

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366325	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2025
NAME OF PROVIDER OR SUPPLIER Ohio Veterans Home		STREET ADDRESS, CITY, STATE, ZIP CODE 3416 Columbus Ave Sandusky, OH 44870	

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 - Minimal harm or potential for 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** Based on medical record review, review of facility self-reported incidents (SRIs) and investigation documents, staff and resident interview, and review a facility policy, the facility failed to ensure residents were free from verbal and physical abuse. This affected three (#3, #4, and #5) of five residents reviewed for abuse. The facility census was 223.</p> <p>Findings Include:</p> <p>1. Review of Resident #3's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included dementia, high blood pressure, and depression.</p> <p>Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #3 was severely cognitively impaired and required extensive assistance of two staff persons for completing his activities of daily living (ADLs).</p> <p>Review of an SRI and corresponding investigation documents dated 03/20/25 revealed, on 02/06/25, staff witnesses reported that Certified Nurse Aide (CNA) #102 was deliberately agitating Resident #3 while other staff were providing Resident #3 a shower. Resident #3 was noticeably upset because of CNA #102's deliberate attempts at agitation and spit in CNA #102's face to which CNA #102 threw a towel at Resident #3, striking him in the face and head area. Upon investigation by facility administrative staff that included resident interviews, staff interviews, and record reviews, the allegation of abuse by CNA #102 to Resident #3 was substantiated. CNA #102's employment was terminated on 03/20/25.</p> <p>2. Review of Resident #4's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included dementia, high blood pressure, and major depressive disorder.</p> <p>Review of the most recent MDS 3.0 assessment dated [DATE] revealed Resident #4 was severely cognitively impaired and required hand on assistance of two staff persons for completing his ADLs.</p> <p>Review of Resident #5's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included dementia, anxiety disorder, and wandering diseases.</p> <p>Review of the most recent MDS 3.0 assessment dated [DATE] revealed Resident #5 was severely cognitively impaired and required hand on assistance of two staff persons for completing his ADLs.</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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of an SRI and corresponding investigation documentation dated 03/21/25 revealed CNA #103 informed administrative staff that between the dates of 03/05/25 and 03/10/25, at around 11:30 P.M., he and CNA #102 were putting Resident #5 to bed and while changing Resident #5's incontinence care products, CNA #102 took an inhalation off his nicotine vaping pen and exhaled the vapor into Resident #5's face. Further review revealed while continuing care for Resident #5, Resident #4 was heard in the hallway shouting, I do not know where to go. Upon hearing Resident #4, CNA #102 left the room and told Resident #4 to, go find a bridge to jump off of. CNA #103 confronted CNA #102 about his actions toward Resident #4 and Resident #5 and was ignored. CNA #102 was already on suspension from a previous SRI investigation and his employment was terminated subsequent to the two incidents reported on 03/20/25 and 03/21/25.</p> <p>Interview with Lieutenant #300 from the facility's police department on 06/06/25 at 2:00 P.M. verified both incidents of CNA #102 being verbally and physically abusive toward Resident #3, exhaling vapor into Resident #5's face during incontinence care, and being verbally abuse to Resident #4. Lieutenant #300 described CNA #102 as someone who thought they could do whatever he wanted to.</p> <p>Review of the policy titled, Abuse, Neglect, and Exploitation, dated 03/25/25, revealed the facility will prohibit and prevent abuse, neglect, exploitation or mistreatment, including injuries of unknown origin and misappropriation of resident property.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00163793.</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NONCOMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.</p> <p>Based on medical record review, review of facility self-reported incidents (SRI) and related investigation documents, staff and resident interview, review of local new reports, and review of a facility policy, the facility failed to ensure residents were free from misappropriation. This affected one (#1) of five residents reviewed for misappropriation. The facility census was 223.</p> <p>Findings Include:</p> <p>Review of Resident #1's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included type two diabetes, chronic kidney disease, and gout.</p> <p>Review of the most recent Minimum Data Set (MDS) 3.0 assessment revealed Resident #1 was cognitively intact and required hands on assistance from one staff person for completing his activities of daily living (ADLs).</p> <p>Review of an SRI and corresponding investigation documentation dated 03/31/25 revealed the facility was made aware of a claim that Resident #1 was missing between \$1000 and \$1500. Resident #1 alleged that theft was done by an African American staffing agency nurse aide. An investigation was immediately initiated which included resident interviews, staff interviews of all staff on-site at the time of the alleged theft, and medical record reviews. During an interview with the facility's police force, Certified Nurse Aide (CNA) #100 confessed to the theft of Resident #1's money from the wallet that was hanging on Resident #1's wheelchair while CNA #100 was in the room. The facility's police force obtained consent to search CNA #100's vehicle and a bag with \$1050 was noted in the middle console of CNA #100's vehicle in dominations of \$20 bills and \$50 bills. Review of a statement completed by Lieutenant #300 with the facility's police department dated 04/03/25 revealed CNA #100 was questioned about Resident #1's money and confessed to take \$1050 out of the resident's bag/wallet hanging over his chair while she was in his room.