

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365746	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2024
NAME OF PROVIDER OR SUPPLIER Brentwood Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 907 Aurora Rd Sagamore Hills, OH 44067	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43061</p> <p>Based on record review and interviews, the facility failed to report a change in condition to Resident #50's responsible party and physician, when the resident was sexually abused and was agitated and crying. This affected one resident (Resident #50) of three residents reviewed for notification of change in condition.</p> <p>Findings include:</p> <p>Review of Resident #50's open medical record revealed the resident was admitted on [DATE] with diagnoses including Parkinson's disease with dyskinesia, unspecified dementia and anxiety disorder.</p> <p>Review of Resident #50's Admission MDS 3.0 assessment dated [DATE] revealed the resident exhibited severe cognitive impairment.</p> <p>Review of Resident #50's police report dated 06/06/24 authored by Police #359 indicated they were called to facility by Resident #50's family regarding an incident that occurred with Resident #50. Resident #50's family was told by staff members a male tried to inappropriately touch her mother under her gown during the evening of 06/05/24.</p> <p>Review of Resident #50's undated Police Department Witness Statement form authored by Licensed Practical Nurse (LPN) #223 indicated she was informed Resident #101 attempted to reach inside Resident #50's brief. She did not witness the activity. A full assessment was completed of Resident #50 for physical trauma or injury.</p> <p>Review of Resident #50's undated Police Department Witness Statement form authored by State tested Nursing Assistant (STNA) #284 indicated on 06/05/24 she observed Resident #101 attempting to touch Resident #50 inappropriately. The residents were separated.</p> <p>Review of Resident #50's undated Police Department Witness Statement form authored by STNA #340 indicated on 06/05/24, the employee overheard a commotion and observed another STNA removing Resident #101 away from Resident #50 because his hands was on the wheelchair and he would not let go. Resident #101 was taken back to his room. Resident #50's incontinence brief was intact.</p> <p>(continued on next page)</p>

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365746	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2024
NAME OF PROVIDER OR SUPPLIER Brentwood Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 907 Aurora Rd Sagamore Hills, OH 44067	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of Resident #50's medical record did not reveal entries in the progress notes concerning physical or sexual abuse by Resident #101 on 06/05/24 per the police report. There was no evidence of the resident's assessment when the incident occurred or following up with the resident after the incident. There was no evidence Resident #50's physician or representative was notified of the incident.</p> <p>Interview on 07/01/24 at 7:50 A.M. with Resident #50's daughter indicated she called the local police department because she felt the resident had increased agitation and possible abuse concerns. She reported not being notified of the incident with Resident #101 or that her mother was upset in any way.</p> <p>Interview on 07/01/24 at 9:53 A.M. with Director of Nursing (DON) confirmed the nursing staff should have contacted the physician and family regarding the change in condition of Resident #50. DON reported she became aware of an incident with Resident #50 on 06/06/24, the next day, when Resident #50's daughter was at the facility and upset that her mom didn't seem right. Resident #50's daughter called the police that day. DON reported Resident #50 had a change in condition on 06/05/24 when she was upset. DON reported the family should have been notified right away of the change in her condition.</p> <p>Interview on 07/01/24 at 10:15 A.M. with LPN #220 revealed Resident #50's daughter asked her on 06/06/24 if something happened to her mom, daughter had tears in her eyes, and LPN #220 did not know anything happened. LPN #220 went and got their supervisor and DON.</p> <p>Interview on 07/01/24 at 2:58 P.M. with STNA #227 indicated she was told by STNA #340 that another resident had reached over and fondled Resident #50 in the lady parts down below. She stated staff intervened when Resident #50 screamed and the residents were separated.</p> <p>Interview on 07/01/24 at 4:37 P.M. with STNA #340 reported she did not witness sexual abuse and denied telling another STNA about the abuse. The resident did not have pants on at the time of the incident. STNA #340 indicated she was the staff member who got the resident out of bed from a nap prior to dinner on 06/05/24 because the husband came in to visit. STNA #340 confirmed she dressed the resident in a top and incontinence brief with no pants or bottoms. She only placed sheet over her legs. STNA #340 stated she placed Resident #50 back in bed following the incident with Resident #101 and the resident still had a top on and a incontinence brief with a sheet over her legs.</p> <p>Interview on 07/02/24 at 7:27 A.M. with STNA #284 revealed Resident #101 was sitting next to Resident #50 on 06/05/24 at the nursing station. Resident #101 had his hand (unknown which hand) in Resident #50's brief. Resident #50 was observed to be crying and Resident #101 was removed from the area. Another STNA (unknown who the employee was) was observed hugging Resident #50 and asked her if she was ok. Resident #50 reported she was not ok.</p> <p>Interview on 07/02/24 at 10:49 A.M. with LPN #223 stated she did not witness the incident between Resident #50 and #101. She confirmed she wrote a statement, and she said a State tested Nursing Assistant (STNA) told her about the sexual abuse incident.</p> <p>Interview on 07/02/24 at 12:20 P.M. with LPN #290 revealed she worked on a different hall on 06/05/24 and was coming up to the nurse's station and remembers Resident #50 was upset, crying, and shaking after the incident with Resident #101.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365746	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2024
NAME OF PROVIDER OR SUPPLIER Brentwood Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 907 Aurora Rd Sagamore Hills, OH 44067	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of facility policy, Notification of Changes, revised 12/15/23, revealed the purpose of this policy is to ensure the facility promptly inform the resident, consults the resident's physician, and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00154684.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365746	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2024
