STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365834	A. Building B. Wing	05/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kent Healthcare and Rehabilitation.	1290 Fairchild Avenue Kent, OH 44240

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 - 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** 44810 Based on observation, record review, facility policy and procedure review and interview the facility failed to prevent an incident of neglect involving Resident #10. Actual Harm occurred on 04/26/22 at 7:10 P.M. when Resident #10, who was cognitively impaired, incontinent of bowel and dependent on staff for activities of daily living care was found to have deep tissue pressure ulcers to her bilateral buttocks as a result of having a bed pan placed underneath her for an unknown period of time. This affected one resident (#10) of three residents reviewed for neglect. Findings include: Review of the medical record for Resident #10 revealed an admitted [DATE] with diagnoses including spina bifida, intellectual disability, osteogenesis imperfecta, and type two diabetes mellitus. Review of a plan of care, dated 12/10/21 revealed Resident #10 had impaired cognition related to a developmental delay. Interventions included the resident required assistance with all decision making and to engage her in simple tasks. Resident #10 had an indwelling urinary catheter and a plan of care related to bowel incontinence. Interventions included to check and change every two hours and to provide perineal care after each incontinent episode. Review of a pressure ulcer risk assessment, dated 04/08/22 revealed Resident #10 was at risk for developing pressure ulcers due to very limited mobility and her skin being very moist. Review of the Minimum Data Set (MDS) 3.0 assessment, dated 04/09/22 revealed Resident #10 had severe cognitive impairment and memory problems. The assessment revealed the resident required extensive one person physical assistance for bed mobility, total dependence from two persons for transfers and total dependence from one person for dressing, eating, toilet use and personal hygiene. Resident #10 had an indwelling urinary catheter for urine and was always incontinent of bowel. Review of a nursing progress note, dated 04/27/22 at 10:28 P.M. and authored by Registered Nurse #300 revealed Resident #10 was on the bed pan. The note indicated the resident was noted to have a deep tissue injury on 04/26/22 when this nurse and another nurse found her on a bed pan. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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 - Actual harm Residents Affected - Few	Review of a wound log, dated 04/27/22 (no time noted) revealed Resident #10 was treated for bilateral buttocks deep tissue injury that was developed in house due to a bed pan. The wound bed was observed as red viable tissue with slough and a small amount of serosanguinous exudate. The peri wound area skin was described as fragile. No measurements were noted for the wound. On 05/11/22 at 2:05 P.M. Registered Nurse (RN) #300 was observed providing wound care for Resident #10's bilateral buttocks. Observation of the wounds revealed they were beefy red and the surrounding skin was dry and intact. A small to moderate amount of drainage was noted, with no odors. The surrounding skin was dry and intact. At the time of the observation, interview with RN #300 revealed the wound to the resident's buttocks had developed on 04/26/22 from sitting on a bed pan for too long. Record review revealed no nursing progress note completed on 04/26/22 related to this incident. In addition, review of the delivery records for care, dated 04/26/22 revealed no medications were ordered or administered on 04/26/22 between 3:00 P.M. and 7:00 P.M. The resident was documented to have a bowel movement on this date at 4:31 A.M. and 10:23 P.M., toileting assistance was noted at 4:31 A.M. and 10:24 P. M. and meal documentation was entered at 10:12 P.M. On 05/11/22 at 4:11 P.M. interview with Regional Registered Nurse (RN) #357 revealed she was aware (unable to provide exact date of notification) Resident #10 developed a deep tissue injury on 04/26/22 after being found on the bed pan. RN #357 reported no one was sure how long the resident had been on the bed pan on that date. RN #357 revealed the deep tissue injury eventually evolved into a Stage III pressure ulcer when it opened on 05/04/22. RN #357 revealed no formal investigation was initiated on 04/26/22 when the deep tissue injury was first discovered to determine the circumstances of the incident. On 05/17/22 at 4:43 P.M. interview with RN #300 revealed she had been functioning as the facility wound nurse on 04/26/22. RN #300 revealed sometime after dinner time on this date, Licensed Practical Nurse #307 reported to her Resident #10 had been found on a bed pan and had a wound to her buttocks because of it. RN #300 revealed she proceeded