Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365972	A. Building B. Wing	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canfield Healthcare Center	2958 Canfield Rd Youngstown, OH 44511

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38092 Based on record review and interviews, the facility did not ensure an allegation of physical abuse was thoroughly investigated. This affected one resident (#70) of three residents reviewed for abuse. The facility census was 62. Findings include: Review of the medical record for Resident #70, revealed an admitted [DATE]. Diagnoses included peripheral neuropathy, repeated falls, presence of other orthopedic joint implants, alcohol dependence, psychoactive substance abuse, cocaine use, vascular dementia, unspecified mood disorder, and schizophrenia. Resident #70 was discharged back to the community on 11/23/23. Review of Resident #70's comprehensive admission Minimum Data Set (MDS) 3.0 assessment, dated 09/12/23, revealed the resident had a Brief Inventory Mental Status (BIMS) score of 15 out of 15 indicating he had intact cognition and no memory impairment. The resident was independent or required supervision for Activities of Daily Living (ADLs) including bed mobility, transfers, ambulation. Review of the medical record for Resident #32 revealed Resident #32 was admitted on [DATE] and had admitting diagnoses including alcohol induced dementia, dementia with behavioral disturbances, auditory hallucinations, anxiety disorder, and antisocial personality disorder. Resident #32's quarterly MDS dated [DATE] revealed the Resident had a BIMS of six (cognitive impairment), revealing he was severely cognitively impaired. Resident #32 needed substantial/maximal assistance for toileting, bathing, and dressing. The resident was listed as independent for transfers and needed supervision with ambulation. Resident #32 had been sent out to the hospital for behavior and agitation on 10/22/23 and returned to the facility on [DATE] at 1:03 P.M. and was put on 15-minute checks post hospitalization . It was then reported in nurse notes on 10/29/24, the day of the reported incident Resident #32 was being aggressive with staff, striking a nurse, and was put on a one to one with staff after incident. Resident #32 was seen by the Physician on 10/31/23 and ordered to the emergency room (ER) for psychiatric evaluation. Resident #32 returned to the facility on [DATE] after a stay at the Geri Psych hospital. Resident #32 was being followed by the facility Medical Director and a Psychiatric Nurse Practitioner. Resident #32 was a current resident in the facility at the time of the complaint survey. (continued on next page)

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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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of a progress note authored by the DON on 10/29/2023 revealed Resident #70 stated another resident came into his room and they had a verbal altercation. The DON stated there was no evidence that Resident #32 had physically assaulted Resident #70, though Resident #70 stated he had. The DON and nurses looked at Resident #70's leg that had the recent surgery, the bandage was disheveled, the stitches and incision were fine and there was no redness or bruising was noted. The DON indicated Resident #70 called the Youngstown police department about the incident. The DON indicated both residents were separated, and Resident #70 felt safe and his psychosocial and physical well-being were intact. The DON indicated she suspected Resident #70 may have been trying to get additional pain killing drugs, especially since he had his Norco (narcotic pain medication) discontinued the previous day. Review of a nurse progress note dated 10/29/2023 by the Nurse Practitioner revealed the resident was complaining of right knee pain post altercation with another resident per nurse report. Resident #70 was in bed when another resident went in his room and stood over him. Resident #70 stated another resident (Resident #32) grabbed his right knee he just had replacement surgery on, and Resident #70 wanted sent out to the hospital. Per nurse report on assessment resident's dressing on his right knee was disheveled however incision was still completely intact. Resident #70 had no redness or bruising noted. No signs of injury or deformity were noted. Resident #70 complained of burning pain at the right knee of nine out of 10 with 10 being the worse pain. Review of the SRI dated 10/29/23 at 4:39 P.M. and related investigation revealed Resident #70 stated another resident (Resident #32) came into his room, and they had a verbal altercation. Resident #70 called the Youngstown police department. Resident #70 stated he felt safe and his psychosocial and physical well-being were intact. Both residents were separated. No injuries