeting.</p> <p>Interview on 09/11/24 at 11:38 A.M. with HRM #600 revealed AD #400 reported to her on 09/05/24 (she was unsure of the time) that STNA #300 forcefully put Resident #78 into her tilt-in- space wheelchair and tilted it fully back so the resident could not move. HRM #600 reported she advised AD #400 to write a statement and get UM #105 involved. HRM #600 stated she did not further report the issue and did not obtain a statement from AD #400. The HRM reported she doesn't deal with abuse allegations and defers them to the management. She stated she was mostly there for the support of the staff. She confirmed she did not follow the facility abuse policy by not reporting it to the Administrator or other leadership staff.</p> <p>Interview on 09/11/24 at 1:13 P.M. with LPN/UM #105 revealed one day last week AA #310 came to her and mentioned that she thought Resident #78 was being restrained in her tilt-in- space wheelchair by STNA #300. UM #105 stated she checked on the resident and removed the leg rest from her tilt-in- space wheelchair. The resident was not tilted back all the way at that time. She shared she provided verbal education to STNA #300 (however, there was no documented evidence of the education) regarding how tipping the chair too far back could be considered a restraint. She stated the next day in morning meeting AD #400 reported to her that STNA #300 had restrained Resident #78 and UM #105 stated she told AD #400 that she had already taken care of it at the time of the incident (with the verbal education provided to STNA #300). UM #105 verified this was not further reported to Administration when she addressed physical restraint use with STNA #300.</p> <p>Review of the facility Self-Reported Incidents in the Enhanced Information Dissemination Center (portal for reporting incidents of alleged abuse) from 09/05/24 through 09/11/24 at 9:00 A.M. revealed no reporting of the incident involving STNA #300 and Resident #78.</p> <p>(continued on next page)</p> |                                                                                        |                                                 |

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| <p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>               | <p>The facility had no investigation related to the incident reported to the Unit Manager #105 or HR #600. The DON was out of the office at the time of the incident and RDCO #320 was unable to locate a statement from AD #400 in the mailbox of the DON.</p> <p>Review of a facility Self-Reported Incident (SRI), tracking number 251771 initiated following the identification of the issue by the State agency, created on 09/11/24 at 1:04 P.M. incorrectly described the incident under the incident information brief description as: Resident allegedly abused STNA. The alleged perpetrator was facility staff or other care provider, and the initial source of the allegation/suspicion was staff. The resident was identified as Resident #78 who was unable to provide meaningful information and under the question What effect did incident have on resident? The facility answered none. The date and time of the occurrence was 09/05/24 at 3:30 P.M. in the secured dementia unit dining room. According to witness accounts, Resident #78 was walking in Memory Care Unit dining room. STNA #300 grabbed the resident, with a diagnosis of dementia and who resided on the secured dementia unit, by the arm and forced her to sit in a tilt-in-space wheelchair. The STNA was yelling at the resident to sit down and placed the tilt-in-space wheelchair with her feet in the air and her head pointing to the ground. The resident was observed to be screaming and crying for help and trying to get out of the inverted specialty wheelchair. The Activity Director approached STNA #300, offering to assist with care for the resident, but the Activity Director was met with the STNA telling the Activity Director to go away. Additionally, Activity Aide (unidentified) heard STNA yelling and when able, observed the resident positioned in her tilt-in-space wheelchair with her feet in the air and her head towards the ground. An SRI was opened (created) and the ED, DON, physician, and local police department were notified. The facility SRI investigation was completed on 09/17/24 at 3:41 P.M. and as a result of the investigation, the facility substantiated the incident of abuse.</p> <p>Interview on 09/12/24 1:06 P.M. with Medical Director #800 revealed he was not notified until today (09/12/24) regarding the incident of alleged abuse involving Resident #78. MD #800 stated it would be his expectation for the facility to immediately report allegations of abuse to administration, remove the STNA from the area and start an immediate investigation.</p> <p>Interview on 09/12/24 1:43 P.M. with the Administrator revealed he was unaware of the abuse allegation involving Resident #78 until it was reported to the surveyor during survey activity on 09/11/24. The Administrator stated he would have initiated an immediate investigation and taken the appropriate steps had he been aware of the incident. He denied hearing the report AD #400 made in morning meeting about the incident.</p> <p>Review of the undated facility Ohio Abuse, Neglect, and Misappropriation policy revealed the supervisor or designee would notify the DON and Executive Director (ED) of the incident or allegation immediately. Required notification of agencies, physician, and resident representee will be completed. The ED will direct the investigation.</p> <p>2. Review of the medical record for Resident #71 revealed an admitted [DATE] with diagnoses including unspecified dementia with moderate behavioral disturbance, other sequelae of cerebral infarction, dysarthria following cerebral infarction, chronic kidney disease stage three, anxiety disorder, and major depressive disorder. The resident was noted to reside on the facility's secured dementia unit.</p> <p>(continued on next page)</p> |                                                                                        |                                                 |

