STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366491	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Strongsville Healthcare and Rehabilitation	18936 Pearl Road Strongsville, OH 44136

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 - Immediate jeopardy to resident health or safety 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** 34297 THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NONCOMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on observation, record review, review of an employee personnel file, review of video surveillance, review of a policy report, review of facility policy and interview, the facility failed to ensure Resident #1, a resident with cognitive impairment, was free from staff to resident abuse when Certified Nursing Assistant (CNA) #813 physically abused the resident while providing care. This resulted in Immediate Jeopardy and actual physical and psychosocial harm as a result of the physical abuse incident which occurred on 10/29/24 at approximately 9:30 P.M. when CNA #813 took Resident #1 to the bathroom and the CNA could he heard hitting (audio of skin to skin contact sounding like two smacks) could be heard on the surveillance video and the resident was heard crying out. Continued video surveillance showed CNA #813 coming out of the bathroom with Resident #1 and putting the resident back in bed at which time CNA #813 was observed hitting Resident #1 in the face. Resident #1 was observed on the surveillance video crying in emotional distress. This affected one resident (#1) of three sampled residents reviewed for abuse. The facility identified 23 residents residing on the secured memory care unit (SMCU), Resident #1, #4, #11, #18, #23, #31, #36, #40, #43, #46, #48, #49, #51, #53, #58, #62, #63, #74, #75, #76, #83, #85 and #89 at the time of the incident. The facility census was 89. On 11/12/24 at 2:27 P.M., the Administrator, Registered Nurse (RN) Corporate Director of Clinical Services (CDCS) #920 and the Director of Nursing (DON) were notified Immediate Jeopardy began on 10/29/24 when the facility failed to protect Resident #1's right to be free from physical and emotional/mental abuse by CNA #813. Video surveillance captured the incidents of abuse that occurred while the CNA was providing personal care services to the resident and video surveillance also captured the resident's emotional distress as a result of the incident. The Immediate Jeopardy was removed and corrected on 10/30/24 when the facility implemented the following corrective actions: On 10/29/24 at 10:17 P.M. following family notification of the incident observed on video surveillance to the local police, CNA #813 was taken into police custody by the police department. CNA #813's employment was terminated on 10/29/24. On 10/29/24 at 11:00 P.M. Resident #1 was assessed by RN Unit Manager (UM) #808. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366491	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER Strongsville Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 18936 Pearl Road Strongsville, OH 44136	

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/30/24 at 10:00 A.M. Resident #1's care plans were reviewed and updated by RN Minimum Data Set (MDS) #914 to include the following new behavioral focus interventions: Any incident of combativeness while providing care must be immediately reported to appropriate clinical management; Any instances of providing hands-on care to Resident #1 now required two qualified staff members, without exception; And assure resident, staff and visitor safety to the best of the staff's ability and within reason. On 10/29/24 from 11:00 P.M. to 10/30/24 at 1:00 A.M. RN UM #808 assessed all residents on the SMCU for evidence of abuse which included skin checks and pain assessments. On 10/30/24 from 10:00 A.M. to 12:00 P.M. all resident, including the 23 residents on the SMCU (Residents #1, #4, #11, #18, #23, #31, #36, #40, #43, #46, #48, #49, #51, #53, #58, #62, #63, #74, #75, #76, #83, #85 and #89) were reviewed by RN MDS #914 to ensure they were accurate to meet the residents' needs. On 10/30/24 at 10:00 A.M. the facility abuse policy was reviewed by RN CDCS #920 with no updates or changes being made. On 10/29/24 at 10:15 P.M. RN CDCS #920 re-educated the Administrator and the DON on the facility abuse policy and procedure. On 10/30/24 at 10:00 A.M. a new procedure was developed by the DON: Residents on the SMCU Become a Two-Person Assist During an Episode of Combative Behavior. Compliance would be monitored by the DON and Administrator three to five days per week for four weeks then quarterly thereafter. All findings of concern would be immediately addressed and reported to the Quality Assurance Performance Improvement (QAPI) committee for further review and prompt response and resolution. On 10/29/24 from 10:42 P.M. to 10/30/24 at 2:00 P.M. the Administrator re-educated all staff on the Abuse Policy and the new procedure for Residents on the SMCU Become a Two-Person Assist During an Episode of Combative Behavior. Re-education was provided