STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366296	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedars of Lebanon Care Center	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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43062 Based on record review, observation, resident interview, staff interview, and policy reviews, the facility failed to ensure residents were treated with dignity and respect. This affected three (#08, #38, and #29) of four residents reviewed for dignity and respect. The facility census was 44. Findings include, 1. Review of Resident #38's medical record an admitted [DATE], with diagnoses including: chronic kidney disease, diabetes mellitus (DM), chronic obstructive sleep apnea (COPD), history of tuberculosis, insomnia, anemia, and heart failure, and major depressive order. Review of the Minimum Data Set (MDS) assessment dated , 09/12/24, revealed Resident #38 was cognitively impaired. Further review of the MDS assessment revealed Resident #38 was dependent on staff for medication administration, eating, oral hygiene, toileting, bathing, and dressing. Observation and interview on 10/15/24 at 10:52 A.M., revealed State tested Nurse Aide (STNA) #900 verified Resident #38 was seated in his chair. STNA #900 verified Resident #38's sweatshirt had dried food substance and crumbs all over it. Resident #39's fingernails were soiled with unknown black substance under his nails. STNA #900 also verified Resident #38's hands and fingers were stained with an unknown brown substance all over them. STNA #900 stated the morning shift did not provide Resident #38 with a clothing protector at breakfast and that was why Resident #38 had crumbs and food stains all over his shirt. Review of the policy titled, Quality of Life-Dignity, dated August 2009, verified each Resident shall be cared for in a manner that promote and enhanced quality of life, dignity, respect, and individuality. Further review of the policy revealed residents will be treated with dignity and respect at at all times. 44083 2. Review of Resident #8's medical record revealed an admitted [DATE]. Diagnoses for Resident #8 included: schizophrenia, depressive disorder and alcoholic induced cirrhosis. Review of the Minimum Data Set, (MDS) comprehensive assessment dated [DATE] revealed the resident had intact cognition and required supervision with dining and meal service. The resident received a No Added Salt regular consistency diet. (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: 366296	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/17/2024

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Cedars of Lebanon Care Center	102 East Silver Street Lebanon, OH 45036

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 10/16/24 at 7:50 A.M., of the breakfast meal in the dining room revealed Resident #8 sitting at a table with Resident#15. Resident #15 was feeding himself the breakfast meal. Resident #8 was observed to become increasing agitated with vocalizations and asking State tested Nurse Aide (STNA) #500 why he was not being served. STNA #500 repeatedly notified the kitchen staff of the need to provide Resident #8 the meal. After Resident #8 waited from 7:50 A.M. to 8:02 A.M., and several other residents at other tables being served, Resident #8 received his meal tray. Resident #8 received a plastic spoon and threw the spoon across the table, stating he would not eat with the plastic spoon. STNA #500 requested metal silverware spoon from the kitchen. Observation on 10/16/24 at 8:10 A.M., revealed Diet Manager, (DM) #800 requested metal silverware instead of plastic ware from [NAME] #810. [NAME] #810 stated the kitchen had run out of silverware spoons to provide for residents at the end of the meal service. Interview on 10/16/24 at 8:15 A.M., with STNA #500 verified Resident #8 waited for over 10 minutes to receive his meal tray while Resident #15 consumed the meal at the same table, which resulted in increased agitation form Resident #8. STNA #500 verified she had attempted to request the meal tray sooner, but the kitchen staff had not prepared the tray. STNA #500 verified Resident #8 received a plastic ware spoon which further increased his agitation. STNA #500 stated many residents, during many meals, receive plastic ware near the end of meal service, which results in agitation. 3. Review of Resident #29's medical record revealed an admitted [DATE]. Diagnoses for Resident #29 included: protein calorie malnutrition, and anxiety. Review of the Minimum Data Set, (MDS) comprehensive assessment dated [DATE] revealed the resident had moderately impaired cognition and received low concentrated sugar and no added salt diet and required supervision for meal service. Interview on 10/15/24 at 1:53 P.M., with Resident #29 stated he often received plastic ware at meals and resulted in increased anxiety. He preferred silverware for meal service and stated he asked for silverware and did not receive it. Interview on 10/16/24 at 8:20 A.M., with DM #800 verified the kitchen had no silverware spoons at the end of meal service and plastic ware has been used. The DM #800 verified residents sitting at a table together should be served at the same time. Review of the policy titled, Dining Room Audits, dated October 2017, revealed residents at each table will be served together. Foods will be served in a homelike setting.