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| <p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>               | <p>Review of Resident #71's admission MDS 3.0 Assessment, dated 07/03/2024, revealed the resident was cognitively intact. The assessment indicated the resident had a lower extremity impairment to one side and utilized a wheelchair. The resident was dependent for showering and did have one to three days of behavioral symptoms towards others including hitting, kicking, pushing, scratching, and grabbing.</p> <p>Review of Resident #71's care plan dated 07/08/24 revealed the resident had behaviors including yelling, cussing at other residents, refusing care, yelling out, being tearful and having loud outbursts, which required nonpharmacological interventions including redirect, reapproach, calm environment, quiet environment, comfort, active listening. Interventions included administer medications as ordered, approach, speak in calm manor, encourage the resident to express feelings, encourage to maintain as much independence and control/decision making as possible, intervene as necessary to protect the rights and safety of others, minimize potential for disruptive behaviors by offering tasks that divert attention, monitor behavioral episodes, and attempt to determine underlying causes, and notify medical provider of increased episodes of behaviors.</p> <p>Review of Resident #71's nursing progress notes for 09/07/24 revealed there were no progress notes regarding any allegation of abuse or issues/incidents related to the shower the resident received on this date.</p> <p>Review of Resident #71's nursing progress note dated 09/09/24 at 11:39 A.M. revealed UM #105 documented This nurse manager noted an aging bruise on the resident's left forearm. When speaking with the resident she stated that I think I bumped it on my bed when I fell . Resident did have an unwitnessed fall on 08/26/24.</p> <p>Review of Resident #71's nursing progress note, dated 09/10/2024 at 9:00 P.M. and created on 09/11/23 3:27 A.M. by Registered Nurse (RN) #315, revealed STNA (unidentified) reported that resident has a bruise on her entire right forearm. Resident was assessed by this nurse. She stated that a male aide, (STNA #200)), with the blonde hair, grabbed her from behind, undressed her in front of everyone and twisted her arm. She said she grabbed his badge to check for his name and he grabbed it back. She said she fought back and screamed. According to her, this incident occurred on Saturday or Sunday between 2:00 P.M. to 4:00 P.M. She also stated that he called for a female aide, but it was only the male aide who was grabbing her arm. I was notified by an STNA (unidentified) that this resident told a similar story to another resident; manager-on-call (Assistant Director of Nursing #100) was notified; Family Member #701 updated via phone call at 10:45 P.M.</p> <p>Observation of Resident #71 on 09/11/23 at 11:10 A.M. revealed the resident had a large bruise with various shades of purple covering the entirety of her right forearm. Also noted was one dime size bruise to her right chest that was light red in color, one quarter sized bruise to the right chest that was light red in color, a scabbed area to her right arm, and a bruise to the right inferior upper arm the size of a thumb print which was light purple in color. The resident was seated in a wheelchair and had a contracture noted to her left hand. She presented to have minimal use of her left upper extremity.</p> <p>(continued on next page)</p> |                                                                                        |                                                 |

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| <p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>               | <p>An interview with Resident #71 at the time of the observation revealed she received these injuries the past weekend when a male STNA (identified through scheduling/interview/description as STNA #200) came up to her from behind, grabbed her right arm and started taking her clothes off. The resident stated the STNA forced her into the shower while she was screaming and yelling for him to stop. The STNA then placed her under hot water and then turned it to cold water. She reported he placed shampoo on her head and face, and she was yelling, screaming, and fighting him to stop but he would not. She then reported another STNA, identified as STNA #300 told Resident #71 she paid him a hundred dollars to do this to her. The resident continued that STNA #300 is not a nice person. She gets mad and vicious. She screams at the residents. The resident reported she received all the injuries from STNA #200 forcing her into the shower. The resident stated that she called her son and told him of the incident and additionally reported the incident to staff members working the day it happened.</p> <p>Interview on 09/11/24 at 11:20 A.M. with Family Member #704 reported he received a phone call from his mother on Saturday (09/07/24) stating that a male STNA threw her in the shower. His mother said she was scared and wanted him to come and get her. Family Member #704 stated he then called the facility nurse (LPN #102) who was working the unit and reported what his mother had told him. He requested that male staff members no longer work with his mother. He stated LPN #102 informed him his mother got aggressive and combative and was hitting a male STNA while he was showering her.</p> <p>A telephone interview on 09/11/24 at 2:08 P.M. with LPN #102 revealed on 09/07/24 STNA #200 went to give Resident #71 a shower. The resident started hitting, kicking and punching the STNA. STNA #200 got STNA #300, and they finished showering and dressing the resident. After her shower Resident #71 was yelling that STNA #200 took her clothes off and threw her in the shower. She was saying that a black person paid him a hundred dollars to do it. The son had called and asked about the incident and stated that his mother said a male STNA threw her in the shower and forced her to get a shower. LPN #102 went on to say the resident's son spoke with her about the encounter and stated he would prefer male staff no longer work with his mother. The nurse told the family member she would let the unit manager (UM #105) know. LPN #102 stated she meant to report the incident and allegation of abuse, but she got busy and did not report it until 09/09/24, in the morning, to Unit Manager #105.</p> <p>A telephone interview on 09/11/24 at 2:23 P.M. with STNA #200 reported Resident #71 was on the list for a shower on 09/07/24. He stated he got her and brought her to the shower room, when he started to undress her, she became aggressive and started hitting, screaming, biting, picked a scab off herself and wiped her blood on him. She was swinging her arm and slamming it into the wall. He continued with the shower and washed her while she was screaming and hitting him the entire time. He stated he pulled the call light and STNA #300 came and assisted with the end of the shower and getting the resident dressed. After they completed the shower, and she was dressed, she continued to be upset and was telling everyone the rest of the night that STNA #200 abused her and STNA #300 paid him to do so. STNA #200 denied STNA #300 paid him to force Resident #71 into the shower.</p> <p>Interview on 09/12/24 at 1:06 P.M. with Medical Director #800 revealed he was not notified until today (09/12/24) regarding the incident of alleged abuse for Resident #71. MD #600 stated it would be his expectation for the facility to immediately report the allegation, remove the STNA from the area and start and investigation.</p> <p>(continued on next page)</p> |                                                                                        |                                                 |