NAME OF PROVIDER OR SUPPLIER Brentwood Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 907 Aurora Rd Sagamore Hills, OH 44067	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43061</p> <p>Based on record review and interview, the facility failed to ensure Resident #6 and Resident #50 were free from resident to resident sexual abuse. This affected two residents (#6 and #50) of three residents reviewed for abuse.</p> <p>Actual physical and/or psychosocial harm, applying the reasonable person concept, occurred on 06/05/24 to Resident #50, a resident with impaired cognition, when Resident #101 who had a history of sexually inappropriate behaviors without care planned interventions in place, placed his hand down Resident #50's incontinence brief (an incident of sexual abuse). Following the incident, Resident #6 was visibly crying and shaking with a noted change by family on 06/06/24.</p> <p>Findings include:</p> <p>1. Review of Resident #50's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including Parkinson's disease with dyskinesia, unspecified dementia and anxiety disorder.</p> <p>Review of Resident #50's admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited severe cognitive impairment.</p> <p>Review of a police report for Resident #50 dated 06/06/24 authored by Police #359 revealed they were called to the facility by Resident #50's family regarding an incident that occurred with Resident #101. Resident #50's family member was told by staff members a male (resident) tried to inappropriately touch her mother (Resident #50) under her gown during the evening of 06/05/24.</p> <p>Review of an undated Police Department Witness Statement form authored by Licensed Practical Nurse (LPN) #223 indicated she was informed Resident #101 attempted to reach inside Resident #50's brief. She did not witness the activity. A full assessment was completed of Resident #50 for physical trauma or injury.</p> <p>Review of an undated Police Department Witness Statement form authored by State tested Nursing Assistant (STNA) #284 indicated on 06/05/24 she observed Resident #101 attempting to touch Resident #50 inappropriately. The residents were separated.</p> <p>Review of an undated Police Department Witness Statement form authored by STNA #340 indicated on 06/05/24, the employee overheard a commotion and observed another STNA removing Resident #101 away from Resident #50 because his hands were on the wheelchair and he would not let go. Resident #101 was taken back to his room. Resident #50's incontinence brief was intact.</p> <p>Review of Resident #50's medical record did not reveal entries in the progress notes concerning physical or sexual abuse by Resident #101 on 06/05/24 per the police report. There was no evidence of the resident's assessment when the incident occurred or of any follow-up with the resident after the incident.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365746	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2024
NAME OF PROVIDER OR SUPPLIER Brentwood Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 907 Aurora Rd Sagamore Hills, OH 44067	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Interview on 07/01/24 at 7:50 A.M. with Resident #50's daughter indicated she called the local police department related to this incident because she felt the resident had increased agitation (as a result of the incident) and related to possible abuse concerns.</p> <p>An attempt to interview Resident #50 on 07/01/24 at 10:01 A.M. was unsuccessful as the resident only knew her name and was not interviewable.</p> <p>Interview on 07/01/24 at 2:58 P.M. with STNA #227 revealed she was told by STNA #340 that another resident had reached over and fondled Resident #50 in the lady parts down below. She stated staff intervened when Resident #50 screamed and the residents were separated.</p> <p>Interview on 07/01/24 at 4:37 P.M. with STNA #340 revealed she did not witness this sexual abuse and denied telling another STNA about the abuse. The STNA further stated, the resident (#50) did not have pants on at the time of the incident. STNA #340 indicated she was the staff member who got Resident #50 out of bed from a nap prior to dinner on 06/05/24 because the resident's husband came in to visit. STNA #340 confirmed she dressed the resident in a top and incontinence brief with no pants or bottoms and only placed a sheet over her legs. STNA #340 stated she placed Resident #50 back in bed following the incident with Resident #101 and the resident still had a top on and a incontinence brief with a sheet over her legs.</p> <p>Interview on 07/02/24 at 7:27 A.M. with STNA #284 revealed Resident #101 was sitting next to Resident #50 on 06/05/24 at the nursing station. Resident #101 had his hand (unknown which hand) in Resident #50's brief. Resident #50 was observed to be crying and Resident #101 was removed from the area. Another STNA (unknown who the employee was) was observed hugging Resident #50 and asked her if she was ok. Resident #50 reported she was not ok.</p> <p>Interview on 07/02/24 at 10:49 A.M. with LPN #223 revealed she did not witness the incident between Resident #50 and #101. She confirmed she wrote a statement, and she said an STNA told her about the sexual abuse incident.</p> <p>Interview on 07/02/24 at 11:26 A.M. with the Director of Nursing (DON) confirmed she was informed of this incident between Resident #50 and #101 on 06/06/24 by staff members. The DON confirmed she was aware the local police department came into the facility on [DATE] to investigate a concern with Resident #50 but stated she did not feel it was abuse so she did not conduct a thorough investigation and did not report the incident to State agency. The DON confirmed the facility could not provide evidence of any type of assessment of Resident #50 after the incident on 06/05/24.</p> <p>Interview on 07/02/24 at 12:20 P.M. with LPN #290 revealed she worked on a different hall on 06/05/24 and was coming up to the nurse's station and remembered Resident #50 was upset, crying, and shaking after the incident with Resident #101.</p> <p>Review of Resident #101's closed medical record revealed the resident was admitted to the facility on [DATE] and discharged on [DATE] (to an assisted living) with diagnoses including hemiplegia, malignant neoplasm of the bladder and anxiety disorder.</p> <p>Review of Resident #101's comprehensive care plan dated 01/19/24 revealed the care plan did not include interventions to address sexual abuse or inappropriate sexual behavior.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365746	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2024
