

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365492	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/05/2024
NAME OF PROVIDER OR SUPPLIER Grand River Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1515 Brookstone Blvd Painesville, OH 44077	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973</p> <p>Based on interview, record review, review of Ohio Department of Health (ODH) Gateway and review of facility policy the facility failed to ensure an allegation of sexual abuse was reported not later than 24 hours to the state survey agency. This affected one resident (#74) out of six residents reviewed for abuse. The facility census was 72.</p> <p>Findings include:</p> <p>Review of the closed medical record for Resident #74 revealed an admitted [DATE]. She was sent to the hospital on 07/22/24 without returning. Her diagnoses included anxiety disorder, elevated white blood cell count, and aphasia (a language disorder that affects communication) following nontraumatic intracerebral hemorrhage.</p> <p>Review of the care plan dated 04/13/24 revealed Resident #74 refused medications and care at times. Interventions included assessing resident's resistance to care, encouraging resident to express fears, feelings and clarify misunderstandings, and reiterate the purpose and advantages of the treatment.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #74 had impaired cognition as her brief interview for mental status (BIMS) score was a nine of 15. She had no behaviors identified and required supervision and/ or touch assist by staff for her activities of daily (ADL) living including toileting hygiene, showering, dressing and transfers. She was occasionally incontinent of urine.</p> <p>Review of the ODH gateway from 05/01/24 to 08/01/24 revealed the facility had not filed any self-reported incidents (SRI) related to Resident #74's allegation of possible sexual abuse.</p> <p>Review of the care plan dated 05/02/24 revealed Resident #74 was at risk for deterioration in her ADL related to cerebral vascular accident with hemiparesis to right side. Interventions included do not rush her and allow extra time to complete her ADL, provide adequate rest periods, and provide assistance as needed.</p> <p>Review of the nursing notes from 06/01/24 to 07/22/24 revealed no documentation regarding Resident #74's allegation of possible sexual abuse.</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the handwritten notes dated on or about 07/01/24 and completed by the Administrator revealed Resident #74 had told her son that she was molested and had told Resident #74's daughter in law someone came in her room and began to grope area. Resident #74 had described to the daughter in law it was a big African American heavy set male staff member. The notes revealed Resident #74 was asked if something happened, she stated no. Resident #74 was asked if a male was in her room, and Resident #74 shook her head side to side (indicating no). Resident #74 was asked if he touched anything in her private area and she indicated no. Resident #74 was asked if he touched her breasts, and she indicated no. Resident #74 was asked if he did anything sexual and Resident #74 stated no. Resident #74 was asked who it was, and she did not know and stated she felt safe at the facility. The note revealed Resident #74's daughter in law was, okay with dropping it- not an issue. The note revealed the Director of Nursing (DON) checked the schedule and per the note stated, none. There was no other investigation including witness statements regarding the allegation.</p> <p>Review of the Insurance Nurse Practitioner (NP) #605 progress note dated 07/01/24 revealed she evaluated Resident #74 due to increase in falls. NP #605 met with Resident #74 and Resident #74's daughter in law, and Resident #74 suggested that she had been groped on her breasts recently by a nurse aide at night. The note revealed it was unclear as to the validity due to Resident #74's dysarthria (speech disorder) but was reported to facility staff by Resident #74's daughter in law and would be further investigated. Resident #74 displayed increased distress due to the inability to speak her needs, and NP #605 planned to speak with speech therapy and determine whether additional types of aides such as flash cards could help her get her needs met.</p> <p>Review of the nursing note dated 07/27/24 at 7:33 A.M. and completed by Social Service Designee #603 revealed Resident #74's family called and stated Resident #74 would not be returning to the facility and that they would be picking up her belongings.