STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365770	A. BUILDING _____ B. WING _____	07/08/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CAMBRIDGE CARE AND REHABILITATION	1471 WILLS CREEK VALLEY DRIVE CAMBRIDGE, OH 43725

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 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 medical record review, investigation review, review of a concern form, staff and resident interviews and policy review the facility failed to ensure allegations of injury of unknown origin involving Resident #2 and mental abuse involving Resident #1 were reported to the State agency timely and as required. This affected two resident (#1 and #2) of three residents reviewed for abuse and injuries of unknown origin. Findings include: 1. Review of Resident #2's closed medical record revealed the resident was admitted for respite care from 06/24/20 to 06/29/20. The resident had [DIAGNOSES REDACTED]. Review of Resident #2's non-pressure skin grids dated 06/24/20 to 06/29/20 revealed no evidence the resident had any documented bruises to her thighs or chest. The resident was noted to have a scab on the right heel, scattered bruising to her bilateral arms, abrasions to right and left elbow and three bruises on the abdomen. There was no description of skin alterations that were identified during the admission. Review of the facility self-reported incidents (SRIs) revealed no evidence of any SRI being completed or submitted involving Resident #2. However, the facility provided an investigation for Resident #2 related to injuries of unknown origin, dated 06/29/20 to 06/30/20. The investigation included a copy of the resident's Medication Administration Record [REDACTED]. The resident was cooperative and pleasant. There was one shower sheet for Resident #2 dated 06/28/20 that indicated the resident received a shower. The shower sheet revealed the anatomic picture of a human front and back view was blank. A summary sheet of events indicated on 06/29/20 the Hospice social worker telephoned the facility to report Resident #2's daughter had found new bruises on the resident's thigh and chest area. Hospice Registered Nurse (RN) #3 stated the resident had fallen prior to coming to the facility and the bruising was from the falls at home prior to admission. On 06/30/20 the facility attempted to call the daughter and left messages; however, she never returned the facility calls. The resident was noted to be at risk for bruising related to the administration of the medication, Aspirin. Skin grids were completed on admission on 06/24/20 and a shower sheet was completed on 06/28/20 that showed no new skin areas. The sheet revealed the facility was unable to verify concerns from the daughter due to her refusal to return phone calls to the facility. There was no evidence the facility investigation included statements/interviews from any staff who had cared for the resident during her stay, any assessments or any statements from Hospice staff, nor was there evidence of a skin assessment completed for Resident #2 on the day of discharge 06/29/20. Interview on 07/08/20 at 8:04 A.M. and 10:14 A.M., with STNA #2 revealed she could not recall if the resident had bruises on her abdomen or not on the day she was discharged . She reported she did help the resident get dressed the day she was discharged , and it could have been possible she had bruises on her abdomen, but the lighting in the bathrooms was poor. She confirmed the resident did have bruising on her arms for sure though. The STNA indicated the resident wandered and was confused at times. She was not combative, however sometimes she would undress herself and walk out into the hallway. STNA #2 verified she did not sign any type of statement regarding the resident's skin assessment on discharge. Interview on 07/08/20 at 8:58 A.M. to 10:07 A.M., with the Administrator revealed she was aware of one incident of injury of unknown origin involving a respite resident (Resident #2). The Administrator reported the Hospice nurse (RN #3) called the facility and reported the resident's daughter had called the hospice office because she found bruising on her mother's thigh and chest area upon discharge from the facility. The nurse and STNA #2 were interviewed and reported they didn't notice any bruising on the resident on the day of discharge. The hospice nurse informed the facility that the resident had fallen three to four times before her admission to the facility. The Administrator verified she did not report the allegation of injury of unknown origin to the State agency and stated this was because the resident's daughter would not return the facility call and she was also instructed not to report the allegation because the incident (falls) didn't happen at the facility since hospice reported she had falls at home. The Administrator indicated she believed the bruises were related to falls the resident had prior to admission and they were just now coming out. Interview with Resident #2's daughter on 07/08/20 at 9:42 A.M., revealed the resident did not have bruises to her chest, abdomen, or inner leg prior to her admission to the nursing home. She stated the hospice home health aide had performed a bath on the resident on the same day she was admitted to the nursing home for a five-day respite stay and the resident did not have any bruising to those areas. Interview on 07/08/20 at 9:59 A.M., with the Director of Nursing (DON) revealed the facility did not complete an SRI because she could not confirm the incident