

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365880	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/14/2024
NAME OF PROVIDER OR SUPPLIER Signature Healthcare of Coshocton		STREET ADDRESS, CITY, STATE, ZIP CODE 100 South Whitewoman Street Coshocton, OH 43812	

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 - Immediate jeopardy to resident health or safety</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** 33019</p> <p>Based on observation, medical record review, review of a facility Self-Reported Incident (SRI) and investigation, review of the facility's abuse policy titled Abuse, Neglect and Misappropriation of Property, and interviews with staff, residents and the authorities, the facility failed to ensure Resident #2 was free from an incident of resident-to-resident abuse. This resulted in Immediate Jeopardy and physical and psychosocial harm on 04/21/24 at approximately 7:45 A.M., when Resident #2, was physically abused/assaulted by Resident #3. Resident #3 struck Resident #2 multiple times resulting in two facial lacerations with bleeding, a laceration to the lower lip, and multiple hematomas (bruises) to the resident's bilateral arms, upper portion of her breasts, and upper chest wall. The incident occurred in the dining room where there were no staff present. Resident #2 also sustained psychosocial harm as a result of the incident, verbalizing her fear of reoccurrence, asking for her room to be inspected for the presence of Resident #3, with no evidence of psychosocial support following the incident resulting in Resident #2 isolating herself from attending preferred activities and meals. Following the incident, Resident #2 was not provided timely medical/hospital evaluation and the facility failed to notify the physician, failed to timely notify the authorities, and failed to ensure appropriate interventions were implemented to ensure resident safety. This affected one resident (#2) of six residents reviewed for abuse. The facility census was 58.</p> <p>On 05/02/24 at 3:56 P.M. the Administrator, Director of Nursing (DON), Regional DON #702, and [NAME] President of Clinical Operations #703 were notified Immediate Jeopardy began on 04/21/24 when Resident #3 initiated a physical altercation with Resident #2, striking Resident #2 multiple times resulting in two facial lacerations with bleeding, a laceration to the lower lip, and multiple hematomas (bruises) to the resident's bilateral arms, upper portion of her breasts, and upper chest wall. The incident occurred in the dining room where there were no staff present. The facility failed to provide appropriate interventions to prevent further verbal and/or physical interactions between other residents and Resident #3, failed to make any staffing changes related to staffing/supervision of cognitively impair residents and/or residents with physical/verbal behaviors while in the dining room prior to breakfast and failed to ensure Resident #2 received timely and appropriate aftercare following the resident-to-resident physical abuse.</p> <p>The Immediate Jeopardy was removed on 05/02/24 when the facility implemented the following corrective actions:</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 - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 05/02/24 at 11:20 A.M. 1:1 supervision was initiated for Resident #3 with one staff member assigned for supervision of the resident. Additional staff were added to the shifts (as needed) to ensure monitoring occurred until the resident's discharge. The following staff provided 1:1 supervision through discharge on 05/03/24: State tested Nursing Assistant (STNA) #130, #148, #160, and Activities Staff #160.</p> <p>On 05/02/24 at 11:30 A.M. an Ad-Hoc Quality Assurance Performance Improvement (QAPI) meeting was held. Regional DON #702 and VPCO #703 educated the Administrator, DON, Medical Director #701, Business Office Manager (BOM) #96, Therapy Manager #95, SSD #100, the ADON, LPN #132, Dietary Manager (DM) #92, Plant Operations (PO) #90, Activities Director #91 on the facility abuse policy, Centers for Medicare and Medicaid abuse reporting guidelines, future expectations with reporting abuse and completing investigations. Topics also discussed during the meeting were resident behaviors and care planned interventions as well as the facility removal plan. QAPI committee meetings would be held weekly for weeks, beginning 05/02/24 then monthly for recommendations and further follow-up regarding the removal plan based upon evaluation of audits and observations. Audits would continue to be submitted to the QAPI committee for review and to ensure compliance goals. QAPI committee reserved the right to modify or extend monitoring times according to outcomes. The Administrator was responsible for the oversight of this plan to ensure ongoing compliance. Any issues identified thru the audits would be reviewed and revised thru the facility QAPI process.</p> <p>On 05/02/24 at approximately 12:00 P.M. the DON and Licensed Practical Nurse (LPN) #132 completed a record review for all 57 residents (the current census on 05/02/24) for behavioral diagnosis including but not limited to traumatic brain injury (TBI), dementia and schizophrenia with no newly identified residents at risk for resident-to-resident abuse through diagnoses.</p> <p>On 05/02/24 at 12:00 P.M. LPN #132 reviewed residents (Residents #51, #27, #49, #20, #60, #9, #17, #35, #32, #36, #13, #2, #8, #29, #38, #23, #64, #6, #54, and #58) determined to be at risk for potential aggressive behaviors to ensure care planned interventions were appropriate.</p> <p>On 05/02/24 at 12:11 P.M. Resident #3 was placed in a private room by Plant Director #158 and Medical Records #126.</p> <p>On 05/02/24 at approximately 1:00 P.M. the Director of Nursing spoke with Resident #6 (the resident who witnessed the incident between Resident #3 and Resident #2) to offer emotional/psychosocial support, but the resident declined.</p> <p>On 05/02/24 at approximately 4:30 P.M. facility resident profiles for residents at risk for potential aggressive behaviors (Residents #51, #27, #49, #20, #60, #9, #17, #35, #32, #36, #13, #2, #8, #29, #38, #23, #64, #6, #54, and #58) were updated to reflect care planned interventions to be followed when caring for a resident with a behavioral care plan by SSD #100, LPN #132 and/or the ADON.</p> <p>On 05/02/24 at 5:15 P.M. Resident #2 was evaluated by Physician #810 regarding the incident with Resident #3 via telehealth. The provider's 05/02/24 progress note indicated there were no lasting effects (as of this date) from the incident. There were no current updates made to the resident's care plan and no new orders were received.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 05/02/24 by 7:00 P.M. all 82 staff (17 nurses, 23 STNA, two Activity Aides, 14 Department Managers, two Agency Nurses, 12 therapy, seven dietary and five housekeeping/laundry) were educated by the Administrator, DON or ADON either in-person or by phone regarding the facility abuse policy and reporting abuse to the Administrator (the facility abuse coordinator).</p> <p>On 05/02/24 by 7:00 P.M. all nursing staff (17 nurses, 23 STNA and two agency nurses) were educated either in person or via phone on access to resident care plans by SSD #100, LPN #132, the DON, or the Assistant Director of Nursing (ADON). A hand-out was also provided regarding how to access the information and the staff who received education via phone will receive the hand-out on their next scheduled shift. Staff will also be required to show a return demonstration or recite the process on their next scheduled shift. The resident profiles are in the electronic medical record (EMR).</p> <p>Beginning 05/02/24 the facility implemented a plan that any facility initiated Self Reportable Incident(s) and facility investigation(s) would be escalated to regional support, Regional DON #702, and [NAME] President of Clinical Operations (VPCO) #703 for review to ensure the facility policy was followed.</p> <p>Beginning 05/02/24, a plan for Social Services Designee (SSD) #100 to conduct weekly psychosocial follow-up with Resident #2 was implemented to ensure no lingering effects from the incident had occurred. Follow up would be completed for four weeks.</p> <p>Beginning 05/02/24 the DON, ADON, and/or LPN #132 would review all new admissions for behavior risks. Auditing would be completed by the Director of Nursing/Assistant Director of Nursing and/or LPN #132 five days a week for the next eight weeks then three times a week for four weeks for all residents, which includes all new admissions.