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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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44083 Based on medical record review, census review, resident interview, staff interview, and policy review, the facility failed to ensure residents or resident's representatives were notified of room changes. This affected four residents, (#4, #11, #19 and #146) of four residents reviewed for room change notification. The facility total census was 44. Findings include: Review of the faciliy census dated 10/03/24 revealed Resident #4, #11 and #146 resided in the same room. 1. Review of Resident #4's medical record revealed an admitted [DATE]. Diagnoses for Resident #4 included: Schizophrenia, bipolar disease, diabetes, and Parkinsonism. Review of the Minimum Data Set, (MDS) comprehensive assessment, dated 07/9/24, revealed the resident had moderately impaired cognition and required supervision with ambulation. The resident received antipsychotic medication due to delusion and aggression due to schizophrenia. Review of notes dated 10/03/24 at 6:23 P.M., revealed Resident #4 and Resident #146 had a physical altercation. Review of Room Changed Notification Assessment documentation dated 10/07/24 revealed Resident #4's reason for room change made on 10/07/24 was to promote resident safety. There was no documentation the resident or representative were offered an explanation of the reason for the move and opportunity to see the new location and ask questions regarding the move. Interview on 10/17/24 at 10:33 A.M., with Resident #4 stated she did not have anyone explain to her why she was moved. 2. Review of Resident #11's medical record revealed an admitted [DATE]. Diagnoses for Resident #11 include chronic kidney disease, dementia, depression, anxiety, and Parkinson disease. Review of the Minimum Data Set, (MDS) comprehensive assessment dated [DATE] revealed the resident had intact cognition. Review of Room Changed Notification Assessment documentation dated 10/07/24 revealed Resident #11's reason for room change made on 10/07/24 was to promote resident safety. There was no documentation the resident or representative were offered an explanation of the reason for the move and opportunity to see the new location and ask questions regarding the move. Interview on 10/1/24 at 9:20 A.M., with Resident #11 stated she did not have anyone talk to her as to why she was moved. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Cedars of Lebanon Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 102 East Silver Street Lebanon, OH 45036	

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of Resident #146s medical record revealed an admitted [DATE]. Diagnoses for Resident #146 included: schizoaffective disorder, and schizophrenia bipolar type. Review of the Minimum Data Set, (MDS) comprehensive assessment dated [DATE] revealed the resident had intact cognition. The resident had a court appointed guardian. Review of notes dated 10/03/24 at 6:23 P.M., revealed Resident #4 and Resident #146 had a physical altercation. Review of Room Changed Notification Assessment documentation dated 10/07/24 revealed Resident #146 reason for room change made on 10/07/24 was to promote resident safety. There was no documentation the resident or representative were offered an explanation of the reason for the move and opportunity to see the new location and ask questions regarding the move. Interview on 10/16/24 at 2:05 P.M., with Social Service Designee (SSD) #175 verified Residents #4 and #146 had a physical altercation on 10/03/24. Resident #146 was hospitalized on [DATE] and returned to the facility on [DATE]. SSD #175 verified the documentation and room change notices were dated 10/07/24. There was no documentation the residents or the residents' representative were notified of the reason of the room moves, and provided an opportunity to ask questions regarding the room moves for Residents #4, #11 and #146. 43062 4. Review of Resident #19's medical record revealed an admitted [DATE]. Her diagnoses included, chronic obstructive pulmonary disease (COPD), diabetes mellitus (DM), hypothyroidism, schizoaffective disorder, bipolar type, congestive heart failure (CHF), and insomnia, Review of the Minimum Data Set (MDS) assessment for Resident #19, dated 07/22/24, revealed Resident #09 was cognitively impaired. Further review of the MDS assessment revealed Resident #19 was dependent on staff for medication administration. Resident #19 required supervision from staff with eating, oral hygiene, toilet use, dressing, and personal hygiene. Review of Resident #19's progress notes dated, 10/06/24, revealed Resident #19 has done well with a recent room change. Review of the facility report titled, Room move notification, dated 10/06/24, was opened and not completed. It was left blank. Interview on 10/16/24 at 2:59 P.M., with State tested Nurse Aide (STNA) #500, verified Resident #19 was moved with several other residents related to the need to move residents for new admissions to the facility. STNA #500 verified Resident #19's move was for about twelve hours because she had to move her back. Interview on 10/16/24 at 4:05 P.M., with the Social Service Director (SSD) #175, verified Resident #19 had a room move on 10/06/24 for about twelve hours and then returned to her original room. SSD #175 verified she has no documentation to confirm the resident, resident roommates, or family were notified of the room change. (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the undated policy titled Room Change / Roommate Assignment revealed prior to the changing a roommate or roommate assignment , all parties involved the change, including resident and their representative, will be given a 24 hours advance notice unless medically necessary for the safety of the resident. The notice will include why the change is being made and information that will assist the roommate with the room and/or roommate change.