STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365291	A. BUILDING _____ B. WING _____	**07/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAURELS OF CANTON, THE	**2714 13TH STREET NW CANTON, OH 44708**

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** Based on observation, interview and policy review the facility failed to prevent verbal abuse of Resident #1 by State tested Nursing Assistant (STNA) #200. This affected one of three residents reviewed for abuse. The facility census was 58. Findings include: Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A Minimum Data Set assessment (MDS) 3.0 dated 05/13/20 revealed the resident was cognitively intact, required extensive assistance of two people for Activities of Daily Living (ADL), and used a power wheelchair for mobility. A Care plan dated 05/07/20 included care areas for fluctuation of mood and behavior including yelling at staff and other residents, attention seeking behaviors, telling staff what to do about other residents, frequently wanting to go to the hospital, dangerous operation of power wheelchair, and noncompliance with care, diet, and with wearing a face mask. Review of two video clips dated 06/26/20 at 9:13 P.M. and 9:25 P.M. from a webcam in Resident #1's room, submitted by the complainant revealed STNA #200 speaking in a gruff, unprofessional manner. In the first video, dated 06/26/20 at 9:13 P.M. Resident #1 asked where the nurse was and STNA #200 responded The nurse is right out there. We got two people passing away and you're worried about getting your butt (indistinguishable). The STNA also stated go ahead and report me, I don't care, as she walked across the room canceled the resident's call light and slammed the door on her way out of the room. In the video dated 06/26/20 at 9:25 P.M. STNA #200 once again entered the room and Resident #1 was off camera in her power wheelchair but could be heard speaking in the back ground. STNA #200 once again canceled the call light and in a harsh, unprofessional tone told the resident to go ahead and report her. Other conversation between the resident and the STNA was indistinguishable. Interview on 06/30/20 at 10:15 A.M. with the Director of Nursing (DON) the Regional Clinical Coordinator and the Administrator on 06/30/20 at 2:10 P.M. verified they had viewed the videos and STNA #200 was inappropriate and unprofessional in her interaction with Resident #1. Interview on 06/30/20 at 10:30 A.M. with Resident #1 and her daughter, the latter via video chat, revealed they felt STNA #200 was verbally abusive to the resident and it was captured on the webcam in the resident's room. The daughter saw the video and filed the complaint. The resident reported no harm as a result of the verbal abuse and felt bad STNA #200 lost her job. Phone interview on 07/01/20 at 9:30 A.M. with STNA #200 verified she was unprofessional in her interactions with Resident #1 on 06/26/20. Review of the July 2019 Abuse Prohibition, Investigation, and Reporting policy revealed the facility did not condone guest (resident) abuse by anyone. The policy identified the importance of understanding behavioral symptoms, including outbursts and yelling and how to respond appropriately. This deficiency substantiates Complaint Numbers OH 707 and OH 705.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and policy review the facility failed to ensure their infection control protocol regarding wearing of face masks by staff during the Coronavirus pandemic was followed by STNA #200 while in Resident #1's room. This affected one of three residents reviewed for infection control. Findings include: Resident #1 was admitted on [DATE] with [DIAGNOSES REDACTED]. A Minimum Data Set assessment (MDS) 3.0 dated 05/13/20 revealed the resident was cognitively intact, required extensive assistance of two people for Activities of Daily Living (ADL), and used a power wheelchair for mobility. A Care plan dated 05/07/20 included care areas for fluctuation of mood and behavior including yelling at staff and other residents, attention seeking behaviors, telling staff what to do about other residents, frequently wanting to go to the hospital, dangerous operation of power wheelchair, and noncompliance with care, diet, and with wearing a face mask. Review of a video clip dated 06/26/20 at 9:13 P.M., submitted by the family from a webcam in Resident #1's room, revealed STNA #200 entered Resident #1's room without wearing a face mask. STNA #200 walked across the resident's room and canceled the call light over the resident's bed without maintaining appropriate social distance by staying a minimum of six feet away from the resident. Interview on 06/30/20 at 10:15 A.M. with the Director of Nursing (DON) and the Regional Clinical Coordinator revealed they had viewed the video and verified STNA #200 should have been wearing a face mask when she was in Resident #1's room. Interview on 07/01/20 at 9:30 A.M. with STNA #200 verified she did not have a mask on while in Resident #1's room on 06/26/20 at 9:13 P.M. as seen in the video. STNA #200 stated the face mask fell on to the floor and she did not get a clean one until she exited the resident's room. Review of the facility Employee Mask Usage memo dated 04/13/20 revealed that staff were to wear their mask at all times unless they were on break or in non Guest (resident) areas.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.