STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365324	A. Building B. Wing	03/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardens of Belden Village	5005 Higbee Avenue NW Canton, OH 44718

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, interview, facility self-reported incident (SRI) review, police report review, and facility policy review, the facility failed to ensure Resident #77 was free from sexual abuse. This affected one resident (Resident #77) of three residents reviewed for abuse.Findings include:Review of the medical record for Resident #77 revealed an admission date of 01/09/26 with diagnoses including but not limited to dementia with psychotic disturbance, cognitive communication deficit and type 2 diabetes mellitus. Review of the care plan dated 01/09/26 revealed Resident #77 has impaired cognitive function/dementia or impaired thought process related to dementia. Interventions included administer medications as ordered, communicate with resident/family, identify self at each interaction, cue, reorient, supervise, keep resident routine consistent, monitor and document and report any changes.Review of Resident #77s 5-Day Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited severe cognitive impairment Review of Resident #77's progress notes revealed no notes regarding physical or sexual abuse by Resident #43 on 02/08/26. Review of the medical record Resident #43 revealed an admission date of 12/27/25 with diagnoses including but not limited to cerebral Infarction, schizophrenia and psychoactive substance abuse.Review of the care plan dated 12/29/25 revealed Resident #43 had no care plans related to sexual history or sexual behaviors.Review of the admission minimum data set (MDS) dated [DATE] revealed Resident #43 had intact cognition and was ambulatory.Review of the facility SRI tracking number 270705 dated 02/08/26 revealed on the evening of 02/08/26 Certified Nursing Assistant (CNA) #221 witnessed Resident #43 lift up Resident #77's shirt and touch her left breast. CNA #221 immediately separated Resident #77 from Resident #43. CNA #221 reported Resident #43 denied doing it and when she asked why, he responded she should wear a bra. CNA #221 reported the incident to Licensed Practical Nurse (LPN) #211 who reported it via phone to Director of Nursing (DON). An investigation was started to include monitoring Resident #77 and Resident #43. An SRI was submitted at that time. The facility investigation concluded no abuse had occurred. Review of the police report #2026-00012974, report date 02/19/26 at 3:50 P.M. revealed Police Officer #300 was notified of a sex offense that occurred on 02/08/26 between Resident #43 and Resident #77. Statements were received by Administrator, LPN #211, CNA #221, and Resident #77's husband. Interview on 02/18/26 at 7:49 A.M. and a second interview on 02/23/26 at 9:07 A.M. with Resident #77's husband revealed he was notified of the alleged sexual abuse but it was downplayed by the Administrator. Resident #77's husband denied any knowledge of her breast being touched inappropriately. He also reported the Administrator told him the police would be notified. Resident #77's husband reported Resident #77 has impaired cognition with confusion and is not able to make her needs known. Resident #77's husband reported the administrator made a motion with his hand circling stomach, to indicated that is where Resident #43 touched his wife. Resident #77's husband reported he never told the Administrator his wife lifted up or pulled off her clothes. Resident #77's husband reported he told the Administrator she would pull at her clothes sometimes. Resident #77's husband then reported on 02/20/26, unable to recall time, he received a call from the police and was told they wanted to interview him and they are (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: 365324	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/02/2026
NAME OF PROVIDER OR SUPPLIER Gardens of Belden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 5005 Higbee Avenue NW Canton, OH 44718	

