STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366113	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liberty Health Care Center Inc	1355 Churchill Hubbard Rd Youngstown, OH 44505

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47570 THE FOLLWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on record review, review of video recorded evidence, review of the facility self-reported incident, review of facility policy, observation and interview, the facility failed to ensure Resident #16 was free from humiliation, intimidation and verbal and physical abuse by staff. Using the reasonable person concept, actual harm occurred on 07/14/24 when Resident #16, who was cognitively impaired and dependent on staff for all activities of daily living (ADL), was forcefully rolled onto his right side for incontinence care by State tested Nursing Assistant (STNA) #434 causing Resident #16's face to go into a pillow requiring him to move his head to yell let me breathe. STNA #434 repeatedly poked him in his ear with his dirty gloves he used to provide incontinence care causing Resident #16 to become agitated and yell get out of here. STNA #435 and #436 were present in the room and did not stop the abuse nor report it. This affected one resident (Resident #16) of the three residents reviewed for abuse. The total census was 103. Findings include: Review of the medical record for Resident #16 revealed an admitted [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting non-dominant side, dysphagia, anxiety, obstructive hydrocephalus, palmar fascial fibromatosis, muscle wasting, difficulty walking, transient cerebral ischemic attack, epileptic seizure, major depression, and chronic obstructive pulmonary disease. The resident was receiving hospice services. Review of the Minimum Data Set (MDS) 3.0 annual assessment dated [DATE] revealed Resident #16 was cognitively impaired , hearing impaired and needed a hearing aid. Resident #16 had clear speech and was able to make self-understood and sometimes understood others. Physical and verbal behavior symptoms were present one to three days but did not interfere with resident care, and there was no behavior impact on others. Rejection of care occurred one to three days. Resident #16 was dependent for feeding, oral hygiene, toilet hygiene, bathing and dressing. Resident #16 was dependent on staff to roll left to right in bed, sit on side of the bed, lay back in bed and did not sit to stand. Resident #16 was dependent of staff for transfers and was always incontinent of urine and bowel. (continued on next page)

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the plan of care dated 07/05/24 revealed Resident #16 could be verbally aggressive. Interventions included administer medication, anticipate resident needs, assess resident coping skills, assess understanding of the situation, allow time for resident to express self and feelings towards situation, give resident choices, positive feedback for good behavior, engage calmly in conversation, and staff to walk away calmly and approach later. Review of a progress note dated 07/15/24 at 12:45 P.M. authored by the Administrator revealed Resident #16's Power of Attorney (POA) was notified by the Administrator that the Ombudsman's office had sent the Administrator a video (date sent was not in this note) and it was reviewed. The employees in the video were suspended, the Ohio Department of Health (ODH) was notified, a head-to-toe assessment was done on Resident #16, the Nurse Practitioner (NP) and Hospice were notified. The NP assessed the resident, and a full staff education was completed. Review of the facility SRI and related investigation dated 07/15/24 revealed on 07/15/24 at 12:06 P.M. the Ombudsman office called the Administrator and said the family of Resident #16 had sent them a video showing abuse. The Ombudsman office sent the video to the Administrator and the video was seven minutes long and time stamped for 07/14/24 at 3:30 P.M. The video showed events that would be investigated as verbal/emotional abuse. Three State tested Nurse Assistants (STNA) #434, #435 and #436 were immediately suspended from work pending investigation. The facility immediately completed a head-to-toe assessment of the resident, notified the physician and the resident would be seen by the NP on 07/15/24. The Administrator and Director of Nursing (DON) spoke to the family about the allegation. The DON attempted to ask the resident about the events of the allegation, and he was unable to articulate how he felt or answer questions which was in line with his usual state of mind. Review of the video showed STNA #434 roll the resident on his side in a way that caused the resident to groan and become upset. STNA #434 was shown touching the resident's face repeatedly causing the resident to become agitated. One of the other STNA in the room stated where the (expletive) is his hearing aid and the third STNA in the room was a witness to the incident and did not report it. STNA #434 was heard making statement you