to assess the resident and verified the resident had wounds to her bilateral buttocks as a result of pressure from the bed pan. RN #300 revealed there was no evidence the resident had refused any type of care on this date and it was not known who put the resident on a bed pan or when she had been put on a bed pan. The RN revealed Resident #10 was not known to ask for a bed pan, was incontinent of bowel with staff checking and changing her every two hours. RN #300 also revealed the resident would be physically unable to take herself off a bed pan. During the interview, RN #300 revealed she reported this incident/concern to the Director of Nursing (DON) and regional nurse the next morning (on 04/27/22). On 05/23/22 at 2:53 P.M. interview with State tested Nursing Assistant (STNA) #322 revealed she worked second shift on 04/26/22 beginning at 3:00 P.M. and was assigned to care for Resident #10. The STNA revealed Resident #10 was always incontinent of bowel and never used or asked for the bed pan. The STNA denied putting Resident #10 on the bed pan on this date or providing any care at all to the resident between 3:00 P.M. and 7:00 P.M. The STNA revealed on 04/26/22 following the incident with the bed pan (at 7:10 P. M.), LPN #307 questioned her if she known Resident #10 was on a bed pan or if she had put her there to which she denied. (continued on next page)

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(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 - Actual harm Residents Affected - Few	On 05/23/22 at 10:10 A.M. interview with STNA #340 revealed she worked day shift beginning at 7:00 A.M. on 04/26/22 and was assigned to care for Resident #10. During the interview, the STNA revealed the resident never used the bed pan, would not ask for a bed pan and denied putting the resident on a bed pan on her shift. On 05/24/22 at 11:04 A.M. during an interview with the DON, the DON revealed he was unsure what the issue was with Resident #10 and her deep tissue injury. The DON initially reported he was not told of the incident but then indicated he did not recall when he was told about the incident. During the interview, the DON confirmed the facility completed no formal investigation, including interviews with staff or obtaining staff statements to determine the circumstances of the incident. There was no evidence the facility investigated to identify who placed Resident #10 on the bed pan, what time the resident was placed on the bed pan, why the resident was placed on the bed pan or why staff failed to identify the resident was on a bed pan until 04/26/22 at 7:10 P.M. when the oncoming nurse went in the resident's room. The DON also verified the incident was not reported to the State agency as an incident of neglect. On 05/24/22 at 12:01 P.M. interview with LPN #307 revealed she worked on 04/26/22 beginning at 7:00 P.M. LPN #307 revealed she was familiar with Resident #10 and frequently checked on this resident first at the beginning of her shift. The LPN denied receiving any information in report regarding the resident and any issues or use of the bed pan. LPN #307 revealed she entered Resident #10's room around 7:10 P.M. and immediately identified the resident was on a bed pan. The LPN revealed the resident had a diagnosis of spina bifida and it was evident based on her body position in bed that she was on a bed pan. The LPN revealed the resident did not normally use a bed pan and at the time she entered the room the resident was not having any type of behaviors/was not resistive to her removing the bed pan at that time. LPN #307 revealed she immediately notified RN #300, the wound care nurse and the resident's skin was assessed. The resident's left and right buttocks were deep purple and bruised appearing in color. During the interview, LPN #307 denied making any type of nursing progress note entry related to the incident. The LPN revealed she did not know how long the resident had been on the bed pan or who put her on the bed pan. She stated she questioned STNA #322, who was assigned to Resident #10's care for second shift to see if she had put her on a bed pan to which STNA #322 denied. The LPN confirmed the incident had occurred on 04/26/22 and could not explain why the nursing progress notes and wound assessment were dated 04/27/22. On 05/24/22 at 2:00 P.M. interview with the Administrator revealed she was not aware Resident #10 had developed a deep tissue injury to her buttocks from a bed pan until 05/11/22 (during the complaint investigation). She confirmed the facility did not complete an investigation into the incident to determine the circumstances of the incident and did not report the incident to the State agency as an incident of neglect. Review of facility policy abuse, neglect, and exploitation, revised June 2019 revealed neglect was the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. This deficiency substantiates Complaint Number OH00132461.

