STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365612	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Acres Nursing Home	44565 Sunset Road Caldwell, OH 43724

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 - Minimal harm or potential for actual harm Residents Affected - Few	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** 28923 Based on record review, review of the facility's related investigation, observation, staff interview, employee file review, and policy review, the facility failed to ensure a resident was free from staff to resident sexual abuse and another resident was free from neglect when the resident was left on a bed pan for fourteen (14) hours. This affected two residents (#44 and #46) of four residents reviewed for abuse/ neglect. Findings include: 1. Review of Resident #44's medical record revealed he was admitted to the facility on [DATE]. His diagnoses included a traumatic brain injury, dementia with behavioral disturbances, pseudobulbar affect, restlessness and agitation, mood disorder, hemiplegia and hemiparesis affecting his right dominant side, contractures of the right upper extremity, abnormalities of gait and mobility, and need for assistance with personal care. Review of Resident #44's annual Minimum Data Set (MDS) assessment completed on 01/08/25 revealed the resident had adequate hearing and unclear speech. He was rarely/ never able to make himself understood and was rarely/ never able to understand others. He had highly impaired vision, without the use of any corrective lenses. Short and long term memory impairment was noted and his cognitive skills for daily decision making was severely impaired. He was known to display physical behaviors and verbal behaviors directed at others. He was also known to display other behaviors not directed at others. He had a functional limitation in his range of motion (ROM) on one side of his upper and lower extremities. He was dependent on staff for all his activities of daily living (ADL's). (continued on next page)

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: 365612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2025
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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #44's active care plans revealed he had a care plan in place for being known to exhibit behaviors that included physical aggression towards staff (kicking, pinching, grabbing, scratching, biting, slapping, and punching). He also was known to have inappropriate touching of female staff. The care plan had been in place since 02/01/23. The goal was for the resident to not harm himself or others during daily care. The interventions included the need for the staff to approach the resident in a calm manner and offer a different time of his choice when refusing care; when the resident was physically abusive towards staff, they were to attempt to redirect the resident, or allow time for resident to calm down and attempt at a later time; they were to maintain a calm environment and provide a consistent approach with the resident as able; they were to observe for behaviors that endangered the resident and/or others; staff to carefully intervene to promote safety; obtain a psychiatric consult/ psychosocial therapy/ psychiatric therapy as ordered by the physician; staff were to observe for any activity or events that trigger the resident's behavior and re-direct/ divert his attention to prevent exacerbation; when the resident was exhibiting behaviors, staff were to keep the resident and others safe. Review of Resident #44's physician's orders revealed the resident had orders in place to receive Remeron 7. 5 milligrams (mg) by mouth every night at bedtime for depression. He also received Vistaril 25 mg by mouth twice a day for agitation. He was not receiving any other psychoactive medications or any other medications to reduce any inappropriate sexual behaviors. Review of Resident #44's nurses' progress notes revealed a nurse's note dated 11/03/24 at 8:00 A.M. that indicated the resident was noted to grab when the staff provided care and attempted to bite, pinch, and hit with his left hand. His right hand and arm were noted to be contracted and the resident held it closely to his body. None of the progress notes documented anything about any known sexually related behaviors. On 01/27/25 at 1:32 P.M., an interview with Certified Nursing Assistant (CNA) #127 revealed she had not personally witnessed any sexually inappropriate behavior involving Resident #44, but had heard three different trainees say the same thing about CNA #114 (who mentored them) that CNA #114 allowed Resident #44 to fondle her breasts. She identified Aide #148 as one of the aides that trained under CNA #114 that had knowledge of that and who took it to the Administrator to report it. She stated she accompanied Aide #148 to the Administrator's office, when the aide reported it. She was not sure if the Administrator had done anything about it or not. She further identified a second aide (Hospitality Aide #187) that was also trained by CNA #114 and was told by her trainer that allowing Resident #44 to touch their breasts was okay. She identified a third aide (CNA #188), as being another aide that had heard CNA #114 say, while in the Unit 2 dining room, she had allowed Resident #44 to touch her breast until he became erect. (continued on next page)

