

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366422	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/16/2024
NAME OF PROVIDER OR SUPPLIER Elmwood Assisted Living & Skilled Nursing of Fremo		STREET ADDRESS, CITY, STATE, ZIP CODE 1545 Fangboner Rd Fremont, OH 43420	

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 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15816</p> <p>Based on medical record review, review of facility self-reported incident (SR), staff interview, review of personnel files, resident interview, review of facility investigation, review of police department incident report, and review of facility policy, the facility failed to ensure residents were afforded privacy by not being video recorded by staff. This affected three (#1, #2, #3) of three residents reviewed for privacy. The facility census was 24.</p> <p>Findings include:</p> <p>Review of the medical record revealed Resident #1 admitted to the facility on [DATE]. Diagnoses included Alzheimer's disease, dementia, and major depressive disorder. The most current Minimum Data Set (MDS) assessment, dated 07/26/24, identified Resident #1 with severe cognitive impairment, inability to understand or make needs known, and dependent on staff for activities of daily living.</p> <p>Review of the medical record revealed Resident #2 admitted to the facility on [DATE]. Diagnoses included dementia, abnormal posture, infection of amputation stump right lower extremity, Parkinson disease, major depression, anxiety disorder, and schizoaffective disorder of bipolar type. The most current MDS assessment, dated 06/28/24, assessed Resident #2 with severely impaired cognition and requiring substantial to maximal assistance with activities of daily living.</p> <p>Review of the medical record revealed Resident #3 admitted to the facility on [DATE]. Diagnoses included major depression, congestive heart failure, and anxiety disorder. The most current MDS assessment, dated 06/25/24, assessed Resident #3 with intact cognition and dependent on staff for the completion of activities of daily living.</p> <p>Review of the facility SRI #250296, dated 07/31/24, for an allegation of emotional/verbal abuse, revealed it was reported to staff on 07/31/24 that two staff members had videos of residents on their cell phones. The alleged videos were of taunting Resident #1 with a baby doll, taunting Resident #3 to say curse words and make rude gestures, and a video of staff mocking Resident #2.</p> <p>Review of the facility investigation noted Agency State tested Nurse Aide (STNA) #402 worked 07/28/24 between 2:00 P.M. and 10:00 P.M. Agency STNA #402's statement, dated 07/31/24, stated she worked 07/28/24. During this shift Registered Nurse (RN) #300 confided to Agency STNA #402 that two of her workers showed her a video of two residents, Resident #1 and Resident #2. Agency STNA #402 documented she came into the facility on [DATE] to report the incidents to the Administrator.</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 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the investigation revealed a statement from RN #300, dated 07/31/24, which confirmed STNA #400 showed her videos of Resident #1 and Resident #2. RN #300's statement revealed STNA #400 and STNA #404 were in a video with Resident #3 seated on the toilet trying to get Resident #3 to say a curse word and raise her middle finger. A different video was observed of STNA #400 picking on Resident #1, getting the resident agitated, and taking her baby doll from her. RN #300's statement revealed another video showed STNA #401 and STNA #403 together in Resident #2's room. The resident was on the mat next to his bed during a transfer with staff grabbing the resident's leg and stating, Only has one leg and laughing. RN #300 stated she did not want to report the videos to the facility because of staff reprisal.</p> <p>Review of the investigation revealed an undated statement from STNA #400 who confirmed working Saturday 07/27/24 between 2:00 P.M. and 10:00 P.M. STNA #400 stated while at the facility she showed a nurse a video talking about an older job STNA #400 had worked. STNA #400 stated that was the only video she had shown to the nurse that night.