</p> <p>Beginning 05/02/24, the Director of Nursing, ADON and/or LPN #132 would review/audit all nursing staff documentation including progress notes, events, observations, and Care Assist documentation to ensure all residents with behaviors have care planned interventions to ensure safety. Auditing would be completed on all current residents five days a week for eight weeks, then three times a week for four weeks.</p> <p>On 05/03/24 at 4:45 P.M. Resident #3 was discharged to a sister facility related to the resident's behavioral health needs.</p> <p>On 05/06/24 at approximately 12:00 P.M. the Administrator, DON, Medical Director #701, Business Office Manager (BOM) #96, Therapy Manager #95, SSD #100, the ADON, LPN #132, Dietary Manager (DM) #92, Plant Operations (PO) #90, and Activities Director #91 conducted an audit (questionnaire) of current interviewable residents, whose Brief Interview for Mental Status (BIMS) score was eight and higher with no reported incidents of abuse and the residents interviewed indicated they felt safe within the facility. Non-interviewable residents (#27, #71, #47, #9 and #58), received a skin assessment on 05/02/24.</p> <p>Although the Immediate Jeopardy was removed on 05/02/24, the facility remained out of compliance at a Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was in the process of implementing their corrective action plan and monitoring to ensure on-going compliance.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Findings include:</p> <p>Review of the medical record for Resident #2 revealed an admitted [DATE] with diagnoses including schizoaffective disorder, bipolar type, anxiety, major depressive disorder, personality disorder, cognitive communication disorder, dysphagia (difficulty swallowing), heart failure, muscle weakness, and seizure disorder.</p> <p>Review of the care plan dated 08/07/20 revealed Resident #2 had verbal behaviors including making disruptive noises that were sometimes directed toward others, screaming at others, cursing, and yelling out [NAME] and moaning or humming. Interventions included sitting with the resident and diverting attention away from disruptive noises/screaming and supervising/monitoring at all meals due to the resident's poor self-monitoring and impulsivity with eating.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 09 of 15, indicating the resident had moderately impaired cognition. The MDS assessment revealed the resident had no psychosis or rejection of care. The assessment also indicated the resident had daily behavioral symptoms not directed toward others (examples given included verbal/vocal symptoms like screaming and disruptive sounds).</p> <p>Review of Resident #2's nursing progress note dated 04/21/24 at 7:45 A.M. (recorded as a late entry on 04/23/24 at 11:55 A.M.), authored by the DON, revealed STNA #102 brought Resident #2 up to her in a wheelchair and her assessment revealed bright red blood on the resident's face, hands, mouth, and clothes. The resident stated, I didn't do anything, Resident #3 attacked me. An abrasion was noted to the left cheek measuring approximately 2.0 centimeters (cm) by 0.5 cm by 0.1 cm and an abrasion was noted to the left side of the nose measuring approximately 1.0 cm by 0.5 cm x 0.1 cm. Areas were cleansed with wound cleanser and steri-strips were applied. Resident #2 was noted to be visibly upset after the altercation and requested to eat lunch in her room. The resident complained of pain and as needed (prn) medication was administered.</p> <p>Review of the Medication Administration Record (MAR) for April 2024 revealed Resident #2 was administered Tramadol 50 milligrams one tablet on 04/21/24 at 4:51 P.M. (somewhat effective) and again at 9:16 P.M. (effective). There was no mention of the pain medication administration in the nursing progress notes.</p> <p>Review of the MAR for April 2024 revealed the resident was administered Tramadol 50 mg on 04/22/24 at 7:45 A.M. (no assessment of the resident's pain) and no documentation of the resident's Tylenol administration on the MAR.</p> <p>Review of Resident #2's nursing progress note dated 04/22/24 at 12:56 P.M., authored by LPN #152, revealed Resident #2 was noted to have increased pain and did not want to go to the dining room for lunch. Tramadol prn was given this morning and Tylenol prn was given at noon.</p> <p>Review of Resident #2's nursing progress note dated 04/22/24 at 5:50 P.M. (recorded as a late entry on 04/23/24 at 2:59 P.M.), authored by LPN #152, revealed STNA alerted the nurse to come into Resident #2's room where scattered bruising was noted to the bilateral forearms and chest, related to the previous incident. The note indicated there were no complaints of pain or discomfort.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #2's nursing progress note dated 04/22/24 at 8:45 P.M. (recorded as a late entry on 04/23/24 at 1:27 A.M.), authored by RN #110, revealed this RN was alerted by Nurse Practitioner (NP) #700 of Resident #2 having multiple injuries during an altercation with Resident #3. During assessment with NP #700, a scratch was noted to the left cheek, measuring approximately 12 cm and another scratch beside of it, measured approximately 4 cm, a laceration of the left side of the lip, two distinct fingerprint bruises to the right forearm, two bruises to the left forearm, two bruises to the left upper breast and two bruises to the left breast, a bruise to the left, flank area. Order received from NP #700 to cleanse the scratches and lip laceration and to apply triple antibiotic ointment to those areas daily and prn. An order was also received to obtain x-rays of the face and chest. The police were called due to resident-to-resident altercation and a police officer came and interviewed the residents.</p> <p>Review of Resident #2's progress note dated 04/22/24 at 9:00 P.M. (recorded as late entry on 04/23/24 at 1:13 A.M.), authored by NP #700, revealed Resident #2 was seen for a routine/regular visit. During assessment, Resident #2 was observed to have two scratches on her face, measuring approximately two to three inches in length with dried blood noted. Bruising to the bilateral arms and anterior chest, and a laceration to the inside of the bottom, left, lateral lip was noted. Resident #2 stated she was in a fight with another resident at the facility on the morning of 04/21/24. Resident disclosures and injuries were reported to the facility RN and DON. Injuries and skin assessment performed with RN #110. Attempted to notify attending physician/medical director #701 with message left requesting a call back. New treatment orders for an x-ray of the facial bones due to trauma/visible injury, a chest x-ray due to visible injury and pain, wound care to abrasions/scratches to face with wound cleanser and antibiotic ointment to be applied.</p> <p>Review of the medical record for Resident #3 revealed an admitted [DATE] with diagnoses including diffuse traumatic brain injury (TBI) with loss of consciousness, major depressive disorder, and mood disorder, anxiety disorder, and muscle weakness.</p> <p>Review of the care plan dated 12/13/22 revealed Resident #3 had a diagnosis of anxiety and depression and experienced instances of feelings of dread/apprehension, little interest or pleasure in doing things, behavioral symptoms such as yelling/cursing at others, manipulation and making inappropriate comments. Interventions included to monitor/report signs and symptoms of anxiety, restlessness, pacing, poor impulse control, and fear/apprehension.</p> <p>Review of the care plan dated 12/20/22 revealed the resident had a memory/recall problem related to cognitive loss, history of TBI, experienced behavioral symptoms, and will yell/curse at others. Interventions included redirecting resident when entering unsafe areas.</p> <p>Review of the care plan dated 12/27/22 revealed the resident had behavior problems related to attention seeking, was non-compliant with the smoking policy and protocols, had physically burned another person during a smoke break, hid cigarettes on her person, was verbally aggressive at times with other residents and staff, made false statements regarding staff and other residents, and was not easily directed. Interventions included to observe for triggers of inappropriate behaviors and alter environment as needed.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 14 of 15, indicating intact cognition. The MDS assessment revealed the resident had no psychosis or rejection of care.