STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365834	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/25/2022
NAME OF PROVIDER OR SUPPLIER Kent Healthcare and Rehabilitation.		STREET ADDRESS, CITY, STATE, ZIP CODE 1290 Fairchild Avenue Kent, OH 44240	
For information on the nursing home's	plan to correct this deficiency, please cont	tact 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)		on)
F 0600 Level of Harm - Actual harm Residents Affected - Few	and neglect by anybody. **NOTE- TERMS IN BRACKETS H Based on observation, record revie prevent an incident of neglect invol Actual Harm occurred on 04/26/22 incontinent of bowel and dependen pressure ulcers to her bilateral butt unknown period of time. This affect Findings include: Review of the medical record for R bifida, intellectual disability, osteog Review of a plan of care, dated 12/ developmental delay. Interventions engage her in simple tasks. Reside bowel incontinence. Interventions in care after each incontinent episode Review of a pressure ulcer risk ass developing pressure ulcers due to Review of the Minimum Data Set (f cognitive impairment and memory f person physical assistance for bed dependence from one person for d indwelling urinary catheter for urine Review of a nursing progress note, revealed Resident #10 was on the	at 7:10 P.M. when Resident #10, who at 7:10 P.M. when Resident #10, who at on staff for activities of daily living ca tocks as a result of having a bed pan p ted one resident (#10) of three residen esident #10 revealed an admitted [DA [*] enesis imperfecta, and type two diabet /10/21 revealed Resident #10 had impa is included the resident required assista ent #10 had an indwelling urinary cathe ncluded to check and change every tw	ONFIDENTIALITY** 44810 and interview the facility failed to was cognitively impaired, re was found to have deep tissue laced underneath her for an ts reviewed for neglect. TE] with diagnoses including spina- tes mellitus. aired cognition related to a nce with all decision making and to the rand a plan of care related to o hours and to provide perineal sident #10 was at risk for givery moist. revealed Resident #10 had severe he resident required extensive one ersons for transfers and total I hygiene. Resident #10 had an hored by Registered Nurse #300 ent was noted to have a deep tissue

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

Facility ID: 365834

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365834	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/25/2022
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For information on the nursing home's	plan to correct this deficiency, please cont	tact the nursing home or the state survey a	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	IENCIES full regulatory or LSC identifying informati	on)
F 0600 Level of Harm - Actual harm Residents Affected - Few	 buttocks deep tissue injury that was red viable tissue with slough and a described as fragile. No measurem On 05/11/22 at 2:05 P.M. Registerer #10's bilateral buttocks. Observatio was dry and intact. A small to mode was dry and intact. A small to mode was dry and intact. At the time of the resident's buttocks had developed of Record review revealed no nursing review of the delivery records for ca administered on 04/26/22 between movement on this date at 4:31 A.M M. and meal documentation was er On 05/11/22 at 4:11 P.M. interview (unable to provide exact date of not being found on the bed pan. RN #35 pan on that date. RN #357 revealed when it opened on 05/04/22. RN #30 deep tissue injury was first discover On 05/17/22 at 4:43 P.M. interview nurse on 04/26/22. RN #300 reveal #307 reported to her Resident #10 of it. RN #300 revealed she proceed bilateral buttocks as a result of press resident had refused any type of ca when she had been put on a bed privas incontinent of bowel with staff or resident would be physically unable she reported this incident/concern to 04/27/22). On 05/23/22 at 2:53 P.M. interview second shift on 04/26/22 beginning revealed Resident #10 was always denied putting Resident #10 on the 3:00 P.M. and 7:00 P.M. The STNA 	ed Nurse (RN) #300 was observed prov n of the wounds revealed they were be erate amount of drainage was noted, w the observation, interview with RN #300 on 04/26/22 from sitting on a bed pan f progress note completed on 04/26/22 are, dated 04/26/22 revealed no medica 3:00 P.M. and 7:00 P.M. The resident . and 10:23 P.M., toileting assistance v	. The wound bed was observed a ate. The peri wound area skin was viding wound care for Resident befy red and the surrounding skin ith no odors. The surrounding skin revealed the wound to the or too long. related to this incident. In additionations were ordered or was documented to have a bowel was noted at 4:31 A.M. and 10:24 #357 revealed she was aware the resident had been on the bed were that a Stage III pressure ulcer as initiated on 04/26/22 when the the incident. functioning as the facility wound date, Licensed Practical Nurse a wound to her buttocks because the resident had wounds to her aled there was no evidence the ho put the resident on a bed pan, nours. RN #300 also revealed the he interview, RN #300 revealed the for Resident #10. The STNA r asked for the bed pan. The STNA risk of the bed pan (at 7:10 P

