STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366144	A. Building B. Wing	04/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mennonite Memorial Home	410 W Elm Street Bluffton, OH 45817

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 - Minimal harm or potential for actual harm Residents Affected - Some	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** 35031 Based on medical record review, staff interview, review of facility census, review of the facility self-reported incidents (SRIs), review of facility investigations, and policy review, the facility failed to ensure residents were free from verbal abuse and mistreatment. This affected one (#32) of two residents reviewed for abuse and had the possibility to affect 31 (#14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30, #31, #32, #33, #34, #35, #36, #37, #38, #39, #40, #41, #42, #43 and #44) residents residing on the hallway. The facility census was 53. Findings include: Review of the SRI dated 03/11/24, revealed State tested Nurse Assistant (STNA) #101 left a note for the Director of Nursing (DON) indicating a concern about STNA #100's reaction to Resident #32's behaviors. STNA #101 had witnessed STNA #100 holding down Resident #32's arms/wrists and placed a paper towel over his mouth after Resident #32 had attempted to spit on her. STNA #101 reportedly intervened and instructed STNA #100 to leave the room and STNA #101 would finish the care to Resident #32. Review of the medical record of Resident #32 revealed an admitted [DATE]. Diagnoses include syncope and collapse, unspecified dementia, and unspecified psychosis. Review of the minimum data set assessment dated [DATE] revealed Resident #32 to have severe cognition impairment. Review of the skin assessment completed on Resident #32 dated 03/11/24 revealed no skin impairments or discolorations. Review of a handwritten report dated 03/09/24 by Licensed Practical Nurse (LPN) #102 revealed. I have continued concerns about the way she speaks with residents. Another STNA came to me with concerns as well. (I did not witness the incident.) I do notice the residents seem to have increased behaviors when she is on duty, and I have had an increase in residents complaining about her attitude. I have attached a statement from STNA #101, who witnessed an incident today. (A note on this form read Nurses, if you are having problems with nursing assistants on the floor that you are in charge of and need assistance with correction of performance, or for any other reason needing my assistance. Please fill out the bottom portion of this form.) (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366144	A. Building B. Wing	04/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mennonite Memorial Home	410 W Elm Street Bluffton, OH 45817

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 - Minimal harm or potential for actual harm Residents Affected - Some	Review of a hand-written note dated 03/09/24 signed by STNA #101 revealed While toileting Resident #32 with STNA #100, Resident #32 began to pull up his pants while STNA #101 was attempting to change them because they were soiled. STNA #101 was trying to remind Resident #32, that his pants were soiled and that they would need to be changed. STNA #101 attempted to pull down Resident #32's pants again, when Resident #32 tried to hit STNA #101 in the face with medium force. STNA #100 then yelled at Resident #32 stating No Resident #32 we aren't going to do that. Then STNA #100 grabbed Resident #32's arms by his wrists and held them down with a lot of force and stated, You are not stronger than me. Resident #32 then attempted to spit on STNA #100. STNA #100 grabbed a paper towel and covered Resident #32's mouth with it. STNA #101 then looked at STNA #100 and said, I can finish care on him, it's okay STNA #100 left the room and STNA #101 finished SR #32's care. Review of the facility investigation dated 03/11/24 revealed on 03/09/24 Stated tested Nursing Assistant (STNA) #101 had reported to Licensed Practical Nurse (LPN) #102, she felt STNA #100 had been unnecessarily rough with Resident #32 during toileting. STNA #101 reported STNA #100 had held a paper towel over Resident #32's mouth and had held his arms down. STNA #101 had told STNA #100 she would complete the care for Resident #32. Review of the facility census revealed 31 residents (#14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30, #31, #32, #33, #34, #35, #36, #37, #38, #39, #40, #41, #42, #43 and #44) residing on the hallway where STNA #100 worked after the incident. Interview on 04/08/24 at 9:49 A.M., with LPN #102, by phone, revealed she related the incident as she had been told on 03/09/24 at approximately 11:00 P.M., by STNA #101. LPN #102 stated she had sent a text message to the Manager on Duty LPN #103 (MoD). LPN #103 stated she sent a picture of the statements from herself and STNA #101. She also placed a note under the DON's office door. She thought the incident occurred sometime between the hours of 8:00 P.M. to 10:00 P.M. Interview on 04/08/24 at 9:40 A.M., with DON revealed she was made aware of the allegation on 04/11/24 after finding a note in her office. She immediately placed STNA #100 on suspension and began the investigation. STNA #100 was terminated on 03/12/24. DON stated they had completed a skin assessment on Resident #32. DON stated STNA #100 had worked 16 hours after the alleged incident, prior to the DON and Administrator being made aware of the incident. Interview on 04/08/24 at 10:12 A.M., with LPN #103 (MoD on 03/09/24) revealed she had received a text message on 03/09/24 at 11:58 P.M. from LPN #102 stating she had an incident to report immediately but did not expand on the incident. LPN #103 stated she had informed LPN #102 to complete a report and give it the Director of Nursing (DON). LPN #103 stated she had not followed up on the text and had not informed the DON of the text. A follow-up interview at 11:00 A.M., with DON revealed she had not been aware of the text sent to LPN #103 on 03/09/24 until LPN #103 informed her during this survey. Review of the policy titled Abuse, Neglect, and Misappropriation dated 10/24/22 revealed verbal abuse defined as the use of oral, written, or gestured communication or sounds that willfully includes disparaging and derogatory to a resident or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability. Mistreatment was defined as the inappropriate treatment or exploitation of a resident. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mennonite Memorial Home	410 W Elm Street Bluffton, OH 45817