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(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 - Minimal harm or potential for actual harm Residents Affected - Few	On 01/28/25 at 9:45 A.M., an interview with Aide #148 confirmed she was trained by CNA #114. She recalled providing care to Resident #44, with CNA #114, when the resident tried touching her (Aide #148's) breasts. She stated she stepped back and was told by CNA #114 that it would be fine if she allowed the resident to do that. She (CNA #114) rationalized that sexually inappropriate behavior by saying it was the only excitement the resident got during the day. She reported she had also heard from another aide CNA #114 had told them the same thing. She identified that other aide as Hospitality Aide #187. She described the resident's action as him knowing what he was doing and it was not an accidental touching of her breasts. She then reported the two of them then went up to the front of the unit by the dining room where CNA #114 told the staff that were up there that she had allowed Resident #44 touch her until he got hard, meaning an erection. She reported the incident happened about a week or two ago. She knew at the time it was inappropriate behavior and knew if her mentor was allowing the resident to do that to her, then the resident would think he could do that to others. She reported everyone (her coworkers) were saying that was sexual abuse and she felt the same. She stated the whole incident made her feel uncomfortable, especially hearing CNA #114 joke about that. She confirmed she reported it to the facility's Administrator the next day, with CNA #127 accompanying her. She claimed she had told the Administrator what had happened. CNA #127 added that it was not right that CNA #114 was training new aides and telling them that was okay. They were concerned that CNA #114 was also training younger aides that were only [AGE] years old. The Administrator told her he was glad they said something about that and that it was horrible. He then told them not to talk about it to anyone and he would handle it. She had not seen any evidence that it had been handled, as CNA #114 had been back to work, and nothing seemed to have changed. On 01/28/25 at 11:49 A.M., an interview with Hospitality Aide #187 revealed she received her training back in August 2024. She was trained by CNA #114 and was trained on Unit 2, where Resident #44 resided. She was familiar with the resident and knew he had behaviors that needed to be redirected. His behaviors included him trying to touch them with his hands and he went for the chest area. She recalled the first day she worked with CNA #114 Resident #44 had his hands on CNA #114's breasts. The resident's left hand was on the CNA's breast and CNA #114 made no attempt to redirect his behavior or remove his hand. She (CNA #114) made some comment about that (Resident #44 touching her breast) calming him down for a second and it allowed them to get what they needed done so they could leave. She denied CNA #114 had ever told her to allow the resident to do that to her. She felt what she witnessed was inappropriate and felt that it may have been considered sexual abuse. She denied that she reported it to anyone at the time. She knew it had since been reported by someone else. She denied she was one of the staff members that were present when CNA #114 allegedly told staff in the dining area of Unit 2 that she allowed Resident #44 touch her until he got an erection. She knew any concerns about potential abuse should be reported to the facility's Administrator. She stated the incident she was talking about happened within the first five minutes of her working at the facility and she did not know who to report that to at the time and was shocked by what happened. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/28/25 at 3:25 P.M., an interview with CNA #188 revealed Resident #44 was known to have behaviors. He did not like to be bothered and would scream and yell at them. One side of his extremities was contracted, but he had the use of his left side. The resident was known to get touchy feely with the staff. They would tell him it was inappropriate behavior and he would just grin. She did not work with CNA #114 that often, as the other aide worked days, and she was on afternoons. They both worked Unit 2 where the resident resided. She had not witnessed any inappropriate interactions between CNA #114 and the resident, but recalled one time during report, CNA #114 told them what she allowed Resident #44 to do. CNA #114 rationalized allowing the resident to do that (touching/fondling her breast), as he was not able to do anything throughout the day, and that was something that made him happy. She described what she heard as something out of the norm when she heard that. She had never heard anyone talk like that before. She kind of knew CNA #114 and did not think she would hurt anyone. CNA #188 then stated she kind of agreed and saw where CNA #114 was coming from, when saying the resident was not able to do anything and that made him happy. She commented that she would not do that personally. CNA #188 was asked specifically what CNA #114 had said she allowed Resident #44 to do. She reported the aide commented about allowing Resident #44 to touch her breasts until he got hard. She was uncertain if allowing a resident to touch her breast was sexual abuse or not. She stated she knew there was a fine line. She then said it would never be appropriate to engage in that type of behavior with a resident. The incident where she heard CNA #114 say what she allowed the resident to do happened about a month ago. She denied that she personally reported it to anyone. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/28/25 at 4:45 P.M., an interview with the facility's Administrator revealed he was the facility's abuse coordinator and was the one that investigated and reported allegations of abuse. The staff were taught to notify their supervisor immediately, at the time of the alleged abuse. It would then need to be reported to him. They followed the State regulations when it came to investigating and reporting. Any allegation of physical abuse or something that was dangerous to the resident, they notified the State within two hours. They had five working days excluding weekends and holidays to complete their investigation and submit their final report. In the past 30 days, he reported he had a couple resident to resident abuse allegations, misappropriation of money (which was found in laundry), but no residents who were on the receiving end that he had been made aware of. He reported there had been an issue that Aide #148 and CNA #127 came to him about. He was told by Aide #148 that a male resident touched her breast and the aide felt that was inappropriate. He asked who was with her and was told CNA #114. He claimed it was reported to him that the male resident brushed against the aide's breast. He informed the aide that was not appropriate and she needed to redirect the resident with that inappropriate behavior. He informed Aide #148 that the behavior was not acceptable or condoned in the facility. He discussed residents with certain behaviors based on their diagnoses that made them act in different ways and she needed to know how to respond to the behaviors. He denied he had spoken with CNA #114 following that reported incident. He was not real familiar with Resident #44, but advised the staff they needed to use caution with any resident. The facility's DON was not there on that day, so he told the staff he would follow up with her (DON) when she came back. He believed the staff members came to him to talk about that, due to the facility's DON not being there at the time. None of the behaviors they described to him was done towards Resident #44, as it was done towards the staff member. He talked with the two aides for about 10-15 minutes with both present at the same time. He denied that he had any other employees sit in during the meeting as a witness. He left it (the concern) open ended for nursing to follow up with because it was a resident initiated behavior. He did not feel the resident was abused or neglected, which would have been reportable. He denied that the two staff members he talked with mentioned anything about any comments CNA#114 made to them about allowing Resident #44 to touch them or that CNA #114 allowed him to touch her breasts until he got an erection. He denied that he had instructed the aides not to talk about that with anyone. He did report he told them he would handle it. He denied he had submitted any self reporting incidents or completed an investigation pertaining what was reported to him. On 01/29/25 at 9:15 A.M., a follow up interview with CNA #127 reconfirmed she was present when Aide #148 talked to the Administrator about what took place with Resident #44. She indicated the meeting with the Administrator occurred on 01/13/25. She was in the office when Aide #148 reported to the Administrator what had taken place. She denied Aide #148 only told the Administrator about the resident brushing up against her (Aide #148's) breasts. They informed him that CNA #114 was saying that she allowed Resident #44 to touch her breast. She reported the word fondled was used when they told the Administrator about the comment CNA #114 made about allowing the resident to fondle her until he got a hard on. She denied the discussion was about the resident brushing against Aide #148's breast. It was about the resident grabbing and holding CNA #114's breasts. She further confirmed the Administrator told them not to talk about it with anyone and that he would handle it. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/29/25 at 3:18 P.M., an interview with Aide #325 revealed she had heard Aide #148 say that Resident #44 had tried touching her breasts, but she did not allow him to. She also heard, when the two (CNA #114 and Aide #48) left the resident's room, CNA #114 was telling Aide #148 that it was okay to allow him to do that because she (CNA #114) let him. Aide #148 then told her and another aide that CNA #114 allowed the resident to get an erection. She denied she had witnessed anything personally between CNA #114 and Resident #44. The only knowledge she had was what Aide #148 had told her. She instructed Aide #148 to tell CNA #127. It was then communicated to Licensed Practical Nurse (LPN) #174, who informed them that they needed to tell the Administrator. She denied she or Aide #148 were asked to write any statements. She thought that was odd that they did not ask her to do that, as she knew that was typically done with any investigation. She was told Hospitality Aide #187 had witnessed inappropriate things between CNA #114 and Resident #44 too. She identified another aide (CNA #213), who reportedly witnessed CNA #114 allow Resident #44 to touch her breasts. She felt that something needed to be done about it and did not feel they were. On 01/29/25 at 4:02 P.M., an interview with CNA #213 revealed he worked often with CNA #114 on day shift and on Unit 2. He was only aware of one incident that involved anything happening between CNA #114 and Resident #44. He recalled they (him and CNA #114) were giving Resident #44 a bed bath. They were about done when the resident reached out and grabbed CNA #114's breast. He intervened and told the resident that that was not appropriate behavior. He denied CNA #114 had attempted to redirect the resident's behavior or to remove his hand. He removed the resident's hand off the other aides breast and then they rolled the resident towards him. His hand was only on her breast for a few seconds. CNA #114 made a comment that the resident did that all the time. While rolling the resident over towards him, he noticed the resident was aroused. When asked to explain what he meant by the resident being aroused, he stated the resident was hard (meaning an erection). He denied there was any indication the other aide allowed that to occur. It was just her comment that he (Resident #44) did it all the time that he took as her allowing the resident to do that. He felt she (CNA #114) allowed that behavior from Resident #44, so she could do care on him, as he could be a difficult resident. During the complaint survey, attempts to interview Resident #44 were unsuccessful as the resident was not able to answer questions appropriately due to the resident's cognitive status. The surveyor was not able to interview CNA #114 during the complaint survey as the employee had called off work. Review of the facility's self reporting incidents (SRI's) that had been submitted in the past three months revealed there had been four SRI's submitted during that time. None of the SRI's submitted involved an allegation of sexual abuse pertaining to Resident #44 and involving CNA #114. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's abuse policy (not dated) revealed it was the policy of the facility not to tolerate mistreatment, abuse, neglect, or misappropriation of it's residents by anyone. It was also the policy of the facility to investigate all allegations, suspicions, and incidents of abuse, neglect, and injuries sustained by its residents. Facility staff should report all such allegations to the Administrator and the Ohio Department of Health (ODH) in accordance with the procedures in this policy. While the policy provided general guidelines, it was not meant to to overrule clinical judgement where such judgement was appropriate. The definition of abuse was willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. It did not define sexual abuse. Training of staff was to be completed upon orientation and periodically thereafter regarding the facility's policy concerning abuse. Those training sessions were to include how to identify abuse and how staff should report their knowledge related to the allegations. Response to allegations or suspicions of abuse included the need for staff to report all incidents immediately to their direct supervisors. All allegations of abuse must be reported immediately to both the Administrator and to ODH. For purposes of that policy, immediately meant as soon as possible, but ought not to exceed 24 hours after the incident. Once the Administrator and ODH were notified, an investigation of the allegation or suspicion would be conducted. The investigation was to be completed within five working days (excluding weekends or legal holidays). 2. Review of Resident #46's medical record revealed he was admitted to the facility on [DATE]. His diagnoses included Lewy Body dementia, Alzheimer's disease, metabolic encephalopathy, abnormalities of gait and mobility, and need for assistance with personal care. Review of Resident #46's admission MDS assessment dated [DATE] revealed the resident had clear speech and adequate hearing. He was sometimes able to make himself understood and was sometimes able to understand others. His vision was highly impaired without the use of any corrective devices. His cognition was severely impaired and he was known to display behaviors that included hallucinations and physical behaviors directed at others. He was not indicated to have rejected any care during his assessment period. He was dependent on staff for toileting hygiene, bed mobility, and transfers. He was coded as always being incontinent of his bowel and bladder and was at risk for pressure ulcers, but did not have any pressure ulcers at the time of the assessment. Review of Resident #46's active care plans revealed the resident had a care plan in place for being incontinent of his bladder. Interventions included the need to check and provide incontinence care as needed. They were to provide physical support/ assist for toileting safety as indicated for the resident. Further review of Resident #46's care plans revealed he had a care plan in place for being at risk for skin breakdown related to impaired mobility, impaired cognition, and bladder and bowel incontinence. The goal was for the resident to not develop any skin breakdown. The interventions included assisting the resident as needed with turning and positioning frequently when in bed; observe resident for any incontinence episodes and provide incontinence care as needed; and apply protective barrier after each incontinent episode. Review of Resident #46's nurses' progress notes revealed a nurse's note dated 12/28/24 at 4:07 A.M. that revealed staff reported excoriation to the resident's buttocks. The physician was notified and a treatment was initiated for cleansing the area with normal saline and apply Triad cream to the resident's buttocks. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nurse's progress note dated 12/30/24 at 11:36 A.M. revealed an initial review was completed for a wound the resident had to his left buttocks. Treatment had been initiated as per the 12/28/24 note, but also specified it was to be completed twice a day and as needed (prn) and it was to be left open to air. Review of Resident #46's physician's orders revealed a treatment was put in place for an area to the left buttock beginning on 12/30/24. The treatment initiated was the same treatment indicated in the nurse's note dated 12/30/24. A physician's order was given on 12/31/24 for treatment to an area on the resident's right buttock. The treatment initiated was the same treatment that had been in place for the left buttock. Review of Resident #46's wound observation reports under the electronic medical record (EMR) revealed a wound observation dated 12/30/24 that indicated the resident was observed to have a Stage I pressure ulcer (intact skin with localized area of non-blanchable redness) to the right buttock. The date the wound was identified was on 12/30/24. It measured 12 centimeters (cm) x 6 cm at date of onset. There was no wound observation report for any wound observations for an area on the resident's left buttock. Subsequent wound observations for Resident #46's Stage I pressure ulcer to the right buttock revealed the wound further deteriorated to a Stage II pressure ulcer (partial thickness loss of skin with exposed dermis) on 01/06/25 and remained as a Stage II pressure ulcer when it was last assessed on 01/27/25. Upon it's last assessment, the Stage II pressure ulcer to the right buttock measured 0.8 cm x 0.2 cm x 0.1 cm. The wound was closed- resurfaced and had no exudate (drainage). On 01/27/25 at 1:32 P.M., an interview with CNA #127 revealed Resident #46 was known to have a sore on his buttocks from being left on a bed pan. She was not there at the time, but was told the resident was left on the bedpan for about 14 hours. There was an actual ring on his buttocks caused by the bedpan. She could not recall exactly when that occurred, but stated the resident was placed on the bedpan during the afternoon shift and was not taken off until sometime during the night shift. The resident still had an imprint of the bedpan on his legs and buttocks and currently had an open area that was closing up. On 01/27/25 at 1:46 P.M., an interview with CNA #223 revealed the incident with Resident #46 being left on the bedpan happened when she was on vacation. When she returned to work, the areas to his buttocks were there. She had heard the skin issue was the result of the resident being left on a bedpan. She stated you could tell the area was caused by a bedpan based on the marks it left on his skin. He currently had areas on both his buttocks. She did not feel the resident being left on the bedpan was intentional, but should not have happened. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/27/25 at 1:57 P.M., an interview with LPN #174 revealed Resident #46 did have skin issues, but she was not sure if they were being classified as pressure ulcers or not. She confirmed the areas were on his buttocks. She was asked how he got those areas and replied the resident was left on a bedpan for an extended period of time. She reported he was placed on a bedpan during the afternoon shift and remained on it into the night shift. She was not certain when that took place, but felt it was likely the end of December 2024. She saw the areas after it was first noted. He had an impression of a bedpan on his buttocks and upper, posterior legs. She denied it was open at it's onset, but did eventually open up. She reported the facility did investigate the concern. She was not sure what staff were involved in the incident. They continued to monitor the resident's buttocks and the area was looking better. The left buttock was also indicated to have been healed. She did not feel leaving the resident on the bedpan was intentional. She had heard he was on the bedpan up until around 4:00 A.M. She could not explain why the resident would not have been found on the bedpan earlier than he was. She confirmed the resident should have been checked and changed every two hours. She recalled being there when the day shift aides informed the afternoon shift aides at shift change (2:00 P.M.) that the resident was on the bedpan and would need assistance getting off. She would have assumed rounds did not get done on the afternoon shift or during the first part of the night shift, as he was not found on the bedpan until 4:00 A.M. that following morning. Review of the facility's self reporting incidents (SRI's) revealed there was no SRI that had been submitted to the State survey agency (ODH) that pertained to any allegations of neglect. They had two SRI's that were pending next onsite review. One pertained to an allegation of physical and verbal/ emotional abuse and the other pertained to sexual abuse involving one resident inappropriately touching another resident. There were two others that had been provided by the facility involving a misappropriation or property and a resident to resident altercation that had been closed with no action necessary. None of the SRI's pertained to an allegation of neglect for Resident #46. During the survey, the facility's corporate support staff (Corporate Nurse #225 and Corporate Nurse #300) was asked to provide any investigation the facility had done on behalf of Resident #46 and the issue where he had reportedly been left on a bedpan for an extended amount of time. The facility's Director of Nursing (DON) had previously provided a file with an investigation pertaining to Resident #46's development of his pressure ulcer that was the result of him being left on the bedpan for an extended amount of time. It did not address the potential neglect of the resident for being left on a bedpan for an extended period of time, which resulted in the development of a pressure ulcer. When asked if they submitted a SRI for neglect of Resident #46, they provided a second file they had that addressed the neglect of the resident. The DON confirmed a SRI had not been completed for an allegation of neglect, but provided the second file as evidence that the concern had been investigated. Review of the facility's investigation file pertaining to Resident #46 and him being left on the bedpan revealed it included an established timeline of the events, statements obtained from four staff directly involved in the incident, a body assessment that had been performed on Resident #46, evidence of a whole house skin sweep of all residents, education provided to staff, and audits that had been completed by the facility since the incident occurred. Review of the timeline that was included as part of the facility's investigation revealed Resident #46 was noted to have a skin assessment completed on 12/28/24 by two separate nurses beginning at 4:00 A.M. On-call physician's service was contacted and treatment was initiated for a reported skin area. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Acres Nursing Home	44565 Sunset Road Caldwell, OH 43724