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review revealed Resident #3 had a history of behaviors, including the following incidents:</p> <p>On 01/21/23 (recorded as late entry on 01/22/23 at 7:15 P.M.), authored by RN #110, revealed this nurse was alerted by two residents there was an incident out in the smoking area. Upon investigation, Resident #3 became angry and verbally abusive to Resident #13 and STNA #169. Resident #3 continued to cuss at both individuals and then ultimately tried to burn Resident #13 with a cigarette, when STNA #169 tried to protect Resident #13, Resident #3 burned STNA #169 numerous times on purpose. Resident #3 confirmed she was trying to hurt both individuals and stated she was cussing and trying to burn people with her cigarette because she was mad at them for telling her to move out of the doorway as other residents were trying to go back inside to get out of the cold weather.</p> <p>Review of Resident #3's nursing progress note, dated 04/15/24 at 5:18 A.M., authored by RN #131, revealed when STNA went into room to check the resident and tried to get the resident up, when Resident #3 started swinging and kicking at the STNA. STNA came and got this nurse to assist. Resident #3 kept kicking and yelling that she don't give a {expletive} if she was wet and was not getting up. The resident was not laying in a wet bed but continued to fight. The resident's roommate was awakened by her yelling.</p> <p>Review of Resident #3's nursing progress note, dated 04/21/24 at 2:11 P.M. (recorded as late entry on 04/23/24 at 1:13 P.M., authored by the DON, revealed the resident was noted to be sitting in the lobby discussing the altercation with other residents. This nurse redirected the resident, and the re-direction was unsuccessful. The note indicated will continue to monitor.</p> <p>Review of Resident #3's nursing progress note, dated 04/22/24 at 9:56 P.M. (recorded as late entry on 04/23/24 at 6:34 P.M.), authored by RN #110, revealed NP #700 asked this RN to go with her to see Resident #3 and interview her related to the altercation with Resident #2. Resident #3 admitted to grabbing, hitting, and scratching Resident #2 because she was upset with her. Resident #3 stated Resident #2 smacked her in the left eye twice, however, no injuries were observed.</p> <p>Review of a facility Self-Reported Incident (SRI), tracking number 24658, with a discovery and submission date of 04/21/24, revealed an allegation/suspicion of physical abuse, with the initial source of the allegation being a resident victim and a resident witness, was reported to the State Survey Agency. The SRI indicated on 04/21/24 at 7:45 A.M. in the dining room, Resident #2 alleged Resident #3 attacked her. There were no staff present during the alleged attack. The only witness was Resident #6. Facility interview with Resident #3 revealed Resident #2 attacked her by pulling her oxygen off and saying, I'm gonna kill you, {expletive}. Facility interview with Resident #2 revealed she didn't do anything, and Resident #2 attacked her. The SRI indicated the initial skin inspection of Resident #2 revealed scratches to the left cheek and left side of her nose, with no other injuries noted. The following day, on 04/22/24, bruises to the chest and bilateral forearms were noted. Resident #2 requested to eat lunch in her room on the day of the allegation due to being fearful of another attack by Resident #3. Facility staff walked with Resident #2 to the dining room daily to ensure she felt safe. The SRI noted a 72-hour psychosocial evaluation was completed (the facility was unable to provide evidence this was completed), and Resident #2 showed no signs or symptoms of adverse reactions related to the event unless she was reminded of the allegation; when this happened, she would state that she was scared, but showed no signs of uneasiness, fearfulness, tearfulness, and attempts to walk to the dining room with staff accompanying her. The facility investigator was listed as the DON.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #6's witness statement, dated 04/21/24 (without the time documented), indicated the statement was verbally given to the DON and the ADON and revealed Resident #2 came over and sat down and started moaning when Resident #6 and Resident #3 asked her to stop. Resident #2 said, you're not my boss. Resident #3 went over to Resident #2 and Resident #2 said, I'm gonna kill you (expletive) and took Resident #3's oxygen off. Resident #3 then scratched Resident #2.</p> <p>Review of Resident #2's witness statement, dated 04/21/24 (without the time documented), indicated the statement was verbally given to the DON and the ADON and revealed Resident #2 stated that she did not do anything, and Resident #3 attacked her.</p> <p>Review of Resident #3's witness statement, dated 04/21/24 (without the time documented), indicated the statement was verbally given to the DON and the ADON and revealed Resident #2 told Resident #3, I'm gonna kill you {expletive}. No other information was provided regarding the investigation.</p> <p>Interview on 04/29/24 at 1:50 P.M. with STNA #101 revealed she was assigned to care for Resident #2 on the next day (on 04/22/24) following the resident-to-resident altercation. STNA #101 stated after she toileted Resident #2, she noticed several bruises on the resident's chest and breast, and immediately notified LPN #152, who took pictures of the bruises and reported the bruising to the DON. STNA #101 further stated that following the incident with Resident #3, Resident #2 had cried and verbalized fear of going to the dining room or common areas alone. She shared the resident verbalized her fear the following day and her fear continued. STNA #101 stated that following the incident, Resident #2 mainly eats meals in her room and would only eat in the dining room if staff stays with her the entire time.</p> <p>Observation of Resident #2 on 04/29/24 at 1:54 P.M. with STNA #101, revealed seven greenish/purple-colored bruises, varying in size, located on the bilateral chest wall and upper breast area were noted on Resident #2. There was a hematoma noted on the right forearm, and scattered bruising noted to both forearms. Two separate lacerations were observed, one on the left side of the resident's nose, and the other on the left cheek. At the time of the observation, interview with Resident #2 revealed the resident voiced she did not feel safe leaving her room because she was afraid to get hit again by Resident #3. Resident #2 was tearful and stated to the surveyor, I'm scared.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 04/30/24 at 11:05 A.M., an interview with the DON revealed she was administering medications on the morning of 04/21/24 at approximately 7:45 A.M. (she was working as a floor nurse due to staffing needs) when STNA #102 brought Resident #2 to her from the dining room. The DON revealed she observed a scratch on Resident #2's left cheek and the side of her nose. The DON stated Resident #2 told her that Resident #3 attacked her and that she didn't know why, because she didn't do anything. The DON stated Resident #2 often moans and the moaning probably bothered Resident #3. The DON stated no staff were present in the dining room because breakfast had not been served yet. The DON confirmed several residents including Resident #2 and Resident #3 often go to the dining room before breakfast and were typically unsupervised until breakfast was served. The DON stated, this is their home, we can't stop the residents from going to the dining room. The DON confirmed she did not obtain a witness statement from STNA #102 and was unsure of what happened following the altercation between the residents and prior to Resident #2 being brought to her in a wheelchair by STNA #102. The DON stated following the incident, she notified the on-call physician, but could not recall the provider's name, and did not document the notification in the resident's medical record. The DON stated her skin assessment on 04/21/24 of Resident #2 following the altercation did not include any bruising of the resident's arms, chest, or breasts, or lip laceration and only indicated two scratches on the resident's face. The DON stated when she was later informed of the bruising and lip laceration, she attributed the injuries to the altercation between Resident #2 and Resident #3 and did not believe them to be injuries of unknown origin.</p> <p>On 04/30/24 at 11:30 A.M., interview with Resident #6 revealed he was waiting for breakfast along with Resident #2 and Resident #3 on the morning of 04/21/24. Resident #6 stated Resident #2 was moaning when Resident #3 told her to shut up. Resident #2 replied, make me. Resident #3 went around the table toward Resident #2 and continued telling her to shut up. Resident #3 swung and missed at first, and then Resident #2 tried to pull Resident #3's oxygen off, when Resident #3 scratched Resident #2's face and hit her. Resident #6 revealed there were no staff present in the dining room and Resident #2 went to the kitchen for help because her face was bleeding, and she was crying. The resident could not recall which staff responded to the incident.</p> <p>On 04/30/24 at 2:24 P.M., an interview with Social Services Director (SSD) #100 confirmed he had not followed-up or interviewed Resident #2 or Resident #3 following the incident that occurred on 04/21/24. SSD #100 further stated he had not followed up with either resident because the DON reported to him that she had followed up with both residents. SSD #100 stated Resident #2 came up to him in the hallway (he was unable to recall when this occurred) and showed him her mouth and stated he told the resident, That's terrible, however, there was not a direct conversation about the altercation at that time.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365880	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/14/2024
