STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366288	A. BUILDING _____ B. WING _____	05/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SUNRISE NURSING HEALTHCARE LLC	3434 STATE ROUTE 132 AMELIA, OH 45102

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed medical record review, staff interviews, review of radiology report, review of hospital records and review of facility policy and procedure, the facility failed to timely notify each resident's physician when there was a significant change in physical status, including significant bruising and complaints of pain. This affected one (Resident #47) of three residents reviewed. The facility census was 45. Findings include: Review of Resident #47's closed medical record revealed the resident was originally admitted to the facility on [DATE]. She was discharged to the behavioral health unit of a hospital on [DATE] and was readmitted to the facility on [DATE]. [DIAGNOSES REDACTED]. The resident was discharged from the facility to the emergency department of a local hospital for evaluation on 04/29/20. Review of a quarterly minimum data set ((MDS) dated [DATE] identified the resident as having severe cognitive deficits. She required physical assistance of two staff persons for bed mobility and transfers, was able to walk in her room and in the corridor with supervision, was unsteady but able to stabilize herself without staff assistance. The resident was assessed as having physical behavioral symptoms, verbal behavioral symptoms, and wandering. The resident had no falls. She received routine anti-psychotic, anti-anxiety, and anti-depressant medications. Review of Resident #47's April 2020 physician's orders [REDACTED]. Review of Resident #47's April 2020 Medication Administration Record [REDACTED]. Review of Resident #47's nursing progress notes for 04/25/20 through 04/29//20 failed to reveal any documentation of the resident having any incidents, falls, altercations with other residents, or any assessment of any bruising or other injuries to her skin. There was no assessment including location and description of any bruising or other injuries, or a nursing assessment including an assessment of the resident's range of motion or vital signs at the time the bruising/injuries were first observed. Review of Speech Language Pathologist (SLP) #101's treatment notes dated 04/27/20 revealed Resident #47 was seen in her room for morning dysphagia therapy. The SLP note included the following observations; Postural adjustment required in bed secondary to the resident's complaints of pain when attempting to sit. Significant forehead and right shoulder bruising and the resident complained of tailbone pain. Per nursing, the resident had an unreported fall over the weekend resulting in tailbone bruising which was impacting her sitting tolerance. Review of SLP #101 treatment notes dated 04/28/20 revealed the resident had removed her clothing and brief. Further bruising assessed with [REDACTED]. The nurse aide assisted the SLP in dressing the resident. Nursing and former Director of Nursing (DON) #93 were notified of the resident's condition. Review of Resident #47's radiology report of 04/29/20 at 10:11 A.M., revealed the resident was diagnosed with [REDACTED]. Review of nursing progress notes dated 04/29/20 at 5:19 P.M., Licensed Practical Nurse (LPN) #61 documented the resident had multi bruising in different areas. The LPN noted she was concerned about the resident's tailbone area per other nurse's report and LPN #61 contacted the resident's physician with her assessment. New orders were received for x-rays. The x-ray findings came back and the physician was notified. A new order was received to transfer the resident for further testing. Review of Resident #47's Emergency Department (ED) history and physical dated 04/29/20 revealed the resident was diagnosed with [REDACTED]. The hospital physician noted multiple bruises to the resident's head and hands. The resident had a recent fall, but the exact time of the fall was uncertain to the physician. The residents blood pressure was 181/71 while in the ED. Review of Resident #47's nursing progress note dated 04/30/20 at 4:19 P.M. revealed LPN #61 documented a late entry for 04/29/20 at 10:00 A.M. LPN #61 noted a physician order [REDACTED]. Further review revealed emergency medical technicians transferred the resident to a local hospital. The resident was transferred to the family's preferred hospital. During an interview with LPN #61 on 05/12/20 at 3:09 P.M. she reported when she arrived for the day shift of duty (7:00 A.M. through 7:00 P.M.) on 04/28/20, she received report from night shift LPN #59 who reported to her the resident had bruising everywhere, that it looked like the resident had been beaten up, and what looked like finger prints on the back of her shoulder. LPN #61 shared that LPN #59 communicated to her that there was no documentation regarding the bruising from the day shift nurse (LPN #74) on 04/27/20. LPN #61 reported that LPN #59 wanted to know what LPN #61 thought about the bruising so LPN #61 assessed the resident, and found the resident had multiple areas of what appeared to be fresh bruising. LPN #61 described the resident's bruising/injuries as follows: bad bruising on the left breast which went down the left side of the sternum; severe bruising on the right shoulder; a large bump on the left back side of the head; and an older bump on the head which was healing. LPN #61 shared that SLP #101 had also came to her the morning of 04/28/20 wanting to know what had happened to Resident #47 as she had also observed the resident's bruising. LPN #61 revealed on 04/28/20 she reported the issues with Resident #47 to former DON #93, and to Assistant Director of Nursing (ADON) #1 who was now the current DON. LPN #61 revealed she told both DON #93 and ADON #1 that the resident had fresh bruises everywhere, the resident was not acting herself, there was no documentation regarding the bruising or any type of incident, and that the resident might need x-rays. LPN #61 stated that ADON #1 told her that she and DON #93 were taking care of the situation and she did not need to fill out, or document, anything. LPN #61 verified she did not make any nursing entries regarding the resident's bruising/injuries until 04/29/20. LPN #61 explained that on 04/29/20 she returned to work the day shift of duty, and the resident was in her bed staring up to the ceiling, looked like she had no life left to her and the resident would not answer her. LPN #61 stated she rolled the resident over to check her and found bruising to the tailbone area. LPN #61 stated at that time she contacted the resident's physician and received new orders for x-rays. LPN #61 stated she told the x-ray technician that she thought the resident had fallen but was not certain. She communicated soon after the x-rays were taken, the radiologist office called and reported the resident had a T12 compression fracture. LPN #61 notified the resident's physician and the family, and the resident was sent out to the hospital for evaluation on 04/29/20. LPN #61 stated she held the resident's [MEDICATION NAME] and aspirin the morning of 04/29/20, however the medications were signed off as being given, and there were no notations on the MAR indicated [REDACTED]. During an interview with LPN #74 on 05/12/20 at 4:48 P.M., LPN #74 stated when she reported to work for the day shift of duty on 04/27/20 the resident was resting in bed with no concerns noted at that time. She indicated she was told the resident had been up during the night. LPN #74 communicated the night nurse, agency LPN #82, did not report the resident as having any incidents or problems during the night shift (7:00 P.M. - 7:00 A.M.) on 04/26/20 into the morning of 04/27/20. LPN #74 stated on 04/27/20 around 9:00 A.M., she was made aware by a nurse aide that the resident had bruising, and she assessed the resident. She stated the resident had what appeared to be new bruising which covered most of her left breast and left shoulder and she had an area on her right buttock. LPN #74 communicated she went to former DON #93 on 04/27/20 and reported the bruising she saw on Resident #47 and asked what was going to be done as there was no documentation regarding any incidents or injuries. She stated former DON #93 told her to do an incident report regarding the fresh bruising. LPN #74 stated she told former DON #93 that she was not going to do the incident report, and she was not going to document the bruising as something that had happened on her shift. She stated former DON #93 told her she would investigate what happened and get the documentation

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.

