STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365316	A. Building B. Wing	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Square Nursing and Rehabilitation	1211 W Market St Akron, OH 44313

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42015 Based on observation of camera footage, interview, record review, and policy review the facility failed to ensure staff members remained awake and alert while on duty to prevent the potential for resident neglect. This had the potential to affect 39 residents (#14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #45, #46, #57, #48, 49, #51, #52, #53, #54, #55, #56, #57, #58, #59, #60, #61, #62, #63, #64, #65, #66, #67, #68, #69) of 39 residents the facility identified as residing on the second and third floors. The facility census was 68. Findings include: An interview was conducted on 04/07/25 at 10:45 A.M. with Resident #15 who reported staff on midnight shift sleep while on duty, and the other night he took several videos of facility staff asleep while call lights were going off. Resident #15 revealed he reported this to the Administrator, and the Administrator stated, I don't want to see those and refused to watch the videos. Resident #15 stated he had wanted facility management to review the videos. Resident #15 also revealed during the time he was taking the videos there were no staff, nurses or nursing assistants on the units except for the employee who was asleep. Review of the medical record for Resident #15 revealed an admitted [DATE]. Review of Resident #15's admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed he had intact cognition. Review of the facility's concern log revealed Resident #15 reported on 03/14/25 that staff were sleeping at night. The Director of Nursing (DON) was assigned to the concern. The resolution stated the DON worked night shift on 03/16/25 and no one slept. The concern was marked as resolved, however, there was no evidence the facility investigated Resident #15's concern in relation to the specific direct care staff who worked the night shift on 03/14/25. Review of the staffing schedules for 03/13/25 from 7:00 P.M. until 03/14/25 at 7:00 A.M. revealed Certified Nursing Assistant (CNA) #417 was the only CNA assigned to the second floor, and Licensed Practical Nurse (LPN) #440 and LPN #319 were assigned to split the second floor for nursing coverage. (continued on next page)

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

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the staffing schedules for 03/14/25 7:00 P.M. until 03/15/25 7:00 A.M. revealed CNA #413 was the only CNA assigned to the second floor, and CNA #236 was assigned to the third floor. LPN #440 was assigned to the third floor and LPN #427 was assigned to the first floor and both were to split the second floor for nursing coverage. An observation was conducted on 04/07/25 at 12:45 P.M. with the Regional Director of Operations (RDO) #500 of the time stamped and date stamped videos and pictures Resident #15 had taken to share with facility management. The videos and photos revealed the following concerns. A photo dated 03/14/25 at 5:24 A.M. revealed CNA #417 was sitting on a chair at the nurse's station with the hood from her sweatshirt covering her head. Her arms spread on the table and her head was laying on her arms with her head face down on her arms. This location was on the second floor of the facility. A photo dated 03/15/25 at 3:08 A.M. of CNA #413 revealed she was sitting in a computer chair at the nurses station with her arm on the table, and she was bent over with her face on her arm facing the nurses station desk and her eyes were closed. This location was on the second floor. A photo dated 03/15/25 at 3:12 A.M. revealed CNA #413 was sitting in a computer chair at the nurses station with her arm on the table. The photo showed the back of her head as it was resting on her arm. The location was on the second floor. A photo dated 03/15/25 at 3:13 A.M. revealed Resident #28's call light was activated. A 15-second video dated 03/15/25 and timed 3:27 A.M. revealed CNA #413 was sitting at the nurse's station with her arm on the desk, her head resting on her arm with her eyes closed. The location was on the second floor. A 15-second video dated 03/15/25 at 3:28 A.M. revealed Resident #28's call light remained activated. A 15-second video dated 03/15/25 at 3:32 A.M. revealed CNA #236 was sitting at a dining table on the third floor. Her upper body was positioned on the dining table, head resting on her hands and her eyes were closed. This location was on the third floor. A 19-second video dated 03/15/25 at 4:04 A.M. revealed CNA #236 remained in the same position with her eyes closed. A six-second video dated 03/15/25 at 4:31 A.M. revealed CNA #236 remained in the same position with her eyes closed. Record review of statements dated 04/09/25 from of LPN #427 and LPN #319 revealed they were not aware of staff sleeping while on their shift. Interview on 04/09/25 at 6:12 A.M. with LPN #440 revealed she worked on 03/14/25 and 03/15/24 on night shift and was unaware whether or not the identfied CNAs were sleeping. LPN #440 confirmed no CNA had asked her to cover them for call lights or resident care on 03/14/25 and 03/15/25. LPN #440 stated if she had been aware of any staff sleeping on the job she would have notified management. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Administrator could not be conducted due to the Administrator being unavailable for interview. Interview on 04/09/25 at 2:00 P.M. with Regional Director of Operation (RDO) #500 revealed it was against facility policy for staff to sleep while on duty. RDO #500 stated if staff want to rest while on duty they can rest during their break time but they are required to do so in their vehicles or in a designated staff break area. RDO #500 verified the contents of the video footage and photos provided by Resident #15 and confirmed the staff assigned to the second and third floor on 03/14/24 and 03/15/25 were resting in resident care areas. RDO #500 stated the pictured CNAs reported that their nurses were covering while they slept but nursing interviews revealed they were not aware of the staff sleeping. Review of the Meals and Breaks facility form revealed Staff members rest breaks are assigned by the supervisor or department head and may be taken in the designated break areas for a total of 30 minutes and be taken in 15-minute increments and are paid. Review if the facility policy, Abuse, Neglect, Exploration, and Misappropriation of Resident property last revised 11/01/19 revealed the definition of neglect is the failure of the facility its employees, or facility service providers to provide goods and services to a resident necessary to avoid physical harm, pain, mental anguish or emotional distress. This deficiency represents non-compliance investigated under Complaint Number OH00163855.