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43062 Based on medical record review, Self-Reported Incident report review, resident interviews, staff interviews, and policy review, the facility failed to report allegations of resident to resident physical abuse and allegation of sexual abuse by unknown person, to the state agency. This affected two (#06 and #19) of four residents reviewed for potential abuse. The facility census was 44. Findings include: 1. Review for Resident #06's medical record revealed an admitted [DATE]. Her diagnoses included, cerebral palsy, major depressive disorder, schizoaffective disorder, personality disorder, essential hypertension, hyperlipidemia, hypothyroidism, hallucinations, hypothyroidism, diabetes mellitus (DM), schizophrenia, anxiety disorder, anemia, and insomnia. Review of Resident #06's most recent Minimum Data Set (MDS) assessment, dated 10/04/24, revealed she had impaired cognition. Further review of the MDS assessment revealed Resident #06 was dependent on staff for medication administration, lower body dressing, and bathing. Resident #06 required maximum assistance from staff with oral hygiene and toilet use. She required supervision from staff with eating. Review of Resident #06's care plans, dated 04/17/23 revealed Resident #06 has potential for disturbance of mood/behavior, altered concept of reality, delusions and/or hallucinations related to diagnosis of schizophrenia. Resident #06's behavior care plan revealed she was care planned for being accusatory, and can be sexually inappropriate at times. Review of Resident #06's progress notes revealed on 10/10/24, Resident #06 was noted to have a bruised on her right knee. Resident #06 stated one of the kids pushed her and she hit her knee. No other documentation related to the incident was identified. Review of the facility interdisciplinary team (IDT) investigation, dated 10/10/24, revealed Resident #06 had a noted discoloration area to her right knee. Resident #06 stated she had been pushed into a door from the little kids and then she stated that it was one of her roommates that had pushed her in the chair out of the way. The intervention was listed as: Resident #06 was reminded to not stop in center of the room. The IDT post summary stated: Resident #06 was noted to have a discoloration on her knee. At initial time, she had stated she had been pushed by the kids. Resident #06 stated she wanted to lay down and told the staff she was pushed by her roommate and ran into something. Two nurses assessed Resident #06. An interview was attached from Resident #19 who stated she did not know she pushed Resident #06 into the door. Interview on 10/15/24 at 9:28 A.M., with Resident #06 revealed Resident #06 she was raped by three men while on an outing. Resident #06 stated the men that raped her lived at the facility, however, the incident of rape occurred during the outing on the bus. Resident #06 became tearful and stated she told her guardian about alleged rape. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and observation on 10/15/24 at 9:30 A.M., reveled Resident #06 was sitting on the side of her bed with her legs hanging off the edge of the bed. Resident #06 had a large black and purple bruise on her right knee with various colors of green, and brown. Resident #06 stated her roommate (identified as Resident #19) pushed her into the bathroom door and it resulted with a large bruise on her right knee. Resident #06 verified she reported the incident to the night nurse. Interview on 10/15/24 at 9:57 A. M., with the Director of Nursing revealed she had no knowledge of Resident #06's allegation of sexual abuse. The DON stated Resident #06 can be delusional and stated Resident #06 has not been on an outing. The DON reported it was not unusual for Resident #06 to make statements that were not accurate and is care planned for her delusional behavior. Interview on 10/16/24 at 2:59 P.M., with State tested Nurse Aide (STNA) #500 verified she assisted Resident #06 to bed on 10/10/24 after dinner. STNA #500 stated Resident #06 reported to STNA #500 that her roommate (Resident #19) pushed her into the door and caused her to hit her knee and if left a bruise. STNA #500 stated she reported to the two nurses on duty and STNA #500 observed the two nurses question Resident #06 about the incident. STNA #500 verified Resident #06's roommate Resident #19 remain in the same room together. Interview on 10/16/24 at 4:11 P.M. ,with Resident #19 (Resident #06's roommate) verified she pushed Resident #06 into the door and caused the bruise on her right knee. Resident #19 explained that Resident #06 continued to roll Resident #06's wheelchair into Resident #19's area of the room. Resident #19 snarled her face and stated Resident #19 pushed Resident #06's wheelchair into the bathroom door. Interview on 10/16/24 at 5:00 P.M., with the Director of Nursing (DON) stated she interviewed Resident #19 and Resident #19 was unable to state what happened. The DON stated Resident #06 told the staff on 10/10/24 that a child pushed her in her wheelchair and this resulted in bruise on her knee. The DON stated Resident #06 told her that a lady tried to move her out of the room and her leg got bumped. The DON verified the facility failed to complete a thorough investigation and is unable to state what truly happened including if Resident #06's bruised knee is a bruise of unknown origin or an abuse situation. Review of the report titled, Weekly Skin Assessment, dated 10/16/24 and signed on 10/17/24, revealed Resident #06 had a bruise to her right front knee that measured 7.0 centimeters (CM) in length, and 6.0 cm in width, and zero depth. The medical record contained no evidence of the bruise being assessed from 10/10/24 to 10/17/24. Review of the Self Reported Incidents on 10/16/24 at 10:00 A.M., revealed the facility failed to report an allegation of unknown origin/physical abuse for the bruise identified on 10/10/24 or an allegation of sexual abuse related to Resident #06's allegation of abuse on 10/16/24 at 9:28 A.M. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/17/24 at 7:55 A.M., with the Administrator verified she investigated the incident on of the unknown bruise 10/16/24 (even though it was documented on 10/10/24) and it revealed Resident #19 reported to her that she pushed Resident #06 into the door. The Administrator reported Resident #19 told her that she pushed Resident #06 into the door because Resident #06 continued to go into Resident #19's side of the room. The Administrator stated Resident #19 stated she would not do it again and that is why she remains in the same room with Resident #06. The Administrator revealed she did not investigate and report the incidents because she would be investigating and reporting incidents up to ten times per day. The Administrator revealed she discussed Resident #06's allegation of sexual abuse with the Director of Nursing (DON) and the DON decided she did not feel the sexual abuse allegation was an allegation that required a complete investigation or required the facility to complete a Self Reported Incident (SRI) investigation. The Administrator stated the DON determined this by the boxes that she checked on the facility abuse form. Interview on 10/17/24 at 1:56 P.M., interview with the Assistant Director of Nursing (ADON) #308 verified the facility did not complete a head to toe assessment following the sexual abuse allegation on 10/15/24. ADON #308 verified the only assessment of the knee injury identified on 10/10/24 was the skin assessment completed on 10/16/24. ADON #308 stated the doctor was notified on 10/10/24, however, ADON #308 was unable to provide documentation verification. Review of the policy titled, Abuse and Neglect Protocol, dated 06/13/21, revealed it was the responsibility of the employees, facility consultants, family members, and visitors to promptly report any incident or suspected incident of neglect or resident abuse, including origins of unknown injuries. The facility policy stated the facility residents have the right to be free from abuse. The facility policy stated, All reports of resident abuse, neglect, and injuries of unknown source shall be promptly and thoroughly investigated by facility management,

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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** 43062 Based on medical record review, Self-Reported Incident report review, resident interviews, staff interviews, and policy review, the facility failed to thoroughly investigate allegations of resident to resident physical abuse and allegation of sexual abuse by unknown person. This affected two (#06 and #19) of four residents reviewed for potential abuse. The facility census was 44. Findings include: 1. Review for Resident #06's medical record revealed an admitted [DATE]. Her diagnoses included, cerebral palsy, major depressive disorder, schizoaffective disorder, personality disorder, essential hypertension, hyperlipidemia, hypothyroidism, hallucinations, hypothyroidism, diabetes mellitus (DM), schizophrenia, anxiety disorder, anemia, and insomnia. Review of Resident #06's most recent Minimum Data Set (MDS) assessment, dated 10/04/24, revealed she had impaired cognition. Further review of the MDS assessment revealed Resident #06 was dependent on staff for medication administration, lower body dressing, and bathing. Resident #06 required maximum assistance from staff with oral hygiene and toilet use. She required supervision from staff with eating. Review of Resident #06's care plans, dated 04/17/23 revealed Resident #06 has potential for disturbance of mood/behavior, altered concept of reality, delusions and/or hallucinations related to diagnosis of schizophrenia. Resident #06's behavior care plan revealed she was care planned for being accusatory, and can be sexually inappropriate at times. Review of Resident #06's progress notes revealed on 10/10/24, Resident #06 was noted to have a bruised on her right knee. Resident #06 stated one of the kids pushed her and she hit her knee. No other documentation related to the incident was identified. Review of the facility interdisciplinary team (IDT) investigation, dated 10/10/24, revealed Resident #06 had a noted discoloration area to her right knee. Resident #06 stated she had been pushed into