NAME OF PROVIDER OR SUPPLIER Signature Healthcare of Coshocton		STREET ADDRESS, CITY, STATE, ZIP CODE 100 South Whitewoman Street Coshocton, OH 43812	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 04/30/24 at 3:34 P.M., interview with the DON revealed on 04/22/24 NP #700 freaked out when she saw Resident #2's bruises and then reported them to RN #110. The DON stated RN #110 took it upon herself to obtain witness statements from all the employees who were working in the facility on the evening of 04/22/24. The DON stated she didn't know why RN #110 obtained the witness statements when the employees were not working at the time of the incident and did not witness the incident between Resident #2 and Resident #3. The DON further revealed NP #700 was no longer working for the facility because she resigned a couple of days following the incident. The DON confirmed the only investigation documentation of the incident was the SRI investigation and report submitted to the State agency. The DON revealed her investigation concluded that abuse did not occur. The DON stated she did not consider the incident to be abuse because she did not think Resident #3 acted willfully and did not intend to injure or hurt Resident #2. The DON further confirmed following the incident, the only resident interviews obtained were from the two residents involved in the altercation and the resident witness. The DON confirmed she did not conduct any additional resident interviews regarding abuse, and other than the skin assessments completed for Resident #2 and Resident #3, no additional skin assessments were completed for non-interviewable residents, and other than the staff interviews obtained by RN #110, no additional staff had been interviewed regarding abuse or the incident. The DON further confirmed Resident #2 and Resident #3's psychiatric providers had not been notified of the altercation and there had been no follow-up from psychiatry for either resident following the incident.</p> <p>On 04/30/24 at 3:35 P.M., an interview with Resident #3 revealed she was in the dining room when Resident #2 was running her mouth and tried to hit her but didn't. Resident #3 stated she told Resident #2 she would make her shut up and then hit her. Resident #3 stated Resident #2 started crying and was bleeding, and then went to the kitchen and told them what had happened. Resident #3 stated a staff member asked her what happened during the incident, but she was unable to recall who had asked.</p> <p>On 04/30/24 at 3:45 P.M., an interview with Dietary Worker (DW) #191 revealed she and DW #190 were getting ready to serve breakfast when Resident #2 came to the kitchen door with blood dripping from her face. DW #191 stated she got a towel for the resident and Dietary Worker #190 went to get a nurse. DW #191 asked Resident #2 what happened, and she said, she hit me and beat me up. When DW #191 asked the resident who beat her up, she pointed to Resident #3. DW #191 then asked Resident #3 what had happened, and Resident #3 said, I hit her because she tried to hit me. DW #191 stated she didn't believe Resident #3, and thought Resident #2 probably irritated Resident #3, and then she hit her and scratched Resident #2. DW #191 stated she has heard Resident #3 tell Resident #2 to shut up before. DW #191 verified when she came out of the kitchen into the dining area, there were no staff present. DW #191 further stated the residents were usually in the dining room without staff until the food was ready to be served, and then staff comes to serve the trays. DW #191 stated every morning the residents come to sit in the dining room, often for one to two hours. DW #191 stated Resident #2 would often get bored and come to the kitchen and ask for coffee, and this calmed her down and helped with her moaning. DW #191 revealed STNA #102 was the aide who came following the incident and helped and cleaned Resident #2. DW #191 revealed Resident #2 would not come to the dining room by herself anymore since the incident happened, and told her, That lady is out there, and I'm scared she will hit me. DW #191 stated Resident #2 would only come to the dining room if an aide was with her but would sit away from the other residents. DW #191 stated, It's sad because she's scared to come alone now. DW #191 shared Resident #2 had enjoyed coming to the dining room every day.</p> <p>On 05/01/24 at 8:40 A.M., an interview with DW #190 revealed she was working in the kitchen on the morning of the incident. DW #190 stated she had heard Resident #3 tell Resident #2 on multiple occasions to shut up and be quiet because of her moaning.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 05/01/24 at 9:40 A.M., an interview with the Administrator confirmed the facility's investigation should have included staff interviews, and all residents should have been interviewed regarding abuse and any resident who could not be interviewed should have had a skin assessment completed. The Administrator further confirmed residents were unsupervised in the dining room when the altercation occurred between Resident #2 and Resident #3.</p> <p>On 05/01/24 at 2:20 P.M., an interview with Resident #14 revealed she often sits in the dining room before breakfast and had witnessed Resident #3 get very irritated with Resident #2's moaning and had heard Resident #3 tell Resident #2 to shut up or that she will make her shut up. Resident #14 stated she knew something was going to happen between the residents and had been worried because she was afraid Resident #3 was going to hurt someone. Resident #14 further stated, this is going to happen again because there is nobody in the dining room to watch them. Resident #14 stated she is afraid of Resident #3 because she doesn't trust her.</p> <p>On 05/01/24 at 2:38 P.M., an interview with NP #700 revealed on the evening of 04/22/24, she went into Resident #2's room for a scheduled, routine visit. NP #700 revealed after she turned the light on, she immediately noticed lacerations on the resident's cheek and nose, both with dry, crusted blood, and a swollen left lip. Resident #2 reported to her that she had gotten into a fight with Resident #3. NP #700 stated the re [TRUNCATED]</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>33019</p> <p>Based on review of a facility Self-Reported Incident (SRI) and investigation, review of the facility's abuse policy titled, Abuse, Neglect, and Misappropriation of Property, and interviews the facility failed to ensure a complete and thorough investigation following an allegation of physical abuse. This affected one (Resident #2) of six residents reviewed for abuse. The facility census was 58.</p> <p>Findings include:</p> <p>Review of the facility Self-Reported Incident (SRI), tracking number 24658, discovery and submission date of 04/21/24, revealed an allegation/suspicion of physical abuse with the initial source of the allegation being a resident victim and a resident witness. The SRI indicated on 04/21/24 at 7:45 A.M. in the dining room, Resident #2 alleged Resident #3 attacked her. There were no staff present during the alleged attack. The only witness was Resident #6. Facility interview with Resident #3 revealed Resident #2 attacked her by pulling her oxygen off and saying, I'm gonna kill you {expletive}. Facility interview with Resident #2 revealed she didn't do anything, and Resident #2 attacked her. Facility interview with Resident #6 revealed Resident #2 was groaning out loud and was told to be quiet and then she threatened Resident #3 and tried to pull her oxygen tubing off, when Resident #3 tried to defend herself by hitting Resident #2. The SRI revealed the initial skin inspection of Resident #2 revealed scratches to the left cheek and left side of nose, with no other injuries noted. The following day, on 04/22/24, bruises to the chest and bilateral forearms were noted. Resident #2 requested to eat lunch in her room on the day of the allegation due to being fearful of another attack by Resident #3. Facility staff walked with Resident #2 to the dining room daily to ensure she felt safe. Resident #3 stated she felt safe in the facility. Resident #3's skin inspection revealed no injuries or concerns. A 72-hour psychosocial evaluation was completed (the facility was unable to provide evidence this intervention was completed), and Resident #2 showed no signs or symptoms of adverse reactions related to the event unless she was reminded of the allegation; when this happens, she will state that she is scared, but shows no signs of uneasiness, fearfulness, tearfulness, and attempts to walk to the dining room with staff accompanying her. The facility's conclusion following investigation revealed the allegation was unsubstantiated and abuse was not suspected. The facility investigator was listed as the Director of Nursing (DON).