STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365665	A. BUILDING _____ B. WING _____	09/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEADOW WIND HEALTH CARE CTR INC	300 23RD STREET NE MASSILLON, OH 44646

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.** Based on review of facility submitted Self Reported Incidents (SRIs), medical record review, policy review and staff interview the facility failed to ensure Resident #18 and Resident #52 were free from physical and/or verbal abuse from a staff member (State tested nursing assistant (STNA) #40). This affected two residents (#18 and #52) of two residents reviewed for abuse. Findings include: 1. Review of the facility Self Reported Incident (SRI), tracking number 0 with a reported and discovery date of 04/12/2020 revealed Resident #18 reported to Licensed Practical Nurse (LPN) #8 that State tested Nursing Assistant (STNA) #40 entered her room on 04/11/2020 during the night, grabbed her by the arm and sat on her legs. The Administrator and Director of Nursing (DON) interview with Resident #18 revealed STNA #40 came to her room when she asked for water, STNA #40 grabbed her left arm and would not let go, he then grabbed her left hand and sat on her legs. Further review of the facility investigation revealed STNA #40 was suspended during the investigation of the allegation and then subsequently terminated. Review of the SRI revealed following the facility investigation, the allegation of abuse was substantiated. Review of Resident #18's medical record revealed a quarterly Minimum Data Set 3.0 assessment completed on 01/27/2020 which indicated Resident #18 had intact cognition. Attempts to interview Resident #18 during the survey were unsuccessful. On 09/08/20 at 1:55 P.M. interview with the Administrator and DON verified the above incident of physical abuse that occurred on 04/11/20 involving Resident #18. 2. Review of SRI, tracking number 0 with a reported and discovery date of 04/13/2020 revealed Resident #52 reported to the Administrator during the investigation of SRI tracking 0 a concern related to STNA #40. The resident revealed on 04/11/20 at approximately 12:00 A.M. the STNA had cleaned his ears and now they hurt. Registered Nurse (RN) #77 assessed Resident #52's ears and observed dried blood in both ear canals. The Administrator and DON interview with Resident #52 revealed on 04/11/2020 STNA #40 informed the resident he had a build up of ear wax and he was going to clean them with cotton tipped swabs. The resident further added STNA #40 was digging into his ears with the swab and hurting him, he advised the STNA to stop but was told to hold still. Resident #52 denied giving permission to STNA #40 to clean his ears with a swab. Further review of the facility investigation revealed the Administrator and DON had already suspended STNA #40 related to the allegations voiced by Resident #18 which were being investigated as part of SRI tracking number 0. Review of the SRI revealed following the facility investigation, the allegation of abuse was substantiated. In addition, review of SRI tracking number 2 with a reported and discovery date of 04/13/2020 revealed Resident #52 reported to the Administrator during the investigation of SRI tracking 0 that STNA #40 moved his head side to side, up and down without his consent and hurt him on 04/10/2020 at approximately 10:00-11:00 P.M After moving his head, STNA #40 then began to bend the resident's finger back without his permission, causing him discomfort. STNA #40 also informed the resident he was the most needy person in the facility and not the only (explicit) person in the facility. Review of the SRI revealed following the facility investigation, the allegation of abuse was substantiated. Review of Resident #52's medical record revealed a quarterly Minimum Data Set 3.0 assessment completed on 04/16/2020 which indicated Resident #52 had intact cognition. The resident no longer resided in the facility at the time of the onsite survey and therefore could not be interviewed. On 09/08/20 at 1:55 P.M. interview with the Administrator and DON verified the above two incidents of physical and verbal abuse involving Resident #52. Review of the facility undated Resident Mistreatment, Neglect, Misappropriation and Abuse of Residents Policy revealed the facility recognized that residents had the right to be free from verbal, sexual, physical and mental abuse, mistreatment, neglect, corporal punishment, involuntary seclusion and misappropriation of property. The policy defined abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Verbal abuse was defined as the use of oral, written or gestured language that willfully included disparaging and derogatory terms to residents . or within their hearing distance Physical abuse included hitting, slapping, pinching, kicking and controlling behavior through corporal punishment. This deficiency substantiates Complaint Number OH 858.