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(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** 44810 Based on observation, record review, facility policy and procedure review and interview the facility failed to ensure an incident of neglect involving Resident #10 was reported to the State agency as required. This affected one resident (#10) of three residents reviewed for neglect. Findings include: Review of the medical record for Resident #10 revealed an admitted [DATE] with diagnoses including spina bifida, intellectual disability, osteogenesis imperfecta, and type two diabetes mellitus. Review of a plan of care, dated 12/10/21 revealed Resident #10 had impaired cognition related to a developmental delay. Interventions included the resident required assistance with all decision making and to engage her in simple tasks. Resident #10 had an indwelling urinary catheter and a plan of care related to bowel incontinence. Interventions included to check and change her every two hours and to provide perineal care after each incontinent episode. Review of a pressure ulcer risk assessment, dated 04/08/22 revealed Resident #10 was at risk for developing pressure ulcers due to very limited mobility and her skin being very moist. Review of the Minimum Data Set (MDS) 3.0 assessment, dated 04/09/22 revealed Resident #10 had severe cognitive impairment and memory problems. The assessment revealed the resident required extensive one person physical assistance for bed mobility, total dependence from two persons for transfers and total dependence from one person for dressing, eating, toilet use and personal hygiene. Resident #10 had an indwelling urinary catheter for urine and was always incontinent of bowel. Review of a nursing progress note, dated 04/27/22 at 10:28 P.M. and authored by Registered Nurse #300 revealed Resident #10 was on the bed pan. The note indicated the resident was noted to have a deep tissue injury on 04/26/22 when this nurse and another nurse found her on a bed pan. Review of a wound log, dated 04/27/22 (no time noted) revealed Resident #10 was treated for bilateral buttocks deep tissue injury that was developed in house due to a bed pan. The wound bed was observed as red viable tissue with slough and a small amount of serosanguinous exudate. The peri wound area skin was described as fragile. No measurements were noted for the wound. On 05/11/22 at 2:05 P.M. Registered Nurse (RN) #300 was observed providing wound care for Resident #10's bilateral buttocks. Observation of the wounds revealed they were beefy red and the surrounding skin was dry and intact. A small to moderate amount of drainage was noted, with no odors. The surrounding skin was dry and intact. At the time of the interview, interview with RN #300 revealed the wound to the resident's buttocks had developed on 04/26/22 from sitting on a bed pan for too long. (continued on next page)

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(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	Record review revealed no nursing progress note completed on 04/26/22 related to this incident. In addition, review of the delivery records for care, dated 04/26/22 revealed no medications were ordered or administered on 04/26/22 between 3:00 P.M. and 7:00 P.M. The resident was documented to have a bowel movement on this date at 4:31 A.M. and 10:23 P.M., toileting assistance was noted at 4:31 A.M. and 10:24 P. M. and meal documentation was entered at 10:12 P.M. On 05/11/22 at 4:11 P.M. interview with Regional Registered Nurse (RN) #357 revealed she was aware (unable to provide exact date of notification) Resident #10 developed a deep tissue injury on 04/26/22 after being found on the bed pan. RN #357 reported no one was sure how long the resident had been on the bed pan on that date. RN #357 revealed the deep tissue injury eventually evolved into a Stage III pressure ulcer when it opened on 05/04/22. RN #357 revealed no formal investigation was initiated on 04/26/22 when the deep tissue injury was first discovered to determine the circumstances of the incident. On 05/17/22 at 4:43 P.M. interview with RN #300 revealed she had been functioning as the facility wound nurse on 04/26/22. RN #300 revealed sometime after dinner time on this date, Licensed Practical Nurse #307 reported to her Resident #10 had been found on a bed pan and had a wound to her buttocks because of it. RN #300 revealed she proceeded to assess the resident and verified the resident had wounds to her bilateral buttocks as a result of pressure from