a door from the little kids and then she stated that it was one of her roommates that had pushed her in the chair out of the way. The intervention was listed as: Resident #06 was reminded to not stop in center of the room. The IDT post summary stated: Resident #06 was noted to have a discoloration on her knee. At initial time, she had stated she had been pushed by the kids. Resident #06 stated she wanted to lay down and told the staff she was pushed by her roommate and ran into something. Two nurses assessed Resident #06. An interview was attached from Resident #19 who stated she did not know she pushed Resident #06 into the door. Interview on 10/15/24 at 9:28 A.M., with Resident #06 revealed Resident #06 she was raped by three men while on an outing. Resident #06 stated the men that raped her lived at the facility, however, the incident of rape occurred during the outing on the bus. Resident #06 became tearful and stated she told her guardian about alleged rape. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and observation on 10/15/24 at 9:30 A.M., reveled Resident #06 was sitting on the side of her bed with her legs hanging off the edge of the bed. Resident #06 had a large black and purple bruise on her right knee with various colors of green, and brown. Resident #06 stated her roommate (identified as Resident #19) pushed her into the bathroom door and it resulted with a large bruise on her right knee. Resident #06 verified she reported the incident to the night nurse. Interview on 10/15/24 at 9:57 A. M., with the Director of Nursing revealed she had no knowledge of Resident #06's allegation of sexual abuse. The DON stated Resident #06 can be delusional and stated Resident #06 has not been on an outing. The DON reported it was not unusual for Resident #06 to make statements that were not accurate and is care planned for her delusional behavior. Interview on 10/16/24 at 2:59 P.M., with State tested Nurse Aide (STNA) #500 verified she assisted Resident #06 to bed on 10/10/24 after dinner. STNA #500 stated Resident #06 reported to STNA #500 that her roommate (Resident #19) pushed her into the door and caused her to hit her knee and if left a bruise. STNA #500 stated she reported to the two nurses on duty and STNA #500 observed the two nurses question Resident #06 about the incident. STNA #500 verified Resident #06's roommate Resident #19 remain in the same room together. Interview on 10/16/24 at 4:11 P.M. ,with Resident #19 (Resident #06's roommate) verified she pushed Resident #06 into the door and caused the bruise on her right knee. Resident #19 explained that Resident #06 continued to roll Resident #06's wheelchair into Resident #19's area of the room. Resident #19 snarled her face and stated Resident #19 pushed Resident #06's wheelchair into the bathroom door. Interview on 10/16/24 at 5:00 P.M., with the Director of Nursing (DON) stated she interviewed Resident #19 and Resident #19 was unable to state what happened. The DON stated Resident #06 told the staff on 10/10/24 that a child pushed her in her wheelchair and this resulted in bruise on her knee. The DON stated Resident #06 told her that a lady tried to move her out of the room and her leg got bumped. The DON verified the facility failed to complete a thorough investigation and is unable to state what truly happened including if Resident #06's bruised knee is a bruise of unknown origin or an abuse situation. Review of the report titled, Weekly Skin Assessment, dated 10/16/24 and signed on 10/17/24, revealed Resident #06 had a bruise to her right front knee that measured 7.0 centimeters (CM) in length, and 6.0 cm in width, and zero depth. The medical record contained no evidence of the bruise being assessed from 10/10/24 to 10/17/24. Review of the Self Reported Incidents on 10/16/24 at 10:00 A.M., revealed the facility failed to report an allegation of unknown origin/physical abuse for the bruise identified on 10/10/24 or an allegation of sexual abuse related to Resident #06's allegation of abuse on 10/16/24 at 9:28 A.M. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/17/24 at 7:55 A.M., with the Administrator verified she investigated the incident on of the unknown bruise 10/16/24 (even though it was documented on 10/10/24) and it revealed Resident #19 reported to her that she pushed Resident #06 into the door. The Administrator reported Resident #19 told her that she pushed Resident #06 into the door because Resident #06 continued to go into Resident #19's side of the room. The Administrator stated Resident #19 stated she would not do it again and that is why she remains in the same room with Resident #06. The Administrator revealed she did not investigate and report the incidents because she would be investigating and reporting incidents up to ten times per day. The Administrator revealed she discussed Resident #06's allegation of sexual abuse with the Director of Nursing (DON) and the DON decided she did not feel the sexual abuse allegation was an allegation that required a complete investigation or required the facility to complete a Self Reported Incident (SRI) investigation. The Administrator stated the DON determined this by the boxes that she checked on the facility abuse form. Interview on 10/17/24 at 1:56 P.M., interview with the Assistant Director of Nursing (ADON) #308 verified the facility did not complete a head to toe assessment following the sexual abuse allegation on 10/15/24. ADON #308 verified the only assessment of the knee injury identified on 10/10/24 was the skin assessment completed on 10/16/24. ADON #308 stated the doctor was notified on 10/10/24, however, ADON #308 was unable to provide documentation verification. Review of the policy titled, Abuse and Neglect Protocol, dated 06/13/21, revealed it was the responsibility of the employees, facility consultants, family members, and visitors to promptly report any incident or suspected incident of neglect or resident abuse, including origins of unknown injuries. The facility policy stated the facility residents have the right to be free from abuse. The facility policy stated, All reports of resident abuse, neglect, and injuries of unknown source shall be promptly and thoroughly investigated by facility management,