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F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) completed. LPN #74 affirmed she did not document the extensive bruising that was on Resident #47 nor did she initiate any neurological checks related to a potential fall, as she was told by former DON #93 that she would take care of it. During an interview with the current DON (formerly the ADON) on 05/13/20 at 1:12 P.M., she stated on 04/27/20 around 9:00 A.M. to 10:00 A.M., LPN #74 notified her Resident #47 was bruised, and she went to observe the resident. The DON stated the resident had a hematoma to her forehead, she believed it was on the right side, a circular bruise to the right shoulder which encompassed the entire shoulder, and one of her breasts was covered in bruising. She reported she did not examine the resident's tailbone, and she did not do a full body assessment of the resident at that time. The current DON stated she went directly to former DON #93 and was under the impression that former DON #93 was completing an investigation into the situation. The current DON affirmed she was aware, after the fact, that LPN #74 did not document the resident's bruising, and affirmed the physician was not notified of the residents bruising on 04/27/20 but should have been notified. An interview was conducted with the Administrator and Corporate DON #99 on 05/13/20 at 1:38 P.M. regarding Resident #47's bruising/injuries and if there was any documentation to support the facility had notified the resident's physician when the bruising was first discovered on 04/27/20. Corporate DON #99 reported the facility did not have any documentation to support the resident's physician was notified on 04/27/20. She affirmed the resident's physician was not notified until 04/29/20 when he ordered x-rays, then ordered the resident to be evaluated at the ED. Review of facility's policy titled Change's in a Resident's Condition or Status revealed the the nurse will notify the resident's attending physician or physician on call when there has been an accident or injury involving the resident; discovery of injuries of unknown source; adverse reaction to medication; change in the resident's physical/emotional/mental condition. The policy also specified that prior to notifying the resident's physician the nurse would make detailed observations and gather pertinent and relevant information for the physician, and the nurse would record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. This is an incidental deficiency found during investigation of Master Complaint Number OH 506 and Complaint Number OH 417.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed medical record review, staff interviews, review of radiology report, review of of hospital records, and review of facility policy, the facility failed to ensure injuries of unknown source were reported immediately to the administrator of the facility and to the State Survey Agency as required. This involved one (Resident #47) of three reviewed. The facility census was 45. Findings include: Review of Resident #47's closed medical record revealed the resident was originally admitted to the facility on [DATE]. She was discharged to the behavioral health unit of a hospital on [DATE] and was readmitted to the facility on [DATE]. [DIAGNOSES REDACTED]. The resident was discharged from the facility to the emergency department of a local hospital for evaluation on 04/29/20. Review of a quarterly minimum data set ((MDS) dated [DATE] identified the resident as having severe cognitive deficits. She required physical assistance of two staff persons for bed mobility and transfers, was able to walk in her room and in the corridor with supervision, was unsteady but able to stabilize herself without staff assistance. The resident was assessed as having physical behavioral symptoms, verbal behavioral symptoms, and wandering. The resident had no falls. She received routine anti-psychotic, anti-anxiety, and anti-depressant medications. Review of the comprehensive plan of care identified the resident as having a behavior problem of sitting on the floor related to major neurocognitive disorder. This behavior placed the resident at increased risk for falls and or injury. The resident could be verbally aggressive towards others, and destructive to facility property. The behavior plan of care for the resident was initiated on 03/31/20 and revised on 0[DATE]0/20. Review of Resident #47's April 2020 physician's orders [REDACTED]. Review of Resident #47's April 2020 Medication Administration Record [REDACTED]. Review of Resident #47's nursing progress notes for 04/25/20 through 04/29/20 failed to reveal any documentation of the resident having any incidents, falls, altercations with other residents, or any assessment of any bruising or other injuries to her skin. There was no assessment including location and description of any bruising or other injuries, or a nursing assessment including an assessment of the resident's range of motion or vital signs at the time the bruising/injuries were first observed. Review of Speech Language Pathologist (SLP) #101's treatment notes dated 04/27/20 revealed Resident #47 was seen in her room for morning dysphagia therapy. The SLP note included the following observations; Postural adjustment required in bed secondary to the resident's complaints of pain when attempting to sit. Significant forehead and right shoulder bruising and the resident complained of tailbone pain. Per nursing, the resident had an unreported fall over the weekend resulting in tailbone bruising which was impacting her sitting tolerance. Review of a weekly skin assessment dated [DATE] at 6:04 P.M., Licensed Practical Nurse (LPN) #74 documented Resident #47 had no new skin abnormalities, and no bruising was documented on the skin assessment. Review of SLP #101 treatment notes dated 04/28/20 revealed the resident had removed her clothing and brief. Further bruising assessed with [REDACTED]. The nurse aide assisted the SLP in dressing the resident. Nursing and former Director of Nursing (DON) #93 were notified of the resident's condition. Review of Resident #47's radiology report dated 04/29/20 at 10:11 A.M., revealed the resident had a compression fracture at T12 with 75 percent (%) stature loss. Review of nursing progress notes dated 04/29/20 at 5:19 P.M., LPN #61 documented the resident had multi bruising in different areas. The LPN noted she was concerned about the resident's tailbone area per other nurse's report and LPN #61 contacted the resident's physician with her assessment. New orders were received for x-rays. The x-ray findings came back and the physician was notified. A new order was received to transfer the resident for further testing. Review of Resident #47's Emergency Department (ED) history and physical dated 04/29/20 revealed the resident was diagnosed with [REDACTED]. The hospital physician noted multiple bruises to the resident's head and hands. The resident had a recent fall, but the exact time of the fall was uncertain to the physician. The residents blood pressure was 181/71 while in the ED. Review of Resident #47's nursing progress note dated 04/30/20 at 4:19 P.M. revealed LPN #61 documented a late entry for 04/29/20 at 10:00 A.M. LPN #61 noted a physician order [REDACTED]. Further review revealed emergency medical technicians transferred the resident to a local hospital. The resident was transferred to the family's preferred hospital. During an interview with LPN #61 on 05/12/20 at 3:09 P.M. she reported when she arrived for the day shift of duty (7:00 A.M. through 7:00 P.M.) on 04/28/20, she received report from night shift LPN #59 who reported to her the resident had bruising everywhere, that it looked like the resident had been beaten up, and what looked like finger prints on the back of her shoulder. LPN #61 shared that LPN #59 communicated to her that there was no documentation regarding the bruising from the day shift nurse (LPN #74) on 04/27/20. LPN #61 reported that LPN #59 wanted to know what LPN #61 thought about the bruising so LPN #61 assessed the resident, and found the resident had multiple areas of what appeared to be fresh bruising. LPN #61 described the resident's bruising/injuries as follows: bad bruising on the left breast which went down the left side of the sternum; severe bruising on the right shoulder; a large bump on the left back side of the head; and an older bump on the head which was healing. LPN #61 shared that SLP #101 had also came to her the morning of 04/28/20 wanting to know what had happened to Resident #47 as she had also observed the resident's bruising. LPN #61 revealed on 04/28/20 she reported the issues with Resident #47 to former DON #93, and to Assistant Director of Nursing (ADON) #1 who was now the current DON. LPN #61 revealed she told both DON #93 and ADON #1 that the resident had fresh bruises everywhere, the resident was not acting herself, there was no documentation regarding the bruising or any type of incident, and that the resident might need x-rays. LPN #61 stated that ADON #1 told her that she and DON #93 were taking care of the situation and she did not need to fill out, or document, anything. LPN #61 verified she did not make any nursing entries regarding the resident's bruising/injuries until 04/29/20. LPN #61 explained that on 04/29/20 she returned to work the day shift of duty, and the resident was in her bed staring up to the ceiling, looked like she had no life left to her and the resident would not answer her. LPN #61 stated she rolled the resident over to check her and found bruising to the tailbone area. LPN #61 stated at that time she contacted the resident's physician and received new orders for x-rays. LPN #61 stated she told the x-ray technician that she thought the resident had fallen but was not certain. She communicated soon after the x-rays were taken, the radiologist office called and reported the resident had a T12 compression fracture. LPN #61 notified the resident's physician and the family, and the resident was sent out to the hospital for evaluation on 04/29/20. LPN #61 stated she held the resident's [MEDICATION NAME] and aspirin the morning of 04/29/20, however the medications were signed off as being given, and there were no notations on the MAR indicated [REDACTED]. During an interview with LPN #74 on 05/12/20 at 4:48 P.M., LPN #74 stated when she reported to work for the day shift of duty on 04/27/20 the resident was resting in bed with no concerns noted at that time. She indicated she was told

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F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) the resident had been up during the night. LPN #74 communicated the night nurse, agency LPN #82, did not report the resident as having any incidents or problems during the night shift (7:00 P.M. - 7:00 A.M.) on 04/26/20 into the morning of 04/27/20. LPN #74 stated on 04/27/20 around 9:00 A.M., she was made aware by a nurse aide that the resident had bruising, and she assessed the resident. She stated the resident had what appeared to be new bruising which covered most of her left breast and left shoulder and she had an area on her right buttock. LPN #74 communicated she went to former DON #93 on 04/27/20 and reported the bruising she saw on Resident #47 and asked what was going to be done as there was no documentation regarding any incidents or injuries. She stated former DON #93 told her to do an incident report regarding the fresh bruising. LPN #74 stated she told former DON #93 that she was not going to do the incident report, and she was not going to document the bruising as something that had happened on her shift. She stated former DON #93 told her she would investigate what happened and get the documentation completed. LPN #74 affirmed she did not document the extensive bruising that was on Resident #47 nor did she initiate any neurological checks related to a potential fall, as she was told by former DON #93 that she would take care of it. LPN #74 communicated that Resident #47's routine was somewhat normal during the day shift of duty on 04/27/20 as the resident was up and walking, and then would get back in bed, and was back up for the evening meal that day. LPN #74 denied any knowledge of the resident having fallen but did document an incident on 04/21/20 in which the resident flipped over her bedside table and sustained a skin tear. During an interview with Temporary Nurse Aide (TNA) #77 on 05/12/20 at 5:42 P.M., TNA #77 reported on 0[DATE] the resident was sitting on the floor in the common area of the unit, which was normal for her, folding laundry and putting it in her basket. TNA #77 stated she went into another room on the unit and heard something loud. TNA #77 stated when she came out of the other resident's room, she observed Resident #47 laying on the floor on her back, and her laundry basket was flipped on the side. She stated she alerted LPN #74 and the other nurse aide, that the resident was lying on the floor, and she did not feel comfortable picking her up. TNA #77 stated LPN #74 and the other nurse aide verbalized that being on the floor was part of the resident's behavior, that the resident would sit on the floor and lay herself back. TNA #77 stated they assisted the resident to stand and walk, and when the resident got halfway down the hall her knees appeared to give out and she went to her knees. TNA #77 was asked to get a walker with a seat, then herself and the other nurse aide put the resident to bed. TNA #77 shared during the night shift of duty Saturday 04/25/20 into Sunday morning 04/26/20 she did a quick walk through on the unit to inform the residents she was their aide for the night. She stated when she got to Resident #47's room the resident was sitting on the floor in the middle of the room, she was not doing anything just putting her fingers on the floor. TNA #77 stated she tried to get the resident up with verbal cueing and the resident pushed her away. She stated she encouraged the resident to get up off the floor, but the resident pushed her away again and using expletive words told the aide to leave her alone as she (TNA #77) had broken the residents back. She reported the resident was bleeding from her elbow and had bruises all over, from her mid forearm to her mid right upper arm, had a bruise on her forehead which was purplish red, and a knot on the back on her head that she thought was from a previous incident. TNA #77 stated she informed the night shift nurse for the unit, agency LPN #82, who stated the resident was having a behavior, that this was normal for the resident and that the resident was fine. The nurse assisted TNA #77 with getting the resident to bed. During the night, the resident did not get out of bed but flipped herself in bed with her head towards the foot board and was hitting her head on the foot board and hitting her elbows on the wall. TNA #77 shared she reported the resident's behaviors to LPN #82 again, at which time the nurse told her that it was part of the resident's behaviors. TNA #77 stated she told the oncoming day shift nurse aide that the resident had been in bed all night, that the resident was in a lot of pain and every time TNA #77 checked on the resident she would try to hit the aide. TNA #77 denied witnessing the resident falling, and stated she only found the resident sitting on the floor. During an interview with the current DON (formerly the ADON) on 05/13/20 at 1:12 P.M., she stated on 04/27/20 around 9:00 A.M. to 10:00 A.M., LPN #74 notified her Resident #47 was bruised, and she went to observe the resident. The DON stated the resident had a hematoma to her forehead, she believed it was on the right side, a circular bruise to the right shoulder which encompassed the entire shoulder, and one of her breasts was covered in bruising. She reported she did not examine the resident's tailbone, and she did not do a full body assessment of the resident at that time. The current DON stated she went directly to former DON #93 and was under the impression that former DON #93 was completing an investigation into the situation. The current DON affirmed she was aware, after the fact, that LPN #74 did not document the resident's bruising, and affirmed the physician was not notified of the residents bruising on 04/27/20 but should have been notified. An interview was conducted with the Administrator and Corporate DON #99 on 05/13/20 at 1:38 P.M. regarding Resident #47's bruising/injuries and if there was any documentation to support the facility had thoroughly documented and assessed the resident's bruising and injuries when first discovered on 04/27/20, had notified the resident's physician when first discovered, had notified the Ohio Department of Health regarding the resident's injuries of unknown origin, or communicated with the resident's physician regarding the continued use of the anti-platelet medication in light of the resident's areas of significant bruising. The Administrator communicated she was not made aware of the extent of the resident's injuries until 05/06/20, and that was when she started her own investigation and the injuries were believed to have occurred related to an unreported fall. Corporate DON #99 stated the facility did not have any documentation regarding assessment of the resident, or notification of the resident's physician, until the day she was sent out to the hospital. Corporate DON #99 also affirmed that no facility Self-Reported Incident (SRI) was submitted, and in hindsight an SRI should have been completed due to the nature of the resident's bruising and injuries. During an interview with agency LPN #82 on 05/13/20 at 3:38 P.M., LPN #82 affirmed she worked at the facility often, typically worked the night shift of duty, and was familiar with Resident #47. She reported she believed she did work the weekend of 04/25/20 and 04/26/20 during the night shift of duty, and was assigned to the secured unit, where Resident #47 resided. LPN #82 shared the resident walked on her own, that she had never seen her fall, but had observed her get down on the floor on her own. She denied that she had been made aware of the resident having any falls or injuries, or complaints of pain during the night shift of duty on 04/25/20 or 04/26/20. LPN #82 did share there was one time, could not recall the date, the resident was sitting on the floor in her room and she helped TNA #77 get her into bed. She explained the resident did have a bruise on her forehead, that she had gotten beforehand from a fall a few weeks before. LPN #82 stated she had charted on the bruising to the resident's head prior and documented that the bruising continued. She stated she did not notice any bruising to the resident other than the bruise to her forehead on 04/25/20 or 04/26/20 but admitted she did not observe the resident undressed. During an interview with contracted SLP #101 on 05/13/20 at 5:13 P.M., SLP #101 reported she had worked at the facility a limited amount of time on contract and had been working with Resident #47 for several weeks to advance her diet. She reported on 04/27/20 she provided treatment to the resident about 11:45 A.M. to 12:00 P.M. The resident was in bed with her door closed, and she tried to have the resident sit up. The resident kept trying to lay down and would slouch to one side and she complained of pain. SLP #101 communicated she got the resident repositioned so she could sit up and eat. The nurse aide working the unit that day (could not recall her name) told SLP #101 that when she dressed the resident she complained of pain. The nurse aide also reported bruising to the resident's tailbone. The nurse aide also told her that LPN #74 had assisted her with dressing the resident and was aware of the tail bone bruising. SLP #101 stated she talked to LPN #74 who voiced she (LPN #74) had looked at the resident's skin and tailbone and affirmed there was bruising present, and that there was nothing in the resident's medical record about it. SLP #101 described bruising to the right side of the resident's forehead that looked established, not developing, but SLP #101 denied the bruising was there on Friday, 04/24/20, when she treated her. SLP #101 reported on 04/28/20 the residents door was closed and as she entered the room the resident had stripped naked and SLP #101 observed the resident with bruising on her right shoulder to bicep half way down her shoulder blade, her left breast was entirely bruised, and she had bruising on her lower spine. SLP #101 stated she assisted the nurse aide with dressing the resident and the resident was very stiff and seemed uncomfortable. She stated the resident did not want to walk. She reported the resident was not talking to her as normal, and SLP #101 went to speak to the nurse, LPN #61, on duty about the resident's condition. SLP #101 stated LPN #61 shared that SLP #101 was the first person to say anything about the resident's bruising, and that there was no documentation in the resident's medical record. LPN #61 told her she was not given anything in report regarding the resident's bruising/injuries. SLP #101 communicated that both herself and LPN #61 went to talk with former DON #93. SLP #101 stated when she told former DON #93 how she found the resident on 04/27/20 and on 04/28/20, that former DON #93 stated x-rays were going to be ordered. She stated she checked at the end of the day, at approximately 4:00 P.M., and there was no evidence of x-rays being done. SLP #101 shared she was made aware that Resident #47 had a fracture of her T12 vertebra the morning of 04/29/20 when she returned to the facility for work. Review of the facility's Abuse and Neglect Protocol revealed it is the responsibility of employees, facility consultants, Attending Physicians, family members, visitors etc to promptly report

