STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365271	A. BUILDING _____ B. WING _____	10/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CARRIAGE INN OF STEUBENVILLE	3102 ST CHARLES DRIVE STEUBENVILLE, OH 43952

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of a facility self reported incident, policy review and resident and staff interview the facility failed to ensure Resident #102 was free from physical abuse. This affected one resident (#102) of three residents reviewed for allegations of physical abuse. Findings include: Review of Resident #102's medical record revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the resident's plan of care revealed a plan, dated 11/27/2018 related to behaviors. The care plan revealed the resident could be verbally abusive, inappropriate, yell out, resistant of care and had sexual tendencies at times. The plan indicated the resident preferred to leave urinal nearby at times leaving it on his bedside table and/or side rails. On 11/28/2018 an intervention was added to provide calm reassurance, redirection or distractions and assess effectiveness. Provide positive reinforcement for appropriate behavior. Confront gently and respectfully when behavior was inappropriate and set limits. Provide a quiet environment as needed. Review of a 07/06/20 quarterly Minimum Data Set (MDS) 3.0 assessment revealed the resident was moderately impaired for daily decision making and displayed verbal and physical behaviors. The resident was assessed to require extensive assistance from two staff for bed mobility, transfers and toileting. Review of a facility self reported incident, tracking number 7 revealed on 09/21/20 an allegation of physical abuse was made involving Resident #102 and State tested Nursing Assistant (STNA) #110. On 09/21/20 Licensed Practical Nurse (LPN) #111 reported to the Director of Nursing and Administrator that STNA #110 reported he hit Resident #102 on the forehead with his knuckles trying to avoid combative behavior (of the resident) while providing care. STNA #102 stated he was assisting STNA #112 to provide care to resident. STNA #110 stated that during care, the resident became combative and was trying to punch and bite him. STNA #110 stated when the resident tried to bite him, he flinched and made contact with the resident on the head with his knuckle. STNA #102 stated he did not intentionally hit the resident, he was trying to avoid him. He then immediately reported it to the nurse on duty. STNA #112 witnessed STNA #110 hit resident on forehead and had him leave the room immediately to de-escalate the situation and prevent further incident. Review of a statement provided by LPN #111, dated 09/21/20 revealed STNA #110 was standing outside of a resident room when she exited and he told her he was going to fill out an incident report. STNA #110 revealed while changing Resident #102, the resident was combative, he was frustrated and popped off and hit him with his knuckle in his head. LPN #111 removed the STNA from the area and assessed the resident. Review of STNA #110's statement revealed he was assisting the other aide with check and change because of multiple incidents of inappropriate comments, physical assaults and biting by the resident. The resident had been incontinent and was belligerent and trying to hit when STNA #112 was performing care. When they were nearly finished Resident #102 punched at STNA #110 and tried to bite him. STNA #110 wrote he flinched and hit him in the head with his knuckle. He immediately left the room and reported himself to the nurse. He indicated he had no intention of striking the resident. He was just heated up and trying to avoid injury. Review of STNA #112's statement indicated around 5:30 A.M. she asked STNA #110 to help her change Resident #102 because he was usually aggressive. As soon as they went into the room STNA #112 indicated STNA #110 wanted to be full force and not ease into it. STNA #112 indicated she tried to ask the resident what his favorite sports teams were but STNA #110 was being too forceful and aggravated the resident more. The STNA's statement revealed, as we were rolling the resident to the side to change his sheets she thought STNA #110 was using too much weight to hold the resident but figured the resident was being strong. When we rolled the resident the other way STNA #112 indicated she only had to hold one of his arms slightly to keep him from fighting. When the resident was rolled on his back the resident started to punch the air and STNA #110 restrained him. As STNA #112 was wrapping a brief on the resident, STNA #110 took his full hand and banged it on the residents forehead. She instantly called STNA#110's name, because she was shocked and told him to leave she would finish cleaning up. Review of an incident note, dated 9/21/20 at 5:55 A.M. revealed the nurse was in another resident's