occurred because the daughter would not return the facility calls. On 07/08/20 at 10:19 A.M., a telephone interview with Hospice RN #3 revealed on 06/24/20 she had done a home visit for Resident #2 to prepare her for a five-day respite stay at the nursing home. The resident had a faint bruise noted on her forehead as a result of a fall she had the previous morning. The resident had chronic bruises on her bilateral arms. The hospice aide had showered the resident that morning on 06/24/20 prior to taking the resident to the nursing home. The aide reported the resident had no skin alterations. On 06/25/20 the nurse went to the nursing home to visit the resident and didn't notice any behaviors. On 06/29/20 the resident's daughter picked Resident #2 up from the nursing home to return her home. The daughter originally declined for hospice to visit that day, however around 3:00 P.M., she called and asked if a nurse could come out for a visit due the resident had multiple bruised areas on her body. The daughter was worried the resident had been sexually abused due to the bruises noted in her inner thigh area. The resident had three bruises on her inner thigh, one on her buttocks, one on her right wrist, and three on her abdomen in various staging of healing. The nurse took pictures and measurements of the bruises at that time. The social worker from hospice had notified the facility of the bruises of unknown origin. On 06/30/20 the nurse stated she had a conference call with the facility due to there being a discrepancy with the resident's narcotic count as well. The nurse indicated she discussed the bruises of unknown origin and indicated the bruising did not appear to be related to a fall due to the various locations of the bruises which were not consistent to fall injuries. Interview on 07/08/20 at 3:10 P.M. with the Administrator and DON revealed there was no additional information to provide for Resident #2 and the complete investigaiton and information was as noted above. Review of facility policy titled Skin Care, dated 11/2018 revealed skin would be observed upon admission and routinely throughout the resident's stay. Review of facility policy titled Abuse, Neglect, Exploitation, & Misappropriation of Resident Property, dated 02/2020 revealed an injury of unknown source was an injury when the injury was not observed by any person, or source of the injury could not be explained by the resident and the injury was suspicious because of the location of the injury. If a staff member was accused or suspected of abuse, the facility should immediately remove the staff member from the facility and the schedule pending the outcome of the investigation. Documentation should be completed in the nurse's notes. The Administrator would be notified immediately of all incidents or allegations. The State agency would be notified in two hours of abuse or serious bodily injury is alleged and all other allegations within 24 hours. An investigation of the allegations would be conducted. The investigation protocol generally takes the following actions: Interview the resident, the accused, and all witnesses. Witnesses generally included anyone who: witnessed or heard the incident, came in

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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CAMBRIDGE CARE AND REHABILITATION	1471 WILLS CREEK VALLEY DRIVE CAMBRIDGE, OH 43725

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F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) close contact with the resident the day of the incident, the employees who worked closely with the accused or alleged victim the day of the incident. For injuries of unknown source, the investigation may generally involve talking with both the shift on duty when the injury was discovered and prior shifts as well. Obtain a statement from the resident, the accused, and each witness. Evidence of the investigation should be documented. After the completion of the investigation, all the evidence should be analyzed, and the Administrator would decide regarding whether the allegation or suspicion was substantiated. The final report would be reported to the State agency no later than five working days. 2. Review of Resident #1's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED].#1 and an allegation of mental abuse. Review of Resident #1's concern quality/assurance form, dated 06/10/20 revealed the resident reported what was documented as a personality issue with dietary manager (DM) #1 regarding restrictions for nursing homes given by the Center of Disease Control (CDC) and the Governor. The Administrator and Director of Nursing (DON) met with Resident #1 on 06/10/20 and the resident reported she was frustrated with the restrictions and it was explained to her that the facility was following the guidelines per the CDC. They also meet with DM #1 and explained she need to be more understanding during the difficult times. There was no mention of the actual incident which was noted to have happened in the courtyard on 06/08/20. Review of DM #1's unsigned typed statement dated 06/10/20 revealed the DM was outside planting and watering the flowers in the outside courtyard area and only asked Resident #1 if she liked the flowers. The statement revealed Resident #1 kept talking under her breath while she was outside, and she only commended to Resident #1 if she was so unhappy then why was she here. The resident went to the smoking area and the DM finished planting and watering the flowers. Review of Cook #10's