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F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) any incident or suspected incident of neglect or resident abuse, including injuries of unknown source. All reports of resident abuse, neglect and injuries of unknown source shall be promptly and thoroughly investigated by facility management. Under Policy Interpretation and Implementation an injury of unknown source is defined as an injury that meets both of the following conditions: The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and the injury is suspicious because of the extent of the injury, the location of the injury, the number of injuries observed at one particular point in time, or the incidence of injuries over time. The implementation also specified that a completed copy of documentation forms and written statements from witnesses, if any, must be provided to the Administrator immediately after the occurrence. If an incident of suspected abuse occurs, facility shall report immediately, but not later then two hours after forming the suspicion if the events that caused the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause suspicion do not result in serious bodily injury to designated state agency. An immediate investigation will be made and a copy of the findings of such investigation will be provided to the state agency within five working days or as designated by state law. This is an incidental deficiency found during investigation of Master Complaint Number OH 506 and Complaint Number OH 417.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed medical record review, staff interviews, review of radiology report and hospital records the facility failed to develop a person centered care plan for one resident which addressed the resident's potential problems and needs associated with the routine use of anti-platelet medications. This affected one (Resident #47) of three residents care plans reviewed. The facility census was 45. Findings include: Review of Resident #47's closed medical record revealed the resident was originally admitted to the facility on [DATE]. She was discharged to the behavioral health unit of a hospital on [DATE] and was readmitted to the facility on [DATE]. [DIAGNOSES REDACTED]. The resident was discharged from the facility to the emergency department of a local hospital for evaluation on 04/29/20. Review of a quarterly minimum data set ((MDS) dated [DATE] identified the resident as having severe cognitive deficits. She required physical assistance of two staff persons for bed mobility and transfers, was able to walk in her room and in the corridor with supervision, was unsteady but able to stabilize herself without staff assistance. The resident was assessed as having physical behavioral symptoms, verbal behavioral symptoms, and wandering. The resident had no falls. She received routine anti-psychotic, anti-anxiety, and anti-depressant medications. Review of Resident #47's April 2020 physician's orders [REDACTED]. Review of Resident #47's April 2020 Medication Administration Record [REDACTED]. Review of Resident #47's nursing progress notes for 04/25/20 through 04/29/20 failed to reveal any documentation of the resident having any incidents, falls, altercations with other residents, or any assessment of any bruising or other injuries to her skin. There was no assessment including location and description of any bruising or other injuries, or a nursing assessment including an assessment of the resident's range of motion or vital signs at the time the bruising/injuries were first observed. Review of a weekly skin assessment dated [DATE] at 6:04 P.M., Licensed Practical Nurse (LPN) #74 documented Resident #47 had no new skin abnormalities, and no bruising was documented on the skin assessment. Review of Resident #47's comprehensive plan of care in effect at the time of her discharge, with goal dates of 07/12/20, failed to reveal any plan of care addressing the resident's use of an anti-platelet medications, as well as routine aspirin use. Review of Resident #47's radiology report dated 04/29/20 at 10:11 A.M., revealed the resident had a compression fracture at T12 with 75 percent (%) stature loss. Review of nursing progress notes dated 04/29/20 at 5:19 P.M., LPN #61 documented the resident had multi bruising in different areas. The LPN noted she was concerned about the resident's tailbone area per other nurse's report and LPN #61 contacted the resident's physician with her assessment. New orders were received for x-rays. The x-ray findings came back and the physician was notified. A new order was received to transfer the resident for further testing. Review of Resident #47's Emergency Department (ED) history and physical dated 04/29/20 revealed the resident was diagnosed with [REDACTED]. The hospital physician noted multiple bruises to the resident's head and hands. The resident had a recent fall, but the exact time of the fall was uncertain to the physician. The residents blood pressure was 181/71 while in the ED. Review of Resident #47's nursing progress note dated 04/30/20 at 4:19 P.M. revealed LPN #61 documented a late entry for 04/29/20 at 10:00 A.M. LPN #61 noted a physician order [REDACTED]. Further review revealed emergency medical technicians transferred the resident to a local hospital. The resident was transferred to the family's preferred hospital. During an interview with LPN #61 on 05/12/20 at 3:09 P.M. she reported when she arrived for the day shift of duty (7:00 A.M. through 7:00 P.M.) on 04/28/20, she received report from night shift LPN #59 who reported to her the resident had bruising everywhere, that it looked like the resident had been beaten up, and what looked like finger prints on the back of her shoulder. LPN #61 shared that LPN #59 communicated to her that there was no documentation regarding the bruising from the day shift nurse (LPN #74) on 04/27/20. LPN #61 reported that LPN #59 wanted to know what LPN #61 thought about the bruising so LPN #61 assessed the resident, and found the resident had multiple areas of what appeared to be fresh bruising. LPN #61 described the resident's bruising/injuries as follows: bad bruising on the left breast which went down the left side of the sternum; severe bruising on the right shoulder; a large bump on the left back side of the head; and an older bump on the head which was healing. LPN #61 shared that SLP #101 had also came to her the morning of 04/28/20 wanting to know what had happened to Resident #47 as she had also observed the resident's bruising. LPN #61 revealed on 04/28/20 she reported the issues with Resident #47 to former Director of Nursing (DON) #93, and to Assistant Director of Nursing (ADON) #1 who was now the current DON. LPN #61 revealed she told both DON #93 and ADON #1 that the resident had fresh bruises everywhere, the resident was not acting herself, there was no documentation regarding the bruising or any type of incident, and that the resident might need x-rays. LPN #61 stated that ADON #1 told her that she and DON #93 were taking care of the situation and she did not need to fill out, or document, anything. LPN #61 verified she did not make any nursing entries regarding the resident's bruising/injuries until 04/29/20. LPN #61 explained that on 04/29/20 she returned to work the day shift of duty, and the resident was in her bed staring up to the ceiling, looked like she had no life left to her and the resident would not answer her. LPN #61 stated she rolled the resident over to check her and found bruising to the tailbone area. LPN #61 stated at that time she contacted the resident's physician and received new orders for x-rays. LPN #61 stated she told the x-ray technician that she thought the resident had fallen but was not certain. She communicated soon after the x-rays were taken, the radiologist office called and reported the resident had a T12 compression fracture. LPN #61 notified the resident's physician and the family, and the resident was sent out to the hospital for evaluation on 04/29/20. LPN #61 stated she held the resident's [MEDICATION NAME] and aspirin the morning of 04/29/20, however the medications were signed off as being given, and there were no notations on the MAR indicated [REDACTED]. During an interview with LPN #74 on 05/12/20 at 4:48 P.M., LPN #74 stated when she reported to work for the day shift of duty on 04/27/20 the resident was resting in bed with no concerns noted at that time. She indicated she was told the resident had been up during the night. LPN #74 communicated the night nurse, agency LPN #82, did not report the resident as having any incidents or problems during the night shift (7:00 P.M. - 7:00 A.M.) on 04/26/20 into the morning of 04/27/20. LPN #74 stated on 04/27/20 around 9:00 A.M., she was made aware by a nurse aide that the resident had bruising, and she assessed the resident. She stated the resident had what appeared to be new bruising which covered most of her left breast and left shoulder and she had an area on her right buttock. LPN #74 communicated she went to former DON #93 on 04/27/20 and reported the bruising she saw on Resident #47 and asked what was going to be done as there was no documentation regarding any incidents or injuries. She stated former DON #93 told her to do an incident report regarding the fresh bruising. LPN #74 stated she told former DON #93 that she was not going to do the incident report, and she was not going to document the bruising as something that had happened on her shift. She stated former DON #93 told her she would investigate what happened and get the documentation completed. LPN #74 affirmed she did not document the extensive bruising that was on Resident #47 nor did she initiate any neurological checks related to a potential fall, as she was told by former DON #93 that she would take care of it. LPN #74 communicated that Resident #47's routine was somewhat normal during the day shift of duty on 04/27/20 as the resident was up and walking, and then would get back in bed, and was back up for the evening meal that day. LPN #74 denied any knowledge of the resident having fallen but did document an incident on 04/21/20 in which the resident flipped over her bedside table and sustained a skin tear. An interview was conducted with the current DON (formerly the ADON) on 05/13/20 at 1:12 P.M., and a follow-up interview conducted on 05/14/20 at 9:20 A.M., regarding Resident #47 and when she was first aware of the resident's bruising/injuries. She stated on the morning of 04/27/20 around 9:00 A.M. to 10:00 A.M., LPN #74 notified her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366288	A. BUILDING _____ B. WING _____	05/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SUNRISE NURSING HEALTHCARE LLC	3434 STATE ROUTE 132 AMELIA, OH 45102

