STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366249	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunnyslope Nursing Home	102 Boyce Drive Bowerston, OH 44695

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 - 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** 26706 THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on medical record review, review of facility self-reported incident (SRI) including investigation, observations, staff and resident interviews and review of facility Abuse, Neglect, and Misappropriation policy, the facility failed to ensure a resident was free from verbal abuse. This affected one resident (#26) of three residents reviewed for abuse. The facility census was 42. Findings Include: Review of Resident #26's record revealed a 09/27/24 admission with diagnoses including Alzheimer's disease, altered mental status, unspecified dementia moderate with agitation, insomnia, anxiety disorder, transient ischemic attack, obstructive sleep apnea, vertigo, myocardial infarction, cardiomegaly, cerebral infarction, congenital renal artery stenosis, and supraventricular tachycardia. Review of a Significant Change in Status minimum data set (MDS) assessment dated [DATE] revealed severely impaired cognitive skills for daily decision making, partial moderate assistance was required with eating, substantial maximal assistance with oral hygiene, bed mobility, toileting, personal hygiene, bathing, upper and lower body dressing, putting on taking off shoes, independent with rolling, partial moderate assistance with sitting to lying, lying to sitting on side of bed, sit to stand, chair bed to chair transfers, and walking 10 feet. Resident #26 also required a secured unit due to diagnosis of dementia with behaviors. Behaviors exhibited included episodes of wandering on the unit with potential for poor decision-making abilities and poor safety awareness. Review of care plan revealed Resident #26 had a potential for mood problems related to Alzheimer's, anxiety, dementia with behavioral disturbance. The resident had repetitive anxious complaints or concerns, and repetitive verbalizations. Direct care staff and social services to practice empathetic listening, conveyance of hope, optimistic attitude, and encouragement of positive coping. Resident #26 also required a secured unit due to diagnosis of dementia with behaviors. Behaviors exhibited included repetitive anxious complaints or concerns, repetitive verbalizations, will exit seek, and spends time looking for her family. (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: 366249	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
NAME OF PROVIDER OR SUPPLIER Sunnyslope Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 102 Boyce Drive Bowerston, OH 44695	

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility SRI 253615 dated 11/02/24 revealed on 11/02/24 at 8:00 A.M. while at the D hall nurse's station/dining room Certified Nursing Assistant (CNA)) #54 verbally abused Resident #26. License Practical Nurse (LPN) #52 had assisted Resident #26 to the dining room to allow the breakfast tray cart to pass up the hallway. Resident #26 immediately propelled self back beside nurse's station preventing the movement of the breakfast tray cart. CNA #54 approached Resident #26 and said I am going to hit you in the nose, with the resident stating, please don't hit me. CNA #54 propelled Resident #26 back into the dining room and said, now stay the hell here. LPN #52 and Housekeeper #51 overheard what CNA #54 said to Resident #26. Review of a 11/02/24 statement by Housekeeper #51 included CNA #54 was collecting breakfast trays. Resident #26 was by the nurse station. LPN #52 wheeled Resident #26 into the dining room so CNA #54 could put the cart beside the nurse station. Resident #26 came back out by the nurse station. CNA #54 said I'm gonna punch you in the nose. CNA #54 wheeled her back to the dining room and said now stay the hell here and don't move. She went to find her supervisor. CNA #54 stopped Housekeeping and said I would never hit anyone back here that slipped out of my mouth. A 11/02/24 statement by LPN #52 included she was by the nurse station getting medication and heard CNA #54 state to resident I'm going to punch you in the nose! then he proceeded to push resident in dining room in wheelchair stating now stay the hell here! She was waiting for CNA #54 to walk away and told him he could not talk to residents like that. Housekeeping heard the CNA talk to the resident like that also, and we decided to report it. Review of a 11/02/24 statement written by CNA #54 included he was trying to do breakfast with nurse. CNA #54 was trying to get Resident #26 from being in the way. CNA #54 accidentally said he was going to hit her in the nose. CNA #54 did apologize to her and the nurse. CNA #54 stated he would never hit any of my residents. CNA #54 was immediately suspended pending investigation. Observation on 11/22/24 at 12:26 P.M. revealed Resident #26 was in the Memory Care dining room in her geri chair sleeping. Interview at the time of the observation with CNA #57 revealed she attempted to get Resident #26 to eat lunch and she just kept saying no, no, no. Review of the personnel file for CNA #54 found the CNA began working at the facility on 10/01/20 and received in-service education on abuse, neglect, and misappropriation during his orientation. His last abuse training was 09/27/24. The facility completed a criminal background check with no negative results returned. Reference checks were completed prior to hire. CNA #54's last day worked was 11/02/24 the day of the incident. He called in and resigned 11/08/24. He had two prior unsubstantiated SRI's on 11/25/20 and 01/12/21. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Sunnyslope Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 102 Boyce Drive Bowerston, OH 44695	

