STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366214	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canterbury Villa of Alliance	1785 Freshley Avenue Alliance, OH 44601

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 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, review of the Self-Reported Incident (SRI), review of facility policy, and interview with the staff, the facility failed to provide effective and appropriate behavior management during care for Resident #68. This affected one resident (#68) of three reviewed for dignity and respect.Findings Include: Review of the medical record revealed Resident #68 was admitted to the facility on [DATE]. Diagnoses included rhabdomyolysis, muscle weakness, schizophrenia, confusional arousals, anxiety disorder, chronic pain, hypertension, post-traumatic stress disorder, transient ischemic attack, dementia, hypothermia, panic disorder, psychosis, and depression. He was discharged to a behavior center on 04/17/26.Review of Resident #68's physician orders revealed an order dated 04/14/26 for Olanzapine 2.5 milligrams (mg) with instructions to give one tablet as needed (PRN) for agitation twice daily for three days.Review of the care plan dated 04/14/26 revealed Resident #68 required assistance with activities of daily living with interventions including he could be confused and disoriented, could transfer with assistance, he was continent of bowel and bladder, and he preferred a shower.Review of the plan of care dated 04/17/26 (day of incident) revealed Resident #68 was non-complaint as evident by refusals of care and treatments including dressing changes and medications administration. Interventions included to document educational attempts made with the resident in relation to compliance, educate resident, family or responsible party on negative outcomes related to non-compliance, explain all procedures prior to starting them and the benefits of the procedure, and notify the physician or nurse practitioner of any non-compliance. The care plan also revealed the resident experienced an alteration in mood and/or behavior as evidenced by noncompliance as the resident was noted to become combative/verbally aggressive with staff, he was noted to kick, hit and bite and make false accusations. Interventions included allow resident to vent and validate feelings, attempt to determine what triggers the behaviors, contact the resident's family for support as needed, decrease stimulation as needed, distraction and redirection as needed, provide and/or suggest rest periods as needed.Review of the Health Status note dated 04/17/26 at 11:15 A.M. revealed Resident #68 became combative with staff and therapy during care and showering. Resident #68 was cursing at staff and attempting to hit staff with a closed fist. Redirection was attempted and was ineffective. The physician was in the facility, and the resident was cursing at the physician calling him a quack, he would not answer the physician's questions but did allow the physician to listen to his lungs. Resident #68 continued to curse at the staff but did allow care to be provided. As needed, medication was administered due to agitation.Review of Resident #68's Medication Administration Record revealed the residents PRN Olanzapine 2.5 mg was administered on 04/17/26 at 11:15 A.M. and it was effective. Review of the Health Status note dated 04/17/26 at 2:33 P.M. revealed Resident #68 received a new order for an inpatient psychiatric evaluation.Review of the Progress Notes from 04/14/26 through 04/17/26 revealed no other incidents of combative or aggressive behavior were documented.Review of the Self-Reported Incident dated 04/17/26 revealed at 1:30 P.M. Resident #68 reported he was physically (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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NAME OF PROVIDER OR SUPPLIER Canterbury Villa of Alliance		STREET ADDRESS, CITY, STATE, ZIP CODE 1785 Freshley Avenue Alliance, OH 44601	

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	abused by the staff. The resident was immediately assessed with no concerns identified. The allegation was immediately reported to the Administrator and an investigation was started. To ensure all residents continued to be protected from potential abuse the facility interviewed staff and immediately educated all staff on the facility policy for abuse identification, response and reporting. Resident #68 was immediately interviewed and stated he was physically abused and was withheld food but was unable to provide information or a description of the abuser. Staff working at the time of the alleged incident were interviewed and reported there was no abuse and they had never seen any abuse towards the resident. Other staff members were interviewed with no concerns identified. Residents were interviewed with no concerns identified, non-interviewable residents were assessed with no concerns identified. Resident #68's responsible party was contacted, and the interdisciplinary team meeting was scheduled. In speaking with the resident's daughter, she stated she did not think that her father was abused and he had a long history of mental health issues and had requested the facility work on placement at an inpatient psychiatric facility for evaluation and treatment. Resident #68 indicated he did not want to notify the police. The physician was updated and a new order was received for inpatient psychiatric evaluation and treatment.Review of the handwritten witness statement authored by Physical Therapy Assistant (PTA) #105 dated 04/17/26 revealed Resident #68 was seen for therapy treatment which mainly consisted of transferring out of bed to the shower chair then back to the bed following the shower. Throughout this time the resident was verbally abusive, name calling and many times stating that if you hurt him he would hurt you, get out, leave him alone, and they were hurting him. Resident #68 made firsts several times and took a swing here and there. Because of these behaviors, both the PTA and Certified Occupational Assistant (COTA) were present as well as the nursing assistant and unit nurse for the safety and protection of all involved. The resident was given reassurance throughout that their intentions were to help him and not hurt him. Resident #68 did participate on a limited basis with transfers through taking steps and following through with hand placement and helping wash his own hair.Review of the handwritten witness statement authored by COTA #103 dated 04/17/26 revealed he saw Resident #68 with the unit nurse, nursing assistant, and PTA due to his