

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365862	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2024
NAME OF PROVIDER OR SUPPLIER The Pines Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3015 17th Street NW Canton, OH 44708	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33019</p> <p>Based on medical record review, facility investigation review, self-reported incident review, facility policy review, and interviews, the facility failed to timely report an allegation of sexual abuse. This affected three (Resident #7, #10, and 14) of four residents reviewed for abuse. The facility census was 77.</p> <p>Findings include:</p> <p>Medical record revealed Resident #7 was admitted to the facility on [DATE] with diagnoses including hemiparesis and hemiplegia following cerebral infarction, schizophrenia, history of substance abuse, muscle weakness, dysphagia, and chronic obstructive pulmonary disease. Further review of the medical record revealed the resident was severely cognitively impaired.</p> <p>Medical record revealed Resident #10 was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction, chronic kidney disease, bipolar disorder, panic disorder, and history of cocaine abuse, and chronic obstructive pulmonary disease. Further review of the medical record revealed the resident was moderately cognitively impaired.</p> <p>Medical record revealed Resident #14 was admitted to the facility on [DATE] with diagnoses including chronic heart failure, acute pancreatitis, depression, anxiety disorder, personal history of trauma, other stimulant abuse, and muscle weakness. Further review of the medical record revealed the resident was cognitively intact.</p> <p>Review of Self-Reported Incident (SRI) #248991, dated 06/24/24, revealed on 06/23/24 Licensed Practical Nurse (LPN) #58 reported to the Director of Nursing (DON) that she had been told by a resident, who heard from another resident, that there was fornication on the smokers' patio with a couple of residents. The residents alleged to be involved were Resident (#7, #10, and #14). The allegation was immediately reported to the Administrator and an investigation was immediately initiated. Following the allegation, the smoking patio was supervised by staff during smoking breaks for all residents. The three residents in question were interviewed with no concerns, and there were no witnesses who confirmed that fornication had occurred on the patio.</p> <p>Interview on 06/27/24 at 1:00 P.M. with the Administrator confirmed the sexual abuse allegation indicated in SRI #248991 was not reported to the State Agency within two hours as required.</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's policy titled, Ohio Abuse, Neglect, and Misappropriation, dated 10/27/21, revealed all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of property, are reported immediately, but no later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00155131.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33019</p> <p>Based on medical record review, self-reported incident review, facility policy review, and interviews, the facility failed to complete an accurate smoking risk assessment for two residents (#7 and #12) and failed to ensure smoking supervision for Resident #7, who was severely cognitively impaired. This affected two (Resident #7 and #12) of four residents reviewed for accidents. The facility census was 77.</p> <p>Findings include:</p> <p>1. Medical record review revealed Resident #7 was admitted to the facility on [DATE] with diagnoses including hemiparesis and hemiplegia following cerebral infarction, schizophrenia, history of substance abuse, muscle weakness, dysphagia (difficulty swallowing), and chronic obstructive pulmonary disease.</p> <p>Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 04/30/24, revealed the resident was severely cognitively impaired.</p> <p>Review of a physician progress note, dated 06/18/24, revealed Resident #7 had the diagnoses of hemiplegia, hemiparesis, dysphagia, and contractures of the right hand/finger.</p> <p>Review of Resident #7's Smoking Assessment v 4, dated 05/24/24, indicated the resident was an independent smoker. The assessment incorrectly indicated that the resident did not have dexterity problems, did not have swallowing difficulties, and that the plan of care reflected the use of nicotine in any form.</p> <p>Review of Self-Reported Incident (SRI) #248991, dated 06/24/24, revealed on 06/23/24 Resident #7 was unsupervised during a smoke break when an allegation of potential sexual abuse occurred.</p> <p>Interview on 06/26/24 at 12:55 P.M. with the Director of Nursing (DON) confirmed Resident #7's smoking assessment dated [DATE] was incorrect and she would re-assess the resident. The DON further confirmed Resident #7's care plan did not indicate the use of nicotine or that the resident was a smoker and that it should have been revised to reflect she used nicotine.