

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366410	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER St Clare Commons		STREET ADDRESS, CITY, STATE, ZIP CODE 12469 Five Point Road Perrysburg, OH 43551	

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 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** 41528</p> <p>Based on medical record review, review of self-reported incidents, resident and staff interview, and review of facility policy, the facility failed to prevent misappropriation of resident funds. This affected one (#40) of one resident reviewed for misappropriation. The facility census was 55.</p> <p>Findings include:</p> <p>Review of the medical record revealed Resident #40 was admitted on [DATE]. Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, acute respiratory failure with hypoxia, dysphagia, chronic kidney disease stage three, and major depressive disorder recurrent.</p> <p>Review of the Minimum Data Set (MDS) assessment, dated 03/31/24, revealed the resident was moderately cognitively impaired.</p> <p>Review of Self-Reported Incident (SRI) #242873, created 01/08/24 and completed on 01/12/24, revealed the Administrator was notified by Resident #40's financial administrator the resident's credit card was taken and used to make in person purchases at three stores (grocery and gas stations) within the area of the facility and many of the purchases were for lottery. Resident #40 denied making the purchases and the resident's financial administrator verified the purchases were not normal purchases made by the resident. The credit card was reported to the bank fraud department and the card was canceled. The local police department was called and a police officer came to the facility to take a report. The facility was informed the case would be given to a detective. On 01/09/24, the Administrator met with the detective and was asked to not share information with the suspect or facility staff until he had the opportunity to bring the suspect in for questioning. The Administrator informed the detective the employee would need to be suspended pending investigation. The detective stated he would be contacting the Ohio Board of Nursing. The complaint was found unsubstantiated due to inconclusive evidence, with abuse/neglect/misappropriation suspected.</p> <p>Further review of SRI #242873 revealed Resident #40 did not authorize anyone to use her credit card. The credit card statement had unauthorized charges posted from three stores (gas and grocery). The unauthorized charges totaled approximately \$5,000.00 and included 31 charges for \$100 each for the state lottery. The alleged perpetrator, Licensed Practical Nurse (LPN) #300, had been a facility employee since 2019 and the last date worked was 01/09/24. LPN #300 resigned on 01/18/24. The SRI included correspondence with the Ohio Board of Nursing and Ohio Department of Health.</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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 04/24/24 at 11:43 A.M. with the Administrator revealed at the time SRI #242873 was submitted the facility did not have all of the information and otherwise would have substantiated the SRI. The Administrator stated misappropriation of Resident #40's credit card was from 11/06/23 through 01/05/24 with an estimated total of \$5,000.00 in unauthorized charges on the resident's credit card. The Administrator verified on 01/09/24 (prior to the facility investigation being completed), the detective brought in surveillance footage of the alleged perpetrator and the Administrator confirmed the suspect was facility employee LPN #300.</p> <p>Interview on 04/25/24 at 2:20 P.M. with Resident #40 verified she provided her credit card to LPN #300. Resident #40 expressed she was hurt when she learned the staff had used her credit card for unauthorized charges.</p> <p>Review of the facility policy, Abuse, Neglect and Exploitation, dated 10/24/22, verified the facility is to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of resident's belongings or money without the resident's consent.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41528</p> <p>Based on medical record review, review of self-reported incidents, staff interview, and review of facility policy, the facility failed to thoroughly investigate misappropriation of resident funds. This affected one (#40) of one resident reviewed for misappropriation. The facility census was 55.</p> <p>Findings include:</p> <p>Review of the medical record revealed Resident #40 was admitted on [DATE]. Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, acute respiratory failure with hypoxia, dysphagia, chronic kidney disease stage three, and major depressive disorder recurrent.</p> <p>Review of the Minimum Data Set (MDS) assessment, dated 03/31/24, revealed Resident #40 was moderately cognitively impaired.</p> <p>Review of Self-Reported Incident (SRI) #242873, created 01/08/24 and completed on 01/12/24, revealed the Administrator was notified by Resident #40's financial administrator the resident's credit card was taken and used to make in person purchases at three stores (grocery and gas stations) within the area of the facility and many of the purchases were for lottery. Resident #40 denied making the purchases and the resident's financial administrator verified the purchases were not normal purchases made by the resident. The credit card was reported to the bank fraud department and the card was canceled. The local police department was called and a police officer came to the facility to file a report. The facility was informed the case would be given to a detective. On 01/09/24, the Administrator met with the detective and was asked not to share any information with the suspect or facility staff until he had the opportunity to bring the suspect in for questioning. The Administrator informed the detective she would need to suspend the employee pending investigation. The detective stated he would be contacting the state board of nursing. Further review of the SRI revealed Resident #40 did not authorize anyone to use her credit card. The credit card statement of unauthorized charges were posted from three stores (gas and grocery). The unauthorized charges totaled approximately \$5,000.00 and included 31 charges for \$100 each for the state lottery. The alleged perpetrator, Licensed Practical Nurse (LPN) #300, had been a facility employee since 2019 and the last date worked was 01/09/24. LPN #300 resigned on 01/18/24. The SRI included correspondence with the state board of nursing and the state health department. The investigation included five resident interviews, resident/victim pertinent medical records, alleged perpetrators personnel file, timecards, and door access times. The facility unsubstantiated misappropriation due to inconclusive evidence, however, abuse/neglect/misappropriation was suspected.