</p> <p>Review of Resident #6's Witness Statement, dated 04/21/24 (without the time documented), indicated the statement was verbally given to the DON and the ADON and revealed Resident #2 came over and sat down and started moaning when Resident #6 and Resident #3 asked her to stop. Resident #2 said, you're not my boss. Resident #3 went over to Resident #2 and Resident #2 said, I'm gonna kill you {expletive} and took Resident #3's oxygen off. Resident #3 then scratched Resident #2.</p> <p>Review of Resident #2's Witness Statement, dated 04/21/24 (without the time documented), indicated the statement was verbally given to the DON and the ADON and revealed Resident #2 stated that she did not do anything, and Resident #3 attacked her.</p> <p>Review of Resident #3's Witness Statement, dated 04/21/24 (without the time documented), indicated the statement was verbally given to the DON and the ADON and revealed Resident #2 told Resident #3, I'm gonna kill you {expletive}.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility investigation provided to the surveyor only consisted of the SRI and the statements from Resident #2, #3 and #6.</p> <p>Observation of Resident #2 on 04/29/24 at 1:54 P.M. with STNA #101, revealed seven greenish/purple-colored bruises, varying in size, located on the bilateral chest wall and upper breast area were noted on Resident #2. There was a hematoma noted on the right forearm, and scattered bruising noted to both forearms. Two separate lacerations were observed, one on the left side of the resident's nose, and the other on the left cheek. At the time of the observation, interview with Resident #2 revealed the resident voiced she did not feel safe leaving her room because she was afraid to get hit again by Resident #3. Resident #2 was tearful and stated to the surveyor, I'm scared.</p> <p>On 04/30/24 at 11:05 A.M., an interview with the DON revealed she was administering medications on the morning of 04/21/24 at approximately 7:45 A.M (she was working as a floor nurse due to staffing needs) when STNA #102 brought Resident #2 to her from the dining room. The DON revealed she observed a scratch on Resident #2's left cheek and the side of her nose. The DON stated Resident #2 told her that Resident #3 attacked her and that she didn't know why, because she didn't do anything. The DON stated Resident #2 often moans and the moaning probably bothered Resident #3. The DON stated no staff were present in the dining room because breakfast had not been served yet. The DON confirmed several residents including Resident #2 and Resident #3 often go to the dining room before breakfast and were typically unsupervised until breakfast was served. The DON stated, this is their home, we can't stop the residents from going to the dining room. The DON confirmed she did not obtain a witness statement from STNA #102 and was unsure of what happened following the altercation between the residents and prior to Resident #2 being brought to her in a wheelchair by STNA #102. The DON stated following the incident, she notified the on-call physician, but could not recall the provider's name, and did not document the notification in the resident's medical record. The DON stated her skin assessment on 04/21/24 of Resident #2 following the altercation did not include any bruising of the resident's arms, chest, or breasts, or lip laceration and only indicated two scratches on the resident's face. The DON stated when she was later informed of the bruising and lip laceration, she attributed the injuries to the altercation between Resident #2 and Resident #3 and did not believe them to be injuries of unknown origin.</p> <p>On 04/30/24 at 2:24 P.M., an interview with Social Services Director (SSD) #100 confirmed he had not followed-up or interviewed Resident #2 or Resident #3 following the incident that occurred on 04/21/24. SSD #100 further stated he had not followed up with either resident because the DON reported to him that she had followed up with both residents. SSD #100 stated Resident #2 came up to him in the hallway (he was unable to recall when this occurred) and showed him her mouth and stated he told the resident, That's terrible, however, there was not a direct conversation about the altercation at that time.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/30/24 at 3:34 P.M., interview with the DON revealed on 04/22/24 NP #700 freaked out when she saw Resident #2's bruises and then reported them to RN #110. The DON stated RN #110 took it upon herself to obtain witness statements from all the employees who were working in the facility on the evening of 04/22/24. The DON stated she didn't know why RN #110 obtained the witness statements when the employees were not working at the time of the incident and did not witness the incident between Resident #2 and Resident #3. The DON further revealed NP #700 was no longer working for the facility because she resigned a couple of days following the incident. The DON confirmed the only investigation documentation of the incident was the SRI investigation and report submitted to the State agency. The DON revealed her investigation concluded that abuse did not occur. The DON stated she did not consider the incident to be abuse because she did not think Resident #3 acted willfully and did not intend to injure or hurt Resident #2. The DON further confirmed following the incident, the only resident interviews obtained were from the two residents involved in the altercation and the resident witness. The DON confirmed she did not conduct any additional resident interviews regarding abuse, and other than the skin assessments completed for Resident #2 and Resident #3, no additional skin assessments were completed for non-interviewable residents, and other than the staff interviews obtained by RN #110, no additional staff had been interviewed regarding abuse or the incident. The DON further confirmed Resident #2 and Resident #3's psychiatric providers had not been notified of the altercation and there had been no follow-up from psychiatry for either resident following the incident.</p> <p>On 04/30/24 at 3:35 P.M., an interview with Resident #3 revealed she was in the dining room when Resident #2 was running her mouth and tried to hit her but didn't. Resident #3 stated she told Resident #2 she would make her shut up and then hit her. Resident #3 stated Resident #2 started crying and was bleeding, and then went to the kitchen and told them what had happened. Resident #3 stated a staff member asked her what happened during the incident, but she was unable to recall who had asked.</p> <p>On 04/30/24 at 3:45 P.M., an interview with Dietary Worker (DW) #191 revealed she and DW #190 were getting ready to serve breakfast when Resident #2 came to the kitchen door with blood dripping from her face. DW #191 stated she got a towel for the resident and Dietary Worker #190 went to get a nurse. DW #191 asked Resident #2 what happened, and she said, she hit me and beat me up. When DW #191 asked the resident who beat her up, she pointed to Resident #3. DW #191 then asked Resident #3 what had happened, and Resident #3 said, I hit her because she tried to hit me. DW #191 stated she didn't believe Resident #3, and thought Resident #2 probably irritated Resident #3, and then she hit her and scratched Resident #2. DW #191 stated she has heard Resident #3 tell Resident #2 to shut up before. DW #191 verified when she came out of the kitchen into the dining area, there were no staff present. DW #191 further stated the residents were usually in the dining room without staff until the food was ready to be served, and then staff comes to serve the trays. DW #191 stated every morning the residents come to sit in the dining room, often for one to two hours. DW #191 stated Resident #2 would often get bored and come to kitchen and ask for coffee, and this calmed her down and helped with her moaning. DW #191 revealed STNA #102 was the aide who came following the incident and helped and cleaned Resident #2. DW #191 revealed Resident #2 would not come to the dining room by herself anymore since the incident happened, and told her, That lady is out there, and I'm scared she will hit me. DW #191 stated Resident #2 would only come to the dining room if an aide was with her but would sit away from the other residents. DW #191 stated, It's sad because she's scared to come alone now. DW #191 shared Resident #2 had enjoyed coming to the dining room every day.