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) the resident was bruised and she went to assess the resident. The DON stated the resident had a hematoma to the forehead, she thought it was on the right side, a circular bruise to the right shoulder which encompassed the entire shoulder, and one of her breasts was covered in bruising. She reported she did not examine the resident's tailbone, and she did not do a full body assessment of the resident at that time. The DON affirmed the resident's physician was not notified on 04/27/20 regarding the resident's bruising/injuries and should have been, and also confirmed the continued use of the clopiogrel should have been addressed with the physician. The DON was asked to review the resident's comprehensive plan of care as a plan of care addressing the residents needs related to the use of anti-platelet medication was not evident, including any interventions for monitoring the resident for adverse effects of physician notified. The DON reported on 05/14/20 at 9:20 A.M. that there was not a comprehensive plan of care present addressed Resident #47's use of an anti-platelet medication, or for aspirin use. This is an incidental deficiency found during investigation of Master Complaint Number OH 506 and Complaint Number OH 417.
F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed medical record review, physician and staff interviews, review of radiology report, review of hospital records, and review of facility policy, the facility failed to provide care and services in accordance to the accepted standards of clinical practice related to identifying, assessing, monitoring, and notifying the physician of a change of condition after a resident who was on anti-platelet medication was discovered with extensive bruising and complained of lower back pain. This affected one (Resident #47) of three residents reviewed for falls. The facility census was 45. Findings include: Review of Resident #47's closed medical record revealed the resident was originally admitted to the facility on [DATE]. She was discharged to the behavioral health unit of a hospital on [DATE] and was readmitted to the facility on [DATE]. [DIAGNOSES REDACTED]. The resident was discharged from the facility to the emergency department of a local hospital for evaluation on 04/29/20. Review of a quarterly minimum data set ((MDS) dated [DATE] identified the resident as having severe cognitive deficits. She required physical assistance of two staff persons for bed mobility and transfers, was able to walk in her room and in the corridor with supervision, was unsteady but able to stabilize herself without staff assistance. The resident was assessed as having physical behavioral symptoms, verbal behavioral symptoms, and wandering. The resident had no falls. She received routine anti-psychotic, anti-anxiety, and anti-depressant medications. Review of the comprehensive plan of care identified the resident as having a behavior problem of sitting on the floor related to major neurocognitive disorder. This behavior placed the resident at increased risk for falls and or injury. The resident could be verbally aggressive towards others, and destructive to facility property. The behavior plan of care for the resident was initiated on 03/31/20 and revised on 04/10/20. Review of Resident #47's April 2020 physician's orders [REDACTED]. Review of Resident #47's April 2020 Medication Administration Record [REDACTED]. Review of Resident #47's nursing progress notes for 04/25/20 through 04/29/20 failed to reveal any documentation of the resident having any incidents, falls, altercations with other residents, or any assessment of any bruising or other injuries to her skin. There was no assessment including location and description of any bruising or other injuries, or a nursing assessment including an assessment of the resident's range of motion or vital signs at the time the bruising/injuries were first observed. Review of Speech Language Pathologist (SLP) #101's treatment notes dated 04/27/20 revealed Resident #47 was seen in her room for morning dysphagia therapy. The SLP note included the following observations; Postural adjustment required in bed secondary to the resident's complaints of pain when attempting to sit. Significant forehead and right shoulder bruising and the resident complained of tailbone pain. Per nursing, the resident had an unreported fall over the weekend resulting in tailbone bruising which was impacting her sitting tolerance. Review of a weekly skin assessment dated [DATE] at 6:04 P.M., Licensed Practical Nurse (LPN) #74 documented Resident #47 had no new skin abnormalities, and no bruising was documented on the skin assessment. Review of SLP #101 treatment notes dated 04/28/20 revealed the resident had removed her clothing and brief. Further bruising assessed with [REDACTED]. The nurse aide assisted the SLP in dressing the resident. Nursing and former Director of Nursing (DON) #93 were notified of the resident's condition. Review of Resident #47's radiology report dated 04/29/20 at 10:11 A.M., revealed the resident had a compression fracture at T12 with 75 percent (%) stature loss. Review of nursing progress notes dated 04/29/20 at 5:19 P.M., LPN #61 documented the resident had multi bruising in different areas. The LPN noted she was concerned about the resident's tailbone area per other nurse's report and LPN #61 contacted the resident's physician with her assessment. New orders were received for x-rays. The x-ray findings came back and the physician was notified. A new order was received to transfer the resident for further testing. Review of Resident #47's Emergency Department (ED) history and physical dated 04/29/20 revealed the resident was diagnosed with [REDACTED]. The hospital physician noted multiple bruises to the resident's head and hands. The resident had a recent fall, but the exact time of the fall was uncertain to the physician. The residents blood pressure was 181/71 while in the ED. Review of Resident #47's nursing progress note dated 04/30/20 at 4:19 P.M. revealed LPN #61 documented a late entry for 04/29/20 at 10:00 A.M. LPN #61 noted a physician order [REDACTED]. Further review revealed emergency medical technicians transferred the resident to a local hospital. The resident was transferred to the family's preferred hospital. During an interview with LPN #61 on 05/12/20 at 3:09 P.M. she reported when she arrived for the day shift of duty (7:00 A.M. through 7:00 P.M.) on 04/28/20, she received report from night shift LPN #59 who reported to her the resident had bruising everywhere, that it looked like the resident had been beaten up, and what looked like finger prints on the back of her shoulder. LPN #61 shared that LPN #59 communicated to her that there was no documentation regarding the bruising from the day shift nurse (LPN #74) on 04/27/20. LPN #61 reported that LPN #59 wanted to know what LPN #61 thought about the bruising so LPN #61 assessed the resident, and found the resident had multiple areas of what appeared to be fresh bruising. LPN #61 described the resident's bruising/injuries as follows: bad bruising on the left breast which went down the left side of the sternum; severe bruising on the right shoulder; a large bump on the left back side of the head; and an older bump on the head which was healing. LPN #61 shared that SLP #101 had also came to her the morning of 04/28/20 wanting to know what had happened to Resident #47 as she had also observed the resident's bruising. LPN #61 revealed on 04/28/20 she reported the issues with Resident #47 to former DON #93, and to Assistant Director of Nursing (ADON) #1 who was now the current DON. LPN #61 revealed she told both DON #93 and ADON #1 that the resident had fresh bruises everywhere, the resident was not acting herself, there was no documentation regarding the bruising or any type of incident, and that the resident might need x-rays. LPN #61 stated that ADON #1 told her that she and DON #93 were taking care of the situation and she did not need to fill out, or document, anything. LPN #61 verified she did not make any nursing entries regarding the resident's bruising/injuries until 04/29/20. LPN #61 explained that on 04/29/20 she returned to work the day shift of duty, and the resident was in her bed staring up to the ceiling, looked like she had no life left to her and the resident would not answer her. LPN #61 stated she rolled the resident over to check her and found bruising to the tailbone area. LPN #61 stated at that time she contacted the resident's physician and received new orders for x-rays. LPN #61 stated she told the x-ray technician that she thought the resident had fallen but was not certain. She communicated soon after the x-rays were taken, the radiologist office called and reported the resident had a T12 compression fracture. LPN #61 notified the resident's physician and the family, and the resident was sent out to the hospital for evaluation on 04/29/20. LPN #61 stated she held the resident's [MEDICATION NAME] and aspirin the morning of 04/29/20, however the medications were signed off as being given, and there were no notations on the MAR indicated [REDACTED]. During an interview with LPN #74 on 05/12/20 at 4:48 P.M., LPN #74 stated when she reported to work for the day shift of duty on 04/27/20 the resident was resting in bed with no concerns noted at that time. She indicated she was told the resident had been up during the night. LPN #74 communicated the night nurse, agency LPN #82, did not report the resident as having any incidents or problems during the night shift (7:00 P.M. - 7:00 A.M.) on 04/26/20 into the morning of 04/27/20. LPN #74 stated on 04/27/20 around 9:00 A.M., she was made aware by a nurse aide that the resident had bruising, and she assessed the resident. She stated the resident had what appeared to be new bruising which covered most of her left breast and left shoulder and she had an area on her right buttock. LPN #74 communicated she went to former DON #93 on 04/27/20 and reported the bruising she saw on Resident #47 and asked what was going to be done as there was no documentation regarding any incidents or injuries. She stated former DON #93 told her to do an incident report regarding the fresh bruising. LPN #74 stated she told former DON #93 that she was not going to do the incident report, and she was not going to document the bruising as something that had happened on her shift. She stated former DON #93 told her she would investigate what happened and get the documentation completed. LPN #74 affirmed she did not document the extensive bruising that was on Resident #47 nor did she initiate any neurological checks related to a potential fall, as she was told by former DON #93 that she would take care of it. LPN #74 communicated that Resident #47's routine was somewhat normal during the day shift of duty on 04/27/20 as the resident was up and walking, and then would get back in bed, and was back

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	366288	A. BUILDING _____ B. WING _____	05/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SUNRISE NURSING HEALTHCARE LLC	3434 STATE ROUTE 132 AMELIA, OH 45102