NAME OF PROVIDER OR SUPPLIER Brentwood Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 907 Aurora Rd Sagamore Hills, OH 44067	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Interview on 07/02/24 at 3:09 P.M. with Licensed Social Worker (LSW) #287, who does care plans for resident behaviors, confirmed Resident #101's did not have a comprehensive and individualized plan of care in place to prevent sexual abuse/address sexually inappropriate behavior(s).</p> <p>2. Review of Resident #6's medical record revealed the resident was admitted on [DATE] and readmitted on [DATE] with diagnoses including unspecified dementia, anxiety disorder and anemia.</p> <p>Review of Resident #6's quarterly MDS 3.0 assessment dated [DATE] revealed the resident exhibited a memory problem.</p> <p>Interview on 07/02/24 at 11:26 A.M. with the DON revealed she had been informed of an incident involving Resident #6 and she stated she felt what was reported to her was not sexual abuse. She stated a nurse had told her Resident #101 had attempted to grab Resident #6 by his pants. She denied reporting this incident of sexual abuse to the State agency and denied doing a thorough investigation because she stated she did not feel it was abuse.</p> <p>An attempt to interview Resident #6 on 07/08/24 at 12:50 P.M. was unsuccessful as the resident was cognitively impaired and was only able to state his name.</p> <p>Review of Resident #6's medical record revealed no evidence the incident between Resident #101 and Resident #6 was documented in his record. The record did not include an assessment after the incident.</p> <p>Review of Resident #101's closed medical record revealed the resident was admitted to the facility on [DATE] and discharged on [DATE] (to an assisted living) with diagnoses including hemiplegia, malignant neoplasm of the bladder and anxiety disorder.</p> <p>Review of Resident #101's comprehensive care plan dated 01/19/24 revealed the care plan did not include interventions to address sexual abuse or inappropriate sexual behavior.</p> <p>Review of Resident #101's progress note dated 04/25/24 at 6:39 A.M. authored by Registered Nurse (RN) #299 revealed the resident was up at the nursing station sitting next to Resident #6 and attempting to grab at Resident #6's penis. The resident was pulling at his pants and trying to put his hand down the resident's pants. Resident #6 yelled and stated, you are hurting me. The resident was moved into the television room and kept coming up to the other residents to touch them inappropriately. The note indicated nursing would continue to monitor.</p> <p>Review of Resident #101's progress note dated 04/28/24 at 11:08 A.M. authored by LPN #290 indicated the resident was wheeling himself up to female and male residents and placing his hand under their clothes and attempting to touch them. The staff removed him away from the residents and observed him by taking him to his room. The physician was notified. The note did not identify which residents were involved.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365746	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2024
NAME OF PROVIDER OR SUPPLIER Brentwood Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 907 Aurora Rd Sagamore Hills, OH 44067	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Interview on 07/02/24 at 12:20 P.M. with LPN #290 revealed on 04/28/24, Resident #101 was wheeling himself up and placing his hands under both male and female resident's clothing. She confirmed Resident #101 had behaviors of touching other residents' underneath of their clothes and stated she had witnessed him placing his hands under a female resident's clothing but she could not recall the resident's name or date of the incident. She stated of course it was sexual abuse however, she could not state who she had reported the incident too.</p> <p>Interview on 07/02/24 at 3:09 P.M. with Licensed Social Worker (LSW) #287, who does care plans for resident behaviors, confirmed Resident #101's did not have a comprehensive and individualized plan of care in place to prevent sexual abuse/address sexually inappropriate behavior(s).</p> <p>Review of the facility policy, Abuse, Neglect, and Exploitation, revised 12/04/23 revealed the facility defined sexual abuse as non-consensual sexual contact of any type with a resident. In addition, the policy revealed the facility would provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00154836 and Complaint Number OH00154684.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365746	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2024
NAME OF PROVIDER OR SUPPLIER Brentwood Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 907 Aurora Rd Sagamore Hills, OH 44067	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43061</p> <p>Based on record review and interview, the facility failed to implement there abuse prohibition policy after an allegation of abuse was made to protect the residents, thoroughly investigation the allegation, and report the allegations and findings to the State agency. This finding affected two residents (Residents #6 and Resident #50) of three residents reviewed for abuse.</p> <p>Findings include:</p> <p>1. Review of Resident #50's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including Parkinson's disease with dyskinesia, unspecified dementia and anxiety disorder.</p> <p>Review of Resident #50's admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited severe cognitive impairment.</p> <p>Review of a police report for Resident #50 dated 06/06/24 authored by Police #359 revealed they were called to the facility by Resident #50's family regarding an incident that occurred with Resident #101. Resident #50's family member was told by staff members a male (resident) tried to inappropriately touch her mother (Resident #50) under her gown during the evening of 06/05/24.</p> <p>Review of an undated Police Department Witness Statement form authored by Licensed Practical Nurse (LPN) #223 indicated she was informed Resident #101 attempted to reach inside Resident #50's brief. She did not witness the activity. A full assessment was completed of Resident #50 for physical trauma or injury.</p> <p>Review of an undated Police Department Witness Statement form authored by State tested Nursing Assistant (STNA) #284 indicated on 06/05/24 she observed Resident #101 attempting to touch Resident #50 inappropriately. The residents were separated.</p> <p>Review of an undated Police Department Witness Statement form authored by STNA #340 indicated on 06/05/24, the employee overheard a commotion and observed another STNA removing Resident #101 away from Resident #50 because his hands were on the wheelchair and he would not let go. Resident #101 was taken back to his room. Resident #50's incontinence brief was intact.</p> <p>Review of Resident #50's medical record did not reveal entries in the progress notes concerning physical or sexual abuse by Resident #101 on 06/05/24 per the police report. There was no evidence of the resident's assessment when the incident occurred or of any follow-up with the resident after the incident.</p> <p>Interview on 07/01/24 at 7:50 A.M. with Resident #50's daughter indicated she called the local police department related to this incident because she felt the resident had increased agitation (as a result of the incident) and related to possible abuse concerns.</p> <p>An attempt to interview Resident #50 on 07/01/24 at 10:01 A.M. was unsuccessful as the resident only knew her name and was not interviewable.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365746	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2024