to a total of five RNs, 19 Licensed Practical Nurses (LPNs), 36 CNAs, 17 dietary Staff, two Activity Staff, 13 Housekeeping/Laundry Staff and 20 therapy staff (all staff in the building). Beginning on 10/29/24 at 9:00 A.M. and continuing through 10/30/24 at 2:00 P.M all current staff were educated on facility's dementia-focus program, Compass Training, by the Administrator. New employees would receive dementia focused training, Compass Training, upon hire during orientation by Activity Director #815 and/or designee, then annually and as necessary thereafter. On 10/30/24 at 11:00 A.M., the Administrator presented the QAPI team with the abuse investigation and all findings were discussed and reviewed. The discussion included an action plan from the incident regarding Resident #1 and the staff to resident abuse. Staff in attendance included the DON, RN UM #808, RN MDS #914, Social Service Designee (SSD) #916, Therapy Director #921, Activity Director #815, Maintenance Director #814, Housekeeping/Laundry Director #842, Dietary Manager #834, Pharmacy Consultant #922, the Medical Director, Human Resources #907 and Business Office Manager (BOM) #848. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/30/24 at 3:00 P.M. an audit was completed by the Administrator and DON to monitor compliance of the abuse education. The audit included monitoring skin assessments for injuries of unknown origin on cognitively impaired residents and interviews of non-cognitively impaired residents for allegations of abuse. On 10/30/24 the facility implemented a plan for the Administrator, DON and/or designee to conduct an audit on three to five residents per week for four weeks, and randomly thereafter. The audit included monitoring skin assessments for injuries of unknown origin on cognitively impaired residents and interviews of non-cognitively impaired residents for allegations of abuse. All findings of concern would be immediately addressed and reported to the QAPI committee for further review and prompt response and resolution. Findings include: Review of Resident #1's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease with late onset, senile degeneration of the brain and unspecified dementia without behavioral disturbance. The resident resided on the facility SMCU. Review of Resident #1's behavioral care plans revealed (with a revision date of 04/21/23) revealed the resident had a behavior problem related to throwing clothes at times, was resistant to care due to dementia, rummages through things. Interventions included to administer medications as ordered, anticipate and meet the resident's needs, provide opportunity for positive interaction and attention, discuss resident's behaviors, praise any indicate of the resident's progress/improvement in behavior, provide a program of activities that was of interest and accommodates the resident's status. Review of Resident #1's annual Minimum Data Set (MDS) assessment dated [DATE] revealed the resident exhibited a memory problem, was occasionally incontinent of urine, always continent of bowel, and required setup or clean-up assistance with toilet hygiene (the ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement). Review of Resident #1's progress note dated 10/29/24 at 4:43 P.M. revealed the resident had restless periods during the day. However, she did not have any incidents of aggressive behavior towards staff, visitors, other residents or family members documented. Review of a facility Self-Reported Incident Investigation (SRI) Tracking Number 253495 dated 10/29/24 revealed the facility reported an incident of physical abuse involving Resident #1. The SRI included at approximately 10:15 P.M. the police were onsite at the request of the resident's family member after witnessing CNA #813 hit Resident #1 on the room surveillance camera. The police arrested and removed CNA #813 from the facility at the time of the incident. The facility immediately suspended CNA #813 pending an investigation and the resident's safety was maintained. CNA #813 was terminated as a result of the facility investigation. The facility substantiated the allegation/incident of abuse. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a police department report revealed abuse occurred on 10/29/24 at 9:33 P.M. The synopsis section of the form indicated on 10/29/24 at approximately 9:34 P.M., the police were dispatched to the facility for an assault that had recently occurred between a patient (Resident #1) and a staff member (CNA #813). The staff member was arrested and charged with patient abuse which was a fourth-degree felony. The documentation reflected surveillance video which was four minutes and 13 seconds long. During the first three minutes and 15 seconds of the video, the resident and CNA #813 seemed to be inside the restroom. At two minutes and thirteen seconds into the video surveillance, CNA #813 asked Resident #1 what she was doing. At two minutes and seventeen seconds into the surveillance video, CNA #813 told Resident #1 to put her underwear on. At two minutes and twenty-five seconds into