

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366296	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
NAME OF PROVIDER OR SUPPLIER Cedars of Lebanon Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 102 East Silver Street Lebanon, OH 45036	

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)
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43062</p> <p>Based on medical record review, staff interview, resident interview, review of Emergency Medical Services (EMS) report, review of hospital records, review of witness statements, review of a facility Self-Reported Incident (SRI), and review of a facility policy, the facility failed to ensure a resident was free from staff-to-resident physical abuse. This resulted in Actual Harm when Resident #10 was physically abused by Stated tested Nursing Assistant (STNA) #101 who restrained the resident's arms against his chest causing numerous skin tears and contusions to the resident's arms and hands. Subsequently, Resident #10 was transferred to a local hospital where he was assessed and treated for injuries including, multiple skin tears, and contusions of the elbow and forearm. This affected one (#10) out of three Residents (#10, #12, and #25) reviewed for abuse. The facility census was 42.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #10 revealed the resident was admitted to the facility on [DATE]. Diagnoses included acute respiratory failure, chronic kidney disease, diabetes mellitus, history of tuberculosis (TB), quadriplegia, insomnia, muscle weakness, encephalopathy, and major depressive episode.</p> <p>Review of a facility document titled Annual State tested Nursing Assistant (STNA) Competency Checks dated 06/02/24, revealed STNA #101 was proficient/expert/highly skilled in abuse and neglect which included making sure the resident was safe and immediately reporting abuse.</p> <p>Review of the most recent Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #10 was mildly cognitively impaired. Resident #10 was dependent on staff for all activities of daily living (ADLs).</p> <p>Review of the SRI dated 07/28/24 at 11:54 A.M., revealed an allegation of physical abuse. Resident #10 reported STNAs were rough with him while getting the resident up from the bed to the chair. Resident #10 alleged STNAs #63 and #101 were rough while performing care on the resident when Resident #10 became agitated and attempted to hit and bite the staff members. The staff attempted to protect Resident #10 and themselves. The staff alerted the nurse to the situation after the incident occurred. Both aides were interviewed and suspended pending the results of the investigation. STNA #101 was agency, and the facility requested for her not to return to the facility. The facility completed their investigation and unsubstantiated the allegation of abuse.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the After Visit Summary (AVS) emergency room (ER) record dated 07/28/24, revealed Resident #10 arrived in the ER at 2:38 P.M. via the local Fire Department with a complaint of an alleged assault from the Skilled Nursing Facility (SNF) where the resident resides at. Resident #10 reported the aide who provided care for him lost her mind and held him down by his arms and scratched him. Resident #10 voiced complaints of pain to his bilateral forearms and was noted with open skin tears to the back of the resident's hand. Resident #10 stated the aides at the nursing home attacked him and squeezed his arms tight and used their fingernails on his arms. The assessment indicated both of the resident's hands and forearms were discolored and seeping blood. Resident #10 had x-rays performed with no abnormalities. Resident #10 was diagnosed with multiple skin tears, and contusion of the elbow and forearm and discharged back to the facility.</p> <p>Review of a nurse's progress note for Resident #10 dated 07/28/24 at 3:29 P.M. and authored by Licensed Practical Nurse (LPN) #58, revealed she heard Resident #10 yelling he was abused. LPN #58 observed seven skin tears on both arms and the right elbow. Resident #10 stated they grabbed his arms and held them. When questioned, the aides reported Resident #10 tried to grab them, hit them, and bite them. LPN #58 questioned why the aides did not stop providing care and get help. Resident #10 has seven skin tears on both arms and right elbows and the aides were sent home pending an investigation.</p> <p>Review of a nurse's progress note dated 07/28/24 at 3:30 P.M. (recorded as a late entry) and authored by the Director of Nursing (DON), revealed on 07/28/24 at 11:31 A.M., the charge nurse indicated Resident #10 had reported his arms were held down by a STNA. The management staff advised the charge nurse to follow the facility's protocol. The Guardian was notified at 1:48 P.M. of the resident's complaints of bruising to bilateral arms with skin tears and the accusations of the STNA. The DON indicated she had consulted the physician, and he ordered for the resident to be seen by the wound Nurse Practitioner (NP) the next day. The DON indicated the resident wanted to go the hospital; however, the guardian requested for the resident to remain in the facility and be followed by the wound nurse on Monday. The DON indicated the physician had not given an order, but they would have to follow protocol.</p> <p>Review of the EMS report dated 07/28/24 at 4:27 P.M., revealed Resident #10 had injuries to his upper extremities due to an assault. Resident #10 told the EMS crew that he was assaulted by his nursing home aides. Resident #10 stated the staff grabbed him and shook him around in his bed. Resident #10 stated the aides used their fingernails to dig into his skin and cut him. Resident #10 was found lying in his bed and was alert, oriented to person, place, time, and event. Resident #10 had bilateral bruising and abrasions on his forearms and hands. Resident #10 complained of neck and back pain. Resident #10 was transported to the hospital.