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	This deficiency represents non-compliance investigated under Complaint Number OH00152270 and Self-Reported Incident Control Number OH00152109.

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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 - Some	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** 35031 Based on medical record review, staff interview, review of facility census, review of the facility self-reported incidents (SRIs), review of facility investigations, and policy review, the facility failed to timely report an allegation of an incident of a staff member potentially verbally abusing and mistreating a resident to the Administrator and state agency. This affected one (#32) of two residents reviewed for abuse and had the possibility to affect 31 (#14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30, #31, #32, #33, #34, #35, #36, #37, #38, #39, #40, #41, #42, #43 and #44) residents residing on the hallway. The facility census was 53. Findings include: Review of the SRI dated 03/11/24, revealed State tested Nurse Assistant (STNA) #101 left a note for the Director of Nursing (DON) indicating a concern about STNA #100's reaction to Resident #32's behaviors. STNA #101 had witnessed STNA #100 holding down Resident #32's arms/wrists and placed a paper towel over his mouth after Resident #32 had attempted to spit on her. STNA #101 reportedly intervened and instructed STNA #100 to leave the room and STNA #101 would finish the care to Resident #32. Review of the medical record of Resident #32 revealed an admitted [DATE]. Diagnoses include syncope and collapse, unspecified dementia, and unspecified psychosis. Review of the minimum data set assessment dated [DATE] revealed Resident #32 to have severe cognition impairment. Review of the skin assessment completed on Resident #32 dated 03/11/24 revealed no skin impairments or discolorations. Review of a handwritten report dated 03/09/24 by Licensed Practical Nurse (LPN) #102 revealed. I have continued concerns about the way she speaks with residents. Another STNA came to me with concerns as well. (I did not witness the incident.) I do notice the residents seem to have increased behaviors when she is on duty, and I have had an increase in residents complaining about her attitude. I have attached a statement from STNA #101, who witnessed an incident today. (A note on this form read Nurses, if you are having problems with nursing assistants on the floor that you are in charge of and need assistance with correction of performance, or for any other reason needing my assistance. Please fill out the bottom portion of this form.) Review of a hand-written note dated 03/09/24 signed by STNA #101 revealed While toileting Resident #32 with STNA #100, Resident #32 began to pull up his pants while STNA #101 was attempting to change them because they were soiled. STNA #101 was trying to remind Resident #32, that his pants were soiled and that they would need to be changed. STNA #101 attempted to pull down Resident #32's pants again, when Resident #32 tried to hit STNA #101 in the face with medium force. STNA #100 then yelled at Resident #32 stating No Resident #32 we aren't going to do that. Then STNA #100 grabbed Resident #32's arms by his wrists and held them down with a lot of force and stated, You are not stronger than me. Resident #32 then attempted to spit on STNA #100. STNA #100 grabbed a paper towel and covered Resident #32's mouth with it. STNA #101 then looked at STNA #100 and said, I can finish care on him, it's okay STNA #100 left the room and STNA #101 finished SR #32's care. (continued on next page)

