| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365847 | A. Building<br>B. Wing | 06/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Bath Manor Special Care Centre | 2330 Smith Road<br>Akron, OH 44333 |

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 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013<br><br>Based on observation, interview, record review and review of the facility policy the facility failed to ensure and allegation of verbal abuse towards Resident #23 was thoroughly investigated. This affected one resident (Resident #23) out of three residents reviewed for abuse. The facility census was 122.<br><br>Findings include:<br><br>Review of Resident #23's medical record revealed an admitted [DATE] and a readmitted [DATE]. Resident #23's diagnoses included hemiplegia (paralysis) and hemiparesis (weakness) following nontraumatic subarachnoid hemorrhage affecting left dominant side, repeated falls, and need for assistance with personal care.<br><br>Review of Resident #23's Self-Reported Incident (SRI) tracking number 246669 dated 04/23/24 included the category of allegation, suspicion was neglect by facility staff. The initial source of the allegation, suspicion was a visitor, family member. Resident #23 provided meaningful information when interviewed. The Administrator received an allegation Resident #23 was being mistreated by a staff member during a shower. The accused staff member was suspended pending investigation. Resident #23 was interviewed and stated abuse did not occur. Resident #23 was cognitively intact. Resident #23 remained at facility at baseline and was annoyed by the accusation. The allegation was made by another residents family member who heard a conversation through the walls. The family member had a history of accusations and did not care for many staff members. Resident #23 received a skin check and denied abuse occurred. Interviewable residents were interviewed with no concerns. Non-interviewable residents received skin checks with no concerns. Staff were inserviced on abuse, neglect and misappropriation. Based on the facility investigation the allegation, suspicion was unsubstantiated.<br><br>(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 |
|---|---|---|---|
| | 365847 | A. Building<br>B. Wing | 06/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Bath Manor Special Care Centre | 2330 Smith Road<br>Akron, OH 44333 |

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 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident #23 Witness Statement dated 04/23/24 and written by Family Member (FM) #340 included FM #340 overheard a young lady (STNA #281) say to Resident #23 why would I do that, I would not bring you out exposed. FM #340 stated she heard STNA #281 say omg these people are getting on my nerves, I can't wait to go home and Resident #23 stated don't take me out, why are you talking to me like that. FM #340 stated STNA #281 rolled Resident #23 into the shower room and the water was hot, Resident #23 said the water was hot, and STNA #281 stated the water was not hot and was that warmer. FM #340 stated STNA #281 left Resident #23 in the shower room alone and was taking selfies before going back in the shower room. FM #340 heard STNA #281 speak in a mean way to Resident #23 while both of them were in the shower room. FM #340 found an unidentified aide to listen outside the door and had the aide get her supervisor to quickly come and hear how STNA #281 was talking to Resident #23. The aide told Licensed Practical Nurse (LPN) #236 to come and listen, but LPN #236 who was assigned to the section did not come to address the concern. FM #340 had LPN #292 come to the shower room because LPN #236 was still sitting at the desk doing nothing. FM #340 stated she told LPN #236 if she did not get up and address the concern she was going to report her. LPN #236 then got up from her chair, went to the shower room and told STNA #281 that FM #340 reported her doing something to Resident #23. STNA #281 was still in the shower room with Resident #23 and stated people need to mind their business and worry about their family, and STNA #281 walked by Resident #65's room where FM #340 was inside the room repeatedly, and made comments about the incident each time. LPN #236 entered Resident #23's room, interviewed her, but seemed like she was directing Resident #23 in her answers.<br><br>Review of Resident #23's Witness Statements dated 04/23/24 written by Assistant Director of Nursing (ADON) #328 included she spoke with Resident #23 concerning an incident this morning that happened during her shower. Resident #23 stated the water temperature was comfortable, and she was satisfied with the care she received. Resident #23 stated she had customer service concerns with STNA #281, although Resident #23 felt cared for despite the concerns.<br><br>Review of Resident #23's Witness Statements dated 04/23/24 written by STNA #281 included STNA #281 stated while she was assisting a resident with their shower at 5:00 A.M. that LPN #236 came in the shower room to see if everything was okay, and STNA #281 told her everything was okay. STNA #281 stated Resident #23 did not share any complaints while LPN #236 was in the shower room, and LPN #236 told STNA #281 she was accused of scolding Resident #23 while she assisted Resident #23 with her shower. STNA #281 stated Resident #23 was able to do most of her bathing including washing her hair while she stood by. STNA #281 stated she would never scold a resident and was very upset with the accusation. STNA #281 stated she heard the visitor (FM #340) was walking in the hall with another visitor looking in the resident rooms, did not think it was appropriate, and STNA #281 mentioned it to a coworker and she thinks the visitor (FM #340) heard her.<br><br>Review of SRI #246669 dated 04/23/24 did not reveal any other Witness Statements from staff who were working and involved in the incident including LPN #236, LPN #292 and other STNA's.<br><br>Review of Resident #23's progress notes dated 04/23/24 through 04/28/24 did not reveal documentation regarding the incident in the shower room with STNA #281 and the allegation she was mistreating Resident #23.<br><br>Review of Resident #23's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #23 was cognitively intact. Resident #23 required supervision or touching assistance for bathing.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365847 | A. Building<br>B. Wing | 06/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Bath Manor Special Care Centre | 2330 Smith Road<br>Akron, OH 44333 |