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 5) up for the evening meal that day. LPN #74 denied any knowledge of the resident having fallen but did document an incident on 04/21/20 in which the resident flipped over her bedside table and sustained a skin tear. During an interview with Temporary Nurse Aide (TNA) #77 on 05/12/20 at 5:42 P.M., TNA #77 reported on 04/23/20 the resident was sitting on the floor in the common area of the unit, which was normal for her, folding laundry and putting it in her basket. TNA #77 stated she went into another room on the unit and heard something loud. TNA #77 stated when she came out of the other resident's room, she observed Resident #47 laying on the floor on her back, and her laundry basket was flipped on the side. She stated she alerted LPN #74 and the other nurse aide, that the resident was lying on the floor, and she did not feel comfortable picking her up. TNA #77 stated LPN #74 and the other nurse aide verbalized that being on the floor was part of the resident's behavior, that the resident would sit on the floor and lay herself back. TNA #77 stated they assisted the resident to stand and walk, and when the resident got halfway down the hall her knees appeared to give out and she went to her knees. TNA #77 was asked to get a walker with a seat, then herself and the other nurse aide put the resident to bed. TNA #77 shared during the night shift of duty Saturday 04/25/20 into Sunday morning 04/26/20 she did a quick walk through on the unit to inform the residents she was their aide for the night. She stated when she got to Resident #47's room the resident was sitting on the floor in the middle of the room, she was not doing anything just putting her fingers on the floor. TNA #77 stated she tried to get the resident up with verbal cueing and the resident pushed her away. She stated she encouraged the resident to get up off the floor, but the resident pushed her away again and using expletive words told the aide to leave her alone as she (TNA #77) had broken the residents back. She reported the resident was bleeding from her elbow and had bruises all over, from her mid forearm to her mid right upper arm, had a bruise on her forehead which was purplish red, and a knot on the back on her head that she thought was from a previous incident. TNA #77 stated she informed the night shift nurse for the unit, agency LPN #82, who stated the resident was having a behavior, that this was normal for the resident and that the resident was fine. The nurse assisted TNA #77 with getting the resident to bed. During the night, the resident did not get out of bed but flipped herself in bed with her head towards the foot board and was hitting her head on the foot board and hitting her elbows on the wall. TNA #77 shared she reported the resident's behaviors to LPN #82 again, at which time the nurse told her that it was part of the resident's behaviors. TNA #77 stated she told the oncoming day shift nurse aide that the resident had been in bed all night, that the resident was in a lot of pain and every time TNA #77 checked on the resident she would try to hit the aide. TNA #77 denied witnessing the resident falling, and stated she only found the resident sitting on the floor. During an interview with the current DON (formerly the ADON) on 05/13/20 at 1:12 P.M., she stated on 04/27/20 around 9:00 A.M. to 10:00 A.M., LPN #74 notified her Resident #47 was bruised, and she went to observe the resident. The DON stated the resident had a hematoma to her forehead, she believed it was on the right side, a circular bruise to the right shoulder which encompassed the entire shoulder, and one of her breasts was covered in bruising. She reported she did not examine the resident's tailbone, and she did not do a full body assessment of the resident at that time. The current DON stated she went directly to former DON #93 and was under the impression that former DON #93 was completing an investigation into the situation. The current DON affirmed she was aware, after the fact, that LPN #74 did not document the resident's bruising, and affirmed the physician was not notified of the residents bruising on 04/27/20 but should have been notified. An interview was conducted with the Administrator and Corporate DON #99 on 05/13/20 at 1:38 P.M. regarding Resident #47's bruising/injuries and if there was any documentation to support the facility had thoroughly documented and assessed the resident's bruising and injuries when first discovered on 04/27/20, had notified the resident's physician when first discovered, had notified the Ohio Department of Health regarding the resident's injuries of unknown origin, or communicated with the resident's physician regarding the continued use of the anti-platelet medication in light of the resident's areas of significant bruising. The Administrator communicated she was not made aware of the extent of the resident's injuries until 05/06/20, and that was when she started her own investigation and the injuries were believed to have occurred related to an unreported fall. Corporate DON #99 stated the facility did not have any documentation regarding assessment of the resident, or notification of the resident's physician, until the day she was sent out to the hospital. Corporate DON #99 also affirmed that no facility Self-Reported Incident (SRI) was submitted, and in hindsight an SRI should have been completed due to the nature of the resident's bruising and injuries. During an interview with agency LPN #82 on 05/13/20 at 3:38 P.M., LPN #82 affirmed she worked at the facility often, typically worked the night shift of duty, and was familiar with Resident #47. She reported she believed she did work the weekend of 04/25/20 and 04/26/20 during the night shift of duty, and was assigned to the secured unit, where Resident #47 resided. LPN #82 shared the resident walked on her own, that she had never seen her fall, but had observed her get down on the floor on her own. She denied that she had been made aware of the resident having any falls or injuries, or complaints of pain during the night shift of duty on 04/25/20 or 04/26/20. LPN #82 did share there was one time, could not recall the date, the resident was sitting on the floor in her room and she helped TNA #77 get her into bed. She explained the resident did have a bruise on her forehead, that she had gotten beforehand from a fall a few weeks before. LPN #82 stated she had charted on the bruising to the resident's head prior and documented that the bruising continued. She stated she did not notice any bruising to the resident other than the bruise to her forehead on 04/25/20 or 04/26/20 but admitted she did not observe the resident undressed. During an interview with contracted SLP #101 on 05/13/20 at 5:13 P.M., SLP #101 reported she had worked at the facility a limited amount of time on contract and had been working with Resident #47 for several weeks to advance her diet. She reported on 04/27/20 she provided treatment to the resident about 11:45 A.M. to 12:00 P.M. The resident was in bed with her door closed, and she tried to have the resident sit up. The resident kept trying to lay down and would slouch to one side and she complained of pain. SLP #101 communicated she got the resident repositioned so she could sit up and eat. The nurse aide working the unit that day (could not recall her name) told SLP #101 that when she dressed the resident she complained of pain. The nurse aide also reported bruising to the resident's tailbone. The nurse aide also told her that LPN #74 had assisted her with dressing the resident and was aware of the tail bone bruising. SLP #101 stated she talked to LPN #74 who voiced she (LPN #74) had looked at the resident's skin and tailbone and affirmed there was bruising present, and that there was nothing in the resident's medical record about it. SLP #101 described bruising to the right side of the resident's forehead that looked established, not developing, but SLP #101 denied the bruising was there on Friday, 04/24/20, when she treated her. SLP #101 reported on 04/28/20 the residents door was closed and as she entered the room the resident had stripped naked and SLP #101 observed the resident with bruising on her right shoulder to bicep half way down her shoulder blade, her left breast was entirely bruised, and she had bruising on her lower spine. SLP #101 stated she assisted the nurse aide with dressing the resident and the resident was very stiff and seemed uncomfortable. She stated the resident did not want to walk. She reported the resident was not talking to her as normal, and SLP #101 went to speak to the nurse, LPN #61, on duty about the resident's condition. SLP #101 stated LPN #61 shared that SLP #101 was the first person to say anything about the resident's bruising, and that there was no documentation in the resident's medical record. LPN #61 told her she was not given anything in report regarding the resident's bruising/injuries. SLP #101 communicated that both herself and LPN #61 went to talk with former DON #93. SLP #101 stated when she told former DON #93 how she found the resident on 04/27/20 and on 04/28/20, that former DON #93 stated x-rays were going to be ordered. She stated she checked at the end of the day, at approximately 4:00 P.M., and there was no evidence of x-rays being done. SLP #101 shared she was made aware that Resident #47 had a fracture of her T12 vertebra the morning of 04/29/20 when she returned to the facility for work. An interview was conducted with Resident #47's attending physician, Physician #200, on 05/14/20 at 4:52 P.M. regarding the resident and her discharge from the facility to the hospital. Physician #200 reported he did not recall being notified of the resident having extensive bruising to her shoulder, breast, and tailbone prior to the day she was sent out to the hospital. He stated the on-call physician might have been notified. He also indicated if the bruising was as extensive as described he would have evaluated the use of the anti-platelet medication and probably would have stopped the [MEDICATION NAME]. Physician #200 stated he would have also sent the resident to the hospital for an evaluation and blood work. Physician #200 reported when he was made aware of the resident's back pain on 04/29/20, x-rays were ordered, and the resident was sent out to the hospital the same day for further evaluation. Review of facility policy titled Accidents and Incidents revealed all accidents or incidents involving residents occurring on or off our premises shall be investigated and reported to the Administrator. The policy interpretation and implementation specified that the Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident. The policy implementation specified that following data (including but not limited to), the nature of the injury/illness (e.g. bruise, fall, nausea), the circumstances surrounding the incident, the date/time the residents' physician was notified and the physician's response, the date/time the resident's family was notified, the condition of the residents including his/her vital signs,

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	366288	A. BUILDING _____ B. WING _____	05/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SUNRISE NURSING HEALTHCARE LLC	3434 STATE ROUTE 132 AMELIA, OH 45102

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 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 6) the disposition of the injured resident, and any corrective action. The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall complete a incident/accident report before end of the shift. This is an incidental deficiency found during investigation of Master Complaint Number OH 506 and Complaint Number OH 417.
F 0684 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed medical record review, physician and staff interviews, review of radiology report and review of hospital records, the facility failed to provide timely care for a resident who had a change in condition after the resident was found on the floor. This resulted in actual harm when the resident sustained [REDACTED]. This affected one (Resident #47) of three residents reviewed for falls. The facility census was 45. Findings include: Review of Resident #47's closed medical record revealed the resident was originally admitted to the facility on [DATE]. She was discharged to the behavioral health unit of a hospital on [DATE] and was readmitted to the facility on [DATE]. [DIAGNOSES REDACTED]. The resident was discharged from the facility to the emergency department of a local hospital for evaluation on 04/29/20. Review of a quarterly minimum data set ((MDS) dated [DATE] identified the resident as having severe cognitive deficits. She required physical assistance of two staff persons for bed mobility and transfers, was able to walk in her room and in the corridor with supervision, was unsteady but able to stabilize herself without staff assistance. The resident was assessed as having physical behavioral symptoms, verbal behavioral symptoms, and wandering. The resident had no falls. She received routine anti-psychotic, anti-anxiety, and anti-depressant medications. Review of the comprehensive plan of care identified the resident as having a behavior problem of sitting on the floor related to major neurocognitive disorder. This behavior placed the resident at increased risk for falls and or injury. The resident could be verbally aggressive towards others, and destructive to facility property. The behavior plan of care for the resident was initiated on 03/31/20 and revised on 04/10/20. Review of Resident #47's April 2020 physician's orders [REDACTED]. Review of Resident #47's April 2020 Medication Administration Record [REDACTED]. Review of Resident #47's nursing progress notes for 04/25/20 through 04/29/20 failed to reveal any documentation of the resident having any incidents, falls, altercations with other residents, or any assessment of any bruising or other injuries to her skin. There was no assessment including location and description of any bruising or other injuries, or a nursing assessment including an assessment of the resident's range of motion or vital signs at the time the bruising/injuries were first observed. Review of Speech Language Pathologist (SLP) #101's treatment notes dated 04/27/20 revealed Resident #47 was seen in her room for morning dysphagia therapy. The SLP note included the following observations; Postural adjustment required in bed secondary to the resident's complaints of pain when attempting to sit. Significant forehead and right shoulder bruising and the resident complained of tailbone pain. Per nursing, the resident had an unreported fall over the weekend resulting in tailbone bruising which was impacting her sitting tolerance. Review of a weekly skin assessment dated [DATE] at 6:04 P.M., Licensed Practical Nurse (LPN) #74 documented Resident #47 had no new skin abnormalities, and no bruising was documented on the skin assessment. Review of SLP #101 treatment notes dated 04/28/20 revealed the resident had removed her clothing and brief. Further bruising assessed with [REDACTED]. The nurse aide assisted the SLP in dressing the resident. Nursing and former Director of Nursing (DON) #93 were notified of the resident's condition. Review of Resident #47's radiology report dated 04/29/20 at 10:11 A.M., revealed the resident had a compression fracture at T12 with 75 percent (%) stature loss. Review of nursing progress notes dated 04/29/20 at 5:19 P.M., LPN #61 documented the resident had multi bruising in different areas. The LPN noted she was concerned about the resident's tailbone area per other nurse's report and LPN #61 contacted the resident's physician with her assessment. New orders were received for x-rays. The x-ray findings came back and the physician was notified. A new order was received to transfer the resident for further testing. Review of Resident #47's Emergency Department (ED) history and physical dated 04/29/20 revealed the resident was diagnosed with [REDACTED]. The hospital physician noted multiple bruises to the resident's head and hands. The resident had a recent fall, but the exact time of the fall was uncertain to the physician. The residents blood pressure was 181/71 while in the ED. Review of Resident #47's nursing progress note dated 04/30/20 at 4:19 P.M. revealed LPN #61 documented a late entry for 04/29/20 at 10:00 A.M. LPN #61 noted a physician order [REDACTED]. Further review revealed emergency medical technicians transferred the resident to a local hospital. The resident was transferred to the family's preferred hospital. During an interview with LPN #61 on 05/12/20 at 3:09 P.M. she reported when she arrived for the day shift of duty (7:00 A.M. through 7:00 P.M.) on 04/28/20, she received report from night shift LPN #59 who reported to her the resident had bruising everywhere, that it looked like the resident had been beaten up, and what looked like finger prints on the back of her shoulder. LPN #61 shared that LPN #59 communicated to her that there was no documentation regarding the bruising from the day shift nurse (LPN #74) on 04/27/20. LPN #61 reported that LPN #59 wanted to know what LPN #61 thought about the bruising so LPN #61 assessed the resident, and found the resident had multiple areas of what appeared to be fresh bruising. LPN #61 described the resident's bruising/injuries as follows: bad bruising on the left breast which went down the left side of the sternum; severe bruising on the right shoulder; a large bump on the left back side of the head; and an older bump on the head which was healing. LPN #61 shared that SLP #101 had also came to her the morning of 04/28/20 wanting to know what had happened to Resident #47 as she had also observed the resident's bruising. LPN #61 revealed on 04/28/20 she reported the issues with Resident #47 to former DON #93, and to Assistant Director of Nursing (ADON) #1 who was now the current DON. LPN #61 revealed she told both DON #93 and ADON #1 that the resident had fresh bruises everywhere, the resident was not acting herself, there was no documentation regarding the bruising or any type of incident, and that the resident might need x-rays. LPN #61 stated that ADON #1 told her that she and DON #93 were taking care of the situation and she did not need to fill out, or document, anything. LPN #61 verified she did not make any nursing entries regarding the resident's bruising/injuries until 04/29/20. LPN #61 explained that on 04/29/20 she returned to work the day shift of duty, and the resident was in her bed staring up to the ceiling, looked like she had no life left to her and the resident would not answer her. LPN #61 stated she rolled the resident over to check her and found bruising to the tailbone area. LPN #61 stated at that time she contacted the resident's physician and received new orders for x-rays. LPN #61 stated she told the x-ray technician that she thought the resident had fallen but was not certain. She communicated soon after the x-rays were taken, the radiologist office called and reported the resident had a T12 compression fracture. LPN #61 notified the resident's physician and the family, and the resident was sent out to the hospital for evaluation on 04/29/20. LPN #61 stated she held the resident's [MEDICATION NAME] and aspirin the morning of 04/29/20, however the medications were signed off as being given, and there were no notations on the MAR indicated [REDACTED]. During an interview with LPN #74 on 05/12/20 at 4:48 P.M., LPN #74 stated when she reported to work for the day shift of duty on 04/27/20 the resident was resting in bed with no concerns noted at that time. She indicated she was told the resident had been up during the night. LPN #74 communicated the night nurse, agency LPN #82, did not report the resident as having any incidents or problems during the night shift (7:00 P.M. - 7:00 A.M.) on 04/26/20 into the morning of 04/27/20. LPN #74 stated on 04/27/20 around 9:00 A.M., she was made aware by a nurse aide that the resident had bruising, and she assessed the resident. She stated the resident had what appeared to be new bruising which covered most of her left breast and left shoulder and she had an area on her right buttock. LPN #74 communicated she went to former DON #93 on 04/27/20 and reported the bruising she saw on Resident #47 and asked what was going to be done as there was no documentation regarding any incidents or injuries. She stated former DON #93 told her to do an incident report regarding the fresh bruising. LPN #74 stated she told former DON #93 that she was not going to do the incident report, and she was not going to document the bruising as something that had happened on her shift. She stated former DON #93 told her she would investigate what happened and get the documentation completed. LPN #74 affirmed she did not document the extensive bruising that was on Resident #47 nor did she initiate any neurological checks related to a potential fall, as she was told by former DON #93 that she would take care of it. LPN #74 communicated that Resident #47's routine was somewhat normal during the day shift of duty on 04/27/20 as the resident was up and walking, and then would get back in bed, and was back up for the evening meal that day. LPN #74 denied any knowledge of the resident having fallen but did document an incident on 04/21/20 in which the resident flipped over her bedside table and sustained a skin tear. During an interview with Temporary Nurse Aide (TNA) #77 on 05/12/20 at 5:42 P.M., TNA #77 reported on 04/23/20 the resident was sitting on the floor in the common area of the unit, which was normal for her, folding laundry and putting it in her basket. TNA #77 stated she went into another room on the unit and heard something loud. TNA #77 stated when she came out of the other resident's room, she observed Resident #47 laying on the floor on her back, and her laundry basket was flipped on the side. She stated she

