

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365453	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/11/2024
NAME OF PROVIDER OR SUPPLIER Ayden Healthcare of Oregon		STREET ADDRESS, CITY, STATE, ZIP CODE 3953 Navarre Ave Oregon, OH 43616	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45445</p> <p>Based on medical record review, staff interview, resident interview, police interview, review of Resident Council meeting minutes, and review of policies, the facility failed to ensure residents were treated in a dignified manner. This affected one (#61) of three residents reviewed resident rights. The facility census was 76.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #61 revealed an admitted [DATE], diagnoses included major depressive disorder, post-traumatic stress disorder, erectile dysfunction, paraplegia, type II diabetes mellitus, chronic kidney disease, and autonomic dysreflexia.</p> <p>Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #61 had moderate cognitive impairment, required moderate assistance for toilet hygiene, showering, dressing and personal hygiene and maximal assistance for transfers. Resident #61 planned to return home upon discharge. A Medicare 5-day MDS assessment dated [DATE] revealed Resident #61 was independent with self-care, mobility, and functional abilities.</p> <p>Interview on 04/10/24 at 10:10 A.M., with Resident #61 revealed concerns related to treatment by a nurse, Licensed Practical Nurse (LPN) #98. Resident #61 stated the nurse disrespected him and verbally assaulted him, using curse words and yelling on 04/06/24 during a verbal altercation.</p> <p>Interview on 04/10/24 at 11:00 A.M., with the Administrator revealed a call was received from LPN #98 on Saturday, 04/06/24, regarding the police being called due Resident #61 becoming verbally and physically aggressive toward LPN #98. Upon further interview with the Administrator, it was revealed in the process of investigating what actually occurred Resident #61 was interviewed on 04/08/24 at which time LPN #98 was placed off to further review the concerns over LPN #98 using foul language directed toward Resident #61.</p> <p>Interview on 04/10/24 at 4:28 P.M., with LPN #98 verified there was a verbal exchange with Resident #61 on 04/06/24 sometime between 5:00 P.M. and 5:30 P.M., and when asked about yelling and cursing, LPN #98 stated I may have, but not unsure, it may have come out in anger.</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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 04/10/24 at 5:19 P.M., with State tested Nursing Assistant (STNA) #99 verified to being witness of part of the verbal exchange that occurred on Saturday, 04/06/24 between Resident #61 and LPN #98. STNA #99 stated the two were arguing back and forth about a schedule book Resident #61 removed from the desk at the nurses station. STNA #99 stated she had to finally ask LPN #98 to let it go and STNA #99 and LPN #98 walked away from Resident #61. STNA #99 stated she did not want the situation to continue to escalate and needed to separate the two.</p> <p>Interview on 04/11/24 at 2:32 P.M., with Police Officer #102 verified the police department was called out to the facility on Saturday 04/06/24 due to a verbal altercation between a resident and a staff member. Officer #102 verified LPN #98 did direct curse words toward Resident #61.</p> <p>Review of the Resident Council meeting minutes dated 03/20/24 revealed resident concerns related to staff not being mindful of residents and their property, huffing and signing when providing care.</p> <p>A follow-up interview on 04/10/24 at 4:00 P.M., with the Administrator revealed mandatory education for all nurses and nursing assistants had occurred on 04/10/24 at 6:30 A.M., 10:30 A.M. and again at 2:30 P.M. regarding appropriate communication, respect and recognizing burnout.</p> <p>Review of the personnel file for LPN #98 revealed education received upon hire on 11/02/23 on resident rights, abuse, code of ethics and safety in the workplace. LPN #98 had also received a discipline on 01/16/24 for poor customer service when administering medications to a resident and received education on empathy, compassion and taking care of residents with a history of addiction.</p> <p>Review of the policy titled Abuse Prevention Program, dated December 2016, stated residents shall have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to the freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms.</p> <p>Review of the policy titled Resident Rights, dated December 2016, revealed employees shall treat all residents with kindness, respect, and dignity.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00152793.</p>		