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 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident #23's care plan dated 05/10/23 included Resident #23 was at risk for self-care deficit due to left sided weakness related to CVA (cerebrovascular accident) and impaired mobility. Resident #23 would have ADL needs met daily through the next review. Interventions included bathing and hygiene with assist of one as needed.<br><br>Interview on 05/28/24 at 3:11 P.M. of FM #340 revealed weeks ago she witnessed a situation where Resident #23 did not want to come out of her room because she felt too naked and STNA #281 told her to be quiet and come on. FM #340 stated she heard STNA #281 say she was so sick of ya'll and I want to go home while she wheeled Resident #23 into the shower room. FM #340 heard Resident #23 say the water was too hot and STNA #281 said she did not do it on purpose in a not very nice way. FM #340 stated during the shower STNA #281 was verbally not nice to Resident #23. FM #340 stated she reported the event immediately and had LPN #231 come to the room to listen to the conversation. FM #340 stated she told LPN #231 to have LPN #236 come to the shower room because she was assigned to the nursing unit. FM #340 stated LPN #236 did not come and she had to threaten to report her to get her to come. When LPN #236 arrived to the shower room she told STNA #281 that FM #340 reported that she was being mean to Resident #23. FM #340 stated LPN #236 should not have told STNA #281 she was the one who reported her because STNA #281 lashed out at her. FM #340 indicated STNA #281 was mean to Resident #23 because she was tired and sleepy. FM #340 stated she spoke with ADON #328 about the situation and STNA #281 being mean to Resident #23.<br><br>Interview on 05/30/24 at 5:25 A.M. of STNA #281 revealed she was giving Resident #23 a shower and when she finished a nurse told her she needed to write a statement because she was accused of being verbally abusive to Resident #23. STNA #281 stated a nurse told her a family member wanted the nurse to listen outside the shower door because STNA #281 was being verbally abusive to Resident #23. STNA #281 stated it was frustrating to her because she did not like being accused of abusing Resident #23. STNA #281 stated she had a strong voice and in the shower room it probably echoed. STNA #281 stated Resident #23 was alert and oriented times three (time, place, person), Resident #23 adjusted the water temperature herself and she just stood by and assisted Resident #23 as needed. STNA #281 stated a nurse did not come to the shower room (even though her witness statement indicated a nurse came into the shower room with her and Resident #23) and she did not know about the allegation until she finished assisting Resident #23 with her shower and went to the nurse's station, and was told a lady was saying she was verbally abusive to Resident #23.<br><br>Interview on 05/30/24 at 5:49 A.M. of LPN #236 revealed she was told by FM #340 that STNA #281 was being mean to and hollering at Resident #23 in the shower room. LPN #236 stated she went into the shower room to make sure Resident #23 was okay, and Resident #23 told her she was alright and the water was not to hot. LPN #236 stated when she went into the shower room with Resident #23, STNA #281 was in the shower room assisting Resident #23 with her shower. LPN #236 stated she told STNA #281 that someone in the hall said she was yelling at and mistreating Resident #23. LPN #236 stated she did not report the verbal abuse allegation because Resident #23 stated nothing was wrong, and there was nothing to report.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365847 | A. Building<br>B. Wing | 06/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Bath Manor Special Care Centre | 2330 Smith Road<br>Akron, OH 44333 |

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 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 05/30/24 at 8:26 A.M. of LPN #231 revealed on 04/23/24 about 5:00 A.M. FM #340 told her STNA #281 was aggressive towards Resident #23. LPN #231 stated she stood for a short time at the door, but did not hear STNA #231 talking aggressively towards Resident 23. LPN #231 stated she told both STNA #281 and FM #340 to write statements about the situation, and once the statements were completed she made copies and slid the statements under the managers door. LPN #231 stated she informed ADON #328 about the situation. LPN #231 stated LPN #236 told STNA #281 that FM #340 brought it to her attention that she was being aggressive to Resident #23.<br><br>Interview on 05/30/24 at 8:49 A.M. of ADON #328 revealed she found out in a round about way about the incident between STNA #281 and Resident #23. ADON #328 stated FM #340 told her STNA #281 was being mean to Resident #23 and ADON #328 went to talk to Resident #23 in the morning. ADON #328 stated Resident #23 told her STNA #281 was not mean, the water was not hot, and ADON #328 further stated STNA #281 was talking loudly because Resident #23 wears hearing aides and she had to speak loudly. ADON #328 stated Resident #23's customer service concerns were she did not think STNA #281 was yelling but was talking loudly. ADON #328 stated she reported the situation to the DON between 7:00 A.M. and 9:00 A.M. and only saw witness statements from FM #340 and STNA #281.<br><br>Interview on 06/02/24 at 2:45 P.M. of LPN #292 revealed she was working on 04/23/24 when STNA #281 was giving Resident #23 a shower. LPN #292 stated she was not assigned to Resident #23, but FM #340 came to get her, and said she wanted me to listen at the shower door because STNA #281 was speaking inappropriately to Resident #23. LPN #292 stated she listened at the shower room door, but did not hear any inappropriate language from STNA #281. LPN #292 stated she heard LPN #236 tell STNA #281 that FM #340 could hear her screaming at Resident #23 and reported it. LPN #292 stated she did not report it because LPN #236 was assigned to Resident #23 and was supposed to be taking care of it. LPN #292 stated she was not asked to write a statement, and did not write a statement concerning the incident.<br><br>Interview on 06/03/24 at 9:50 A.M. of the Administrator and Regional Director of Clinical Services (RDCS) #342 revealed the Administrator stated she spoke with Resident #23 and anyone with involvement and determined straight away that nothing happened. RDCS #342 confirmed the questions residents were asked pertaining to the investigation did not include questions specific for abuse.<br><br>Observation on 06/03/24 at 4:09 P.M. of Resident #116 revealed she was lying in bed watching television.<br><br>Interview on 06/03/24 at 4:09 P.M. of Resident #116 revealed she was Resident #23's roommate and when Resident #23 returned from her shower with STNA #281 she was almost in tears. Resident #116 stated STNA #281 did not want to give Resident #23 her shower. Resident #116 stated STNA #281 stated she was not supposed to give showers and both Resident's #23 and #116 put their call light on to damned much and STNA #281 slammed the door on her way out of their room. Resident #116 indicated after STNA #281 left the room Resident #23 was in tears and stated she would never let STNA #281 give her a shower again. Resident #116 indicated Resident #23 told her STNA #281 would not let her wash herself, and washed her real quick and was hollering and screaming. Resident #116 stated Resident #23 was really sad. Resident #116 stated she felt STNA #281 was verbally abusive to her.<br><br>Observation on 06/03/24 at 4:15 P.M. of Resident #23 revealed she was in her wheelchair in the common area and was heading back to her room.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365847 | A. Building<br>B. Wing | 06/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Bath Manor Special Care Centre | 2330 Smith Road<br>Akron, OH 44333 |