</p> <p>Review of the local Police Department incident report revealed on 07/31/24 officers responded to the facility due to a report of harassment. The report documented the ED reported RN #300 had informed the ED another employee, STNA #400, had videos on her phone of STNA #400 pinching a resident's nipples, a video of STNA #400 recording a resident throwing their baby doll which was used as a comfort item due to Alzheimer's disease, and video of staff taking the doll from her while trying to get the resident aggravated. Officers spoke with STNA #400 who denied the alleged allegations and stated the video involving the baby doll was only of the resident throwing the doll at another aid and nobody was taking the doll from the resident. Officers contacted RN #300 and confirmed STNA #400 showed her these videos on her phone while at work on 07/27/24. STNA #400 allowed officers to search through her photos on her phone and no video involving anyone pinching a resident was on the phone. STNA #400 did however show officers the video of a resident throwing their doll.</p> <p>Review of the investigation revealed a statement from STNA #401 dated 08/01/24. STNA #401 did admit to being in a video with STNA #403 involving the transfer of Resident #2.</p> <p>Review of the investigation revealed a statement from Resident #3 dated 08/01/24. Resident #3 remembered STNA #400 and the middle finger. Resident #3 stated they made her feel Horrible.</p> <p>Review of the investigation revealed a statement from STNA #404 dated 08/05/24 revealed STNA #404 denied any videos. When told by the ED that STNA #404 was observed in a video, STNA #404 did not deny it.</p> <p>Review of the personnel files for STNA #400, STNA #404, STNA #401 and STNA #403 revealed all four STNAs were terminated on 08/05/24 for unauthorized video taping of residents.</p> <p>On 09/03/24 at 12:23 P.M. interview with Executive Director (ED) #1 verified staff were identified to use personal cell phones to obtain video footage of residents during private and personal interactions with residents. The video footage violated facility privacy and personal cell phone use policy.</p> <p>(continued on next page)</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Telephone interview on 09/04/24 at 8:30 A.M. with RN #300 revealed on 07/28/24 at approximately 2:00 A.M. , STNA #400 showed her video footage on her phone of facility residents. The footage took place sometime in March 2024. Footage included STNA #400 and STNA #404 in a video with Resident #3 seated on the toilet. The STNAs were trying to get Resident #3 to repeat a curse word and raise her middle finger. A different video was observed of STNA #400 picking on Resident #1, getting the resident agitated, and taking her baby doll from her. RN #300 stated she saw an additional video of STNA #400 touching Resident #1 in the area of the breast, stomach or side to get a reaction. The resident was wearing a shirt and RN #300 was unable to determine an actual anatomical location of the touching. RN #300 went on to state on 07/28/24 during the evening, STNA #403 showed video of STNA #401 and STNA #403 together in Resident #2's room with the resident on the mat next to his bed during a transfer.</p> <p>Review of facility policy titled Electronic Communications & Computer Networking, reviewed 09/23, revealed personal cell phones are not to be on the employee during working hours, except department leaders. Cell phones are to be kept in a locker or in the employee's vehicle during working hours. Personal cell phones are to only be accessed and used during scheduled break times. At no time is a photo to be taken of the facility or of its residents as this is a violation of confidentiality. If an employee has been found to have their cell phone on their person, the employee shall hand over their cell phone to their supervisor or department leader where it will be locked up until the end of their shift. Violations will result in progressive disciplinary action up to and not limited to termination.</p> <p>This was an incidental deficiency discovered during the complaint investigation.</p>		

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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>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** 15816</p> <p>Based on medical record review, staff interview, review of the facility Self-Reported Incident (SRI), review of facility investigation, review of local police incident report, review of personnel files, and review of facility policy for abuse, the facility failed to ensure residents were protected from mental abuse by staff. This resulted in Immediate Jeopardy and the potential for serious mental, emotional, and/or psychosocial harm when facility staff willfully harassed, mocked, and ridiculed three residents (#1, #2, and #3) by laughing at them during care, making fun of their physical disabilities during care, teasing them to elicit an angry response, and encouraging them to curse and show a middle finger. As a result, one resident (#2) began to have agitated behaviors which included throwing an item at staff and one resident (#3) stated the interaction with the staff made them feel horrible. This affected three (#1, #2, #3) of three residents reviewed for staff to resident treatment and care in a facility census of 24.