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Mennonite Memorial Home	410 W Elm Street Bluffton, OH 45817

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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 - Some	Review of the facility investigation dated 03/11/24 revealed on 03/09/24 Stated tested Nursing Assistant (STNA) #101 had reported to Licensed Practical Nurse (LPN) #102, she felt STNA #100 had been unnecessarily rough with Resident #32 during toileting. STNA #101 reported STNA #100 had held a paper towel over Resident #32's mouth and had held his arms down. STNA #101 had told STNA #100 she would complete the care for Resident #32. Review of the facility census revealed 31 residents (#14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30, #31, #32, #33, #34, #35, #36, #37, #38, #39, #40, #41, #42, #43 and #44) residing on the hallway where STNA #100 worked after the incident. Interview on 04/08/24 at 9:49 A.M., with LPN #102, by phone, revealed she related the incident as she had been told on 03/09/24 at approximately 11:00 P.M., by STNA #101. LPN #102 stated she had sent a text message to the Manager on Duty LPN #103 (MoD). LPN #103 stated she sent a picture of the statements from herself and STNA #101. She also placed a note under the DON's office door. She thought the incident occurred sometime between the hours of 8:00 P.M. to 10:00 P.M. Interview on 04/08/24 at 9:40 A.M., with DON revealed she was made aware of the allegation on 04/11/24 after finding a note in her office. She immediately placed STNA #100 on suspension and began the investigation. STNA #100 was terminated on 03/12/24. DON stated they had completed a skin assessment on Resident #32 but no other resident at the time. DON stated they had interviewed only the two STNAs involved and no other residents or staff. DON stated STNA #100 had worked 16 hours after the alleged incident, prior to the DON and Administrator being made aware of the incident. Interview on 04/08/24 at 10:12 A.M., with LPN #103 (MoD on 03/09/24) revealed she had received a text message on 03/09/24 at 11:58 P.M. from LPN #102 stating she had an incident to report immediately but did not expand on the incident. LPN #103 stated she had informed LPN #102 to complete a report and give it the Director of Nursing (DON). LPN #103 stated she had not followed up on the text and had not informed the DON of the text. A follow-up interview at 11:00 A.M., with DON revealed she had not been aware of the text sent to LPN #103 on 03/09/24 until LPN #103 informed her during this survey. Review of the facility policy titled Abuse, Neglect, and Misappropriation dated 10/24/22, revealed the facility will report all alleged violations to the Administrator and state agency, no later than two hours after the allegation is made. This deficiency represents non-compliance investigated under Complaint Number OH00152270 and Self-Reported Incident Control Number OH00152109.

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Mennonite Memorial Home	410 W Elm Street Bluffton, OH 45817