</p> <p>Interview on 08/01/24 at 10:36 A.M. and 4:16 P.M. with the Administrator revealed Resident #74's daughter in law came to the DON and stated Resident #74 had told Resident #74's son that she had been molested and then Resident #74 had told Resident #74's daughter in law that a large heavy set African American that she had never seen before had come into her room and began to grope her. The Administrator revealed she met with the Director of Nursing, Resident #74, and Resident #74 daughter in law regarding the incident. She revealed she had questioned Resident #74 several different ways if she was touched inappropriately including in her upper and lower private areas and Resident #74 denied. She revealed Resident #74's daughter in law had stated, I do not think we have an issue at this time and the Administrator stated she told the daughter in law that she was going to check the video footage if anyone had entered her room fitting that description. She revealed she had shared with the daughter-in-law that if there was, she would contact her. The Administrator revealed they had checked the camera footage and had not noted anyone meeting that description entering her room and that the Director of Nursing had checked the schedule, and nobody was on duty fit that description. The Administrator verified the facility did not file an SRI regarding the allegation.</p> <p>Interview on 08/01/24 at 2:36 P.M. with Insurance NP #605 revealed on 07/01/24 Resident #74's daughter in law had informed her on her visit to the facility that Resident #74 had stated that she had been groped by a staff member. She revealed she questioned Resident #74 who had stated she had been groped on her chest by staff but that it was unclear as to the validity due to her aphasia as well as Resident #74's story changed. NP #605 informed Resident #74's daughter in law to report the allegation to the facility administration which she did. NP #605 revealed she had never heard Resident #74 make this type of allegation previously and felt it was odd.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 08/01/24 at 3:18 A.M. with Resident #74's daughter in law revealed the beginning of July 2024 Resident #74 had reported to her an African American heavy- set male had entered her room during the night and started touching her in the breast area. Resident #74's daughter in law stated Resident #74 had also reported to her son that she was molested. Resident #74's daughter in law revealed Insurance NP #605 was at the facility and she had her question Resident #74 to see if her story changed and that Resident #74 had revealed to Insurance NP #605 also that she had been groped on her breast area by a staff member. Resident #74's daughter in law revealed Insurance NP #605 advised her to report the incident to the facility which she did. She stated she had reported the incident to the Administrator and the DON that Resident #74 had stated she was molested as someone came into her room and began to grope her breast area and described the individual as an African American heavy-set male that she had not seen before. She revealed the Administrator and DON met with her and Resident #74 and during the interview, Resident #74 was very clear that she was touched on her top half (breast area). Resident #74's daughter in law revealed she had requested the incident be investigated, and Resident #74's son (after the incident) was making plans to move her out of the facility because of the incident. Resident #74's daughter in law revealed at no time did she tell the facility that it was not an incident and to stop investigating. Resident #74's daughter in law revealed the facility had never contacted her regarding any results of the investigation and felt that they did not take Resident #74's allegation seriously even though she felt during the interview Resident #74 was alert and able to communicate what had happened in a clear manner.</p> <p>Interview on 08/01/24 at 3:37 P.M. with the DON revealed Resident #74's daughter in law came to her office the beginning of July 2024 and reported that Resident #74 had stated someone had come into her room and inappropriately touched her. She revealed the Administrator, DON, Resident #74's daughter in law and Resident #74 met in her office to discuss the incident and at that time Resident #74 had denied being touched inappropriately. She revealed the previous night around 3:00 A.M. or 4:00 A.M. a large African American male assisted her to the bathroom but denied him touching her inappropriately. She revealed Resident #74's daughter in law stated, obviously then nothing inappropriately happened and had asked the facility to stop investigating. The DON verified a self-reported incident (SRI) was not filed of the allegation.</p> <p>Review of ODH gateway revealed on 08/01/24 at 5:33 P.M. an SRI with tracking number #250346 was filed by the Administrator revealing the surveyor reported family presented an allegation of sexual abuse involving Resident #74.</p> <p>Review of the facility policy labeled, Ohio Resident Abuse Policy, dated May 2008 and last revised 07/11/24, revealed the facility would not tolerate abuse, neglect, mistreatment and exploitation of residents. It was the facilities policy to investigate all allegations, suspicions and incidents of abuse. The policy revealed staff must report immediately all allegations to the Administrator/ Abuse Coordinator and the Administrator/ Abuse Coordinator would immediately begin an investigation and notify local and state agencies in accordance with the policy. The policy revealed sexual abuse was non-consensual sexual contact of any type. The policy revealed if the facility suspected that a crime had been committed it would be reported in accordance with its crime reporting policies.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00155730.</p>		