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49771 Based on record review, form instruction review, staff interview, and policy review, the facility failed to ensure a Pre-Admission Screening and Resident Review (PASARR) was completed as required. This affected two (#15 and #01) of four residents reviewed for PASARR's. The facility census was 44. Findings include: 1. Review of the medical record revealed Resident #15 was admitted on [DATE], with current diagnoses of schizophrenia, malignant neoplasm base of tongue and dementia. Review of the Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #15 had moderate cognitive impairment and was frequently incontinent of bowel and bladder. The resident required supervision with eating, moderate assistance with oral hygiene, bed mobility and transfers and maximal assistance with toileting, bathing, dressing and personal hygiene. Review of Resident #15's Level of Care Determination completed by the Council on Aging of Southwestern Ohio, dated 07/12/12, revealed Resident #15 had no indications of serious mental illness nor a developmental disability. Review of Resident #15's medical record diagnoses revealed Resident #15 was assigned the diagnoses of paranoid schizophrenia on 05/03/13. Review of Resident #15's medical record revealed the PASARR designated as being for Resident #15 was a PASARR for another resident. Interview on 10/17/24 at 10:40 A.M., with Social Services Designee #175 verified the facility does not have a PASARR or Level II determination for Resident #15. 44083 2. Review of Resident #1's medical record revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #1 included schizophrenia, urogenital implants, overactive bladder, and dysfunction of bladder. Review of the Minimum Data Set, (MDS) comprehensive assessment dated [DATE] revealed the resident had intact cognition. Review of the Pre-Admission Screening and Resident Review, (PASRR), dated 07/23/18 revealed Resident #1 was approved for admission at a nursing facility. There were no further PASRR documents provided. Review of Resident #1's medical diagnoses documentation revealed the new diagnosis of paranoid schizophrenia was added on 01/25/19. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/16/24 at 2:05 P.M., Social Service Designee, (SSD) # 175 verified Resident #1 had a new diagnosis of paranoid schizophrenia on 01/25/19. SSD #175 stated there should have been a new PASRR completed for Resident #1 due to a new addition of a mental health diagnosis. Review of Ohio Department of Medicaid PASRR instructions, listed on the PASRR form, dated September 2019, revealed a new PASRR is to be completed for nursing facility residents who experience a significant change in condition. Review of the undated policy titled Admissions revealed a PASARR will be provided, as appropriate, to the facility prior to or upon the resident's admission to the facility.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 44083 Based on observation, medical record reviews, menu spread sheet review, policy review and staff interviews, the facility failed to prepare foods as planned by the Registered Dietitian. This affected four (#6, #15, #16 and #39) of four residents reviewed for pureed diets. The facility total census was 44. Finding include: Review of Residents #6, #15, #16 and #39's physician orders verified the residents were to receive a puree consistency diet. Review of the menu spreadsheet of the lunch meal revealed the puree residents were to receive four ounces of puree green beans and puree honey mustard chicken tenders. According to the recipe, the chicken tenders were to be prepared with the honey mustard sauce. Observation on 10/16/24 at 12:18 P.M., of the lunch meal revealed [NAME] #810 served Residents #6, #15, #16 and #39, pureed coleslaw instead of puree green beans as listed on the spreadsheet. The [NAME] #810 pureed the chicken with a gravy mix and water. Interview on 10/16/24 at 12:20 P.M., with [NAME] #810 verified Residents #6, #15, #16 and #39 should have received puree green beans. [NAME] #810 stated she had not read the spreadsheet and had not followed the recipe instructions to prepare the puree green beans and the chicken tenders. Interview on 10/16/24 at 12:20 P.M with Diet Manager #800 verified Residents #6, #15, #16 and #39 should have received puree green beans. DM #800 also verified the [NAME] #810 did not have access to the puree green beans and chicken tenders recipe instructions. The puree recipe instructions for puree food preparation were not available for any of the pureed meals served to the residents. Review of the policy titled, Puree Diet dated 2023, revealed the puree diet is to improve or maintain foods that are safe to swallow.