handwritten statement dated 06/10/20 revealed on 06/08/20 DM #1 and herself were in the courtyard planting flowers and the DM asked a few of the resident's that were out there, if they liked the flowers they were planting. Resident #1 mumbled something they couldn't understand. The resident kept mumbling to the DM hatefully and the DM had just asked her if she was so unhappy why does she stay. The statement indicated the DM was never near the resident and never touched her. Interview on 07/08/20 at 8:25 A.M., with Resident #1 revealed in the last month she reported she had been mentally abused by DM #1. She stated she had reported the incident to the Administrator and the local Ombudsman and had not heard back from either one as of this time. The resident reported on more than one occasion DM #1 had mentally abused her in the past month. The DM asked the resident one time if she was so unhappy here why did she stay here and on another occasion when she was at the nurse's station while waiting on staff to give her cigarettes DM #1 took her elbow and intentionally nudged the resident's arm and said maybe she should take up smoking. She stated there were two incidents in the main lobby when the DM told her to get back to her room. And one incident just recently when she had gone to the front lobby to drop off a package, which she got permission from the Administrator to do and the DM told her to get back to room. The resident reported she had permission and the DM kept on talking so she just turned her back and walked away. The resident indicated it was so bad she felt like she had to walk around on pins and needles around DM #1. Interview on 07/08/20 at 8:38 A.M. with the Administrator revealed she was aware of an issue with Resident #1 and DM #1, however she was not aware of the physical contact. She thought the concern was over the DM instructing the resident to return in her room and not hang out in the lobby per COVID guidelines. The Administrator reported she had recently talked to the Ombudsman as well and they decided to direct DM #1 not to have any contact with the resident. On 07/08/20 at 8:42 A.M. telephone interview with the Ombudsman revealed she was aware of the incident with Resident #1 and DM #1. The Ombudsman stated she had complaints DM #1 was rude to residents. She thought it was a personality conflict between the two and advised the DM not to have contact with the resident. The Ombudsman was aware of the incident when the DM used her elbow to touch the resident, however the DM denied doing so. When the DM told the resident she couldn't go into the lobby area because of the rules it just added to fuel to the fire. On 07/08/20 at 12:36 P.M. and 1:31 P.M., interview with the Administrator revealed she had spoken to Resident #1 and confirmed DM #1 had intentionally bumped her with her elbow at the nurse's station while the resident was waiting on her cigarettes a few days prior to the incident on 06/08/20. The Administrator revealed DM #1 was on vacation this week but denied touching the resident and reported the resident was out to get her. The Administrator confirmed the DM had an interaction with the resident this past Monday after being told not to interact with the resident and would be disciplined upon return from vacation and an SRI would be started. The Administrator verified no previous SRI had been completed or submitted involving Resident #1 and DM #1. The Administrator reported she gave the resident permission this past Monday (07/06/20) to take a gift up to the front lobby to drop it off and the DM told the resident she was not permitted to be in the lobby. The Administrator confirmed the Cooks statement on 06/10/20 indicated there were a few residents in the courtyard (at the time of the incident on 06/08/20), however no statements from those residents were obtained as part of a facility investigation. Interview on 07/08/20 at 3:10 P.M. with the Administrator and DON revealed there was no additional information to provide for Resident #1 and the complete investigation and information was as noted above. Review of facility policy titled Abuse, Neglect, Exploitation, & Misappropriation of Resident Property, dated 02/2020 revealed abuse included mental abuse. If a staff member was accused or suspected of abuse, the facility should immediately remove the staff member from the facility and the schedule pending the outcome of the investigation. Documentation should be completed in the nurse's notes. The Administrator would be notified immediately of all incidents or allegations. The State agency would be notified in two hours of abuse or serious bodily injury is alleged and all other allegations within 24 hours. An investigation of the allegations would be conducted. The investigation protocol generally takes the following actions: Interview the resident, the accused, and all witnesses. Witness generally include anyone who: witnessed or heard the incident, came in close contact with the resident the day of the incident, the employees who worked closely with the accused or alleged victim the day of the incident. Obtain a statement from the resident, the accused, and each witness. Evidence of the investigation should be documented. After the completion of the investigation, all the evidence should be analyzed, and the Administrator would decide regarding whether the allegation or suspicion was substantiated. The final report would be reported to the State agency no later than five working days. This deficiency substantiates Complaint Number OH 886.