the bed pan. RN #300 revealed there was no evidence the resident had refused any type of care on this date and it was not known who put the resident on a bed pan or when she had been put on a bed pan. The RN revealed Resident #10 was not known to ask for a bed pan, was incontinent of bowel with staff checking and changing her every two hours. RN #300 also revealed the resident would be physically unable to take herself off a bed pan. During the interview, RN #300 revealed she reported this concern to the Director of Nursing (DON) and regional nurse the next morning (on 04/27/22). On 05/23/22 at 2:53 P.M. interview with State tested Nursing Assistant (STNA) #322 revealed she worked second shift on 04/26/22 beginning at 3:00 P.M. and was assigned to care for Resident #10. The STNA revealed Resident #10 was always incontinent of bowel and never used or asked for the bed pan. The STNA denied putting Resident #10 on the bed pan on this date or providing any care at all to the resident between 3:00 P.M. and 7:00 P.M. The STNA revealed on 04/26/22 following the incident with the bed pan (at 7:10 P. M.), LPN #307 questioned her if she known Resident #10 was on a bed pan or if she had put her there to which she denied. On 05/23/22 at 10:10 A.M. interview with STNA #340 revealed she worked day shift beginning at 7:00 A.M. on 04/26/22 and was assigned to care for Resident #10. During the interview, the STNA revealed the resident never used the bed pan, would not ask for a bed pan and denied putting the resident on a bed pan on her shift. (continued on next page)

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(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	On 05/24/22 at 11:04 A.M. during an interview with the DON, the DON revealed he was unsure what the issue was with Resident #10 and her deep tissue injury. The DON initially reported he was not told of the incident but then indicated he did not recall when he was told about the incident. During the interview, the DON confirmed the facility completed no formal investigation, including interviews with staff or obtaining staff statements to determine the circumstances of the incident. There was no evidence the facility investigated to identify who placed Resident #10 on the bed pan, what time the resident was placed on the bed pan, why the resident was placed on the bed pan or why staff failed to identify the resident was on a bed pan until 04/26/22 at 7:10 P.M. when the oncoming nurse went in the resident's room. The DON also verified the incident was not reported to the State agency as an incident of neglect. On 05/24/22 at 12:01 P.M. interview with LPN #307 revealed she worked on 04/26/22 beginning at 7:00 P.M. LPN #307 revealed she was familiar with Resident #10 and frequently checked on this resident first at the beginning of her shift. The LPN denied receiving any information in report regarding the resident and any issues or use of the bed pan. LPN #307 revealed she entered Resident #10's room around 7:10 P.M. and immediately identified the resident was on a bed pan. The LPN revealed the resident had a diagnosis of spina bifida and it was evident based on her body position in bed that she was on a bed pan. The LPN revealed the resident did not normally use a bed pan and did not have any type of behaviors/was not resistive to her removing the bed pan at that time. LPN #307 revealed she immediately notified RN #300, the wound care nurse and the resident's skin was assessed. The resident's left and right buttocks were deep purple and bruised appearing in color. During the interview, LPN #307 denied making any type of nursing progress note entry related to the incident. The LPN revealed she did not know how long the resident had been on the bed pan or who put her on the bed pan. She stated she questioned STNA #322, who was assigned to Resident #10's care for second shift to see if she had put her on a bed pan to which STNA #322 denied. The LPN confirmed the incident had occurred on 04/26/22 and could not explain why the nursing progress notes and wound assessment were dated 04/27/22. On 05/24/22 at 2:00 P.M. interview with the Administrator revealed she was not aware Resident #10 had developed a deep tissue injury to her buttocks from a bed pan until 05/11/22 (during the complaint investigation). She confirmed the facility did not complete an investigation into the incident to determine the circumstances of the incident and did not report the incident to the State agency as an incident of neglect. Review of facility policy abuse, neglect, and exploitation, revised June 2019, revealed each occurrence of resident incident, bruise, abrasion, or injury of unknown source or report of alleged abuse, neglect, or misappropriation of funds would be identified and reported to the supervisor and investigated timely. After the immediate reporting for the alleged violation was completed, the facility would conduct a thorough investigation and report the results of the investigation to the following entities within five working days of the incident: the facility administrator, the Ohio Department of Health and other state officials. This deficiency substantiates Complaint Number OH00132461.