

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365566	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2024
NAME OF PROVIDER OR SUPPLIER Heritage Center for Rehab and Speciality Care		STREET ADDRESS, CITY, STATE, ZIP CODE 24 North Hamilton Street Minster, OH 45865	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48570</p> <p>Based on record review, staff interview, and policy review, the facility failed to prevent resident to resident abuse. This affected two (Residents #52 and #45) of four reviewed for abuse. The facility census was 63.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #52 revealed an admitted [DATE] with a diagnosis of Alzheimer's disease.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #52 had moderate cognitive impairment, required set-up assistance with eating and personal hygiene, required supervision with oral hygiene. Resident was independent with dressing, bed mobility, transfers, and ambulation.</p> <p>Review of the Care Plan dated 04/09/24 revealed Resident #52 required a secured unit.</p> <p>Review of progress notes revealed on 07/11/24 at 8:17 P.M., Resident #52 was walking towards the nurse's station when a male resident turned and put his arm around her head from behind and shoved a pudding cup into her face.</p> <p>2. Review of the medical record for Resident #45 revealed an admitted [DATE] with diagnoses of unspecified dementia, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.</p> <p>Review of the Admission MDS assessment dated [DATE] revealed Resident #45 had severe cognitive impairment and required supervision assistance with eating, oral hygiene, toileting hygiene, bed mobility, transfers, and ambulation.</p> <p>Review of Resident #45's care plan revealed no goals or interventions in place for Resident #45 having behaviors.</p> <p>(continued on next page)</p>

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365566	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2024
NAME OF PROVIDER OR SUPPLIER Heritage Center for Rehab and Speciality Care		STREET ADDRESS, CITY, STATE, ZIP CODE 24 North Hamilton Street Minster, OH 45865	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the progress note dated 7/11/24 at 8:05 P.M. revealed Resident #45 came to the nurse's station and picked up a pudding. While the nurse went to get a spoon for Resident#45, the resident turned to another resident (Resident #52), wrapped his arm around the other resident's head from behind, and pushed the pudding into the resident's face. Resident #45 was visibly agitated with fist raised. A State tested Nurse Aide (STNA) attempted to calm Resident #45 down, with the resident attempting to strike the STNA.</p> <p>Interview on 07/23/24 at 2:20 P.M. with the Director of Nursing (DON) confirmed Resident #45 had behaviors prior to the incident that occurred on 07/11/24. Interview confirmed that on 07/08/24, Resident #45 had a butter knife and attempted to attack staff and it took two staff members to get the knife away from the resident. Resident #45's care plan was not updated after the butter knife incident for behaviors. Interview also confirmed on 07/11/24, Resident #45 grabbed Resident #52 from behind, wrapped his arms around her head and shoved a pudding cup in her face. Interview confirmed Resident #45's care plan did not include behaviors or interventions for behaviors and did not include his use of psychotropic medications. Resident #45's care plan did not include any interventions for behaviors since his admission on 05/08/24. Interview also confirmed Resident #45's care plan has not been updated with any behaviors and that staff had no way of knowing what interventions were to be used with the resident.</p> <p>Interview on 07/23/24 at 2:36 P.M. with the Administrator revealed an incident occurred between Resident #45 and Resident #52 where, Resident #45 grabbed Resident #52 from behind and shoved a pudding cup into her face. Interview confirmed the incident did occur, but the facility unsubstantiated the incident due to Resident #45 having dementia and that the facility thought if an incident occurs with a resident with dementia, it is not substantiated due to the diagnosis. Interview also confirmed Resident #45's care plan did not have any interventions implemented for behaviors and that the care plan had not been updated with behaviors since admission on 05/08/24.</p> <p>Review of the, Abuse, Neglect, Exploitation & Misappropriation of Residents Property, policy dated 08/10/23 revealed the facility will not tolerate abuse, neglect, exploitation of its residents or the misappropriation of resident property. It is the facility's policy to investigate all alleged violations involving Abuse, Neglect, exploitation, mistreatment of a resident, or misappropriation of resident property, including injuries of unknown source, in accordance with this policy. Review of the policy also revealed facility procedures will include the assessment, care planning, and monitoring of residents with needs and behaviors which might lead to conflict or neglect, such as residents with a history of aggressive behaviors, residents who have behaviors such as entering other residents rooms, residents with self-injurious behaviors, residents with communication disorders, and those that require heavy nursing care and / or totally dependent on staff.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00155796.</p>		