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F 0684 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 7) alerted LPN #74 and the other nurse aide, that the resident was lying on the floor, and she did not feel comfortable picking her up. TNA #77 stated LPN #74 and the other nurse aide verbalized that being on the floor was part of the resident's behavior, that the resident would sit on the floor and lay herself back. TNA #77 stated they assisted the resident to stand and walk, and when the resident got halfway down the hall her knees appeared to give out and she went to her knees. TNA #77 was asked to get a walker with a seat, then herself and the other nurse aide put the resident to bed. TNA #77 shared during the night shift of duty Saturday 04/25/20 into Sunday morning 04/26/20 she did a quick walk through on the unit to inform the residents she was their aide for the night. She stated when she got to Resident #47's room the resident was sitting on the floor in the middle of the room, she was not doing anything just putting her fingers on the floor. TNA #77 stated she tried to get the resident up with verbal cueing and the resident pushed her away. She stated she encouraged the resident to get up off the floor, but the resident pushed her away again and using expletive words told the aide to leave her alone as she (TNA #77) had broken the residents back. She reported the resident was bleeding from her elbow and had bruises all over, from her mid forearm to her mid right upper arm, had a bruise on her forehead which was purplish red, and a knot on the back on her head that she thought was from a previous incident. TNA #77 stated she informed the night shift nurse for the unit, agency LPN #82, who stated the resident was having a behavior, that this was normal for the resident and that the resident was fine. The nurse assisted TNA #77 with getting the resident to bed. During the night, the resident did not get out of bed but flipped herself in bed with her head towards the foot board and was hitting her head on the foot board and hitting her elbows on the wall. TNA #77 shared she reported the resident's behaviors to LPN #82 again, at which time the nurse told her that it was part of the resident's behaviors. TNA #77 stated she told the oncoming day shift nurse aide that the resident had been in bed all night, that the resident was in a lot of pain and every time TNA #77 checked on the resident she would try to hit the aide. TNA #77 denied witnessing the resident falling, and stated she only found the resident sitting on the floor. During an interview with the current DON (formerly the ADON) on 05/13/20 at 1:12 P.M., she stated on 04/27/20 around 9:00 A.M. to 10:00 A.M., LPN #74 notified her Resident #47 was bruised, and she went to observe the resident. The DON stated the resident had a hematoma to her forehead, she believed it was on the right side, a circular bruise to the right shoulder which encompassed the entire shoulder, and one of her breasts was covered in bruising. She reported she did not examine the resident's tailbone, and she did not do a full body assessment of the resident at that time. The current DON stated she went directly to former DON #93 and was under the impression that former DON #93 was completing an investigation into the situation. The current DON affirmed she was aware, after the fact, that LPN #74 did not document the resident's bruising, and affirmed the physician was not notified of the residents bruising on 04/27/20 but should have been notified. An interview was conducted with the Administrator and Corporate DON #99 on 05/13/20 at 1:38 P.M. regarding Resident #47's bruising/injuries and if there was any documentation to support the facility had thoroughly documented and assessed the resident's bruising and injuries when first discovered on 04/27/20, had notified the resident's physician when first discovered, had notified the Ohio Department of Health regarding the resident's injuries of unknown origin, or communicated with the resident's physician regarding the continued use of the anti-platelet medication in light of the resident's areas of significant bruising. The Administrator communicated she was not made aware of the extent of the resident's injuries until 05/06/20, and that was when she started her own investigation and the injuries were believed to have occurred related to an unreported fall. Corporate DON #99 stated the facility did not have any documentation regarding assessment of the resident, or notification of the resident's physician, until the day she was sent out to the hospital. Corporate DON #99 also affirmed that no facility Self-Reported Incident (SRI) was submitted, and in hindsight an SRI should have been completed due to the nature of the resident's bruising and injuries. During an interview with agency LPN #82 on 05/13/20 at 3:38 P.M., LPN #82 affirmed she worked at the facility often, typically worked the night shift of duty, and was familiar with Resident #47. She reported she believed she did work the weekend of 04/25/20 and 04/26/20 during the night shift of duty, and was assigned to the secured unit, where Resident #47 resided. LPN #82 shared the resident walked on her own, that she had never seen her fall, but had observed her get down on the floor on her own. She denied that she had been made aware of the resident having any falls or injuries, or complaints of pain during the night shift of duty on 04/25/20 or 04/26/20. LPN #82 did share there was one time, could not recall the date, the resident was sitting on the floor in her room and she helped TNA #77 get her into bed. She explained the resident did have a bruise on her forehead, that she had gotten beforehand from a fall a few weeks before. LPN #82 stated she had charted on the bruising to the resident's head prior and documented that the bruising continued. She stated she did not notice any bruising to the resident other than the bruise to her forehead on 04/25/20 or 04/26/20 but admitted she did not observe the resident undressed. During an interview with contracted SLP #101 on 05/13/20 at 5:13 P.M., SLP #101 reported she had worked at the facility a limited amount of time on contract and had been working with Resident #47 for several weeks to advance her diet. She reported on 04/27/20 she provided treatment to the resident about 11:45 A.M. to 12:00 P.M. The resident was in bed with her door closed, and she tried to have the resident sit up. The resident kept trying to lay down and would slouch to one side and she complained of pain. SLP #101 communicated she got the resident repositioned so she could sit up and eat. The nurse aide working the unit that day (could not recall her name) told SLP #101 that when she dressed the resident she complained of pain. The nurse aide also reported bruising to the resident's tailbone. The nurse aide also told her that LPN #74 had assisted her with dressing the resident and was aware of the tail bone bruising. SLP #101 stated she talked to LPN #74 who voiced she (LPN #74) had looked at the resident's skin and tailbone and affirmed there was bruising present, and that there was nothing in the resident's medical record about it. SLP #101 described bruising to the right side of the resident's forehead that looked established, not developing, but SLP #101 denied the bruising was there on Friday, 04/24/20, when she treated her. SLP #101 reported on 04/28/20 the residents door was closed and as she entered the room the resident had stripped naked and SLP #101 observed the resident with bruising on her right shoulder to bicep half way down her shoulder blade, her left breast was entirely bruised, and she had bruising on her lower spine. SLP #101 stated she assisted the nurse aide with dressing the resident and the resident was very stiff and seemed uncomfortable. She stated the resident did not want to walk. She reported the resident was not talking to her as normal, and SLP #101 went to speak to the nurse, LPN #61, on duty about the resident's condition. SLP #101 stated LPN #61 shared that SLP #101 was the first person to say anything about the resident's bruising, and that there was no documentation in the resident's medical record. LPN #61 told her she was not given anything in report regarding the resident's bruising/injuries. SLP #101 communicated that both herself and LPN #61 went to talk with former DON #93. SLP #101 stated when she told former DON #93 how she found the resident on 04/27/20 and on 04/28/20, that former DON #93 stated x-rays were going to be ordered. She stated she checked at the end of the day, at approximately 4:00 P.M., and there was no evidence of x-rays being done. SLP #101 shared she was made aware that Resident #47 had a fracture of her T12 vertebra the morning of 04/29/20 when she returned to the facility for work. An interview was conducted with Resident #47's attending physician, Physician #200, on 05/14/20 at 4:52 P.M. regarding the resident and her discharge from the facility to the hospital. Physician #200 reported he did not recall being notified of the resident having extensive bruising to her shoulder, breast, and tailbone prior to the day she was sent out to the hospital. He stated the on-call physician might have been notified. He also indicated if the bruising was as extensive as described he would have evaluated the use of the anti-platelet medication and probably would have stopped the [MEDICATION NAME]. Physician #200 stated he would have also sent the resident to the hospital for an evaluation and blood work. Physician #200 reported when he was made aware of the resident's back pain on 04/29/20, x-rays were ordered, and the resident was sent out to the hospital the same day for further evaluation. This is an incidental deficiency found during investigation of Master Complaint Numbers OH 506 and OH 417.
F 0757 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed medical record review, physician and staff interviews, review of readiology report, review of hospital records and review of facility policy and procedure, the facility failed to ensure a resident, who was on anti-platelet medications, was monitored for the presence of potential adverse consequences related to the use of the medications. This affected one (Resident #47) of three residents reviewed. The facility census was 45. Findings include: Review of Resident #47's closed medical record revealed the resident was originally admitted to the facility on [DATE]. She was discharged to the behavioral health unit of a hospital on [DATE] and was readmitted to the facility on [DATE]. [DIAGNOSES REDACTED]. The resident was discharged from the facility to the emergency department of a local hospital for evaluation on 04/29/20. Review of a quarterly minimum data set ((MDS) dated [DATE] identified the resident as having severe cognitive deficits. She required physical assistance of two staff persons for bed mobility and transfers, was able to walk in her room and in the corridor with supervision, was unsteady but able to stabilize herself without staff assistance. The