the surveillance video, CNA #813 tells Resident #813 to stand up and at two minutes twenty-six seconds into the surveillance video, the resident said she was not standing up. A smacking sound was heard on the surveillance video. At two minutes and twenty-eight seconds into the surveillance video, another smacking sound was heard and then Resident #813 was heard sobbing and saying oh, my God many times. At three minutes and fifteen seconds into the surveillance video, CNA #813 and Resident #1 were observed walking out of the restroom and the resident was guided by the CNA towards the bed while the resident was sobbing. At three minutes and 29 seconds into the surveillance video, CNA #813 placed Resident #1's legs on the bed while the resident was striking the CNAs shoulder. At three minutes and thirty-one seconds into the surveillance video, CNA #813 hit the resident's face with her open palm which caused the resident to cover her face and state oh, my God and start to sob. At four minutes and thirteen seconds into the surveillance video, CNA #813 turned off the lights and opened the door of the room. Review of Resident #1's progress note dated 10/29/24 at 11:00 P.M. revealed the resident was resting quietly in bed with her eyes closed. The nurse assessed the resident and the resident's pulse oximetry on room air and the resident had not voiced any complaints of pain/discomfort at the time. Vital signs were obtained with a blood pressure at 144/55, pulse 65 beats per minute (BPM) and respirations 18 breaths per minute. The resident's temperature was 97.6 degrees Fahrenheit. Review of Resident #1's progress note dated 10/30/24 at 6:51 A.M. revealed the resident returned to the facility with the daughter at this time and had dinner on leave of absence (LOA). Observation on 11/12/24 at 5:31 A.M. revealed Resident #1's door was shut. The resident was observed in a room on the facility SMCU. Observation on 11/12/24 at 5:57 A.M. revealed Resident #1 was in the dining room and small lounge off the dining room (directly beside the nursing station) on the SMCU. She appeared clean and was ambulatory. The resident was wearing nonskid socks and her hair was combed. No bruising was noted to the resident's face, head or neck area. However, due to the resident's cognitive impairment she was not interviewable or able to answer questions related to the incident of abuse. Interview on 11/12/24 at 6:12 A.M. with RN UM #808 revealed she was called on 10/29/24 by the DON and told to go to the facility because something happened. She stated she arrived approximately ten minutes after the call and was informed the police had arrested CNA #813. RN UM #808 stated the police and CNA #813 were already gone from the facility when she clocked in on 10/29/24 at 10:54 P.M. She denied Resident #1 had any new (visible) injuries, but stated she did have a yellow area on the right cheek from a prior fall and a bruise on her thigh from a prior fall. RN UM #808 stated at that time, the police, CNA #813 and (resident's)family were in the parking lot, but the resident's family members declined to come in the building. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 11/12/24 at 6:35 A.M. with RN #812 (dayshift on the SMCU) revealed he had worked an extra four hours on the SMCU on 10/29/24 from approximately 6:30 P.M. to 10:25 P.M. and was unaware of any abuse concerns until the police walked up to the nursing station and addressed CNA #813. RN #812 indicated Resident #1 was in the main dining area on 10/29/24 around 9:15 P.M. when CNA #813 took the resident to her room for resident care and finished at an unknown time. RN #812 stated CNA #813 was sitting behind the nursing desk playing on her phone when the police came into the SMCU on 10/29/24 around 10:15 P.M. and addressed the CNA specifically. RN #812 stated the police did not talk to him and asked CNA #813 if she was aware of what was on video footage. RN #812 stated CNA #813 told the police she was trying to hold the resident's head down and the police told the CNA that was not evidenced per the video. RN #812 stated the police told CNA #813 that if Resident #1's family pressed charges, they were taking the CNA to jail. RN #812 stated the police then asked CNA #813 to walk with them and they left the unit. RN #812 stated he had assessed Resident #1 who was in bed sleeping and did not identify injuries to the resident per his assessment. Interview on 11/12/24 at 7:25 A.M. with the DON indicated she received a call from RN #816, the nightshift supervisor who stated the police were in the building to arrest CNA #813. The DON stated RN #816 had watched the video surveillance provided by Resident #1's family which confirmed physical abuse. The DON stated she had watched the video surveillance at a later (unknown) time and stated CNA #813 put Resident #1 in bed and the resident was patting the CNA on her shoulder. The DON stated after CNA #813 put the resident in bed, she hit her in the forehead with an open palm. The DON stated the facility provided documentation including the type of camera approved