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 - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #46's skin assessment that was completed on 12/30/24 revealed the assessment was documented using a body diagram form. It documented wounds the resident was noted to have after being left on the bedpan for an extended period of time. The body diagram described the areas where red lines were noted. The resident was noted to have a red outline from the bedpan that started at the lower back, upper buttock area midway over the left buttock. It was a slightly diagonal line that was shaped like a backwards L with the base of the L slightly higher than the start of it ending about 3/4 of the way above the right buttock/ flank area. The base of the L then extended down to the upper part of the right buttock. A curved line shaped like a backwards C then extended from the end of the base of the L down the resident's right outer buttock ending below his gluteal fold near the inner, upper, posterior leg. The diagram indicated the red outline was blanchable. Review of a written statement by Hospitality Aide #187 dated 12/30/24 revealed she came in to work (on 12/27/24) at 5:00 P.M. She indicated she was aware Resident #46 was dependent on staff and claimed she had informed the other aide (Aide #335) whom she was working with of the same. She was also aware he (Resident#46) needed to be checked and changed. She took responsibility for not checking him (Resident #46). She was watching another resident, but stated that was no reason. Review of a written statement by Registered Nurse (RN) #117 dated 12/30/24 revealed she had given Resident #46 his medications the evening of 12/27/24. She stated the resident did not appear to be on a bedpan at that time. A staff member (Hospitality Aide #187) summoned her back to the resident's room approximately at 4:00 A.M. on 12/28/24 to look at the resident. Upon entering the resident's room, Aide #335 was assisting the resident with care and a bedpan was noted on the floor. A body assessment was completed with a dark purple outline from the bedpan being noted to the resident's right buttocks. The aides informed the nurse that previous rounds were not completed on the resident due to him sleeping. The nurse immediately disciplined the two aides on duty for the incident and not providing care to the resident the majority of their shift. Review of a written statement by Aide #335 dated 12/31/24 revealed when they got around to their check and changes it was extremely late, due to behaviors. When the other aide had helped her in Resident #46's room, they discovered he had been put on a bedpan. They notified the nurse when they found him and she came back to assess him. He had a ring around his bottom from the amount of time he had been left on the bedpan. Review of a written statement by CNA #171 dated 12/31/24 revealed she worked day shift (12/27/24) on Unit 2 before working on the memory care unit on the 2:00 P.M. to 10:00 P.M. shift. She indicated one of the girls (aides) was walking down the hall giving CNA #131 report and told her Resident #46 was on the bedpan. The day shift girls stated they told them he was on the bedpan, but she could not remember. When report was over, she started to give showers and taking residents in the dining room to the restroom. Hospitality Aide #187 stated she would do Resident #46's bed bath, since she did the others. Hospitality Aide #187 also fed the resident dinner. She (CNA #171) took all the residents in the dining room to the bathroom (after dinner) and changed them, but she did not go down the hall that evening except to pick up trays. Review of the education provided to the nursing staff following the incident involving Resident #46 being left on the bedpan revealed the facility's DON educated the nursing staff (aides and nurses) on the need for residents to be checked and changed every two hours. They were also [TRUNCATED]

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Acres Nursing Home	44565 Sunset Road Caldwell, OH 43724

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on record review, review of the facility's related investigation, observation, staff interview, review of employee files, and policy review, the facility failed to ensure allegations of staff to resident sexual abuse and resident neglect were reported to the State survey agency as required. This affected two residents (#44 and #46) of four residents reviewed for abuse/ neglect. Findings include: 1. Review of Resident #44's medical record revealed he was admitted to the facility on [DATE]. His diagnoses included a traumatic brain injury, dementia with behavioral disturbances, pseudobulbar affect, restlessness and agitation, mood disorder, hemiplegia and hemiparesis affecting his right dominant side, contractures of the right upper extremity, abnormalities of gait and mobility, and need for assistance with personal care. Review of Resident #44's annual Minimum Data Set (MDS) assessment completed on 01/08/25 revealed the resident had adequate hearing and unclear speech. He was rarely/ never able to make himself understood and was rarely/ never able to understand others. He had highly impaired vision, without the use of any corrective lenses. Short and long term memory impairment was noted and his cognitive skills for daily decision making was severely impaired. He was known to display physical behaviors and verbal behaviors directed at others. He was also known to display other behaviors not directed at others. He had a functional limitation in his range of motion (ROM) on one side of his upper and lower extremities. He was dependent on staff for all his activities of daily living (ADL's). Review of Resident #44's active care plans revealed he had a care plan in place for being known to exhibit behaviors that included physical aggression towards staff (kicking, pinching, grabbing, scratching, biting, slapping, and punching). He also was known to have inappropriate touching of female staff. The care plan had been in place since 02/01/23. The goal was for the resident to not harm himself or others during daily care. The interventions included the need for the staff to approach the resident in a calm manner and offer a different time of his choice when refusing care; when the resident was physically abusive towards staff, they were to attempt to redirect the resident, or allow time for resident to calm down and attempt at a later time; they were to maintain a calm environment and provide a consistent approach with the resident as able; they were to observe for behaviors that endangered the resident and/or others; staff to carefully intervene to promote safety; obtain a psychiatric consult/ psychosocial therapy/ psychiatric therapy as ordered by the physician; staff were to observe for any activity or events that trigger the resident's behavior and re-direct/ divert his attention to prevent exacerbation; when the resident was exhibiting behaviors, staff were to keep the resident and others safe. Review of Resident #44's physician's orders revealed the resident had orders in place to receive Remeron 7. 5 milligrams (mg) by mouth every night at bedtime for depression. He also received Vistaril 25 mg by mouth twice a day for agitation. He was not receiving any other psychoactive medications or any other medications to reduce any inappropriate sexual behaviors. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Summit Acres Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 44565 Sunset Road Caldwell, OH 43724	

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #44's nurses' progress notes revealed a nurse's note dated 11/03/24 at 8:00 A.M. that indicated the resident was noted to grab when the staff provided care and attempted to bite, pinch, and hit with his left hand. His right hand and arm were noted to be contracted and the resident held it closely to his body. None of the progress notes documented anything about any known sexually related behaviors. On 01/27/25 at 1:32 P.M., an interview with Certified Nursing Assistant (CNA) #127 revealed she had not personally witnessed any sexually inappropriate behavior involving Resident #44, but had heard three different trainees say the same thing about CNA #114 (who mentored them) that CNA #114 allowed Resident #44 to fondle her breasts. She identified Aide #148 as one of the aides that trained under CNA #114 that had knowledge of that and who took it to the Administrator to report it. She stated she accompanied Aide #148 to the Administrator's office, when the aide reported it. She was not sure if the Administrator had done anything about it or not. She further identified a second aide (Hospitality Aide #187) that was also trained by CNA #114 and was told by her trainer that allowing Resident #44 to touch their breasts was okay. She identified a third aide (CNA #188), as being another aide that had heard CNA #114 say, while in the Unit 2 dining room, she had allowed Resident #44 to touch her breast until he became erect. On 01/28/25 at 9:45 A.M., an interview with Aide #148 confirmed she was trained by CNA #114. She recalled providing care to Resident #44, with CNA #114, when the resident tried touching her (Aide #148's) breasts. She stated she stepped back and was told by CNA #114 that it would be fine if she allowed the resident to do that. She (CNA #114) rationalized that sexually inappropriate behavior by saying it was the only excitement the resident got during the day. She reported she had also heard from another aide CNA #114 had told them the same thing. She identified that other aide as Hospitality Aide #187. She described the resident's action as him knowing what he was doing and it was not an accidental touching of her breasts. She then reported the two of them then went up to the front of the unit by the dining room where CNA #114 told the staff that were up there that she had allowed Resident #44 touch her until he got hard, meaning an erection. She reported the incident happened about a week or two ago. She knew at the time it was inappropriate behavior and knew if her mentor was allowing the resident to do that to her, then the resident would think he could do that to others. She reported everyone (her coworkers) were saying that was sexual abuse and she felt the same. She stated the whole incident made her feel uncomfortable, especially hearing CNA #114 joke about that. She confirmed she reported it to the facility's Administrator the next day, with CNA #127 accompanying her. She claimed she had told the Administrator what had happened. CNA #127 added that it was not right that CNA #114 was training new aides and telling them that was okay. They were concerned that CNA #114 was also training younger aides that were only [AGE] years old. The Administrator told her he was glad they said something about that and that it was horrible. He then told them not to talk about it to anyone and he would handle it. She had not seen any evidence that it had been handled, as CNA #114 had been back to work, and nothing seemed to have changed. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Acres Nursing Home	44565 Sunset Road Caldwell, OH 43724

