STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365779	A. Building B. Wing	10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wyant Woods Healthcare Center	200 Wyant Rd Akron, OH 44313

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 - Immediate jeopardy to resident health or safety 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** 44808 THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on record review, review of the facility's self-reported incident (SRI) and associated facility investigation, review of police reports, review of facility policy, and interviews, the facility failed to prevent an incident of staff to resident abuse for Resident #78. This resulted in Immediate Jeopardy and actual physical and psychosocial harm on 09/19/24 when State tested Nursing Assistant (STNA) #942 physically abused Resident #78 by spraying the resident in the face with oleoresin capsicum (OC) spray (also known as pepper spray). As a result, Resident #78 complained of his eyes burning and facility staff observed his eyes were red. In addition, a Post-Traumatic Stress Disorder (PTSD) Assessment was completed for Resident #78 on 09/20/24, which indicated Resident #78 considered the event traumatic, had nightmares or thought about the event when he did not want to, had been frequently on guard or watchful or easily startled, and felt guilty or unable to stop blaming himself or others for the event. On 10/17/24 at 4:38 P.M., the Administrator, Director of Nursing (DON), Regional Nurse #938, and Regional Director of Operations #943 were notified Immediate Jeopardy began on 09/19/24 when STNA #942 physically abused Resident #78 by spraying the resident in the face with pepper spray. Resident #78 complained of his eyes burning and his eyes were red as observed and reported by Licensed Practical Nurse (LPN) #941. STNA #919 alerted Unit Manager #809 via text message on 09/19/24 at 9:54 A.M. that a resident had been maced and help was needed. Per the facility's timeline for the incident, an investigation did not begin until 09/19/24 at 1:56 P.M., approximately four hours after the incident was reported to Unit Manager #809. STNA #942 continued working in the facility until 2:17 P.M. A PTSD Assessment, completed 09/20/24, indicated Resident #78 considered the incident traumatic and described the incident as he had a heated conversation with staff and then he was sprayed in the face with pepper spray. The Immediate Jeopardy was removed and the deficient practice was corrected on 09/25/24 when the facility implemented the following corrective actions: On 09/19/24 at 1:51 P.M. STNA #919 notified the DON that Resident #78 was maced. Educated STNA #919 that she was to report any incidents related to abuse to the Administrator and DON immediately. Obtained STNA #919's witness statement. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 09/19/24 at 1:54 P.M. the DON interviewed STNA #942 of the alleged incident. STNA #942 relayed she was cleaning the hallway and Resident #78 must have touched the railing and touched his eyes. She also stated the floor nurse already educated her and made her dispose of the cleaning supplies. The DON obtained STNA #942's witness statement and placed STNA #942 in the receptionist area to immediately separate Resident #78 and STNA #942. On 09/19/24 at 1:59 P.M. the DON interviewed Licensed Practical Nurse (LPN) #941 who communicated cleaning supplies were used on Hickory unit and that she made STNA #942 empty the chemical mixture and educated her on not using cleaning supplies in the facility again. On 09/19/24 at 2:00 P.M. the DON notified the Administrator, Regional Director of Operations #943 and Regional Director of Clinical Operations #944 of the incident. On 09/19/24 at 2:00 P.M. the DON notified the facility's nurse practitioner (NP) of the incident and requested for NP to assess resident. The resident was assessed at 2:28 P.M. On 09/19/24 at 2:10 P.M. the DON suspended STNA #942 for possibly spraying [NAME] towards Resident #78. On 09/19/24 at 2:30 P.M. the DON obtained a new order to monitor Resident #78's eyes and face for abnormalities. New order confirmed. The resident was assessed by the DON on 09/19/24 at 3:20 P.M. related to the incident and for pain. Additional assessment was completed on 09/20/24 at 4:37 P.M. On 09/19/24 at 2:30 P.M. the DON attempted to call Resident #78's guardian to notify the guardian of the incident. A voicemail message was left. The guardian was notified at 6:46 P.M. On 9/19/24 2:59 P.M. the DON notified the local police department of the incident. On 09/19/24 at 3:00 P.M. Unit Manager #809 completed a respiratory assessment on Resident #78. On 09/19/24 at 3:03 P.M. Unit Manager #835 suspended LPN #941. On 09/19/24 3:45 P.M. all residents on the Hickory unit were assessed for respiratory, skin and eye concerns related to the chemicals that were sprayed on the unit. On 09/19/24 all interviewable residents were interviewed regarding abuse by Unit Manager #861. Skin sweeps were completed for residents with a low cognition. On 09/19/24 at 4:20 P.M. facility managers completed skin checks and interviews on all facility residents. On 09/19/24 at 4:30 P.M. the DON notified the Medical Director of the incident. On 09/19/24 at 4:52 P.M. social services staff met with Resident #78 to provide support to the resident. On 09/19/24 at 7:04 P.M. Resident #78's psych physician was notified of incident and new orders were given to increase Seroquel (antipsychotic medication). (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 