STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365619	A. Building B. Wing	12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy Bucyrus	1170 W Mansfield Street Bucyrus, OH 44820

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** 48568 Based on medical record review, staff interview, review of Self Reported Incidents (SRI), review of facility investigations, review of the local police report, and review of policies and procedures, the facility failed to prevent an inappropriate resident to resident altercation that was sexual in nature. This affected one resident (#105) out of three residents reviewed for abuse. Findings Include: Review of the medical record for Resident #105 revealed an admitted [DATE]. The resident was discharged on [DATE]. Diagnoses included hemiplegia and hemiparesis following other cerebrovascular disease affecting the right dominant side, cerebrovascular disease, dysphagia following cerebral infarction, and type two diabetes mellitus with chronic kidney disease. The resident was only admitted for a short term respite stay. Review of the Discharge Return Not Anticipated Minimum Data Set (MDS) assessment, dated 11/25/24, revealed Resident #105 did not have a brief interview for mental status (BIMS), cognitive assessment, or mood assessment completed. The assessment revealed Resident #105 did not present any behaviors. The resident required substantial/maximum assistance or was dependent for bed mobility, transfers, and ambulation. Review of the plan of care for Resident #105 revealed she required the use of psychotropic medications with the potential for adverse reactions related to depression. Interventions included administering medications per physicians orders, monitoring resident mood/behavior, and monitoring, documenting and reporting to the physician side effects and unaltered depression. Review of the medical record for Resident #82 revealed an initial admitted [DATE]. The resident was discharged to the hospital on 11/23/24 and readmitted to the facility on [DATE]. Diagnoses included paranoid schizophrenia, bipolar II disorder, and other symptoms and signs involving the musculoskeletal system. The resident was his own responsible party. Review of the quarterly Minimum Data Set (MDS) assessment, dated 11/01/24, revealed Resident #82 had impaired cognition with a BIMS score of 09 (indicating moderate cognitive impairment) and no behaviors were present. The resident was independent for bed mobility, transfers, and ambulation. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the plan of care for Resident #82 revealed he did have a focus of impaired cognitive function/thought processes and socially inappropriate behaviors. Resident #82's care plan did not have any new interventions for sexual behaviors after the incident from 11/23/24. Review of the SRI dated 11/23/24 at 5:11 P.M. revealed a nurse reported to the Director of Nursing (DON) on 11/23/24 that Resident #82 was discovered in Resident #105's room with his hand up her dress on her breast area. The residents were immediately separated and Resident #82 was immediately placed on one on one supervision. Resident #105 had a skin/pain assessment with no areas of concern. Hospice was notified for Resident #105 and they went into the facility and completed their own assessments with no concerns. The police were notified and spoke to Resident #82's family. The police assisted in finding appropriate placement for Resident #82. Resident #105 presented with no changes in behavior or signs of stress. Resident #82 was sent out to a local medical facility and alternative placement was being pursued. All residents were interviewed for instances of sexual abuse, and all denied any issues. All non-alert residents had skin assessments performed with no concerns. Staff were educated on the abuse and neglect policy to ensure compliance and understanding. The facility marked the SRI as physical abuse (instead of sexual abuse) and determined the allegation was unsubstantiated. Review of the facility investigation dated 11/23/24 and timed 5:11 P.M. included a copy of the SRI, one on one documentation with Resident #82, the staff schedule for 11/23/24, staff abuse/neglect in-services, resident interviews, resident skin checks after the incident, the incident report, the police officer application for emergency admission form (also referred to as a pink slip), Resident #82's urinalysis, staff interviews, and staff statements. Review of the staff statement from LPN #63 revealed she noticed Resident #82 pacing hallways around 4:00 P.M. Resident #82 was going in and out of rooms, collecting miscellaneous items, and attempting to lay down in bed with Resident #105, and she had removed and redirected the resident. A little after 4:00 P.M., LPN #63 noticed Resident #82 was laying in bed with Resident #105 with his hand up Resident #105's gown groping her breast. LPN #63 immediately removed his hand from Resident #105. Resident #82 got up and LPN #63 escorted him out of Resident #105's room. Education was given to Resident #82 about appropriate behavior. Resident #82 was placed on one on one supervision at that time. The police department, doctor, DON, ADON #27, and Viaquest were notified. Orders were received to send Resident #82 to the emergency room for evaluation. Since Resident #105 was a hospice resident, they were notified as well. Resident #105's skin was assessed by the facility and hospice assessed Resident #105's skin as well. The statement revealed the residents family requested to press charges. Resident #105 was unable to state where she was, date, year, or situation. Review of the incident