STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365800	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heather Hill Care Communities	12340 Bass Lake Road Chardon, OH 44024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37095 Based on observation, record review, and interview, the facility failed to protect Resident #6 from resident to resident abuse. This affected one resident (#6) of three residents reviewed for abuse prohibition. The facility census was 95. Findings include: Record review for Resident #6 revealed he was admitted to the facility on [DATE] with diagnoses including unspecified intracranial injury, bipolar disorder, and anxiety disorder. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed he was rarely or never understood. Review of a social worker note dated 04/01/25 revealed there had been an incident of Resident #6 being kissed by another resident (Resident #80) and Resident #6 did not respond when asked about being kissed by another resident. Review of the initial physician assessment, dated 04/01/25, revealed Resident #6 was being seen for the admission assessment. The incident regarding Resident #6 being kissed by another resident was not noted in this assessment, and there were no notations regarding any negative behaviors or expressed concerns for Resident #6. The physician noted Resident #6 resided on an all male behavior unit. Review of the psychiatric note, dated 05/09/25 and authored by Psychiatric Nurse Practitioner (PNP) #900 revealed Resident #6 was being seen for a comprehensive psychiatric evaluation and he was inattentive and selectively non-verbal and when he did choose to speak it was in a soft, drawn out voice with few words. Resident #6's mood was stable and there was nothing noted in this assessment regarding the incident on 04/01/25 when Resident #6 was kissed by another resident. Record review for Resident #80 revealed he was admitted [DATE] and had diagnoses including paranoid schizophrenia, unspecified psychosis, and other sexual disorders. Review of Resident #80's care plan revealed the care plan noted behaviors including throwing food, walking around naked, and approaching staff asking them to have sex with him (dated 08/11/24). (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
	365800	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heather Hill Care Communities	12340 Bass Lake Road Chardon, OH 44024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of progress notes for Resident #80 revealed on 03/25/25 Resident #80 attempted to touch another resident and on 04/01/25 Resident #80 was witnessed approaching another male resident and kissing him on the lips so he was hospitalized that day. Resident #80 returned to the facility on [DATE]. Review of a psychiatric note for Resident #80, dated 04/01/25 and authored by PNP #900, revealed staff reported he kissed another resident without consent and a 'pink slip' was completed for safety same day as incident. Resident #80 would not answer any questions about the kissing incident stating multiple times you can leave now. Record review of the Self-Reported Incident (SRI) dated 04/01/25 revealed on that date Certified Nurse Aide (CNA) #401 witnessed Resident #80 approach and kiss Resident #6 on the lips while Resident #6 was sitting in his wheelchair in a common room. Resident #80 then went back to his room. CNA #401 notified Licensed Practical Nurse (LPN) #402 then interviewed Resident #80, who said he wanted to know what it felt like. LPN #402 educated Resident #80 his behavior was inappropriate, and Resident #80 was sent to the hospital. Psychosocial support was given to Resident #6 with no adverse findings. The facility assessed or interviewed all other residents on the unit with no findings and educated staff on abuse prohibition. The facility categorized the incident as alleged physical abuse and concluded abuse did not occur. Record review of the related facility investigation for the SRI dated 04/01/25 revealed an application for emergency hospital admission, dated 04/01/25 and authored by PNP #900, which said Resident #80 was noted to be sexually inappropriate towards another resident by kissing them on the lips without consent. Per staff, the victim had to push a table to get away. An emergency psychiatric evaluation was needed to promote safety because his impulsiveness posed an immediate risk to others. In addition, a witness statement by CNA #401 stated he saw Resident #80 kiss Resident #6, who shoved his tray to get him away. CNA #401 then told the nurse, and together they interviewed Resident #80 who said he kissed Resident #6 because he wanted to know what it felt like. A witness statement by LPN #402 said the aide told them of the kiss, and LPN #402 interviewed Resident #6 who laughed and said yes, and confirmed he 'only' was kissed. An interview form with Resident #6 revealed he mouthed yes when asked if he felt safe here. An interview with Resident #6 on 05/22/25 at 9:59 A.M. revealed he was asleep in the common area and was woken up by another resident kissing him. He said he no longer wanted to reside on the same unit with Resident #80 because he hated Resident #80. When the surveyor specifically asked if he felt abused Resident #6 answered yes. Observation of Resident #6 during this interview revealed he laughed before answering multiple questions, then presented with a distraught facial expression when asked if he felt abused by the event. Resident #6 did not report any further incidents with Resident #80 since the incident on 04/01/25 and he did not report telling the staff he did not want to reside on a unit with Resident #80. An interview with Regional Nurse (RN) #502 on 05/22/25 at 10:41 A.M. revealed Resident #6 had not mentioned anything to the staff about not wanting to reside in the same unit as Resident #80. RN #502 said now aware and in response, the facility would assess to see if Resident #6 was appropriate to move to a different unit. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365800	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heather Hill Care Communities	12340 Bass Lake Road Chardon, OH 44024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with LPN #402 on 05/22/25 at 12:54 P.M. revealed he sent Resident #80 to the hospital after he kissed Resident #6. When LPN #402 interviewed Resident #6, Resident #6 revealed Resident #80 stuck his tongue in his mouth. Resident #6 did not seem distraught at the time of the interview. LPN #402 stated Resident #80 had a history of behaviors including urinating on the floor, walking around naked, and pulling the common room television off the wall. LPN #402 stated Resident #80 was currently hospitalized so was not available for interview. An interview was conducted with the Administrator on 05/22/25 at 1:22 P.M. to review the SRI involving Resident #6 and Resident #80. The Administrator verified the SRI and related facility investigation, and reviewed the above findings including that an event of resident-to-resident abuse occurred at the facility between Resident #80 and Resident #6.