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	03/25/2026

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 0744 Level of Harm - Actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a closed record review, review of facility self reported incidents, review of hospital emergency department documentation, facility policy review, and interviews, the facility failed to develop and implement comprehensive, individualized, and effective behavioral health treatment plans and services to prevent resident to resident altercations. This affected two of three residents reviewed for dementia care (Residents #51 and #50). The facility census was 46.Actual Harm occurred on 11/09/25 when Resident #51 sustained significant facial trauma, including ecchymosis and swelling to the left side of the face, left periorbital area, and ear, as well as a closed head injury and head laceration. These injuries resulted from a resident to resident altercation in which Resident #50 struck Resident #51. Following the incident Resident #51 had difficulty opening his mouth to eat, had decreased oral intake, was more lethargic and then began to self-isolate. Prior to the incident, both residents exhibited wandering and/or aggressive behaviors that were not effectively managed by the facility. There was no evidence of effective monitoring or non pharmacological interventions in place to address either resident's behavioral health care needs or prevent resident to resident altercations.Findings include: Review of Resident #50's closed medical record revealed the resident was admitted on [DATE] with diagnoses that included dementia with behavioral disturbance, congestive heart failure, ischemic cardiomyopathy, and anxiety disorder. Resident #50 discharged from the facility on 11/24/25.Review of an order/administration note dated 09/25/25 at 3:42 A.M. authored by Licensed Practical Nurse (LPN) #124 revealed Resident #50 continued to wander in and out of other resident rooms. The resident needed redirection multiple times during the shift. Review of a psychiatric services note dated 09/25/25 revealed Resident #50 was ordered Haldol (an antipsychotic) 10 milligrams (mg) intramuscularly every 24 hours as needed, Ativan (a benzodiazepine used for anxiety) one mg by mouth every four hours as needed, Ativan one mg by mouth four times a day, and Vistaril (an antihistamine used for anxiety) 50 mg every four hours as needed. An initial evaluation was completed for Resident #50 with a history of vascular dementia, agitation, and anxiety. Resident #50 was sitting in a wheelchair and was currently sedated. The staff reported the resident had a hard time adjusting to the facility. The resident had sundowning (prevalent among people with some form of dementia and characterized by increased confusion and restlessness beginning in the late afternoon and early evening) and became combative with staff at night. On 09/24/25, the resident threw a chair. It was reported Resident #50 was not sleeping at night and had been walking around naked. A new order was given to start Depakote (an anticonvulsant used at times as a mood stabilizer) sprinkles 125 mg at dinner time. Review of a health status note dated 09/26/25 at 9:00 P.M. authored by Registered Nurse (RN) #104 revealed Resident #50 was wandering the hallways and entering other resident rooms frequently. Review of an order/administration note dated 09/27/25 at 4:00 A.M. authored by RN #104 revealed Resident #50 was administered Ativan one mg as needed due to being very anxious and agitated. The resident was wandering into other residents' rooms and pacing the hallways. Continued review of Resident #50's record revealed orders were received on 09/29/25 to discontinue Resident #50's Ativan one mg four times a day and every (continued on next page)

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

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F 0744 Level of Harm - Actual harm Residents Affected - Few	four hours as needed. Ativan 0.5 mg twice a day was to be started and Ativan one mg every hour as needed. A new order was also received for Trazodone (an antidepressant which has properties to aid sleep) 50 mg at bedtime.Review of Resident #50's plan of care dated 09/29/25 revealed Resident #50 had a mood problem related to repetitive anxious complaints or concerns, anxiousness, restlessness and agitation. Interventions included arranging for a consultation by social services or other counselors, administering medications per order and observing response to treatment, and updating physician as needed. Record review revealed no evidence of any type of non-pharmacological