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/28/25 at 11:49 A.M., an interview with Hospitality Aide #187 revealed she received her training back in August 2024. She was trained by CNA #114 and was trained on Unit 2, where Resident #44 resided. She was familiar with the resident and knew he had behaviors that needed to be redirected. His behaviors included him trying to touch them with his hands and he went for the chest area. She recalled the first day she worked with CNA #114 Resident #44 had his hands on CNA #114's breasts. The resident's left hand was on the CNA's breast and CNA #114 made no attempt to redirect his behavior or remove his hand. She (CNA #114) made some comment about that calming him down for a second and it allowed them to get what they needed done so they could leave. She denied CNA #114 had ever told her to allow the resident to do that to her. She felt what she witnessed was inappropriate and felt that it may have been considered sexual abuse. She denied that she reported it to anyone at the time. She knew it had since been reported by someone else. She denied she was one of the staff members that were present when CNA #114 allegedly told staff in the dining area of Unit 2 that she allowed Resident #44 touch her until he got an erection. She knew any concerns about potential abuse should be reported to the facility's Administrator. She stated the incident she was talking about happened within the first five minutes of her working at the facility and she did not know who to report that to at the time and was shocked by what happened. On 01/28/25 at 3:25 P.M., an interview with CNA #188 revealed Resident #44 was known to have behaviors. He did not like to be bothered and would scream and yell at them. One side of his extremities was contracted, but he had the use of his left side. The resident was known to get touchy feely with the staff. They would tell him it was inappropriate behavior and he would just grin. She did not work with CNA #114 that often, as the other aide worked days, and she was on afternoons. They both worked Unit 2 where the resident resided. She had not witnessed any inappropriate interactions between CNA #114 and the resident, but recalled one time during report, CNA #114 told them what she allowed Resident #44 to do. CNA #114 rationalized allowing the resident to do that, as he was not able to do anything throughout the day, and that was something that made him happy. She described what she heard as something out of the norm when she heard that. She had never heard anyone talk like that before. She kind of knew CNA #114 and did not think she would hurt anyone. She then stated she kind of agreed and seen where CNA #114 was coming from, when saying the resident was not able to do anything and that made him happy. She commented that she would not do that personally. She was asked specifically what CNA #114 had said she allowed Resident #44 to do. She reported the aide commented about allowing Resident #44 to touch her breasts until he got hard. CNA #188 was uncertain if allowing a resident to touch her breast was sexual abuse or not. She stated she knew there was a fine line. She then said it would never be appropriate to engage in that type of behavior with a resident. The incident where she heard CNA #114 say what she allowed the resident to do happened about a month ago. She denied that she personally reported it to anyone. (continued on next page)

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	365612	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Acres Nursing Home	44565 Sunset Road Caldwell, OH 43724

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/28/25 at 4:45 P.M., an interview with the facility's Administrator revealed he was the facility's abuse coordinator and was the one that investigated and reported allegations of abuse. The staff were taught to notify their supervisor immediately, at the time of the alleged abuse. It would then need to be reported to him. They followed the State regulations when it came to investigating and reporting. Any allegation of physical abuse or something that was dangerous to the resident, they notified the State within two hours. They had five working days excluding weekends and holidays to complete their investigation and submit their final report. In the past 30 days, he reported he had a couple resident to resident abuse allegations, misappropriation of money (which was found in laundry), but no residents who were on the receiving end that he had been made aware of. He reported there had been an issue that Aide #148 and CNA #127 came to him about. He was told by Aide #148 that a male resident touched her breast and the aide felt that was inappropriate. He asked who was with her and was told CNA #114. He claimed it was reported to him that the male resident brushed against the aide's breast. He informed the aide that was not appropriate and she needed to redirect the resident with that inappropriate behavior. He informed Aide #148 that the behavior was not acceptable or condoned in the facility. He discussed residents with certain behaviors based on their diagnoses that made them act in different ways and she needed to know how to respond to the behaviors. He denied he had spoken with CNA #114 following that reported incident. He was not real familiar with Resident #44, but advised the staff they needed to use caution with any resident. The facility's DON was not there on that day, so he told the staff he would follow up with her (DON) when she came back. He believed the staff members came to him to talk about that, due to the facility's DON not being there at the time. None of the behaviors they described to him was done towards Resident #44, as it was done towards the staff member. He talked with the two aides for about 10-15 minutes with both present at the same time. He denied that he had any other employees sit in during the meeting as a witness. He left it (the concern) open ended for nursing to follow up with because it was a resident initiated behavior. He did not feel the resident was abused or neglected, which would have been reportable. He denied that the two staff members he talked with mentioned anything about any comments CNA#114 made to them about allowing Resident #44 to touch them or that CNA #114 allowed him to touch her breasts until he got an erection. He denied that he had instructed the aides not to talk about that with anyone. He did report he told them he would handle it. He denied he had submitted any self reporting incidents or completed an investigation pertaining what was reported to him. On 01/29/25 at 9:15 A.M., a follow up interview with CNA #127 reconfirmed she was present when Aide #148 talked to the Administrator about what took place with Resident #44. She indicated the meeting with the Administrator occurred on 01/13/25. She was in the office when Aide #148 reported to the Administrator what had taken place. She denied Aide #148 only told the Administrator about the resident brushing up against her (Aide #148's) breasts. They informed him that CNA #114 was saying that she allowed Resident #44 to touch her breast. She reported the word fondled was used when they told the Administrator about the comment CNA #114 made about allowing the resident to fondle her until he got a hard on. She denied the discussion was about the resident brushing against Aide #148's breast. It was about the resident grabbing and holding CNA #114's breasts. She further confirmed the Administrator told them not to talk about it with anyone and that he would handle it. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Summit Acres Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 44565 Sunset Road Caldwell, OH 43724	

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/29/25 at 3:18 P.M., an interview with Aide #325 revealed she had heard Aide #148 say that Resident #44 had tried touching her breasts, but she did not allow him to. She also heard, when the two (CNA #114 and Aide #48) left the resident's room, CNA #114 was telling Aide #148 that it was okay to allow him to do that because she (CNA #114) let him. Aide #148 then told her and another aide that CNA #114 allowed the resident to get an erection. She denied she had witnessed anything personally between CNA #114 and Resident #44. The only knowledge she had was what Aide #148 had told her. She instructed Aide #148 to tell CNA #127. It was then communicated to LPN #174, who informed them that they needed to tell the Administrator. She denied she or Aide #148 were asked to write any statements. She thought that was odd that they did not ask her to do that, as she knew that was typically done with any investigation. She was told Hospitality Aide #187 had witnessed inappropriate things between CNA #114 and Resident #44 too. She identified another aide (CNA #213), who reportedly witnessed CNA #114 allow Resident #44 to touch her breasts. She felt that something needed to be done about it and did not feel they were. On 01/29/25 at 4:02 P.M., an interview with CNA #213 revealed he worked often with CNA #114 on day shift and on Unit 2. He was only aware of one incident that involved anything happening between CNA #114 and Resident #44. He recalled they (him and CNA #114) were giving Resident #44 a bed bath. They were about done when the resident reached out and grabbed CNA #114's breast. He intervened and told the resident that that was not appropriate behavior. He denied CNA #114 had attempted to redirect the resident's behavior or to remove his hand. He removed the resident's hand off the other aides breast and then they rolled the resident towards him. His hand was only on her breast for a few seconds. CNA #114 made a comment that the resident did that all the time. While rolling the resident over towards him, he noticed the resident was aroused. When asked to explain what he meant by the resident being aroused, he stated the resident was hard (meaning an erection). He denied there was any indication the other aide allowed that to occur. It was just her comment that he (Resident #44) did it all the time that he took as her allowing the resident to do that. He felt she (CNA #114) allowed that behavior from Resident #44, so she could do care on him, as he could be a difficult resident. Review of the facility's self reporting incidents (SRI's) that had been submitted in the past three months revealed there had been four SRI's submitted during that time. None of the SRI's submitted involved an allegation of sexual abuse pertaining to Resident #44 and involving CNA #114. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Summit Acres Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE: 44565 Sunset Road Caldwell, OH 43724	