NAME OF PROVIDER OR SUPPLIER Brentwood Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 907 Aurora Rd Sagamore Hills, OH 44067	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 07/01/24 at 2:58 P.M. with STNA #227 revealed she was told by STNA #340 that another resident had reached over and fondled Resident #50 in the lady parts down below. She stated staff intervened when Resident #50 screamed and the residents were separated.</p> <p>Interview on 07/01/24 at 4:37 P.M. with STNA #340 revealed she did not witness this sexual abuse and denied telling another STNA about the abuse. The STNA further stated, the resident (#50) did not have pants on at the time of the incident. STNA #340 indicated she was the staff member who got Resident #50 out of bed from a nap prior to dinner on 06/05/24 because the resident's husband came in to visit. STNA #340 confirmed she dressed the resident in a top and incontinence brief with no pants or bottoms and only placed a sheet over her legs. STNA #340 stated she placed Resident #50 back in bed following the incident with Resident #101 and the resident still had a top on and a incontinence brief with a sheet over her legs.</p> <p>Interview on 07/02/24 at 7:27 A.M. with STNA #284 revealed Resident #101 was sitting next to Resident #50 on 06/05/24 at the nursing station. Resident #101 had his hand (unknown which hand) in Resident #50's brief. Resident #50 was observed to be crying and Resident #101 was removed from the area. Another STNA (unknown who the employee was) was observed hugging Resident #50 and asked her if she was ok. Resident #50 reported she was not ok.</p> <p>Interview on 07/02/24 at 10:49 A.M. with LPN #223 revealed she did not witness the incident between Resident #50 and #101. She confirmed she wrote a statement, and she said an STNA told her about the sexual abuse incident.</p> <p>Interview on 07/02/24 at 11:26 A.M. with the Director of Nursing (DON) confirmed she was informed of this incident between Resident #50 and #101 on 06/06/24 by staff members. The DON confirmed she was aware the local police department came into the facility on [DATE] to investigate a concern with Resident #50 but stated she did not feel it was abuse so she did not conduct a thorough investigation and did not report the incident to State agency. The DON confirmed the facility could not provide evidence of any type of assessment of Resident #50 after the incident on 06/05/24.</p> <p>Interview on 07/02/24 at 12:20 P.M. with LPN #290 revealed she worked on a different hall on 06/05/24 and was coming up to the nurse's station and remembered Resident #50 was upset, crying, and shaking after the incident with Resident #101.</p> <p>Review of Resident #101's closed medical record revealed the resident was admitted to the facility on [DATE] and discharged on [DATE] (to an assisted living) with diagnoses including hemiplegia, malignant neoplasm of the bladder and anxiety disorder.</p> <p>Review of Resident #101's comprehensive care plan dated 01/19/24 revealed the care plan did not include interventions to address sexual abuse or inappropriate sexual behavior.</p> <p>Interview on 07/02/24 at 3:09 P.M. with Licensed Social Worker (LSW) #287, who does care plans for resident behaviors, confirmed Resident #101's did not have a comprehensive and individualized plan of care in place to prevent sexual abuse/address sexually inappropriate behavior(s).</p> <p>2. Review of Resident #6's medical record revealed the resident was admitted on [DATE] and readmitted on [DATE] with diagnoses including unspecified dementia, anxiety disorder and anemia.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365746	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2024
NAME OF PROVIDER OR SUPPLIER Brentwood Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 907 Aurora Rd Sagamore Hills, OH 44067	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #6's quarterly MDS 3.0 assessment dated [DATE] revealed the resident exhibited a memory problem.</p> <p>Interview on 07/02/24 at 11:26 A.M. with the DON revealed she had been informed of an incident involving Resident #6 and she stated she felt what was reported to her was not sexual abuse. She stated a nurse had told her Resident #101 had attempted to grab Resident #6 by his pants. She denied reporting this incident of sexual abuse to the State agency and denied doing a thorough investigation because she stated she did not feel it was abuse.</p> <p>An attempt to interview Resident #6 on 07/08/24 at 12:50 P.M. was unsuccessful as the resident was cognitively impaired and was only able to state his name.</p> <p>Review of Resident #6's medical record revealed no evidence the incident between Resident #101 and Resident #6 was documented in his record. The record did not include an assessment after the incident.</p> <p>Review of Resident #101's closed medical record revealed the resident was admitted to the facility on [DATE] and discharged on [DATE] (to an assisted living) with diagnoses including hemiplegia, malignant neoplasm of the bladder and anxiety disorder.</p> <p>Review of Resident #101's comprehensive care plan dated 01/19/24 revealed the care plan did not include interventions to address sexual abuse or inappropriate sexual behavior.</p> <p>Review of Resident #101's progress note dated 04/25/24 at 6:39 A.M. authored by Registered Nurse (RN) #299 revealed the resident was up at the nursing station sitting next to Resident #6 and attempting to grab at Resident #6's penis. The resident was pulling at his pants and trying to put his hand down the resident's pants. Resident #6 yelled and stated, you are hurting me. The resident was moved into the television room and kept coming up to the other residents to touch them inappropriately. The note indicated nursing would continue to monitor.</p> <p>Review of Resident #101's progress note dated 04/28/24 at 11:08 A.M. authored by LPN #290 indicated the resident was wheeling himself up to female and male residents and placing his hand under their clothes and attempting to touch them. The staff removed him away from the residents and observed him by taking him to his room. The physician was notified. The note did not identify which residents were involved.</p> <p>Interview on 07/02/24 at 12:20 P.M. with LPN #290 revealed on 04/28/24, Resident #101 was wheeling himself up and placing his hands under both male and female resident's clothing. She confirmed Resident #101 had behaviors of touching other residents' underneath of their clothes and stated she had witnessed him placing his hands under a female resident's clothing but she could not recall the resident's name or date of the incident. She stated of course it was sexual abuse however, she could not state who she had reported the incident too.</p> <p>Interview on 07/02/24 at 3:09 P.M. with Licensed Social Worker (LSW) #287, who does care plans for resident behaviors, confirmed Resident #101's did not have a comprehensive and individualized plan of care in place to prevent sexual abuse/address sexually inappropriate behavior(s).</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365746	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2024