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| <p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>               | <p>Interview on 09/12/24 at 1:43 P.M., with the Administrator confirmed the facility did not follow their abuse reporting policy resulting in a delayed investigation into the report that STNA #200 physically abused the resident and STNA #300 paid him to do so. He confirmed it would be his expectation for STNA #200 to stop care and follow the residents care plan related to behaviors when she became upset.</p> <p>Review of a facility Self-Reported Incident (tracking number 251754), submitted to the State agency after the surveyor identified this abuse situation, created on 09/11/24 at 9:26 A.M. with an incorrect date and time of occurrence as 09/11/24 at 9:30 A.M., revealed Resident #71 alleged she was physically abused by STNA. The resident provided meaningful information during the interview and had bruising on her (unidentified) arm. The narrative summary of the incident revealed on 09/07/2024, a male STNA gave female (resident) a shower in facility memory care unit. During the shower, Resident #71 became combative. STNA #200 stuck his head out of the shower room to ask for assistance from other staff. STNA #300 came to assist. The resident continued to be combative and STNA #300 ceased attempting care and spoke to Resident #71 to calm her down with STNA #200 still in the room. The resident calmed down and allowed staff to complete dressing her. Once out of the shower room, the resident expressed to (unidentified) nurse that she was upset that her hair was washed, her makeup was washed off &amp; that a male showered her. The resident began making accusations that STNA #200 forced her in the shower and stripped her clothes off. Once the SRI was created, facility staff were interviewed. Residents on the Connections Unit (where Resident #71 resided) were not interviewed due to cognition status, so skin assessments were performed. Staff and residents downstairs were also interviewed and/or assessed. Family, the ED, DON and physician were notified. The local police department was notified (Case Number #2024-12273). STNA #200 was suspended upon investigation, immediately upon submission of SRI (on 09/11/24). Review of the facility self-reported incident documentation revealed the facility substantiated the allegation of abuse but after a thorough investigation, due to the combative history of the resident, the facility could not conclude abuse occurred. However, STNA #200's employment with the facility was terminated.</p> <p>Review of the facility undated Ohio Abuse, Neglect, and Misappropriation policy revealed the supervisor or designee would notify the DON and Executive Director (ED) of the incident or allegation immediately. Required notification of agencies, physician, and resident representee would be completed. The ED would direct the investigation.</p> <p>This deficiency is an incidental finding discovered during the complaint investigation.</p> |                                                                                        |                                                 |

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| <p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>               | <p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42015</b></p> <p>Based on observation, medical record reviews, review of facility Self-Reported Incidents (SRI), facility policy review and interview, the facility failed to implement the facility abuse policy related to allegations of physical and emotional abuse by allowing alleged perpetrators continued access to the specified victims and/or other vulnerable residents and failed to timely initiate an investigation regarding the allegations of abuse. This resulted in Immediate Jeopardy and the potential for serious life-threatening harm/injuries and psychosocial harm beginning on 09/05/24 at approximately 3:15 P.M. when Activity Director (AD) #400 witnessed State tested Nursing Assistant (STNA) #300 grab and force Resident #78 to sit in her specialty tilt-in-space wheelchair (a specialty wheelchair that offers both a tilting function and a reclining function and should not be considered an independent mobility device due to their size and weight) while yelling at the resident to sit down. STNA #300 then positioned the tilt-in-space wheelchair with the resident's feet in the air and her head pointing toward the ground. The resident was observed to be tearful and crying out I'm scared of you while attempting to get out of the inverted specialty wheelchair. The resident remained in this position until approximately 3:30 P.M. when Activity Assistant (AA) #301 responded after hearing STNA #300 yelling at the resident. STNA #300 was not immediately removed from the facility and an immediate investigation was not initiated despite reports of the allegation to leadership staff placing residents on the secured dementia unit, including Resident #78 at risk for further abuse.</p> <p>The Immediate Jeopardy and actual physical harm continued on 09/07/24 at approximately 11:00 A.M. when STNA #200 was physically abusive to Resident #71. On 09/07/24 while STNA #200 was assisting Resident #71 into the shower room for her scheduled shower, the resident became agitated. STNA #200 continued the shower despite the resident's reaction. Following the incident, Resident #71 reported to Licensed Practical Nurse (LPN) #102 that STNA #200 forcefully grabbed her, undressed her, and threw her in the shower. Resident #71 also reported the incident to her son who called the facility and reported the allegations to LPN #102, requesting no male staff provide further care to his mother. LPN #102 acknowledged to the resident's son there had been an altercation between the resident and staff; however, the LPN failed to report an allegation of physical abuse to leadership staff. On 09/10/24, Resident #71 was noted to have a 25 centimeter (cm) by 20 cm bruise covering the entirety of her right forearm, one dime size bruise to the right chest, one quarter sized bruise to her right chest, a scabbed area to her right arm, and a bruise to her right inferior upper arm the size of a thumb print. The resident's injuries were consistent with the resident's report of physical abuse, and it was identified the resident had three fractures to her right wrist. STNA #200 was not immediately removed from the facility and an immediate investigation was not initiated despite reports of the allegation to leadership staff placing residents on the secured dementia unit, including Resident #71 at risk. This affected two residents (#78 and #71) of three residents reviewed for abuse. The facility census was 102.</p> <p>(continued on next page)</p> |                                                                                        |                                                 |