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's abuse policy (not dated) revealed it was the policy of the facility not to tolerate mistreatment, abuse, neglect, or misappropriation of it's residents by anyone. It was also the policy of the facility to investigate all allegations, suspicions, and incidents of abuse, neglect, and injuries sustained by its residents. Facility staff should report all such allegations to the Administrator and the Ohio Department of Health (ODH) in accordance with the procedures in this policy. While the policy provided general guidelines, it was not meant to to overrule clinical judgement where such judgement was appropriate. The definition of abuse was willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. It did not define sexual abuse. Training of staff was to be completed upon orientation and periodically thereafter regarding the facility's policy concerning abuse. Those training sessions were to include how to identify abuse and how staff should report their knowledge related to the allegations. Response to allegations or suspicions of abuse included the need for staff to report all incidents immediately to their direct supervisors. All allegations of abuse must be reported immediately to both the Administrator and to ODH. For purposes of that policy, immediately meant as soon as possible, but ought not to exceed 24 hours after the incident. Once the Administrator and ODH were notified, an investigation of the allegation or suspicion would be conducted. The investigation was to be completed within five working days (excluding weekends or legal holidays). 2. Review of Resident #46's medical record revealed he was admitted to the facility on [DATE]. His diagnoses included Lewy Body dementia, Alzheimer's disease, metabolic encephalopathy, abnormalities of gait and mobility, and need for assistance with personal care. Review of Resident #46's admission MDS assessment dated [DATE] revealed the resident had clear speech and adequate hearing. He was sometimes able to make himself understood and was sometimes able to understand others. His vision was highly impaired without the use of any corrective devices. His cognition was severely impaired and he was known to display behaviors that included hallucinations and physical behaviors directed at others. He was not indicated to have rejected any care during his assessment period. He was dependent on staff for toileting hygiene, bed mobility, and transfers. He was coded as always being incontinent of his bowel and bladder and was at risk for pressure ulcers, but not have any pressure ulcers at the time of the assessment. Review of Resident #46's active care plans revealed the resident had a care plan in place for being incontinent of his bladder. Interventions included the need to check and provide incontinence care as needed. They were to provide physical support/ assist for toileting safety as indicated for the resident. Further review of Resident #46's care plans revealed he had a care plan in place for being at risk for skin breakdown related to impaired mobility, impaired cognition, and bladder and bowel incontinence. The goal was for the resident to not develop any skin breakdown. The interventions included assisting the resident as needed with turning and positioning frequently when in bed; observe resident for any incontinence episodes and provide incontinence care as needed; and apply protective barrier after each incontinent episode. Review of Resident #46's nurses' progress notes revealed a nurse's noted dated 12/28/24 at 4:07 A.M. that revealed staff reported excoriation to the resident's buttocks. The physician was notified and a treatment was initiated for cleansing the area with normal saline and apply Triad cream to the resident's buttocks. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nurse's progress note dated 12/30/24 at 11:36 A.M. revealed an initial review was completed for a wound the resident had to his left buttocks. Treatment had been initiated as per the 12/28/24 note, but also specified it was to be completed twice a day and prn and it was to be left open to air. Review of Resident #46's physician's orders revealed a treatment was put in place for an area to the left buttock beginning on 12/30/24. The treatment initiated was the same treatment indicated in the nurse's note dated 12/30/24. A physician's order was given on 12/31/24 for treatment to an area on the resident's right buttock. The treatment initiated was the same treatment that had been in place for the left buttock. Review of Resident #46's wound observation reports under the electronic medical record (EMR) revealed a wound observation dated 12/30/24 that indicated the resident was observed to have a Stage I pressure ulcer (intact skin with localized area of non-blanchable redness) to the right buttock. The date the wound was identified was on 12/30/24. It measured 12 centimeters (cm) x 6 cm at date of onset. There was no wound observation report for any wound observations for an area on the resident's left buttock. Subsequent wound observations for Resident #46's Stage I pressure ulcer to the right buttock revealed the wound further deteriorated to a Stage II pressure ulcer (partial thickness loss of skin with exposed dermis) on 01/06/25 and remained as a Stage II pressure ulcer when it was last assessed on 01/27/25. Upon it's last assessment, the Stage II pressure ulcer to the right buttock measured 0.8 cm x 0.2 cm x 0.1 cm. The wound was closed- resurfaced and had not exudate (drainage). On 01/27/25 at 1:32 P.M., an interview with CNA #127 revealed Resident #46 was known to have a sore on his buttocks from being left on a bed pan. She was not there at the time, but was told the resident was left on the bedpan for about 14 hours. There was an actual ring on his buttocks caused by the bedpan. She could not recall exactly when that occurred, but stated the resident was placed on the bedpan during the afternoon shift and was not taken off until sometime during the night shift. The resident still had an imprint of the bedpan on his legs and buttocks and currently had an open area that was closing up. On 01/27/25 at 1:46 P.M., an interview with CNA #223 revealed the incident with Resident #46 being left on the bedpan happened when she was on vacation. When she returned to work, the areas to his buttocks were there. She had heard the skin issue was the result of the resident being left on a bedpan. She stated you could tell the area was caused by a bedpan based on the marks it left on his skin. He currently had areas on both his buttocks. She did not feel the resident being left on the bedpan was intentional, but should not have happened. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Summit Acres Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE: 44565 Sunset Road Caldwell, OH 43724	

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/27/25 at 1:57 P.M., an interview with Licensed Practical Nurse (LPN) #174 revealed Resident #46 did have skin issues, but she was not sure if they were being classified as pressure ulcers or not. She confirmed the areas were on his buttocks. She was asked how he got those areas and replied the resident was left on a bedpan for an extended period of time. She reported he was placed on a bedpan during the afternoon shift and remained on it into the night shift. She was not certain when that took place, but felt it was likely the end of December 2024. She seen the areas after it was first noted. He had an impression of a bedpan on his buttocks and upper, posterior legs. She denied it was open at it's onset, but did eventually open up. She reported the facility did investigate the concern. She was not sure what staff were involved in the incident. They continued to monitor the resident's buttocks and the area was looking better. The left buttock was also indicated to have been healed. She did not feel leaving the resident on the bedpan was intentional. She had heard he was on the bedpan up until around 4:00 A.M. She could not explain why the resident would not have been found on the bedpan earlier than he was. She confirmed the resident should have been checked and changed every two hours. She recalled being there when the day shift aides informed the afternoon shift aides at shift change (2:00 P.M.) that the resident was on the bedpan and would need assistance getting off. She would have assumed rounds did not get done on the afternoon shift or during the first part of the night shift, as he was not found on the bedpan until 4:00 A.M. that following morning. Review of the facility's self reporting incidents (SRI's) revealed there was no SRI that had been submitted to the State survey agency (ODH) that pertained to any allegations of neglect. They had two SRI's that were pending next onsite review. One pertained to an allegation of physical and verbal/ emotional abuse and the other pertained to sexual abuse involving one resident inappropriately touching another resident. There were two others that had been provided by the facility involving a misappropriation or property and a resident to resident altercation that had been closed with no action necessary. None of the SRI's pertained to an allegation of neglect for Resident #46. During the survey, the facility's corporate support staff (Corporate Nurse #225 and Corporate Nurse #300) was asked to provide any investigation the facility had done on behalf of Resident #46 and the issue where he had reportedly been left on a bedpan for an extended amount of time. The facility's Director of Nursing (DON) had previously provided a file with an investigation pertaining to Resident #46's development of his pressure ulcer that was the result of him being left on the bedpan for an extended amount of time. It did not address the potential neglect of the resident for being left on a bedpan for an extended period of time, which resulted in the development of a pressure ulcer. When asked if they submitted an SRI for neglect of Resident #46, they provided a second file they had that addressed the neglect of the resident. The DON confirmed a SRI had not been completed for an allegation of neglect, but provided the second file as evidence that the concern had been investigated. Review of the facility's investigation file pertaining to Resident #46 and him being left on the bedpan revealed it included an established timeline of the events, statements obtained from four staff directly involved in the incident, a body assessment that had been performed on Resident #46, evidence of a whole house skin sweep of all residents, education provided to staff, and audits that had been completed by the facility since the incident occurred. Review of the timeline that was included as part of the facility's investigation revealed Resident #46 was noted to have a skin assessment completed on 12/28/24 by two separate nurses beginning at 4:00 A.M. On-call physician's service was contacted and treatment was initiated for a reported skin area. (continued on next page)

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Summit Acres Nursing Home	44565 Sunset Road Caldwell, OH 43724

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #46's skin assessment that was completed on 12/30/24 revealed the assessment was documented using a body diagram form. It documented wounds the resident was noted to have after being left on the bedpan for an extended period of time. The body diagram described the areas where red lines were noted. The resident was noted to have a red outline from the bedpan that started at the lower back, upper buttock area midway over the left buttock. It was a slightly diagonal line that was shaped like a backwards L with the base of the L slightly higher than the start of it ending about 3/4 of the way above the right buttock/ flank area. The base of the L then extended down to the upper part of the right buttock. A curved line shaped like a backwards C then extended from the end of the base of the L down the resident's right outer buttock ending below his gluteal fold near the inner, upper, posterior leg. The diagram indicated the red outline was blanchable. Review of a written statement by Hospitality Aide #187 dated 12/30/24 revealed she came in to work (on 12/27/24) at 5:00 P.M. She indicated she was aware Resident #46 was dependent on staff and claimed she had informed the other aide (Aide #335) whom she was working with of the same. She was also aware he (Resident#46) needed to be checked and changed. She took responsibility for not checking him (Resident #46). She was watching another resident, but stated that was no reason. Review of a written statement by Registered Nurse (RN) #117 dated 12/30/24 revealed she had given Resident #46 his medications the evening of 12/27/24. She stated the resident did not appear to be on a bedpan at that time. A staff member (Hospitality Aide #187) summoned her back to the resident's room approximately at 4:00 A.M. on 12/28/24 to look at the resident. Upon entering the resident's room, Aide #335 was assisting the resident with care and a bedpan was noted on the floor. A body assessment was completed with a dark purple outline from the bedpan being noted to the resident's right buttocks. The aides informed the nurse that previous rounds were not completed on the resident due to him sleeping. The nurse immediately disciplined the two aides on duty for the incident and not providing care to the resident the majority of their shift. Review of a written statement by Aide #335 dated 12/31/24 revealed when they got around to their check and changes it was extremely late, due to behaviors. When the other aide had helped her in Resident #46's room, they discovered he had been put on a bedpan. They notified the nurse when they found him and she came back to assess him. He had a ring around his bottom from the amount of time he had been left on the bedpan. Review of a written statement by CNA #171 dated 12/31/24 revealed she worked day shift (12/27/24) on Unit 2 before working on the memory care unit on the 2:00 P.M. to 10:00 P.M. shift. She indicated one of the girls (aides) was walking down the hall giving CNA #131 report and told her Resident #46 was on the bedpan. The day shift girls stated they told them he was on the bedpan, but she could not remember. When report was over, she started to give showers and taking residents in the dining room to the restroom. Hospitality Aide #187 stated she would do Resident #46's bed bath, since she did the others. Hospitality Aide #187 also fed the resident dinner. She (CNA #171) took all the residents in the dining room to the bathroom (after dinner) and changed them, but she did not go down the hall that evening except to pick up trays. Review of the education provided to the nursing staff following the incident involving Resident #46 being left on the bedpan revealed the facility's DON educated the nursing staff (aides and nurses) on the need for residents to be checked and changed every two hours. They were also informed that residents should only be left on the bedpan for five to 10 minutes. Staff were also educated on the definition of dependent residents and the facility's incontinence care policy and procedures. (continued on next page)

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	365612	A. Building B. Wing	01/30/2025

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/27/25 at 3:09 P.M., an observation of Resident #46's skin revealed the resident had four separate areas on his buttocks (two on the left buttock and two on the right buttock). Both sides of his buttocks had [TRUNCATED]