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365834	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/25/2022
NAME OF PROVIDER OR SUPPLIER Kent Healthcare and Rehabilitation.		STREET ADDRESS, CITY, STATE, ZI 1290 Fairchild Avenue Kent, OH 44240	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	l tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	on)
F 0600 Level of Harm - Actual harm Residents Affected - Few	 on 04/26/22 and was assigned to c resident never used the bed pan, w on her shift. On 05/24/22 at 11:04 A.M. during a issue was with Resident #10 and h incident but then indicated he did n DON confirmed the facility complet statements to determine the circum identify who placed Resident #10 or resident was placed on the bed par 04/26/22 at 7:10 P.M. when the ordincident was not reported to the State Don 05/24/22 at 12:01 P.M. interview LPN #307 revealed she was familia beginning of her shift. The LPN der issues or use of the bed pan. LPN is immediately identified the resident is pina bifida and it was evident base revealed the resident did not norma not having any type of behaviors/w revealed she immediately notified F The resident's left and right buttock LPN #307 denied making any type she did not know how long the resis she questioned STNA #322, who wher on a bed pan to which STNA #3 and could not explain why the nurs On 05/24/22 at 2:00 P.M. interview developed a deep tissue injury to h investigation). She confirmed the facility policy abuse, neg of the facility policy abuse, neg of the facility, its employees or server 	w with STNA #340 revealed she worke are for Resident #10. During the interv yould not ask for a bed pan and denied an interview with the DON, the DON rev- er deep tissue injury. The DON initially ot recall when he was told about the in ed no formal investigation, including in- istances of the incident. There was no n the bed pan, what time the resident's ro- ate agency as an incident of neglect. w with LPN #307 revealed she worked ar with Resident #10 and frequently che- hied receiving any information in report #307 revealed she entered Resident # was on a bed pan. The LPN revealed the ed on her body position in bed that she ally use a bed pan and at the time she is were deep purple and bruised appear of nursing progress note entry related dent had been on the bed pan or who p ras assigned to Resident #10's care for 322 denied. The LPN confirmed the inci- ing progress notes and wound assessing with the Administrator revealed she was er buttocks from a bed pan until 05/11/ acility did not complete an investigation did not report the incident to the State ar lect, and exploitation, revised June 20' rice providers to provide goods and ser pain, mental anguish, or emotional dist plaint Number OH00132461.	ew, the STNA revealed the putting the resident on a bed pan reported he was not told of the cident. During the interview, the rerviews with staff or obtaining staff evidence the facility investigated to vas placed on the bed pan, why the ent was on a bed pan until im. The DON also verified the on 04/26/22 beginning at 7:00 P.M. ecked on this resident first at the regarding the resident and any 10's room around 7:10 P.M. and he resident had a diagnosis of was on a bed pan. The LPN entered the room the resident was d pan at that time. LPN #307 e resident's skin was assessed. ring in color. During the interview, to the incident. The LPN revealed but her on the bed pan. She stated second shift to see if she had put ident had occurred on 04/26/22 nent were dated 04/27/22. as not aware Resident #10 had 22 (during the complaint into the incident to determine the gency as an incident of neglect. I9 revealed neglect was the failure vices to a resident that are

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365834	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/25/2022
NAME OF PROVIDER OR SUPPLIE	D	STREET ADDRESS, CITY, STATE, ZI	
Kent Healthcare and Rehabilitation.		1290 Fairchild Avenue Kent, OH 44240	
For information on the nursing home's	plan to correct this deficiency, please con	tact 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)		on)
F 0609	Timely report suspected abuse, neg authorities.	glect, or theft and report the results of t	he investigation to proper
Level of Harm - Minimal harm or potential for actual harm	**NOTE- TERMS IN BRACKETS H	AVE BEEN EDITED TO PROTECT CO	ONFIDENTIALITY** 44810
Residents Affected - Few		w, facility policy and procedure review ing Resident #10 was reported to the s 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 developmental delay. Interventions included the resident required assistance with all de engage her in simple tasks. Resident #10 had an indwelling urinary catheter and a plan bowel incontinence. Interventions included to check and change her every two hours ar care after each incontinent episode.		nce with all decision making and to ter and a plan of care related to
		essment, dated 04/08/22 revealed Res very limited mobility and her skin being	
	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.		