</p> <p>On 09/04/24 at 1:26 P.M., the Executive Director (ED), the ED of Assisted Living, the Minimum Data Set (MDS) Registered Nurse (RN), the Administrator, and the Director of Nursing (DON) were notified the Immediate Jeopardy began on 07/28/24 at 2:00 A.M. when RN #300 observed video footage contained on State tested Nurse Aide (STNA) #400's personal cell phone. The video footage included STNA #400 and STNA #404 causing Resident #1 to become agitated resulting in behaviors and Resident #3 being coerced to use inappropriate language and related hand gestures while being recorded on video. In addition, STNA #403 showed RN #300 cell phone video footage of STNA #401 and STNA #403 laughing at Resident #2 during a transfer due to the resident having an amputated leg.</p> <p>The Immediate Jeopardy was removed on 09/04/24 when the facility implemented the following corrective actions:</p> <p>On 07/31/24, the ED placed RN #300, STNA #400, STNA #401, STNA #403, and STNA #404 on suspension pending investigation.</p> <p>On 07/31/24, the ED began an investigation into the abuse allegations. The allegations were reported to the State Survey Agency and Law Enforcement. The local police were contacted.</p> <p>On 07/31/24, the local police came to the facility and interviewed staff regarding the allegations. No further actions were taken by law enforcement.</p> <p>On 07/31/24, the ED began education for all staff regarding potential abuse and exploitation. All staff were in-serviced by 08/05/24.</p> <p>On 07/31/24, the ED notified the family of Resident #3 regarding the allegations. The families of Resident #1 and Resident #2 were notified on 08/01/24 by the ED.</p> <p>On 08/01/24, the DON completed skin assessments for Resident #1, #2, and #3 with no skin concerns identified.</p> <p>(continued on next page)</p>		

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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>On 08/02/24, Certified Nurse Practitioner (CNP) assessed Residents #1, #2, and #3 with no concerns identified.</p> <p>On 08/05/24, the facility terminated the employment of RN #300, STNA #400, STNA #401, STNA #403, and STNA #404.</p> <p>On 09/03/24, interview with Licensed Practical Nurse (LPN) #500, STNA #600, and STNA #601 confirmed in-service attendance regarding potential abuse and exploitation.</p> <p>On 09/04/24, the ED interviewed 11 additional interviewable residents to assess for any abuse having occurred. The ED also interviewed 24 additional staff regarding any additional knowledge of abuse. All residents and staff denied any knowledge of abuse.</p> <p>On 09/09/24, the ED began monitoring for abuse by completing random interviews three times a week with residents able to be interviewed. The ED began making random observations three times a week for those residents who cannot be interviewed to ensure there are no negative signs of abuse or reports of inappropriate staff to resident interactions.</p> <p>Although the Immediate Jeopardy was removed on 09/04/24, the deficiency remained at a Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was in the process of implementing their corrective action plan and were monitoring to ensure on-going compliance.</p> <p>Findings include:</p> <p>Review of the facility SRI #250296, dated 07/31/24, for an allegation of emotional/verbal abuse, revealed it was reported to staff on 07/31/24 that two staff members had videos of residents on their cell phones. The alleged videos were to be of taunting with a baby doll, pinching a resident's breast, taunting a resident to say curse words and make rude gestures, and a video of staff mocking a resident with an amputation. The SRI revealed five staff members involved were placed on suspension pending the outcome of the investigation. The facility conclusion substantiated abuse and as a result of the investigation all five staff members have been terminated.</p> <p>Review of the facility investigation noted Agency STNA #402 worked 07/28/24 between 2:00 P.M. and 10:00 P.M. Agency STNA #402's statement, dated 07/31/24, stated she worked 07/28/24. During this shift RN #300 confided to Agency STNA #402 that two of her workers showed her a video of them abusing two residents. RN #300 had stated staff were pinching Resident #1's nipples and laughing at her reaction. Staff were making fun of Resident #2 for having one leg, laughing, and acting like they were going to drop him. Agency STNA #402 documented she came into the facility on [DATE] to report the incidents to the Administrator.</p> <p>(continued on next page)</p>		