NAME OF PROVIDER OR SUPPLIER Brentwood Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 907 Aurora Rd Sagamore Hills, OH 44067	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy, Abuse, Neglect, and Exploitation, revised 12/04/23 revealed the facility defined sexual abuse as non-consensual sexual contact of any type with a resident. The policy revealed the facility would provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property.</p> <p>Investigation of Alleged, Neglect and Exploitation included an immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. Written procedures for investigation include: identifying staff responsible for the investigation; exercising caution in handing evidence that could be used in a criminal investigation, investigating different types of alleged violations, identifying and interviewing all persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; focusing the investigation on determining is abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause, and provide complete and thorough documentation of the investigation.</p> <p>Protection of Resident included the facility will make efforts to ensure all residents are protected from physical and psychosocial harm as well as additional abuse, during and after the investigation. Examples include but are not limited to: Responding immediately to protect the alleged victim and integrity of the investigation; examining the victim for any sign of injury, including a physician examination or psychosocial assessment if needed; increased supervision of the alleged victim and residents; room or staffing changes, if necessary, to protect the resident from the alleged perpetrator; protection from retaliation; providing emotional support and counseling to the resident during and after the investigation, as needed; revision of the resident's care plan if the resident's medical, nursing, physical, mental, or psychosocial needs or preferences change as a result of an incident of abuse.</p> <p>Reporting Response included the facility will have written procedures that include but are not limited to: reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies within specified timeframes which are immediately, but not later than two hours after the allegation is made if that even that causes the allegation involve abuse or result in seriously body injury or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury; assuring that reporters are free fro retaliation or reprisal; promoting a culture of safety and open communication in the work environment prohibiting retaliation against any employee who reports suspicion of a crime; taking all necessary actions as a result if the investigation, which may include, but are not limited to the following: analyzing the occurrence(s) to determine why abuse, neglect, misappropriation of resident occurred, and what changes are needed to prevent further occurrences; defining how care provision will be changed and/or improved to protect residents receiving services; training of staff on changes made and demonstration of staff competency after training is implemented; the expected date for implementation; and identification of staff responsible for monitoring the implementation of the plan. Administrator will follow up with government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within five working days of the incident, as required by state agencies.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00154836 and Complaint Number OH00154684.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365746	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2024
NAME OF PROVIDER OR SUPPLIER Brentwood Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 907 Aurora Rd Sagamore Hills, OH 44067	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43061</p> <p>Based on record review, interview, and policy review, the facility failed to timely report allegations of sexual abuse to the Administrator and State agency. This finding affected two residents (Residents #6 and Resident #50) of three residents reviewed for abuse.</p> <p>Findings include:</p> <p>1. Review of Resident #50's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including Parkinson's disease with dyskinesia, unspecified dementia and anxiety disorder.</p> <p>Review of Resident #50's admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited severe cognitive impairment.</p> <p>Review of a police report for Resident #50 dated 06/06/24 authored by Police #359 revealed they were called to the facility by Resident #50's family regarding an incident that occurred with Resident #101. Resident #50's family member was told by staff members a male (resident) tried to inappropriately touch her mother (Resident #50) under her gown during the evening of 06/05/24.</p> <p>Review of an undated Police Department Witness Statement form authored by Licensed Practical Nurse (LPN) #223 indicated she was informed Resident #101 attempted to reach inside Resident #50's brief. She did not witness the activity. A full assessment was completed of Resident #50 for physical trauma or injury.</p> <p>Review of an undated Police Department Witness Statement form authored by State tested Nursing Assistant (STNA) #284 indicated on 06/05/24 she observed Resident #101 attempting to touch Resident #50 inappropriately. The residents were separated.</p> <p>Review of an undated Police Department Witness Statement form authored by STNA #340 indicated on 06/05/24, the employee overheard a commotion and observed another STNA removing Resident #101 away from Resident #50 because his hands were on the wheelchair and he would not let go. Resident #101 was taken back to his room. Resident #50's incontinence brief was intact.</p> <p>Review of Resident #50's medical record did not reveal entries in the progress notes concerning physical or sexual abuse by Resident #101 on 06/05/24 per the police report. There was no evidence of the resident's assessment when the incident occurred or of any follow-up with the resident after the incident.</p> <p>Interview on 07/01/24 at 7:50 A.M. with Resident #50's daughter indicated she called the local police department related to this incident because she felt the resident had increased agitation (as a result of the incident) and related to possible abuse concerns.</p> <p>An attempt to interview Resident #50 on 07/01/24 at 10:01 A.M. was unsuccessful as the resident only knew her name and was not interviewable.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365746	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2024