combative behavior. Therapy treatment was to focus on transferring to bed following maximum cues and redirection. The resident demonstrated extreme agitation by way of verbal abuse and name calling. The resident frequently stated if they hurt him, he would hurt us, get out, leave him alone and they were hurting him. The statements were made prior to them physically assisting the resident with transfers. Validation was provided throughout treatment to the resident that therapy and nursing staff were there to help him so he should get into the shower. The resident eventually did participate with transfers with minimal effort, and he washed his own hair. Review of the handwritten witness statement authored by Registered Nurse (RN) #104 dated 04/17/26 revealed Resident #68 was approached for a shower. COTA #103, PTA #105, Certified Nursing Assistant (CNA) #100 and herself were in the resident's room, and he was assisted to the shower chair by the staff. She held the back of the shower chair while the other staff transferred him. Resident #68 cursed and yelled at the staff, attempted to bite CNA #100, and attempted to hit them with closed fists. Resident #68 continued to curse and yell at the staff, but he did allow care to be provided. He was pushed to the shower room in the shower chair and then she left the shower room at that time. She came back to the shower room about eight to 10 minutes later to check on the staff and resident. CNA #100 was drying the resident off as he continued to yell and curse at the staff. He was taken back to his room. His mattress was switched out at this time and new linens applied to the new mattress while the resident continued to curse at the staff and call them names, but he did not attempt to be physical. The physician came in the room to assess the resident, and he cursed at the physician and called him a quack. The resident did allow the physician to listen to his lungs but would not answer his questions. CNA #100 and PTA #105 transferred him back into bed then therapy left the room and CNA #100 and herself put a clean pad and brief on him as he was incontinent during the shower. Resident #68 continued to curse at the staff and call them names but did turn in bed side to (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	side to allow care to be provided. On 04/23/26 at 11:00 A.M. an interview with COTA #103 revealed he went to assist the nursing assistant in getting Resident #68 up out of bed and into the shower chair, but the resident was not thrilled about it. He stated the resident was very messy with food all over him, smelled like urine, and had been refusing to be cleaned. He stated Resident #68 was being verbally abusive and they were just trying to reassure him that they were only trying to help him. He stated they were finally able to get him to the side of the bed, but he was not happy about it and at that time he was just yelling at them. He stated he had not become combative until after he was up in the shower chair and getting his shower. He stated both him and PTA #105 went into the shower room with the nursing assistant because he did not believe she should be alone with him in the shower room because of his behavior. He stated there were four staff in the room, himself, PTA #105, RN #104 and CNA #100, and three in the shower room. He verified they never stopped and left the room to give the resident time to calm down. He stated this was the first time working with the resident, but he had a history of combative behaviors per his daughter, and he needed to be cleaned up. He stated they never abused him and they were calm they whole time and never forced him.On 04/23/26 at 11:28 A.M. an interview with CNA #100 revealed on 04/17/26, Resident #68 had been yelling and cussing the whole morning, he wanted to go to Lowe's and get a shower. She stated she told the nurse earlier in the day how he was acting and how confused he was. She stated therapy came to her and stated they wanted to help her give him a shower because she told them he was screaming at her, calling her names and swinging at her. She stated he never refused to get a shower, so they sat him on the side of the bed and the whole time she was yelling at them. She stated he did not like the male therapist at all and every time he saw him, he would get more upset. She stated they finally got him in the shower chair and took him down to the shower and therapy stayed in there the whole time while she showered him. She stated he was yelling and swinging at her the whole time. She stated he still had a brief stuck to his bottom because he would not allow her to take it off and he also had the bed pad in his hands and would not let go of it. She stated she was told by RN #104 he had to be showered because he smelled like urine really bad and they had to get him up anyway to the change the bed and they wanted to put a new mattress on the bed. She stated he was like that and combative the whole time he had been there. She stated she had been trained on behaviors and how to redirect a resident. She stated he did stop hitting her to wash his own hair. She stated they never hurt him or were rough with him.On 04/23/26 at 2:45 P.M. an interview with RN #104 revealed it had been Resident #68's shower day, and it was her, the aide, and therapy in the room. She stated his baseline was combative and that was why they had all been in the room. She stated they got him in the shower chair, and she left the room to go do her own work. She stated when they were done with the shower she helped to get him back to his room. She stated she was brushing his hair when the physician came into the room. She stated he was combative but never refused care but he did cuss and scream at staff during care. She stated they never made him get a shower and he never refused. She stated they would normally leave the room and reapproach someone who had post traumatic stress disorder but verified they had not done that at that time.On 04/23/26 at 3:30 P.M. an interview with the Director of Nursing verified there was no documentation in the progress notes of Resident #68 having behaviors or acting out prior to 04/17/26.Review of the facility policy titled, Behavior Management, dated 03/01/16 revealed the facility's behavior management system addressed residents with behavior patterns that interfere with their functional capacity and ensuring that these patterns were reduced or eliminated to maximize the resident's dignity, independence, and self-determination.The following deficiency is based on incidental findings discovered during the course of this complaint investigation.