F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, investigation review, review of a concern form, staff and resident interviews and policy review the facility failed to ensure allegations of injury of unknown origin involving Resident #2 and mental abuse involving Resident #1 were thoroughly reported as required. This affected two resident (#1 and #2) of three residents reviewed for abuse and injuries of unknown origin. Findings include: 1. Review of Resident #2's closed medical record revealed the resident was admitted for respite care from 06/24/20 to 06/29/20. The resident had [DIAGNOSES REDACTED]. Review of Resident #2's non-pressure skin grids dated 06/24/20 to 06/29/20 revealed no evidence the resident had any documented bruises to her thighs or chest. The resident was noted to have a scab on the right heel, scattered bruising to her bilateral arms, abrasions to right and left elbow and three bruises on the abdomen. There was no description of skin alterations that were identified during the admission. Review of the facility self-reported incidents (SRIs) revealed no evidence of any SRI being completed or submitted involving Resident #2. However, the facility provided an investigation for Resident #2 related to injuries of unknown origin, dated 06/29/20 to 06/30/20. The investigation included a copy of the resident's Medication Administration Record [REDACTED]. The resident was cooperative and pleasant. There was one shower sheet for Resident #2 dated 06/28/20 that indicated the resident received a shower. The shower sheet revealed the anatomic picture of a human front and back view was blank. A summary sheet of events indicated on 06/29/20 the Hospice social worker telephoned the facility to report Resident #2's daughter had found new bruises on the resident's thigh and chest area. Hospice Registered Nurse (RN) #3 stated the resident had fallen prior to coming to the facility and the bruising was from the falls at home prior to admission. On 06/30/20 the facility attempted to call the daughter and left messages; however, she never returned the facility calls. The resident was noted to be at risk for bruising related to the administration of the medication, Aspirin. Skin grids were completed on admission on 06/24/20 and a shower sheet was completed on 06/28/20 that showed no new skin areas. The sheet revealed the facility was unable to verify concerns from the daughter due to her refusal to return phone calls to the facility. There was no evidence the facility investigation included statements/interviews from any staff who had cared for the resident during her stay, any assessments or any statements from Hospice staff, nor was there evidence of a skin assessment completed for Resident #2 on the day of discharge 06/29/20. Interview on 07/08/20 at 8:04 A.M. and 10:14 A.M., with STNA #2 revealed she could not recall if the resident had bruises on her abdomen or not on the day she was discharged . She reported she did help the resident get dressed the day she was discharged , and it could have been possible she had bruises on her abdomen, but the lighting in the bathrooms was poor. She confirmed the resident did have bruising on her arms for sure though. The STNA indicated the resident wandered and was

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F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) confused at times. She was not combative, however sometimes she would undress herself and walk out into the hallway. STNA #2 verified she did not sign any type of statement regarding the resident's skin assessment on discharge. Interview on 07/08/20 at 8:58 A.M. to 10:07 A.M., with the Administrator revealed she was aware of one incident of injury of unknown origin involving a respite resident (Resident #2). The Administrator reported the Hospice nurse (RN #3) called the facility and reported the resident's daughter had called the hospice office because she found bruising on her mother's thigh and chest area upon discharge from the facility. The nurse and STNA #2 were interviewed and reported they didn't notice any bruising on the resident on the day of discharge. The hospice nurse informed the facility that the resident had fallen three to four times before her admission to the facility. The Administrator verified she did not report the allegation of injury of unknown origin to the State agency and stated this was because the resident's daughter would not return the facility call and she was also instructed not to report the allegation because the incident (falls) didn't happen at the facility since hospice reported she had falls at home. The Administrator indicated she believed the bruises were related to falls the resident had prior to admission and they were just now coming out. Interview with Resident #2's daughter on 07/08/20 at 9:42 A.M., revealed the resident did not have bruises to her chest, abdomen, or inner leg prior to her admission to the nursing home. She stated the hospice home health aide had performed a bath on the resident on the same day she was admitted to the nursing home for a five-day respite stay and the resident did not have any bruising to those areas. Interview on 07/08/20 at 9:59 A.M., with the Director of Nursing (DON) revealed the facility did not complete an SRI because she could not confirm the incident occurred because the daughter would not return the facility calls. On 07/08/20 