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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>Review of the investigation revealed a statement from RN #300, dated 07/31/24, which confirmed STNA #400 showed her videos of Resident #1 and Resident #2. RN #300's statement revealed STNA #400 and STNA #404 were in a video with Resident #3 seated on the toilet trying to get Resident #3 to say a curse word and raise her middle finger. A different video was observed of STNA #400 picking on Resident #1, getting the resident agitated, and taking her baby doll from her. There was an additional video of STNA #400 pinching Resident #1's breast to get a reaction. RN #300's statement revealed another video showed STNA #401 and STNA #403 together in Resident #2's room. The resident was on the mat next to his bed during a transfer with staff grabbing the resident's leg and stating, Only has one leg and laughing. RN #300 stated she did not want to report the incidents to the facility because of staff reprisal.</p> <p>Review of the investigation revealed an undated statement from STNA #400 who confirmed working Saturday 07/27/24 between 2:00 P.M. and 10:00 P.M. STNA #400 stated while at the facility she showed a nurse a video talking about an older job STNA #400 had worked. STNA #400 stated that was the only video she had shown to the nurse that night.</p> <p>Review of the local Police Department incident report revealed on 07/31/24 officers responded to the facility due to a report of harassment. The report documented the ED reported RN #300 had informed the ED another employee, STNA #400, had videos on her phone of STNA #400 pinching a resident's nipples, a video of STNA #400 recording a resident throwing their baby doll which was used as a comfort item due to Alzheimer's disease, and video of staff taking the doll from her while trying to get the resident aggravated. Officers spoke with STNA #400 and adviser her of her rights. STNA #400 denied the alleged allegations and stated the video involving the baby doll was only of the resident throwing the doll at another aid and nobody was taking the doll from the resident. Officers contacted RN #300 and confirmed STNA #400 showed her these videos on her phone while at work on 07/27/24. The report contained an additional interview with STNA #400 who denied any such knowledge of videos, stating she did tickle a resident on the sides after the resident playfully grabbed at her scrubs. STNA #400 stated she did not record the tickle on her phone and does not think anyone else may have recorded it either. STNA #400 allowed officers to search through her photos on her phone and no video involving anyone pinching a resident was on the phone. STNA #400 did however show officers the video of a resident throwing their doll. Officers told STNA #400 the video involving the doll was inappropriate to which STNA #400 agreed. The ED provided STNA #400 a work suspension pending investigation. STNA #400 left the building without issue.</p> <p>Review of the investigation revealed a statement from STNA #401 dated 08/01/24. STNA #401 denied taking videos on her phone. STNA #401 did admit to being in a video with STNA #403 involving the transfer of Resident #2.</p> <p>Review of the investigation revealed a statement from STNA #403 dated 08/01/24. STNA #403 denied taking a phone into any resident's rooms.</p> <p>Review of the investigation revealed a statement from Resident #3 dated 08/01/24. Resident #3 remembered STNA #400 and the middle finger. Resident #3 stated they made her feel Horrible.</p> <p>Review of the investigation revealed a statement from STNA #404 dated 08/05/24 revealed STNA #404 denied any videos. When told by the ED that STNA #404 was observed in a video, STNA #404 did not deny it.</p> <p>(continued on next page)</p>		

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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>Review of the medical record revealed Resident #1 admitted to the facility on [DATE]. Diagnoses included Alzheimer's disease, dementia, and major depressive disorder. The most current Minimum Data Set (MDS) assessment, dated 07/26/24, identified Resident #1 with severe cognitive impairment, inability to understand or make needs known, and dependent on staff for activities of daily living.</p> <p>Review of the medical record revealed Resident #2 admitted to the facility on [DATE]. Diagnoses included dementia, abnormal posture, infection of amputation stump right lower extremity, Parkinson disease, major depression, anxiety disorder, and schizoaffective disorder of bipolar type. The most current MDS assessment, dated 06/28/24, assessed Resident #2 with severely impaired cognition and requiring substantial to maximal assistance with activities of daily living.