

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365830	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/09/2024
NAME OF PROVIDER OR SUPPLIER Bryan Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1104 Wesley Avenue Bryan, OH 43506	

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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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** 41528</p> <p>THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.</p> <p>Based on review of Self-Report Incidents (SRI), review of open and closed medical records, review of facility incident reports, staff interview and review of facility policy, the facility failed to prevent resident to resident sexual abuse. This affected two (#8 and #12) of three residents reviewed for abuse. The facility census was 79.</p> <p>Findings include:</p> <p>1. Review of the closed medical record revealed Resident #8 was admitted to the facility on [DATE] and discharged on [DATE]. Diagnoses included atherosclerotic heart disease of native coronary artery without angina pectoris, essential hypertension, hyperlipidemia and paroxysmal atrial fibrillation.</p> <p>Review of the Minimum Data Set (MDS) assessment, dated 10/22/24, revealed Resident #8 was moderately cognitively impaired.</p> <p>Review of Self-Reported Incident #253805, dated 11/07/24 at 10:12 A.M., revealed at approximately 8:45 A. M. Resident #9 was observed to walk up to Resident #8 and touched her breast on top of her clothing. Resident #9 was placed on one-on-one staff supervision. Resident #9 remained on one-on-one staff supervision until discharge on [DATE].</p> <p>Review of the resident to resident altercation incident report, dated 11/07/24 at 5:27 P.M., revealed the nurse was completing morning medication pass and pushing the medication cart when she looked over and saw a male resident (Resident #9) with his hand down Resident #8's shirt. The male resident (Resident #9) was directed to another chair away from Resident #8.</p> <p>3. Review of the medical record revealed Resident #12 was admitted [DATE]. Diagnoses included pressure ulcer of sacral region stage 4, unspecified dementia severe with anxiety, rheumatoid arthritis without rheumatoid factor, and cognitive communication deficit.</p> <p>Review of the MDS assessment, dated 10/29/24, revealed Resident #12 was rarely understood.</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
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of SRI #253810, dated 11/07/24 at 11:48 A.M., revealed it was reported Resident #9 walked away from staff and before staff could intervene, he was witnessed touching Resident #12's brief, near her crotch area. Staff immediately separated the residents and were able to redirect Resident #9 to another area of the unit with a staff member by his side to continue monitoring. Resident #9 remained on one-on-one staff supervision until discharged on [DATE].</p> <p>Review of the resident to resident altercation incident report, dated 11/07/24 at 5:03 P.M., revealed, after assisting another resident and transportation personnel out the locked doors, the nurse walked back into the lounge area and saw a male resident (Resident #9) beside Resident #12, who was in her wheelchair, with his hand in her pants. The nurse proceeded to redirect Resident #9 and moved him to a different area, without other residents in his presence.</p> <p>Interview on 12/09/24 at 9:10 A.M. with Certified Nursing Assistant (CNA) #202 revealed she worked on 11/07/24, during the time of both incidents involving Resident #9 and Residents #8 and #12. CNA #202 verified Resident #9 was placed on one-on-one supervision after the first incident with Resident #8. CNA #202 confirmed Licensed Practical Nurse (LPN) #201 was providing the one-on-one supervision for Resident #9 when she left him unsupervised and walked down the hall to let visitors off of the unit. CNA #202 verified it was during the time LPN #201 left Resident #9 unsupervised that the second incident involving Resident #12 occurred.</p> <p>Review of the facility policy titled Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property, dated October 2022, revealed residents have the right to be free from abuse, neglect, exploitation and misappropriation of resident property.</p> <p>As a result of the incident, the facility took the following actions to correct the deficient practice by 11/12/24:</p> <p>On 11/07/24, Resident #9 was placed on one-on-one staff supervision.</p> <p>On 11/07/24, social services assessed Resident #12 with no negative findings. Resident #12 was at baseline.</p> <p>On 11/07/24, social services assessed Resident #8 with no negative findings. Resident #8 was at baseline.</p> <p>On 11/07/24, Resident #9 was transferred to the hospital for further evaluation and treatment. Resident #9 returned to the facility on [DATE] at approximately 12:30 A.M. and remained on one-on-one staff supervision until discharge from the facility later that day.</p> <p>On 11/07/24, the Director of Nursing (DON) or designee, interviewed all interviewable residents related to abuse. Residents who were not interviewable received skin assessments. No adverse findings were identified.</p> <p>On 11/07/24, the DON or designee completed a staff questionnaire for all staff related to witnessing abuse and inquired if this resident (Resident #9) was witnessed off the unit with any other residents with no negative findings.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 11/07/24, the DON or designee assessed all residents/care plans to ensure no residents currently had sexually inappropriate behaviors, with no negative findings identified.</p> <p>On 11/07/24, the DON or designee re-educated all staff on the facility's abuse policy, including reporting of abuse. On 11/07/24, the Administrator or designee re-educated all staff on the facility procedures following an incident, with an emphasis on one-on-one staff supervision and abuse prevention. One-on-one staff supervision education included: one staff member must be assigned; if a staff member goes on a break, shift change or needs to leave the one-on-one supervision to complete any task, they must have another staff member take over the one-on-one staff supervision prior to leaving the one-on-one supervision assignment; and under no circumstances should a resident who is on one- on-one be left unattended.</p> <p>Beginning on 11/07/24, the DON or designee will complete ten random staff competencies weekly for four weeks to ensure staff knowledge of the procedures related to one-on-one staff supervision.</p> <p>Beginning on 11/07/24, the DON or designee will conduct random observations one time weekly for four weeks across all three shifts to ensure staff are following one-on-one procedures.</p> <p>On 11/12/24, an ad hoc Quality Assurance Performance Improvement (QAPI) meeting was held to review the incidents, corrective action and relevant policies.</p> <p>The results of the weekly audits will be reviewed by QAPI and any concerns will be addressed by QAPI.</p> <p>This violation represents non-compliance investigated under Complaint Number OH00159861.</p>		