STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365932	A. Building B. Wing	10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgewood Manor of Lucasville II	10098a Bear Creek Road Lucasville, OH 45648

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42728 Based on medical record review, review of facility Self-Reported Incidents (SRIs), and review of the facility policy, the facility failed to timely report an allegation of staff to resident physical abuse. This affected one (Resident #9) of three residents reviewed for abuse. The facility census was 65 residents. Findings include: Review of the medical record for Resident #9 revealed an admitted [DATE] with diagnoses including muscle weakness, unsteadiness on feet, difficulty walking, paranoid schizophrenia, and anxiety disorder. Review of the Minimum Data Set (MDS) assessment for Resident #9 dated 09/04/24 revealed the resident was moderately cognitively impaired. Review of the facility SRI form for Resident #9 dated 10/11/24 timed at 8:38 A.M. revealed the facility reported an allegation of physical abuse per Licensed Practical Nurse (LPN) #205 towards Resident #9. Review of witness statements per Certified Nursing Assistants (CNAs) # 163 and #166 obtained by the Director of Nursing (DON) on 10/11/24 revealed between approximately 4:00 A.M. to 4:30 A.M. on 10/11/24 the two CNAs witnessed LPN #205 place his hands on the chest of Resident #9 and push him backwards, causing the resident to fall. CNA#163 reported sending a text message to Facility Scheduler (FS) #200 at 4:20 A.M. on 10/11/24 stating they had a serious issue at the facility and a second text message at 4:38 A.M. on 10/11/24 asking to speak to FS #200 privately when FS #200 arrived at the facility. CNA #163 reported FS #200 responded to the text messages at 4:43 A.M. on 10/11/24 by replying with the word okay. Interview on 10/25/24 at 10:20 A.M. with Assistant Director of Nursing (ADON) #156 confirmed FS #200 called her at 6:54 A.M. on 10/11/24 to report an allegation of abuse per LPN #205 towards Resident #9 which had allegedly occurred sometime between 4:00 A.M. and 4:30 A.M. on 10/11/24. ADON #156 confirmed she immediately called the DON and reported the allegation to the DON because the DON was closer to the facility. The ADON confirmed all allegations of abuse should be reported to administration immediately. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Telephone interview on 10/25/24 at 11:52 A.M. with FS #200 confirmed on 10/11/24 at 6:30 A.M. CNAs #163 and #166 reported an allegation of physical abuse per LPN #205 towards Resident #9 which they witnessed on 10/11/24 around 4:00 A.M. to 4:30 A.M. FS #200 stated the CNAs said they did not report the allegation at the time of occurrence because the only other nurse in the building was LPN #205's (the alleged perpetratror's) spouse. Interview on 10/25/24 at 12:15 P.M. with the Administrator confirmed CNAs #163 and #166 did not report the allegation of abuse per LPN #205 towards Resident #9 in a timely manner. The Administrator further confirmed the facility SRI was not initiated in a timely manner with the SRI timed on 10/11/24 at 8:38 A.M. which was approximately four hours after the alleged incident. Telephone interview on 10/25/24 at 12:31 P.M. with the DON confirmed CNAs #163 and #166 should have reported the allegation of abuse per LPN #205 towards Resident #9 at the time of occurrence which was 10/11/24 between 4:00 A.M. and 4:30 P.M. The DON confirmed the CNAs stated they did not report the incident when it occurred due to fear of retaliation by LPN #205 and his spouse who were the only nurses working at the time of the incident. Review of the facility policy titled Residents Right to Freedom from Abuse, Neglect, and Exploitation Policy and Procedure undated revealed the facility staff should report allegations of abuse to administration immediately and the facility would report allegations of physical abuse to the state agency immediately. This deficiency represents noncompliance investigated under Complaint Number OH00158949.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42728 Based on medical record review, review of facility Self-Reported Incidents (SRIs), and review of the facility policy, the facility failed to ensure residents were protected from further possible abuse during an abuse investigation. This affected one (Resident #9) of three residents reviewed for abuse. The facility census was 65 residents. Findings include: Review of the medical record for Resident #9 revealed an admitted [DATE] with diagnoses including muscle weakness, unsteadiness on feet, difficulty walking, paranoid schizophrenia, and anxiety disorder. Review of the Minimum Data Set (MDS) assessment for Resident #9 dated 09/04/24 revealed the resident was moderately cognitively impaired. Review of the facility SRI form for Resident #9 dated 10/11/24 timed at 8:38 A.M. revealed the facility reported an allegation of physical abuse per Licensed Practical Nurse (LPN) #205 towards Resident #9. Review of witness statements per Certified Nursing Assistants (CNAs) # 163 and #166 obtained by the Director of Nursing (DON) on 10/11/24 revealed at approximately 4:00 A.M. to 4:30 A.M. on 10/11/24 the two CNAs witnessed LPN #205 place his hands on the chest of Resident #9 and push him backwards, causing the resident to fall. CNA#163 reported sending a text message to Facility Scheduler (FS) #200 at 4:20 A.M. on 10/11/24 stating they had a serious issue at the facility and a second text message at 4:38 A.M. on 10/11/24 asking to speak to FS #200 privately when FS #200 arrived at the facility. CNA #163 reported FS #200 responded to the text messages at 4:43 A.M. on 10/11/24 by replying with the word okay. Interview on 10/25/24 at 10:20 A.M. with Assistant Director of Nursing (ADON) #156 confirmed FS #200 called her at 6:54 A.M. on 10/11/24 to report an allegation of abuse per LPN #205 towards Resident #9 which had allegedly occurred sometime between 4:00 A.M. and 4:30 A.M. on 10/11/24. ADON #156 confirmed she immediately called the DON and reported the allegation to the DON because the DON was closer to the facility. The ADON confirmed all allegations of abuse should be reported to administration immediately. Telephone interview on 10/25/24 at 11:52 A.M. with FS #200 confirmed on 10/11/24 at 6:30 A.M. CNAs #163 and #166 reported an allegation of physical abuse per LPN #205 towards Resident #9 which they witnessed on 10/11/24 around 4:00 A.M. to 4:30 A.M. FS #200 stated the CNAs said they did not report the allegation at the time of occurrence because the only other nurse in the building was LPN #205's (the alleged perpetratror's) spouse. Interview on 10/25/24 at 12:15 P.M. with the Administrator confirmed CNAs #163 and #166 did not report the allegation of abuse per LPN #205 towards Resident #9 in a timely manner. The Administrator confirmed LPN #205 was permitted to work till 7:30 A.M. on 10/11/24 and alleged abuse had occurred between 4:00 A.M. to 4:30 A.M. on 10/11/24 (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Telephone interview on 10/25/24 at 12:31 P.M. with the DON confirmed CNAs #163 and #166 should have reported the allegation of abuse per LPN #205 towards Resident #9 at the time of occurrence, which was 10/11/24 between 4:00 A.M. and 4:30 P.M. The DON confirmed the CNAs stated they did not report the incident when it occurred due to fear of retaliation by LPN #205 and his spouse who were the only nurses working at the time of the incident. The DON further confirmed LPN #205 was permitted to work till 7:30 A.M. on 10/11/24 and alleged abuse had occurred between 4:00 A.M. to 4:30 A.M. on 10/11/24. Review of the facility policy titled Residents Right to Freedom from Abuse, Neglect, and Exploitation Policy and Procedure undated revealed when the facility had identified abuse, the facility would take all appropriate steps to remediate the noncompliance and protect residents from additional abuse immediately. This deficiency represents noncompliance investigated under Complaint Number OH00158949.