09/19/24 the DON/Designee interviewed staff on any potential abuse to ensure all incidents had been investigated and reported. On 09/19/24 the DON/Designee interviewed all staff on the current shift and next shift to identify if any weapons were on the facility grounds. On 09/19/24 the DON/Designee educated all staff on the facility policy identified as, abuse, neglect, and misappropriation with emphasis on timely reporting, who to report incidents of abuse to, ensuring safety of the residents, and effective investigation. On 09/19/24 the DON/Designee educated all staff on no tolerance/allowance of weapons in the facility with emphasis on what was considered a weapon. Staff were educated that all harmful substances on person, key chains, purses, backpacks must be left outside of facility. All harmful substances on keychains must be removed prior to entrance in the building. Staff educated that increase observation would be ongoing for such items and that all violations identified would result in suspension until a thorough investigation was completed and had the potential to lead to termination. On 09/19/24 the DON/Designee educated all facility department managers on increase supervision and Ambassador rounds with emphasis on monitoring and observation of any form of weapon, this includes observation of uniforms, keys, and open bags or purses. On 09/19/24 around 5:00 P.M. via a zoom call Divisional [NAME] President of Risk educated the DON and Unit Managers on reporting guidelines related to abuse, investigation, reporting, maintaining safety of residents, and what constitutes an allegation, company weapons policy and expectations. On 09/20/24 STNA #942's employment was terminated related to the incident with Resident #78. On 09/20/24 at 7:34 P.M. local police were updated with findings of the facility investigation. The police were pursuing assault charges against STNA #942. On 09/23/24 the Administrator/Designee reviewed LPN #941 and STNA #942's employee files for background checks, references, abuse and resident rights training due to the fact they were the perpetrators in this incident. On 09/23/24 all facility staff were educated by an outside company on Empathy, Psychiatric Behaviors, and De-Escalation. Staff on Leave or Paid Time Off will be educated upon return and prior to working. Two employees remain on leave and will be educated by the ED/Designee upon return. Beginning the week of 09/25/24 the facility implemented a plan for the DON/Designee to educate all new staff in behavioral health management, abuse, and weapons policy. This would be ongoing as part of new hire orientation which was ongoing. Beginning the week of 09/24/24 the DON/Designee would interview five residents weekly for four weeks for any abuse concerns. Then three residents weekly for four weeks. Then randomly thereafter until compliance was confirmed. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Beginning the week of 09/25/24 the Administrator/Designee would interview five staff members weekly for four weeks for any abuse concerns. Then three staff members weekly for four weeks. Then randomly thereafter until compliance was confirmed. Beginning the week of 09/25/24 the DON/Designee would review five weekly skin assessments on residents who were unable to be interviewed to ensure no new skin findings for four weeks. Then three weekly skin assessments weekly four weeks. Then randomly thereafter. Beginning the week of 09/25/24 the Administrator/Designee would audit completion of daily ambassador rounds for increased surveillance of weapons in the facility daily for four weeks then three times weekly for four weeks, then randomly thereafter. Beginning the week of 09/25/24 the Administrator/Designee would audit completion of new hire education on Weapon Free Workplace policy weekly for four weeks then randomly thereafter. Beginning the week of 09/25/24 the Administrator or DON would monitor compliance in monthly Quality Assessment and Performance Improvement (QAPI) meeting for three months, then as needed for one year. Beginning on 10/01/24 to ensure staff comprehend understanding of education on responding to challenging behaviors the facility implemented monthly monitoring with education and pre/post test times for months. The facility implemented a plan for all allegations of abuse to be reported to the Regional Director of Clinical Operations #944 by the Director of Nursing or Administrator as soon as the allegation was made as additional oversight. The facility implemented a plan for Regional Director of Clinical Operations #944 to monitor compliance during monthly visits for three months then on an as needed basis. Findings include: Review of the medical record for Resident #78 revealed an admitted [DATE] and re-admitted [DATE]. Diagnoses included hemiplegia and hemiparesis affecting right dominant side, aphasia following cerebral infarction, hypertension, vascular dementia with mood and behavior disturbance, expressive language disorder, adjustment disorder with mixed disturbance of emotions and conduct, dysphagia following cerebral infarction, impulse disorder, anxiety disorder, delusional disorders, intermittent explosive disorder, bipolar disorder, and major depressive disorder. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the behavior care plan, revised 08/27/24, revealed Resident #78 had a behavior problem related to impulse disorder, dementia, bipolar disorder, verbally aggressive or threatening, touching staff inappropriately, making inappropriate comments, and refusal of care. Interventions included provide medications as ordered (01/06/23), approach and speak in a calm manner (01/06/23), consult behavioral health as needed (01/06/23), communicate with resident regarding behaviors and treatment (01/06/23), encourage resident to express feelings (01/06/23), encourage resident to maintain as much independence and control or decision making as possible (01/06/23), intervene as necessary to protect the rights and safety of others (01/06/23), minimize the potential for disruptive behaviors by offering snacks that divert attention (01/06/23), monitor behavioral episodes and attempt to determine underlying causes (01/06/23), notify medical director of increased behaviors (01/06/23), observe and anticipate resident's needs (01/06/23), praise any indication of progress in behaviors (01/06/23), psychosocial assessment completed (09/19/24), and PTSD screen completed (09/19/24). Review of a nursing note dated 09/19/24 at 2:00 P.M. revealed the nurse practitioner was notified by the Director of Nursing (DON) that Resident #78 had possible contact with chemical to eyes. Another note dated 09/19/24 at 2:00 P.M. revealed the DON notified the Administrator, Regional Director of Operations, and Regional Director of Clinical Services of the incident. A note dated 09/19/24 at 2:28 P.M. revealed the nurse practitioner assessed Resident #78 and noted Resident #78's face and eyes were clear with no redness or swelling noted. Resident #78 denied pain and reported to the nurse practitioner that he had been rubbing his eyes. A note dated 09/19/24 at 3:20 P.M. revealed Resident #78 was assessed to be pleasant without signs of discomfort or distress and there was no redness or irritation to Resident #78's eyes, face, or skin. Review of a facility submitted SRI dated 09/19/24 revealed a chemical made contact with Resident #78's eyes. Further review of the facility's SRI investigation revealed STNA #942 had sprayed oleoresin capsicum (OC) spray (also known as pepper spray) toward Resident #78. Review of facility witness statements revealed Resident #81 witnessed STNA #942 spray Resident #78 with [NAME]. STNA #919's statement indicated STNA #942 told STNA #919 that she sprayed Resident #78 with [NAME] and STNA #919 reported it to the nurse and unit manager immediately. Licensed Practical Nurse (LPN) #941's statement indicated Resident #78's eyes were burning and red and Resident #78 indicated he was sprayed with something. STNA #942's witness statement indicated she was cleaning the unit railings and door handles with a cleaning chemical and Resident #78 got some on his hands and then touched his face. There was no mention of pepper spray or [NAME] in STNA #942's witness statement. Review of Maintenance Director #899's witness statement indicated he was notified of a chemical odor on 09/19/24 at 9:40 A.M., he went to the designated unit, he did not smell anything unusual, and staff on the unit reported the odor was cleaning chemicals. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's timeline of their investigation indicated the alleged incident occurred around 10:00 A.M., facility management were not notified of the alleged abuse until 1:55 P.M., and the investigation of the incident began at 1:56 P.M. The facility's timeline further indicated STNA #942 was suspended on 09/19/24 at 2:15 P. M. and LPN #941 was suspended on 09/19/24 at 3:03 P.M. as a result of the incident. Review of the time punch detail for STNA #942 revealed she worked on 09/19/24 from 7:07 A.M. to 2:17 P. M. Review of the time punch detail for LPN #941 revealed she worked on 09/19/24 from 6:03 A.M. to 3:06 P. M. Review of the nurse aide behavior task record for 09/19/24 revealed Resident #78 refused care at 2:06 A.M. and no other behaviors were documented to have occurred. Review of the behavior monitoring report for September 2024 revealed Resident #78 had no documented behaviors on 09/19/24. Review of the police report, dated 09/19/24 at 2:59 P.M., revealed the local police department was contacted by the DON to report Resident #78 got a chemical in his eyes. Review of a second police report, dated 09/20/24 at 7:34 P.M., revealed the local police department was contacted by the DON to report staff to resident abuse and to update that the chemical in Resident #78's eyes was pepper spray. Review of the Post-Traumatic Stress Disorder (PTSD) Assessment, dated 09/20/24, indicated Resident #78 considered the event (that had occurred on 09/19/24) traumatic, had nightmares or thought about the event when he did not want to, had been frequently on guard or watchful or easily startled, and felt guilty or unable to stop blaming himself or others for the event. Resident #78 described the event as he got into a heated conversation with staff about the smoke break, he got agitated, and the next thing he knew was he was getting sprayed in the eyes with pepper spray. Review of the PTSD Assessment, dated 09/21/24, indicated Resident #78 considered the event (that occurred on 09/19/24) traumatic and had been frequently on guard or watchful or easily startled. He described the event as he got into an argument with staff over the smoke break, he got agitated, and the next thing he knew was he was getting sprayed in the eyes with that spray. Review of the quarterly Minimum Data Set (MDS) Assessment, dated 09/23/24, revealed Resident #78 was rarely or never understood with moderately impaired cognitive skills for daily decision making. The assessment indicated Resident #78 did not have any indicators of psychosis and no physical or verbal behaviors during the seven-day lookback period. Further review of Resident #78's record revealed there was no other documentation regarding the incident prior to the progress note dated 09/19/24 at 2:00 P.M. On 10/16/24 at 9:11 A.M., an interview with LPN Unit Manager #835 revealed Resident #78 could be combative with care sometimes and that his behaviors were not serious enough to cause fear or require restraint. She stated Resident #78 was usually cooperative with care. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/16/24 at 11:55 A.M., an interview with the Administrator and DON revealed the Administrator was out of town at the time of the incident and the DON conducted the investigation. The Administrator and DON confirmed STNA #942 sprayed Resident #78 with pepper spray. The Administrator and DON said initially it was reported that Resident #78 got cleaning chemicals in his eyes and further investigation determined that was inaccurate. On 10/16/24 at 2:00 P.M., an interview with Unit Manager #861 stated the management team was sitting in morning meeting around 9:30 A.M. on the day of the incident when one of the managers received a text about someone being maced on the unit and there was an odor. Unit Manager #861 stated maintenance staff went to the unit and the nurse closed the door in his face. Unit Manager #861 asked LPN #941 three times about the reported odor on the unit and LPN #941 told him on the third time, which Unit Manager #861 said was around 12:00 P.M., that it was cleaning chemicals that had been used and since thrown out. Unit Manager #861 said he was not involved in the entire investigation. On 10/16/24 at 2:31 P.M., an attempt was made to contact STNA #942 was unsuccessful. A recorded message indicated the number was out of service. On 10/16/24 at 2:50 P.M., an interview with the Administrator and DON confirmed the facility's timeline for the incident as noted above, including that management staff were not aware of the incident until 09/19/24 at 1:55 P.M. and suspensions were implemented after management staff were notified. On 10/17/24 at 10:49 A.M., an interview with STNA #919 revealed she was assisting another resident with breakfast when she heard a commotion in the hallway. Upon entering the hallway, she noted Resident #78 had an orange residue dripping down his face and STNA #942 told her Resident #78 tried to hit STNA #942 and she maced him. STNA #919 stated she alerted the nurse, Resident #78's eyes were cleaned, and Resident #78 was given a shower to remove the remaining orange residue from his hair and face. STNA #919 said she texted Unit Manager #809 on 09/19/24 at 9:54 A.M. to notify her that Resident #78 had been maced on the unit. Observation of the text conversation at the time of interview confirmed the date and time the text message notification was sent from STNA #919 to Unit Manager #809. On 10/17/24 at 11:27 A.M., an interview with Unit Manager #809 revealed she was in morning meeting when someone reported an odor on the unit. Unit Manager #809 confirmed STNA #919 texted her on 09/19/24 at 9:54 A.M. notifying her that someone had been massed on the unit, STNA #919 then clarified it smelled like bear [NAME], and STNA #919 said Resident #78 needed help. Unit Manager #809 said she asked STNA #919 if the nurse was over there and STNA #919 said she told LPN #941 and LPN #941 was in the office. Unit Manager #809 said she texted LPN #941 on 09/19/24 at 10:34 A.M. to ask if everything was okay and LPN #941 texted back that Resident #78 must have gotten a chemical in his eyes because his eyes were burning, and they flushed his eyes. Unit Manager #809 stated she went to the unit around 11:15 A.M. to assess Resident #78 with no significant findings, there was no odor of [NAME] on the unit, and none of the residents complained of burning sensations or difficulty breathing at that time. Unit Manager #809 further stated that STNA #919 did not approach management staff until later in the day to state what really happened and that's when management began investigating the possibility of [NAME] instead of a cleaning chemical. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/22/24 at 1:07 P.M., and interview with LPN #941 revealed Resident #78 got some sort of chemical in his eyes, she assessed him, flushed his eyes, and alerted the unit manager he got a chemical in his eyes and she had flushed them. LPN #941 revealed she had the STNA dispose of the chemical and she denied knowledge of the chemical being [NAME] or pepper spray. LPN #941 revealed later in the day she was suspected pending an investigation and at the time, she didn't have any reason to suspect it was anything other than a cleaning chemical because what is what the STNA reported to her. LPN revealed she was fired for supposedly covering up abuse of a resident but she denies she did this. LPN #941 revealed staff were fearful for their lives because of the dangerous people in the building, and management staff did not care and told staff they couldn't restrain residents or lay a hand on the residents to protect themselves in any way from resident behaviors. LPN #941 reiterated it was dangerous at the facility. Review of the facility's policy titled OHIO Abuse, Neglect & Misappropriation, dated 10/27/21, revealed the facility would prevent abuse, mistreatment, or neglect of residents and provide guidance to staff to manage any concerns or allegations of