</p> <p>On 05/01/24 at 8:40 A.M., an interview with DW #190 revealed she was working in the kitchen on the morning of the incident. DW #190 stated she had heard Resident #3 tell Resident #2 on multiple occasions to shut up and be quiet because of her moaning.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 05/01/24 at 9:40 A.M., an interview with the Administrator confirmed the facility's investigation should have included staff interviews, and all residents should have been interviewed regarding abuse and any resident who could not be interviewed should have had a skin assessment completed. The Administrator further confirmed residents were unsupervised in the dining room when the altercation occurred between Resident #2 and Resident #3.</p> <p>On 05/01/24 at 2:38 P.M., an interview with NP #700 revealed on the evening of 04/22/24, she went into Resident #2's room for a scheduled, routine visit. NP #700 revealed after she turned the light on, she immediately noticed lacerations on the resident's cheek and nose, both with dry, crusted blood, and a swollen left lip. Resident #2 reported to her that she had gotten into a fight with Resident #3. NP #700 stated the resident also had a handprint on the right arm and multiple bruises on her arms, chest, and upper breast area. NP #700 stated she notified RN #110 of the injuries, and they proceeded to do a complete skin assessment. NP #700 stated RN #110 then notified the police and obtained staff witness statements. NP #700 stated there was no documentation in the medical record regarding the altercation or of any injuries. NP #700 stated she ordered x-rays of the resident's chest and face due to the trauma; and ordered a wound treatment for the lacerations. NP #700 stated RN #110 called the DON and placed her on speaker phone. The DON stated she had notified the State agency of the incident but had not called for treatment orders or notified the physician of the incident. NP #700 asked the DON why she had not been notified and the DON stated, because I have worked seven days in a row. NP #700 stated she called Resident #2's attending physician, who was also the medical director, to ask if he had been notified of the incident and he stated that he had not. NP #700 further confirmed she checked the on-call log for Sunday, 04/21/24, and there was no documentation of a phone call being made by the DON or from the facility staff regarding the incident and there was no documentation of the incident in the red physician communication binder kept at the nursing station. NP #700 stated if she had not seen Resident #2 for a routine visit, she would have not known about the incident or injuries. NP #700 stated two (unidentified) STNAs thanked her for doing something for Resident #2. NP #700 stated she did not believe the DON handled the incident correctly.</p> <p>Interview on 05/02/24 at 12:58 P.M. with STNA #107 revealed she was assigned to care for Resident #2 on 04/21/24 and the resident had deep scratches on her face and multiple bruises on her arms, chest, and breasts. STNA #107 stated Resident #2 was awake all night because she said that she was afraid to go to sleep and she was scared that Resident #3 would come into her room during the night. Lastly, the STNA shared the resident requested her room be searched to ensure Resident #3 was not hiding in her room.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 05/10/24 at 2:52 P.M. a telephone interview with RN #110 revealed she had worked on another unit the night of 04/22/24 however, NP #700 came to her unit and asked if she would assist the NP. Resident #2 was observed in bed with dried blood on her face and injuries to her body including the flank area. She decided to contact the police as she stated this was what you would do in a situation like this. She did not provide wound care to the resident until the police came and talked with the resident and took photographs. She further stated she was unaware of any situation that had occurred, and it looked like the resident had been pushed so hard in the chest, it also caused bruising to the flank area. RN #110 immediately began getting statements from staff. She said RN #131 was assigned to care for the resident and was unaware of the situation until RN #110 had been made aware as well. RN #131 said the DON informed her later the situation was being addressed but RN #110 stated nothing had been documented in the medical record regarding an altercation and she wanted to ensure it was addressed as she was also the nurse in charge. The RN also stated Resident #2 was very fearful for her life and the facility wouldn't allow Resident #2 in the dining room unless staff were with her, due to the incident that was almost assault by Resident #3. Lastly, RN #110 verified the resident had been scared, fearful and traumatized by the incident as she really enjoyed going to the dining room and waving to others as they entered and also saying hello but she doesn't do that anymore and can't go to the dining room until she was ready to be served and could be accompanied by staff.</p> <p>On 05/10/24 at 6:57 P.M., a telephone interview with STNA #102 revealed her normal morning routine was to wake Resident #2 and Resident #104 and then send them to the dining room. STNA #102 revealed she was passing trays on Sunday morning 04/21/24 when DW #190 came running down the hall saying Resident #2 was bleeding and needed help. STNA #102 stated she ran to the kitchen and Resident #2 was standing with her walker with blood covering her face and dripping everywhere. STNA #102 stated Resident #2 had bruises on her arms and chest. Resident #2 stated Resident #3 scratched and hit her. STNA #102 stated there were only two other residents in the dining room at the time, Resident #3 and Resident #6. At this point, the nurse came (unable to recall her name) and tried to apply a dressing to the wounds on Resident #2's face, but the dressing wouldn't stay in place because the nurse couldn't get the bleeding to stop. STNA #102 stated because of the bleeding, she got a wheelchair and wheeled the resident down the hallway to the DON. STNA #102 stated the nurse took Resident #2 to clean her up and she and the DON went to the dining room. STNA #102 stated the DON questioned Resident #3 and she told her what happened and then immediately questioned Resident #6 who repeated the same answers. STNA #102 stated she doesn't know if Resident #6 just repeated the same answers as Resident #3 or if those answers were really what happened. STNA #102 stated she doesn't believe Resident #2 instigated the altercation by saying she was going to kill Resident #3 because Resident #2 was very soft spoken, and she had never witnessed any behavior like that from the resident. STNA #102 stated following the incident, Resident #2 was scared and crying. STNA #102 revealed the DON told her to keep Resident #2 in her room, but on the second day of this, STNA #102 stated she told the DON something has got to give, this is not fair and she was told Resident #2 could leave her room, but only with staff with her.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Signature Healthcare of Coshocton		STREET ADDRESS, CITY, STATE, ZIP CODE 100 South Whitewoman Street Coshocton, OH 43812	