</p> <p>Review of the medical record revealed Resident #3 admitted to the facility on [DATE]. Diagnoses included major depression, congestive heart failure, and anxiety disorder. The most current MDS assessment, dated 06/25/24, assessed Resident #3 with intact cognition and dependent on staff for the completion of activities of daily living.</p> <p>Review of the personnel files for STNA #400, STNA #404, and RN #300 revealed they were suspended from work starting on 07/31/24. Review of the personnel files for STNA #401 and STNA #403 revealed they were suspended from work starting on 08/01/24. The personnel files revealed all four STNAs were terminated on 08/05/24 for unauthorized video taping of residents. RN #300 was terminated on 08/05/24 for not reporting the allegations to the administrator.</p> <p>Interview on 09/03/24 at 9:55 A.M. with the Administrator revealed she was made aware of the incident on 07/31/24. Involved staff were suspended pending investigation on 07/31/24 with employment terminated on 08/05/24.</p> <p>Telephone interview on 09/04/24 at 8:30 A.M. with RN #300 revealed on 07/28/24 at approximately 2:00 A.M. , STNA #400 showed her video footage on her phone of facility residents. The footage took place sometime in March 2024. Footage included STNA #400 and STNA #404 in a video with Resident #3 seated on the toilet. The STNAs were trying to get Resident #3 to repeat a curse word and raise her middle finger. A different video was observed of STNA #400 picking on Resident #1, getting the resident agitated, and taking her baby doll from her. RN #300 stated she saw an additional video of STNA #400 pinching Resident #1 in the area of the breast, stomach or side to get a reaction. The resident was wearing a shirt and RN #300 was unable to determine an actual anatomical location of the touching. RN #300 went on to state on 07/28/24 during the evening, STNA #403 showed video of STNA #401 and STNA #403 together in Resident #2's room with the resident on the mat next to his bed during a transfer. The staff were grabbing the resident's leg and stating, Only has one leg and laughing. RN #300 stated she did not want to report these incidents to the facility because of staff reprisal.</p> <p>Review of facility policy titled Abuse, Neglect, Exploitation, and Misappropriation of Property, reviewed 11/16, revealed it is the philosophy of the facility to provide each resident with protection from harm whether it is from another resident, staff member, or visitor. The facility shall assure residents are free from abuse. The policy defines abuse as the willful infliction of injury, intimidation, pain or mental anguish. Willful means the individual must have acted deliberately. Mental abuse is defined as humiliation, harassment, threats of punishment or deprivations. Verbal abuse includes the use of oral or gestured language that willfully includes disparaging and derogatory terms to residents regardless of their ability to comprehend.</p> <p>(continued on next page)</p>		

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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>This deficiency represents non-compliance discovered during the investigation of Complaint Number OH00156582.</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** 15816</p> <p>Based on medical record review, review of facility self-reported incident (SRI), review of facility investigation, review of personnel files, staff interview, and review of facility policy, the facility ensure staff timely reported alleged violations of abuse to the administrator. This affected three (#1, #2, #3) of three residents reviewed for resident abuse and mistreatment in a facility census of 24.</p> <p>Findings include:</p> <p>Review of the medical record revealed Resident #1 admitted to the facility on [DATE]. Diagnoses included Alzheimer's disease, dementia, and major depressive disorder. The most current Minimum Data Set (MDS) assessment, dated 07/26/24, identified Resident #1 with severe cognitive impairment, inability to understand or make needs known, and dependent on staff for activities of daily living.</p> <p>Review of the medical record revealed Resident #2 admitted to the facility on [DATE]. Diagnoses included dementia, abnormal posture, infection of amputation stump right lower extremity, Parkinson disease, major depression, anxiety disorder, and schizoaffective disorder of bipolar type. The most current MDS assessment, dated 06/28/24, assessed Resident #2 with severely impaired cognition and requiring substantial to maximal assistance with activities of daily living.