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| <p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>               | <p>On 09/12/24 at 5:44 P.M. the Administrator (also known as the Executive Director or ED), and Regional Director of Clinical Operations (RDCO) #320 were notified Immediate Jeopardy began on 09/05/24 at approximately 3:15 P.M., when AD #400 witnessed STNA #300 grab Resident #78 by the arm and force the resident into her tilt-in- space wheelchair and inverted the chair, so her head was positioned towards the floor and her feet in the air consistent with a situation of physical abuse. The resident was tearful and crying I'm scared of you and attempting to get out of the inverted chair. Although the incident was reported to Human Resource Manager (HRM) #600, the allegation was not immediately investigated and STNA #300 continued to work at the facility, providing care to the residents on the secured dementia unit, including Resident #71.</p> <p>Additionally, on 09/07/24, Resident #71 alleged physical abuse involving STNA #200 when the STNA forced her to take a shower. The resident sustained multiple injuries as a result of the incident and was subsequently diagnosed with fractures to her right wrist consistent with an incident of physical abuse. Although several staff were aware of the incident, the incident was not immediately investigated and STNA #200 continued to work at the facility, providing care to the residents on the secured dementia unit, including Resident #78.</p> <p>The Immediate Jeopardy was removed on 09/16/24 when the facility implemented the following corrective actions:</p> <p>On 9/10/24 at 10:30 P.M. Registered Nurse (RN) #315 assessed Resident #71 for pain. On 09/12/24 at 7:59 A.M. Unit Manager #105 completed a skin check for Resident #71. On 09/12/24 at 10:30 A.M. Resident #71 had an in-person assessment completed by the nurse practitioner of the facility psych services (Psych 360)</p> <p>On 9/11/24 at 9:30 A.M. State tested Nursing Assistant (STNA) #200 was suspended pending investigation by the Administrator/Executive Director.</p> <p>On 09/11/2024 at 9:35 A.M. the Administrator/ED notified the local police department of the incident that had occurred between Resident #71 and STNA #200 on 09/07/24.</p> <p>On 9/11/24 at 1:00 P.M. ADON #100 notified Medical Director #800 of the incident with Resident #71 and STNA #200 (that occurred on 09/07/24) and of the incident with Resident #78 and STNA #300 (that occurred on 09/05/24).</p> <p>On 09/11/2024 at 1:15 P.M. the ED notified the local police department of the incident that had occurred between Resident #78 and STNA #300 on 09/05/24.</p> <p>On 09/11/24 at 3:00 P.M. STNA #300 was suspended pending investigation by Executive Director.</p> <p>On 09/12/24 at 11:00 A.M. Resident #78 had an in-person assessment completed by the nurse practitioner of the facility psych services (Psych 360). On 09/12/24 at 8:06 P.M. LPN #226 reassessed Resident #78 for skin issues. On 09/13/24 at 1:48 P.M. Resident #78 had pain assessment completed by LPN #105.</p> <p>(continued on next page)</p> |                                                                                        |                                                 |

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| <p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>               | <p>On 9/12/2024 beginning at 6:00 P.M. 61 residents with a Brief Interview for Mental Status Score (BIMS) score of 10 (out of a possible 15) and higher were interviewed by ADON# 100, Clinical Manager #101, and RDCO #320 to identify any additional occurrences of abuse. Beginning at 7:00 P.M. skin assessments were performed by LPN #430, ADON #100, Clinical Manager #101 and RDCO #320 on all other residents who had a BIMS under 10 or were not interviewable. All 102 residents were interviewed and/or assessed at this time.</p> <p>On 9/12/2024 at 4:44 P.M. the ED sent a text message to all 121 staff members, to notify them of required in-service education that was being completed by RDCO #320. The education included a quiz. Elements of the education included: Using a tilt-and-space (chair) as a restraint, dementia care, de-escalating a catastrophic reaction, abuse, securing resident safety in cases of suspected abuse, staff removing perpetrators from facility, reporting incident to supervisor immediately, phone numbers of department heads, including abuse coordinator, and proper steps/timelines in abuse investigation 17 employees completed the education on this day.</p> <p>On 09/12/24 at 430 P.M., Regional Director of Operations (RDO) #750 educated HRM #600 on the policy and procedure for appropriate pre-employment checks to be completed prior to hire. On 9/13/2024 at 10:45 A.M. RDCO #320 educated HRM #600 verbally via telephone on proper policies and procedures for the use of Restraints, Dementia Care, Aggressive/Combative Behavior, Abuse Policy, Abuse Reporting, and Abuse Investigation. HRM #600 was educated that if an employee reported abuse to her, she should first make sure the resident was safe and the perpetrator was out of the facility, and then report the incident to the facility Abuse Coordinator, who was the Administrator/Executive Director.