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F 0757 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 8) resident was assessed as having physical behavioral symptoms, verbal behavioral symptoms, and wandering. The resident had no falls. She received routine anti-psychotic, anti-anxiety, and anti-depressant medications. Review of the comprehensive plan of care identified the resident as having a behavior problem of sitting on the floor related to major neurocognitive disorder. This behavior placed the resident at increased risk for falls and or injury. The resident could be verbally aggressive towards others, and destructive to facility property. The behavior plan of care for the resident was initiated on 03/31/20 and revised on 04/10/20. Review of Resident #47's April 2020 physician's orders [REDACTED]. Review of Resident #47's April 2020 Medication Administration Record [REDACTED]. Review of Resident #47's nursing progress notes for 04/25/20 through 04/29/20 failed to reveal any documentation of the resident having any incidents, falls, altercations with other residents, or any assessment of any bruising or other injuries to her skin. There was no assessment including location and description of any bruising or other injuries, or a nursing assessment including an assessment of the resident's range of motion or vital signs at the time the bruising/injuries were first observed. Review of Speech Language Pathologist (SLP) #101's treatment notes dated 04/27/20 revealed Resident #47 was seen in her room for morning dysphagia therapy. The SLP note included the following observations; Postural adjustment required in bed secondary to the resident's complaints of pain when attempting to sit. Significant forehead and right shoulder bruising and the resident complained of tailbone pain. Per nursing, the resident had an unreported fall over the weekend resulting in tailbone bruising which was impacting her sitting tolerance. Review of SLP #101 treatment notes dated 04/28/20 revealed the resident had removed her clothing and brief. Further bruising assessed with [REDACTED]. The nurse aide assisted the SLP in dressing the resident. Nursing and former Director of Nursing (DON) #93 were notified of the resident's condition. Review of Resident #47's radiology report dated 04/29/20 at 10:11 A.M., revealed the resident had a compression fracture at T12 with 75 percent (%) stature loss. Review of nursing progress notes dated 04/29/20 at 5:19 P.M., LPN #61 documented the resident had multi bruising in different areas. The LPN noted she was concerned about the resident's tailbone area per other nurse's report and LPN #61 contacted the resident's physician with her assessment. New orders were received for x-rays. The x-ray findings came back and the physician was notified. A new order was received to transfer the resident for further testing. Review of Resident #47's Emergency Department (ED) history and physical dated 04/29/20 revealed the resident was diagnosed with [REDACTED]. The hospital physician noted multiple bruises to the resident's head and hands. The resident had a recent fall, but the exact time of the fall was uncertain to the physician. The residents blood pressure was 181/71 while in the ED. Review of Resident #47's nursing progress note dated 04/30/20 at 4:19 P.M. revealed LPN #61 documented a late entry for 04/29/20 at 10:00 A.M. LPN #61 noted a physician order [REDACTED]. Further review revealed emergency medical technicians transferred the resident to a local hospital. The resident was transferred to the family's preferred hospital. During an interview with LPN #61 on 05/12/20 at 3:09 P.M. she reported when she arrived for the day shift of duty (7:00 A.M. through 7:00 P.M.) on 04/28/20, she received report from night shift LPN #59 who reported to her the resident had bruising everywhere, that it looked like the resident had been beaten up, and what looked like finger prints on the back of her shoulder. LPN #61 shared that LPN #59 communicated to her that there was no documentation regarding the bruising from the day shift nurse (LPN #74) on 04/27/20. LPN #61 reported that LPN #59 wanted to know what LPN #61 thought about the bruising so LPN #61 assessed the resident, and found the resident had multiple areas of what appeared to be fresh bruising. LPN #61 described the resident's bruising/injuries as follows: bad bruising on the left breast which went down the left side of the sternum; severe bruising on the right shoulder; a large bump on the left back side of the head; and an older bump on the head which was healing. LPN #61 shared that SLP #101 had also came to her the morning of 04/28/20 wanting to know what had happened to Resident #47 as she had also observed the resident's bruising. LPN #61 revealed on 04/28/20 she reported the issues with Resident #47 to former DON #93, and to Assistant Director of Nursing (ADON) #1 who was now the current DON. LPN #61 revealed she told both DON #93 and ADON #1 that the resident had fresh bruises everywhere, the resident was not acting herself, there was no documentation regarding the bruising or any type of incident, and that the resident might need x-rays. LPN #61 stated that ADON #1 told her that she and DON #93 were taking care of the situation and she did not need to fill out, or document, anything. LPN #61 verified she did not make any nursing entries regarding the resident's bruising/injuries until 04/29/20. LPN #61 explained that on 04/29/20 she returned to work the day shift of duty, and the resident was in her bed staring up to the ceiling, looked like she had no life left to her and the resident would not answer her. LPN #61 stated she rolled the resident over to check her and found bruising to the tailbone area. LPN #61 stated at that time she contacted the resident's physician and received new orders for x-rays. LPN #61 stated she told the x-ray technician that she thought the resident had fallen but was not certain. She communicated soon after the x-rays were taken, the radiologist office called and reported the resident had a T12 compression fracture. LPN #61 notified the resident's physician and the family, and the resident was sent out to the hospital for evaluation on 04/29/20. LPN #61 stated she held the resident's [MEDICATION NAME] and aspirin the morning of 04/29/20, however the medications were signed off as being given, and there were no notations on the MAR indicated [REDACTED]. During an interview with LPN #74 on 05/12/20 at 4:48 P.M., LPN #74 stated when she reported to work for the day shift of duty on 04/27/20 the resident was resting in bed with no concerns noted at that time. She indicated she was told the resident had been up during the night. LPN #74 communicated the night nurse, agency LPN #82, did not report the resident as having any incidents or problems during the night shift (7:00 P.M. - 7:00 A.M.) on 04/26/20 into the morning of 04/27/20. LPN #74 stated on 04/27/20 around 9:00 A.M., she was made aware by a nurse aide that the resident had bruising, and she assessed the resident. She stated the resident had what appeared to be new bruising which covered most of her left breast and left shoulder and she had an area on her right buttock. LPN #74 communicated she went to former DON #93 on 04/27/20 and reported the bruising she saw on Resident #47 and asked what was going to be done as there was no documentation regarding any incidents or injuries. She stated former DON #93 told her to do an incident report regarding the fresh bruising. LPN #74 stated she told former DON #93 that she was not going to do the incident report, and she was not going to document the bruising as something that had happened on her shift. She stated former DON #93 told her she would investigate what happened and get the documentation completed. LPN #74 affirmed she did not document the extensive bruising that was on Resident #47 nor did she initiate any neurological checks related to a potential fall, as she was told by former DON #93 that she would take care of it. LPN #74 communicated that Resident #47's routine was somewhat normal during the day shift of duty on 04/27/20 as the resident was up and walking, and then would get back in bed, and was back up for the evening meal that day. LPN #74 denied any knowledge of the resident having fallen but did document an incident on 04/21/20 in which the resident flipped over her bedside table and sustained a skin tear. An interview was conducted with the current DON (formerly the ADON) on 05/13/20 at 1:12 P.M., and a follow-up interview conducted on 05/14/20 at 9:20 A.M., regarding Resident #47 and when she was first aware of the resident's bruising/injuries. She stated on the morning of 04/27/20 around 9:00 A.M. to 10:00 A.M., LPN #74 notified her the resident was bruised and she went to assess the resident. The DON stated the resident had a hematoma to the forehead, she thought it was on the right side, a circular bruise to the right shoulder which encompassed the entire shoulder, and one of her breasts was covered in bruising. She reported she did not examine the resident's tailbone, and she did not do a full body assessment of the resident at that time. The DON stated she went directly to former DON #93 and informed her of the bruising, and to the best of her knowledge DON #93 was completing an investigation into the situation. She affirmed that she was aware after the fact that LPN #74 did not document the resident's bruising. The DON affirmed the resident's physician was not notified on 04/27/20 regarding the resident's bruising/injuries and should have been, and also confirmed the continued use of the clopiogrel should have been addressed with the physician when the bruising was discovered. An interview was conducted with the Administrator and Corporate DON #99 on 05/13/20 at 1:38 P.M. regarding Resident #47's bruising/injuries and if there was any documentation to support the facility had notified the resident's physician when the bruising was first discovered on 04/27/20. Corporate DON #99 reported the facility did not have any documentation to support the resident's physician was notified on 04/27/20. She affirmed the resident's physician was not notified until 04/29/20 when he ordered x-rays, and then ordered the resident be sent to the hospital for evaluation. When Corporate DON #99 was asked to review the resident's April 2020 MAR indicated [REDACTED]. An interview was conducted with Resident #47's attending physician, Physician #200, on 05/14/20 at 4:52 P.M. regarding the resident and her discharge from the facility to the hospital. Physician #200 reported he did not recall being notified of the resident having extensive bruising to her shoulder, breast, and tailbone prior to the day she was sent out to the hospital. He stated the on-call physician might have been notified. He also indicated if the bruising was as extensive as described he would have evaluated the use of the anti-platelet medication and probably would have stopped the [MEDICATION NAME]. Physician #200 stated he would have also sent the resident to the hospital for an evaluation and blood work. Physician #200 reported when he was made aware of the resident's back pain on 04/29/20, x-rays were ordered, and the resident was sent out to the hospital the same day for further evaluation. Review of the facility's policy titled Change's

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	366288	A. BUILDING _____ B. WING _____	05/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SUNRISE NURSING HEALTHCARE LLC	3434 STATE ROUTE 132 AMELIA, OH 45102