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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** 44810 Based on observation, record review, facility policy and procedure review and interview the facility failed to immediately and comprehensively investigate an incident of neglect involving Resident #10. This affected one resident (#10) of one resident reviewed for neglect. Findings include: Review of the medical record for Resident #10 revealed an admitted [DATE] with diagnoses including spina bifida, intellectual disability, osteogenesis imperfecta, and type two diabetes mellitus. Review of a plan of care, dated 12/10/21 revealed Resident #10 had impaired cognition related to a developmental delay. Interventions included the resident required assistance with all decision making and to engage her in simple tasks. Resident #10 had an indwelling urinary catheter and a plan of care related to bowel incontinence. Interventions included to check and change her every two hours and to provide perineal care after each incontinent episode. Review of a pressure ulcer risk assessment, dated 04/08/22 revealed Resident #10 was at risk for developing pressure ulcers due to very limited mobility and her skin being very moist. Review of the Minimum Data Set (MDS) 3.0 assessment, dated 04/09/22 revealed Resident #10 had severe cognitive impairment and memory problems. The assessment revealed the resident required extensive one person physical assistance for bed mobility, total dependence from two persons for transfers and total dependence from one person for dressing, eating, toilet use and personal hygiene. Resident #10 had an indwelling urinary catheter for urine and was always incontinent of bowel. Review of a nursing progress note, dated 04/27/22 at 10:28 P.M. and authored by Registered Nurse #300 revealed Resident #10 was on the bed pan. The note indicated the resident was noted to have a deep tissue injury on 04/26/22 when this nurse and another nurse found her on a bed pan. Review of a wound log, dated 04/27/22 (no time noted) revealed Resident #10 was treated for bilateral buttocks deep tissue injury that was developed in house due to a bed pan. The wound bed was observed as red viable tissue with slough and a small amount of serosanguinous exudate. The peri wound area skin was described as fragile. No measurements were noted for the wound. On 05/11/22 at 2:05 P.M. Registered Nurse (RN) #300 was observed providing wound care for Resident #10's bilateral buttocks. Observation of the wounds revealed they were beefy red and the surrounding skin was dry and intact. A small to moderate amount of drainage was noted, with no odors. The surrounding skin was dry and intact. At the time of the interview, interview with RN #300 revealed the wound to the resident's buttocks had developed on 04/26/22 from sitting on a bed pan for too long. Record review revealed no nursing progress note completed on 04/26/22 related to this incident. In addition, review of the delivery records for care, dated 04/26/22 revealed no medications were ordered or administered on 04/26/22 between 3:00 P.M. and 7:00 P.M. The resident was documented to have a bowel movement on this date at 4:31 A.M. and 10:23 P.M., toileting assistance was noted at 4:31 A.M. and 10:24 P. M. and meal documentation was entered at 10:12 P.M. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/11/22 at 4:11 P.M. interview with Regional Registered Nurse (RN) #357 revealed she was aware (unable to provide exact date of notification) Resident #10 developed a deep tissue injury on 04/26/22 after being found on the bed pan. RN #357 reported no one was sure how long the resident had been on the bed pan on that date. RN #357 revealed the deep tissue injury eventually evolved into a Stage III pressure ulcer when it opened on 05/04/22. RN #357 revealed no formal investigation was initiated on 04/26/22 when the deep tissue injury was first discovered to determine the circumstances of the incident. On 05/17/22 at 4:43 P.M. interview with RN #300 revealed she had been functioning as the facility wound nurse on 04/26/22. RN #300 revealed sometime after dinner time on this date, Licensed Practical Nurse #307 reported to her Resident #10 had been found on a bed pan and had a wound to her buttocks because of it. RN #300 revealed she proceeded to assess the resident and verified the resident had wounds to her bilateral buttocks as a result of pressure from the bed pan. RN #300 revealed there was no evidence the resident had refused any type of care on this date and it was not known who put the resident on a bed pan or when she had been put on a bed pan. The RN revealed Resident #10 was not known to ask for a bed pan, was incontinent of bowel with staff checking and changing her every two hours. RN #300 also revealed the resident would be physically unable to take herself off a bed pan. During the interview, RN #300 revealed she reported this concern to the Director of Nursing (DON) and regional nurse the next morning (on 04/27/22). On 05/23/22 at 2:53 P.M. interview with State tested Nursing Assistant (STNA) #322 revealed she worked second shift on 04/26/22 beginning at 3:00 P.M. and was assigned to care for Resident #10. The STNA revealed Resident #10 was always incontinent of bowel and never used or asked for the bed pan. The STNA denied putting Resident #10 on the bed pan on this date or providing any care at all to the resident between 3:00 P.M. and 7:00 P.M. The STNA revealed on 04/26/22 following the incident with the bed pan (at 7:10 P. M.), LPN #307 questioned her if she known Resident #10 was on a bed pan or if she had put her there to which she denied. On 05/23/22 at 10:10 A.M. interview with STNA #340 revealed she worked day shift beginning at 7:00 A.M. on 04/26/22 and was assigned to care for Resident #10. During the interview, the STNA revealed the resident never used the bed pan, would not ask for a bed pan and denied putting the resident on a bed pan on her shift. On 05/24/22 at 11:04 A.M. during an interview with the DON, the DON revealed he was unsure what the issue was with Resident #10 and her deep tissue injury. The DON initially reported he was not told of the incident but then indicated he did not recall when he was told about the incident. During the interview, the DON confirmed the facility completed no formal investigation, including interviews with staff or obtaining staff statements to determine the circumstances of the incident. There was no evidence the facility investigated to identify who placed Resident #10 on the bed pan, what time the resident was placed on the bed pan, why the resident was placed on the bed pan or why staff failed to identify the resident was on a bed pan until 04/26/22 at 7:10 P.M. when the oncoming nurse went in the resident's room. The DON also verified the incident was not reported to the State agency as an incident of neglect. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/24/22 at 12:01 P.M. interview with LPN #307 revealed she worked on 04/26/22 beginning at 7:00 P.M. LPN #307 revealed she was familiar with Resident #10 and frequently checked on this resident first at the beginning of her shift. The LPN denied receiving any information in report regarding the resident and any issues or use of the bed pan. LPN #307 revealed she entered Resident #10's room around 7:10 P.M. and immediately identified the resident was on a bed pan. The LPN revealed the resident had a diagnosis of spina bifida and it was evident based on her body position in bed that she was on a bed pan. The LPN revealed the resident did not normally use a bed pan and did not have any type of behaviors/was not resistive to her removing the bed pan at that time. LPN #307 revealed she immediately notified RN #300, the wound care nurse and the resident's skin was assessed. The resident's left and right buttocks were deep purple and bruised appearing in color. During the interview, LPN #307 denied making any type of nursing progress note entry related to the incident. The LPN revealed she did not know how long the resident had been on the bed pan or who put her on the bed pan. She stated she questioned STNA #322, who was assigned to Resident #10's care for second shift to see if she had put her on a bed pan to which STNA #322 denied. The LPN confirmed the incident had occurred on 04/26/22 and could not explain why the nursing progress notes and wound assessment