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 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 06/03/24 at 4:15 P.M. of Resident #23 revealed when STNA #281 gave her a shower she was mean to her, speaking in a nasty voice and was yelling continually and saying things like she did not have to be there and she was ready to leave. Resident #23 asked STNA #281 why she was yelling at her and STNA #281 said she was not yelling, that the way she was talking was her regular voice, but Resident #23 said she knew that was not her regular voice because she was yelling. Resident #23 stated she was so upset when she was in the shower room with STNA #281 because she didn't want to be in the shower room with her, she was very uncomfortable, and could not wait for the shower to be over. Resident #23 stated she told STNA #281 she could wash her own hair, but STNA #281 would not let her, and continued to wash it herself. Resident #23 stated she felt STNA #281 was verbally abusive to her.<br><br>Review of Resident #23's SRI dated 04/23/24 revealed the questions residents were asked were not specific to abuse. The questions were Do staff assist you with your needs?; Do staff members assist you with incontinence care?; Do you receive your medications?; Are you assisted when you need help with something?; and Do you have anything else you would like to tell me?.<br><br>Review of the facility policy titled Ohio Resident Abuse Policy revised 03/03/17 included the facility would not tolerate abuse, neglect, mistreatment, exploitation of residents, and misappropriation of resident property by anyone. It was the facility policy to investigate all allegations, suspicions and incidents of abuse, neglect, involuntary seclusion, exploitation of residents, misappropriation of resident property and injuries of unknown source. Facility must immediately report all such allegations to the Administrator or Abuse Coordinator, and the Administrator or Abuse Coordinator would immediately begin an investigation and notify the applicable local and state agencies in accordance with the procedures in the policy. Residents, interested family members, or other persons might contact any member of the administration, or the facilities nursing staff at any time with concerns relating to abuse, mistreatment, neglect, involuntary seclusion, the misappropriation of a resident's property, or concerns about a resident's injury. Verbal abuse was defined as the use of oral, written, or gestured language that willfully included disparaging and derogatory terms to residents or their families, or within hearing distance, regardless of their age, ability to comprehend, or disability. Documentation in the nurses' notes should include the results of the resident's ROM, body assessment, vital signs, the notification of the physician and the responsible party and treatment provided. All allegations of Abuse, Neglect, Involuntary Seclusion, Injuries of unknown source, and misappropriation of resident property must be reported immediately to the Administrator, Director of Nursing and to the applicable State Agency. If the event that caused the allegation involved an allegation of abuse or serious bodily injury, it should be reported to eh DOH (Department of Health) immediately, but no later than two hours after the allegation was made. The person investigating the incident should interview the resident, the accused, and all witnesses. Witnesses generally include anyone who witnessed or heard the incident, came in close contact with the resident the day of the incident, and employees who worked closely with the accused employee and or alleged victim the day of the incident.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00153519. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365847 | A. Building<br>B. Wing | 06/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Bath Manor Special Care Centre | 2330 Smith Road<br>Akron, OH 44333 |

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 0660<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Plan the resident's discharge to meet the resident's goals and needs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013<br><br>Based on interview, record review and review of the facility policy the facility failed to ensure Resident #125's physician was provided accurate information regarding a discharge Against Medical Advice to ensure the safest discharge possible. This affected one resident (Resident #125) out of three residents reviewed for a safe discharge. The facility census was 122.<br><br>Findings include:<br><br>Review of Resident #125's medical record revealed an admitted [DATE] and diagnoses included anxiety disorder, depression, and disorder of the brain, unspecified.<br><br>Review of Resident #125's Admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #125 was independent for self-care, needed some help with ambulation, and used a walker.<br><br>Review of Resident #125's physician orders dated [DATE] revealed Resident #125 may go on LOA (leave of absence) with supervision.<br><br>Review of Resident #125's Quarterly Minimum Data Set, dated dated dated [DATE] revealed Resident #125 was cognitively intact.<br><br>Review of Resident #125's care plan dated [DATE] included Resident #125 required suprvised leave of absences (LOA) related to Resident #125 was a [AGE] year old widowed femaile admitted to the facility on [DATE] with a diagnosis of disorder of the brain, depression, anxiety and other diagnoses, Resident #125 was alert and oriented times three (time, place, person), was forgetful, impulsive, easily frustrated and easily tearful. Resident #125 would be safe while out of the facility as evidenced by no falls or bodily harm. Interventions included nursing would acquire a physician order for leave of absence status, for example independent, supervised; educate Resident #125 on the importance of coming back on time for medication, treatments.<br><br>Review of Resident #125's physician orders dated [DATE] revealed Resident #125 could go on LOA up to four hours daily as needed.<br><br>Review of Resident #125's progress notes dated [DATE] at 7:12 P.M. included Resident #125 stated she was leaving the facility due to her dinner being cold. Staff offered a new dinner, but Resident #125 refused and continued to cuss and yell at the staff. Attempt to contact Resident #125's sons was unsuccessful. Resident #125 went to the front lobby, pushed the doors open, sounding the alarm and left the building. Staff went after her, but were unable to get her to come back inside the facility. Staff currently outside with Resident #125, and she refused to sign an AMA (against medical advice) form.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365847 | A. Building<br>B. Wing | 06/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Bath Manor Special Care Centre | 2330 Smith Road<br>Akron, OH 44333 |