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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 - Minimal harm or potential for actual harm Residents Affected - Few	starting an investigation.An attempt to interview Resident #77 on 02/18/26 at 9:29 A.M. was unsuccessful as Resident #77 was only able to state her name but unable to answer any questions. Interview on 02/18/26 at 10:30 A.M. with DON revealed she was notified by LPN #211 that Resident #77 who was touched inappropriately by Resident #43 and the facility immediately separated the residents and Resident #43 was put on 1:1 observation. DON reported she notified the Administrator, Regional Director of Operations (RDO) #289 and Regional Nurse #288 by phone of the alleged sexual abuse. Investigation was started. Interview on 02/18/26 at 2:21 P.M. with CNA #221, via phone, revealed on 02/08/26 at approximately 10:30 P.M. she witnessed Resident #43 lift up Resident #77's shirt and rubbing her left boob at the nurses station. CNA #221 reported she immediately went to him, and asked what he was doing and he threw her shirt back down and ran to his room. CNA #221 reported the allegation to LPN #211 and LPN #267 who approached the aide because they heard the aide questioning Resident #43. Interview on 02/18/26 at 2:50 P.M. with Administrator reported he was initially notified on 02/08/26 by the DON who informed him the alleged victim was Resident #24 but it was discovered during the investigation, the alleged victim was Resident #77. Administrator revealed the information provided by the DON initially of the resident involved was incorrect. Administrator revealed he was notified on 02/08/26 regarding alleged sexual abuse with Resident #77. Administrator revealed the facility found the allegation of sexual abuse to be unsubstantiated because it was reported the resident lifted her shirt up and there was no witnesses. In review of CNA #221's witness statement that Resident #43 touched Resident #77's breast with Administrator, the Administrator revealed he was unaware of this. Interview on 02/23/26 at 3:47 P.M. with Police Officer (PO) #300, via phone, revealed she received a call on 02/19/26 at 3:50 P.M. approximately from the Administrator regarding a sexual abuse allegation. PO #300 reported she spoke with Resident #77's husband who felt the facility downplayed what really happened. PO #300 reported she went to the facility on [DATE] that evening and interviewed LPN #211 and CNA #221 working on 02/08/26. PO #300 reported Resident #77 was asleep, and she didn't interview based on her interview with the LPN #211 and CNA #221 who reported Resident #77 had dementia, was confused, and unable to make her needs know. PO #300 reported Resident #77's husband wanted to think about it over the weekend and let them know if he wanted to press charges. On 02/24/26 at 6:32 P.M. a voice message from PO #300 revealed Resident #77's husband was pressing charges and PO #300 would no longer be her case. PO #300 reported Detective #301's will follow the case since it was a sexual offense. Review of the facility policy, Abuse, Neglect, Exploitation & Misappropriation of Resident Property, revised 11/01/2019, revealed the policy is to investigate all alleged violations of abuse and the person investigating the incident should take the following actions to include interviewing all witnesses to cover all employees on the unit. This deficiency represents non-compliance investigated under Master Complaint Number 2787731 and Complaint Number 2743289.

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NAME OF PROVIDER OR SUPPLIER Gardens of Belden Village		STREET ADDRESS, CITY, STATE, ZIP CODE 5005 Higbee Avenue NW Canton, OH 44718	

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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** Based on record review, interview, facility self-reported incident (SRI) review, police report, and facility policy review, the facility failed to thoroughly investigate a sexual abuse allegation for Resident #77. This affected one resident (Resident #77) out of three residents reviewed for abuse. The facility census was 92.Findings include:Review of the medical record for Resident #77 revealed an admission date of 01/09/26 with diagnoses including but not limited to dementia with psychotic disturbance, cognitive communication deficit and type 2 diabetes mellitus. Review of the care plan dated 01/09/26 revealed Resident #77 has impaired cognitive function/dementia or impaired thought process related to dementia. Interventions included administer medications as ordered, communicate with resident/family, identify self at each interaction, cue, reorient, supervise, keep resident routine consistent, monitor and document and report any changes.Review of Resident #77s 5-Day Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited severe cognitive impairment Review of Resident #77's progress notes revealed no notes regarding physical or sexual abuse by Resident #43 on 02/08/26. Review of the medical record Resident #43 revealed an admission date of 12/27/25 with diagnoses including but not limited to cerebral Infarction, schizophrenia and psychoactive substance abuse.Review of the care plan dated 12/29/25 revealed Resident #43 had no care plans related to