report dated 11/23/24 for Resident #105 revealed a nurse entered her room and found a male resident in her bed with his hand under her gown on her breast, the male resident was immediately removed from the room. Resident #105 was unable to provide a statement and she denied any memory of the incident. A head to toe assessment was completed with no injuries noted. Resident #105 remained calm with no distress noted, and denied any pain. Resident #105's family member, hospice, and physician were notified. (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 incident reported dated 11/23/24 for Resident #82 revealed a nurse entered Resident #105's room and found Resident #82 in bed with a female resident. As the nurse approached the bed and asked Resident #82 what he was doing, she saw his hand under the female's gown on her breast. Resident #82 was unable to give an accurate statement. Resident #82 was rambling, paranoid, and talking about drugs. Resident #82 was cooperative with the nurse and escorted out of the room with no injuries observed. Resident #82 was returned to his room and a Certified Nursing Assistant (CNA) provided one on one supervision. Predisposing physiological factors listed for Resident #82 were that he had confusion, psychiatric diagnoses, and a recent change in cognition. Predisposing situation factors for Resident #82 were listed as a recent room change and unassisted ambulation. A family member and physician were called and notified about the incident. Review of Resident #105 progress note dated 11/23/24 at 4:06 P.M. revealed Resident #105 was observed to have a male resident lying in bed with her with his hand up her gown and on her breasts. Resident #105 was alert and oriented to one person and was nonconsensual to the activity. The male resident's hand was removed from her body and he was escorted out of the room immediately. The police, doctor, DON, Assistant Director of Nursing (ADON) #27, hospice, and family were notified. A skin assessment was initiated and findings were unfounded. Hospice notified the facility that they would be in the facility to assess. Review of Resident #105's progress note dated 11/23/24 at 4:10 P.M. revealed Resident #105 was unable to state place, time, and situation. Resident #105 did not recall the situation with the male resident and she did not appear to be in any distress at the time. Review of Resident #105's progress note dated 11/23/24 at 8:02 P.M. revealed LPN #63 and the hospice nurse completed a thorough skin assessment on the resident while providing personal care. No new skin areas were noted and the resident denied any new pain. Review of the hospice documentation dated 11/23/24 revealed LPN #63 called to report an altercation with a male resident. A head to toe skin assessment was completed with no abnormal findings identified. When the hospice nurse arrived, a police report was made and staff was sitting outside the door. Resident #105 was talkative, and no behaviors were noted. Resident #105 was unable to recall what she had for dinner, she was not in any pain, and stated she had not had any visitors tonight. A full body assessment was completed and there was no noted redness or bruising on her arms or legs. Resident #105 was able to follow commands from the hospice nurse. Resident #105's brief was changed with facility staff nurses present and there was no pain, redness, swelling, discomfort, or vaginal drainage noted. The hospice nurse talked with the residents family, and they noted Resident #105 told them the same thing she told the nurse. Resident #105 had no change in expression and was not showing any signs of being afraid or tearful. Resident #105 displayed no changes in behavior during personal care from the hospice nurse or staff. The family was agreeable to the resident staying and refusing to have the resident moved to another room when offered. Review of Resident #82's progress note dated 11/23/23 at 4:06 P.M. revealed Resident #82 was observed laying in bed with a female resident. Resident #82 was observed having his hand under the female's gown touching her breast. The female was alert and oriented to person. Resident #82 was escorted out of the room and back into his assigned room. Resident #82 was placed on one on one supervision. The doctor, DON, and ADON #27 were notified of the incident. (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 Resident #82's progress note dated 11/23/24 at 4:30 P.M. revealed police were in the facility and spoke to Resident #82. Resident #82 was unable to have an intelligible conversation with the police officer. A pink slip was filled out by the officer for an evaluation. Review of the application for emergency admission, also known as a pink slip, dated 11/23/24 at 4:10 P.M. revealed Resident #82 would benefit from treatment in a hospital for his mental illness and was in need of such treatment as manifested by evidence of behaviors that created a grave and imminent risk to the substantial rights of others or himself. The officer also detailed Resident #82 sexually assaulted another resident, and his mental state had substantially declined. The form was signed by the police officer. Review of the local law enforcement report dated 11/23/24 revealed police arrived on scene at 5:32 P.M. The police officer spoke to Licensed Practical Nurse (LPN) #63 upon arrival, who told the officer that a resident in the nursing home sexually assaulted another resident. LPN #63 said Resident #82 who had mental health issues, went into Resident #105's room and got into bed with her. LPN #63 stated at approximately 4:00 P. M. she walked into the room and caught