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 0660<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident #125's police incident report dated [DATE] at 7:01 P.M. included it was super dark outside, hard to see, at least six people were standing on street as if in distress, and someone was waving a flashlight around, possibly signaling for help. The police officers were told Resident #125 was leaving the facility without consent. During the investigation it was found out that Resident #125 was her own power of attorney and could leave the nursing home. Officers help was not needed.<br><br>Review of Resident #125's progress notes dated [DATE] at 7:24 P.M. included a physician was notified of the incident. AMA signed by the resident and DON (Director of Nursing) aware. Resident #125's progress notes did not state which physician was notified, and if the physician was notified prior to Resident #125 signing the AMA form or after the AMA form was signed, or what the physicians recommendations were. The progress notes did not specify what happened after Resident #125 signed the AMA paper, and the police left. Resident #125's progress notes did not document what the temperature was, what Resident #125 was wearing, if she had a coat and shoes on, and if she walked away from the facility. Resident #125's progress notes did not state if Resident #125 was picked up by her friend.<br><br>Review of Resident #125's police incident report dated [DATE] at 12:34 A.M. included a Resident (Resident #125) at the facility was lost in the woods of the facility, and stated she was freezing. Resident #125 was roughly 30 feet from the street, could no longer crawl from weakness, and was also wet. The caller (Resident #125) was disoriented, stated she was in the woods but unsure of any other direction. The caller (Resident #125) stated she left the facility because she was angry. Resident #125 was found on [DATE] at 12:47 A.M. EMS was going to try to return Resident #125 to the facility.<br><br>Review of Resident #125's local fire department patient care record included a call was received on [DATE] at 12:33 A.M. and EMS (Emergency Medical Services) were on scene and at patient at 12:50 A.M. Resident #125 was alert, and at 12:58 A.M. had a blood pressure of ,d+[DATE], pulse 98, and temperature of 98.7 Fahrenheit. Resident #125's skin was cold to touch. EMS was dispatched for a chief complaint of cold exposure. EMS arrived on scene and found Resident #125 outside about 30 feet off the side of the road right next to the nursing home. Resident #125 was able to ambulate to the med unit. Resident #125 stated her lunch and dinner were late at the nursing home, this made her mad, so she signed herself out. Resident #125 stated she walked around but now was too cold and wanted to return to the nursing home. Resident #125 was alert and oriented times four (time, place, person, event), was escorted back to the nursing home, the nursing home supervisor was contacted and agreed to allow Resident #125 to return.<br><br>Interview on [DATE] at 12:51 P.M. with Licensed Practical Nurse (LPN) #290 revealed Resident #125 was angry her food was cold and tried to exit the facility through the front entrance. LPN #290 stated she talked Resident #125 into coming back inside the facility, and Resident #125 became angry again and said we were plotting against her, and she left through the back door to the facility. LPN #290 stated she tried to get Resident #125 to come back inside the facility, but she would not come. LPN #290 had another nurse assist them, they took a wheelchair outside and Resident #125 came back inside the facility, but would not sign the AMA form. LPM #290 indicated quite a few staff were assisting with Resident #125. LPN #290 stated she put the note in Resident #125's progress notes stating the physician had been called, but she did not call the physician, it was the nurse helping her who called Resident #125's physician. LPN #290 stated she spoke to the DON and the DON told her she notified Resident #125's physician. LPN #290 indicated she did not have Resident #125 sign the AMA form, but it was the other nurse who had her sign it. LPN #290 stated she did not know what happened after that because it was shift change and she went home.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365847 | A. Building<br>B. Wing | 06/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Bath Manor Special Care Centre | 2330 Smith Road<br>Akron, OH 44333 |

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 0660<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on [DATE] at 1:09 P.M. with LPN #231 revealed on [DATE] she arrived for work at 6:30 P.M. and was told Resident #125 was on a rampage all day, Resident #125 ran out of the building, and the staff was able to bring her back inside the facility. LPN #231 stated she was told someone called to get her. LPN #231 indicated she was able to have Resident #125 sign the AMA form, the police came and said we had to let her go because she signed the AMA form. LPN #231 stated she was not assigned to care for Resident #125 and she was not sure if Resident #125's physician was contacted about Resident #125 leaving the facility AMA. LPN #231 stated Resident #125 fell asleep in a ditch after she left the facility, and when she returned she was cold, was given food and readmitted .<br><br>Interview on [DATE] at 2:03 P.M. with the Director of Nursing (DON) revealed she did not know much about the incident where Resident #125 signed herself out of the facility AMA. The DON stated Resident #125 did not like her food and she told the staff to offer her different food from the kitchen, but Resident #125 was unable to be redirected and was adamant she wanted to leave the facility. The DON indicated Resident #125 said someone was going to pick her up, but the DON did not remember if anyone came to pick up Resident #125. The DON stated she told someone to call Resident #125's Nurse Practitioner or physician, but she did not remember who she told. The DON stated her direction was to call Resident #125's physician, and to make sure Resident #125 signed the AMA form if she was unable to be redirected, and wanted to leave the facility. The DON stated she wanted Resident #125 to be sent to the ER (emergency room ). The DON stated she was called in the middle of the night, Resident #125's friend did not pick her up and the police and an ambulance brought Resident #125 back to the facility.<br><br>Interview on [DATE] at 3:30 P.M. with Nurse Practitioner (NP) #343 revealed Resident #125's husband died in ,d+[DATE] and a close friend who was a resident at the facility passed away in ,d+[DATE] and Resident #125 was not allowed by the family to say goodbye to her friend. NP #343 stated Resident #125 was spiraling and did not have the best decision making for herself at the time she signed herself out AMA. NP #343 stated it was a tricky situation, Resident #125 was alert and oriented times four, and she could tell right from wrong. NP #343 stated she was not called until after Resident #125 signed herself out AMA and left the facility, but if she had been called before she signed herself out AMA she would have encouraged her to stay at the facility, call family to sit with her, and send Resident #125 to the hospital for a psych evaluation if she was spiraling.<br><br>Interview on [DATE] at 10:28 A.M. with the Administrator and Regional Director of Clinical Services (RDCS) #342 revealed the facility Medical Director was notified per the Director of Nursing. The Administrator stated Resident #125 was upset, the staff walked with her and was able to stop her at the top of the driveway. The Administrator stated Resident #125 was adamant about leaving, she did not want facility staff near her, and she signed the AMA form. The Administrator indicated the police said she signed AMA papers and to leave her alone. The Administrator revealed Resident #125 was sitting on a rock waiting for her friend to pick her up, but staff did not see Resident #125 get picked up by anyone. RDCS #342 stated Resident #125 was homeless before she came to the facility.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365847 | A. Building<br>B. Wing | 06/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Bath Manor Special Care Centre | 2330 Smith Road<br>Akron, OH 44333 |