sexual history or sexual behaviors.Review of the admission minimum data set (MDS) dated [DATE] revealed Resident #43 had intact cognition and was ambulatory.Review of the facility SRI tracking number 270705 dated 02/08/26 revealed on the evening of 02/08/26 Certified Nursing Assistant (CNA) #221 witnessed Resident #43 lift up Resident #77's shirt and touch her left breast. CNA #221 immediately separated Resident #77 from Resident #43. CNA #221 reported Resident #43 denied doing it and when she asked why, he responded she should wear a bra. CNA #221 reported the incident to Licensed Practical Nurse (LPN) #211 who reported it via phone to Director of Nursing (DON). An investigation was started to include monitoring Resident #77 and Resident #43. An SRI was submitted at that time. The facility investigation concluded no abuse had occurred. Further in the investigation LPN #267 was never interviewed and she was working the evening CNA #221 reported it to LPN #211. LPN #267 was oriented with LPN #211. Review of the police report #2026-00012974, report date 02/19/26 at 3:50 P.M. revealed Police Officer #300 was notified of a sex offense that occurred on 02/08/26 between Resident #43 and Resident #77. Statements were received by Administrator, LPN #211, CNA #221, and Resident #77's husband. Interview on 02/18/26 at 7:49 A.M. and a second interview on 02/23/26 at 9:07 A.M. with Resident #77's husband revealed he was notified of the alleged sexual abuse but it was downplayed by the Administrator. Resident #77's husband denied any knowledge of her breast being touched inappropriately. He also reported the Administrator told him the police would be notified. Resident #77's husband reported Resident #77 has impaired cognition with confusion and is not able to make her needs known. Resident #77's husband reported the administrator made a motion with his hand circling stomach, to indicated that is where Resident #43 touched his wife. Resident #77's husband reported he never told the Administrator his wife lifted up or pulled off her clothes. Resident #77's husband reported he told the Administrator she would pull at her clothes sometimes. Resident #77's husband then reported on 02/20/26, unable to recall time, he received a call from the police and was told they wanted to interview him and they are starting an investigation.An attempt to interview Resident #77 on 02/18/26 at 9:29 A.M. was unsuccessful as Resident #77 was only able to state her name but unable to answer any questions. Interview on 02/18/26 at 10:30 A.M. with Director of Nursing (DON) revealed she was notified on 02/08/26 by Licensed Practical Nurse (LPN) #267 on 02/08/26 Resident #43 went into Resident #24's room and was touching Resident #24 inappropriately. Interview on 02/18/26 at 2:21 P.M. with CNA #221, via phone, revealed on 02/08/26 at approximately 10:30 P.M. she witnessed Resident #43 lift up Resident #77's shirt and rubbing her left boob at the (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nurses station. CNA #221 reported she immediately went to him, and asked what he was doing and he threw her shirt back down and ran to his room. CNA #221 reported the allegation to LPN #211 and LPN #267 who approached the aide because they heard the aide questioning Resident #43. Interview on 02/18/26 at 2:50 P.M. with Administrator reported he was initially notified on 02/08/26, late evening, by the DON who informed him of alleged sexual abuse and the alleged victim was Resident #24 but it was discovered during the investigation, the alleged victim was Resident #77. Administrator reported he started an investigation and initiated a SRI immediately and confirmed he did not interview LPN #267 during the investigation. Administrator revealed the facility found the allegation of sexual abuse to be unsubstantiated because it was reported the resident lifted her shirt up and there was no witnesses. In review of CNA #221's witness statement that Resident #43 touched Resident #77's breast with Administrator, the Administrator revealed he was unaware of this. Interview on 02/18/26 at 3:54 P.M. with LPN #267 revealed she worked on 02/08/26 with LPN #211 when the incident occurred with Resident #43 touching Resident #77 inappropriately. LPN #267 reported she was orienting with LPN #211 when they came out of a resident's room and walking down the hall when CNA #221 reported the sexual abuse to LPN #211. LPN #267 reported CNA #221 reported Resident #43 went into Resident #77's shirt and started rubbing her breast. LPN #267 reported she was never interviewed or asked to write a statement regarding sexual abuse. Interview on 02/23/26 at 3:47 P.M. with Police Officer (PO) #300, via