approach/interventions to address the resident's behavioral health care needs and/or mood problems.Continued review of the plan of care dated 09/29/25 revealed Resident #50 had a behavior problem related to disruptive, resisting care, being socially inappropriate, wandering in and out of other resident rooms, exit seeking, and being combative. Interventions included monitoring and documenting behaviors and redirect gently out of rooms. The plan did not include any other type of non-pharmacological intervention other than redirection.Review of a health status note dated 10/06/25 at 11:11 P.M. authored by RN #109 revealed Resident #50 continued to wander in the halls and enter other resident rooms. There was no evidence of any type of intervention being initiated or attempted to address the resident's wandering. Review of a health status note dated 10/13/25 at 5:00 P.M. authored by RN #104 revealed the nurse was at the medication cart and observed Resident #50 ambulating in the hallway. Resident #50 was very agitated and talking to himself and unseen entities. Resident #51 was sitting in a chair next to the nurse's station when Resident #50 approached Resident #51 and hit Resident #51 on the left jaw. As a result of the incident, Resident #50 was placed on increased supervision for 72 hours.Review of new orders dated 10/14/25 revealed Resident #50's Ativan was to be increased to 0.5 mg three times a day and his Depakote increased to 125 mg to twice a day. Resident #50's daughter agreed to the Depakote being increased but did not want Ativan increased. Record review revealed no evidence of any type of non-pharmacological approach/interventions to address the resident's behavioral health care needs and/or mood problems.Review of a health status note dated 10/17/25 at 6:35 P.M. authored by LPN #124 revealed the nurse was at the medication cart and Resident #51 was sitting in a chair by the nurse's station. Resident #50 was ambulating with a wheeled walker and purposely hit Resident #51's feet and legs multiple times with the walker. Resident #51 remained seated and grabbed the walker. Resident #50 yelled to let go. Resident #51 stood up and hit Resident #50 on the left side of the face. Resident #50 grabbed Resident #51's face and left scratches on Resident #51's face.Review of a Self-Reported Incident (SRI) dated 10/17/25 revealed on 10/13/25 at 4:45 P.M. (wrong date and time) Resident #50 hit Resident #51. Resident #51 was sitting at the nurse's station. Resident #50 rammed his walker into Resident #51's legs. Resident #51 stood up and hit Resident #50 in the face. Resident #50 then hit Resident #51 in the face. Resident #50 was sent to the hospital for a psychiatric evaluation and Resident #51 was sent to the hospital for a medical evaluation. Resident #51 had scratches on his face. Review of the hospital after visit summary dated 10/17/25 revealed Resident #50 had vascular dementia with agitation and was sent to the emergency department for a behavioral and explosive outburst. The hospital did not have geriatric psychiatry services available and did not feel the need to transfer Resident #50 to a place that offered geriatric psychiatric services. It was recommended to have an on-call psychiatrist at the nursing facility see Resident #50 as soon as possible and, if able, avoid interactions with the other resident (Resident #51) that Resident #50 had been having altercations with. Review of Resident #51's closed medical record revealed the resident was admitted on [DATE] with diagnoses that included behavioral disturbance and agitation, intermittent explosive disorder, major depressive disorder, psychotic disorder, and delirium. Resident #51 discharged from the facility on 01/06/26.Review of the hospital after visit summary dated 10/17/25 revealed Resident #51 had been assaulted and had a facial contusion and laceration. The laceration to the right check was closed with tissue glue while the resident was in the emergency department. The laceration measured 0.8 centimeters (cm) long by two cm deep. Resident #51 returned to the facility.Review of a (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	health status note dated 10/20/25 at 4:11 P.M. authored by LPN #124 revealed Resident #51 was wandering in and out of rooms multiple times. Resident #51 did not display any agitation or aggression towards staff or peers. Record review revealed no evidence of any type of non-pharmacological approach/interventions to address the resident's wandering at this time. Review of a health status note dated 10/22/25 at 2:18 A.M. authored by RN #108 revealed Resident #51 continuously wandered into other