</p> <p>On 09/13/24 at 9:30 A.M. Unit Manager #105 along with the interdisciplinary team who included the ED, ADON #100, Clinical Manager #101, Electronic Health Records Manager #751, LSW #753, Housekeeping Director #754, Maintenance Director #755, Culinary Manager #390, Activities Director #400, LPN #338, Business Office Manager #756, Mobile BOM #757, and Therapy Director #705 were educated by RDO #750. Education was in-person and included a review of proper policy and procedures on the use of Restraints, Dementia Care, Aggressive/Combative Behavior, Abuse Policy, Abuse Reporting, and Abuse Investigation. At 10:00 am, RDCO #320 educated Unit Manger #105 on Abuse Prevention, the use of restraints, and aggressive/combative behavior with emphasis on de-escalating catastrophic reactions, abuse investigation (including resident assessments &amp; documentation) and reporting, and use of restraints. At 1:00 pm, RDCO #320 educated LPN #102 on abuse reporting, including the identity of the abuse coordinator, timelines, and proper notifications in instances of abuse allegations. Elements of these policies that were emphasized include: Using a tilt-and-space (chair) as a restraint, dementia care, de-escalating a catastrophic reaction, abuse, securing resident safety in cases of suspected abuse</p> <p>On 9/13/2024 at 10:45 A.M. RDCO #320 educated the DON verbally via telephone on proper policies and procedures for the use of Restraints, Dementia Care, Aggressive/Combative Behavior, Abuse Policy, Abuse Reporting, and Abuse Investigation.</p> <p>On 09/13/24 between 1:00 P.M. and 4:45 P.M. the remaining 104 staff including LPN #102 and Unit Manager #105 were educated in person or via telephone on the use of restraints, Dementia Care, Aggressive/Combative Behavior, Abuse Policy, Abuse Reporting, and Abuse Investigation by RDCO#320/designee. The facility indicated all new hires would be educated on the first day of orientation by social service staff.</p> <p>(continued on next page)</p> |                                                                                        |                                                 |

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| <p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>               | <p>On 9/13/24 at 1:30 P.M. the facility Quality Assessment and Performance Improvement (QAPI) committee met to conduct a root cause analysis of the incidents involving Resident #78 and Resident #71. The QAPI committee included ED, RDO #750, RDCO #320, MD #800, and the DON via telephone. The QAPI committee determined the root causes of the incidents included staff working in memory care unit without proper training in Dementia Care and Aggressive/Combative Behavior, staff needed education on the Use of Restraints in terms of tilt-and-space chairs, and staff were unaware of the Abuse Coordinator, proper reporting protocols, and proper steps/requirements of abuse investigation.</p> <p>On 9/14/2024 at 11:33 A.M. Resident #71 went to the hospital to have labs performed. While in the hospital, Resident #71 reported the incident of abuse to hospital staff. The hospital performed x-rays and found three fractures in Resident #71's right wrist. Resident #71 returned to facility with an order for a splint to the right wrist. An appointment was set for the resident to see an orthopedist on 09/24/24 at 8:25 A.M.</p> <p>On 9/16/2024 at 11:00 A.M. the DON/designees reviewed care plans for additional residents, Resident #2, #3, #7, #8, #9, #12, #17, #18, #19, #22, #24, #30, #41, #43, #44, #49, #50, #51, #54, #55, #56, #60, #62, #63, #65, #66, #69, #75, #76, #84, #85, #86, #87, #91, #96, #98, and #102 with history of catastrophic reactions.</p> <p>On 09/16/24 at 2:00 P.M. Resident #71's care plan was reviewed by LPN #105. The care plan was updated for the resident to have two staff members during showers, and no males were to provide care during all showers. Additionally, the residents care plan was updated related to her fracture. Changes were communicated to staff through the resident's Kardex in Point Click Care.</p> <p>Beginning on 09/16/24 the Administrator or designee would interview two staff and three residents once a week for four weeks to ensure that no incidents of abuse had occurred.</p> <p>Beginning on 09/16/24 the DON/designee would perform two random skin assessments daily for four weeks to ensure care is being provided appropriately.</p> <p>Beginning on 09/16/24 the DON/Designee would audit the Connections (memory care) Unit 5 days a week for four weeks. Audits would include observation of activity of daily living assistance and meal service to ensure residents were receiving proper care.</p> <p>Beginning on 09/16/24 the ED/designee would audit HR once a week for four weeks to ensure new hires were properly screened with BCI checks and reference checks. Audits would also ensure new hires were properly signed up for Relias for in-service training and receive proper abuse and dementia care training upon hire.</p> <p>Beginning on 09/16/24 the ED/designee would audit employee evaluations once a week for four weeks to ensure any issues mentioned in employee evaluations were followed with proper education or discipline by DON/designee.</p> <p>Beginning on 09/16/24 RDCO #320/designee would audit 24-hour reports daily for four weeks to see if any reportable incidents occurred. The RDCO/designee would also audit to ensure facility Self-Report Incidents (SRIs) were reported to the State (ODH) agency portal in a timely fashion.</p> <p>(continued on next page)</p> |                                                                                        |                                                 |

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| F 0610<br><br>Level of Harm - Immediate<br>jeopardy to resident health or<br>safety<br><br>Residents Affected - Few                | <p>The results of all audits would be submitted to QAPI committee for review upon completion and quarterly thereafter.</p> <p>STNA #300 was terminated on 09/17/24 at 3:45 P.M.</p> <p>STNA #200 was terminated on 09/17/24 at 3:50 P.M.</p> <p>Although the Immediate Jeopardy was removed on 09/16/24, the facility remained out of compliance at a Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was in the process of implementing their corrective action plan and monitoring to ensure on-going compliance.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #78 revealed an admitted [DATE] with diagnoses including unspecified dementia, generalized anxiety disorder, hypertension, and diabetes mellitus type two. The resident resided on the secured memory care unit in the facility.</p> <p>Review of Resident #78's care plan, initiated on 02/02/24, revealed she had a self-care deficit requiring staff assistance with activities of daily living (ADL) related to functional decline, impaired mobility, and impaired cognition. Interventions included the resident was allowed up ad lib (out of bed/chair whenever they prefer).