STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366346	A. Building B. Wing	06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manor of Grande Village	2610 East Aurora Road Twinsburg, OH 44087

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42734 Based on record reviews, review of three self-reported incidents (SRIs) and interviews the facility failed to ensure Resident #52 was free from physical abuse by Resident #54. This affected one resident (Resident #52) of five residents reviewed for abuse. The census was 76. Findings include: Review of SRI #244843 started on 03/05/24 and timed at 6:36 P.M. and completed on 03/11/24 and timed at 3:33 P.M. revealed Resident #54 struck Resident #52 several times on the left eye and left side of face. Staff separated immediately, assessed, completed skin checks and vitals. Immediate interventions put in place were one-on-one supervision, then every 15-minute checks for two days, deep-breathing and distraction. Review of progress noted dated 03/05/24 revealed Resident #54 had a new order for Ativan as needed for 14 days. Physician assistant and psychiatry consultations were ordered. Review of progress note on 03/08/24 revealed a care conference was held with the responsible party where the abuse policy was reviewed and alternate placement was discussed but no decision was made at that time. Review of SRI #245441 started on 03/20/24 and timed at 12:08 P.M. and completed on 03/25/24 and timed at 2:01 P.M. revealed Resident #54 struck Resident #52 on his left side. Staff separated the residents. Resident #54 was being aggressive and refused vitals. Resident #54 was sent to the emergency room at 12:44 A.M. and returned at 5:16 A.M. with no new orders. The facility was attempting to find alternate placement. The resident had one-on-one supervision until she was sent to psychiatric hospital on 03/21/24 at 7:36 P.M. Progress notes revealed Resident #54 returned to the facility on [DATE]. Review of progress note on 04/18/24 revealed social service spoke with responsible party about alternative placement. Review of SRI # 247879 started on 05/23/24 and timed at 9:13 P.M. and completed on 05/30/24 and timed at 4:38 P.M. revealed Resident #54 was witnessed holding Resident #52 against the wall then they began to strike one another across the face. They were separated and assessed. Resident #54 was placed on one-on-one observations. The intervention was Resident #54 was sent to the emergency room however she returned the same day with no new orders. Prior interventions for Resident #54 included hospitalization and medication review and every 15-minute checks for two days after incidents. (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

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Record review of Resident #54 revealed an admitted [DATE] with diagnoses including Wernicke's encephalopathy, unspecified psychosis not due to a substance or known physiological condition, anxiety disorder, unspecified disorder of adult personality and behavior, major depressive disorder and depression. Review of Resident #54's care plan dated 11/27/23 revealed a goal for monitoring her behaviors. Interventions included medicating as prescribed and monitoring effectiveness, praising positive behaviors and removing from public area when behavior was unacceptable. The care plan was not revised since initiated or after each incident Resident #54 displayed aggressive, abusive behavior. Review of Resident #54's progress note dated 05/23/24 at 8:15 P.M. revealed a state tested nursing assistant (STNA) saw Resident #54 with her hands around the neck of Resident #52. The note stated they began to strike one another back and forth on the face. The residents were separated and assessed. A skin check was performed, vitals were stable, one-on-one supervision was initiated, and all parties were notified. b. Record review of Resident #52 revealed an initial admitted [DATE] and re-admitted [DATE] with diagnoses including cerebral infarction, dementia in other diseases classified elsewhere without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety and Alzheimer's Disease. Review of Resident #52's progress note dated 05/23/24 at 8:10 P.M. revealed a STNA saw Resident #52 being held against the wall by another resident with a hand around his neck. The residents began to strike each other back and forth on the face. The residents were separated and assessed. A skin assessment was completed. Resident #52 had an abrasion to the left side of his neck and right side of his face. He denied pain. It stated he would be sent to the hospital when transportation was available. Interviews on 06/03/24 from 3:20 P.M. to 5:00 P.M. with STNA #201 revealed Resident #54 was upset about missing money and it escalated. She believed Resident #54 knew what she was doing at the time though she did not recall later. Licensed Practical Nurse (LPN) #203 revealed she had seen her be accusatory before. She stated the resident was forgetful. STNA #209 revealed what Resident #52's nickname was which was how Resident #54 identified him as when questioned. STNA #201, STNA #202 and STNA #209 did not mention specific interventions attempted when asked. Review of the record revealed no evidence of non-pharmacological interventions attempted. Interview and observation on 06/03/24 at 5:14 P.M. revealed Resident #54 was sitting in the dining room outside of the nursing station window talking to LPN #203. Resident denied being aware of any incidents with other residents and looked surprised but said if someone said it happened, it must have. She said the only person she could think of having an issue with was Resident #52, calling him by his nickname, unbeknownst to the surveyor at the time. Interview and observation on 06/03/24 at 5:18 P.M. revealed Resident #52 was sitting in the common area on the couch beside a female resident watching TV. When we caught each other's eyes, he smiled but did not initially respond to his nickname when called. When asked how he was he said good. He did not answer further questions. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/04/24 at 10:59 A.M. with Social Service Designee (SSD) #211 revealed she was attempting to find alternative placement for Resident #54 since March because of behaviors. She stated the responsible party was not initially receptive. She verified there were three SRIs involving allegations of abuse with Resident #54 as the aggressor against Resident #52. Interview on 06/04/24 at 11:45 A.M. with LPN #210 revealed there were three SRIs involving allegations of abuse between Resident #52 and Resident #54. Resident #54 had some medication changes since March. She verified the care plan did not reflect any revisions to Resident #54's interventions, especially non-pharmacological ones. She reviewed the progress notes with the surveyor revealing Resident #54 was sent to the hospitalER on [DATE] but returned the same day with no new orders. There were no additional medication changes until 05/29/24. She stated the STNAs may be the ones doing interventions but there was no evidence of what interventions were attempted. LPN #210 stated the resident did not normally have behaviors. LPN #210 stated Resident #52 and #54 seek each other out and hang out together. She stated Resident #54 does not flinch or try to hide from her. Interview on 06/04/24 at 2:00 P.M. with the Administrator revealed the facility has been actively seeking alternate placement for Resident #54 and an Emergency discharge notice was given. He stated the Ombudsman was aware. He stated the past interventions have been medication changes and hospitalization s. He verified the care plan did not have any revisions to the interventions for Resident #54's behaviors. He stated Resident #52 and Resident #54 have the right to interact with one another and the facility could not stop them from doing so. Review of the facility policy titled Abuse, Neglect, Exploitation and Misappropriation of Resident Property, dated 10/2022 revealed the facility prevention and identification was to include the assessment, care planning and monitoring of residents with history of aggressive behaviors. The interdisciplinary team was to determine proper interventions for resident to resident cases. This deficiency represents non-compliance investigated under Complaint Number OH00154414.