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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of facility policy titled Abuse, Neglect and Misappropriation of Property, dated 09/15/23, revealed abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Physical abuse includes, but is not limited to, hitting, slapping, pinching, kicking, controlling behavior through corporal punishment, or any similar touching of a resident that does not have an appropriate therapeutic purpose and that is not reasonably related to the appropriate provision of ordered care and services. Identification of occurrences of abuse is an ongoing process and responsibility of all persons defined within the facility.</p> <p>Prevention: establishing a safe environment that supports, to the extent possible, a resident's safety; identifying, correcting, and intervening in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur; ensuring residents are free from neglect by having the structures and processes to provide needed care and services to all residents; the identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect.</p> <p>Investigation Guidelines: the facility Administrator will investigate all allegations, reports, grievances, and incidents that potentially could constitute allegations of abuse. The Administrator may delegate some or all of the investigation as appropriate, but the Administrator retains the ultimate responsibility to oversee and complete the investigation, and to draw conclusions regarding the nature of the incident. The investigation should include interviews of involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; to the extent possible and applicable, provide complete and thorough documentation of the investigations. The Administrator will make reasonable efforts to determine the root cause of the alleged violation and will implement corrective action consistent with the investigation findings and take steps to eliminate any ongoing danger to the resident or residents; any affected resident's physician and family/responsible party will be informed of the result of the investigation.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00153265.</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>33019</p> <p>Based on record review, review of the Administrator and Director of Nursing (DON) Job Descriptions, review of a facility self-reported incident (SRI) and investigation, and interviews the facility failed to maintain effective administrative services to provide a comprehensive abuse prohibition program to prevent, timely identify and investigate situations of resident-to-resident physical abuse. This affected one resident (#2) and had the potential to affect all residents residing in the facility. The census was 58.</p> <p>Findings include:</p> <p>Review of the Administrator Job Description, Version 03.2021 revealed the position was to lead and direct the overall operations of the facility in accordance with customer needs, government regulations and Company policies, with focus on maintaining excellent care for the residents while achieving the facility's business objectives.</p> <p>Review of the Director of Nursing (DON) Job Description, version 03.21, revealed the position was to manage the overall operations of the Nursing Department in accordance with Company policies, standards of nursing practices and governmental regulations so as to maintain excellent care of all residents' needs. The DON would spend their time including by not limited to: Plan, develop, organize, implement, evaluate and direct the nursing services department, as well as its programs and activities, in accordance with current rules, regulations, and guidelines that govern the long-term care facility; Assume administrative authority, responsibility and accountability for all functions, activities, and training of the nursing department; Organize, develop, and direct the administration and resident care of the nursing service department; Inform state of any reportable incidents within appropriate time frames. Complete investigative analysis as required; Regularly inspect the facility and nursing practices for compliance with federal, state, and local standards and regulations; Assure residents a comfortable, clean, orderly and safe environment.</p> <p>(continued on next page)</p>

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of a facility Self-Reported Incident (SRI), tracking number 24658, with a discovery and submission date of 04/21/24, revealed an allegation/suspicion of physical abuse, with the initial source of the allegation being a resident victim and a resident witness, was reported to the State Survey Agency. The SRI indicated on 04/21/24 at 7:45 A.M. in the dining room, Resident #2 alleged Resident #3 attacked her. There were no staff present during the alleged attack. The only witness was Resident #6. Facility interview with Resident #3 revealed Resident #2 attacked her by pulling her oxygen off and saying, I'm gonna kill you, {expletive}. Facility interview with Resident #2 revealed she didn't do anything, and Resident #2 attacked her. The SRI indicated the initial skin inspection of Resident #2 revealed scratches to the left cheek and left side of her nose, with no other injuries noted. The following day, on 04/22/24, bruises to the chest and bilateral forearms were noted. Resident #2 requested to eat lunch in her room on the day of the allegation due to being fearful of another attack by Resident #3. Facility staff walked with Resident #2 to the dining room daily to ensure she felt safe. The SRI noted a 72-hour psychosocial evaluation was completed (the facility was unable to provide evidence this was completed), and Resident #2 showed no signs or symptoms of adverse reactions related to the event unless she was reminded of the allegation; when this happened, she would state that she was scared, but showed no signs of uneasiness, fearfulness, tearfulness, and attempts to walk to the dining room with staff accompanying her. The facility investigator was listed as the DON.</p> <p>Review of Resident #6's witness statement, dated 04/21/24 (without the time documented), indicated the statement was verbally given to the DON and the ADON and revealed Resident #2 came over and sat down and started moaning when Resident #6 and Resident #3 asked her to stop. Resident #2 said, you're not my boss. Resident #3 went over to Resident #2 and Resident #2 said, I'm gonna kill you (expletive) and took Resident #3's oxygen off. Resident #3 then scratched Resident #2.</p> <p>Review of Resident #2's witness statement, dated 04/21/24 (without the time documented), indicated the statement was verbally given to the DON and the ADON and revealed Resident #2 stated that she did not do anything, and Resident #3 attacked her.</p> <p>Review of Resident #3's witness statement, dated 04/21/24 (without the time documented), indicated the statement was verbally given to the DON and the ADON and revealed Resident #2 told Resident #3, I'm gonna kill you {expletive}. No other information was provided regarding the investigation, including staff statements and/or interviews.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 04/30/24 at 11:05 A.M., an interview with the DON revealed she was administering medications on the morning of 04/21/24 at approximately 7:45 A.M (she was working as a floor nurse due to staffing needs) when STNA #102 brought Resident #2 to her from the dining room. The DON revealed she observed a scratch on Resident #2's left cheek and the side of her nose. The DON stated Resident #2 told her that Resident #3 attacked her and that she didn't know why, because she didn't do anything. The DON stated Resident #2 often moans and the moaning probably bothered Resident #3. The DON stated no staff were present in the dining room because breakfast had not been served yet. The DON confirmed several residents including Resident #2 and Resident #3 often go to the dining room before breakfast and were typically unsupervised until breakfast was served. The DON stated, this is their home, we can't stop the residents from going to the dining room. The DON confirmed she did not obtain a witness statement from STNA #102 and was unsure of what happened following the altercation between the residents and prior to Resident #2 being brought to her in a wheelchair by STNA #102. The DON stated following the incident, she notified the on-call physician, but could not recall the provider's name, and did not document the notification in the resident's medical record. The DON stated her skin assessment on 04/21/24 of Resident #2 following the altercation did not include any bruising of the resident's arms, chest, or breasts, or lip laceration and only indicated two scratches on the resident's face. The DON stated when she was later informed of the bruising and lip laceration, she attributed the injuries to the altercation between Resident #2 and Resident #3 and did not believe them to be injuries of unknown origin. Lastly, the DON verified no interventions were implemented following the incident as she did not feel there was willful intent from Resident #3 to harm Resident #2.