abuse or neglect. Employees would receive abuse prevention training during orientation, annually, and as needed. Staff would be educated upon hire, annually, and as needed to include reporting allegations of abuse or neglect without fear of reprisal, interventions to deal with aggressive behaviors, and timely reporting of reasonable suspicion of a crime in the facility. Any employee who was alleged or accused of being a party to abuse or neglect would be immediately removed from the area of resident care, interviewed by facility leadership for a written statement, and not left alone. After completing their statement, the employee(s) would be asked to vacate the facility until further investigation of the incident was completed. Appropriate measures would be taken with the employee post investigation including disciplinary action and termination if appropriate. Each occurrence of resident incidents or alleged abuse would be identified and reported to the supervisor for timely investigation. The supervisor or designee would notify the DON and ED of the allegation immediately and the ED would direct the investigation. This deficiency represents non-compliance investigated under Complaint Numbers OH00159114, OH00158216, and OH00158183.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44808 Based on record review, review of the facility's self-reported incident (SRI) and associated facility investigation, review of facility policy, and staff interviews, the facility failed to ensure staff reported allegations of abuse in a timely manner. This affected one resident (#78) of three reviewed for abuse. The facility census was 167. Findings include: Review of the medical record for Resident #78 revealed an admitted [DATE] and re-admitted [DATE]. Diagnoses included hemiplegia and hemiparesis affecting right dominant side, aphasia following cerebral infarction, hypertension, vascular dementia with mood and behavior disturbance, expressive language disorder, adjustment disorder with mixed disturbance of emotions and conduct, dysphagia following cerebral infarction, impulse disorder, anxiety disorder, delusional disorders, intermittent explosive disorder, bipolar disorder, and major depressive disorder. Review of the behavior care plan, revised 08/27/24, revealed Resident #78 had a behavior problem related to impulse disorder, dementia, bipolar disorder, verbally aggressive or threatening, touching staff inappropriately, making inappropriate comments, and refusal of care. Interventions included provide medications as ordered (01/06/23), approach and speak in a calm manner (01/06/23), consult behavioral health as needed (01/06/23), communicate with resident regarding behaviors and treatment (01/06/23), encourage resident to express feelings (01/06/23), encourage resident to maintain as much independence and control or decision making as possible (01/06/23), intervene as necessary to protect the rights and safety of others (01/06/23), minimize the potential for disruptive behaviors by offering snacks that divert attention (01/06/23), monitor behavioral episodes and attempt to determine underlying causes (01/06/23), notify medical director of increased behaviors (01/06/23), observe and anticipate resident's needs (01/06/23), praise any indication of progress in behaviors (01/06/23), psychosocial assessment completed (09/19/24), and PTSD screen completed (09/19/24). Review of the facility submitted SRI dated 09/19/24 revealed a chemical made contact with Resident #78's eyes. Further review of the facility's SRI investigation revealed STNA #942 had sprayed oleoresin capsicum (OC) spray (also known as pepper spray) toward Resident #78. Review of the witness statements revealed Resident #81 witnessed STNA #942 spray Resident #78 with [NAME], STNA #919's statement indicated STNA #942 told STNA #919 that she sprayed Resident #78 with [NAME] and STNA #919 reported it to the nurse and unit manager immediately, and Licensed Practical Nurse (LPN) #941's statement indicated Resident #78's eyes were burning and red and Resident #78 indicated he was sprayed with something. The facility's timeline of their investigation indicated the alleged incident occurred around 10:00 A.M., facility management were not notified of the alleged abuse until 1:55 P.M., and the investigation of the incident began at 1:56 P.M. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Post-Traumatic Stress Disorder (PTSD) Assessment, dated 09/20/24, indicated Resident #78 considered the event traumatic, had nightmares or thought about the event when he did not want to, had been frequently on guard or watchful or easily startled, and felt guilty or unable to stop blaming himself or others for the event. Resident #78 described the event as he got into a heated conversation with staff about the smoke break, he got agitated, and the next thing he knew was he was getting sprayed in the eyes with pepper spray. Review of the PTSD Assessment, dated 09/21/24, indicated Resident #78 considered the event traumatic and had been frequently on guard or watchful or easily startled. He described the event as he got into an argument with staff over the smoke break, he got agitated, and the next thing he knew was he was getting sprayed in the eyes with that spray. On 10/16/24 at 11:55 A.M., an interview with the Administrator and DON stated the Administrator was out of town at the time of the incident and the DON conducted the investigation. The Administrator and DON confirmed STNA #942 sprayed Resident #78 with pepper