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 0660<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on [DATE] at 3:35 P.M. of Physician #344 revealed he cared for Resident #125 for several months while she was at the facility. Physician #344 stated Resident #125 was depressed because she was close to a resident who passed away at the facility. Physician #344 indicated he was called on the day Resident #125 signed herself out AMA, but could not remember who called or if he was called before or after Resident #125 signed herself out AMA. Physician #344 stated he was told someone came to pick her up, was not aware the friend did not pick her up, and he thought someone picked her up. Physician #344 indicated he did not know Resident #125 walked off into the night. Physician #344 stated he could not remember details about his conversation with the facility staff, if he gave recommendations on how the facility should proceed, or how Resident #125 returned to the facility.<br><br>Review of the facility policy titled Discharge Against Medical Advice (AMA) policy revised [DATE] included any mentally competent adult resident had the right to discharge themselves from the facility even if it was thought that refusal of treatment might result in serious harm. The direct nursing staff and or social service designee would advise the resident of the risks involved in discontinuing treatment or leaving the facility before it was medically indicated to encourage a resident to continue to their prescribed course of medical treatment. The Director of Nursing, the Administrator, the Attending Physician, Provider and Psychiatrist if applicable would be notified of the resident's decision to self-discharge by the nurse in charge. The nurse in charge and social service designee would document in the resident's medical record all parties notified, interventions attempted to prevent an unsafe discharge, any counseling given to the resident and the resident's condition at time of self-discharge.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00154128. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365847 | A. Building<br>B. Wing | 06/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Bath Manor Special Care Centre | 2330 Smith Road<br>Akron, OH 44333 |

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 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013<br><br>Based on observation, interview, record review, facility Self-Reported Incident review, hospital record review, and review of the facility policy the facility failed to ensure a comprehensive fall risk assessment with individualized interventions was in place for Resident #83 and failed to timely assess and properly treat the resident after a fall.<br><br>Actual harm occurred on 04/29/24 when Resident #83, who was at risk for falls did not have individualized interventions in place to address the risk, fell in her room and was not thoroughly assessed before being returned to bed. This resulted in the resident experiencing severe pain to her leg and a delay in immediate treatment. The resident was subsequently transferred to the emergency room for treatment of a femur fracture requiring surgical repair. This affected one resident (#83) of three residents reviewed for falls. The facility census was 122.<br><br>Findings include:<br><br>Review of Resident #83's medical record revealed an admitted [DATE] and a readmitted [DATE]. Resident #83's diagnoses included displaced intertrochanteric fracture of the right femur, type two diabetes mellitus without complications, rhabdomyolysis and bipolar disorder, current episode depressed, mild or moderate severity.<br><br>Review of Resident #83's handwritten Preadmission Fall Review dated 04/10/24 included yes was checked for mental status, but the document did not specify as indicated if Resident #83 was confused, had delirium, had altered level of consciousness, disorganized thinking, memory or cognitive impairment, or poor safety awareness. Mobility was checked, but the document did not specify as indicated if Resident #83 had ataxia, unsteady, shuffling gait, ambulated with assistance of one person, had balance impairment or was unable to transfer, ambulate. The Preadmission Fall Review further included if yes was checked for either category of mental status or mobility the resident was considered high risk and appropriate interventions should be implemented. A preliminary review of pre-admission medical information revealed factors that might place the resident at a greater risk for falls. Please note the following interventions made by therapy and nursing in an attempt to decrease the risk of falls. The area stating what the risk factors were was not completed. Immediate Fall Prevention Interventions circled were bed in lowest position.<br><br>Review of Resident #83's handwritten Therapy-to-Nursing Communication Form dated 04/12/24 revealed the front of the form was not completed, and the back of the form had a [NAME] Fall Risk Questionnaire which was completed, but unsigned. The Questionnaire included Resident #83 had a fall or near fall in the past year. Resident #83 felt uneasy or unsteady when walking down the aisle of a supermarket or in an area congested with other people. Resident #83 took medication for depression, anxiety, nerves, sleep or pain.<br><br>Review of Resident #83's Admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #83 was cognitively intact. The assessment also noted Resident #83 had a fall within the last month of her admission to the facility.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365847 | A. Building<br>B. Wing | 06/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Bath Manor Special Care Centre | 2330 Smith Road<br>Akron, OH 44333 |