by the facility and costs for installing/mounting the camera as well as release forms per Esther's Law on 10/28/24 but was unaware the family had put a camera in the room by the resident's bed for video surveillance. Telephone interview on 11/12/24 at 8:12 A.M. with CNA #817 revealed CNA #813 was working on the SMCU by herself, and she came in on 10/29/24 around 11:00 P.M. after the police had arrested CNA #813. CNA #817 stated she did not see any physical injuries when she had provided care to Resident #1 following the abuse incident. CNA #817 confirmed following the incident, she received education on abuse. Telephone interview on 11/12/24 at 9:40 A.M. with Resident #1's daughter confirmed she had viewed STNA #813 hitting her mother on the video surveillance (on 10/29/24) in the resident's room. Observation on 11/12/24 at 10:36 A.M. of the video surveillance provided by Resident #1's daughter and power-of-attorney (POA) for healthcare and financial revealed a clock in the surveillance video on the wall in the resident's room stated it was 9:27 P.M./ 9:28 P.M. The surveillance video confirmed two smacking sounds could be heard while Resident #1 and CNA #813 were in the bathroom followed both times by the resident's crying in emotional distress. Further observation revealed CNA #813 and Resident #1 walked out of the bathroom, the CNA roughly pushed the resident onto the bed, swung her legs up in the bed and hit the resident in the face. The resident was observed holding her face and crying out in emotional distress as a result of the incident. Interview on 11/12/24 at 11:38 A.M. with the DON revealed only full-time staff members who worked on the SMCU were provided Compass Dementia training the facility had implemented several months prior. The DON revealed CNA #813 was not a full-time staff member on the SMCU and therefore she had not been provided the Compass Dementia training although the employee was scheduled to work on the unit. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Telephone interview on 11/13/24 at 9:22 A.M. with CNA #813 revealed she had provided care to Resident #1 and the resident was always hitting and kicking. When asked if she or anyone else hit or called Resident #1 names, she denied the allegation. The CNA then stated she would not discuss anything else with the surveyor unless her lawyer was present. Review of CNA #813's employee file revealed a hire date of 06/12/24 with a signed Job Description form dated 06/12/24. The Job Description form revealed to perform all duties within the guidelines of quality of care always including following resident rights policies and report any concerns to the licensed nurse. The employee's file included an Employee Corrective Action Form dated 10/29/24 which included the employee was terminated due to performance/policy violation and conduct issues. The termination was issued via the telephone. Observations during the onsite investigation revealed there were four units in the facility with a total census of 89 residents. The Special Care Unit (secured memory care unit or SMCU) had 23 residents residing on it which included, Resident #1, #4, #11, #18, #23, #31, #36, #40, #43, #46, #48, #49, #51, #53, #58, #62, #63, #74, #75, #76, #83, #85 and #89. Review of the facility undated Abuse Prohibition policy revealed each resident had the right to be free from abuse, neglect, and corporal punishment of any type by anyone. Abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also included the deprivation by an individual, including a caretaker, of goods or services that were necessary to attain or maintain physical, mental, and psychosocial well-being. Review of the facility Behavior Management; Dementia policy revised 02/2023 revealed the purpose of the policy was to ensure each resident received the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompassed a residents whole emotional and mental well-being, which included, but was not limited to, the prevention and treatment of mental and substance use disorders. This deficiency represents non-compliance investigated under Complaint Number OH00159638 and Complaint Number OH00159450.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34297 Based on observation, record review, policy review, and interview, the facility failed to ensure Resident #1's care planned interventions were implemented related to wandering behavior and her safety was maintained at all times to prevent elopement from the facility. This finding affected one (Resident #1) of three residents reviewed for accidents and hazards. Findings include: Review of Resident #1's medical record revealed the resident was admitted on [DATE] with diagnoses including Alzheimer's disease with late onset, senile degeneration of the brain and unspecified dementia without behavioral disturbance. The resident resided on the secured memory care unit (SMCU). Review of Resident #1's care plans dated 12/27/22 and revised on 09/16/24 revealed the resident was an elopement risk/wanderer related to the resident's cognitive status and disorientation to place. An