</p> <p>Review of Resident #78's quarterly Minimum Data Set 3.0 (MDS) assessment, dated 07/10/24, revealed the resident had a moderate cognitive impairment. The assessment indicated the resident did not have an impairment to her upper or lower extremities and utilized a wheelchair. The resident was not assessed to have any behaviors.</p> <p>Review of Resident #78's Occupational Therapy (OT) Discharge Summary, dated 08/26/24, revealed the resident met her goal to sit upright in a new custom tilt-in-space wheelchair to facilitate correct anatomical alignment for two hours without sliding or complaint of discomfort.</p> <p>Further review of the medical record revealed no physician order for the tilt-in-space wheelchair, any use of physical restraints and no care plan regarding the tilt-in-space wheelchair.</p> <p>Review of Resident #78's progress notes revealed no documentation of restraint use, allegations of abuse, or resident assessments on 09/05/24 or 09/06/24.</p> <p>(continued on next page)</p> |                                                                                        |                                                 |

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| <p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>               | <p>During an interview on 09/11/24 at 10:30 A.M. with Activity Assistant (AA) #301, the AA voiced concerns that some of the staff working on the memory care unit were not treating the residents right and management would not do anything about it. She reported two of her coworkers (AD #400 and AA #310) witnessed abuse last Thursday (09/05/24). She shared STNA #300 forced Resident #78 into her tilt-in-space wheelchair and positioned her with her head to the floor and her feet in the air. AA #301 stated it was reported to the facility and they continued to allow STNA #300 to care for residents on the unit. AA #301 went on to say last Thursday (09/05/24) around 3:15 P.M. she heard STNA #300 yelling at a resident (AA reported she was unable to hear what the STNA was saying due to being in another room with residents). She stated around 3:30 P.M. she was able to respond, after she left a resident's room, while passing snacks. At that time, she witnessed Resident #78 positioned all the way back in her tilt-in-space wheelchair with her head towards the ground and her feet in the air. The resident was crying and visibly upset. She stated she went to the resident and positioned her in an upright position and gave her a snack to help her calm down.</p> <p>Interview on 09/11/24 at 10:41 A.M. with AD #400 revealed on 09/05/24 she was doing her rounds on the memory care unit. Between 3:15 P.M and 3:30 P.M. she was visiting with residents on the unit and heard some commotion. Resident #78 was observed to be walking around the unit, and she heard STNA #300, in a very loud voice, tell the resident to sit down. She then witnessed STNA #300 forcefully grab the resident's arm (she cannot recall which arm) and pull the resident down into the tilt-in-space wheelchair. AD #400 stated she intervened and asked STNA #300, is there anything I can do? STNA #300 then told the AD to back off. The resident then attempted to swing at STNA #300 and remove herself from the chair. STNA #300 stated, she done hit me and positioned the chair with the resident's head towards the floor and her feet in the air. The resident began to cry and stated, I'm scared of you. STNA #300 was then heard stating now you can't move. AD #400 stated she left right away and went to Human Resource Manager #600 (identified as Employee Life Cycle Manager by the facility but the employee identified herself as Human Resource Manager) and reported the incident. The HR manager advised AD #400 to write a statement and give it to LPN/Unit Manager # 105. AD #400 reported she wrote a statement and placed the statement in the DON's mailbox. She stated she then returned to the unit and observed the resident in the same position but at that time, AA #301 was walking to the resident and repositioned her in an upright position and provided her a snack. AD #400 reported the resident stated to AA #301 I'm glad you came when you did. AD #400 went on to say the next day (09/06/24) she let everyone know in morning meeting, including Administration (AD #400 was unable to recall which administrative staff were present but did state the Administrator and UM #105 were present) about the incident. Unit Manager #105 reported she should have told her right away, and that she would deal with it. AD #400 reported she was detailed and clear about what she saw when she reported the observation to HRM #600, her written statement left in the DON's mailbox, and when she reported the incident again during the morning meeting.</p> <p>Interview on 09/11/24 at 11:38 A.M. with HRM #600 revealed AD #400 reported to her on 09/05/24 (she was unsure of the time) that STNA #300 forcefully put Resident #78 into her tilt-in- space wheelchair and tilted it fully back so the resident could not move. HRM #600 reported she advised AD #400 to write a statement and get UM #105 involved. HRM #600 stated she did not further report the issue and did not obtain a statement from AD #400. The HRM reported she doesn't deal with abuse allegations and defers them to the management. She stated she was mostly there for the support of the staff. She confirmed she did not follow the facility abuse policy by not reporting it to the Administrator or other leadership staff.</p> <p>(continued on next page)</p> |                                                                                        |                                                 |

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| <p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>               | <p>Interview on 09/11/24 at 1:13 P.M. with LPN/UM #105 revealed one day last week AA #310 came to her and mentioned that she thought Resident #78 was being restrained in her tilt-in- space wheelchair by STNA #300. UM #105 stated she checked on the resident and removed the leg rest from her tilt-in- space wheelchair. The resident was not tilted back all the way at that time. She shared she provided verbal education to STNA #300 (however, there was no documented evidence of the education) regarding how tipping the chair too far back could be considered a restraint. She stated the next day in morning meeting AD #400 reported to her that STNA #300 had restrained Resident #78 and UM #105 stated she told AD #400 that she had already taken care of it at the time of the incident (with the verbal education provided to STNA #300). UM #105 verified this was not further reported to Administration when she addressed physical restraint use with STNA #300.