at 10:19 A.M., a telephone interview with Hospice RN #3 revealed on 06/24/20 she had done a home visit for Resident #2 to prepare her for a five-day respite stay at the nursing home. The resident had a faint bruise noted on her forehead as a result of a fall she had the previous morning. The resident had chronic bruises on her bilateral arms. The hospice aide had showered the resident that morning on 06/24/20 prior to taking the resident to the nursing home. The aide reported the resident had no skin alterations. On 06/25/20 the nurse went to the nursing home to visit the resident and didn't notice any behaviors. On 06/29/20 the resident's daughter picked Resident #2 up from the nursing home to return her home. The daughter originally declined for hospice to visit that day, however around 3:00 P.M., she called and asked if a nurse could come out for a visit due the resident had multiple bruised areas on her body. The daughter was worried the resident had been sexually abused due to the bruises noted in her inner thigh area. The resident had three bruises on her inner thigh, one on her buttocks, one on her right wrist, and three on her abdomen in various staging of healing. The nurse took pictures and measurements of the bruises at that time. The social worker from hospice had notified the facility of the bruises of unknown origin. On 06/30/20 the nurse stated she had a conference call with the facility due to there being a discrepancy with the resident's narcotic count as well. The nurse indicated she discussed the bruises of unknown origin and indicated the bruising did not appear to be related to a fall due to the various locations of the bruises which were not consistent to fall injuries. Interview on 07/08/20 at 3:10 P.M. with the Administrator and DON revealed there was no additional information to provide for Resident #2 and the complete investigaiton and information was as noted above. Review of facility policy titled Skin Care, dated 11/2018 revealed skin would be observed upon admission and routinely throughout the resident's stay. Review of facility policy titled Abuse, Neglect, Exploitation, & Misappropriation of Resident Property, dated 02/2020 revealed an injury of unknown source was an injury when the injury was not observed by any person, or source of the injury could not be explained by the resident and the injury was suspicious because of the location of the injury. If a staff member was accused or suspected of abuse, the facility should immediately remove the staff member from the facility and the schedule pending the outcome of the investigation. Documentation should be completed in the nurse's notes. The Administrator would be notified immediately of all incidents or allegations. The State agency would be notified in two hours of abuse or serious bodily injury is alleged and all other allegations within 24 hours. An investigation of the allegations would be conducted. The investigation protocol generally takes the following actions: Interview the resident, the accused, and all witnesses. Witnesses generally included anyone who: witnessed or heard the incident, came in close contact with the resident the day of the incident, the employees who worked closely with the accused or alleged victim the day of the incident. For injuries of unknown source, the investigation may generally involve talking with both the shift on duty when the injury was discovered and prior shifts as well. Obtain a statement from the resident, the accused, and each witness. Evidence of the investigation should be documented. After the completion of the investigation, all the evidence should be analyzed, and the Administrator would decide regarding whether the allegation or suspicion was substantiated. The final report would be reported to the State agency no later than five working days. 2. Review of Resident #1's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED].#1 and an allegation of mental abuse. Review of Resident #1's concern quality/assurance form, dated 06/10/20 revealed the resident reported what was documented as a personality issue with dietary manager (DM) #1 regarding restrictions for nursing homes given by the Center of Disease Control (CDC) and the Governor. The Administrator and Director of Nursing (DON) met with Resident #1 on 06/10/20 and the resident reported she was frustrated with the restrictions and it was explained to her that the facility was following the guidelines per the CDC. They also meet with DM #1 and explained she need to be more understanding during the difficult times. There was no mention of the actual incident which was noted to have happened in the courtyard on 06/08/20. Review of DM #1's unsigned typed statement dated 06/10/20 revealed the DM was outside planting and watering the flowers in the outside courtyard area and only asked Resident #1 if she liked the flowers. The statement revealed Resident #1 kept talking under her breath while she was outside, and she only commended to Resident #1 if she was so unhappy then why was she here. The resident went to the smoking area and the DM finished planting and watering the flowers. Review of Cook #10's handwritten statement dated 06/10/20 revealed on 06/08/20 DM #1 and herself were in the courtyard planting flowers and the DM asked a few of the resident's that were out there, if they liked the flowers they were planting. Resident #1 mumbled something