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 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Review of Resident #83's care plan (initiated 04/10/24) included Resident #83 was at risk for falls related to impaired balance, muscle weakness, med use, debility, and impaired mobility. Resident #83 would minimize risk for falls and minimize injuries related to falls with a target date of 12/01/24. However, there were not fall interventions identified to address the fall risk. On 04/23/24 an intervention stated a fall risk evaluation would be completed to identify and minimize initial risk factors for falls and injury. There was no evidence individualized interventions were implemented including bed in lowest position until 04/29/24 (the date of Resident #83's injury of unknown origin). Interventions documented on 04/29/24 included encourage Resident #83 to keep bed in low position; fall risk assessment per routine and as needed; maintain call light within reach; reinforce need to call for assistance. When attempt was made to click on each intervention on 04/29/24 to review the history of the intervention, there were no historical interventions identified to review.<br><br>Review of Resident #83's progress notes and care plan dated 04/10/24 through 04/29/24 did not reveal evidence Resident #83's bed was in the lowest position.<br><br>Review of Resident #83's medical record including progress notes from 04/10/24 through 04/29/24 did not reveal a fall risk evaluation was completed.<br><br>Review of Resident #83's care plan dated 04/23/24 included Resident #83 was at risk for deterioration in ADLs due to immobility, fall risk, diagnosis process, medications, and incontinence. The goal indicated Resident #83 would not deteriorate in ADLs as evidenced by maintaining ability to eat after set up. Interventions included to provide assistance for all ADLs.<br><br>Review of Resident #83's progress notes dated 04/29/24 at 8:00 A.M. revealed Resident #83 was complaining of right lower extremity (RLE) pain. New order obtained from Certified Nurse Practitioner (CNP), and responsible party notified. There was no documentation describing what was causing the pain or the appearance of Resident #83's right lower extremity at this time.<br><br>Review of Resident #83's physician's orders dated 04/29/24 at 9:26 A.M. revealed an order for a stat x-ray right femur 1-2 view, and stat x-ray right hip 1-2 view.<br><br>Review of Resident #83's Physical Therapy Missed Visit Details dated 04/29/24 revealed nursing hold due to Resident #83 had complaints of hip pain after possible fall. X-rays ordered.<br><br>Review of Resident #83's progress notes dated 04/29/24 at 3:15 P.M. revealed Resident #83 was noted to have pain in the right lower extremity, and was painful to touch. Resident #83's Nurse Practitioner (NP), NP #339, was notified and x-rays were ordered. Resulted with comminuted mild displaced femoral fracture. NP gave order to transfer Resident #83 to the local hospital orthopedic department for further evaluation. Responsible party notified.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365847 | A. Building<br>B. Wing | 06/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Bath Manor Special Care Centre | 2330 Smith Road<br>Akron, OH 44333 |

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 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Review of an Event Report initiated 04/29/24 at 3:10 P.M. and completed 05/21/24 at 4:56 P.M. included Resident #83 had a fracture of the right femur and the location where the event occurred was unknown. Resident #83 complained of pain in right lower extremity, painful to touch, Resident #83's Nurse Practitioner (NP), NP #339, was notified and gave orders for an x-ray. Resident #83's x-ray results were comminuted (fracture producing multiple bone splinters) mild displaced femoral fracture. When Resident #83 was asked what happened she stated she fell at home. Resident #83 was transported to the hospital emergency room . The report indicated Resident #83 was oriented to person, and was ambulatory with assistance. The event was not witnessed. Further review of the Event Report included the facility completed a thorough investigation and was not able to determine the cause of the fracture. Resident #83 was alert and oriented times two with confusion. Resident #83 stated she had a fall at her apartment prior to coming to the facility. Resident #83 had a history of noncompliance with ambulating without assistance and fall prior to admission at home and also in hospital. After interviewing all staff and residents no abuse or fall was suspected. Resident #83 had the ability to self-transfer, ambulate and get herself off the floor. Resident #83 was receiving therapy services (PT, OT, and ST) and was ambulating in therapy up to 100 feet.<br><br>Review of a facility self-reported incident (SRI), tracking number 246928, dated 04/29/24 revealed the facility reported Resident #83 had an injury of unknown source. The SRI included Resident #83 did not provide meaningful information when interviewed. The Administrator was notified Resident #83 had a fracture of unknown origin. Resident #83 complained of RLE pain and when interviewed she stated she fell at home. The facility obtained an x-ray which showed a fracture. The nurse practitioner (NP) gave orders to transport Resident #83 to the emergency room for further evaluation from orthopedics. The facility was obtaining hospital notes prior to nursing home admission to see if Resident #83's fracture was prior and RLE complaint of pain was present. Resident #83 had an extensive social history, APS involvement, unsafe and unsanitary living conditions. Resident #83 had a Brief Interview for Mental Status of 14 (cognitively intact), and stated she fell at home but the facility was not aware of fracture prior to admission. Resident #83 received surgery to repair the fracture and would return to the facility. The SRI revealed all nurses and State tested Nursing Assistants (STNAs) assigned to care for Resident #83 were interviewed and all staff denied Resident #83 fell as well as any other events taking place. The facility believed the incident happened at home (prior to the 04/10/24 admission) as Resident #83 described or while at the hospital prior to admission to the facility.<br><br>Review of the staffing schedule revealed on 04/28/24 at 10:00 P.M. through 04/29/24 at 6:00 A.M. there were nine STNA staff, including four male STNA's. STNA #257 was assigned to care for Resident #83.<br><br>Review of Licensed Practical Nurse (LPN) #341's Witness Statement dated 05/29/24 (meant 04/29/24) revealed after report and counting (medications) an unidentified aide asked her to come to Resident #83's room and look at her related to complaints of pain while the aide was dressing her. LPN #341 stated upon assessment she observed internal rotation to the right foot and Resident #83 complained of RLE pain. LPN #341 contacted the on call and obtained orders for an x-ray.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365847 | A. Building<br>B. Wing | 06/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Bath Manor Special Care Centre | 2330 Smith Road<br>Akron, OH 44333 |