room administering medication and when exiting the room, STNA (#110) was standing in the hall outside of the room and stated to this nurse I am gonna fill out an incident report on myself. This nurse questioned him if he was hurt or injured and he stated no while changing (resident) he was combative and I was frustrated and I popped off and hit him with my knuckle in the head. The nurse immediately instructed the STNA to go to the nurse's station and sit while this nurse went to assess resident. During the assessment the resident stated the STNA hit him in the head and then slapped this nurse in the side of the head and said just like that. Upon entering the room the resident was quiet and laying in the bed. This nurse turned the overhead light on and the resident stated to yell at the nurse stating if its him get him out of here. The resident was assessed from head to toe and no injuries were noted. There was no observed injured area to the said spot where the resident pointed out where the STNA hit him. The resident was noted to have a red rash like areas noted to his right arm. No other areas noted. This nurse then went to the nurse's station where STNA #110 was sitting and had him fill out a statement and then he was sent home and did not come into contact with any other resident. The Director of Nursing (DON) was in the facility at the time of incident and aware of the incident after the resident assessment was completed. Resident #102 was then assessed by both nurses on the unit at the time of the incident and another body check was completed with no injuries noted and no areas. Vital signs were obtained and noted: Blood Pressure 120/64, Pulse 74 beats per minute, Respirations 14 breaths per minute, Temperature 97.7 Fahrenheit and SPO2 96% oxygen saturation on room air. The resident denied any pain or discomfort at that time. Review of STNA #110's payroll punches revealed he punched out at 6:14 A.M. on 09/21/20. On 09/21/20 at 8:40 A.M. the Director of Nursing (DON) interviewed Resident #102. When asked if anything unusual happened he said you mean with the (explicit)? We had a disagreement and I got mad. I was pulling away and he slapped me in my forehead. When asked how he was struck he indicated with the palm of his hand he struck me in my (explicit) head. When asked if STNA#110 said anything he indicated not really he just told me to stop it. The resident denied being aggressive during care. He said he didn't want that (explicit) in there ever again. When asked if he thought it was accidental or on purpose he stated well he slapped me in the forehead so I guess he meant to do it. Wouldn't you think that if I reached over and slapped your face? It means I wanted to slap your explicit face. So did he. There was no bruising to the resident's face or forehead. The resident remained very angry over the incident. The DON followed up with the resident on 09/28/20 and told him the results of the investigation and who it was reported to. The resident was satisfied with that. He was asked if he wanted local law enforcement called and he declined and said he would turn the other cheek. Based on review of the facility investigation, the facility substantiated abuse, neglect or misappropriation verified by evidence. The abuse was reported to the STNA Registry Board. The resident did not want it reported to law enforcement. STNA #110 was immediately suspended pending investigation and terminated at the completion of the investigation. Review of STNA #110's personnel file revealed he was hired 11/01/16 as a housekeeping aide, went through a Nurse Aide Training and Competency Program and was current on the registry through 09/20/22. Termination papers, dated 09/29/20 revealed STNA #110 was terminated for gross misconduct and unsatisfactory performance.

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 0600 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) During an interview on 10/08/20 at 12:45 P.M. with Resident #102, the resident said nothing happened when asked about the incident with STNA #110. Review of the facility Abuse, Neglect, Exploitation and Misappropriation of Resident Property policy, revised 11/28/16 included the definition of abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse and mental abuse including abuse facilitated or enabled through the use of technology, such as through the use of photographs and recording devices to demean or humiliate a resident. Review of the policy revealed it did not address intervention(s) by coworkers including to ask coworkers to leave the area to compose themselves when actions indicate impatience and frustration which could led to abuse. On 10/08/20 at 4:56 P.M. interview with Registered Nurse #113 verified the facility investigation substantiated the incident of physical abuse involving Resident #102. This deficiency substantiates Control Number OH 156.