</p> <p>Review of the medical record revealed Resident #3 admitted to the facility on [DATE]. Diagnoses included major depression, congestive heart failure, and anxiety disorder. The most current MDS assessment, dated 06/25/24, assessed Resident #3 with intact cognition and dependent on staff for the completion of activities of daily living.</p> <p>Review of the facility SRI #250296, dated 07/31/24, for an allegation of emotional/verbal abuse, revealed it was reported to staff on 07/31/24 that two staff members had videos of residents on their cell phones. The alleged videos were to be of taunting with a baby doll, pinching a resident's breast, taunting a resident to say curse words and make rude gestures, and a video of staff mocking a resident with an amputation. The SRI revealed five staff members involved were placed on suspension pending the outcome of the investigation. The facility conclusion substantiated abuse and as a result of the investigation all five staff members have been terminated.</p> <p>Review of the facility investigation noted Agency State tested Nurse Aide (STNA) #402 worked 07/28/24 between 2:00 P.M. and 10:00 P.M. Agency STNA #402's statement, dated 07/31/24, stated she worked 07/28/24. During this shift Registered Nurse (RN) #300 confided to Agency STNA #402 that two of her workers showed her a video of them abusing two residents. RN #300 had stated staff were pinching Resident #1's nipples and laughing at her reaction. Staff were making fun of Resident #2 for having one leg, laughing, and acting like they were going to drop him. Agency STNA #402 documented she came into the facility on [DATE] to report the incidents to the Administrator.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366422	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/16/2024
NAME OF PROVIDER OR SUPPLIER Elmwood Assisted Living & Skilled Nursing of Fremo		STREET ADDRESS, CITY, STATE, ZIP CODE 1545 Fangboner Rd Fremont, OH 43420	
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the investigation revealed a statement from RN #300, dated 07/31/24, which confirmed STNA #400 showed her videos of Resident #1 and Resident #2. RN #300's statement revealed STNA #400 and STNA #404 were in a video with Resident #3 seated on the toilet trying to get Resident #3 to say a curse word and raise her middle finger. A different video was observed of STNA #400 picking on Resident #1, getting the resident agitated, and taking her baby doll from her. There was an additional video of STNA #400 pinching Resident #1's breast to get a reaction. RN #300's statement revealed another video showed STNA #401 and STNA #403 together in Resident #2's room. The resident was on the mat next to his bed during a transfer with staff grabbing the resident's leg and stating, Only has one leg and laughing. RN #300 stated she did not want to report the incidents to the facility because of staff reprisal.</p> <p>Review of the personnel file for RN #300 revealed a Discussion Summary form, dated 07/31/24, which noted RN #300 to be suspended due to an allegation of mistreatment of residents was brought to RN #300's knowledge and she did not report this to the Administrator. According to Employee Termination/Resignation Report, dated 08/09/24, RN #300 was terminated on 08/05/24 due to failed to report such resident violation.</p> <p>Interview on 09/03/24 at 9:55 A.M. with the Administrator revealed she was made aware of the incident on 07/31/24.</p> <p>Telephone interview on 09/04/24 at 8:30 A.M. with RN #300 revealed on 07/28/24 at approximately 2:00 A.M. , STNA #400 showed her video footage on her phone of facility residents. The footage took place sometime in March 2024. Footage included STNA #400 and STNA #404 in a video with Resident #3 seated on the toilet. The STNAs were trying to get Resident #3 to repeat a curse word and raise her middle finger. A different video was observed of STNA #400 picking on Resident #1, getting the resident agitated, and taking her baby doll from her. RN #300 stated she saw an additional video of STNA #400 pinching Resident #1 in the area of the breast, stomach or side to get a reaction. The resident was wearing a shirt and RN #300 was unable to determine an actual anatomical location of the touching. RN #300 went on to state on 07/28/24 during the evening, STNA #403 showed video of STNA #401 and STNA #403 together in Resident #2's room with the resident on the mat next to his bed during a transfer. The staff were grabbing the resident's leg and stating, Only has one leg and laughing. RN #300 stated she did not want to report these incidents to the facility because of staff reprisal.</p> <p>Review of facility policy titled Abuse, Neglect, Exploitation, and Misappropriation of Property, reviewed 11/16, revealed any employee, family member, resident, visitor or volunteer are to immediately report any known or suspected episodes of resident mistreatment, neglect, or abuse without fear of retaliation. Reports may be made directly to the Chief Executive Officer, ED/Administrator, or Director of Nursing. Any staff who witnesses or suspects resident abuse or neglect shall immediately report the incident to his/her immediate supervisor. The Executive Director (ED)/Administrator will immediately be notified if reported to a supervisor.</p> <p>This deficiency is an incidental finding discovered during the complaint investigation.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366422	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/16/2024