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44083 Based on observations, staff interviews, temperature log review, and policy review, the facility failed to store, prepare and serve food under sanitary conditions. This affected all 44 residents receiving food from the facility. The facility total census was 44. Finding include: 1. Observations on 10/15/24 at 8:50 A.M., revealed the following: In the reach in refrigerator there were packages of grated cheese and sliced cheese with no date. The stove had an a black substance built up of the appearance of grease on the stove surface ad in the heating elements. There as a built up of wet substance with the appearance of grease on the hood louvers above the stove cooking surface. There was one large food storage bin label sugar with the food scoop stored on top of the sugar. Two large food storage bins containing foods were not labeled. There three opened hamburger bun packages without open dates. The ice machine had a pink substance constant with mold on the inside were ice was stored. In the reach in freezer, there were three open packages of food with no open dates and were not sufficiently sealed. In the dry storage area, three was a bottle of open golden liquid with no label, no open date and no sufficient lid. There was an open bag of rice with no open date. In the reach in refrigerator, there was milk spillage on thawing chicken and on the adjacent shelves and bottom of the refrigerator. Interview on 10/15/24 at 8:50 A.M., with Diet Manager, (DM) #800 verified the kitchen observations including opened undated foods, unlabeled foods, food scoops stored in the food bins and the need for cleaning of the ice machine, stove, stove louvers, and refrigerator. 2. Observation on 10/16/24 at 10:40 A.M., of the resident food storage refrigerator in the nurse station, revealed the following: The October 2024 temperature log dated 10/01/24 through 10/16/24 had six days of no documentation of day shift refrigerator temperatures. There were two large bags of multiple foods which were unlabeled and undated. There were two liters of opened soda, an open bottle of salad dressing and opened vegetables undated and unlabeled. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 10/16/24 at 10:40 A.M., with Licensed Practical Nurse (LPN) #401 verified the resident food storage refrigerator in the nurse station had an incomplete refrigerator temperature log in October 2024, and unlabeled and undated open food items. 3. Observation on 10/16/24 at 3:36 P.M., of [NAME] #810 pre-washing the blender used for puree foods. The [NAME] #810 was observed to reassemble the washed blender blade into the blender with the same gloved hands used to operate the dishwasher. The blender blade came into contact with the puree foods. Observation on 10/16/24 at 4:28 P.M., revealed [NAME] #810 served the supper meal consisting of a pork sausage on a bun. [NAME] #810 was observed to wear gloves touching the food cart, the food lids, the serving counter and utensils and then opened a bun with the same gloved hand. [NAME] #810 continued touching items and returning to open subsequent buns without changing gloves. [NAME] #810 touched and spun the inside of a resident plate with the same gloved hands. Interview on 10/16/24 at 4:45 P.M., with [NAME] #810 verified she should have changed gloves or used a utensil to open the inside of the bun and should not have touched the inside of a resident plate with the same gloved hands. [NAME] #810 verified she should have changed gloves prior to reassembling the blender blade. Review of the policy titled, Food Receiving and Storage, dated October 2017, revealed foods shall be stored in a manner that complies with safe food handling practices, including foods will be covered, labeled and dated, refrigerated food temperatures will be monitored, foods belonging to residents will be labeled with the resident's name and dated, and food areas kept clean. Review of the policy tilted, Sanitation, dated October 2008, revealed all equipment will be kept clean and ice machines will be cleaned and sanitized per manufacturer instructions. Review of the policy titled, Food Preparation and Service, dated October 2017, revealed gloves must be worn when handling food directly, however gloves can be contaminated and must be changed between tasks.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43062 Based on observation, resident interview, staff interview, and record review, the facility failed to maintain a clean and safe environment. This affected three (#06, #19, #35) of four residents reviewed for environment The facility census was 44. Findings include: 1, Record review for Resident #19 revealed she as admitted to the facility on [DATE]. Her diagnoses included, chronic obstructive pulmonary disease, diabetes mellitus (DM), hypothyroidism, schizoaffective disorder, bipolar disorder, insomnia, and congestive heart failure (CHF). Review of the Minimum Data Set (MDS) assessment for Resident#19 revealed she was cognitively impaired. Further review of the MDS assessment revealed she required supervision from staff with eating, oral hygiene, toilet use, dressing and personal hygiene. Interview and observation on 10/15/24 at 9:41 A.M., with State tested Nurse Aide (STNA) #900 verified the wall behind Resident #19's bed was soiled with dirt and debris. STNA #900 verified various circles of white drywall repair that had not been painted beside Resident 19's bed. STNA #900 verified the toilet seat in Resident #19's bathroom was too small for the toilet and did not feel properly. STNA #900 verified the toilet had no seat cover and that it was broken off. STNA #900 verified the toilet was soiled with dried brown substance, the bathroom had no asperities, and there was dirt and splatter around the walls. 