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 04/24/24 at 11:43 A.M. with the Administrator revealed at the time SRI #242873 was submitted, the facility did not have all of the information and otherwise misappropriation would have been substantiated. The Administrator stated misappropriation of Resident #40's credit card was from 11/06/23 through 01/05/24 with an estimated total of \$5,000.00. On 01/09/24 (prior to the facility investigation being completed), the detective brought in surveillance footage of the suspect and the Administrator confirmed the suspect was a facility employee, LPN #300. While the Administrator stated the detective conducted two staff interviews and requested the facility not interview staff, the facility investigation did not include the confirmation of LPN #300 in the surveillance footage, only included five resident interviews, no in-service was conducted, and no audits were initiated.</p> <p>Review of policy, Abuse, Neglect and Exploitation, dated 10/24/22, verified the facility is to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Written procedures for investigation include identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations. The facility must also focus the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause. In addition, the facility will provide complete and thorough documentation of the investigation.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for 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** 41528</p> <p>Based on medical record review, observation, resident representative and staff interview, and review of facility policy, the facility failed to ensure fall interventions were in place for two (#21 and #47) of three residents reviewed for falls. In addition, the facility failed to ensure one (#28) of three residents reviewed for transfers were assisted by two staff for transfer with a mechanical hooyer lift. The facility census was 55.</p> <p>Findings include:</p> <p>1. Review of the medical record review revealed Resident #21 was admitted on [DATE]. Diagnoses included fracture of neck, unspecified fracture of shaft of humerus left arm, malignant neoplasm of unspecified breast, and non-Hodgkin lymphoma.</p> <p>Review of the Minimum Data Set (MDS) assessment, dated 04/12/24, revealed the resident was cognitively intact.</p> <p>Review of the most recent care plan revealed Resident #21 was at risk for falls, with an actual fall on 3/9/24. Fall interventions, updated 03/13/24, included to keep the bed in the lowest position when in it to prevent from rolling out and being injured.</p> <p>Observation on 04/24/24 at 2:55 P.M. revealed Resident #21 in bed. The bed was not in the lowest position.</p> <p>Interview on 04/24/24 at 3:44 P.M. with State tested Nursing Assistant (STNA) #202 verified Resident #21 was in bed and the bed was not in the lowest position.</p> <p>2. Review of the medical record review revealed Resident #47 was admitted on [DATE]. Diagnoses included memory deficit following cerebral infarction, unspecified diastolic heart failure, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, and pneumonia.</p> <p>Review of the MDS assessment, dated 03/26/24, revealed the resident was rarely understood. The resident was dependent on staff for showers and bathing.</p> <p>Review of the most recent care plan revealed Resident #47 was care planned for falls, with interventions including bilateral mats to the floor and ensure the bed was kept in the lowest position.</p> <p>Interview on 04/24/24 at 10:24 A.M. with Resident #47's resident representative revealed there had been no fall mats in place and the bed was often not in the lowest position.</p> <p>Observation on 04/24/24 at 2:53 P.M. revealed Resident #47 was in bed. There were no fall mats in place and the bed was not in the lowest position.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 04/24/24 at 2:54 P.M. with STNA #111 verified Resident #47 was in bed with no fall mats in place and the bed was not in the lowest position. STNA #111 stated she did not know the resident used fall mats because there were none in the room.</p> <p>Review of policy, Fall Risk Assessment, revised 09/07/21, verified the facility will provide an environment that is free from accident hazards over which the facility has control and provides supervision and assistance devices to each resident to prevent avoidable accidents. An at risk for falls care plan will be completed for each resident to address each item identified on the risk assessment and will be updated accordingly. The care plan will include interventions to reduce the risk and the interventions will be monitored and modified as necessary.</p> <p>3. Review of the medical record review revealed Resident #28 was admitted on [DATE]. Diagnoses included Alzheimer's disease, major depressive disorder, supraventricular tachycardia, muscle weakness, abnormal posture and age-related physical debility.</p> <p>Review of the MDS assessment, dated 03/31/24, revealed Resident #28 was rarely understood. Resident #28 had functional range of motion impairment on both sides and utilized a wheelchair. Resident #28 was dependent for chair/bed to chair transfer.</p> <p>Review of the most recent care plan revealed Resident #28 required a mechanical hooyer lift for transferring with assistance of two staff members.</p> <p>Observation on 04/25/24 at 7:46 A.M. revealed Resident #28 was in bed.</p> <p>Observation on 04/25/24 at 8:21 A.M. revealed STNA #209 entered Resident #28's with a mechanical hooyer lift. Continued observation at 8:40 A.M. revealed STNA #209 exited Resident #28's room with the resident in a wheelchair. No other staff were observed in the area.</p> <p>Interview on 04/25/24 at 8:41 A.M. with STNA #209 verified she transferred Resident #28, utilizing the mechanical hooyer lift, from bed to wheelchair without assistance from a second staff. STNA #209 stated, at times, the nurse would help; however, Resident #28 was small enough that she could transfer the resident by herself.</p> <p>Review of facility policy, Using a Mechanical Lifting Machine, dated July 2017, verified at least two nursing assistants are needed to safely move a resident with a mechanical lift.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00153040.</p>		