	revealed Resident #10 was on the	dated 04/27/22 at 10:28 P.M. and auth bed pan. The note indicated the reside and another nurse found her on a bed	nt was noted to have a deep tissue
	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)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365834	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/25/2022
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	on)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	 review of the delivery records for caradministered on 04/26/22 between movement on this date at 4:31 A.M.M. and meal documentation was en On 05/11/22 at 4:11 P.M. interview (unable to provide exact date of no being found on the bed pan. RN #3 pan on that date. RN #357 revealed when it opened on 05/04/22. RN #3 deep tissue injury was first discove On 05/17/22 at 4:43 P.M. interview nurse on 04/26/22. RN #300 revealed she proceebilateral buttocks as a result of preseresident had refused any type of carbon when she had been put on a bed p was incontinent of bowel with staff resident would be physically unable she reported this concern to the Dir 04/27/22). On 05/23/22 at 2:53 P.M. interview second shift on 04/26/22 beginning revealed Resident #10 on the 3:00 P.M. and 7:00 P.M. The STNAM.), LPN #307 questioned her if sh which she denied. On 05/23/22 at 10:10 A.M. interview on 04/26/22 and was assigned to cord 	progress note completed on 04/26/22 are, dated 04/26/22 revealed no medica 3:00 P.M. and 7:00 P.M. The resident . and 10:23 P.M., toileting assistance v ntered at 10:12 P.M. with Regional Registered Nurse (RN) ; tification) Resident #10 developed a de 57 reported no one was sure how long d the deep tissue injury eventually evol 357 revealed no formal investigation wa red to determine the circumstances of i with RN #300 revealed she had been to had been found on a bed pan and had ded to assess the resident and verified ssure from the bed pan. RN #300 revea rere on this date and it was not known w an. The RN revealed Resident #10 was checking and changing her every two f a to take herself off a bed pan. During t rector of Nursing (DON) and regional n with State tested Nursing Assistant (S ² at 3:00 P.M. and was assigned to care incontinent of bowel and never used o bed pan on this date or providing any A revealed on 04/26/22 following the intervi- rould not ask for a bed pan and denied	ations were ordered or was documented to have a bowel vas noted at 4:31 A.M. and 10:24 F #357 revealed she was aware eep tissue injury on 04/26/22 after the resident had been on the bed ved into a Stage III pressure ulcer as initiated on 04/26/22 when the the incident. functioning as the facility wound date, Licensed Practical Nurse a wound to her buttocks because I the resident had wounds to her aled there was no evidence the tho put the resident on a bed pan of s not known to ask for a bed pan, nours. RN #300 also revealed the he interview, RN #300 revealed urse the next morning (on TNA) #322 revealed she worked e for Resident #10. The STNA r asked for the bed pan. The STNA care at all to the resident between cident with the bed pan (at 7:10 P. an or if she had put her there to d day shift beginning at 7:00 A.M. iew, the STNA revealed the

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 365834 NAME OF PROVIDER OR SUPPLIER Kent Healthcare and Rehabilitation.		(X2) MULTIPLE CONSTRUCTION A. Building B. Wing STREET ADDRESS, CITY, STATE, ZI 1290 Fairchild Avenue Kent, OH 44240	(X3) DATE SURVEY COMPLETED 05/25/2022 P CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	issue was with Resident #10 and h incident but then indicated he did n DON confirmed the facility complet statements to determine the circum identify who placed Resident #10 or resident was placed on the bed par 04/26/22 at 7:10 P.M. when the om incident was not reported to the Sta On 05/24/22 at 12:01 P.M. interview LPN #307 revealed she was familia beginning of her shift. The LPN der issues or use of the bed pan. LPN i immediately identified the resident spina bifida and it was evident bass revealed the resident did not norma resistive to her removing the bed p wound care nurse and the resident purple and bruised appearing in co progress note entry