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 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Review of a Witness Statement written by the Director of Nursing (DON) included on the morning of 04/29/24 an unidentified floor nurse noted Resident #83 voiced complaints of pain in the lower back and right hip. Upon assessment Resident #83's right hip was painful to touch. When asked what happened Resident #83 stated she had a fall at home prior to coming to the facility. The DON asked if she had a fall at the facility at any time Resident #83 stated no. The NP was notified, and orders were given to get an x-ray due to pain.<br><br>Review of Resident #83's Ortho Consult at the hospital on 04/29/24 at 9:35 P.M. included Resident #83 presented with right hip pain after a fall from standing at her facility (contradictory account of the accident from the facility injury of unknown origin report and investigation). Resident #83 was unable to get up and had to call for help. Resident #83 denied new significant pain other than right hip. Resident #83 denied head trauma and loss of consciousness. Resident #83 was awake and oriented times three (person, place, time), and her mood and affect were calm and appropriate to the situation. Resident #83 was in bed and unable to ambulate secondary to known injury. Resident #83's right lower extremity was shortened and externally rotated. Resident #83's x-ray of the right hip dated 04/29/24 revealed she had a four part intertrochanteric femur fracture. No other acute fracture or dislocation. X-ray results of the right femur were pending. Plan for surgery (OR) for right hip cephalomedullary nailing (CMN) on 04/30/24.<br><br>Review of Resident #83's progress notes dated 04/30/24 at 12:01 P.M. included Resident #83 was admitted to the local hospital and was scheduled for surgery this morning per NP #339.<br><br>Review of Resident #83's Discharge Summary for her hospital admitted d 04/29/24 through 05/08/24 included Resident #83 had a right intertrochanteric femur fracture, status post (s/p) CMN on 04/30/24.<br><br>Review of Resident #83's physician progress note dated 05/13/24 written by NP #339 included on 04/29/24 Resident #83 was sent to the emergency room after a fall with RLE pain, an x-ray showed right intertrochanteric femur fracture. Resident #83 underwent CMN on 04/30/24. Resident #83 returned to the facility for rehab.<br><br>Observation on 05/29/24 at 5:04 P.M. revealed Resident #83 was lying in bed, the lights were dim and observation of her window blinds revealed a couple slats were broken and large pieces of the blinds were missing.<br><br>During an interview with Resident #83 on 05/29/24 at 5:04 P.M. the resident revealed she fractured her hip. Resident #83 stated (on 04/29/24) she got out of bed, she was standing and went to hang her clothing on a chair and fell down. Resident #83 stated she broke her blinds when she fell . The resident stated she laid on the floor and knew she broke something when she fell . Resident #83 stated a guy came into her room, picked her up, was not gentle, put her in bed and he really hurt her as he was putting her in bed. Resident #83 stated her fall happened between 12:00 A.M. and 1:00 A.M. Resident #83 stated she did not remember anyone coming in her room after that, her call button was not in her reach and she could not activate it to call for help. Resident #83 indicated she did not know how long she laid on the floor before the guy came in and put her to bed. Resident #83 stated later in the day the paramedics were called and she was taken to the hospital.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365847 | A. Building<br>B. Wing | 06/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Bath Manor Special Care Centre | 2330 Smith Road<br>Akron, OH 44333 |

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 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | During a follow-up interview with Resident #83 on 05/30/24 at 9:54 A.M., the resident revealed she had told the staff about her fall at the facility (on 04/29/24), how she was standing in her room, turned around and fell , and the aide picked her up and roughly put her in bed. Resident #83 stated she did not tell the staff she fell at home. Resident #83 again stated after the aide put her back in bed no one came in to see how she was, and that surprised her because she thought a nurse would come in to see if she was okay. Resident #83 stated she was in a lot of pain and her hip hurt so bad. Resident #83 indicated she was trying to remember what the male aides name was, but she could not remember.<br><br>An interview with STNA #257 on 05/30/24 at 3:30 P.M. revealed she was assigned to care for Resident #83 on 04/29/24 but she could not recall an incident with Resident #83 on 04/29/24 and did not know anything about Resident #83's injury.<br><br>Interview on 06/03/24 at 11:55 A.M. with Minimum Data Set (MDS) Nurse #237 revealed the facility recently changed companies for Residents Electronic Health Records (EHR), and the date of the change was 04/08/24. MDS Nurse #237 revealed Resident #83 was admitted two days after the facility changed companies. MDS #237 confirmed she edited Resident #83's care plan on 04/29/24, but stated she could not remember the details surrounding the edit. MDS Nurse #237 stated some of the problems and interventions were copied and pasted from the old EHR company to the care plans of the new EHR during the transition. The MDS Nurse stated she could not remember if she copied and pasted the problem and intervention for falls into Resident #83's care plan on 04/29/24, but said it was likely because when the interventions were clicked on in the care plan a history could not be seen.<br><br>Interview on 06/03/24 at 2:39 P.M. with LPN #341 revealed on 04/29/24 she worked day shift and arrived for work at 7:00 A.M. LPN #341 stated she got report, counted and was preparing for the med pass when an unidentified aide yelled for her to go to Resident #83's room because she was having pain. LPN #341 stated Resident #83 was having pain and it was obvious her leg did not look normal, it was turned in and did not look right. LPN #341 indicated she barely touched Resident #83 leg and the touch caused severe pain. LPN #341 stated she called the nurse who worked night shift, but the nurse had no knowledge of any incident regarding Resident #83, and said nothing was reported to her. LPN #341 stated she told NP #339 there was definitely something wrong with Resident #83's leg and obtained an order for an x-ray. LPN #341 stated she asked Resident #83 what happened and Resident #83 said at around 2:00 A.M. she fell and was on the floor and a guy that helped everyone helped her up, but she did not know his name. LPN #341 stated she told Unit Manager (UM) #200 that Resident #83 fell , was on the floor and a male aide helped her off the floor and put her back to bed. When asked why she did not include Resident #83 had a fall, was found on the floor and helped back to bed by a male aide in her witness statement regarding the incident, LPN #341 stated she was told to write a statement of what she found when she got to Resident #83's room, so she only put that and not what Resident #83 told her. LPN #341 stated that was why she did not write anything else about Resident #83's fall and assistance back to bed by a male aide.<br><br>Interview on 06/03/24 at 2:44 P.M. with Unit Manager (UM) #200 revealed UM #200 stated from her understanding Resident #83 was in bed and said her leg was hurting. UM #200 indicated a couple STNAs were asked what happened but they could not say. UM #200 stated Resident #83 was reaching for her pants, she heard Resident #83 was on the floor and an aide helped her up. UM #200 stated she did not interview Resident #83, only observed her leg. UM #200 stated Resident #83 required extensive assistance and could not ambulate safely by self.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365847 | A. Building<br>B. Wing | 06/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Bath Manor Special Care Centre | 2330 Smith Road<br>Akron, OH 44333 |