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 0757 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 9) in a Resident's Condition or Status revealed the nurse will notify the resident's attending physician or physician on call when there has been an adverse reaction to medication. The policy also specified that prior to notifying the resident's physician the nurse would make detailed observations and gather pertinent and relevant information for the physician, and the nurse would record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. This is an incidental deficiency found during investigation of Master Complaint Number OH 506 and Complaint Number OH 417.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed medical record review, and staff interview, the facility failed to document a complete and accurate accounting of the care and services provided to residents during their stay at the facility. This involved one (Resident #47) of three residents reviewed. The facility census was 45. Findings include: Review of Resident #47's closed medical record revealed the resident was originally admitted to the facility on [DATE]. She was discharged to the behavioral health unit of a hospital on [DATE] and was readmitted to the facility on [DATE]. [DIAGNOSES REDACTED]. The resident was discharged from the facility to the emergency department of a local hospital for evaluation on 04/29/20. Review of a quarterly minimum data set ((MDS) dated [DATE] identified the resident as having severe cognitive deficits. She required physical assistance of two staff persons for bed mobility and transfers, was able to walk in her room and in the corridor with supervision, was unsteady but able to stabilize herself without staff assistance. The resident was assessed as having physical behavioral symptoms, verbal behavioral symptoms, and wandering. The resident had no falls. She received routine anti-psychotic, anti-anxiety, and anti-depressant medications. Review of Resident #47's April 2020 physician's orders [REDACTED]. Review of Resident #47's April 2020 Medication Administration Record [REDACTED]. Review of Resident #47's nursing progress notes for 04/25/20 through 04/29/20 failed to reveal any documentation of the resident having any incidents, falls, altercations with other residents, or any assessment of any bruising or other injuries to her skin. There was no assessment including location and description of any bruising or other injuries, or a nursing assessment including an assessment of the resident's range of motion or vital signs at the time the bruising/injuries were first observed. Review of a weekly skin assessment dated [DATE] at 6:04 P.M., Licensed Practical Nurse (LPN) #74 documented Resident #47 had no new skin abnormalities, and no bruising was documented on the skin assessment. Review of nursing progress notes dated 04/29/20 at 5:19 P.M., LPN #61 documented the resident had multi bruising in different areas. The LPN noted she was concerned about the resident's tailbone area per other nurse's report and LPN #61 contacted the resident's physician with her assessment. New orders were received for x-rays. The x-ray findings came back and the physician was notified. A new order was received to transfer the resident for further testing. Review of Resident #47's Emergency Department (ED) history and physical dated 04/29/20 revealed the resident was diagnosed with [REDACTED]. The hospital physician noted multiple bruises to the resident's head and hands. The resident had a recent fall, but the exact time of the fall was uncertain to the physician. The residents blood pressure was 181/71 while in the ED. Review of Resident #47's nursing progress note dated 04/30/20 at 4:19 P.M. revealed LPN #61 documented a late entry for 04/29/20 at 10:00 A.M. LPN #61 noted a physician order [REDACTED]. Further review revealed emergency medical technicians transferred the resident to a local hospital. The resident was transferred to the family's preferred hospital. During an interview with LPN #61 on 05/12/20 at 3:09 P.M. she reported when she arrived for the day shift of duty (7:00 A.M. through 7:00 P.M.) on 04/28/20, she received report from night shift LPN #59 who reported to her the resident had bruising everywhere, that it looked like the resident had been beaten up, and what looked like finger prints on the back of her shoulder. LPN #61 shared that LPN #59 communicated to her that there was no documentation regarding the bruising from the day shift nurse (LPN #74) on 04/27/20. LPN #61 reported that LPN #59 wanted to know what LPN #61 thought about the bruising so LPN #61 assessed the resident, and found the resident had multiple areas of what appeared to be fresh bruising. LPN #61 described the resident's bruising/injuries as follows: bad bruising on the left breast which went down the left side of the sternum; severe bruising on the right shoulder; a large bump on the left back side of the head; and an older bump on the head which was healing. LPN #61 shared that SLP #101 had also came to her the morning of 04/28/20 wanting to know what had happened to Resident #47 as she had also observed the resident's bruising. LPN #61 revealed on 04/28/20 she reported the issues with Resident #47 to former DON #93, and to Assistant Director of Nursing (ADON) #1 who was now the current DON. LPN #61 revealed she told both DON #93 and ADON #1 that the resident had fresh bruises everywhere, the resident was not acting herself, there was no documentation regarding the bruising or any type of incident, and that the resident might need x-rays. LPN #61 stated that ADON #1 told her that she and DON #93 were taking care of the situation and she did not need to fill out, or document, anything. LPN #61 verified she did not make any nursing entries regarding the resident's bruising/injuries until 04/29/20. LPN #61 explained that on 04/29/20 she returned to work the day shift of duty, and the resident was in her bed staring up to the ceiling, looked like she had no life left to her and the resident would not answer her. LPN #61 stated she rolled the resident over to check her and found bruising to the tailbone area. LPN #61 stated at that time she contacted the resident's physician and received new orders for x-rays. LPN #61 stated she told the x-ray technician that she thought the resident had fallen but was not certain. She communicated soon after the x-rays were taken, the radiologist office called and reported the resident had a T12 compression fracture. LPN #61 notified the resident's physician and the family, and the resident was sent out to the hospital for evaluation on 04/29/20. LPN #61 stated she held the resident's [MEDICATION NAME] and aspirin the morning of 04/29/20, however the medications were signed off as being given, and there were no notations on the MAR indicated [REDACTED]. LPN #61 also revealed on 04/29/20 after the resident had been transferred to the hospital, that former DON #93 came to her and asked if there were any neurological check work sheets completed for Resident #47. She stated she told former DON #93 that she had not completed any neurological check sheets, and there was no reason for her to completed them as she had not been made aware of the resident having any falls. She verbalized that former DON #93 stated there needed to be a neurological check worksheet, and DON #93 handed her a neurological check worksheet to fill out for three shifts that she had not even worked. LPN #61 stated she filled out the neurological worksheet as requested by DON #93, even through she had not actually completed the neurological checks for Resident #47. She stated she was fearful of former DON #93. She stated she reported to the Administrator what DON #93 had asked her to do. She communicated she also showed the fabricated neurological check worksheet to LPN #59 as her name/initials had been added to the neurological check worksheet created by former DON #93. LPN #61 reported that LPN #59 stated to her that she had not filled out any portion of a numerological check worksheet for Resident #47 on the days prior to her discharge on 04/29/20. During an interview with LPN #74 on 05/12/20 at 4:48 P.M., LPN #74 stated when she reported to work for the day shift of duty on 04/27/20 the resident was resting in bed with no concerns noted at that time. She indicated she was told the resident had been up during the night. LPN #74 communicated the night nurse, agency LPN #82, did not report the resident as having any incidents or problems during the night shift (7:00 P.M. - 7:00 A.M.) on 04/26/20 into the morning of 04/27/20. LPN #74 stated on 04/27/20 around 9:00 A.M., she was made aware by a nurse aide that the resident had bruising, and she assessed the resident. She stated the resident had what appeared to be new bruising which covered most of her left breast and left shoulder and she had an area on her right buttock. LPN #74 communicated she went to former DON #93 on 04/27/20 and reported the bruising she saw on Resident #47 and asked what was going to be done as there was no documentation regarding any incidents or injuries. She stated former DON #93 told her to do an incident report regarding the fresh bruising. LPN #74 stated she told former DON #93 that she was not going to do the incident report, and she was not going to document the bruising as something that had happened on her shift. She stated former DON #93 told her she would investigate what happened and get the documentation completed. LPN #74 affirmed she did not document the extensive bruising that was on Resident #47 nor did she initiate any neurological checks related to a potential fall, as she was told by former DON #93 that she would take care of it. An interview was conducted with the Administrator on 05/12/20 at 5:15 P.M. to ascertain if any staff had falsified, or been asked to falsify, neurological checks or any other documents for Resident #47. She reported on 05/06/20 a couple nurses came to her with a neurological check worksheet for Resident #47 that had five different nurses names on it. It was for the time period leading up to Resident #47's discharge on 04/29/20. The Administrator explained that on investigation, three of the nurses had never signed the neurological check worksheet, and two of the five reported they had signed the sheet as former DON #93 had asked them to do so. The Administrator reported it was former DON #93 that had asked the licensed nurses to falsify the document, and she had reported what happened to the

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SUNRISE NURSING HEALTHCARE LLC	**3434 STATE ROUTE 132 AMELIA, OH 45102**

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 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 10) Ohio Board of Nursing, and former DON #93's employment was terminated. During an interview with the current DON (formerly the ADON) on 05/13/20 at 1:12 P.M., she stated on 04/27/20 around 9:00 A.M. to 10:00 A.M., LPN #74 notified her Resident #47 was bruised, and she went to observe the resident. The DON stated the resident had a hematoma to her forehead, she believed it was on the right side, a circular bruise to the right shoulder which encompassed the entire shoulder, and one of her breasts was covered in bruising. She reported she did not examine the resident's tailbone, and she did not do a full body assessment of the resident at that time. The current DON stated she went directly to former DON #93 and was under the impression that former DON #93 was completing an investigation into the situation. The current DON affirmed she was aware, after the fact, that LPN #74 did not document the resident's bruising. During an interview with agency LPN #82 on 05/13/20 at 3:38 P.M., LPN #82 affirmed she worked at the facility often, typically worked the night shift of duty, and was familiar with Resident #47. She reported she believed she did work the weekend of 04/25/20 and 04/26/20 during the night shift of duty, and was assigned to the secured unit, where Resident #47 resided. LPN #82 shared the resident walked on her own, that she had never seen her fall, but had observed her get down on the floor on her own. She denied that she had been made aware of the resident having any falls or injuries, or complaints of pain during the night shift of duty on 04/25/20 or 04/26/20. LPN #82 did share there was one time, could not recall the date, the resident was sitting on the floor in her room and she helped TNA #77 get her into bed. She explained the resident did have a bruise on her forehead, that she had gotten beforehand from a fall a few weeks before. LPN #82 stated she had charted on the bruising to the resident's head prior and documented that the bruising continued. She stated she did not notice any bruising to the resident other than the bruise to her forehead on 04/25/20 or 04/26/20 but admitted she did not observe the resident undressed. Agency :LPN #82 denied being asked to falsify any documentation regarding Resident #47 after the bruising to the resident was discovered on 04/27/20. She stated she was contacted by a Corporate staff person who asked if she had done any neurological checks on the resident, as the Corporate staff person had in her possession a neurological check worksheet in which someone had signed agency LPN #82's name. LPN #82 reported she told the Corporate staff person that she had not started or signed off on any neurological checks for Resident #47. An interview was conducted with the Administrator and Corporate DON #99 on 05/13/20 at 1:38 P.M. regarding Resident #47's bruising/injuries and to ascertain if there was any documentation to support the facility had thoroughly documented and assessed the resident's bruising and injuries when first discovered on 04/27/20. Corporate DON #99 stated the facility did not have any documentation regarding assessment of the resident's bruising/injuries, or notification of the resident's physician, until the day she was sent out to the hospital (04/29/20). This deficiency substantiates Complaint Number OH 506.