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility Abuse, Neglect, Exploitation and Misappropriation of Resident Property Policy (revised 11/2016) revealed it was the intent of the facility to ensure the facility appropriately responds to and investigates all alleged violations involving Abuse, Neglect, Exploitation, Mistreatment of a resident, or Misappropriation of Resident Property, including Injuries of Unknown source. Abuse included verbal abuse, sexual abuse, physical abuse and mental abuse. The policy was followed in the events surrounding the verbal, emotional and threat of physical abuse of Resident #26's by CNA #54. Interview on 11/22/24 at 1:45 P.M. with the Director of Nursing, revealed the facility had no further incidents of abuse from a staff member. The deficient practice was corrected on 11/08/24 when the facility implemented the following corrective actions: Immediate removal of CNA #54 from the schedule with suspension pending investigation on 11/02/24 at 8:10 A.M Immediately following the incident on 11/02/24, Resident #26 had comfort support provided by nursing staff. Resident #26 was given a Brief Interview for Mental Status test 11/02/24 at 10:00 A.M. with no change in psychosocial demeanor. Resident #26 had a head to toe assessment completed on 11/02/24 without significant findings. All residents residing on the secured unit were interviewed 11/02/24 with no significant findings and all non-interviewable residents had head to toe assessment with no significant findings. Resident #26's physician and psychiatry support were notified with no new orders on 11/02/24. Family was notified with no new concerns on 11/02/24. Staff education on the abuse/neglect policy was completed on 11/02/24 to 49 staff, all staff except those on a leave of absence, and staff questionnaire completed. The questionnaires included have they seen abuse, neglect or misappropriation without reporting, Have they been educated on the facility abuse policy and did they know who the abuse coordinator was. Social Worker followed up with Resident #26 on 11/02/24 and due to her cognition does not remember incident. Care plan for Resident #26 reviewed and updated as needed on 11/02/24. Facility staffing reviewed on 11/02/24 and found to be at more than appropriate levels. Social Service followed up on 11/02/24 and Resident #26 remains at baseline with no signs/symptoms of emotional damage, fear, or any other negative effect observed. Resident #26 will continue to be provided emotional support to ensure no lasting effect on resident psychosocial health. The facility substantiated - abuse, neglect or misappropriation verified by evidence on 11/08/24. CNA #54 phoned the facility and resigned 11/08/24. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interviews on 11/22/24 with Registered Nurses (RN's) (#50, #53), and CNA #53 were able to identify types of abuse and procedures for escalating behaviors and abuse allegations. They reported they received training on abuse policies and procedures, escalating behaviors, and dining. On 11/22/24, two additional residents (#29 and #39) were sampled and reviewed for abuse. No concerns were identified. On 11/22/24, surveyor review of the facility SRI's revealed there were no further concerns identified regarding abuse. This deficiency represents non-compliance investigated under Self-Reported Incident Complaint Number OH00159797.