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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 - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35031 Based on medical record review, staff interview, review of facility census, review of the facility self-reported incidents (SRIs), review of facility investigations, and policy review, the facility failed to timely begin an investigation, complete a thorough investigation and provide protection to residents, when an allegation of a staff member potentially verbally abusing and mistreating a resident was made. This affected one (#32) of two residents reviewed for abuse and had the possibility to affect 31 (#14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30, #31, #32, #33, #34, #35, #36, #37, #38, #39, #40, #41, #42, #43 and #44) residents residing on the hallway. The facility census was 53. Findings include: Review of the SRI dated 03/11/24, revealed State tested Nurse Assistant (STNA) #101 left a note for the Director of Nursing (DON) indicating a concern about STNA #100's reaction to Resident #32's behaviors. STNA #101 had witnessed STNA #100 holding down Resident #32's arms/wrists and placed a paper towel over his mouth after Resident #32 had attempted to spit on her. STNA #101 reportedly intervened and instructed STNA #100 to leave the room and STNA #101 would finish the care to Resident #32. Review of the medical record of Resident #32 revealed an admitted [DATE]. Diagnoses include syncope and collapse, unspecified dementia, and unspecified psychosis. Review of the minimum data set assessment dated [DATE] revealed Resident #32 to have severe cognition impairment. Review of the skin assessment completed on Resident #32 dated 03/11/24 revealed no skin impairments or discolorations. Review of a handwritten report dated 03/09/24 by Licensed Practical Nurse (LPN) #102 revealed. I have continued concerns about the way she speaks with residents. Another STNA came to me with concerns as well. (I did not witness the incident.) I do notice the residents seem to have increased behaviors when she is on duty, and I have had an increase in residents complaining about her attitude. I have attached a statement from STNA #101, who witnessed an incident today. (A note on this form read Nurses, if you are having problems with nursing assistants on the floor that you are in charge of and need assistance with correction of performance, or for any other reason needing my assistance. Please fill out the bottom portion of this form.) Review of a hand-written note dated 03/09/24 signed by STNA #101 revealed While toileting Resident #32 with STNA #100, Resident #32 began to pull up his pants while STNA #101 was attempting to change them because they were soiled. STNA #101 was trying to remind Resident #32, that his pants were soiled and that they would need to be changed. STNA #101 attempted to pull down Resident #32's pants again, when Resident #32 tried to hit STNA #101 in the face with medium force. STNA #100 then yelled at Resident #32 stating No Resident #32 we aren't going to do that. Then STNA #100 grabbed Resident #32's arms by his wrists and held them down with a lot of force and stated, You are not stronger than me. Resident #32 then attempted to spit on STNA #100. STNA #100 grabbed a paper towel and covered Resident #32's mouth with it. STNA #101 then looked at STNA #100 and said, I can finish care on him, it's okay STNA #100 left the room and STNA #101 finished SR #32's care. (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 - Some	Review of the facility investigation dated 03/11/24 revealed on 03/09/24 Stated tested Nursing Assistant (STNA) #101 had reported to Licensed Practical Nurse (LPN) #102, she felt STNA #100 had been unnecessarily rough with Resident #32 during toileting. STNA #101 reported STNA #100 had held a paper towel over Resident #32's mouth and had held his arms down. STNA #101 had told STNA #100 she would complete the care for Resident #32. Review of the facility census revealed 31 residents (#14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30, #31, #32, #33, #34, #35, #36, #37, #38, #39, #40, #41, #42, #43 and #44) residing on the hallway where STNA #100 worked after the incident. Interview on 04/08/24 at 9:49 A.M., with LPN #102, by phone, revealed she related the incident as she had been told on 03/09/24 at approximately 11:00 P.M., by STNA #101. LPN #102 stated she had sent a text message to the Manager on Duty LPN #103 (MoD). LPN #103 stated she sent a picture of the statements from herself and STNA #101. She also placed a note under the DON's office door. She thought the incident occurred sometime between the hours of 8:00 P.M. to 10:00 P.M. Interview on 04/08/24 at 9:40 A.M., with DON revealed she was made aware of the allegation on 04/11/24 after finding a note in her office. She immediately placed STNA #100 on suspension and began the investigation. STNA #100 was terminated on 03/12/24. DON stated they had completed a skin assessment on Resident #32 but no other resident at the time. DON stated they had interviewed only the two STNAs involved and no other residents or staff. DON stated STNA #100 had worked 16 hours after the alleged incident, prior to the DON and Administrator being made aware of the incident. Interview on 04/08/24 at 10:12 A.M., with LPN #103 (MoD on 03/09/24) revealed she had received a text message on 03/09/24 at 11:58 P.M. from LPN #102 stating she had an incident to report immediately but did not expand on the incident. LPN #103 stated she had informed LPN #102 to complete a report and give it the Director of Nursing (DON). LPN #103 stated she had not followed up on the text and had not informed the DON of the text. A follow-up interview at 11:00 A.M., with DON revealed she had not been aware of the text sent to LPN #103 on 03/09/24 until LPN #103 informed her during this survey. Review of the policy titled Abuse, Neglect, and Misappropriation dated 10/24/22 revealed the facility will identify and interview all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations. The facility will provide complete and thorough documentation of the investigation. Under the protection of the resident the policy identified the facility will make efforts ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. This deficiency represents non-compliance investigated under Complaint Number OH00152270 and Self-Reported Incident Control Number OH00152109.