

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365608	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/08/2025
NAME OF PROVIDER OR SUPPLIER Aristocrat Berea Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<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** 32650</p> <p>Based on interviews, medical record review, and policy review, the facility failed to report an allegation of abuse as required. This affected one (Resident #63) of of six residents reviewed for abuse. The facility census was 143.</p> <p>Findings Include:</p> <p>Medical record review revealed Resident #63 was admitted to the facility on [DATE] with diagnoses including schizoaffective disorder, bipolar disorder, anxiety, depression, and chronic obstructive pulmonary disease.</p> <p>Review of the admission comprehensive Minimum Data Set (MDS) assessment, dated 01/24/25, revealed Resident #63 was cognitively intact, had delusions, verbal outbursts directed towards others, and wandered.</p> <p>Review of a nurse note dated 03/10/25 timed 6:45 A.M. revealed Resident #63 was verbally abusive, intrusive and arguing with staff and residents. Further review of the nurses notes from February 2025 to current revealed no information related to Resident #63 making an allegation of nursing staff twisting her arm.</p> <p>Interview on 04/03/25 at 9:05 A.M. with the Director of Nursing (DON), Regional Registered Nurse (RRN) #601, and the Administrator revealed an allegation was made recently (unable to provide exact date) that staff had twisted the arm of Resident #63 behind her back. Resident #63's statement kept changing about what happened and staff would not provide statements when requested because they did not believe anything had happened. The facility did not report the allegation of abuse made by Resident #63 to the State agency.</p> <p>Interview with the Administrator on 04/03/25 at 12:45 P.M. revealed they did no report the allegation made by Resident #63 because the resident retracted her allegation 10 minutes after making it. However, they did investigate the situation and made a soft file. Resident #63 had a habit of making false allegations.</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 a Root Cause Analysis/soft file investigation dated 03/31/25 revealed Resident #63 initially claimed two aides were taking her to her room and once they were in her room they twisted her arm behind her back. During a second interview, Resident #63 stated Certified Nurse Aide (CNA) #406 threw her walker in the hall then twisted her right arm back refracturing her arm and then walked her down to her room. The incident was reported to staff on 03/31/25 but Resident #63 said it happened on 03/30/25 then changed her mind and said it happened on 03/29/25. An investigation was immediately begun by the Interdisciplinary Team (IDT). The investigation revealed that Resident #63 asked CNA #520 for some hygiene products. CNA #520 asked the resident to give her a minute and she would get them for her. Resident #63 changed her statement several times and indicated CNA #520 was the one who twisted her arm behind her back and not CNA #406. Resident #63 retracted her allegation while talking to Unit Manager (UM) #474 and apologized to the staff for getting them in trouble. Resident #63 became impatient and accusatory if staff did not meet her needs as soon as she asked. The Root Cause Analysis investigation indicated upon many witness statements, creating a time line, review of past behavioral history, a head to toe assessment and the resident retracting her statement the interdisciplinary team (IDT) determined the allegation was a false statement because she did not receive her requested hygiene products immediately.</p> <p>Interviews with Certified Nursing Assistant (CNA) #415 and CNA #420 on 04/04/25 from 12:00 P.M. through 12:55 P.M. revealed Resident #63 had a long history of making false allegations but always apologized afterwards because she wanted staff to like her.</p> <p>Interview with Licensed Practical Nurse (LPN) #506 on 04/04/25 at 1:07 P.M. revealed false allegations were a daily behavior for Resident #63. Although the allegation was made over the weekend of 03/29/25 and 03/30/25, LPN #506 said she worked that weekend and nothing unusual happened. LPN #506 was unaware the allegation had been made until 04/03/25. LPN #506 said Resident #63 made apologies to the staff for getting them in trouble.</p> <p>Review of the facility's Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property policy, last revised 01/02/25, revealed all allegations of any type of abuse were to be reported to the Administrator and the State agency. If a staff member was accused or suspected of abuse they were to be removed immediately from the facility in order to protect the resident. If abuse was alleged the State agency must be notified immediately, but not later than two hours after the allegation was made. An investigation was to be completed and the results reported to the state agency within five days. Staff training was to be completed with each allegation.</p> <p>This deficiency represents noncompliance investigated under Complaint Numbers OH00164255, OH00163358, and OH00162492.</p>		