they couldn't understand. The resident kept mumbling to the DM hatefully and the DM had just asked her if she was so unhappy why does she stay. The statement indicated the DM was never near the resident and never touched her. Interview on 07/08/20 at 8:25 A.M., with Resident #1 revealed in the last month she reported she had been mentally abused by DM #1. She stated she had reported the incident to the Administrator and the local Ombudsman and had not heard back from either one as of this time. The resident reported on more than one occasion DM #1 had mentally abused her in the past month. The DM asked the resident one time if she was so unhappy here why did she stay here and on another occasion when she was at the nurse's station while waiting on staff to give her cigarettes DM #1 took her elbow and intentionally nudged the resident's arm and said maybe she should take up smoking. She stated there were two incidents in the main lobby when the DM told her to get back to her room. And one incident just recently when she had gone to the front lobby to drop off a package, which she got permission from the Administrator to do and the DM told her to get back to room. The resident reported she had permission and the DM kept on talking so she just turned her back and walked away. The resident indicated it was so bad she felt like she had to walk around on pins and needles around DM #1. Interview on 07/08/20 at 8:38 A.M. with the Administrator revealed she was aware of an issue with Resident #1 and DM #1, however she was not aware of the physical contact. She thought the concern was over the DM instructing the resident to return in her room and not hang out in the lobby per COVID guidelines. The Administrator reported she had recently talked to the Ombudsman as well and they decided to direct DM #1 not to have any contact with the resident. On 07/08/20 at 8:42 A.M. telephone interview with the Ombudsman revealed she was aware of the incident with Resident #1 and DM #1. The Ombudsman stated she had complaints DM #1 was rude to residents. She thought it was a personality conflict between the two and advised the DM not to have contact with the resident. The Ombudsman was aware of the incident when the DM used her elbow to touch the resident, however the DM denied doing so. When the DM told the resident she couldn't go into the lobby area because of the rules it just added to fuel to the fire. On 07/08/20 at 12:36 P.M. and 1:31 P.M., interview with the Administrator revealed she had spoken to Resident #1 and confirmed DM #1 had intentionally bumped her with her elbow at the nurse's station while the resident was waiting on her cigarettes a few days prior to the incident on 06/08/20. The Administrator revealed DM #1 was on vacation this week but denied touching the resident and reported the resident was out to get her. The Administrator confirmed the DM had an interaction with the resident this past Monday after being told not to interact with the resident and would be disciplined upon return from vacation and an SRI would be started. The Administrator verified no previous SRI had been completed or submitted involving Resident #1 and DM #1. The Administrator reported she gave the resident permission this past Monday (07/06/20) to take a gift up to the front lobby to drop it off and the DM told the resident she was not permitted to be in the lobby. The Administrator confirmed the Cooks statement on 06/10/20 indicated there were a few residents in the courtyard (at the time of the incident on 06/08/20), however no statements from those residents were obtained as part of a facility investigation. Interview on 07/08/20 at 3:10 P.M. with

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F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) the Administrator and DON revealed there was no additional information to provide for Resident #1 and the complete investigation and information was as noted above. Review of facility policy titled Abuse, Neglect, Exploitation, & Misappropriation of Resident Property, dated 02/2020 revealed abuse included mental abuse. If a staff member was accused or suspected of abuse, the facility should immediately remove the staff member from the facility and the schedule pending the outcome of the investigation. Documentation should be completed in the nurse's notes. The Administrator would be notified immediately of all incidents or allegations. The State agency would be notified in two hours of abuse or serious bodily injury is alleged and all other allegations within 24 hours. An investigation of the allegations would be conducted. The investigation protocol generally takes the following actions: Interview the resident, the accused, and all witnesses. Witness generally include anyone who: witnessed or heard the incident, came in close contact with the resident the day of the incident, the employees who worked closely with the accused or alleged victim the day of the incident. Obtain a statement from the resident, the accused, and each witness. Evidence of the investigation should be documented. After the completion of the investigation, all the evidence should be analyzed, and the Administrator would decide regarding whether the allegation or suspicion was substantiated. The final report would be reported to the State agency no later than five working days. This deficiency substantiates Complaint Number OH 886.