spray. The Administrator and DON said initially it was reported that Resident #78 got cleaning chemicals in his eyes and further investigation determined that was inaccurate. On 10/16/24 at 2:00 P.M., an interview with Unit Manager #861 stated the management team was sitting in morning meeting around 9:30 A.M. on the day of the incident when one of the managers received a text about someone being maced on the unit and there was an odor. On 10/16/24 at 2:50 P.M., an interview with the Administrator and DON confirmed the facility's timeline for the incident, including that management staff were not aware of the incident until 09/19/24 at 1:55 P.M. On 10/17/24 at 10:49 A.M., an interview with STNA #919 stated she was assisting another resident with breakfast when she heard a commotion in the hallway. Upon entering the hallway, she noted Resident #78 had an orange residue dripping down his face and STNA #942 told her Resident #78 tried to hit STNA #942 and she maced him. STNA #919 stated she alerted the nurse, Resident #78's eyes were cleaned, and Resident #78 was given a shower to remove the remaining orange residue from his hair and face. STNA #919 said she texted Unit Manager #809 on 09/19/24 at 9:54 A.M. to notify her that Resident #78 had been maced on the unit. Observation of the text conversation at the time of interview confirmed the date and time the text message notification was sent from STNA #919 to Unit Manager #809. On 10/17/24 at 11:27 A.M., an interview with Unit Manager #809 stated she was in morning meeting when someone reported an odor on the unit. Unit Manager #809 confirmed STNA #919 texted her on 09/19/24 at 9:54 A.M. notifying her that someone had been massed on the unit, STNA #919 then clarified it smelled like bear [NAME], and STNA #919 said Resident #78 needed help. Unit Manager #809 said she asked STNA #919 if the nurse was over there and STNA #919 said she told LPN #941 and LPN #941 was in the office. Unit Manager #809 said she texted LPN #941 on 09/19/24 at 10:34 A.M. to ask if everything was okay and LPN #941 texted back that Resident #78 must have gotten a chemical in his eyes because his eyes were burning and they flushed his eyes. Unit Manager #809 stated she went to the unit around 11:15 A.M. to assess Resident #78 with no significant findings, there was no odor of [NAME] on the unit, and none of the residents complained of burning sensations or difficulty breathing at that time. Unit Manager #809 further stated that STNA #919 did not approach management staff until later in the day to state what really happened and that's when management began investigating the possibility of [NAME] instead of a cleaning chemical. (continued on next page)

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	365779	A. Building B. Wing	10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wyant Woods Healthcare Center	200 Wyant Rd Akron, OH 44313

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled OHIO Abuse, Neglect & Misappropriation, dated 10/27/21, revealed the facility would prevent abuse, mistreatment, or neglect of residents and provide guidance to staff to manage any concerns or allegations of abuse or neglect. Each occurrence of resident incidents or alleged abuse would be identified and reported to the supervisor for timely investigation. The supervisor or designee would notify the DON and ED of the allegation immediately and the ED would direct the investigation. This deficiency represents non-compliance investigated under Complaint Numbers OH00159114, OH00158216, and OH00158183.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44808 Based on record review, review of the facility's self-reported incident (SRI) and associated facility investigation, review of facility policy, and staff interviews, the facility failed to remove a perpetrator of abuse from the facility immediately to ensure all residents were protected from further abuse. This affected one resident (#78) and had the potential to affect 22 additional residents (#61, #62, #63, #64, #65, #66, #67, #68, #69, #70, #71, #72, #73, #74, #75, #76, #77, #79, #80, #81, #82, and #83) who resided on the secured Hickory unit. The facility census was 167. Findings include: Review of the medical record for Resident #78 revealed an admitted [DATE] and re-admitted [DATE]. Diagnoses included hemiplegia and hemiparesis affecting right dominant side, aphasia following cerebral infarction, hypertension, vascular dementia with mood and behavior disturbance, expressive language disorder, adjustment disorder with mixed disturbance of emotions and conduct, dysphagia following cerebral infarction, impulse disorder, anxiety disorder, delusional disorders, intermittent explosive disorder, bipolar disorder, and major depressive disorder. Review of the facility submitted SRI dated 09/19/24 revealed a chemical made contact with Resident #78's eyes. Further review of the facility's SRI investigation revealed STNA #942 had sprayed oleoresin capsicum (OC) spray (also known as pepper spray) toward Resident #78. Review of the witness statements revealed Resident #81 witnessed STNA #942 spray Resident #78 with [NAME], STNA #919's statement indicated STNA #942 told STNA #919 that she sprayed Resident #78 with [NAME] and STNA #919 reported it to the nurse and unit manager immediately, and Licensed Practical Nurse (LPN) #941's statement indicated Resident #78's eyes were burning and red and Resident #78 indicated he was sprayed with something. The facility's timeline of their investigation indicated