resident rooms and was found in other resident's recliners or beds. Review of a health status note dated 10/25/25 at 10:30 A.M. authored by RN #106 revealed Resident #50 was in his room and a Certified Nursing Assistant (CNA) saw another resident heading towards Resident #50's room. Resident #50 yelled for Resident #51 to get out of his room. The CNA yelled for the nurse because Resident #50 and #51 were fighting. Resident #50's family was notified and came to the facility to sit with Resident #50. As needed Ativan was administered but had no effect. Record review revealed no evidence of any type of non-pharmacological approach/interventions to address the residents' behavior health care needs at this time and/or to prevent additional altercations between the residents. A health status note dated 10/25/25 at 3:53 P.M. authored by RN #106 revealed she was at the nurse's station when she heard a resident yelling to get away. A CNA yelled they needed help. When the nurse arrived at the dining room, Resident #51 was leaning over the recliner holding onto another resident's (#16) shirt and the CNA was trying to get Resident #51 to let go. Resident #51 was placed on 15-minute checks and staff were advised that Resident #51 needed to be one-on-one when out of his room. Record review revealed no evidence of any type of non-pharmacological approach/interventions to address the resident's behavioral health care needs and/or mood problems.Review of new orders received on 10/28/25 revealed an order to stop Resident #50's as needed and scheduled Ativan and to start Klonopin (a benzodiazepine used for anxiety) 0.25 mg twice a day and Klonopin 0.25 mg every day as needed. Record review revealed no evidence of any type of non-pharmacological approach/interventions to address the resident's behavioral health care needs and/or mood problems. Review of a health status note dated 10/29/25 at 5:40 A.M. authored by LPN #124 revealed Resident #50 had been pacing, yelling, and wandering. One-on-one, multiple interventions, and redirection were not effective. However, the note did not include what the interventions were and/or why they were not effective.Review of a health status note dated 10/30/25 at 6:09 P.M. authored by RN #106 revealed Resident #50 was agitated and angry all shift. Resident #50 was yelling and slamming chairs and doors. Resident #50 kept coming to the nurses' station and yelling at another resident. Record review revealed no evidence of any type of non-pharmacological approach/interventions to address the resident's behavioral health care needs and/or mood problems.Review of a health status note dated 11/01/25 at 3:41 P.M. authored by RN #103 revealed Resident #50 was very agitated, verbally aggressive, and threatening towards staff and other residents. Record review revealed no evidence of any type of non-pharmacological approach/interventions to address the resident's behavioral health care needs and/or mood problems.Review of new orders received from psychiatric services revealed to stop Resident #50's current scheduled and as needed Klonopin and start Klonopin 0.5 mg twice a day and Klonopin 0.5 mg daily as needed. Review of a health status note dated 11/07/25 at 6:49 A.M. authored by LPN #124 revealed Resident #51 was up wandering into rooms and rearranged chairs in the dining room. Record review revealed no evidence of any type of non-pharmacological approach/interventions to address the resident's wandering and/or to prevent resident to resident altercations at this time. Review of a health status note dated 11/09/25 at 12:00 A.M. authored by RN #108 in both Resident #50 and #51's chart revealed a loud noise was heard down the hall from the nurse's station. A CNA opened the door to Resident #50's room and called for assistance. Resident #50 was standing in the middle of the room beside a recliner that was flipped upside down. Resident #51 was observed lying on the floor in the doorway with moderate facial bleeding, a swollen and discolored left eye, and a laceration to the right scalp. Residents #50 and #51 were both transferred to the hospital for evaluation. Review of an SRI dated 11/09/25 at 1:57 A.M. revealed Resident #50 hit Resident #51. Staff heard a commotion and (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	found Resident #51 had wandered into Resident #50's room. While in the room, Resident #50 hit Resident #51 in the face. Resident #51 had bruises on his face and Resident #50 had bruised knuckles. Resident #50 and Resident #51 returned from the hospital and were placed on increased supervision. Record review revealed no evidence of any type of non-pharmacological