know I don't play with him, (expletive) and speaking disrespectfully to the resident. The facility substantiated abuse and terminated the employment of all three STNA on 07/17/24. Further review of the facility investigation revealed a statement written by the DON dated 07/15/24 indicating Hospice was notified on 07/15/24 at 3:30 P.M., of the incident and that the investigation process was explained to Hospice. Review of a Weekly Skin Evaluation dated 07/15/24 at 1:01 P.M. revealed Resident #16 had no new skin areas identified, and no new open areas identified. Review of a progress note dated 07/15/24 authored by Nurse Practitioner (NP) #438 revealed Resident #16 did not appear to be in any acute distress, his behaviors had been stable and Resident #16 denied pain. Review of a written statement dated 07/17/24 obtained from STNA #434 revealed STNA #434 stated he did not need to see the video, as the facility already fired him. STNA #434 gave his badge to the Administrator. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of a written statement from STNA #436 on 07/17/24 revealed on 07/14/24 she entered Resident #16's room with a Hoyer lift. STNA #436 confirmed she stated, where the (expletive) is his hearing aid. STNA #436 indicated she was not aware verbal or emotional abuse had happened. Review of a witness statement by STNA #435 on 07/17/24 revealed she confirmed she worked on 07/14/24 with Resident #16 and made no further comment after watching the video of care Resident #16 received that day of the incident. Interview on 08/22/24 at 9:30 A.M. with Ombudsman #429 revealed Resident #16's family contacted the Ombudsman office on 07/15/24 regarding video footage they witnessed on 07/14/24. The Ombudsman stated Resident #16 was upset when STNA # 434 continued to poke the resident in the ear. STNA # 435 laughed when STNA #434 poked his finger in the resident's ear. The Ombudsman stated STNA # 434 cleaned Resident #16's peri area with a gloved hand and used the same gloved hand to poke the resident's nose and ear. The Ombudsman state the female aids in the room dismissed the behavior of STNA #434. The Ombudsman stated a reasonable person would be upset by the actions of the staff members. The Ombudsman also stated during the video a female aid stood in front of the camera and it was possible, but not certain, a slap sound was heard, and after that Resident #16 went quiet. Interview on 08/22/24 at 10:14 A.M. with Resident #16's POA revealed the family had a camera in the resident's room because Resident #16 was too cognitively impaired to speak up for himself. The POA stated Resident #16 was visibly upset STNA #434 was rough with changing Resident #16 diaper and STNA #434 put his fingers in resident's ear to get the resident's attention. The POA stated it looked like Resident #16 was visibly upset and did not like how rough STNA # 434 was after changing his brief. POA stated she observed STNA #434 use the same gloved hand to wipe the resident's peri-area then put his finger in the resident's ear and by the mouth. POA stated they heard a smack at the end of the video. The POA stated other staff that entered the room did not stop STNA #434's treatment of the resident. Interview on 08/22/24 at 10:37 A.M. with Resident # 16's family member #432 revealed it appeared STNA #434 antagonized her brother by putting their finger in the resident's ear twelve to thirteen times. Family member # 432 stated Resident #16 was uncomfortable with his care. Interview on 08/22/24 at 11:38 A.M. with STNA #435 confirmed they watched the video of STNA #434 poke Resident #16 in the ear and the care Resident #16 received and realized it was abuse. STNA #435 stated they regretted not reporting the incident. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Observation on 08/22/24 at 12:45 P.M. with The Administrator and the DON of the video submitted by the Ombudsman revealed camera footage of Resident #16 in his room and the video captured footage on 07/14/24. The Administrator and the DON confirmed STNA #434 poked Resident #16 in the ear twelve times. Resident #16 would yell get out of here when poked in the ear. STNA #434 put his finger in Resident #16's left ear multiple times for unknown reasons which appeared to upset Resident #16. STNA #434 did not explain care that was done. STNA #434 opened Resident #16's brief and provided peri area care and continued to poke Resident #16 in the ear with the same gloved hand. It was verified by The Administrator STNA #434 forcefully rolled Resident #16 onto his right side with his face in a pillow. Resident #16 had to move his head to speak. STNA #434 made a comment to Resident #16 I ain't playing with you, you know that. and you want to be real? Guess what. Resident #16 yelled out let me breath. STNA #434 stated you breath with your mouth not with your back and made a comment you ain't gonna be rude to me. S*** Resident #16 asked STNA #434 not be tough when rolling him, STNA stated I am tough A female STNA entered Resident #16 room (STNA # 435) and stated, we have