related to the in been on the bed pan or who put he assigned to Resident #10's care for denied. The LPN confirmed the inc progress notes and wound assess On 05/24/22 at 2:00 P.M. interview developed a deep tissue injury to h investigation). She confirmed the fac circumstances of the incident and o Review of facility policy abuse, neg resident incident, bruise, abrasion, misappropriation of funds would be immediate reporting for the alleged investigation and report the results	with the Administrator revealed she was ber buttocks from a bed pan until 05/11/ acility did not complete an investigation did not report the incident to the State a plect, and exploitation, revised June 20 ⁻⁷ or injury of unknown source or report of e identified and reported to the supervis l violation was completed, the facility we of the investigation to the following ent he Ohio Department of Health and othe	reported he was not told of the cident. During the interview, the terviews with staff or obtaining staff evidence the facility investigated to was placed on the bed pan, why the ent was on a bed pan until m. The DON also verified the on 04/26/22 beginning at 7:00 P.M. Eacked on this resident first at the regarding the resident and any 10's room around 7:10 P.M. and he resident had a diagnosis of was on a bed pan. The LPN y type of behaviors/was not a timmediately notified RN #300, the ft and right buttocks were deep hied making any type of nursing know how long the resident had tioned STNA #322, who was on a bed pan to which STNA #322 uld not explain why the nursing as not aware Resident #10 had 22 (during the complaint into the incident to determine the igency as an incident of neglect.

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Kent Healthcare and Rehabilitation			
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
F 0610	Respond appropriately to all allege	d violations.	
Level of Harm - Minimal harm or potential for actual harm	**NOTE- TERMS IN BRACKETS H	IAVE BEEN EDITED TO PROTECT C	ONFIDENTIALITY** 44810
Residents Affected - Few		w, facility policy and procedure review investigate an incident of neglect involver 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.		
	developmental delay. Interventions engage her in simple tasks. Reside	10/21 revealed Resident #10 had impa included the resident required assista ant #10 had an indwelling urinary cathe ncluded to check and change her ever	nce with all decision making and to ter and a plan of care related to
		essment, dated 04/08/22 revealed Resvery limited mobility and her skin being	
	cognitive impairment and memory person physical assistance for bed dependence from one person for d	MDS) 3.0 assessment, dated 04/09/22 problems. The assessment revealed th mobility, total dependence from two pa ressing, eating, toilet use and personal and was always incontinent of bowel.	e resident required extensive one ersons for transfers and total
	revealed Resident #10 was on the	dated 04/27/22 at 10:28 P.M. and aut bed pan. The note indicated the reside and another nurse found her on a bed	nt was noted to have a deep tissue
	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.		
	#10's bilateral buttocks. Observation was dry and intact. A small to mode was dry and intact. At the time of th	11/22 at 2:05 P.M. Registered Nurse (RN) #300 was observed providing wound care for Resident illateral buttocks. Observation of the wounds revealed they were beefy red and the surrounding skin y and intact. A small to moderate amount of drainage was noted, with no odors. The surrounding skin y and intact. At the time of the interview, interview with RN #300 revealed the wound to the resident's is had developed on 04/26/22 from sitting on a bed pan for too long.	
	review of the delivery records for ca administered on 04/26/22 between	progress note completed on 04/26/22 are, dated 04/26/22 revealed no medic 3:00 P.M. and 7:00 P.M. The resident I. and 10:23 P.M., toileting assistance w intered at 10:12 P.M.	ations were ordered or was documented to have a bowel
	(continued on next page)		

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For information on the nursing home's	plan to correct this deficiency, please con	Kent, OH 44240	agency.