intervention dated 12/27/22 stated to assess for fall risk; an intervention dated 12/27/22 to distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television and books; and an intervention dated 12/27/22 to provide structured activities, toileting, walking strategies including signs, pictures and memory boxes. Review of Resident #1's Annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited a memory problem. Observation on 11/14/24 at 2:08 P.M. of the facility surveillance video (no sound) of the secured memory care unit (SMCU) with the Director of Nursing (DON) revealed on 11/08/24 at 6:29 P.M., Resident #1 put a doll in a chair and pushed the chair across the common lounge then walked out into the hall, turned left and walked down the hall to the 15-second egress door on the left side of the SMCU (only a small portion of the door was observed on the facility surveillance video which was pointed at the common lounge area). The door was observed to open and close. Further observation revealed on 11/08/24 at 6:30 P.M., Registered Nurse (RN) #812 went to the 15-second egress door on the left hand side and opened the door but did not go out of the door to look for Resident #1. RN #812 was observed to walk back up the hall and towards the nursing station. Observation of the surveillance video on 11/08/24 at 6:42 P.M. revealed Laundry Aide #847 walking with Resident #1 back into the SMCU. The resident was outside of the building approximately thirteen minutes. Interview on 11/14/24 at 2:11 PM. with Laundry Aide #847 revealed she was in her car preparing to go home as she had clocked out at 6:32 P.M. when she observed Resident #1 standing on the side of the building by herself with no staff members nearby. Observation on 11/14/24 at 2:15 P.M. with the DON revealed the door on the SMCU in which Resident #1 went out was 101 steps from the window/grassy area where the resident was found (around the side of the building and standing beside the side windows on the property). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Telephone interview on 11/14/24 at 2:15 P.M. with RN #812 revealed he thought staff were outside talking to Resident #1 and he thought those staff members would bring the resident back into the building. He was unable to state who the staff members were. RN #812 confirmed he did not go out and retrieve Resident #1 to ensure the resident's safety as indicated in the elopement policy. Interview on 11/14/24 at 2:22 P.M. with the DON confirmed Resident #1 was off the SMCU approximately 13 minutes per the facility surveillance video. The DON confirmed RN #812 should have went through the door to look for Resident #1 when the resident exited the building unsupervised. DON confirmed Resident #1's medical record did not include the resident's elopement. DON revealed they were unaware the resident was out of the building for 13 minutes. Review of the facility provided incident/accident log revealed Resident #1's elopement was not on the log. The facility did not have an investigation of the elopement for review. Review of Resident #1's medical record revealed the facility did not document the resident's 10/29/24 elopement or follow up measures to ensure the residents wellness and safety. Review of the Elopement policy revised 10/2022 revealed the purpose of the policy was to identify a resident's risk for elopement, prevent a resident from exiting the facility without the knowledge of the staff and to delineate the reporting process if an elopement occurs. A situation in which a resident leaves the premises or a safe area without the facility knowledge and supervision, if necessary, would be considered an elopement. The situation represents a risk to the resident's health and safety. If a resident is missing from the facility the facility would take steps including but not limited to the nurse/designee will initiate a full house head count of the residents. The staff member will announce Code Purple over the intercom system to alert the staff that a search will begin for the resident. The staff will report to the nurse's station and await further instructions from the Administrator, DON, or charge nurse. Staff will perform a thorough search of the inside of the facility and outside grounds of the facility. If the resident is located, the license nurses, will perform a head-to-toe body assessment and document the findings. The licensed nurse will complete an incident report with interview statements to reflect an investigation, and document in the nurses' notes. A detailed investigation as to the circumstances surrounding the incident will be completed by the Administrator and DON. The Administrator or DON will assure that an incident report is completed, a copy of the police report is obtained, staff interviews are gathered, interventions to prevent further incident are to be implement, and the care plan will be updated. The interdisciplinary Team will meet following an elopement to determine the resident's further needs. Cases of elopement will have corrective action and tracking by the QAA Committee.