STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365748	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Oak Manor	1926 Ridge Avenue Warren, OH 44484

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48565 Based on record review, interview and facility policy review, the facility failed to implement their abuse policy regarding thoroughly investigating and failing to submit a self-reported incident (SRI) to the state agency of an allegation of staff-to-resident verbal abuse for Resident #2. This affected one resident (#2) of three residents reviewed for abuse. The facility census was 34. Findings include: Review of the medical record revealed Resident#2 was admitted to the facility on [DATE] with diagnoses including depression, anxiety, morbid obesity, and a need for assistance with personal care. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #2 was cognitively intact. Review of the care plan dated 03/25/24 revealed Resident #2 had an activity of daily living (ADL) deficit and required the assistance of one to two staff to complete bathing, toileting and grooming. The care plan also revealed Resident #2 can display accusatory and paranoid behaviors and refused for certain staff to be in her room. Interventions included allow resident to discuss feelings, approach and speak to resident in a calm voice. On 05/07/02 at 10:26 A.M. an interview with Long Term Care Ombudsman (LTCOs) # 98 and #99 revealed they were at the facility on 04/23/24. They interviewed Resident #2 during their visit, and Resident #2 told them State tested Nurse Aide (STNA) #63 had called her a [expletive]. LTCOs #98 and #99 stated they told the facility Administrator immediately after the interview with Resident #2. LTCOs #98 and #99 stated they called the facility for follow-up on 04/26/24 and were informed by the Administrator a care conference was held with Resident #2, and the allegation of staff-to-resident abuse did not need to be thoroughly investigated. On 05/07/24 at 1:00 P.M.an interview with the Administrator and the Director of Nursing (DON) revealed they did not implement their abuse policy and investigated the allegation of staff-to-resident verbal abuse for Resident #2. Both stated they had a care conference with Resident #2, and her son and Resident #2 did not feel abused or mistreated. Both stated State tested Nursing Assistant (STNA) #63, the alleged perpetrator, was removed from being assigned to Resident #2 but was not removed from schedule. Both verified there were no staff witness statements for the day of the occurrence nor were there resident interviews regarding the incident. In addition, the facility did not submit an (SRI) to the state agency. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the policy titled, Abuse, Neglect and Exploitation dated 10/01/22, revealed on page four, section five, point A: An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. The policy also revealed on page four, section seven, point A, subpoint 1: Reporting of alleged violations to the Administrator, state agency, adult protective services and to all other required agency within specified timeframes: shall occur no later than two hours if events that cause the allegation do involve abuse and result in serious bodily injury. Reporting should not occur later than 24 hours if events that cause the allegation do not involve abuse and do not result in serious bodily injury. This deficiency represents non-compliance investigated under Complaint Number OH00153594

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365748	A. Building B. Wing	05/08/2024

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White Oak Manor	1926 Ridge Avenue Warren, OH 44484

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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 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** 48565 Based on record review, interview and facility policy review, the facility failed to report an allegation of staff-to-resident verbal abuse to the state agency for Resident #2. This affected one resident (#2) of three residents reviewed for abuse. The facility census was 34. Findings include: Review of the medical record revealed Resident#2 was admitted to the facility on [DATE] with diagnoses including depression, anxiety, morbid obesity, and a need for assistance with personal care. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #2 was cognitively intact and had verbal behaviors one to three times in the seven day look back period. Review of the care plan dated 03/25/24 revealed Resident #2 had an activity of daily living (ADL) deficit and required the assistance of one to two staff to complete bathing, toileting and grooming. The care plan also revealed Resident #2 can display accusatory and paranoid behaviors and refuses for certain staff to be in her room. Interventions included allow resident to discuss feelings, approach and speak to resident in a calm voice. On 05/07/02 at 10:26 A.M. an interview with Long Term Care Ombudsman (LTCOs) #98 and #99 revealed they were at the facility on 04/23/24. They interviewed Resident #2 during their visit, and Resident #2 told them State tested Nurse Aide (STNA) #63 had called her a [expletive]. LTCOs #98 and #99 stated they told the facility Administrator immediately after the interview with Resident #2. LTCOs #98 and #99 stated they called the facility for follow-up on 04/26/24 and were informed by the Administrator a care conference was held with Resident #2, and the allegation of staff-to-resident abuse did not need to be thoroughly investigated. An interview was conducted on 05/07/24 at 1:00 P.M. with the Administrator and the Director of Nursing (DON) who both verified they had not reported the allegation of staff-to-resident abuse involving Resident #2 to the state agency. The Administrator and DON verified the allegation was brought to administration's attention by the Ombudsman on 04/23/24. A review of the policy titled, Abuse, Neglect and Exploitation, dated 10/01/22, revealed on page four, section seven, point A, subpoint 1: Reporting of alleged violations to the Administrator, stated agency, adult protective services and to all other required agency within specified timeframes: shall occur no later than two hours if events that cause the allegation do involve abuse and result in serious bodily injury. Reporting should not occur later than 24 hours if events that cause the allegation do not involve abuse and do not result in serious bodily injury. This deficiency represents non-compliance investigated under Complaint Number OH00153594

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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 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** 48565 Based on record review, interview and facility policy review, the facility failed to thoroughly investigate an allegation of staff-to-resident verbal abuse for Resident #2. This affected one resident (#2) of three residents reviewed for abuse. The facility census was 34. Findings include: Review of the medical record revealed Resident#2 was admitted to the facility on [DATE] with diagnoses including depression, anxiety, morbid obesity, and a need for assistance with personal care. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #2 was cognitively intact. Review of the care plan dated 03/25/24 revealed Resident #2 had an activity of daily living (ADL) deficit and required the assistance of one to two staff to complete bathing, toileting and grooming. The care plan also revealed Resident #2 can display accusatory and paranoid behaviors and refuses for certain staff to be in her room. Interventions included allow resident to discuss feelings, approach and speak to resident in a calm voice. On 05/07/02 at 10:26 A.M. an interview with Long Term Care Ombudsman (LTCOs) #98 and #99 revealed they were at the facility on 04/23/24. They interviewed Resident #2 during their visit, and Resident #2 told them State tested Nurse Aide (STNA) #63 had called her a [expletive]. LTCOs #98 and #99 stated they told the facility Administrator immediately after the interview with Resident #2. LTCOs #98 and #99 stated they called the facility for follow-up on 04/26/24 and were informed by the Administrator a care conference was held with Resident #2, and the allegation of staff-to-resident abuse did not need to be thoroughly investigated. On 05/07/24 at 1:00 P.M.an nterview with the Administrator and the Director of Nursing (DON) revealed they did not thoroughly investigate the allegation of staff-to-resident verbal abuse for Resident #2. Both stated they had a care conference with Resident #2, and her son and Resident #2 did not feel abused or mistreated. Both stated STNA #63 was removed from being assigned to Resident #2 but was not removed from schedule. Both verified there were no staff witness statements for the day of the occurrence nor were there resident interviews regarding the incident. A review of the policy titled, Abuse, Neglect and Exploitation dated 10/01/22, revealed on page four, section five, point A: An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. This deficiency represents non-compliance investigated under Complaint Number OH00153594