STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365608	A. Building B. Wing	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aristocrat Berea Healthcare and Rehabilitation	255 Front Street Berea, OH 44017

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 - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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** 42730 Based on observation, record review, review of a facility Self-Reported Incident (SRI) and related facility investigation, review of hospital records, facility policy review and interviews, the facility failed to ensure Resident #143 was free from an incident of resident-to-resident physical abuse. This affected one resident (#143) of three residents reviewed for abuse. The facility census was 145. Actual harm occurred on 06/18/24 when Resident #143, who was cognitively impaired and had been independent with activities of daily living (ADLs) prior to 06/18/24, sustained a fall after being pushed by Resident #109, was sent to the local hospital emergency room for an examination on 06/18/24 and was found to have a left humerus (major upper arm bone) fracture. Although he returned to the facility on [DATE] he was sent out a second time to the hospital on 06/22/24 after complaints of right wrist pain developed at the facility and was diagnosed with a right wrist fracture. The facility investigation confirmed both fractures resulted from the incident on 06/18/24. As a result of the incident related fractures, Resident #143 was no longer independent with his ADLs and required staff to provide assistance to him. Findings include: Review of medical record for Resident #143 revealed an admitted [DATE] with diagnoses including fracture of upper end of left humerus, fracture of the lower end of right radius, and dementia. Review of the 03/24/24 quarterly Minimum Data Set (MDS) assessment for Resident #143 revealed the resident had a Brief Interview for Mental Status (BIMS) score of seven out of 15 indicating he was alert and oriented with cognition impairment. The assessment revealed the resident had inattention and disorganized thinking. Further review of the MDS assessment revealed Resident #143 was independent for activities of daily living (ADLs) such as dressing, bathing, eating, toileting, bed mobility and transfers. Review of the care plan, dated 03/24/24, revealed Resident #143 had a history of aggressive behaviors, including but not limited to, throwing things at staff, cursing at others, pacing, hallucinations, delusions and agitation and cognition impairment and dementia. Interventions included to provide assistance as needed, administer medications as ordered, monitor, observe, and report to physician. (continued on next page)

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of medical record for Resident #109 revealed an admitted [DATE] with diagnoses including pancytopenia, schizoaffective disorder and cognitive communication deficit. Review of the care plan, dated 08/24/18, revealed Resident #109 had a history of delusions, physically aggressive behaviors, including throwing things at staff, threatening and verbally aggressive, cursing at others, pacing, hallucinations, agitation and cognition impairment and dementia. Interventions included intervening as needed, analyze triggers and circumstances, provide assistance as needed, administering medications as ordered, monitoring, observe, and reporting to physician. Review of the 04/24/24 quarterly MDS assessment for Resident #109 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 14 that indicated he was alert and oriented to person, place, and time. The assessment revealed the resident had disorganized thinking. Review of the MDS assessment revealed Resident #109 was independent for activities of daily living (ADLs). Further review of the medical record for both Resident #143 and Resident #109 did not reveal any documented incidents of resident-to-resident abuse prior to an incident on 06/18/24. The residents had been roommates for approximately one year. Review of a facility self-reported incident (SRI), dated 06/18/24 revealed an allegation of physical abuse was reported to the State agency involving Resident #143 and Resident #109. Review of the SRI revealed Resident #143 reported, his previous roommate, Resident #109 pushed him from behind causing him to fall and was subsequently sent to the emergency room for evaluation due to also reporting hitting his head. Resident #109 was asked and denied having any physical contact with Resident #143 and subsequently given a room change. Review of the SRI revealed Resident #109 initially denied any physical contact but later admitted to pushing Resident #143 due to him getting in between him and his wife, however, Resident #109 had never been married and was actively having delusional thoughts. Review of the SRI revealed neither resident had a history of resident-to-resident physical altercations, therefore, the facility unsubstantiated the findings. As a result of the resident-to-resident physical altercation, Resident #143 suffered a fracture of the right wrist and left humerus. Review of the facility investigation and witness statement from Licensed Practical Nurse (LPN) #948 revealed Resident #109 stated Resident #143 had fallen on the floor. Upon entry into the shared room, Resident #143 was observed laying at the foot of the bed with blood coming from his nose and left arm out of place. Resident #143 stated the curly head guy (Resident #109) did it to him and broke his arm. Resident #109 denied having physical contact. Resident #143 was sent to the hospital via 911 and Resident #109 received a room change. Review of the progress note dated 06/18/24 at 4:50 A.M. revealed Resident #143 was sent to the hospital via 911 at 4:00 A.M. during the shift with injuries. Review of the progress note dated 06/18/24 at 5:18 A.M. revealed Resident #143 was sent to the emergency room via 911 with visible injuries to the face and upper extremities. Resident #143's guardian and physician were notified. Review of the progress note dated 06/18/24 at 12:57 P.M. revealed Resident #143 stated he was in a tussle with Resident #109 and was pushed down. Resident #143 was resting in bed, verbalized feeling safe, and verbalized no concerns with new roommate. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the progress note dated 06/18/24 at 1:10 P.M. revealed Resident #109 admitted to pushing previous roommate (Resident #143) claiming he fell to the ground. Resident #109 was unable to explain how or why the altercation began stating delusions related to previous high school classmates being involved. Resident #109 continued with delusional thoughts throughout conversation but verbalized being apologetic. Resident #109 assessed, emotional support provided, and scheduled to be seen by psych on the next visit. Review of the progress note dated 06/18/24 at 6:02 P.M. revealed Resident #143 returned from the emergency room after multiple tests completed. Resident #143's testing indicated fracture of left humerus with splint and/or sling to remain in place until orthopedic follow-up completed. Review of the hospital After Visit Summary dated 06/18/24 revealed Resident #143 received care instructions for a broken arm, to follow-up with the orthopedic surgeon within three to five days and to keep the arm in a splint or cast to allow it to heal or keep stable. Further review revealed Resident #143 had a displaced comminuted fracture of the left humerus. Review of the physician orders for Resident #143, dated 06/18/24, revealed orders for splint and/or sling to left upper extremity to be always worn and not removed until further instructions per orthopedics and non-weight bearing to lower upper extremity for preventative care. Review of the progress note dated 06/21/24 at 2:42 P.M. revealed Resident #143's right wrist looked a little swollen and red. Resident #143's wrist was assessed, and an order was obtained for a stat x-ray of right wrist. Resident #143 received orders for Tylenol and Norco oral tablets for pain. Review of the physician orders dated 06/21/24 revealed orders for Tylenol oral tablet to be given 500 milligrams by mouth three times a day for pain and Norco 325 milligram oral tablet to be given one tablet by mouth every six hours as needed for pain for 14 days. Review of portable x-ray results dated 06/21/24 revealed Resident #143 had an acute wrist fracture and a closed displaced comminuted fracture of shaft of left humerus with nonunion. Review of the progress note dated 06/21/24 at 10:21 P.M. revealed Resident #143 was to be transported to the hospital emergency room within the next few hours for evaluation due to x-ray result showing right wrist fracture. Review of the hospital After Visit Summary dated 06/22/24 revealed Resident #143 was seen for an arm injury and instructions included to continue immobilizer to left humerus fracture, right wrist fracture was splinted and to continue to use sling for comfort, continue Norco pain medication as prescribed, use wheelchair to prevent further falls, physical and occupation therapy at the facility and follow up with orthopedics as soon as possible. Review of the progress note dated 06/22/24 at 4:37 P.M. revealed Resident #143 returned from the hospital with right wrist fracture with splint applied in emergency room following examination. Resident #143 received pain medication for bilateral upper extremities with extensive assistance of two for transfers. Review of the physician orders dated 06/23/24 revealed an order for sling to right upper extremity for elevation and comfort. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the physician orders dated 06/24/24 revealed orders for an orthopedic follow-up as soon as possible and an order to elevate right upper extremity when up in chair and in bed. Further review of the medical record revealed Resident #143 attended the orthopedic follow-up appointment on 06/24/24. Interview on 06/25/24 at 1:35 P.M. with Regional Clinical Support (RCS) #957 revealed Resident #109 and #143 had been roommates when Resident #109 pushed Resident #143 he fell on his hand, but it was initially reported as a tussle between the two. RCS #957 revealed Resident #109 denied it at first but after being investigated, he admitted he pushed Resident #143 due to him getting in between him and his wife, despite Resident #109 never being married. RCS #957 revealed Resident #143 was assessed and sent to the emergency room due to reporting arm pain and hitting his head. RCS #957 revealed Resident #143 sustained a broken arm and wrist and Resident #109 received a room change. RCS #957 revealed both residents had cognition impairment and had diagnoses of schizophrenia but with no known history of resident-to-resident physical altercations. Interviews were attempted on 06/25/24 at 4:11 P.M. and 07/02/24 at 2:19 P.M. and 4:23 P.M. with LPN #884 and LPN #948 who were on duty at the time of the incident, however, neither LPN returned the calls. Interview on 07/01/24 at 2:00 P.M. with the Administrator confirmed and verified the above findings and that Resident #143 had sustained fractures because of falling after being pushed (an incident of physical abuse) by Resident #109 who was responding to delusions. Interview on 07/02/24 at 10:34 A.M. with LPN #935 and at 10:46 A.M. with LPN #830 revealed they both were familiar with Resident #109 and Resident #143, and stated they were not aware of any recent incidents of physical aggression with either resident. LPN #830 said Resident #109 was known to be pleasant but did have delusions and was to be monitored for behaviors due to a history of physical aggression towards staff. Interview conducted on 07/02/24 at 2:15 P.M. with Resident #143 revealing he was alert with confusion. An observation at the time of the interview revealed Resident #143 was sitting in the dining room with his left arm in a sling and his right wrist in a splint. Resident #143 removed the splint from his right wrist and a reddish-purple looking bruise was located on the forearm. Resident #143 revealed Resident #109 tussled and grabbed him while in the room and he now had pain. At that time, Resident #143 then declined to continue to the interview. Interview on 07/02/24 at 2:30 P.M. with Resident #109 revealed he was alert sitting in his room. Observation at the time of the interview revealed Resident #109 appeared free from injury and his room was located on another floor away from Resident #143. Resident #109 revealed he did not recall the incident in question regarding Resident #143. Review of the facility document titled Abuse, Neglect, and Exploitation Policy revised June 2021, revealed the facility defined physical abuse as hitting, slapping, pinching, kicking, flicking with fingers or striking in any manner that was demeaning. It also included controlling behavior through corporal punishment. This deficiency represents non-compliance investigated under Master Complaint Number #OH00155125.