were noted to either resident. Resident #32 was currently in the hospital (for a psychiatric admission). Resident #32 had a BIMS of 5 (indicating severe cognitive impairment) Resident #70 had a BIMs of 15. Resident #32 wandered into Resident #70's room and was going through his belongings. Resident #70 started to yell for him to get out. Staff immediately responded and removed Resident #32 from the room and was placed at the nurse's station with no further incident. After investigation the facility did not feel abuse occurred based on the resident's cognitive status. Resident #32 was unable to tell the staff what he was doing. There was no intent by Resident #32 to harm the other resident. The investigation did not include skin checks of non-interviewable residents, did not include interviews with interviewable residents, did not mention the details about Resident #70's bandages on his leg being disheveled and made no mention of allegation of physical abuse by Resident #70. The investigation did include staff witness statements indicating yelling was heard coming from the room of Resident #70 and staff had to remove Resident #32 from his room. Review of the local law enforcement report 10/29/23 at 9:32 A.M revealed Resident #70 called and told Officer #500 that he had returned from the hospital and there was another male in his room. From there he said the other male jumped him and took his meds (medications). Resident #70 also stated Resident #32 punched a nurse and if the officer didn't get him out of here, he would. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on 04/17/24 at 11:55 A.M., with the DON revealed she did the investigation along with the Corporate Nurse #200 and filed an SRI for alleged verbal abuse. The DON did not believe physical abuse occurred because she believed Resident #70 had a regular pattern of this type of behavior, where he was a chronic substance abuser in the community, unhappy about being at the facility, and would engage in chronic attention seeking behaviors especially in behaviors that may result in him receiving additional pain medications. The DON stated no staff witnessed any physical altercation between Resident #70 and Resident #32, or Resident #32 and any other resident. The DON did state that Resident #32 had struck a nurse that night who was trying to deescalate Resident #32. Resident #32 was put on a one to one and sent out for a psychiatric hospitalization for agitation and suicidal ideation. DON verified despite Resident #70 indicating he was physically attacked, there was no investigation conducted pertaining to alleged physical abuse. Interview on 04/17/24 at 12:14 P.M. with the Ombudsman revealed the Ombudsman stated she had spoken to the facility on [DATE] to review an allegation of physical abuse involving Resident #70 as the alleged victim. The Ombudsman said the Director of Nursing (DON) verified for her that the alleged perpetrator was Resident #32 and did involve a resident-to-resident incident with Resident #70. The DON said no physical abuse had occurred only alleged verbal abuse, so the DON filed a self-reported incident (SRI) with the Ohio Department of Health for alleged verbal abuse involving Resident #70 and Resident #32. The Ombudsman said she had explained to the DON that the allegation of physical abuse reported to her office also included that the same alleged perpetrator allegedly assaulted another resident (name not specified) who was a white male in a wheelchair and nonverbal, assaulted a nurse and that the facility was doing nothing about preventing Resident #32 from continuing to assault other staff and residents. The Ombudsman stated on 11/29/23 she visited the facility and spoke with the DON again, who reported she did not file an SRI to the Ohio Department of Health for alleged physical abuse and was not planning on doing such, despite the Ombudsman specifically reporting allegations of physical abuse involving Resident #70 and potentially other residents were also affected by Resident #32. The Ombudsman stated physical abuse was clearly different than a verbal altercation. Interview with Resident #70 (who was not currently living in the facility) via phone on 04/17/24 at 12:27 P.M. revealed he repeated his allegation that he was physically attacked, not just a verbal altercation, by Resident #32 and that he had made it known to the facility staff that Resident #32 physically attacked him on the day of the incident. Review of facility policy titled Ohio Abuse, Neglect, and Misappropriation which was undated revealed accurate and timely reporting of incidents, both alleged and substantiated, will be sent to officials in accordance with the state law. The facility will complete a thorough investigation. This deficiency represents noncompliance identified during the investigation of Master Complaint Number OH00152747.