</p> <p>Review of the Interdisciplinary Team (IDT) Post Investigation Summary dated 07/28/24 and authored by the DON, revealed the DON received a phone call from LPN #58 on 07/28/24 indicating Resident #10 made allegations against the aides who were caring for him. Resident #10 had multiple skin tears on bilateral arms and bruising. The STNAs were removed from resident care and statements were obtained. Resident #10 was being assisted up when his Foley catheter fell and as the aide reached to grab it, the resident's head hit the wall. Resident #10 became upset, cussing and started fighting with the staff by swinging, hitting and trying to bite. The charge nurse provided first-aid to the resident and the resident was sent to the ER. Resident #10 returned back to the facility on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a witness statement by Resident #10 dated 07/28/24 and narrated by Social Services Director #61, revealed the agency aide (identified as STNA #101) grabbed the resident and dug her fingernails into his arms. The STNA crossed the resident's arms and pulled them until it felt like they were coming out of socket. Resident #10 was yelling for STNA #63 to help him and STNA #63 said there was nothing wrong. The STNA ripped his shirt off and got blood on the resident's clothes. Resident #10 indicated the aides tried to clean his arms with wipes which was burning and caused unbearable pains.</p> <p>Review of a witness statement from STNA #101 dated 07/28/24, revealed her and an aide (identified as STNA #63) were getting ready to get Resident #10 up and as they were turning him on his side, the resident said they were pulling on his catheter too hard, so she picked it up and put it on the bed. Resident #10 started cussing at them and tried to bite her several times and the resident broke his skin open with the Hoyer lift. STNA #101 indicated they let him calm down then STNA #63 took the resident out to smoke. STNA #63 noted the nurse was notified and they did not hold, hit or restrain the resident.</p> <p>Review of a witness statement from STNA #63 dated 07/28/24, revealed she asked STNA #101 to help get Resident #10 up. STNA #63 noted as they rolled the resident over to put him on the Hoyer pad, the resident hit his head on the wall and got aggravated and immediately accused STNA #101 of abusing him. Resident #10 attempted to bite STNA #101 then STNA #101 held his arms down in order for him to not hurt the STNAs or himself. STNA #63 indicated she left the room to get gloves and when she returned, STNA #101 was still holding the resident's arms down. STNA #63 indicated she observed blood on the resident's arm but did not see any abuse, only the resident being restrained.</p> <p>Review of a witness statement from Housekeeping Manager #91 dated 07/28/24, revealed she was bringing a resident inside from a smoke break, when STNAs #101 and #63 were bringing Resident #10 out of his room. Resident #10 was yelling and crying for help and said he was abused and asked for her to get the nurse. Resident #10 was taken outside for a smoke break around 11:30 A.M. and LPN #58 was outside on the porch. Housekeeping Manager #91 indicated she came back in from a smoke break and called the Administrator and the DON. There was blood and skin tears visible.</p> <p>Review of an undated witness statement from LPN #58, revealed when Resident #10 came out to smoke, he was yelling that they abused him. Resident #10 was asking LPN #58 to look at him. LPN #58 observed skin tears, and the resident stated a STNA was holding him down and abused him. Resident #10 identified STNA #101 along with STNA #63. LPN #58 noted she questioned STNAs #101 and #63 on what happened. Both STNAs were saying the resident was trying to bite STNA #101 and he was swinging his arms around and cussing at them. LPN #58 removed STNAs #101 and #63, got their statements and called the DON.</p> <p>Review of a physician's progress note for Resident #10 dated 07/29/24, revealed the resident was seen for ongoing management of medical conditions including his arms. There was an alleged altercation between the aides and Resident #10 with an active investigation. Resident #10 had bilateral arm skin tears and monitor for signs of infection.</p> <p>Review of a wound NP progress note for Resident #10 dated 07/29/24, revealed the resident was seen for new skin tears to bilateral arms and right hand. Resident #10 was noted with skin tears and bruising to right hand, right forearm and left forearm.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with STNA #63 on 08/26/24 at 11:30 A.M., revealed she was assigned to care for Resident #10 on 07/28/24 when she asked STNA #101 for assistance with transferring Resident #10 from his bed to his geriatric (geri) chair (large reclining, padded chairs with wheeled bases, and are designed to assist persons with limited mobility) so he could go on a smoke break. STNA #63 stated Resident #10 became resistant to care and was swinging his arms and tried to bite STNA #101. STNA #63 stated STNA #101 had long fingernails and held Resident #10's arms down around the lower arms and wrist against the bed. STNA #63 stated she was shocked at what she saw and did not know what to do. STNA #63 stated Resident #10 was bleeding from his arms due to multiple open areas. STNA #63 stated they finished transferring Resident #10 to the geri-chair then took Resident #10 outside for a smoke break. STNA #63 stated the resident had blood covering both arms. STNA #63 reported she did not stop the incident when it occurred because at the time of the incident, she did not know what to do; however, she wishes she had just stopped and got a nurse. STNA #63 stated she took Resident #10 outside to the porch to smoke and did not report to the incident to anyone. STNA #63 stated when she got Resident #10 outside, STNA #69 who was assisting residents with the smoke break, noticed the blood all over the resident's arms and called for a nurse. STNA #63 confirmed she received training related to resident abuse and reporting abuse upon being hired in May 2024.