</p> <p>Review of the facility Self-Reported Incidents in the Enhanced Information Dissemination Center (portal for reporting incidents of alleged abuse) from 09/05/24 through 09/11/24 at 9:00 A.M. revealed no reporting of the incident involving STNA #300 and Resident #78.</p> <p>The facility had no investigation related to the incident reported to the Unit Manager #105 or HR #600. The DON was out of the office at the time of the incident and RDCO #320 was unable to locate a statement from AD #400 in the mailbox of the DON.</p> <p>Review of STNA #300's time clock report revealed the STNA worked 09/05/24 from 6:54 A.M. until 6:54 P.M. , 09/07/24 from 6:54 A.M. until 5:46 P.M., and 09/10/ 24 from 6:53 A.M. until 6:55 P.M. Review of the staff schedule dated 09/05/24 through 09/10/24 revealed STNA #300 was scheduled to work on the secured unit.</p> <p>Review of a facility Self-Reported Incident (SRI), tracking number 251771 initiated following the identification of the issue by the State agency, created on 09/11/24 at 1:04 P.M. incorrectly described the incident under the incident information brief description as: Resident allegedly abused STNA. The alleged perpetrator was facility staff or other care provider, and the initial source of the allegation/suspicion was staff. The resident was identified as Resident #78 who was unable to provide meaningful information and under the question What effect did incident have on Resident? The facility answered none. The date and time of the occurrence was 09/05/24 at 3:30 P.M. in the secured dementia unit dining room. According to witness accounts, Resident #78 was walking in Memory Care Unit dining room. STNA #300 grabbed the resident, with a diagnosis of dementia and who resided on the secured dementia unit, by the arm and forced her to sit in a tilt-in- space wheelchair. The STNA was yelling at the resident to sit down and placed the tilt-in-space wheelchair with her feet in the air and her head pointing to the ground. The resident was observed to be screaming and crying for help and trying to get out of the inverted specialty wheelchair. The Activity Director approached STNA #300, offering to assist with care for the resident, but the Activity Director was met with the STNA telling the Activity Director to go away. Additionally, Activity Aide (unidentified) heard STNA yelling and when able, observed the resident positioned in her tilt-in-space wheelchair with her feet in the air and her head towards the ground. An SRI was opened (created) and the ED, DON, physician, and local police department were notified. The facility SRI investigation was completed on 09/17/24 at 3:41 P.M. and as a result of the investigation, the facility substantiated the incident of abuse.</p> <p>Interview on 09/12/24 1:06 P.M. with Medical Director #800 revealed he was not notified until today (09/12/24) regarding the incident of alleged abuse involving Resident #78. MD #800 stated it would be his expectation for the facility to immediately report allegations of abuse to administration, remove the STNA from the area and start an immediate investigation.</p> <p>(continued on next page)</p> |                                                                                        |                                                 |

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| <p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>               | <p>Interview on 09/12/24 1:43 PM with the Administrator revealed he was unaware of the abuse allegation involving Resident #78 until it was reported to the surveyor during survey activity on 09/11/24. The Administrator stated he would have initiated an immediate investigation and taken the appropriate steps had he been aware of the incident. He denied hearing the report AD #400 made in morning meeting about the incident.</p> <p>2. Review of the medical record for Resident #71 revealed an admitted [DATE] with diagnoses including unspecified dementia with moderate behavioral disturbance, other sequelae of cerebral infarction, dysarthria following cerebral infarction, chronic kidney disease stage three, anxiety disorder, and major depressive disorder. The resident was noted to reside on the facility's secured dementia unit.</p> <p>Review of Resident #71's admission MDS 3.0 Assessment, dated 07/03/2024, revealed the resident was cognitively intact. The assessment indicated the resident had a lower extremity impairment to one side and utilized a wheelchair. The resident was dependent for showering and did have one to three days of behavioral symptoms towards others including hitting, kicking, pushing, scratching, and grabbing.</p> <p>Review of Resident #71's care plan dated 07/08/24 revealed the resident had behaviors including yelling, cussing at other residents, refusing care, yelling out, being tearful and having loud outbursts, which required nonpharmacological interventions including redirect, reapproach, calm environment, quiet environment, comfort, active listening. Interventions included administer medications as ordered, approach, speak in calm manor, encourage the resident to express feelings, encourage to maintain as much independence and control/decision making as possible, intervene as necessary to protect the rights and safety of others, minimize potential for disruptive behaviors by offering tasks that divert attention, monitor behavioral episodes, and attempt to determine underlying causes, and notify medical provider of increased episodes of behaviors.</p> <p>Review of Resident #71's nursing progress notes for 09/07/24 revealed there were no progress notes regarding any allegation of abuse or issues/incidents related to the shower the resident received on this date.</p> <p>Review of Resident #71's nursing progress note dated 09/09/24 at 11:39 A.M. revealed UM #105 documented This nurse manager noted an aging bruise on the resident's left forearm. When speaking with the resident she stated that I think I bumped it on my bed when I fell . Resident did have an unwitnessed fall on 08/26/24.</p> <p>Review of Resident #71's nursing progress note dated 09/10/2024 at 9:00 P.M. and created on 09/11/23 3:27 A.M. by Registered Nurse (RN) #315 revealed STNA (unidentified) reported that resident has a bruise on her entire right forearm. Resident was assessed by this nurse. She stated that a male aide, (STNA #200), with the blonde hair, grabbed her from behind, undressed her in front of everyone and twisted her arm. She said she grabbed his badge to check for his name and he grabbed it back. She said she fought back and screamed. According to her, this incident occurred on Saturday or Sunday between 2:00 P.M. to 4:00 P.M. She also stated that he called for a female aide, but it was only the male aide who was grabbing her arm. I was notified by an STNA (unidentified) that this resident told a similar story to another resident; manager-on-call (Assistant Director of Nursing #100) was notified; Family Member #701 updated via phone call at 10:45 P.M.</p> <p>(continued on next page)</p> |                                                                                        |                                                 |