F 0602 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from the wrongful use of the resident's belongings or money.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of a facility self reported incident, medical record review, policy review and staff interview the facility failed to prevent the misappropriation of narcotic medications by Licensed Practical Nurse (LPN) #66 for Resident #49, Resident #50 and Resident #51. This affected three residents (#49, #50 and #51) of seven residents reviewed for medication. Findings include: Review of a facility self reported incident (SRI), tracking number 5 with a discovery and reported to the State agency date of 02/03/2020 revealed Registered Nurse (RN) #23 and an LPN informed the Director of Nursing of concerns LPN #66 was misappropriating resident narcotic medications for her personal use. Further review of the SRI revealed LPN #66 had forged signatures of RN #28 and RN #36 on the controlled medication record for Resident #49, #50 and #51. Further review of the facility investigation revealed the following findings: a. LPN #66 documented an [MEDICATION NAME] (narcotic [MEDICATION NAME] medication) 5/325 milligram (mg) tablet was wasted for Resident #51 on 02/03/2020 at 10:31 A.M The medication wasting was co-signed as being witnessed by RN #28 at the same time. However, staff witnesses which included the Administrator, Director of Nursing (DON), assistant DON and Business Office Manager indicated RN #28 was in morning stand up meeting until 10:45 A.M. and could not have witnessed the medication being wasted by LPN #66. RN #28 also verified the signature on the controlled medication record was not hers. b. LPN #66 documented a [MEDICATION NAME] (narcotic [MEDICATION NAME] medication) 7.5/325 mg tablet was wasted for Resident #50 on 02/03/2020 at 7:00 A.M The controlled medication record revealed RN #28 co-signed and witnessed the medication being wasted by LPN #66. Review of the facility time/punch sheets indicated RN #28 was not in the facility at 7:00 A.M. and did not arrive to the facility until 8:28 A.M RN #28 also verified the signature on the controlled medication record was not hers. c. LPN #66 documented an [MEDICATION NAME] 5/325 mg tablet was wasted for Resident #49 on 01/14/2020. This medication being wasted was co-signed as witnessed by RN #36. However, during the facility investigation, RN #36 verified the signature was not hers. On 09/10/2020 at 8:00 A.M. interview with the Administrator and DON verified LPN #66 misappropriated narcotic medication prescribed for Resident #49, #50 and #51. The Administrator and DON revealed as part of their investigation, they reported LPN #66 to local law enforcement, State Board of Nursing and State Board of Pharmacy. Review of the facility undated Resident Mistreatment, Neglect, Misappropriation and Abuse of Residents Policy revealed the facility recognized that residents had the right to be free from verbal, sexual, physical and mental abuse, mistreatment, neglect, corporal punishment, involuntary seclusion and misappropriation of property. The facility policy defined misappropriation of resident property as the deliberate misplacement, exploitation or wrongful, temporary or permanent use of a resident's belongings or money without the residents' consent. This deficiency is an incidental finding to Complaint Number OH 858.
F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that residents are free from significant medication errors.**

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 0760 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed medical record review and staff interview the facility failed to ensure medications were administered as ordered for Resident #47 resulting in a significant medication error. This affected one resident (#47) of seven residents reviewed for medication administration. Findings include: Review of Resident #47's closed medical record revealed an admission date of [DATE] with a [DIAGNOSES REDACTED]. Record review revealed the resident was prescribed the steroid medication, [MEDICATION NAME] related to the benign neoplasm diagnosis. On 06/19/2019 a physician's orders [REDACTED]. Review of the Medication Administration Record [REDACTED]. However, review of the July 2019 MAR indicated [REDACTED]. On 07/02/2019 [MEDICATION NAME] 1.5 mg was administered, not the [MEDICATION NAME] 3.5 mg as ordered. From 07/03/2019 to 07/08/2019 the resident was administered [MEDICATION NAME] 0.5 mg and not the [MEDICATION NAME] 3.5 mg on 07/03/2019 or [MEDICATION NAME] 3 mg from 07/04/2019 through 07/08/2019 as ordered. O 09/15/20 at 10:05 A.M. interview with the director of nursing (DON) verified Resident #47's [MEDICATION NAME] order was not followed as ordered by the physician for the month of July 2019 which resulted in the above significant medication error for the resident. The DON indicated a new electronic MAR indicated [REDACTED]. However, the DON revealed this should have been caught by the nurse doing the monthly change over from June to July 2019. This deficiency substantiates Complaint Number OH 517.