</p> <p>Review of a local news report dated 04/30/25 revealed CNA #100 was booked into the local county jail on 04/04/25 and charged with theft from the elderly which was classified as a fourth-degree felony and carried at minimum a six-month jail sentence to a maximum of 18 months.</p> <p>Interview with the Administrator on 06/06/25 at 10:00 A.M. verified the facility was made aware of an allegation of misappropriation of Resident #1's funds and immediately began an investigation. The Administrator stated through investigation it was determined CNA #100 was responsible for stealing Resident #1's money.</p> <p>Interview with Resident #1 on 06/06/25 at 10:30 A.M. stated he had money taken from his room and it was reported to the facility. Resident #1 stated the facility conducted an investigation and caught the person that stole it.</p> <p>Review of the policy titled, Abuse, Neglect, and Exploitation, dated 03/25/25, revealed the facility will prohibit and prevent abuse, neglect, exploitation or mistreatment, including injuries of of unknown origin and misappropriation of resident property.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>As a result of the incident, the facility took the following actions to correct the deficient practice by 04/08/25:</p> <ul style="list-style-type: none"> &bull; On 03/31/25, all staff working at the time of the alleged incident were interviewed and questioned by both facility clinical staff and the police department. &bull; On 03/31/25, CNA #100 was escorted off the property upon confession of the theft. &bull; On 03/31/25, CNA #100's employer was contacted and CNA #100 was put on the do not return list for the facility. &bull; On 03/31/25, CNA #100 was reported to the Nurse Aide Registry. &bull; On 03/31/25, all residents with a Brief Interview for Mental Status (BIMS) score of eight (indicating moderate cognitive impairment) or higher were interviewed regarding concerns with CNA #100 or any other staff related to misappropriation with no negative findings. All residents with BIMS scores indicating they were cognitively impaired had their medical records reviewed for concerns of misappropriation with no issues identified. The interviews and medical record reviews were completed by 04/01/25. &bull; On 04/03/25, Resident #1's stolen funds were returned to the resident after processing for the criminal investigation into CNA #100's actions. &bull; Immediately after the incident, all staff were assigned an online education regarding abuse, neglect, and misappropriation with all staff completing the in-service as of 04/08/25. &bull; Review of facility SRIs on 06/06/25, completed between 04/01/25 and 05/19/25, revealed no further confirmed allegations of misappropriation and no trends or patterns were identified. &bull; <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 06/06/25, review of four (#2, #3, #4, and #5) additional resident medical records revealed no concerns related to misappropriation.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00164401.</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of a self-reported incident (SRI) and related investigation documents, staff interview, and review of a facility policy, the facility failed to timely report an allegation of abuse to the State Survey Agency in a timely manner. This affected one (#3) of five residents reviewed for abuse. The facility census was 223.</p> <p>Findings Include:</p> <p>Review of Resident #3's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included dementia, high blood pressure, and depression.</p> <p>Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #3 was severely cognitively impaired and required extensive assistance of two staff persons for completing his activities of daily living (ADLs).</p> <p>Review of an SRI and corresponding investigation documents dated 03/20/25 revealed, on 02/06/25, staff witnesses reported Certified Nurse Aide (CNA) #102 was deliberately agitating Resident #3 while other staff were providing Resident #3 his shower. Resident #3 was noticeably upset and spit in CNA #102's face, to which CNA #102 threw a towel at the resident striking Resident #3's in the face and head area. Further review revealed the alleged incident was reported to the State Survey Agency more than a month after it occurred.</p> <p>Interview with the current Administrator on 06/06/25 at 3:45 P.M. verified the previous Administrator did not report the allegation which occurred on 02/06/25 involving Resident #3 and CNA #102 to the State Survey Agency in a timely manner.</p> <p>Review of the policy titled, Abuse, Neglect, and Exploitation, dated 03/25/25, revealed the nursing home administrator shall be designated the Abuse Prevention Coordinator at the facility. This employee is responsible for reporting allegations or suspected abuse, neglect, or exploitation to the state survey agency and other officials in accordance with state law. The facility will report to the Administrator immediately but no later than two (2) hours after the allegation was made, if the events of the allegation involved abuse or resulted in serious bodily injury or not later than 24 hours if the events that caused the allegation do not involve abuse and do not results in serious bodily injury. The facility will also report to the state agency, adult protective services, law enforcement, and to all other required agencies, as applicable.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00165363.