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| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                        |                                                 |
| F 0610<br><br>Level of Harm - Immediate<br>jeopardy to resident health or<br>safety<br><br>Residents Affected - Few                | <p>Observation of Resident #71 on 09/11/23 at 11:10 A.M. revealed the resident had a large bruise with various shades of purple covering the entirety of her right forearm. Also noted was one dime size bruise to her right chest that was light red in color, one quarter sized bruise to the right chest that was light red in color, a scabbed area to her right arm, and a bruise to the right inferior upper arm the size of a thumb print which was light purple in color. The resident was seated in a wheelchair and had a contracture noted to her left hand. She presented to have minimal use of her left upper extremity.</p> <p>An interview with Resident #71 at the time of the observation revealed she received these injuries the past weekend when a male STNA (identified through scheduling/interview/description as STNA #200) came up to her from behind, grabbed her right arm and started taking her clothes off. The resident stated the STNA forced her into the shower while she was screaming and yelling for him to stop. The STNA then placed her under hot water and then turned it to cold water. She reported he placed shampoo on her head and face, and she was yelling, screaming, and fighting him to stop but he would not. She then reported another STNA, identified as STNA #300 told Resident #71 she paid him a hundred dollars to do this to her. The resident continued that STNA #300 is not a nice person. She gets mad and vicious. She screams at the residents. The resident reported she received all the injuries from STNA #200 forcing her into the shower. The resident stated that she called her son and told him of the incident and additionally reported the incident to staff members working the day it happened.</p> <p>Interview on 09/11/24 at 11:20 A.M. with Family Member #704 reported he received a phone call from his mother on Saturday (09/07/24) stating that a male STNA threw her in the shower. His mother said she was scared and wanted him to come and get her. Family Member #704 stated he then called the facility nurse (LPN #102) who was working the unit and reported what his mother had told him. He requested that male staff members no longer work with his mother. He stated LPN #102 informed him his mother got aggressive and combative and was hitting a male STNA while he was showering her.</p> <p>Review of STNA #200 punch details revealed the STNA worked 09/07/24 from 6:54 A.M until 7:06 P.M., on 09/08/24 from 6:53 A.M until 6:57 P.M., and 09/11/24 from 6:59 A.M. until 9:54 A.M.</p> <p>(continued on next page)</p> |                                                                                        |                                                 |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>365292                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                               | (X3) DATE SURVEY<br>COMPLETED<br><br>09/23/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Hanover Healthcare Center                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>435 Avis Avenue NW<br>Massillon, OH 44646 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                        |                                                 |
| F 0610<br><br>Level of Harm - Immediate<br>jeopardy to resident health or<br>safety<br><br>Residents Affected - Few                | <p>Review of a facility Self-Reported Incident (tracking number 251754), submitted to the State agency after the surveyor identified this abuse situation, created on 09/11/24 at 9:26 A.M. with an incorrect date and time of occurrence as 09/11/24 at 9:30 A.M., revealed Resident #71 alleged she was physically abused by STNA. The resident provided meaningful information during the interview and had bruising on her (unidentified) arm. The narrative summary of the incident revealed on 09/07/2024, a male STNA gave female (resident) a shower in facility memory care unit. During the shower, Resident #71 became combative. STNA #200 stuck his head out of the shower room to ask for assistance from other staff. STNA #300 came to assist. The resident continued to be combative and STNA #300 ceased attempting care and spoke to Resident #71 to calm her down with STNA #200 still in the room. The resident calmed down and allowed staff to complete dressing her. Once out of the shower room, the resident expressed to (unidentified) nurse that she was upset that her hair was washed, her makeup was washed off &amp; that a male showered her. The resident began making accusations that STNA #200 forced her in the shower and stripped her clothes off. Once the SRI was created, facility staff were interviewed. Residents on the Connections Unit (where Resident #71 resided) were not interviewed due to cognition status, so skin assessments were performed. Staff and residents downstairs were also interviewed and/or assessed. Family, the ED, DON and physician were notified. The local police department was notified (Case Number #2024-12273). STNA #200 was suspended upon investigation, immediately upon submission of SRI (on 09/11/24). Review of the facility self-reported incident documentation revealed the facility substantiated the allegation of abuse but after a thorough investigation, due to the combative history of the resident, the facility could not conclude abuse occurred. However, STNA #200's employment with the facility was terminated.</p> <p>A telephone interview on 09/11/24 at 2:08 P.M. with LPN #102 revealed on 09/07/24 STNA #200 went to give Resident #71 a shower. The resident started hitting, kicking and punching the STNA. STNA #200 got STNA #300, and they finished showering and dressing the resident. After her shower Resident #71 was yelling that STNA #200 took her clothes off and threw her i [TRUNCATED]</p> |                                                                                        |                                                 |