approach/interventions to address the residents' behavioral health care needs and/or mood problems or to prevent resident to resident altercations.Review of a health status note dated 11/09/25 at 5:30 A.M. authored by RN #108 revealed Resident #51 returned from the hospital. Resident #51's left eye laceration was glued, and instructions included for the resident to return to the hospital if there was any change in level of consciousness. Review of a hospital encounter summary dated 11/09/25 for Resident #51 revealed emergency medical technicians reported Resident #51 was sitting on the floor after getting into an altercation with another resident. Resident #51 had facial abrasion and ecchymosis and swelling to left face, eye, and ear. History of present injury revealed Resident #51 wandered into another resident's room and was involved in a physical assault. It was not known by emergency medical services if Resident #51 lost consciousness. Resident #51 arrived with significant facial trauma with periorbital swelling on the left. The hospital visit noted diagnoses included closed head injury and laceration of head without foreign body. Review of a health status note dated 11/09/25 at 8:00 A.M. authored by RN #106 revealed psychiatric services were notified of the incident between Resident #50 and Resident #51. Psychiatric services felt Resident #50 needed to be sent out to have medications adjusted. A pink slip (legal process for involuntary psychiatric commitment, allowing for emergency hospitalization of individuals who may pose a danger to themselves or others due to mental illness) was issued for Resident #50. The decision was made after talking with psychiatric services, the Director of Nursing (DON), and the Assistant Director of Nursing (ADON) to ensure the safety of all residents.Review of an intradisciplinary team (IDT) note dated 11/09/25 at 10:59 A.M. authored by the DON revealed Resident #51 was involved in an incident on 11/09/25 with another resident. Resident #51 had bruising to face and right thigh. Resident #51 was a wanderer and had wandered into another resident's room. Resident #51 had bruising to facial area and right thigh. A door alarm was ordered to alert staff when Resident #51 exited his room. Review of a psychiatric note dated 11/09/25 revealed an emergency tele-psychiatric assessment was completed for Resident #50. When Resident #50 was questioned about his right hand being wrapped in an ace bandage, the resident could not recall what happened. Despite multiple medication changes, Resident #50 continued to be verbally and physically aggressive with staff and other residents. Resident #50 had been sent to the emergency department twice for behaviors. Resident #50 was sent to the hospital on the night of 11/08/25 for punching another resident and returned with an ace wrap to right hand due to a contusion. Staff report Resident #50 experienced visual hallucinations which escalated his agitation and aggression. Resident #50's routinely disagreed with medication adjustments to manage visual hallucinations and aggression. Resident #50 posed a threat to others and required admission to an inpatient behavioral health hospital. An application for emergency admission was sent to the hospital, and staff were asked to continue close monitoring of Resident #50 until he could be transferred out. Review of a health status note dated 11/09/25 at 1:31 P.M. authored by RN #106 revealed Resident #51 was very lethargic. The resident's face was very swollen, and the resident had a hard time opening his mouth to eat, was unsteady on his feet and had to be walked to his room. Review of a health status note dated 11/09/25 at 6:15 P.M. authored by RN #106 revealed Resident #51 had been in bed sleeping most of the day. Resident #51 would answer some yes or no questions but would not open his eyes and moaned with care. The resident ate only 25-percent of his mashed potatoes at dinner. Review of a wound observation form dated 11/10/25 revealed Resident #51 had a laceration to the top of his scalp that measured two centimeters (cm) long by 0.2 cm wide. Resident #51 also had bruising to his entire face and scattered scratches. Review of a psychosocial note dated 11/11/25 at 4:40 P.M. revealed a thirty-day discharge notification was sent to Resident #50's family. Review of a health status note dated 11/12/25 at 6:57 A.M. authored by LPN #124 revealed Resident (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	#51 continued to wander the unit and enter multiple rooms. Resident #51's left eye remained swollen and was dark purple in color. Record review revealed no evidence of any type