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on record review, review of the facility's related investigation, staff interview, and policy review, the facility failed to ensure an allegation of sexually inappropriate behavior between a resident and a staff member was recognized as possible sexual abuse and investigated as required. This affected one resident (#44) of four residents reviewed for abuse/ neglect. Findings include: Review of Resident #44's medical record revealed he was admitted to the facility on [DATE]. His diagnoses included a traumatic brain injury, dementia with behavioral disturbances, pseudobulbar affect, restlessness and agitation, mood disorder, hemiplegia and hemiparesis affecting his right dominant side, contractures of the right upper extremity, abnormalities of gait and mobility, and need for assistance with personal care. Review of Resident #44's annual Minimum Data Set (MDS) assessment completed on 01/08/25 revealed the resident had adequate hearing and unclear speech. He was rarely/ never able to make himself understood and was rarely/ never able to understand others. He had highly impaired vision, without the use of any corrective lenses. Short and long term memory impairment was noted and his cognitive skills for daily decision making was severely impaired. He was known to display physical behaviors and verbal behaviors directed at others. He was also known to display other behaviors not directed at others. He had a functional limitation in his range of motion (ROM) on one side of his upper and lower extremities. He was dependent on staff for all his activities of daily living (ADL's). Review of Resident #44's active care plans revealed he had a care plan in place for being known to exhibit behaviors that included physical aggression towards staff (kicking, pinching, grabbing, scratching, biting, slapping, and punching). He also was known to have inappropriate touching of female staff. The care plan had been in place since 02/01/23. The goal was for the resident to not harm himself or others during daily care. The interventions included the need for the staff to approach the resident in a calm manner and offer a different time of his choice when refusing care; when the resident was physically abusive towards staff, they were to attempt to redirect the resident, or allow time for resident to calm down and attempt at a later time; they were to maintain a calm environment and provide a consistent approach with the resident as able; they were to observe for behaviors that endangered the resident and/or others; staff to carefully intervene to promote safety; obtain a psychiatric consult/ psychosocial therapy/ psychiatric therapy as ordered by the physician; staff were to observe for any activity or events that trigger the resident's behavior and re-direct/ divert his attention to prevent exacerbation; when the resident was exhibiting behaviors, staff were to keep the resident and others safe. Review of Resident #44's physician's orders revealed the resident had orders in place to receive Remeron 7. 5 milligrams (mg) by mouth every night at bedtime for depression. He also received Vistaril 25 mg by mouth twice a day for agitation. He was not receiving any other psychoactive medications or any other medications to reduce any inappropriate sexual behaviors. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #44's nurses' progress notes revealed a nurse's note dated 11/03/24 at 8:00 A.M. that indicated the resident was noted to grab when the staff provided care and attempted to bite, pinch, and hit with his left hand. His right hand and arm were noted to be contracted and the resident held it closely to his body. None of the progress notes documented anything about any known sexually related behaviors. On 01/27/25 at 1:32 P.M., an interview with Certified Nursing Assistant (CNA) #127 revealed she had not personally witnessed any sexually inappropriate behavior involving Resident #44, but had heard three different trainees say the same thing about CNA #114 (who mentored them) that CNA #114 allowed Resident #44 to fondle her breasts. She identified Aide #148 as one of the aides that trained under CNA #114 that had knowledge of that and who took it to the Administrator to report it. She stated she accompanied Aide #148 to the Administrator's office, when the aide reported it. She was not sure if the Administrator had done anything about it or not. She further identified a second aide (Hospitality Aide #187) that was also trained by CNA #114 and was told by her trainer that allowing Resident #44 to touch their breasts was okay. She identified a third aide (CNA #188), as being another aide that had heard CNA #114 say, while in the Unit 2 dining room, she had allowed Resident #44 to touch her breast until he became erect. On 01/28/25 at 9:45 A.M., an interview with Aide #148 confirmed she was trained by CNA #114. She recalled providing care to Resident #44, with CNA #114, when the resident tried touching her (Aide #148's) breasts. She stated she stepped back and was told by CNA #114 that it would be fine if she allowed the resident to do that. She (CNA #114) rationalized that sexually inappropriate behavior by saying it was the only excitement the resident got during the day. She reported she had also heard from another aide CNA #114 had told them the same thing. She identified that other aide as Hospitality Aide #187. She described the resident's action as him knowing what he was doing and it was not an accidental touching of her breasts. She then reported the two of them then went up to the front of the unit by the dining room where CNA #114 told the staff that were up there that she had allowed Resident #44 touch her until he got hard, meaning an erection. She reported the incident happened about a week or two ago. She knew at the time it was inappropriate behavior and knew if her mentor was allowing the resident to do that to her, then the resident would think he could do that to others. She reported everyone (her coworkers) were saying that was sexual abuse and she felt the same. She stated the whole incident made her feel uncomfortable, especially hearing CNA #114 joke about that. She confirmed she reported it to the facility's Administrator the next day, with CNA #127 accompanying her. She claimed she had told the Administrator what had happened. CNA #127 added that it was not right that CNA #114 was training new aides and telling them that was okay. They were concerned that CNA #114 was also training younger aides that were only [AGE] years old. The Administrator told her he was glad they said something about that and that it was horrible. He then told them not to talk about it to anyone and he would handle it. She had not seen any evidence that it had been handled, as CNA #114 had been back to work, and nothing seemed to have changed. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/28/25 at 11:49 A.M., an interview with Hospitality Aide #187 revealed she received her training back in August 2024. She was trained by CNA #114 and was trained on Unit 2, where Resident #44 resided. She was familiar with the resident and knew he had behaviors that needed to be redirected. His behaviors included him trying to touch them with his hands and he went for the chest area. She recalled the first day she worked with CNA #114 Resident #44 had his hands on CNA #114's breasts. The resident's left hand was on the CNA's breast and CNA #114 made no attempt to redirect his behavior or remove his hand. She (CNA #114) made some comment about that calming him down for a second and it allowed them to get what they needed done so they could leave. She denied CNA #114 had ever told her to allow the resident to do that to her. She felt what she witnessed was inappropriate and felt that it may have been considered sexual abuse. She denied that she reported it to anyone at the time. She knew it had since been reported by someone else. She denied she was one of the staff members that were present when CNA #114 allegedly told staff in the dining area of Unit 2 that she allowed Resident #44 touch her until he got an erection. She knew any concerns about potential abuse should be reported to the facility's Administrator. She stated the incident she was talking about happened within the first five minutes of her working at the facility and she did not know who to report that to at the time and was shocked by what happened. On 01/28/25 at 3:25 P.M., an interview with CNA #188 revealed Resident #44 was known to have behaviors. He did not like to be bothered and would scream and yell at them. One side of his extremities was contracted, but he had the use of his left side. The resident was known to get touchy feely with the staff. They would tell him it was inappropriate behavior and he would just grin. She did not work with CNA #114 that often, as the other aide worked days, and she was on afternoons. They both worked Unit 2 where the resident resided. She had not witnessed any inappropriate interactions between CNA #114 and the resident, but recalled one time during report, CNA #114 told them what she allowed Resident #44 to do. CNA #114 rationalized allowing the resident to do that, as he was not able to do anything throughout the day, and that was something that made him happy. She described what she heard as something out of the norm when she heard that. She had never heard anyone talk like that before. She kind of knew CNA #114 and did not think she would hurt anyone. She then stated she kind of agreed and seen where CNA #114 was coming from, when saying the resident was not able to do anything and that made him happy. She commented that she would not do that personally. She was asked specifically what CNA #114 had said she allowed Resident #44 to do. She reported the aide commented about allowing Resident #44 to touch her breasts until he got hard. She was uncertain if allowing a resident to touch her breast was sexual abuse or not. She stated she knew there was a fine line. She then said it would never be appropriate to engage in that type of behavior with a resident. The incident where she heard CNA #114 say what she allowed the resident to do happened about a month ago. She denied that she personally reported it to anyone. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/28/25 at 4:45 P.M., an interview with the facility's Administrator revealed he was the facility's abuse coordinator and was the one that investigated and reported allegations of abuse. The staff were taught to notify their supervisor immediately, at the time of the alleged abuse. It would then need to be reported to him. They followed the State regulations when it came to investigating and reporting. Any allegation of physical abuse or something that was dangerous to the resident, they notified the State within two hours. They had five working days excluding weekends and holidays to complete their investigation and submit their final report. In the past 30 days, he reported he had a couple resident to resident abuse allegations, misappropriation of money (which was found in laundry), but no residents who were on the receiving end that he had been made aware of. He reported there had been an issue that Aide #148 and CNA #127 came to him about. He was told by Aide #148 that a male resident touched her breast and the aide felt that was inappropriate. He asked who was with her and was told CNA #114. He claimed it was reported to him that the male resident brushed against the aide's breast. He informed the aide that was not appropriate and she needed to redirect the resident with that inappropriate behavior. He informed Aide #148 that the behavior was not acceptable or condoned in the facility. He discussed residents with certain behaviors based on their diagnoses that made them act in different ways and she needed to know how to respond to the behaviors. He denied he had spoken with CNA #114 following that reported incident. He was not real familiar with Resident #44, but advised the staff they needed to use caution with any resident. The facility's DON was not there on that day, so he told the staff he would follow up with her (DON) when she came back. He believed the staff members came to him to talk about that, due to the facility's DON not being there at the time. None of the behaviors they described to him was done towards Resident #44, as it was done towards the staff member. He talked with the two aides for about 10-15 minutes with both present at the same time. He denied that he had any other employees sit in during the meeting as a witness. He left it (the concern) open ended for nursing to follow up with because it was a resident initiated behavior. He did not feel the resident was abused or neglected, which would have been reportable. He denied that the two staff members he talked with mentioned anything about any comments CNA#114 made to them about allowing Resident #44 to touch them or that CNA #114 allowed him to touch her breasts until he got an erection. He denied that he had instructed the aides not to talk about that with anyone. He did report he told them he would handle it. He denied he had submitted any self reporting incidents or completed an investigation pertaining what was reported to him. On 01/29/25 at 9:15 A.M., a follow up interview with CNA #127 reconfirmed she was present when Aide #148 talked to the Administrator about what took place with Resident #44. She indicated the meeting with the Administrator occurred on 01/13/25. She was in the office when Aide #148 reported to the Administrator what had taken place. She denied Aide #148 only told the Administrator about the resident brushing up against her (Aide #148's) breasts. They informed him that CNA #114 was saying that she allowed Resident #44 to touch her breast. She reported the word fondled was used when they told the Administrator about the comment CNA #114 made about allowing the resident to fondle her until he got a hard on. She denied the discussion was about the resident brushing against Aide #148's breast. It was about the resident grabbing and holding CNA #114's breasts. She further confirmed the Administrator told them not to talk about it with anyone and that he would handle it. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/29/25 at 3:18 P.M., an interview with Aide #325 revealed she had heard Aide #148 say that Resident #44 had tried touching her breasts, but she did not allow him to. She also heard, when the two (CNA #114 and Aide #48) left the resident's room, CNA #114 was telling Aide #148 that it was okay to allow him to do that because she (CNA #114) let him. Aide #148 then told her and another aide that CNA #114 allowed the resident to get an erection. She denied she had witnessed anything personally between CNA #114 and Resident #44. The only knowledge she had was what Aide #148 had told her. She instructed Aide #148 to tell CNA #127. It was then communicated to LPN #174, who informed them that they needed to tell the Administrator. She denied she or Aide #148 were asked to write any statements. She thought that was odd that they did not ask her to do that, as she knew that was typically done with any investigation. She was told Hospitality Aide #187 had witnessed inappropriate things between CNA #114 and Resident #44 too. She identified another aide (CNA #213), who reportedly witnessed CNA #114 allow Resident #44 to touch her breasts. She felt that something needed to be done about it and did not feel they were. On 01/29/25 at 4:02 P.M., an interview with CNA #213 revealed he worked often with CNA #114 on day shift and on Unit 2. He was only aware of one incident that involved anything happening between CNA #114 and Resident #44. He recalled they (him and CNA #114) were giving Resident #44 a bed bath. They were about done when the resident reached out and grabbed CNA #114's breast. He intervened and told the resident that that was not appropriate behavior. He denied CNA #114 had attempted to redirect the resident's behavior or to remove his hand. He removed the resident's hand off the other aides breast and then they rolled the resident towards him. His hand was only on her breast for a few seconds. CNA #114 made a comment that the resident did that all the time. While rolling the resident over towards him, he noticed the resident was aroused. When asked to explain what he meant by the resident being aroused, he stated the resident was hard (meaning an erection). He denied there was any indication the other aide allowed that to occur. It was just her comment that he (Resident #44) did it all the time that he took as her allowing the resident to do that. He felt she (CNA #114) allowed that behavior from Resident #44, so she could do care on him, as he could be a difficult resident. Review of the facility's self reporting incidents (SRI's) that had been submitted in the past three months revealed there had been four SRI's submitted during that time. None of the SRI's submitted involved an allegation of sexual abuse pertaining to Resident #44 and involving CNA #114. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2025
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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's abuse policy (not dated) revealed it was the policy of the facility not to tolerate mistreatment, abuse, neglect, or misappropriation of it's residents by anyone. It was also the policy of the facility to investigate all allegations, suspicions, and incidents of abuse, neglect, and injuries sustained by its residents. Facility staff should report all such allegations to the Administrator and the Ohio Department of Health (ODH) in accordance with the procedures in this policy. While the policy provided general guidelines, it was not meant to to overrule clinical judgement where such judgement was appropriate. The definition of abuse was willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. It did not define sexual abuse. Training of staff was to be completed upon orientation and periodically thereafter regarding the facility's policy concerning abuse. Those training sessions were to include how to identify abuse and how staff should report their knowledge related to the allegations. Response to allegations or suspicions of abuse included the need for staff to report all incidents immediately to their direct supervisors. All allegations of abuse must be reported immediately to both the Administrator and to ODH. For purposes of that policy, immediately meant as soon as possible, but ought not to exceed 24 hours after the incident. Once the Administrator and ODH were notified, an investigation of the allegation or suspicion would be conducted. The investigation was to be completed within five working days (excluding weekends or legal holidays). This deficiency represents non-compliance investigated under Complaint Number OH00161702.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY Based on record review, review of the facility's related investigation, observation, staff interview, and policy review, the facility failed to ensure a resident who entered the facility without any skin breakdown received the care and services to prevent an avoidable pressure ulcer from developing. This affected one resident (#46) of two residents reviewed for pressure ulcers. Findings include: Review of Resident #46's medical record revealed he was admitted to the facility on [DATE]. His diagnoses included Lewy Body dementia, Alzheimer's disease, metabolic encephalopathy, abnormalities of gait and mobility, and need for assistance with personal care. Review of Resident #46's admission MDS assessment dated [DATE] revealed the resident had clear speech and adequate hearing. He was sometimes able to make himself understood and was sometimes able to understand others. His vision was highly impaired without the use of any corrective devices. His cognition was severely impaired and he was known to display behaviors that included hallucinations and physical behaviors directed at others. He was not indicated to have rejected any care during his assessment period. He was dependent on staff for toileting hygiene, bed mobility, and transfers. He was coded as always being incontinent of his bowel and bladder and was at risk for pressure ulcers, but did not have any pressure ulcers at the time of the assessment. Review of Resident #46's active care plans revealed the resident had a care plan in place for being incontinent of his bladder. Interventions included the need to check and provide incontinence care as needed. They were to provide physical support/ assist for toileting safety as indicated for the resident. Further review of Resident #46's care plans revealed he had a care plan in place for being at risk for skin breakdown related to impaired mobility, impaired cognition, and bladder and bowel incontinence. The goal was for the resident to not develop any skin breakdown. The interventions included assisting the resident as needed with turning and positioning frequently when in bed; observe resident for any incontinence episodes and provide incontinence care as needed; and apply protective barrier after each incontinent episode. Review of Resident #46's nurses' progress notes revealed a nurse's note dated 12/28/24 at 4:07 A.M. that revealed staff reported excoriation to the resident's buttocks. The physician was notified and a treatment was initiated for cleansing the area with normal saline and apply Triad cream to the resident's buttocks. A nurse's progress note dated 12/30/24 at 11:36 A.M. revealed an initial review was completed for a wound the resident had to his left buttocks. Treatment had been initiated as per the 12/28/24 note, but also specified it was to be completed twice a day and as needed (prn) and it was to be left open to air. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #46's physician's orders revealed a treatment was put in place for an area on the left buttock beginning on 12/30/24. Treatment initiated was same treatment indicated in the nurse's note dated 12/30/24. A physician's order was given on 12/31/24 for treatment to an area on the resident's right buttock. The treatment initiated was the same treatment that had been in place for the left buttock. Review of Resident #46's wound observation reports under the electronic medical record (EMR) revealed a wound observation dated 12/30/24 that indicated the resident was observed to have a Stage I pressure ulcer (intact skin with localized area of non-blanchable redness) to the right buttock. The date the wound was identified was on 12/30/24. It measured 12 centimeters (cm) x 6 cm at date of onset. Subsequent wound observations for Resident #46's Stage I pressure ulcer to the right buttock revealed the wound further deteriorated to a Stage II pressure ulcer (partial thickness loss of skin with exposed dermis) on 01/06/25 and remained as a Stage II pressure ulcer when it was last assessed on 01/27/25. Upon it's last assessment, the Stage II pressure ulcer to the right buttock measured 0.8 cm x 0.2 cm x 0.1 cm. The wound was closed- resurfaced and had no exudate (drainage). There were no current wound observations for any areas the resident had on his left buttock due to reports the left buttock wound had resolved. On 01/27/25 at 1:32 P.M., an interview with Certified Nursing Assistant (CNA) #127 revealed Resident #46 was known to have a sore on his buttocks from being left on a bed pan. She was told the resident was left on the bedpan for about 14 hours, which resulted in the sore on his buttock. There was an actual ring on his buttocks from the bedpan. She could not recall exactly when that occurred, but stated the resident was placed on the bedpan during the afternoon shift and was not taken off until sometime during the night shift. The resident still had an imprint of the bedpan on his legs and buttocks and currently had an open area that was starting to close up. On 01/27/25 at 1:46 P.M., an interview with CNA #223 revealed the incident with Resident #46 being left on the bed pan happened when she was on vacation. When she returned to work, the areas to his buttocks were there. She had heard the skin issue was the result of him being left on a bedpan. She stated you could tell the area was caused by a bedpan based on the marks it left on his skin. He currently had areas on both his buttocks. She did not feel the resident being left on the bedpan was intentional, but she stated it should not have happened. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/27/25 at 1:57 P.M., an interview with Licensed Practical Nurse (LPN) #174 revealed Resident #46 did have skin issues, but she was not sure if they were being classified as pressure ulcers or not. She confirmed the areas were on his buttocks. She was asked how he got that area and replied the resident was left on a bedpan for an extended period of time. She reported he was placed on a bedpan during the afternoon shift and remained on it into the night shift. She was not certain when that took place, but felt it was likely the end of December 2024. She saw the areas after it was first noted. He had an impression of a bedpan on his buttocks and on his upper, posterior legs. She denied it was open at it's onset, but did eventually open. She reported the facility did investigate the concern. She was not sure what staff were involved in the incident. They continued to monitor the resident's buttocks and the area was looking better. The left buttock was also indicated to have been healed. She had heard the resident was left on the bedpan until around 4:00 A.M. She could not explain why the resident would not have been found on the bedpan earlier than he was. She confirmed the resident should have been a check and change every two hours. She recalled being there when the day shift aides informed the afternoon shift aides at shift change (2:00 P.M.) that the resident was on the bed pan and would need assistance getting off. She would have assumed rounds did not get done on the afternoon shift or during the first part of the night shift, as he was not found still on the bedpan until 4:00 A.M. that following morning. On 01/27/25 at 3:09 P.M., an observation of Resident #46's skin revealed the resident had four separate areas on his buttocks (two on the left buttock and two on the right buttock). Both sides of his buttocks had open areas present that were superficial and presented as Stage II pressure ulcers. He still had red marks on his skin that ran vertically on his left buttock and horizontally on his right buttock. There was a small red mark that ran vertically from the end of the horizontal line on his right buttock down about four inches. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/27/25 at 3:38 P.M., an interview with RN #117 revealed she was the night shift nurse working on the memory care unit on 12/27/24 into 12/28/24, when Resident #46 was found to have the areas on his buttocks that was related to being left on a bedpan. She recalled the aides came up to her desk at around 4:00 A.M. and reported the resident had new skin areas. She and another nurse went and assessed the resident's skin. The resident had the whole bedpan ring imprinted on his buttocks that was more significant on the right side of his buttocks. The ring was a purple indentation that was blanchable at the time. She didn't know at the time, but was informed in the morning, when she called the DON, that a day shift aide working 12/28/24 said they had put the resident on the bedpan at the request of the resident's daughter the day before. That was how she was able to determine how long he had been on the bedpan before he was found. She denied that it was likely the resident had been taken off the bedpan and then put back on at some point during the afternoon shift, as he was not one to use the bedpan. He did not know when he had to go. She reported the aides that worked the afternoon shift on 12/27/24 would have been Hospitality Aide #187 and CNA #171. She confirmed Hospitality Aide #187 came in later in the shift, around 5:00 P.M. and CNA #131 was there with CNA #171, until Hospital Aide #187 came in. CNA #131 then went to work on another unit. She reported when she went to the office to talk to the DON about what happened, the DON was on the phone with CNA #171 and Hospitality Aide #187 was in the office talking about it too. She confirmed she gave a written statement on what had happened as part of a facility investigation. She denied she talked with the three afternoon shift aides to see if they had done anything with the resident during the evening of 12/27/24. Hospitality Aide #187 and Aide #335 worked the night shift from 10:00 P.M. to 6:00 A.M. going from 12/27/24 into 12/28/24. She did ask those aides if they had done anything with the resident that night before finding him still on the bedpan at 4:00 A.M. They told her they had been in his room before that, but he was sleeping, so they did not want to bother him. She stated the resident was one that the staff should have been checking every two hours and assisting him with incontinence care as needed. She felt the aides should have realized he was on the bedpan before 4:00 A.M., if they were checking him how they should have been. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/29/25 at 11:49 A.M., an interview with Hospitality Aide #187 confirmed she arrived to work on 12/27/24 at 5:00 P.M. and worked on the memory care unit. She recalled it was around supper time that she arrived. Resident #46 was in bed being fed by CNA #131. She denied she had any interactions with the resident between 5:00 P.M. on 12/27/24 until 4:00 A.M. on 12/28/24. She verified the resident was known to be incontinent and would have been one they needed to check and change every two hours. He was not able to inform the staff when he needed to go to the bathroom. To her knowledge CNA #171 went in the resident's room, but she guessed the aide must not have. She denied she had seen CNA #171 provide any care to Resident #46, after she came in to work at 5:00 P.M. She confirmed she was in the lounge/ dining area, so she may not have seen who went in or out of the resident's room. The resident was the only two person assist they had on that unit. They did not normally do rounds together. She stated she knew she should have went in to assist with the resident's care, since he was a two person assist. She confirmed she continued to work over into the night shift and worked the entire night shift. She denied that she went into the resident's room until they went in at 4:00 A.M. They seen that the resident was sleeping earlier in the night, so they did not want to bother him. They found him still on the bedpan when they went into his room at 4:00 A.M. They immediately notified the nurse when they found the resident still on his bedpan. The nurse came back and checked the resident. She was in the room at the time the nurse checked her and saw there were red marks on the resident's buttocks caused by the impression from the bedpan. She stated she was not sure how long the resident was on the bedpan. She was unaware he was on the bedpan when she came in at 5:00 P.M. She never saw him on a bedpan prior to finding him at 4:00 A.M. She confirmed she was given education on neglect, the need to do check and change rounds every two hours, and not to leave a resident on the bedpan longer than five to 10 minutes. Review of the facility's investigation file pertaining to Resident #46 and him being left on the bedpan revealed it included an established timeline of the events, statements obtained from four staff directly involved in the incident, a body assessment that had been performed on Resident #46, evidence of a whole house skin sweep of all residents, education provided to staff, and audits that had been completed by the facility since the incident occurred. Review of the timeline that was included as part of the facility's investigation revealed Resident #46 was noted to have a skin assessment completed on 12/28/24 by two separate nurses at 4:00 A.M. and again at 4:05 A.M. On-call physician's service was contacted and treatment was initiated for a reported skin area. Review of Resident #46's skin assessment that was completed on 12/30/24, as part of the facility's investigation, revealed the assessment was documented using a body diagram form. It documented wounds the resident was noted to have, after being left on the bedpan for an extended period of time. The body diagram showed the areas where red lines were noted. The resident was noted to have a red outline from the bedpan that started at the lower back/ upper buttock area midway over the left buttock. It was a slightly diagonal line that was shaped like a backwards L with the base of the L slightly higher than the start of it ending about 3/4 of the way above the right buttock/ flank area. The base of the L then extended down into the upper part of the right buttock. A curved line shaped like a backwards C then extended from the end of the base of the backwards L down the resident's right outer buttock ending below his gluteal fold near the inner, upper, posterior leg. The diagram indicated the red outline was blanchable. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a written statement by Hospitality Aide #187 dated 12/30/24 revealed she came in to work (on 12/27/24) at 5:00 P.M. She indicated she was aware Resident #46 was dependent on staff and claimed she had informed the other aide (Aide #335) that she was working with of the same. She was also aware he needed to be checked and changed. She wrote that she took responsibility for not checking him (Resident #46). She was watching another resident, but stated that was no reason. Review of a written statement by RN #117 dated 12/30/24 revealed she had given Resident #46 his medications the evening of 12/27/24. She stated he did not appear to be on a bedpan at that time. A staff member (Hospitality Aide #187) summoned her back to the resident's room approximately at 4:00 A.M. on 12/28/24 to look at the resident. Upon entering the resident's room, Aide #335 was assisting the resident with care and a bedpan was noted on the floor. A body assessment was completed with a dark purple outline from the bedpan being noted to the resident's right buttocks. The aides informed the nurse that previous rounds were not completed on the resident due to him sleeping. The nurse indicated in her statement that she immediately disciplined the two aides on duty for the incident and not providing care to the resident the majority of their shift. Review of a written statement by Aide #335 dated 12/31/24 revealed when they got around to their check and changes it was extremely late, due to behaviors. When the other aide had helped her in Resident #46's room, they discovered he had been put on a bedpan. They notified the nurse when they found him and she came back to assess him. He had a ring around his bottom from the amount of time he had been on the bedpan. Review of a written statement by CNA #171 dated 12/31/24 revealed she worked day shift (12/27/24) on Unit 2 and then worked on memory care unit on the 2:00 P.M. to 10:00 P.M. shift. She indicated one of the girls (aides) was walking down the hall giving CNA #131 report and told her the Resident #46 was on the bedpan. The day shift girls stated they told them he was on the bedpan, but she could not remember. When report was over, she started to give showers and taking residents in the dining room to the restroom. Hospitality Aide #187 stated she would do Resident #46's bed bath, since she did the others. Hospitality Aide #187 also fed the resident dinner. She (CNA #171) took all the residents in the dining room to the bathroom (after dinner) and changed them, but she did not go down the hall that evening except to pick up trays. Review of the education provided to the nursing staff following the incident involving Resident #46 being left on the bedpan revealed the facility's DON educated the nursing staff (aides and nurses) on the need to be checked and changed every two hours. They were also informed that residents should only be left on the bedpan for five to 10 minutes. Staff were also educated on the definition of dependent residents. Review of the employee file for Hospitality Aide #187 revealed she had a personnel action form in her file pertaining to the incident involving a resident (Resident #46) being left on a bedpan for an extended period of time causing skin injury. It was indicated to have been an official discipline. The DON followed up with the CNA on 12/30/24 and reviewed the disciplinary action with her and informed her that was her first offense. Review of the employee file for CNA #171 revealed she had a personnel action form that revealed she was given a third offense violation on 12/30/24 for failing to complete check and change on a resident (Resident #46) for a whole shift. She was given in report that the resident was on a bedpan, but did not check on him. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy on Routine Resident Checks (updated 10/20/22) revealed it was the facility's policy that routine resident checks should be made to ensure that the resident's safety and weel-being were maintained. To ensure the safety and well-being of the resident's, a resident check would be completed at least every two hours throughout each 24-hour shift by nursing service personnel. Routine resident checks involve entering the resident's room to determine if the resident had needs that needed to be met, such as a change in the resident's condition, if the resident needed toileted or changed, if the resident needed turned and repositioned etc. The deficient practice was corrected on 12/30/24 when the facility implemented the following corrective actions: On 12/28/24 at 4:05 A.M., a skin assessment was completed on Resident #46 by two nurses to identify areas of skin impairment. On 12/28/24 at 4:07 A.M., the on-call physician's service was notified and treatment was initiated. On 12/28/24, RN Supervisor provided one on one immediate education to two CNA's that were on duty at the time on completing every two hour checks. On 12/28/24 at 7:00 A.M., Resident #46's resident representative was notified of skin impairment and the treatment initiated. On 12/30/24, a whole house skin sweep was completed by the DON with no skin integrity issues noted. By 12/30/24, an education was completed by the DON for all nurses and CNA's on routine resident checks policy and procedure, meaning of a dependent resident, not leaving residents on the bedpan for more than five to 10 minutes, and incontinence care. Beginning 12/30/24, the DON or designee will complete random audits 3 x's/ week x 4 weeks and prn to ensure residents were checked and changed every two hours with results of those audits to be reviewed in Ad Hoc QAPI. On 01/28/25 at 10:10 A.M., 01/28/25 at 10:17 A.M., and 01/29/25 at 11:49 A.M., surveyor interviews were conducted with CNA #223, LPN #174, and Hospital Aide #187 respectively and confirmed they were provided education on the facility's abuse/ neglect policy, incontinence care, need to complete check and change rounds every two hours, and not to leave a resident on a bedpan for longer than five to 10 minutes. On 01/28/25 review of the facility audits revealed no concerns. This deficiency represents non-compliance investigated under Master Complaint Number OH00161816.