NAME OF PROVIDER OR SUPPLIER Brentwood Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 907 Aurora Rd Sagamore Hills, OH 44067	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 07/01/24 at 2:58 P.M. with STNA #227 revealed she was told by STNA #340 that another resident had reached over and fondled Resident #50 in the lady parts down below. She stated staff intervened when Resident #50 screamed and the residents were separated.</p> <p>Interview on 07/01/24 at 4:37 P.M. with STNA #340 revealed she did not witness this sexual abuse and denied telling another STNA about the abuse. The STNA further stated, the resident (#50) did not have pants on at the time of the incident. STNA #340 indicated she was the staff member who got Resident #50 out of bed from a nap prior to dinner on 06/05/24 because the resident's husband came in to visit. STNA #340 confirmed she dressed the resident in a top and incontinence brief with no pants or bottoms and only placed a sheet over her legs. STNA #340 stated she placed Resident #50 back in bed following the incident with Resident #101 and the resident still had a top on and an incontinence brief with a sheet over her legs.</p> <p>Interview on 07/02/24 at 7:27 A.M. with STNA #284 revealed Resident #101 was sitting next to Resident #50 on 06/05/24 at the nursing station. Resident #101 had his hand (unknown which hand) in Resident #50's brief. Resident #50 was observed to be crying and Resident #101 was removed from the area. Another STNA (unknown who the employee was) was observed hugging Resident #50 and asked her if she was ok. Resident #50 reported she was not ok.</p> <p>Interview on 07/02/24 at 10:49 A.M. with LPN #223 revealed she did not witness the incident between Resident #50 and #101. She confirmed she wrote a statement, and she said an STNA told her about the sexual abuse incident.</p> <p>Interview on 07/02/24 at 11:26 A.M. with the Director of Nursing (DON) confirmed she was informed of this incident between Resident #50 and #101 on 06/06/24 by staff members. The DON confirmed she was aware the local police department came into the facility on [DATE] to investigate a concern with Resident #50 but stated she did not feel it was abuse so she did not conduct a thorough investigation and did not report the incident to State agency. The DON confirmed the facility could not provide evidence of any type of assessment of Resident #50 after the incident on 06/05/24.</p> <p>Interview on 07/02/24 at 12:20 P.M. with LPN #290 revealed she worked on a different hall on 06/05/24 and was coming up to the nurse's station and remembered Resident #50 was upset, crying, and shaking after the incident with Resident #101.</p> <p>Review of Resident #101's closed medical record revealed the resident was admitted to the facility on [DATE] and discharged on [DATE] (to an assisted living) with diagnoses including hemiplegia, malignant neoplasm of the bladder and anxiety disorder.</p> <p>Review of Resident #101's comprehensive care plan dated 01/19/24 revealed the care plan did not include interventions to address sexual abuse or inappropriate sexual behavior.</p> <p>Interview on 07/02/24 at 3:09 P.M. with Licensed Social Worker (LSW) #287, who does care plans for resident behaviors, confirmed Resident #101's did not have a comprehensive and individualized plan of care in place to prevent sexual abuse/address sexually inappropriate behavior(s).</p> <p>2. Review of Resident #6's medical record revealed the resident was admitted on [DATE] and readmitted on [DATE] with diagnoses including unspecified dementia, anxiety disorder and anemia.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365746	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2024
NAME OF PROVIDER OR SUPPLIER Brentwood Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 907 Aurora Rd Sagamore Hills, OH 44067	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #6's quarterly MDS 3.0 assessment dated [DATE] revealed the resident exhibited a memory problem.</p> <p>Interview on 07/02/24 at 11:26 A.M. with the DON revealed she had been informed of an incident involving Resident #6 and she stated she felt what was reported to her was not sexual abuse. She stated a nurse had told her Resident #101 had attempted to grab Resident #6 by his pants. She denied reporting this incident of sexual abuse to the State agency and denied doing a thorough investigation because she stated she did not feel it was abuse.</p> <p>An attempt to interview Resident #6 on 07/08/24 at 12:50 P.M. was unsuccessful as the resident was cognitively impaired and was only able to state his name.</p> <p>Review of Resident #6's medical record revealed no evidence the incident between Resident #101 and Resident #6 was documented in his record. The record did not include an assessment after the incident.</p> <p>Review of Resident #101's closed medical record revealed the resident was admitted to the facility on [DATE] and discharged on [DATE] (to an assisted living) with diagnoses including hemiplegia, malignant neoplasm of the bladder and anxiety disorder.</p> <p>Review of Resident #101's comprehensive care plan dated 01/19/24 revealed the care plan did not include interventions to address sexual abuse or inappropriate sexual behavior.</p> <p>Review of Resident #101's progress note dated 04/25/24 at 6:39 A.M. authored by Registered Nurse (RN) #299 revealed the resident was up at the nursing station sitting next to Resident #6 and attempting to grab at Resident #6's penis. The resident was pulling at his pants and trying to put his hand down the resident's pants. Resident #6 yelled and stated, you are hurting me. The resident was moved into the television room and kept coming up to the other residents to touch them inappropriately. The note indicated nursing would continue to monitor.</p> <p>Review of Resident #101's progress note dated 04/28/24 at 11:08 A.M. authored by LPN #290 indicated the resident was wheeling himself up to female and male residents and placing his hand under their clothes and attempting to touch them. The staff removed him away from the residents and observed him by taking him to his room. The physician was notified. The note did not identify which residents were involved.</p> <p>Interview on 07/02/24 at 12:20 P.M. with LPN #290 revealed on 04/28/24, Resident #101 was wheeling himself up and placing his hands under both male and female resident's clothing. She confirmed Resident #101 had behaviors of touching other residents' underneath of their clothes and stated she had witnessed him placing his hands under a female resident's clothing but she could not recall the resident's name or date of the incident. She stated of course it was sexual abuse however, she could not state who she had reported the incident too.</p> <p>Interview on 07/02/24 at 3:09 P.M. with Licensed Social Worker (LSW) #287, who does care plans for resident behaviors, confirmed Resident #101's did not have a comprehensive and individualized plan of care in place to prevent sexual abuse/address sexually inappropriate behavior(s).</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365746	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2024