</p> <p>On 04/30/24 at 3:34 P.M., interview with the DON revealed on 04/22/24 NP #700 freaked out when she saw Resident #2's bruises and then reported them to RN #110. The DON stated RN #110 took it upon herself to obtain witness statements from all the employees who were working in the facility on the evening of 04/22/24. The DON stated she didn't know why RN #110 obtained the witness statements when the employees were not working at the time of the incident and did not witness the incident between Resident #2 and Resident #3. The DON confirmed the only investigation documentation of the incident was the SRI investigation and report submitted to the State agency. The DON revealed her investigation concluded that abuse did not occur. The DON stated she did not consider the incident to be abuse because she did not think Resident #3 acted willfully and did not intend to injure or hurt Resident #2. The DON further confirmed following the incident, the only resident interviews obtained were from the two residents involved in the altercation and the resident witness. The DON confirmed she did not conduct any additional resident interviews regarding abuse, and other than the skin assessments completed for Resident #2 and Resident #3, no additional skin assessments were completed for non-interviewable residents, and other than the staff interviews obtained by RN #110, no additional staff had been interviewed regarding abuse or the incident. The DON further confirmed Resident #2 and Resident #3's psychiatric providers had not been notified of the altercation and there had been no follow-up from psychiatry for either resident following the incident.</p> <p>On 05/01/24 at 9:40 A.M., an interview with the Administrator confirmed the facility's investigation should have included staff interviews, and all residents should have been interviewed regarding abuse and any resident who could not be interviewed should have had a skin assessment completed. The Administrator further confirmed residents were unsupervised in the dining room when the altercation occurred between Resident #2 and Resident #3. The Administrator verified she was the facility Abuse Coordinator and, according to facility policy, renders her responsible to ensure a thorough investigation is completed.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 05/01/24 at 2:38 P.M., an interview with NP #700 revealed on the evening of 04/22/24, she went into Resident #2's room for a scheduled, routine visit. NP #700 revealed after she turned the light on, she immediately noticed lacerations on the resident's cheek and nose, both with dry, crusted blood, and a swollen left lip. Resident #2 reported to her that she had gotten into a fight with Resident #3. NP #700 stated the resident also had a handprint on the right arm and multiple bruises on her arms, chest, and upper breast area. NP #700 stated she notified RN #110 of the injuries, and they proceeded to do a complete skin assessment. NP #700 stated RN #110 then notified the police and obtained staff witness statements. NP #700 stated there was no documentation in the medical record regarding the altercation or of any injuries. NP #700 stated she ordered x-rays of the resident's chest and face due to the trauma; and ordered a wound treatment for the lacerations. NP #700 stated RN #110 called the DON and placed her on speaker phone. The DON stated she had notified the State agency of the incident but had not called for treatment orders or notified the physician of the incident. NP #700 asked the DON why she had not been notified and the DON stated, because I have worked seven days in a row. NP #700 stated she called Resident #2's attending physician, who was also the medical director, to ask if he had been notified of the incident and he stated that he had not. NP #700 further confirmed she checked the on-call log for Sunday, 04/21/24, and there was no documentation of a phone call being made by the DON or from the facility staff regarding the incident and there was no documentation of the incident in the red physician communication binder kept at the nursing station. NP #700 stated if she had not seen Resident #2 for a routine visit, she would have not known about the incident or injuries. NP #700 stated two (unidentified) STNAs thanked her for doing something for Resident #2. NP #700 stated she did not believe the DON handled the incident correctly.</p> <p>During the onsite State agency investigation, it was identified other residents had heard Resident #3 make statements to Resident #2, telling her to shut up or that she was going to hit her prior to this incident. Staff that were involved after the altercation were not asked to provide a statement and there was no staff interview information to determine the root cause of the altercation. No preventative interventions were implemented because of the altercation. The DON did not identify this incident as abuse, resulting in the facility failing to ensure corrective actions were implemented to prevent recurrence and to provide the other residents with a safe environment, resulting in potential for recurrence. The Administration also did not identify the need for psychosocial support for Resident #2 following the incident despite verbalizations to staff, asking for them to inspect her room to ensure Resident #3 was not hiding in her room, Resident #2 was isolating herself from preferred activities such as attending the dining room for meals and follow-up psychosocial assessments were not completed as indicated in the SRI. The DON also did not notify Resident #2's physician resulting in delay of treatment and she did not send the resident to the hospital for an emergent evaluation and lastly, did not contact the authorities for involvement. The Administrator was identified as the facility Abuse Coordinator in the facility Abuse Policy and retained the ultimate responsibility to oversee and complete the investigation, and to draw conclusions regarding the nature of the incident.</p> <p>Review of facility policy titled Abuse, Neglect and Misappropriation of Property, dated 09/15/23, revealed abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also included the deprivation by an individual, including a caretaker, of goods or services that were necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, included verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Physical abuse included, but was not limited to, hitting, slapping, pinching, kicking, controlling behavior through corporal punishment, or any similar touching of a resident that does not have an appropriate therapeutic purpose and that was not reasonably related to the appropriate provision of ordered care and services. Identification of occurrences of abuse was an ongoing process and responsibility of all persons defined within the facility.</p> <p>Training: Identifying what constituted abuse, neglect, exploitation, and misappropriation of resident property, such as physical or psychological indicators; understanding behavioral symptoms of residents that may increase the risk of abuse and neglect and how to respond. These symptoms include, but were not limited to, the following: aggressive/or catastrophic reactions of residents, wandering or elopement-type behaviors, resistance to care, outbursts or yelling out, and difficulty in adjusting to new routines or stakeholder.</p> <p>Prevention: Establishing a safe environment that supports, to the extent possible, a resident's safety; identifying, correcting, and intervening in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property was more likely to occur; ensuring residents were free from neglect by having the structures and processes to provide needed care and services to all residents; the identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect.</p> <p>Investigation Guidelines: the facility Administrator would investigate all allegations, reports, grievances, and incidents that potentially could constitute allegations of abuse. The Administrator may delegate some or all of the investigation as appropriate, but the Administrator retained the ultimate responsibility to oversee and complete the investigation, and to draw conclusions regarding the nature of the incident. The investigation should include interviews of involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; to the extent possible and applicable, provide complete and thorough documentation of the investigations. The Administrator would make reasonable efforts to determine the root cause of the alleged violation and would implement corrective action consistent with the investigation findings and take steps to eliminate any ongoing danger to the resident or residents; any affected resident's physician and family/responsible party would be informed of the result of the investigation.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00153408 and Complaint Number OH00153265.</p>		