STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366320	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shawneespring Health Care Center	10111 Simonson Road Harrison, OH 45030

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 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** Based on medical record review, review of witness statements, review of facility Self-Reported Incidents (SRI's), staff interviews and policy review, the facility failed to report an allegation of sexual abuse to the state survey agency. This affected one (#14) of three residents reviewed for abuse. The facility census was 123. Findings include: Review of the medical record for Resident #14 revealed an admissions date of 10/28/25 with diagnoses including psychosis, hallucinations, Parkinson's disease, and neurocognitive disorder with lewy bodies. Review of Resident #14's Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact. Review of Administrator's written witness statement dated 10/31/25 revealed Administrator spoke with Resident #14 regarding a sexual abuse allegation. Resident #14 stated that someone had grabbed his penis. Further review revealed that Administrator had talked to Resident #14's son, determining that the resident was having hallucinations and decided not to investigate. Review of the facility's SRI's from 10/01/25 to 01/05/25, revealed the facility had not reported any allegations of sexual abuse related to Resident #14. Interview on 01/05/25 at 10:36 A.M. with Social Worker #66 revealed that Resident #14 triggered for a level two Preadmission Screening and Resident Review (PASRR). While the assessor was completing her screening, Resident #14 stated that someone had grabbed his penis. Social Worker #66 verified that Administrator was notified of the allegation of sexual abuse. Interview on 01/05/25 at 10:45 A.M. with Administrator revealed that she was aware that Resident #14 alleged that someone had grabbed his penis. Administrator stated that Resident #14 was experiencing hallucinations at that time and after discussion with the family, it was decided that the allegation was likely a hallucination. Administrator verified that an SRI was not initiated and there was no further investigation. Administrator verified the facility failed to follow their abuse policy once the allegations of sexual abuse were discovered. Interview on 01/05/25 at 2:35 P.M. with Director of Nursing (DON) revealed that Resident #14 was being seen by the an assessor for a level two PASRR when Resident #14 told the assessor that someone had touched his penis. DON verified that the Administrator was notified of the allegation. Review of the facility policy titled, Abuse/Neglect/Misappropriation of Property, dated September 2022, revealed if there is allegation of abuse or serious bodily injury, it should be reported to State Survey Agency immediately, but not later than two hours after the allegation is made. This deficiency represents non-compliance investigated under Complaint Number 2661357.

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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(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** Based on medical record review, review of witness statements, review of facility Self-Reported Incidents (SRI's), staff interviews and policy review, the facility failed to thoroughly investigate an allegation of sexual abuse. This affected one (#14) of three residents reviewed for abuse. The facility census was 123. Findings include: Review of the medical record for Resident #14 revealed an admissions date of 10/28/25 with diagnoses including psychosis, hallucinations, Parkinson's disease, and neurocognitive disorder with lewy bodies. Review of Resident #14's Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact. Review of Administrator's written witness statement dated 10/31/25 revealed Administrator spoke with Resident #14 regarding a sexual abuse allegation. Resident #14 stated that someone had grabbed his penis. Further review revealed that Administrator had talked to Resident #14's son, determining that the resident was having hallucinations and decided not to investigate. Review of the facility's SRI's from 10/01/25 to 01/05/25, revealed the facility had not reported any allegations of sexual abuse related to Resident #14. Interview on 01/05/25 at 10:36 A.M. with Social Worker #66 revealed that Resident #14 triggered for a level two Preadmission Screening and Resident Review (PASRR). While the assessor was completing her screening, Resident #14 stated that someone had grabbed his penis. Social Worker #66 verified that Administrator was notified of the allegation of sexual abuse. Interview on 01/05/25 at 10:45 A.M. with Administrator revealed that she was aware that Resident #14 alleged that someone had grabbed his penis. Administrator stated that Resident #14 was experiencing hallucinations at that time and after discussion with the family, it was decided that the allegation was likely a hallucination. Administrator verified that an SRI was not initiated and there was no further investigation. Administrator verified the facility failed to follow their abuse policy once the allegations of sexual abuse were discovered. Interview on 01/05/25 at 2:35 P.M. with Director of Nursing (DON) revealed that Resident #14 was being seen by the an assessor for a level two PASRR when Resident #14 told the assessor that someone had touched his penis. DON verified that the Administrator was notified of the allegation. Review of the facility policy titled, Abuse/Neglect/Misappropriation of Property, dated September 2022, revealed if there is allegation of abuse or serious bodily injury, it should be reported to State Survey Agency immediately, but not later than two hours after the allegation is made. This deficiency represents non-compliance investigated under Complaint Number 2661357.