2. Record review for Resident #35 revealed he admitted to the facility on [DATE]. His diagnoses included, schizoaffective disorder, diabetes mellitus, hyperlipidemia, essential primary hypertension, and dementia, chronic pain syndrome. Review of the most recent Minimum Data Set (MDS) assessment, dated 08/30/24, revealed Resident #06 was cognitively intact. Further review of the MDS assessment revealed he was dependent on staff for medication administration, toilet use, bathing, and lower body dressing. He required supervision from staff with eating. Resident #06 required maximum assistance from staff with oral hygiene, upper body dressing, and personal hygiene. Interview and observation on 10/15/24 at 11:11 A.M. with Licensed Practical Nurse (LPN) #401 verified Resident #35's bathroom had black stain around the toilet with water around the base of th toilet. LPN #401 verified there was active flying gnats around Resident #35's toilet. LPN #401 stated she is not sure if the soiled black ring all around the base of the toilet was dirt or urine. LPN #401 verified Resident #35's bathroom had a very strong odor. LPN #401 verified the wall behind Resident #35's bed was soiled and contained a hole in the wall . LPN #401 verified the wall across from Resident #35's bed had dirt and splatter running from the ceiling to the floor along the wall. LPN #401 verified the walls had a black substance on the floor at the base of the walls and the floor. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of Resident #06's medical record revealed an admitted [DATE]. Resident #06's diagnoses included: cerebral palsy, major depressive disorder, schizoaffective disorder, personality disorder, essential hypertension, hyperlipidemia, hypothyroidism, hallucinations, hypothyroidism, diabetes mellitus (DM), schizophrenia, anxiety disorder, anemia, and insomnia. Review of Resident #06's most recent Minimum Data Set (MDS) assessment, dated 10/04/24, revealed she had impaired cognition. Further review of the MDS assessment revealed Resident #06 was dependent on staff for lower body dressing and bathing. Resident #06 required maximum assistance from staff with oral hygiene and toilet use. She required supervision from staff with eating. Interview and observation on 10/15/24 at 9:28 A.M., revealed Resident #06 was in her bed with her wheelchair next to the bed. Resident #06's wheelchair arms were cracking, and torn. Resident #06 stated her physician told her she had to use the wheelchair for safety. The seat to the wheelchair had a tear on the side where it attaches to the frame of the wheelchair. Interview and observation on 10/15/24 at 9:30 A.M., with State tested Nurse Aide (STNA) #900 verified the arms of Resident #06's wheelchair were cracked and torn. STNA #900 verified the rip on the side of the seat of Resident #06's wheelchair where it connects to the frame.

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide behavior health training consistent with the requirements and as determined by a facility assessment. 49771 Based on employee file review, interview, and review of the facility assessment, the facility failed to ensure all staff received education on mental and behavioral health. This affected three State tested Nursing Assistants (STNAs)(#505, #504 and #503) of five STNAs reviewed for mental and behavioral health training. This had the potential to affect all 44 residents residing in the facility. The faciliy census was 44. Findings include: Review of the facility Assessment updated 07/29/24 revealed the facility is a 45-bed secured facility specializing in behaviors and mental health. The facility has a majority of long-term residents with the entire facility specializing in mental and behavioral health. There is no specific unit or area designated for the behavioral or mental health residents. The facility provides staff training/education and competencies that are necessary to provide care and support needed for our resident population. The facility provides the following training topics and competencies that include but is not limited to care/management for persons with dementia and behavioral health training. 1. Review of the employee file of STNA #505 revealed a hire date of 01/04/15. Review of STNA #505's file revealed STNA #505 had no documented evidence of receiving education on mental and behavioral health. 2. Review of the employee file of STNA #504 revealed a hire date of 05/24/23. Review of STNA #504's file revealed STNA #504 had no documented evidence of receiving education on mental and behavioral health. 3. Review of the employee file of STNA #503 revealed a hire date of 08/23/23. Review of STNA #503's file revealed STNA #503 had no documented evidence of receiving education on mental and behavioral health. Interview on 10/17/24 at 2:24 P.M., with Human Resources #105 verified STNA's #505, #504 and #503 did not have documented evidence of receiving education on mental and behavioral health from the facility.