

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365855	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/03/2024
NAME OF PROVIDER OR SUPPLIER Laurie Ann Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 Milton Boulevard Newton Falls, OH 44444	

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** 45441</p> <p>THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.</p> <p>Based on record review, interview, facility self-reported incident (SRI) review, and facility policy review, the facility failed to ensure Resident #55 was free from staff-to-resident physical abuse. This affected one resident (#55) of three residents reviewed for abuse. The facility census was 54.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #55 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included sepsis, muscle weakness, epilepsy, bipolar disorder, anxiety, and paraplegia.</p> <p>Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed resident #55 was cognitively intact. He was completely dependent on staff for eating, oral care, personal hygiene, showering, toileting, and dressing.</p> <p>Review of the care plan dated 08/06/24 revealed Resident #55 had inappropriate behaviors such as agitation and combativeness, aggression with staff, cursing at staff, and refusing to lie down. Interventions included approaching the resident in a slow, calm manner, bringing the resident to a quiet environment as needed, and observing for possible environmental causes of behaviors.</p> <p>Review of SRI tracking number 252677 dated 10/06/24 at 10:41 A.M. revealed Resident #55 reported a facility nurse slapped him. The perpetrator was identified as Registered Nurse (RN) #205 who was suspended pending an investigation.</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 the facility investigation for SRI tracking number 252677 revealed Resident #55 reported RN #205 was providing care when he became verbally aggressive with RN #205. He alleged RN #205 slapped his mouth. Resident #55 reported RN# 205 left his room after the occurrence. Interview with RN #205 confirmed Resident #55's report, stating she utilized the back of her hand to slap Resident #55's mouth, then exited the room. An interview with Certified Nurse Aide (CNA) #206 revealed she was present in the room and confirmed both Resident #55 and RN #205's reports of what occurred. Like residents were interviewed as well as all staff working at the time of the incident, and no further issues were noted. Resident #55 was assessed, and no injuries were noted, vital signs were obtained and reported blood pressure was 110/75, pulse 88, respirations 16, temperature 97.5 degrees Fahrenheit (F) and oxygen saturation was 98%.</p> <p>Review of the progress note dated 10/07/24 at 11:59 P.M. written by Advanced Practice Registered Nurse (APRN) #203 revealed Resident #55 had an altercation with another person (RN #205) and was struck in the face. An examination was completed, and the resident had no bruising swelling or redness noted to either side of the face. The resident was noted to be in good spirits.</p> <p>Interview on 11/03/24 at 9:44 A.M. revealed the facility was aware of the abuse of Resident #55 by RN #205. The facility had completed the investigation and substantiated the allegation of abuse. RN #205 was terminated as a result of the incident.</p> <p>Interview on 11/03/24 at 9:52 A.M. with RN #205 revealed she reported the incident of abuse to her immediate supervisor within an hour of the occurrence. She would provide no further information regarding the incident.</p> <p>Interview on 11/03/24 at 10:02 A.M. with CNA #200 revealed she came in to work at approximately 4:30 A.M. on 10/06/24. RN #205 told her she had called the on-call manager and was being sent home. CNA #200 revealed talking to Resident #55 who asked to speak with the Administrator, whom she called immediately. She had no knowledge of any other concerns regarding any incidences or suspicions of resident abuse.</p> <p>Interview on 11/03/25 at 10:35 A.M. with Licensed Practical Nurse (LPN) #204 revealed she was the manager on duty on 10/06/24 when she received a call at approximately 4:30 A.M. from RN #205. RN #205 admitted she slapped a resident. LPN #204 instructed RN #205 to write a witness statement, clock out, and go home. LPN #204 revealed she notified the Director of Nursing (DON) and Administrator, came to work and immediately started collecting witness statements and performing skin checks on residents.</p> <p>Review of the personnel file for RN #205 revealed her last shift worked was 10/05/24 from 7:00 P.M. to 10/06/24 at 4:30 A.M. She was terminated on 10/11/24 for poor work performance.</p> <p>Review of the facility policy titled Abuse, dated 01/31/20, revealed abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment resulting in physical harm, pain or mental anguish. The facility would not tolerate abuse, neglect or exploitation, and residents had the right to be free from abuse including corporal punishment, involuntary seclusion, and physical or chemical restraint.</p> <p>The deficient practice was corrected on 10/08/24 when the facility implemented the following corrective actions:</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>RN #205 was suspended on 10/06/24 immediately after reporting the abuse. Her employment was terminated on 10/11/24.</p> <p>On 10/06/24, Resident #55 was assessed and interviewed regarding the abuse; no injuries were noted or reported.</p> <p>On 10/06/24 all staff working at the time of the incident were interviewed, and residents were either assessed for injuries or interviewed.</p> <p>On 10/07/24, Resident #55 was assessed by APRN #203. There were no new orders.</p> <p>On 10/06/24, all staff education regarding abuse identification, prevention and requirements of reporting began, and was completed on 10/07/24.</p> <p>On 10/06/24, an ad hoc Quality Assurance and Performance Improvement (QAPI) meeting was held to review the occurrence and perform a root cause analysis.</p> <p>On 10/07/24, RN #205 was reported to the Board of Nursing.</p> <p>On 10/08/24 at approximately 11:45 A.M. a police report was filed by the facility, incident #24-14722. Resident #55 was adamant a police report was not necessary. Resident #55 was his own responsible party.</p> <p>On 10/08/24 a follow-up psychosocial assessment was completed for Resident #55 with no changes noted.</p> <p>One 10/08/24, the facility began weekly audits of staff's understanding of abuse prevention, identification and requirements of reporting for a period of four weeks.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00159222 and Complaint Number OH00158827.</p>