to be though when you don't listen STNA #435 laughed when STNA # 434 would stick his finger in Resident #16's ear and face. Another female STNA # 436 entered Resident #16 room with a Hoyer lift. Female STNA #436 was in front of the camera when more yelling continued by Resident #16, the resident went quiet after STNA # 434 stated don't play with me the video ended. There was no slapping noise evidenced in the video as was reported by Resident #16's family and the Ombudsman. Interview with The Administrator on 08/22/24 at 12:45 P.M. revealed the facility was notified by the Ombudsman on 07/15/24 at 12:09 P.M. regarding an incident that happened 07/14/24. STNA # 434 was immediately suspended and after review of the video submitted by the Ombudsman STNA # 435 and # 436 were suspended. The Administrator stated this was not appropriate treatment towards a resident and verified because of the investigation the abuse was substantiated. Interview on 08/22/24 at 2:21 P.M. with Resident #16 was conducted to determine if he remembered anything about the incident on 07/14/24. Resident #16 stated he did remember and said he felt shaky and stated, I never know what he was going to do and stated he did not like to be poked in the ear. Observation of the room at the time of the interview revealed a camera was fixed to the wall. Resident #16 was resting in his bed and had no behaviors at the time of the observation. Interview on 08/22/24 at 2:40 P.M. with STNA #434 confirmed he worked 07/14/24 with Resident #16. STNA #434 verified his behavior was not appropriate towards Resident #16. STNA #434 stated he had no reason to poke Resident #16's ear as much as they did. STNA #434 also stated he was frustrated with Resident #16 on 07/14/24. Interview was attempted with STNA #436 on 08/22/24 at 11:07 A.M. and 5:00 P.M. but the phone was no longer in service. Review of the facility policy titled Resident Abuse Prevention Practices, dated 11/2023, revealed abuse was defined as knowingly causing physical harm to the resident and included the willful infliction of intimidation and mental anguish by a caretaker. Physical abuse included hitting, slapping, pinching or kicking and rough corporal punishment. Verbal abuse included any use of oral disparaging and/or derogatory terms to the residents regardless of their ability to comprehend or their disability. Mental abuse included but was not limited to humiliation, harassment, threats of punishment or deprivation. Mistreatment was defined as to inappropriately treat or exploit a resident. Staff must report suspicion of abuse immediately to a supervisor. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The deficient practice was corrected on 07/15/24 when the facility implemented the following corrective actions: Protection of immediate resident safety by suspending STNA # 434, # 435 and #436 following appropriate abuse prohibition on 07/15/24. Termination of employment on 07/17/24. The Physician and Nurse Practitioner (NP) were notified. The NP was in the facility and performed a bedside evaluation on Resident #16 and the Registered Nurse performed a physical assessment on 07/15/24 without any findings of physical injuries. All residents with a Brief Interview for Mental Status (BIMS) score of eight or less were assessed for signs of abuse without findings on 07/15/24. All residents with a BIMS of nine for greater were interviewed for concerns of abuse without findings on 07/15/24. Staff re-education by the Administrator for abuse prevention and reporting was completed on 07/15/24 or prior to next working shift for all 164 staff. The facility Director of Nursing held an Ad Hoc Quality Assurance Performance Improvement (QAPI) meeting with QAPI members to develop a plan on 07/15/24. The facility filed an SRI with ODH on 07/15/24. Hospice was notified of the findings on 07/15/24 for coordination of care. Additional re-education for behaviors and combative care was initiated on 07/17/24 with all staff and will be completed on 07/24/24. The facility Director of Nursing/Designee began random staff competencies on 07/17/24 and will continue twice weekly for three weeks. Findings will be reviewed in scheduled QAPI meetings. The facility Director of Nursing/Designee began random observations of staff to resident interactions on 07/17/24 to ensure dignity and respect was provided and will continue twice weekly for three weeks. Findings will be reviewed in scheduled QAPI meetings. Weekly ongoing audits on staff abuse competencies began on 07/17/24 and would continue twice weekly for three weeks. Findings would be reviewed in scheduled QAPI meeting. Random observation by the DON/designee of all staff to resident interactions began on 07/17/24 to ensure dignity and respect and abuse prohibition and would continue twice weekly for three weeks. Findings would be reviewed in scheduled QAPI meetings. As of the date of the survey on 08/29/24 no other instances of abuse had been identified. This deficiency represents noncompliance investigated under Complaint Number OH00156377