NAME OF PROVIDER OR SUPPLIER Elmwood Assisted Living & Skilled Nursing of Fremo		STREET ADDRESS, CITY, STATE, ZIP CODE 1545 Fangboner Rd Fremont, OH 43420	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<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** 15816</p> <p>Based on medical record review, review of a self-reported incident (SRI), staff interview, review of facility investigation, review of personnel files, review of Time Card Reports, and review of facility policy, the facility failed ensure residents were protected from mistreatment from staff who continued working after an allegation of abuse and failed to thoroughly investigate allegations of staff to resident abuse and harassment. This affected three (#1, #2, #3) of three residents reviewed for abuse and mistreatment in a facility census of 24.</p> <p>Findings include:</p> <p>Review of the medical record revealed Resident #1 admitted to the facility on [DATE]. Diagnoses included Alzheimer's disease, dementia, and major depressive disorder. The most current Minimum Data Set (MDS) assessment, dated 07/26/24, identified Resident #1 with severe cognitive impairment, inability to understand or make needs known, and dependent on staff for activities of daily living.</p> <p>Review of the medical record revealed Resident #2 admitted to the facility on [DATE]. Diagnoses included dementia, abnormal posture, infection of amputation stump right lower extremity, Parkinson disease, major depression, anxiety disorder, and schizoaffective disorder of bipolar type. The most current MDS assessment, dated 06/28/24, assessed Resident #2 with severely impaired cognition and requiring substantial to maximal assistance with activities of daily living.</p> <p>Review of the medical record revealed Resident #3 admitted to the facility on [DATE]. Diagnoses included major depression, congestive heart failure, and anxiety disorder. The most current MDS assessment, dated 06/25/24, assessed Resident #3 with intact cognition and dependent on staff for the completion of activities of daily living.</p> <p>Review of the facility SRI #250296, dated 07/31/24, for an allegation of emotional/verbal abuse, revealed it was reported to staff on 07/31/24 that two staff members had videos of residents on their cell phones. The alleged videos were to be of taunting with a baby doll, pinching a resident's breast, taunting a resident to say curse words and make rude gestures, and a video of staff mocking a resident with an amputation. The SRI revealed five staff members involved were placed on suspension pending the outcome of the investigation. The facility conclusion substantiated abuse and as a result of the investigation all five staff members have been terminated.</p> <p>Review of the facility investigation noted Agency State tested Nurse Aide (STNA) #402 worked 07/28/24 between 2:00 P.M. and 10:00 P.M. Agency STNA #402's statement, dated 07/31/24, stated she worked 07/28/24. During this shift Registered Nurse (RN) #300 confided to Agency STNA #402 that two of her workers showed her a video of them abusing two residents. RN #300 had stated staff were pinching Resident #1's nipples and laughing at her reaction. Staff were making fun of Resident #2 for having one leg, laughing, and acting like they were going to drop him. Agency STNA #402 documented she came into the facility on [DATE] to report the incidents to the Administrator.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Elmwood Assisted Living & Skilled Nursing of Fremo		STREET ADDRESS, CITY, STATE, ZIP CODE 1545 Fangboner Rd Fremont, OH 43420	