the alleged incident occurred around 10:00 A.M., facility management were not notified of the alleged abuse until 1:55 P.M., and the investigation of the incident began at 1:56 P.M. The facility's timeline further indicated STNA #942 was suspended on 09/19/24 at 2:15 P. M. and LPN #941 was suspended on 09/19/24 at 3:03 P.M. Review of the time punch detail for STNA #942 revealed she worked on 09/19/24 from 7:07 A.M. to 2:17 P.M. Review of the time punch detail for LPN #941 revealed she worked on 09/19/24 from 6:03 A.M. to 3:06 P.M. Review of the Post-Traumatic Stress Disorder (PTSD) Assessment, dated 09/20/24, indicated Resident #78 considered the event traumatic, had nightmares or thought about the event when he did not want to, had been frequently on guard or watchful or easily startled, and felt guilty or unable to stop blaming himself or others for the event. Resident #78 described the event as he got into a heated conversation with staff about the smoke break, he got agitated, and the next thing he knew was he was getting sprayed in the eyes with pepper spray. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the PTSD Assessment, dated 09/21/24, indicated Resident #78 considered the event traumatic and had been frequently on guard or watchful or easily startled. He described the event as he got into an argument with staff over the smoke break, he got agitated, and the next thing he knew was he was getting sprayed in the eyes with that spray. On 10/16/24 at 2:00 P.M., an interview with Unit Manager #861 stated the management team was sitting in morning meeting around 9:30 A.M. on the day of the incident when one of the managers received a text about someone being maced on the unit and there was an odor. On 10/16/24 at 2:50 P.M., an interview with the Administrator and DON confirmed the facility's timeline for the incident, including that management staff were not aware of the incident until 09/19/24 at 1:55 P.M. and suspensions were implemented after management staff were notified. On 10/17/24 at 10:49 A.M., an interview with STNA #919 stated she was assisting another resident with breakfast when she heard a commotion in the hallway. Upon entering the hallway, she noted Resident #78 had an orange residue dripping down his face and STNA #942 told her Resident #78 tried to hit STNA #942 and she maced him. STNA #919 stated she alerted the nurse, Resident #78's eyes were cleaned, and Resident #78 was given a shower to remove the remaining orange residue from his hair and face. STNA #919 said she texted Unit Manager #809 on 09/19/24 at 9:54 A.M. to notify her that Resident #78 had been maced on the unit. Observation of the text conversation at the time of interview confirmed the date and time the text message notification was sent from STNA #919 to Unit Manager #809. On 10/17/24 at 11:27 A.M., an interview with Unit Manager #809 confirmed STNA #919 texted her on 09/19/24 at 9:54 A.M. notifying her that someone had been massed on the unit, STNA #919 then clarified it smelled like bear [NAME], and STNA #919 said Resident #78 needed help. Unit Manager #809 said she asked STNA #919 if the nurse was over there and STNA #919 said she told LPN #941 and LPN #941 was in the office. Unit Manager #809 said she texted LPN #941 on 09/19/24 at 10:34 A.M. to ask if everything was okay and LPN #941 texted back that Resident #78 must have gotten a chemical in his eyes because his eyes were burning and they flushed his eyes. Review of a list of residents STNA #942 cared for on 09/19/24 revealed Resident #61, #62, #63, #64, #65, #66, #67, #68, #69, #70, #71, #72, #73, #74, #75, #76, #77, #79, #80, #81, #82, and #83 had the potential to be affected. Review of the facility's policy titled OHIO Abuse, Neglect & Misappropriation, dated 10/27/21, revealed the facility would prevent abuse, mistreatment, or neglect of residents and provide guidance to staff to manage any concerns or allegations of abuse or neglect. Staff would be educated upon hire, annually, and as needed to include reporting allegations of abuse or neglect without fear of reprisal, interventions to deal with aggressive behaviors, and timely reporting of reasonable suspicion of a crime in the facility. Any employee who was alleged or accused of being a party to abuse or neglect would be immediately removed from the area of resident care, interviewed by facility leadership for a written statement, and not left alone. After completing their statement, the employee(s) would be asked to vacate the facility until further investigation of the incident was completed. Appropriate measures would be taken with the employee post investigation including disciplinary action and termination if appropriate. This deficiency represents non-compliance investigated under Complaint Numbers OH00159114, OH00158216, and OH00158183.