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 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Interview on 06/03/24 at 2:55 P.M. with STNA #203 and #228 revealed they took care of Resident #83 and were familiar with her. STNA #228 stated Resident #83 liked to stay up until around 1:00 A.M. then she would put her call light on for them to assist her into bed. STNA #228 stated Resident #83 had to be reminded to use the call light and she would try to get up on her own if she did not have the call light close by. STNA #228 stated before Resident #83's incident on 04/29/24 Resident #83's leg was not painful to touch or turned in. STNA #228 stated he wrote a witness statement stating he had no knowledge of Resident #83's incident. STNA #203 stated he was not asked about the incident or told to write a witness statement because Resident #83 was not his resident.<br><br>Interview on 06/03/24 at 3:00 P.M. with STNA #228 revealed he was not usually assigned to care for Resident #83, but the STNA's on the nursing unit worked together as a team and would help each other out with the assignments. STNA #228 stated he knew Resident #83 well and often went in her room to assist with her needs. STNA #228 stated he could not recall an incident on 04/29/24 and had no knowledge of a fall.<br><br>Interview on 06/03/24 at 3:36 P.M. with the DON revealed on 04/29/24 she was driving to the facility and she was called by UM #200 regarding Resident #83 and UM #200 was going to assess her. The DON stated NP #339 was in the facility, saw Resident #83 and ordered x-rays. The DON indicated the x-rays showed Resident #83 had a fracture and NP #339 gave orders for Resident #83 to be transported to the hospital for evaluation. The DON stated the facility started an investigation for injury of unknown origin, and stated she interviewed Resident #83 multiple times. The DON indicated Resident #83 stated she fell at her apartment, not at the facility. The DON stated no one told her Resident #83 fell at the facility or that Resident #83 said she fell and a male helped her back to bed. The DON indicated Resident #83 had a history of falls before she was admitted to the facility.<br><br>Interview on 06/03/24 at 4:41 P.M. with NP #339 revealed she received a call on 04/29/24 at around 8:00 A.M. by a nurse who just came on shift. NP #339 stated the nurse told her Resident #83 had fallen overnight, was having a lot of pain, and her leg did not look right. NP #339 stated she requested an x-ray and the x-ray showed Resident #83 had a fracture. NP #339 indicated she did not talk to Resident #83 about her fall because she not in the facility that day. NP #339 stated Resident #83's fall was around 3:00 A.M., somebody picked her up and put her back to bed, the facility did an investigation about that but she was not sure of the outcome. NP #339 stated Resident #83 had frequent falls at home, but she did not recall having any information about a fracture at home before she was admitted to the facility. NP #339 stated in her previous visits with Resident #83 before the fall on 04/29/24 she did not remember her leg being internally rotated or painful to the touch. NP #339 stated she read the hospital records and Resident #83's assessment when she arrived to the ED, and the assessment was not what Resident #83 had prior to her fall. NP #339 stated her leg did not look like that prior to the fall on 04/29/24.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365847 | A. Building<br>B. Wing | 06/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Bath Manor Special Care Centre | 2330 Smith Road<br>Akron, OH 44333 |

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 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Interview on 06/04/24 at 9:35 A.M. with Regional Director of Clinical Services (RDCS) #342 revealed the RDCS did not believe the facility had evidence Resident #83 fell and hurt her hip. RDCS #342 stated Resident #83 had pain, the DON called her, and a self-reported incident was opened for an Injury of Unknown Origin. RDCS #342 stated the DON said she did not know how Resident #83 fell , an investigation was conducted, everyone was interviewed, and no one admitted to picking Resident #83 off the floor and putting her back to bed. RDCS #342 stated she did not know how Resident #83 fell and got herself back to bed. When Resident #83 returned to the facility they made sure all interventions were in place and the facility ruled out abuse. RDCS #342 indicated she talked to the therapy department staff and was told Resident #83 was ambulatory and could walk 100 feet. RDCS #342 stated she did not know what truly happened. RDCS #342 confirmed Resident #83 did not have a fall risk evaluation completed when she was admitted to the facility. RDCS #342 indicated the handwritten Preadmission Assessment was completed by therapy and was usually completed by nursing or therapy or both.<br><br>Review of the facility policy titled Fall Prevention and Management, references were State Operations Manual 2017 and included residents would be assessed for fall risks on admission, quarterly, after any fall and as needed. If risks were identified, preventative measures would be put in place and care planned. All falls would be reviewed and investigated. Providers would be consulted regarding risks and interventions, feedback, and any further approaches.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00154506, OH00153567, and OH00154128. |