Resident #82 groping Resident #105's breast under her gown. LPN #63 told the officer Resident #82's mental health has been substantially declining in the past couple of weeks prompting changes to his medication. LPN #63 also told the officer that Resident #105 was not fully alert or aware causing her to not be able to give or revoke consent. The officer interviewed Resident #105 in her room and she was unable to tell him what happened. The officer was able to tell Resident #105 was confused and did not know what was happening. The officer asked Resident #105 if she remembered a man coming into her room or getting in bed with her and touching her in appropriately and the resident answered no to both of the questions. The officer then interviewed Resident #82 in his room. The officer asked Resident #82 if he went into another resident's room and got in bed with them and Resident #82 replied no. The officer noted he was unable have a intelligible conversation with Resident #82 due to his mental state. LPN #63 reiterated to the officer that Resident #82's mental state had been rapidly declining and advised that his status is not how he was a few weeks or months ago. The officer documented, due to Resident #82's rapid decline in his mental state and the risk to other residents, the officer decided to pink slip him. An ambulance service came to transport Resident #82 to the emergency room . Resident #82 did not comply so two officers physically put Resident #82 on a gurney. The officer spoke to Resident #105's family member and advised him of the situation. The residents family wanted to press charges on Resident #105's behalf. The officer stated he would be sending the report to the prosecutor for charges. The officer noted that Resident #105 did not have a power of attorney. Review of Resident #82's progress note dated 11/23/24 at 8:20 P.M. revealed Resident #82 was notified of an order to go to the emergency room (ER) for an evaluation. Resident #82 became resistive to the transfer and two officers had to transfer the resident from the bed to a cot. The ER was called, and a report was given. Review of Resident #82's progress note dated 11/23/24 at 10:33 P.M. revealed Resident #82 was accepted into a behavioral facility. Review of Resident #82's progress note dated 12/06/24 at 3:46 P.M. revealed Resident #82 was readmitted into the facility and reoriented to his room. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Telephone Interview on 12/10/24 at 12:20 P.M. with LPN #63 revealed she witnessed resident to resident sexual abuse with Resident #82 and Resident #105. LPN #63 revealed she knew for a little while Resident #82's behaviors were peaking. She stated that the day the abuse occurred, she noticed him wandering in and out of people's rooms and he was babbling and more delusional. LPN #63 stated she kept a close eye on him that day, redirecting him, giving him snacks, and providing education. LPN #63 revealed it occurred near the time she was checking blood sugars, she went into Resident #105's room and Resident #82 was touching Resident #105 inappropriately, his hand was underneath Resident #105's gown and was touching her breast. She pulled Resident #82's hand away from Resident #105 and escorted Resident #82 out of the room and provided one on one at that time for him. LPN #63 revealed she had a staff member sit outside Resident #82's room and was doing 15 minute checks to keep him in that area. LPN #63 stated she called the medical doctor, DON, Viaquest, hospice, and the residents' Power of Attorney (POA). LPN #63 revealed she talked to a police officer and completed a report with him. They were able to get Resident #82 sent to the ER. LPN #63 revealed the situation was sexual abuse because Resident #105 could not consent to it. Interview on 12/10/2024 at 2:50 P.M. with ADON #27 revealed the MDS nurse was still working on the care plan and that's why there were no new interventions listed for Resident #82 after the incident. Interview on 12/10/24 at 4:00 P.M. with the DON revealed interventions for Resident #82 to return to the facility included continued behavior monitoring, a private room, and the behavioral health facility he discharged from completed a medication stabilization. Telephone interview on 12/11/2024 at 1:39 P.M. with LPN #63 revealed Resident #105 had no reaction when she found Resident #82's hand on her breast. She also stated Resident #105's brief was intact after the incident. Interview on 12/11/2024 at 2:32 P.M. with ADON #27 revealed they did not believe the incident was not a significant change for Resident #82. Interview on 12/11/2024 at 3:08 P.M. with the DON confirmed the incident required a care plan update, and they would be revising Resident #82's care plan. Interview on 12/09/24 at 1:31 P.M. with Resident #82 revealed he didn't think staff provided supervision, care, and services to prevent resident abuse. Resident #82 also stated that he had not had issues with abuse. Review of facility policy titled Abuse, Neglect, Exploitation & Misappropriation of Resident Property, dated 06/08/22, revealed the policy stated residents had the right to be free from abuse, neglect, exploitation, and misappropriation of resident property. The policy also revealed the facility's procedures included completing ongoing assessments and care planning for appropriate interventions and monitoring of residents with behaviors, including, but not limited to sexually aggressive behaviors (e.g., inappropriate touching or grabbing, saying sexual things, etc.). This deficiency represents non-compliance investigated under Complaint Numbers OH00160335 and OH00160308.