</p> <p>Interview with the DON on 08/26/24 at 12:53 P.M., revealed she was contacted by the facility staff on 07/28/24 at 11:31 A.M. and was made aware of the allegations of abuse by Resident #10. The DON stated she did not feel the incident was an abuse situation due her thoughts of the STNAs were only attempting to keep the resident and themselves safe. The DON stated the facility staff did not call 911 immediately because they were waiting on a call back from the Guardian to determine if the resident needed to go the ER. The DON stated Resident #10 called 911 at 2:08 P.M. because he insisted on going to the ER. The DON stated the facility suspended STNA #63 and asked the agency for STNA #101 to be placed on the do not return list. The DON stated there was no abuse and she felt STNAs #63 and #101 were trying to keep Resident #10 safe by preventing Resident #10 from swinging his arms and hitting items. The DON confirmed the facility does not allow residents to be restrained even for safety reasons.</p> <p>Interview with STNA #69 on 08/26/24 at 2:52 P.M., revealed she worked on 07/28/24 on another unit. STNA #69 stated she was on the porch by the exit door on 07/28/24 during the 11:00 A.M. smoke break when she observed STNA #63 transporting Resident #10 to the porch for his smoke break. STNA #69 stated Resident #10 was bleeding from both arms and yelling the aides abused him. STNA #69 instructed STNA #63 to go straight to the break room and not to provide care to anyone because she needed to report this allegation as soon as possible. STNA #69 stated she called for the nurse who was also on the porch to report the abuse allegations and the bleeding on Resident #10's arms.</p> <p>Interview with Resident #10 on 08/26/24 at 3:23 P.M., revealed he was abused and the facility refused to call 911, so he called 911 on 07/28/24. Resident #10 stated a STNA (identified as STNA #101) crossed his arms and pushed his arms down against his chest making it hard to breath. Resident #10 stated the STNA held his arms and caused bruises and scratches on his arms.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with LPN #58 on 08/26/24 at 4:12 P.M., revealed she was the nurse assigned to care for Resident #10 on 07/28/24. LPN #58 stated STNAs #63 and #101 were not gentle when they repositioned Resident #10 in bed or when moving the resident's legs. LPN #58 stated she was not in the room at the time when the alleged abuse occurred; however, LPN #58 stated she was in the resident's room prior to the incident because STNAs #63 and #101 were bickering with Resident #10. LPN #58 stated she instructed STNAs #63 and #101 to do their jobs and stop bickering with Resident #10. LPN #58 stated at that time, she did not observe any blood or bruising on Resident #10's arms. LPN #58 stated she went from Resident #10's room to the porch outside to assist with the 11:00 A.M. smoke break. LPN #58 stated she observed STNA #63 assisting Resident #10 to the porch and then left him. LPN #58 stated Resident #10 was yelling that he was abused and when she looked up from the other end of the porch, she observed the blood on Resident #10's arms. LPN #58 stated the blood was smeared and appeared as though someone tried to clean it up. LPN #58 stated she was amazed at the amount of skin tears that Resident #10 had. LPN #58 stated witness statements were obtained from both STNA #63 and STNA #101. LPN #58 stated she contacted the DON, and she did not want Resident #10 sent out to the hospital or the police called. LPN #58 stated she was instructed to write in her report that Resident #10 was swinging his arms, which caused the injuries. LPN #58 stated she advised Resident #10 to contact the police if he wanted to go to the hospital and the resident called 911 himself.</p> <p>Review of electronic mail (e-mail) correspondence from the Administrator dated 08/29/24 at 10:30 A.M., revealed the facility notified the local Police Department, and the Police Department closed the case. The Administrator stated the facility did not press any charges against STNAs #63 or #101. The Administrator stated the facility identified an opportunity for education; however, does not feel that abuse occurred.</p> <p>Review of the personnel file for STNA #63, revealed she was hired on 05/29/24 and received training on resident abuse. STNA #63 had an active STNA license with no restrictions. There were no disciplinary actions or coachable moments identified in her record.</p> <p>Review of the facility policy titled, Abuse and Neglect Protocol, dated 09/24/18, revealed the residents have the right to be free from any form of abuse and this included, physical abuse, verbal abuse, and physical restraints. The policy indicated any individual who observed abuse or suspects abuse must immediately report such incident to the Director of Nursing (DON).</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00156392.</p>		