phone, revealed she received a call on 02/19/26 at 3:50 P.M. approximately from the Administrator regarding a sexual abuse allegation. PO #300 reported she spoke with Resident #77's husband who felt the facility downplayed what really happened. PO #300 reported she went to the facility on [DATE] that evening and interviewed LPN #211 and CNA #221 working on 02/08/26. PO #300 reported Resident #77 was asleep, and she didn't interview based on her interview with the LPN #211 and CNA #221 who reported Resident #77 had dementia, was confused, and unable to make her needs know. PO #300 reported Resident #77's husband wanted to think about it over the weekend and let them know if he wanted to press charges. On 02/24/26 at 6:32 P.M. a voice message from PO #300 revealed Resident #77's husband was pressing charges and PO #300 would no longer be her case. PO #300 reported Detective #301's will follow the case since it was a sexual offense. Review of the facility policy, Abuse, Neglect, Exploitation & Misappropriation of Resident Property, revised 11/01/2019, revealed the policy is to investigate all alleged violations of abuse and the person investigating the incident should take the following actions to include interviewing all witnesses to cover all employees on the unit. This deficiency represents non-compliance investigated under Master Complaint Number 2787731 and Complaint Number 2743289.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and facility policy review, the facility failed to ensure am individualized comprehensive nutrition plan was in place for Resident #5 and Resident #95 to properly monitor weights, nutritional status, and treat weight loss properly. This affected two residents (Resident #5 and #95) out of three residents reviewed for weights. Facility census was 92.Findings include:1.Review of the medical record for Resident #95 revealed an admission date of 12/19/25 and a discharge date of 02/16/26 to the hospital. Diagnoses included but not limited to Alzheimer's Disease, intermittent explosive disorder, and dementia.Review of the physician order for 12/19/25 revealed an order for regular diet, regular texture, thin liquids and for Med pass supplement 6 ounces (oz) with meals to give one container serving and record amount consumed. The order was discontinued on 02/13/26.Review of the care plan dated 12/19/25, revised on 12/27/25 revealed Resident #95 was at increased risk for malnutrition due to diagnoses of Alzheimer's Disease, dementia, depression, depression medications and order for supplement. Interventions included administer medications as ordered, monitor, document, and report refusing to eat, monitor/record/report to physician as needed signs and symptoms of malnutrition to include significant weight loss. The care plan wasn't revised or individualized to include the weight loss.Review of the weights for Resident #95 revealed admission weight on 12/19/25 of 121.2 pounds (#), next weight taken on 01/05/26 of 117.8 #, next weight on 01/16/26 of 112.6 #, and last weight on 02/04/26 of 110 #. Weekly weights were not taken weekly the first four weeks of admission.Review of the admission minimum data set (MDS), dated [DATE] revealed Resident #95 had severely impaired cognition with a Brief Interview Mental Status (BIMS) score of three (3) out of fifteen (15) which indicated severe impaired cognition.Review of the Registered Dietician (RD) #293 note dated 01/19/26 a significant weight change of 8% in one month. RD #293 ordered to discontinue current supplement, Med Pass 6 oz with meals with new order for Med Pass 4 oz six (6) times a day and to monitor weights per physician order. Physician and Resident family representee were notified.Review of the physician orders for 01/19/26 revealed the Med Pass Supplement of 6 oz with meals was not discontinued until 01/30/26. The new order for Med Pass supplement 4 oz, 6 times a day and to monitor weights per physician order was ordered on 01/30/26, 11 days after RD #293 changed the med pass supplement orders. Review of the Medication Administration Records (MARS) for January 2026 revealed the order for Med Pass 4 oz, 6 times a day was put in on 01/30/26.Interview on 02/25/26 at 12:28 P.M. with Registered Dietician (RD) #293 confirmed weights were not taken as ordered to be on admission, weekly for four weeks and then when a significant change was identified should have been take weekly until stable. RD #293 unable to state why this didn't occur. RD #293 confirmed the order for the supplement change on 01/19/26 should have been changed to Med Pass 4 oz, six time a day but was unable to state why it occurred. RD #293 revealed she develops and revises nutrition