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34297 Based on observation, record review and interview, the facility failed to appropriately assess and monitor Resident #80's closed reduction of the resident's left ankle fracture, a closed reduction of the resident's right first proximal phalanx fracture and a L1 inferior endplate fracture. This finding affected one (Resident #80) of three residents reviewed for quality of care. Findings include: Review of Resident #80's hospital progress note prior to facility admission, dated 08/08/24 at 10:36 A.M., revealed the resident had a closed reduction of the resident's left ankle fracture, a closed reduction of the resident's right first proximal phalanx fracture and a L1 inferior endplate fracture. A closed reduction of the left ankle was completed in the hospital. The left lower extremity was placed in a bulky splint and the toes had minimal edema. Review of Resident #80's medical record revealed the resident was admitted on [DATE] with diagnoses including nondisplaced fracture of the medial malleolus of the left tibia, anemia and schizoaffective disorder bipolar type. Review of Resident #80's Modified Admission Minimum Data Set (MDS) 3.0 Comprehensive assessment dated [DATE] revealed the resident exhibited moderate cognitive impairment. Review of Resident #80's history and physical form dated 08/10/24 revealed the resident was identified to have a closed left ankle fracture and a first proximal phalanx fracture and was placed in a fixed mobilization. The facility would continue her care as ordered and would work with therapy to improve the resident's function and plan for post-acute care as well. Review of Resident #80's physician orders, medication administration records (MARS) and treatment administration records (TARS) from 08/09/24 to 10/16/24 did not reveal evidence of assessments and monitoring of the closed reduction of the resident's left ankle fracture, a closed reduction of the resident's right first proximal phalanx fracture and a L1 inferior endplate fracture. A telephone interview on 10/16/24 at 10:56 A.M. with Hospital Scheduling #940 indicated the resident's original orthopedic appointment was on 09/12/24 and the appointment was canceled. Hospital Scheduling #940 stated on 10/01/24 a staff member called in and rescheduled the appointment for 10/31/24. She indicated their office needed the financial information for the resident. Review of Resident #80's physician orders revealed an order dated 10/30/24 for an orthopedic follow-up appointment dated 10/31/24; and an order dated 08/09/24 for a wound consult. Observation on 10/16/24 at 11:27 A.M. with Regional Nurse #938 of Resident #80's bilateral feet revealed the resident had wrapped her right foot in paper products and debris. No wounds were identified on the right foot when the resident removed the dressings. Further observations revealed the resident removed a plastic bag and paper on the left foot. The left foot/leg was wrapped with a soiled ace wrap and underneath of the wrap, the resident had a soft sided cast. The resident's toes appeared within normal limits and no edema or odors were identified. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Telephone interview on 10/16/24 at 11:40 A.M. with Nurse Practitioner (NP) #939 indicated she did not follow Resident #80's left lower extremity fracture, and the facility wound nurse as well as the wound NP followed this resident for the left lower extremity. Interview on 10/16/24 at 12:02 P.M. with Licensed Practical Nurse (LPN) Unit Manager (UM) #807 (facility wound nurse) stated the resident was a surgical resident and was not being followed by her or the Wound NP on the left lower extremity fracture. Interview on 10/16/24 at 12:10 P.M. with the Administrator confirmed Resident #80's orthopedic appointment was canceled on 09/12/24 because of insurance issues and the resident was rescheduled for an appointment on 10/31/24 with Medicaid insurance. The Administrator confirmed Resident #80's medical record did not have assessments and monitoring of the closed reduction of the resident's left ankle fracture, a closed reduction of the resident's right first proximal phalanx fracture and a L1 inferior endplate fracture. Review of the undated Wound Care policy revealed residents/patients admitted with or develop skin integrity issues would receive treatment as indicated based on location, stage and drainage. This deficiency represents non-compliance investigated under Complaint Number OH00158183.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44808 Based on observation and interview, the facility failed to discard expired food items timely and appropriately label or date opened and prepared food items. This had the potential to affect all 166 of 167 resident who received food from the kitchen as Resident #151 received nothing by mouth (NPO). The facility census was 167. Findings include: On [DATE] from 6:45 A.M. to 7:00 A.M., the initial walkthrough of the kitchen revealed the reach-in refrigerator contained the following: - One container of beans that was not labeled or dated. - One container of mayonnaise that was not labeled with the open date. - One container of sour cream with an expiration date of [DATE]. - Three plastic wrapped bundles of sliced cheese that were not labeled or dated. - One bag of lettuce that was not labeled or dated. - One plastic tub containing open packages of hot dogs that was not labeled or dated. - Two small containers of a brown substance that were not labeled or dated. - One container of Dannon Light + Fit vanilla yogurt with an expiration date of [DATE] and writing in black marker indicated the container had been opened on [DATE]. Interview at the time of observation with Culinary Supervisor #818 verified the above observations. Culinary Supervisor #818 stated all staff in the kitchen were responsible for ensuring items were appropriately labeled and dated and to check the expiration date on food items. Culinary Supervisor #818 further stated the expiration date of the yogurt should have been checked before it was opened and served to residents. This deficiency represents non-compliance investigated under Complaint Numbers OH00158037 and OH00158183.