STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366102	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Francis Senior Ministries	182 St Francis Ave Tiffin, OH 44883

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49742 Based on medical record review, review of the facility Self-Reported Incidents (SRIs), staff interview and review of facility policy, the facility failed to ensure staff implemented the facility's abuse policy related to immediate reporting of allegations of abuse to the Administrator. This affected one (#32) of one resident reviewed for abuse. The facility census was 52. Findings include: Review of Resident #32's medical record revealed an admitted [DATE]. Diagnoses including phantom limb syndrome with pain, chronic respiratory failure, and acquired absence of left leg above the knee. Review of the quarterly Minimum Data Set (MDS) assessment, dated 03/21/25, revealed a Brief Interview of Mental Status (BIMS) score of 14, indicating Resident #32 was cognitively intact. Review of the facility submitted SRI, created 01/26/25, revealed on 01/25/25, Resident #32 reported to Certified Nursing Assistant (CNA) #310 and Licensed Practical Nurse (LPN) #315 that at approximately 1:30 A.M., an unidentified staff member used force while applying cream to his left lower extremity (LLE) stump and, while providing incontinence care, it felt like the staff inserted a digit into his rectum. Further review of the SRI revealed LPN #315 did not report the alleged abuse to the facility administration until 01/26/25. At the time LPN #315 reported the alleged abuse, the facility immediately began an investigation, made appropriate notifications, and suspended the possible staff members pending the results of the facility investigation. Interview on 04/10/25 at 2:02 P.M. with the Director of Nursing (DON) confirmed Resident #32 initially reported an allegation of abuse to LPN #315 on 01/25/25, but LPN #315 did not report it to administration until the resident made the allegation a second time on 01/26/24. Review of the facility policy titled, Abuse, Neglect, and Exploitation, dated 11/21/24, revealed all alleged violations would be reported to the Administrator immediately, but not later than two hours after the allegation was made.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 49793 Based observation and staff interview the facility failed to ensure the facility was adequately maintained. This had the potential to affect all 52 residents residing in the facility. The facility census was 52. Findings include: Observation on 04/10/25 from 8:09 A.M. through 9:05 A.M., during an environmental tour with the Administrator, revealed the following: Outside the main elevator on the first floor, and continued down the hallway and into the dining room, were damaged and improperly fitted ceiling tiles. Multiple ceiling tiles in the first floor dining hall, near the solarium opening, had dried water stains. On the second floor, outside the main elevator and down the south hall (200-220 unit), and continued down the west hall (221-239 unit), were multiple water stained, damaged, and improperly fitted ceiling tiles. On the first-floor memory care unit, fluorescent light ballast covers contained dirt and debris, including perished bugs and flies, and several covers were cracked with partially broken covers throughout both south and east halls. Concurrent interview with the Administrator verified the above findings.