were dated 04/27/22. On 05/24/22 at 2:00 P.M. interview with the Administrator revealed she was not aware Resident #10 had developed a deep tissue injury to her buttocks from a bed pan until 05/11/22 (during the complaint investigation). She confirmed the facility did not complete an investigation into the incident to determine the circumstances of the incident and did not report the incident to the State agency as an incident of neglect. Review of facility policy abuse, neglect, and exploitation, revised June 2019, revealed each occurrence of resident incident, bruise, abrasion, or injury of unknown source; or report of alleged abuse, neglect, or misappropriation of funds would be identified and reported to the supervisor and investigated timely. After the immediate reporting for the alleged violation was completed, the facility would conduct a thorough investigation and report the results of the investigation to the following entities within five working days of the incident: the facility administrator, the Ohio Department of Health, and other state officials. This deficiency substantiates Complaint Number OH00132461.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365834	A. Building B. Wing	05/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kent Healthcare and Rehabilitation.	1290 Fairchild Avenue Kent, OH 44240

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44810 Based on observation, record review, facility policy and procedure review and interview the facility failed to ensure adequate wound care was provided for Resident #10 to prevent the risk of wound infection. This affected one resident (#10) of three residents observed for wound/incontinence care. Findings include: Review of the medical record for Resident #10 revealed an admitted [DATE] with diagnoses including spina bifida, osteogenesis imperfecta and type two diabetes mellitus. Review of care plan, dated 12/10/21 revealed Resident #10 had a potential for skin breakdown. Interventions included to provide weekly skin evaluation and if resident refused treatment to try alternative methods to gain compliance. Review of pressure ulcer risk assessment, dated 04/08/22 for Resident #10 revealed the resident was at risk for developing pressure ulcers. Review of annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #10 had severe cognitive impairment and memory problems. Resident #10 required extensive one person physical assistance for bed mobility, total dependence from two persons for transfers and total dependence from one person for dressing, eating, toilet use and personal hygiene. Resident #10 had an indwelling urinary catheter and was always incontinent of bowel. Review of a weekly wound log, dated 04/27/22 revealed Resident #10 was treated for bilateral buttocks deep tissue injury that was acquired in house. Review of a physician's order, dated 04/28/22 for Resident #10 revealed to clean bilateral buttocks with Dakin's (cleaning solution) soaked gauze, pat dry, apply alginate (wound debriding dressing) cut to size and barrier cream with two abdominal pad dressings two times daily and as needed. On 05/11/22 at 2:05 P.M. Registered Nurse (RN) #300 was observed completing wound/incontinence care for Resident #10. RN #300 removed Resident #10's incontinence brief and old wound dressings, folded them up and pushed them to the side. She then removed her gloves and immediately re-applied new gloves without first washing her hands or performing any type of hand hygiene. RN #300 then cleaned Resident #10's wound, removed her gloves and re-applied new gloves without first washing her hands or performing any type of hand hygiene. RN #300 applied cream to Resident #10's wound, wiped the excess cream off on the soiled incontinence brief, applied new abdominal (ABD) pads to the wound and a new incontinence brief. RN #300 then cleaned up the work area and removed gloves and washed her hands. On 05/11/22 at 2:20 P.M. interview with RN #300 confirmed she did not wash her hands after removing her gloves twice and confirmed she wiped excess cream off her gloves onto the resident's soiled incontinence brief. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy titled wound care, revised April 2018 revealed staff should put on exam gloves, loosen tape and remove dressing, then pull glove over dressing and discard into the appropriate receptacle. The staff should then wash and dry hands thoroughly. Then clean and dress the wound according to the physician's orders. This deficiency substantiates Complaint Number OH00132461.