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	04/01/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33019 Based on medical record review, review of a Self-Reported Incident (SRI), abuse policy review, and interview, the facility failed to prevent a former employee, who verbally abused a resident, from entering the facility, including resident care areas. This affected one (Resident #26) of three residents reviewed for abuse. The facility census was 40. Findings include: Review of the medical record for Resident #26 revealed an admitted [DATE] with diagnoses including Alzheimer's disease, altered mental status, dementia with moderate with agitation, insomnia, anxiety disorder, transient ischemic attack, obstructive sleep apnea and vertigo. The resident received hospice services and expired on [DATE]. Review of SRI #253615, dated [DATE], revealed while on the D Hall nursing 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 herself back beside the 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. Following the incident, CNA #54 was immediately placed on suspension pending the investigation and subsequently resigned from his employment at the facility on [DATE]. The facility substantiated the allegation of abuse. Review of the facility's survey history revealed on [DATE] an onsite complaint investigation identified a concern related to an incident of verbal abuse involving Resident #26 and CNA #54. Non-compliance was identified and certification and licensure violations were issued. Following the incident, the facility implemented corrective actions including immediately suspending CNA #54 and providing education to all staff on the facility's abuse/neglect policy. Interview on [DATE] at 1150 A.M. with an anonymous person revealed she had witnessed CNA #54 on numerous occasions in the facility following the abuse incident and his termination from employment and she has reported this to the Director of Nursing (DON) who had done nothing about it. The Anonymous person stated they observed CNA #54 in the facility and had attended the Christmas party in [DATE]. The anonymous person stated the Director of Nursing also attended the Christmas party and knew CNA #54 was in the facility. (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
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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 - Few	Interview on [DATE] at 11:25 A.M. with Licensed Practical Nurse (LPN) #4 verified CNA #54 has been in the facility on several occasions to use the bathroom or sit in the nursing station until she is finished with her shift. LPN #4 stated that she doesn't drive and CNA #54 picks her up from work. Interview on [DATE] at 11:32 A.M. with Therapy Director #9 revealed she had witnessed CNA #54 in the facility following the abuse incident a few times, often in the hallway or in the memory care unit. Interview on [DATE] at 11:42 A.M. with LPN #6 revealed she has witnessed CNA #54 sitting at the nursing station several times while waiting to pick his wife up from work. LPN #6 stated she has reported this to the DON and nothing has happened. LPN #6 stated, he should not be here. Interview on [DATE] at 12:10 P.M. with CNA #7 revealed she witnessed CNA #54 at the Christmas party in December and the DON was also in attendance. CNA #7 stated she had witnessed CNA #54 sitting in the nursing station, usually on the weekends from 5:00 P.M. to 7:00 P.M., while waiting to pick up his wife from work. Interview on [DATE] at 12:25 P.M. with the Administrator revealed he first became aware on [DATE] of CNA #54 having been in the facility after being notified by staff. The Administrator stated he incorrectly thought CNA #54 was picking up his daughter, however, it was his wife, an employee of the facility. The Administrator stated that he contacted CNA #54 and advised him that he was not permitted to enter the facility, and CNA #54 agreed that he would not. The Administrator further stated that this will not happen again. Review of a statement authored by the Administrator, undated, revealed on [DATE] he was made aware that CNA #54, a past employee, was coming into the facility to pick up his daughter. Upon learning this, he contacted CNA #54 and left him a message to contact me (the Administrator). He (CNA #54) called on [DATE] at which time the Administrator informed him that he was not to enter the facility under any circumstance. He responded by saying he understood. Review of the policy titled, Abuse, Neglect, and Exploitation, dated [DATE], revealed it is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. This deficiency represents noncompliance investigated under Master Complaint Number OH00164117 and OH00163189.