NAME OF PROVIDER OR SUPPLIER Brentwood Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 907 Aurora Rd Sagamore Hills, OH 44067	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy, Abuse, Neglect, and Exploitation, revised 12/04/23 revealed the facility defined sexual abuse as non-consensual sexual contact of any type with a resident. The policy revealed the facility would provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property.</p> <p>Reporting Response included the facility will have written procedures that include but are not limited to: reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies within specified timeframes which are immediately, but not later than two hours after the allegation is made if that even that causes the allegation involve abuse or result in seriously body injury or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury; assuring that reporters are free fro retaliation or reprisal; promoting a culture of safety and open communication in the work environment prohibiting retaliation against any employee who reports suspicion of a crime; taking all necessary actions as a result if the investigation, which may include, but are not limited to the following: analyzing the occurrence(s) to determine why abuse, neglect, misappropriation of resident occurred, and what changes are needed to prevent further occurrences; defining how care provision will be changed and/or improved to protect residents receiving services; training of staff on changes made and demonstration of staff competency after training is implemented; the expected date for implementation; and identification of staff responsible for monitoring the implementation of the plan. Administrator will follow up with government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within five working days of the incident, as required by state agencies.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00154836 and Complaint Number OH00154684.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365746	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2024
NAME OF PROVIDER OR SUPPLIER Brentwood Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 907 Aurora Rd Sagamore Hills, OH 44067	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43061</p> <p>Based on record review, interview, and policy review, the facility failed to thoroughly investigate allegations of resident to resident sexual abuse for Resident #6 and Resident #50. This affected two residents (Resident 6 and Resident #50) of three residents reviewed for abuse.</p> <p>Findings include:</p> <p>1. Review of Resident #50's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including Parkinson's disease with dyskinesia, unspecified dementia and anxiety disorder.</p> <p>Review of Resident #50's admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited severe cognitive impairment.</p> <p>Review of a police report for Resident #50 dated 06/06/24 authored by Police #359 revealed they were called to the facility by Resident #50's family regarding an incident that occurred with Resident #101. Resident #50's family member was told by staff members a male (resident) tried to inappropriately touch her mother (Resident #50) under her gown during the evening of 06/05/24.</p> <p>Review of an undated Police Department Witness Statement form authored by Licensed Practical Nurse (LPN) #223 indicated she was informed Resident #101 attempted to reach inside Resident #50's brief. She did not witness the activity. A full assessment was completed of Resident #50 for physical trauma or injury.</p> <p>Review of an undated Police Department Witness Statement form authored by State tested Nursing Assistant (STNA) #284 indicated on 06/05/24 she observed Resident #101 attempting to touch Resident #50 inappropriately. The residents were separated.</p> <p>Review of an undated Police Department Witness Statement form authored by STNA #340 indicated on 06/05/24, the employee overheard a commotion and observed another STNA removing Resident #101 away from Resident #50 because his hands were on the wheelchair and he would not let go. Resident #101 was taken back to his room. Resident #50's incontinence brief was intact.</p> <p>Review of Resident #50's medical record did not reveal entries in the progress notes concerning physical or sexual abuse by Resident #101 on 06/05/24 per the police report. There was no evidence of the resident's assessment when the incident occurred or of any follow-up with the resident after the incident.</p> <p>Interview on 07/01/24 at 7:50 A.M. with Resident #50's daughter indicated she called the local police department related to this incident because she felt the resident had increased agitation (as a result of the incident) and related to possible abuse concerns.</p> <p>An attempt to interview Resident #50 on 07/01/24 at 10:01 A.M. was unsuccessful as the resident only knew her name and was not interviewable.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365746	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2024
NAME OF PROVIDER OR SUPPLIER Brentwood Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 907 Aurora Rd Sagamore Hills, OH 44067	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 07/01/24 at 2:58 P.M. with STNA #227 revealed she was told by STNA #340 that another resident had reached over and fondled Resident #50 in the lady parts down below. She stated staff intervened when Resident #50 screamed and the residents were separated.</p> <p>Interview on 07/01/24 at 4:37 P.M. with STNA #340 revealed she did not witness this sexual abuse and denied telling another STNA about the abuse. The STNA further stated, the resident (#50) did not have pants on at the time of the incident. STNA #340 indicated she was the staff member who got Resident #50 out of bed from a nap prior to dinner on 06/05/24 because the resident's husband came in to visit. STNA #340 confirmed she dressed the resident in a top and incontinence brief with no pants or bottoms and only placed a sheet over her legs. STNA #340 stated she placed Resident #50 back in bed following the incident with Resident #101 and the resident still had a top on and a incontinence brief with a sheet over her legs.</p> <p>Interview on 07/02/24 at 7:27 A.M. with STNA #284 revealed Resident #101 was sitting next to Resident #50 on 06/05/24 at the nursing station. Resident #101 had his hand (unknown which hand) in Resident #50's brief. Resident #50 was observed to be crying and Resident #101 was removed from the area. Another STNA (unknown who the employee was) was observed hugging Resident #50 and asked her if she was ok. Resident #50 reported she was not ok.</p> <p>Interview on 07/02/24 at 10:49 A.M. with LPN #223 revealed she did not witness the incident between Resident #50 and #101. She confirmed she wrote a statement, and she said an STNA told her about the sexual abuse incident.</p> <p>Interview on 07/02/24 at 11:26 A.M. with the Director of Nursing (DON) confirmed she was informed of this incident between Resident #50 and #101 on 06/06/24 by staff members. The DON confirmed she was aware the local police department came into the facility on [DATE] to investigate a concern with Resident #50 but stated she did not feel it was abuse so she did not conduct a thorough investigation and did not report the incident to State agency. The DON confirmed the facility could not provide evidence of any type of assessment of Resident #50 after the incident on 06/05/24.</p> <p>Interview on 07/02/24 at 12:20 P.M. with LPN #290 revealed she worked on a different hall on 06/05/24 and was coming up to the nurse's station and remembered Resident #50 was upset, crying, and shaking after the incident with Resident #101.</p> <p>Review of Resident #101's closed medical record revealed the resident was admitted to the facility on [DATE] and discharged on [DATE] (to an assisted living) with diagnoses including hemiplegia, malignant neoplasm of the bladder and anxiety disorder.</p> <p>Review of Resident #101's comprehensive care plan dated 01/19/24 revealed the care plan did not include interventions to address sexual abuse or inappropriate sexual behavior.</p> <p>Interview on 07/02/24 at 3:09 P.M. with Licensed Social Worker (LSW) #287, who does care plans for resident behaviors, confirmed Resident #101's did not have a comprehensive and individualized plan of care in place to prevent sexual abuse/address sexually inappropriate behavior(s).</p> <p>2. Review of Resident #6's medical record revealed the resident was admitted on [DATE] and readmitted on [DATE] with diagnoses including unspecified dementia, anxiety disorder and anemia.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365746	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2024