</p> <p>Following Resident #7's smoking re-assessment completed by the DON during the complaint investigation revealed the resident had a dexterity problem, swallowing difficulties, and required smoking supervision.</p> <p>Interview on 06/26/24 at 4:15 P.M. with the Administrator confirmed Resident #7 had been unsupervised during her smoking breaks, but going forward she will be supervised during her smoking breaks.</p> <p>2. Medical record revealed Resident #12 was admitted to the facility on [DATE] with diagnoses including infarction, dementia, diabetes mellitus, psychotic disturbance, mood disturbance, anxiety, and chronic obstructive pulmonary disease.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Minimum Data Set (MDS) 3.0 assessment, dated 03/29/24, revealed the resident was moderately cognitively impaired and had a diagnosis of dementia.</p> <p>Review of Resident #12's Smoking Assessment v 4, dated 06/20/24, incorrectly revealed the resident did not have a diagnosis of dementia.</p> <p>Interview on 06/26/24 at 4:20 P.M. with the Administrator confirmed Resident #12's smoking assessment incorrectly indicated the resident did not have a diagnosis of dementia.</p> <p>Review of the facility's policy titled, Resident Smoking Guidelines, undated, revealed it is the policy of the facility to promote resident centered care by providing a safe smoking area for residents that request to smoke and are capable of safe smoking behaviors either independently or with supervision. Assessment, observation, and designation of independent or supervised smoker will be made by the interdisciplinary team (IDT) for each resident who requests to smoke in the facility. The smoking assessment includes the assessment of the level of dexterity to manage smoking and smoking materials.</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33019</p> <p>Based on medical record review, self-reported incident (SRI) review, facility investigation review, facility policy review, and interview, the facility failed to maintain complete medical records. This affected three (Resident #7, #10, and #14) of four residents reviewed for abuse. The facility census was 77.</p> <p>Findings include:</p> <p>Medical record review revealed Resident #7 was admitted to the facility on [DATE] with diagnoses including hemiparesis and hemiplegia following cerebral infarction, schizophrenia, history of substance abuse, muscle weakness, dysphagia, and chronic obstructive pulmonary disease. Further review revealed the resident was severely cognitively impaired.</p> <p>Medical record review revealed Resident #10 was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction, chronic kidney disease, bipolar disorder, panic disorder, and history of cocaine abuse, and chronic obstructive pulmonary disease. Further review revealed the resident was moderately cognitively impaired.</p> <p>Medical record review revealed Resident #14 was admitted to the facility on [DATE] with diagnoses including chronic heart failure, acute pancreatitis, depression, anxiety disorder, personal history of trauma, other stimulant abuse, and muscle weakness. Further review revealed the resident was cognitively intact.</p> <p>Review of Self-Reported Incident (SRI) #248991, dated 06/24/24, revealed on 06/23/24 Licensed Practical Nurse (LPN) #58 reported to the Director of Nursing (DON) that she had been told by a resident, who heard from another resident, that there was fornication on the smoker's patio with a couple of residents. The residents alleged to be involved were Resident (#7, #10, and #14). The allegation was immediately reported to the Administrator and an investigation was immediately initiated. Following the allegation, the smoking patio was supervised by staff during smoking breaks for all residents. The three residents in question were interviewed with no concerns, and there were no witnesses who confirmed that fornication had occurred on the patio.</p> <p>Review of Resident (#7, #10, and #14's) medical records revealed no documentation of the alleged incident of sexual abuse as indicated in SRI #248991.</p> <p>Interview on 06/24/24 at 3:16 P.M. with the Administrator confirmed Resident #7, #10, and #14's medical records did not contain documentation of the incident indicated in SRI #248991. The Administrator further confirmed the incident should have been documented in Resident #7, #10, and #14's medical records.</p> <p>Review of the facility's policy titled, Ohio Abuse, Neglect, and Misappropriation, dated 10/27/21, revealed investigation of incidents: documentation of the facts and findings will be completed in each resident medical record and the physician of each resident will be notified.</p> <p>(continued on next page)</p>		

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