

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  11/06/2025
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 - Immediate jeopardy to resident health or safety</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>(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 - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY Based on review of the medical record, review of a facility Self-Reported Incident (SRI), review of an SRI investigation, review of staff statements, review of the staffing schedule, review of employee time records, review of a police report, review of video surveillance, review of an incident report, staff interviews, resident interview, family interview, and review of facility policy, the facility staff failed to ensure Resident #241 was free from staff to resident verbal and physical abuse. This resulted in Immediate Jeopardy when Resident #241 was thrown from his wheelchair on 09/16/25 at approximately 7:50 P.M. by Licensed Practical Nurse (LPN) #602 placing the resident at risk for potential serious life-threatening harm, injuries, and/or negative health outcomes. Additionally, the facility failed to protect the resident from further abuse and failed to immediately report resident abuse to the administrator placing 26 additional residents who resided on the Memory Care Unit at risk for abuse. On 09/16/25 beginning at approximately 7:50 P.M., Certified Nursing Assistant (CNA) #400 witnessed LPN #602 aggressively pushing Resident #241 out of his room and swearing at the resident while the resident was trying to stop the wheelchair by reaching out his arms, placing his feet on the ground and yelling no. LPN #602 then continued to push Resident #241 toward the nurses' station where LPN #602 hit the resident's arm and pulled on the back of the resident's shirt to keep the resident in the wheelchair. LPN #602 then aggressively pushed Resident #241 in his wheelchair into a recliner causing the resident to fly forward hitting the recliner and then landing on the floor. While Resident #241 was on the floor, LPN #602 tried to pick the resident up by the back of his pants. Resident #241 then rolled onto his buttocks. LPN #602 sat in the resident's wheelchair next to the resident on the floor and later kicked the back of the resident's right leg. CNA #400 failed to intervene to protect the resident and failed to call for additional help. LPN #614 arrived on the unit and LPN #602 reported the resident had fallen. Registered Nurse (RN) Supervisor #700 then arrived on the unit to assess Resident #241 all while LPN #602 remained working on the Memory Care Unit until CNA #400 reported the abuse to RN Supervisor #700 at approximately 9:15 P.M. This resulted in serious psychosocial harm as Resident #241 was agitated and upset attempting to get away from LPN #602. Resident #241 also sustained three skin tears to the bilateral upper extremities. Furthermore, all residents on the Memory Care Unit were placed at potential risk for serious injury and/or harm when LPN #602 continued to work on the unit until 9:15 P.M. This affected one (#241) of four residents reviewed for abuse and had the potential to affect 26 additional residents (#02, #08, #30, #33, #35, #49, #59, #87, #90, #91, #95, #99, #103, #109, #117, #121, #123, #152, #154, #165, #174, #188, #190, #209, #216, and #220) residing on the Memory Care unit. The facility census was 241. On 10/20/25 at 4:52 P.M., the Administrator and Director of Nursing (DON) were notified Immediate Jeopardy began on 09/16/25 at 7:50 P.M., when Resident #241 was thrown from his wheelchair by LPN #602 placing the resident at risk for serious life-threatening harm, injuries, and/or negative health outcomes. Additionally, the facility failed to protect the resident from further abuse and failed to immediately report resident abuse to the administrator placing 26 additional residents who resided on the Memory Care Unit at risk for abuse. On 09/16/25 beginning at approximately 7:50 P.M., CNA #400 witnessed LPN #602 aggressively pushing Resident #241 out of his room and swearing at the resident while the resident was trying to stop the wheelchair by reaching out his arms, placing his feet on the ground and yelling no. 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