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of hospital medical records, interview with staff, Medical Director (MD) #90 and Nurse Practitioner (NP) #9, policy review and review of information from the National Library of Medicine, the facility failed to monitor a resident's bowel movements and implement their bowel monitoring policy when the resident did not have a bowel movement for five consecutive days. This resulted in a fecal impaction with a perforated bowel requiring hospitalization. This resulted in Immediate Jeopardy when Resident #10, with a history of constipation, was placed at risk for serious life-threatening harm, negative health outcomes, and/or death when the facility failed to monitor the resident's bowel status by implementing their bowel monitoring policy when the resident did not have a bowel movement for five consecutive days. Resident #10 began experiencing abdominal pain and labored breathing and was transferred to the hospital on [DATE]. Resident #10 was treated for a bowel impaction with a perforated bowel and died at the hospital on [DATE]. This affected one (Resident #10) of three residents reviewed for change of condition. The facility census was 123. On [DATE] at 3:59 P.M. the Administrator, Director of Nursing (DON), Regional Director of Operations (RDO) #95, Registered Nurse (RN) #96 and RN #97 were notified that Immediate Jeopardy began on [DATE] at 9:00 P.M. when Resident #10 did not have a bowel movement for five consecutive days. Resident #10 complained of abdominal pain with labored breathing. Resident #10 was sent to local emergency room for evaluation and treated for a fecal impaction with a perforated bowel. Resident #10 subsequently died at the hospital on [DATE]. The Immediate Jeopardy was removed on [DATE] when the facility implemented the following corrective actions: On [DATE] by 1:00 P.M. the DON reviewed all current residents with any new progress notes during the past 24 hours to review for residents with a possible change of condition. No concerns were identified. On [DATE] at 2:15 P.M., a Quality Assurance (QA) meeting was held with the Administrator, MD #90, DON, Assistant Director of Nursing (ADON) #89, Corporate Nurse Educator (CNE) #96, RDO #95, and [NAME] President (VP) of Nursing #99 to review findings. The QA committee developed, reviewed, and approved the plan of action. The QA review included but was not limited to Resident Assessment and change of condition including bowel monitoring and notification. No changes were made to the Change of Condition or Bowel Monitoring Policies. Determination was made for plan of action including but not limited to plan to evaluate bowel status for current residents and review of progress notes for 24 hours for potential change of condition. On [DATE] at 2:30 P.M. the DON and ADON #89 were provided with an in-service education by CNE #96 on Change in Condition Policy and conducting assessments including but not limited to abdominal assessment and change in bowel movements. On [DATE] at 2:30 P.M. an audit was initiated by DON and RN Unit Managers (UM) #50 and #76. This audit reviewed each resident that had not had a bowel movement for three days and the residents were assessed, if appropriate providers were contacted and interventions were implemented as needed. Those three residents were Resident #32, #33, and #34 and the bowel monitoring policy was implemented. This audit was completed on [DATE] at 9:30 P.M. Starting on [DATE] at 3:00 P.M. the DON, ADON #89, and Team Lead #60 started an additional in-service education for current licensed nurses. The education included but was not limited to ensuring nurse timely assesses residents for potential change in condition, reviewing clinical dashboard in the electronic medical record, including absence of bowel movements. Any licensed nurse not on-site was provided education via telephone by the DON, ADON #89, and Team Lead #60. All licensed nurses were provided education by [DATE] at 8:10 P.M. Any licensed nurses unavailable for education (four as needed licensed nurses were identified) have not worked since [DATE] and will not work until the education is complete. Licensed nurses were able to verbalize (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	understanding of the educational content. On [DATE] at 4:00 P.M., QA Nurse #96 initiated an audit to ensure appropriate care plan interventions are in place and being implemented as needed. This audit was completed on [DATE] at 12:00 P.M. Beginning on [DATE] to monitor ongoing compliance for potential change of condition, the DON, ADON #89, or UM #50 and #75 will review current residents, including those at risk for constipation, progress notes daily from the past 24 hours to review for residents with possible change of conditions. This will be completed for 30 days. Beginning on [DATE] to monitor ongoing compliance for bowel monitoring, the DON, ADON #89, or UM #50 and #75 will review residents, including the at risk for constipation, without a bowel movement noted for three days to ensure assessment and intervention and physician notification as appropriate. Beginning on [DATE] a Performance Improvement audit worksheet is being completed for 10 residents to ensure residents are assessed for potential changes in condition related to not having a bowel movement in three days. This Performance Improvement audit worksheet is being completed by the DON, ADON #89, or QA Nurse #96 daily for seven days, then three times a week per week for four weeks, weekly for four weeks, and then monthly. Results of the Performance Improvement worksheet will be reported to the QA committee for a determination of the need for further ongoing formal monitoring. A QA meeting was held on [DATE] with the Administrator, MD #90, DON, ADON #89, Regional QA Nurse #96, RDO #95, and VP of Nursing #99 to review education, audit findings, and ongoing schedule for audits. The QA committee reviewed the plan. No concerns were identified. The QA Committee will monitor weekly for four weeks. Although the Immediate Jeopardy was removed on [DATE], the facility remains out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility is still in the process of implementing their corrective action plan and monitoring to ensure on-going compliance. Findings include: Review of Resident #10's medical record revealed he was admitted to the facility on [DATE]. Diagnoses included Parkinson's disease, anemia, constipation, depression, and edema. Resident #10 was sent out to the hospital [DATE] and died on [DATE]. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #10 had moderate cognitive deficits, required supervision to dependent of staff for activities of daily living, and was frequently incontinent of bowels. Review of the care plan dated [DATE] revealed Resident #10 had the potential for constipation related to decreased mobility and side effects of medications. Interventions dated [DATE] included to monitor and record frequency of bowel movements and administer laxatives per doctor's order. Review of Resident #10's physician order dated [DATE] revealed an order for polyethylene glycol (Miralax), a laxative, give 17 grams by mouth one time a day for constipation. Review of the bowel tracking report dated [DATE], revealed Resident #10 had a small bowel movement on [DATE]. Resident #10 had no bowel movements recorded on [DATE], [DATE], [DATE], [DATE], and [DATE]. Review of the pain levels documented in the electronic medical record revealed on [DATE] at 8:47 P.M., Resident #10 reported a pain score of five on a zero to ten pain scale. Review of a nursing note dated [DATE] at 10:44 P.M. revealed Resident #10 had complaints of abdominal pain with pain upon palpation, coughing up mucus, and labored breathing. Notified on-call MD and received new order to send Resident #10 out to the Emergency Department (ED) for evaluation and treatment due to possible delay of treatment due to Thanksgiving holiday. Resident #10's wife notified and is fine with sending Resident #10 out and will be meeting him at the hospital. Report given to nurse at the ED. Review of SBAR (Situation, Background, Assessment, Recommendation) Communication Form and Progress note dated [DATE] revealed Licensed Practical Nurse (LPN) #88 documented Resident #10's last bowel movement was on [DATE]. Review of the hospital Computed Tomography Angiography (CTA) dated [DATE] for Resident #10 revealed the resident had a large amount of stool within the rectum with mild wall thickening, large (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	amount of stool also present in the upstream sigmoid colon where there is mild wall thickening and induration of the associated mesentery, and moderate amount of pneumoperitoneum is present, for which the source is suggested in the sigmoid colon. Review of the impression of the CTA revealed moderate amount of pneumoperitoneum consistent with bowel perforation, likely rising from the sigmoid colon. This may be related to a fecal impaction and stercoral colitis. Review of a nursing note dated [DATE] at 5:06 A.M. revealed Resident #10 was admitted to local hospital for urinary tract infection and further evaluation. Review of nursing note at 6:29 A.M. revealed the facility called the hospital for an update on Resident #10 and was advised to call the family. A call was placed to Resident #10's family who stated Resident #10 had passed away. Review of Resident #10's death certificate revealed the resident passed away on [DATE] at 4:53 A.M. Resident #10's cause of death was cardiac respiratory arrest. During an interview on [DATE] at 2:09 P.M., the DON verified Resident #10 had a small bowel movement on [DATE] and the charting documented he had not had a bowel movement for five days, from [DATE] through [DATE]. The DON verified on the third day when a resident does not have a bowel movement, the dashboard in the electronic medical record would alert the nurse. The DON confirmed the electronic medical record should have alerted the nurses that Resident #10 did not have a bowel movement after the third day with no bowel movement. The DON verified there was no action documented indicating the bowel monitoring policy had been implemented after Resident #10 had no bowel movement for multiple consecutive days. During an interview on [DATE] at 11:13 A.M., MD #90 stated that five consecutive days with no bowel movement could cause a fecal impaction, which is 100 percent preventable. MD #90 stated he did not get a call from the facility when Resident #10 was on day three of no bowel movement, however one of his on-call NP's could have received a call. During a phone interview on [DATE] at 12:53 P.M., NP #91 stated she was not informed that Resident #10 had not had a bowel movement after three days. NP #91 stated it is the expectation to be called when it is noticed that a resident has not had a bowel movement in three days so a new order can be given. Review of the facility policy titled, Bowel Monitoring, dated 08/2017, revealed the charge nurse will review the electronic medical record for residents without a bowel movement for three consecutive days. Charge nurses may administer any as needed laxative medication or other interventions such as prune juice, and/or notify clinician. Review of information from the National Library of Medicine at https://www.ncbi.nlm.nih.gov/books/NBK560608/ revealed stercoral colitis is a rare inflammatory colitis that occurs when impacted fecal material leads to distention of the colon and eventually fecaloma formation. Fecalomas can lead to focal pressure necrosis and perforation, while colonic distention and increased intraluminal pressure can lead to compromise of the vascular supply and ischemic colitis. Review of information from the National Library of Medicine at https://medlineplus.gov/ency/patientinstructions/000120.htm revealed Constipation is when you do not pass stool as often as you normally do. Your stool may become hard and dry, and it can be difficult to pass. And under the section, When to contact a medical professional, Contact your provider if you have not had a bowel movement in 3 days. This deficiency represents non-compliance investigated under Complaint Number 2700642.