</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of a self-reported incident (SRI) and related investigation documents, review of a hospital record, review of an employee skills checklist, and policy review, the facility failed to complete resident transfers using a mechanical lift with appropriate assistance as care planned and as ordered. Actual Harm occurred on 04/29/25 when Resident #2, who was care planned for two-person assistance with all personal care and had a physician order to always be transferred using two people, was transferred in her room by one staff member using a mechanical lift without assistance. Resident #2 sustained a right femur fracture as a result of the improper transfer. This affected one (#2) of three residents reviewed for accidents. The facility census was 223.</p> <p>Findings Include:</p> <p>Review of Resident #2's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included dementia, peripheral vascular disease, and constipation.</p> <p>Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #2 was severely cognitively impaired and required extensive assistance of two staff persons for completing her activities of daily living (ADLs) including transfers.</p> <p>Review of the care plan for Resident #2 dated 08/04/21 revealed Resident #2 required two staff persons for all personal care.</p> <p>Review of Resident #2's physician orders revealed an order dated 03/17/23 for Resident #2 to always be transferred by two persons.</p> <p>Review of an SRI and related investigation documentation dated 04/29/25 revealed on 04/29/25 Resident #2 was observed at dinner at approximately 7:45 P.M. and was noted to be not be acting right. Registered Nurse Clinical Care Coordinator (RNCCC) #200 documented noticeable painful facial grimacing and bruising to Resident #2's left leg and left facial abrasions, which RNCCC #200 felt was consistent with Resident #2 bumping her leg on the wall and rubbing her face with her hand as she often did. Upon further assessment, RNCCC #200 observed a deformity to Resident #2's right knee. Resident #2 was unable to verbalize to staff how she obtained the injuries. RNCCC #200 placed a call to Resident #2's primary care physician (PCP) and received orders to obtain x-rays of Resident #2's right knee and right hip. The facility was informed by the x-ray company that Resident #2 had a fracture to her right femur and new orders were obtained to send Resident #2 to a local hospital for evaluation.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Further review of the SRI investigation dated 04/29/25 revealed common area video camera footage was reviewed by the facility's police department, the Administrator, and nursing administration. On the video, Certified Nurse Aide (CNA) #101 was seen entering Resident #2's room by herself around 5:10 P.M., bringing in a non-weight bearing lift inside the room. Approximately two minutes later, CNA #101 was seen exiting Resident #2's room with the non-weight bearing lift and placing the lift by the wall. CNA #101 then proceeded to interact with an unknown visitor. Once the interaction between the two was complete, video camera footage showed CNA #101 entered Resident #2's room by herself again, bringing the non-weight bearing lift with her. Approximately twelve (12) minutes later, CNA #101 was seen exiting the room, pushing Resident #2 in the cradle chair, and leaving the room with the non-weight bearing lift. The facility concluded after conducting interviews and statements from nursing staff and other interviews conducted by the facility police department that video footage and other investigation findings revealed CNA #101 failed to follow Resident #2's plan of care and physician orders, and failed to follow the facility policy and procedure for two staff members for all transfers with non-weight bearing residents. CNA #101 was escorted out of the building and the facility notified her staffing agency that she was placed on the do not return list.</p> <p>Review of the hospital x-ray evaluation dated 04/29/25 revealed Resident #2 had a supracondylar femur fracture (a fracture of the thigh bone just above the knee) with minimal comminution (a type of bone fracture where the bone breaks into three or more pieces, but the fragments are relatively small and relatively stable) and posterior displacement.</p> <p>Review of the document titled, Skills Checklist for State Tested Nurse Aide (STNA)/CNA, for CNA #101 dated 01/17/25, revealed CNA #101 was deemed capable to perform resident transfers.</p> <p>Interview with Lieutenant #300 from the facility's police department on 06/06/25 at 2:00 P.M. verified the events of the SRI dated 04/29/25 and CNA #101's failure to follow Resident #2's plan of care and physician order related to transferring the resident with resulting in the fracture of Resident #2's right femur.</p> <p>Interview with the Director of Nursing (DON) on 06/06/25 at 3:00 P.M. revealed, as a result of the incident when CNA #101 transferred Resident #2 by herself using a mechanical lift resulting in a fractured right femur on 04/29/25, the facility was engaging staff with re-education of the proper techniques of how to mechanical (Hoyer) lift transfer and the facility had not completed all staff education as of 06/06/25.</p> <p>Interview with the Assistant Director of Nursing (ADON) on 06/06/25 at 3:30 P.M. revealed she was the primary clinical investigator and during interview with CNA #101 and confirmed CNA #101 stated Resident #2's injury occurred during the transfer on 04/29/25. The ADON further stated CNA #101 did not identify she had any assistance transferring Resident #2 on 04/29/25.</p> <p>Review of the policy titled, Full Body Mechanical Lift Bed to Chair Transfer Work Instructions, dated 04/01/25, revealed all transfers involving the use of full body mechanical lift require two-assist for transfer.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00165363.</p>		