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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the investigation revealed a statement from RN #300, dated 07/31/24, which confirmed STNA #400 showed her videos of Resident #1 and Resident #2. RN #300's statement revealed STNA #400 and STNA #404 were in a video with Resident #3 seated on the toilet trying to get Resident #3 to say a curse word and raise her middle finger. A different video was observed of STNA #400 picking on Resident #1, getting the resident agitated, and taking her baby doll from her. There was an additional video of STNA #400 pinching Resident #1's breast to get a reaction. RN #300's statement revealed another video showed STNA #401 and STNA #403 together in Resident #2's room. The resident was on the mat next to his bed during a transfer with staff grabbing the resident's leg and stating, Only has one leg and laughing. RN #300 stated she did not want to report the incidents to the facility because of staff reprisal.</p> <p>Review of the investigation revealed a statement from STNA #401 dated 08/01/24. STNA #401 denied taking videos on her phone. STNA #401 did admit to being in a video with STNA #403 involving the transfer of Resident #2.</p> <p>Review of the investigation revealed a statement from Resident #3 dated 08/01/24. Resident #3 remembered STNA #400 and the middle finger. Resident #3 stated they made her feel Horrible.</p> <p>Review of the investigation revealed a statement from STNA #404 dated 08/05/24 revealed STNA #404 denied any videos. When told by the ED that STNA #404 was observed in a video, STNA #404 did not deny it.</p> <p>Review of the investigation revealed the only staff interviewed during the investigation of the mistreatment of Resident #1, Resident #2, and Resident #3 were STNA #400, STNA #401, STNA #403, STNA #404, Agency STNA #402, and RN #300. There were no interviews with any of the other facility staff to identify any other witnesses, nor were any residents not included in the allegations interviewed.</p> <p>Review of the personnel files for STNA #400, STNA #404, and RN #300 revealed they were suspended from work starting on 07/31/24. Review of the personnel files for STNA #401 and STNA #403 revealed they were suspended from work starting on 08/01/24. The personnel files revealed all four STNAs were terminated on 08/05/24 for unauthorized video taping of residents. RN #300 was terminated on 08/05/24 for not reporting the allegations to the administrator.</p> <p>Review the Time Card Report noted STNA #400 to continue working at the facility after RN #300 was made aware of the allegations. Recorded work periods were: 07/28/24 between 12:00 A.M. to 6:16 A.M. and between 1:55 P.M. and 10:15 P.M., on 07/30/24 between 5:55 A.M. and 2:15 P.M., and on 07/31/24 between 1:55 P.M. and 4:00 P.M.</p> <p>Review the Time Card Report noted STNA #401 continued working at the facility after RN #300 was aware of the allegations. Recorded work periods were: 07/28/24 between 12:00 A.M. to 6:15 A.M. and 9:55 P.M. to 07/29/24 at 6:15 A.M.</p> <p>Review the Time Card Report noted STNA #403 to continue working at the facility after RN #300 was aware of the allegations. Recorded work periods were: 07/28/24 between 9:55 P.M. to 07/29/24 at 6:15 A.M. and on 07/30/24 from 9:55 P.M. to 07/31/24 at 6:20 A.M.</p> <p>Review the Time Card Report noted STNA #404 to continue working at the facility after RN #300 was aware of the allegations. Recorded work periods were: 07/28/24 between 2:04 P.M. to 3:17 P.M.</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 09/03/24 at 9:55 A.M. with the Administrator revealed she was made aware of the incident on 07/31/24. Involved staff were suspended pending investigation on 07/31/24.</p> <p>Interview on 09/03/24 at 12:23 P.M. with Executive Director (ED) #1 confirmed no additional staff working on 07/28/24 were interviewed. ED #1 stated a delay of reporting resulted in alleged staff working after RN #300 was made aware of video footage. ED #1 stated they conducted interviews with the affected residents (#1, #2, #3). However, additional residents were not interviewed to determine if other residents were involved or witnesses</p> <p>Review of facility policy titled Abuse, Neglect, Exploitation, and Misappropriation of Property, reviewed 11/16, revealed the ED/Administrator will instruct the reporting party to complete an incident report and follow that policy. The ED/Administrator will remove the employee (s) alleged to be involved in the suspected incident from direct resident care until the completion of the investigation if there is reason to suspect abuse, neglect, exploitation, or misappropriation related to the incident. The ED/Administrator will conduct an investigation and shall be completed within 48 hours, if able, but always within five business days. The investigation shall include interviewing the resident, the accused, and any witnesses. Obtaining written statements from the resident if possible, the accused and each witness; and reviewing residents medical record. If there are no direct witnesses, the interviews may be expanded.</p> <p>This deficiency is an incidental finding discovered during the complaint investigation.</p>		