(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 (unable to provide exact date of no being found on the bed pan. RN #3 pan on that date. RN #357 revealed when it opened on 05/04/22. RN #3 deep tissue injury was first discove On 05/17/22 at 4:43 P.M. interview nurse on 04/26/22. RN #300 reveal #307 reported to her Resident #10 of it. RN #300 revealed she procee bilateral buttocks as a result of pres resident had refused any type of ca when she had been put on a bed p was incontinent of bowel with staff resident would be physically unable she reported this concern to the Dii 04/27/22). On 05/23/22 at 2:53 P.M. interview second shift on 04/26/22 beginning revealed Resident #10 was always denied putting Resident #10 on the 3:00 P.M. and 7:00 P.M. The STNA M.), LPN #307 questioned her if sh which she denied. On 05/23/22 at 10:10 A.M. interview on 04/26/22 and was assigned to c resident never used the bed pan, w on her shift. On 05/24/22 at 11:04 A.M. during a issue was with Resident #10 and h incident but then indicated he did n DON confirmed the facility complet statements to determine the circurr identify who placed Resident #10 or resident was placed on the bed pan 04/26/22 at 7:10 P.M. when the ond 	full regulatory or LSC identifying informati- with Regional Registered Nurse (RN) is tification) Resident #10 developed a de 57 reported no one was sure how long d the deep tissue injury eventually evol 357 revealed no formal investigation ware red to determine the circumstances of the with RN #300 revealed she had been to led sometime after dinner time on this of had been found on a bed pan and had ded to assess the resident and verified sure from the bed pan. RN #300 revea- are on this date and it was not known wan. The RN revealed Resident #10 was checking and changing her every two here to take herself off a bed pan. During the rector of Nursing (DON) and regional no with State tested Nursing Assistant (Si at 3:00 P.M. and was assigned to care incontinent of bowel and never used of bed pan on this date or providing any A revealed on 04/26/22 following the intervi- vould not ask for a bed pan and denied an interview with the DON, the DON rev- er deep tissue injury. The DON initially ot recall when he was told about the in- ed no formal investigation, including inti- stances of the incident. There was no on the bed pan, what time the resident wo no or why staff failed to identify the resid coming nurse went in the resident's roo ate agency as an incident of neglect.	 #357 revealed she was aware seep tissue injury on 04/26/22 after of the resident had been on the bed ved into a Stage III pressure ulcer as initiated on 04/26/22 when the the incident. functioning as the facility wound date, Licensed Practical Nurse a wound to her buttocks because I the resident had wounds to her aled there was no evidence the tho put the resident on a bed pan or s not known to ask for a bed pan, nours. RN #300 also revealed the he interview, RN #300 revealed urse the next morning (on TNA) #322 revealed she worked a for Resident #10. The STNA or asked for the bed pan. The STNA care at all to the resident between cident with the bed pan (at 7:10 P. an or if she had put her there to d day shift beginning at 7:00 A.M. iew, the STNA revealed the reported he was not told of the cident. During the interview, the terviews with staff or obtaining staff evidence the facility investigated to was placed on the bed pan, why the lent was on a bed pan until

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	365834	B. Wing	05/25/2022
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	P CODE
Kent Healthcare and Rehabilitation.		1290 Fairchild Avenue Kent, OH 44240	
For information on the nursing home's p	plan to correct this deficiency, please cont	tact the nursing home or the state survey a	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	IENCIES full regulatory or LSC identifying information	on)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN #307 revealed she was familia beginning of her shift. The LPN der issues or use of the bed pan. LPN a immediately identified the resident of spina bifida and it was evident base revealed the resident did not normal resistive to her removing the bed pa wound care nurse and the resident purple and bruised appearing in col progress note entry related to the ir been on the bed pan or who put he assigned to Resident #10's care for denied. The LPN confirmed the inci progress notes and wound assess On 05/24/22 at 2:00 P.M. interview developed a deep tissue injury to h investigation). She confirmed the fa circumstances of the incident