care plans and confirmed Resident #95's care plan was not individualized or updated to reflect the weight loss. Interview on 02/26/26 at 8:44 A.M. with (RD) #293 and Regional Director of Operations (RDO) #289 confirmed weights are to be taken on admission and then weekly for four weeks. RD #293 and RDO #289 confirmed Resident #95's weights were not taken correctly, and the care plan was not updated to reflect the weight loss. RD #293 and RDO #289 confirmed the order to change the supplement on 01/19/26 was not ordered in the computer until 01/30/26. RD #293 and RDO #289 unable to provide a reason as to why this wasn't done. Interview on 03/02/26 at 10:15 A.M. with DON confirmed for Resident #95's order for Med Pass 4 oz, 6 times a day was not ordered on 01/19/26. DON unable to give a reason as to why. DON stated when she was checking orders she saw Resident #45's med pass wasn't ordered so she entered it on 01/30/26. DON confirmed weights are to be done on admission, then weekly for four weeks, and continue weekly for a significant weight change. DON confirmed Resident #95's weight wasn't monitored weekly and her care plan was not (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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	updated/revised with weight changes.Review of the facility policy, Weight Assessment and Intervention - Garden and Northwood Healthcare, revised 01/10/23, revealed nursing staff will measure resident weights on admission and then weekly for four weeks. If no weight concerns are noted at this point, weights will be measured monthly thereafter. Any weight change of 5% or more since last weight assessment will be retaken the next day for confirmation. The threshold for significant unplanned and undesired weight loss will be based on the following criteria, 1 month of 5% weight loss is significant. Care planning for weight loss or impaired nutrition will be multidisciplinary effort and individualized care plans shall address the identified causes of weight loss, goals for improvement and time frames and parameters for monitoring and reassessment. 2. Review of the medical record Resident #43, revealed an admission date of 12/27/25. Diagnoses included but not limited to cerebral Infarction, schizophrenia and psychoactive substance abuse.Review of the care plan dated 12/29/25 for Resident #43 revealed there was no care plan for the weight loss.Review of the admission minimum data set (MDS) dated [DATE] revealed Resident #43 had intact cognition. Review of the weights for Resident #43 revealed admission weight on 12/30/25 164 #, on 01/05/26 166 #, on 01/06/26 156 #, and on 02/04/26 154 #. Resident #42's weight was not taken at admission or weekly for four weeks upon admission.Review of the quarterly minimum data set (MDS) dated [DATE] revealed Resident #5 had intact cognition.Review of the RD #293 note dated 02/12/26 at 10:57 A.M. revealed Resident #43 had a significant weight change of 7% in one month. Intervention was to discontinue current rate and flush bolus 250 ml Jevity 1.5 with 185 ml six (6) times per day. Nutrition monitoring to continue and monitor weights per physician order and notifications to physician and resident done.Interview on 02/26/26 at 8:44 A.M. with RD #293 and RDO #289 confirmed weights were not taken as ordered to be on admission, weekly times for four weeks and then when a significant change was identified should have been take weekly until stable. RD #293 reported weights should have been taken on 12/27/25, admission weight, 01/03/26, 01/10/26 and 01/17/26. RD #293 was unable to state why this didn't occur. RD #293 confirmed a significant weight loss occurred. RD #293 reported weights should have been taken weekly with the weight loss. RD #293 confirmed there was no care plan to address the weight loss and was unable to give a reason why there was no care plan.Review of the facility policy, Weight Assessment and Intervention - Garden and Northwood Healthcare, revised 01/10/23, revealed nursing staff will measure resident weights on admission and then weekly for four weeks. If no weight concerns are noted at this point, weights will be measured monthly thereafter. Any weight change of 5% or more since last weight assessment will be retaken the next day for confirmation. The threshold for significant unplanned and undesired weight loss will be based on the following criteria, 1 month of 5% weight loss is significant. Care planning for weight loss or impaired nutrition will be multidisciplinary effort and individualized care plans shall address the identified causes of weight loss, goals for improvement and time frames and parameters for monitoring and reassessment.