NAME OF PROVIDER OR SUPPLIER Brentwood Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 907 Aurora Rd Sagamore Hills, OH 44067	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #6's quarterly MDS 3.0 assessment dated [DATE] revealed the resident exhibited a memory problem.</p> <p>Interview on 07/02/24 at 11:26 A.M. with the DON revealed she had been informed of an incident involving Resident #6 and she stated she felt what was reported to her was not sexual abuse. She stated a nurse had told her Resident #101 had attempted to grab Resident #6 by his pants. She denied reporting this incident of sexual abuse to the State agency and denied doing a thorough investigation because she stated she did not feel it was abuse.</p> <p>An attempt to interview Resident #6 on 07/08/24 at 12:50 P.M. was unsuccessful as the resident was cognitively impaired and was only able to state his name.</p> <p>Review of Resident #6's medical record revealed no evidence the incident between Resident #101 and Resident #6 was documented in his record. The record did not include an assessment after the incident.</p> <p>Review of Resident #101's closed medical record revealed the resident was admitted to the facility on [DATE] and discharged on [DATE] (to an assisted living) with diagnoses including hemiplegia, malignant neoplasm of the bladder and anxiety disorder.</p> <p>Review of Resident #101's comprehensive care plan dated 01/19/24 revealed the care plan did not include interventions to address sexual abuse or inappropriate sexual behavior.</p> <p>Review of Resident #101's progress note dated 04/25/24 at 6:39 A.M. authored by Registered Nurse (RN) #299 revealed the resident was up at the nursing station sitting next to Resident #6 and attempting to grab at Resident #6's penis. The resident was pulling at his pants and trying to put his hand down the resident's pants. Resident #6 yelled and stated, you are hurting me. The resident was moved into the television room and kept coming up to the other residents to touch them inappropriately. The note indicated nursing would continue to monitor.</p> <p>Review of Resident #101's progress note dated 04/28/24 at 11:08 A.M. authored by LPN #290 indicated the resident was wheeling himself up to female and male residents and placing his hand under their clothes and attempting to touch them. The staff removed him away from the residents and observed him by taking him to his room. The physician was notified. The note did not identify which residents were involved.</p> <p>Interview on 07/02/24 at 12:20 P.M. with LPN #290 revealed on 04/28/24, Resident #101 was wheeling himself up and placing his hands under both male and female resident's clothing. She confirmed Resident #101 had behaviors of touching other residents' underneath of their clothes and stated she had witnessed him placing his hands under a female resident's clothing but she could not recall the resident's name or date of the incident. She stated of course it was sexual abuse however, she could not state who she had reported the incident too.</p> <p>Interview on 07/02/24 at 3:09 P.M. with Licensed Social Worker (LSW) #287, who does care plans for resident behaviors, confirmed Resident #101's did not have a comprehensive and individualized plan of care in place to prevent sexual abuse/address sexually inappropriate behavior(s).</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365746	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2024
NAME OF PROVIDER OR SUPPLIER Brentwood Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 907 Aurora Rd Sagamore Hills, OH 44067	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy, Abuse, Neglect, and Exploitation, revised 12/04/23 revealed the facility defined sexual abuse as non-consensual sexual contact of any type with a resident. The policy revealed the facility would provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property.</p> <p>Investigation of Alleged, Neglect and Exploitation included an immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. Written procedures for investigation include: identifying staff responsible for the investigation; exercising caution in handing evidence that could be used in a criminal investigation, investigating different types of alleged violations, identifying and interviewing all persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; focusing the investigation on determining is abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause, and provide complete and thorough documentation of the investigation.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00154836 and Complaint Number OH00154684.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365746	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2024
NAME OF PROVIDER OR SUPPLIER Brentwood Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 907 Aurora Rd Sagamore Hills, OH 44067	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43061</p> <p>Based on record review and interview, the facility failed to develop and implement comprehensive care plans for Resident #100's Intravenous (IV) medication. This affected one residents (Resident #100) out of three residents reviewed for care plans.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #100 revealed an admitted [DATE] and a discharge date of [DATE] with diagnosis including but not limited to displaced intertrochanteric fracture of right femur, rheumatoid arthritis, chronic obstructive pulmonary disease (COPD), paroxysmal atrial fibrillation, chronic diastolic congestive heart failure, anxiety disorder, and depression.</p> <p>Review of the Medicare 5 day Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #100 had intact cognition.</p> <p>Review of the physician order dated 04/15/24 revealed an order for Intravenous (IV) for Zosyn (antibiotic medication) reconstitute 3.375 (3-0.375) gram (gm) (piperacillin sodium-tazobactam sodium) administer every 6 hours for atelectasis (complete or partial collapse of lung).</p> <p>Review of the current care plan dated 03/22/24 revealed no care plan to address Resident #100's IV medication.</p> <p>Interview on 07/02/24 at 1:50 P.M. with LPN #285 (MDS Nurse) confirmed there was no care plan for the IV for Resident #100.</p>