and o Review of facility policy abuse, neg resident incident, bruise, abrasion, misappropriation of funds would be immediate reporting for the alleged investigation and report the results	with the Administrator revealed she wa er buttocks from a bed pan until 05/11/ icility did not complete an investigation lid not report the incident to the State a lect, and exploitation, revised June 201 or injury of unknown source; or report of identified and reported to the supervis- violation was completed, the facility wo of the investigation to the following enti- he Ohio Department of Health, and othe	ecked on this resident first at the regarding the resident and any 10's room around 7:10 P.M. and he resident had a diagnosis of was on a bed pan. The LPN y type of behaviors/was not immediately notified RN #300, the ft and right buttocks were deep nied making any type of nursing know how long the resident had tioned STNA #322, who was on a bed pan to which STNA #322 uld not explain why the nursing as not aware Resident #10 had 22 (during the complaint into the incident to determine the gency as an incident of neglect. 19, revealed each occurrence of of alleged abuse, neglect, or or and investigated timely. After the buld conduct a thorough ities within five working days of the

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For information on the nursing home's	plan to correct this deficiency, please cont	tact the nursing home or the state survey a	agency.
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by f		TENCIES full regulatory or LSC identifying informati	on)
F 0686	Provide appropriate pressure ulcer	care and prevent new ulcers from deve	eloping.
Level of Harm - Minimal harm or potential for actual harm	**NOTE- TERMS IN BRACKETS H	AVE BEEN EDITED TO PROTECT CO	ONFIDENTIALITY** 44810
Residents Affected - Few	ensure adequate wound care was p	w, facility policy and procedure review provided for Resident #10 to prevent th e residents observed for wound/incontir	e risk of wound infection. This
	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 reveale included to provide weekly skin evaluation a compliance.			
	Review of pressure ulcer risk assessment, dated 04/08/22 for Resident #10 revealed the resident was at risl for developing pressure ulcers.		
	Review of annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed severe cognitive impairment and memory problems. Resident #10 required extensive assistance for bed mobility, total dependence from two persons for transfers and tota person for dressing, eating, toilet use and personal hygiene. Resident #10 had an include and was always incontinent of bowel.		d extensive one person physical ers and total dependence from one
	Review of a weekly wound log, date tissue injury that was acquired in ho	ed 04/27/22 revealed Resident #10 was	s treated for bilateral buttocks dee
	Dakin's (cleaning solution) soaked	d 04/28/22 for Resident #10 revealed t gauze, pat dry, apply alginate (wound o ad dressings two times daily and as ne	debriding dressing) cut to size and
	for Resident #10. RN #300 remove up and pushed them to the side. Sh without first washing her hands or p #10's wound, removed her gloves a any type of hand hygiene. RN #300 the soiled incontinence brief, applie	ed Nurse (RN) #300 was observed com d Resident #10's incontinence brief and be then removed her gloves and immed berforming any type of hand hygiene. R and re-applied new gloves without first 0 applied cream to Resident #10's wour ed new abdominal (ABD) pads to the we area and removed gloves and washed	d old wound dressings, folded the diately re-applied new gloves N #300 then cleaned Resident washing her hands or performing nd, wiped the excess cream off or ound and a new incontinence brie
		with RN #300 confirmed she did not w bed excess cream off her gloves onto th	0
	(continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365834	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/25/2022
NAME OF PROVIDER OR SUPPLIER Kent Healthcare and Rehabilitation.		STREET ADDRESS, CITY, STATE, ZI 1290 Fairchild Avenue Kent, OH 44240	P CODE
For information on the nursing home's	plan to correct this deficiency, please cont	tact the nursing home or the state survey a	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	IENCIES full regulatory or LSC identifying information	on)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	loosen tape and remove dressing, t	d care, revised April 2018 revealed stat hen pull glove over dressing and disca hands thoroughly. Then clean and dre plaint Number OH00132461.	rd into the appropriate receptacle.