of non-pharmacological approach/interventions to address the resident's wandering and/or to prevent resident to resident altercations at this time. Review of a health status note dated 11/15/25 at 1:29 P.M. authored by RN #104 revealed Resident #51 remained in his room more than normal and was beginning to self-isolate. Resident #51 moaned and had facial grimacing with incontinence care and repositioning in bed. Review of a health status note dated 11/18/25 at 3:06 P.M. authored by RN #106 revealed Resident #51 had a dark purple bruise from right lateral hip to knee. The note included the bruise was from an incident on 11/09/25 and was getting darker in color. Review of the quarterly MDS assessment dated [DATE] revealed Resident #51's cognition was not assessed. Resident #51 had behaviors not directed towards others, rejected care, and wandered daily. Review of a subsequent discharge MDS dated [DATE] revealed Resident #51 had severely impaired cognition. Physical behavior towards others occurred four to six days. Verbal behaviors towards others and behavioral symptoms not directed towards others occurred one to three days. Resident #51 rejected care four to six days and wandered daily.An interview on 03/18/26 at 8:43 A.M. with RN #106 revealed staff on the behavior unit redirected residents with behaviors as best they could. RN #106 stated psychiatric services were contacted when residents had behaviors. An interview on 03/19/26 at 8:12 A.M. with Social Services #141 verified Resident #50 was pink slipped and went to a psychiatric hospital as a result of an altercation. The facility did also issue a 30-day notice to Resident #50's family after the altercation with Resident #51 on 11/09/25. An interview on 03/19/26 at 1:20 P.M. revealed the Director of Nursing (DON) verified there was an incident on 10/13/25 and 10/17/25 between Resident #50 and #51. The DON revealed SRI tracking number 266519 was for the incident on 10/17/25 but entered the wrong occurrence date (10/13/25) when the SRI was submitted.An interview on 03/19/26 at 1:07 P.M. with the DON revealed staff were to be trained upon hire and annually for Alzheimer's disease, behaviors, caring for those with cognitive impairment, de-escalation techniques, and managing aggressive behaviors. The DON stated managing behaviors was also discussed at all staff meetings. An interview on 03/19/26 at 1:44 P.M. with RN #106 revealed Resident #50 had explosive episodes. RN #106 revealed Resident #50 and #51 did not like each other and staff were to try to keep the residents separated. RN #106 stated she had suggested moving Resident #51, but there was not an empty room to move Resident #51 to. RN #106 stated she kept saying Resident #50 needed help did not believe Resident #50's daughter was receptive to medications and did not want Resident #50 sent out for inpatient psychiatric services. RN #106 stated the staff on the behavior unit just learned residents and what interventions to put in place. RN #106 stated she found out after Resident #50 was admitted he had gone after his granddaughter and a hospice staff member with a knife and that was why he was admitted to a nursing facility. RN #106 stated that music would sometimes help when Resident #50 had behaviors. An interview on 03/23/26 at 9:28 A.M. with the DON revealed the only empty room in November that Resident #51 could be moved to was next to Resident #50. The DON stated she felt it would be better to leave Resident #51 in room across the hall from Resident #50. The DON stated the altercations between Resident #50 and #51 occurred out in the common areas. Resident #50 and #51 would be fine and then suddenly have an aggressive outburst and unfortunately Resident #51 was the one who would receive injuries. The DON verified no new interventions had been put in place after Resident #50 and/or Resident #51 had behaviors other than increased or one-on-one supervision for a limited time. An interview on 03/23/26 at 12:53 P.M. with RN #104 revealed Resident #50 and #51 were redirected and had staff supervision to try to control behaviors. RN #104 revealed Resident #50 and #51 did not like each other. Review of the policy titled Dementia Care dated 12/08/25 revealed care plan goals would be achievable and the facility would provide resources necessary for the resident to be successful in meeting their goals. The care plan interventions would be related to each resident's individual symptomology and rate of dementia progression with the end result being noted improvement or maintained of the expected stable rate of (continued on next page)

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