STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365284	A. BUILDING _____ B. WING _____	**03/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CRESTWOOD CARE CENTER	**225 W MAIN STREET SHELBY, OH 44875**

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 record review, review of the facility's self-reported incident and investigation, review of the facility's policy and staff interview, the facility failed to timely report an allegation of abuse to the State Survey Agency. This affected one (Resident #95) of three residents reviewed for abuse. The facility census was 120. Findings Include: Review of the medical record for Resident #95 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the quarterly Minimum Data Set (MDS) assessment, dated 02/14/20, revealed the resident was severely cognitively impaired. Review of the facility's investigation for self-reported incident, dated 03/04/20, revealed on 03/04/20, Human Resource Manager (HRM) #600 reported to the Administrator that State tested Nurse Aide (STNA) #800 and STNA #801 reported to her that STNA #500 was in a resident room giving care when he climbed into the resident's bed, hugged her, stated this is my girlfriend, and kissed the resident on the cheek. Review of the signed HRM #600 witness statement revealed on 03/04/20, STNA #800 and #801 approached her and informed her that STNA #500 told them on her first day at the facility while in training, STNA #400 climbed in bed with a female resident, put his arms around her, stated she was his girlfriend, and kissed her. STNA #400's first day at work was 02/13/20 and this was the day that STNA #500 was training her. Review of STNA #500's witness statement revealed on 02/13/20, STNA #400 and himself got Resident #95 up and ready for the day. STNA #400 gave SR #1 a hug, told her that her shirt was pretty, and gave her a peck on the cheek. STNA #500 did not report the incident to the Administrator or Director of Nursing (DON) on 02/13/20 and the incident was not reported to the Administrator until 03/04/20. Interview with DON on 03/10/20 at 4:49 P.M. verified STNA #500 did not report the allegation of abuse to the DON or Administrator until 03/04/20 despite witnessing it on 02/13/20. The DON verified the allegation of abuse was not reported to the State Survey Agency until 03/04/20 despite STNA #500 having witnessed the alleged abuse on 02/13/20. Review of the facility's policy titled Ohio Abuse, Neglect, and Misappropriation, last revised 04/01/19, revealed all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury. If the events that cause the allegations involve abuse and/or serious bodily injury the self-report must be made immediately, but not later than two hours after the allegation is made. The self-report incident will be made to the executive director (ED), adult protective services (APS), and State Survey Agency and other local authorities including but not limited to, local police, if appropriate. If the events that cause the allegations do not result in serious bodily injury, reporting to the administrator and to other reporting regulatory bodies must occur within 24 hours. This is an example of continued non-compliance from survey dated 01/27/20.

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