

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365456	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/16/2026
NAME OF PROVIDER OR SUPPLIER  Circleville Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  1155 Atwater Avenue Circleville, OH 43113	
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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on personnel file review, staff interview, and facility policy review, this facility failed to provide a verbal abuse free environment for residents. This affected one resident (#75) of the one resident reviewed for abuse with the potential to affect all 71 residents who received care from Certified Nursing Aide (CNA) #114. The facility census was 90. Findings include: Review of the employee personnel record for Certified Nursing Aide (CNA) #114 revealed multiple corrective action forms including poor customer service, unprofessional behavior including being rude and negative towards residents and coworkers. Review of the Employee Counseling Form dated 09/30/2025 revealed CNA #114 failed to maintain respect for a resident. Review of the Employee Counseling Form dated 10/03/2025 revealed CNA #114 failed to maintain respect of a resident related to poor customer service. Review of a typed statement dated 01/14/2026 provided by Licensed Practical Nurse (LPN) #236 revealed, On 01/13/2026, I had to verbally educate CNA #114 on her tone of voice to a resident in the [NAME] dining room. Reminding her that this is the resident's home and we have to respect it and also if she needed to come talk to me she could do so in my office with the door shut due to residents and family members being around. Review of a typed statement dated 01/19/2026 provided by the Administrator revealed, I received complaints from employees that a resident on [NAME] Unit was upset with the care she was receiving from an CNA. I called into the facility and spoke with the resident (Resident #75) and asked her what was going on. Resident #75 shared that CNA #114 had been mean to her since the day she got here. Resident #75 said when she asked for help, CNA #114 said, If you can't learn to be patient, you will be moved to the bad hall and there are more residents there and it will take even longer for you to get help there. Review of a typed statement dated 01/19/2026 given by Unit Manager #184 revealed, I have personally witnessed CNA #114 displaying rude and unprofessional behavior towards both staff and residents in the last two weeks. CNA #114's conduct has been disrespectful and inappropriate. This staff member has been observed raising her voice in the hallways and discussing residents in a loud manner where others could overhear. For example, she made a statement indicating that a resident refused a shower and commented that the resident stinks and needs to shower. This behavior is not respectful and does not align with expected standards of professionalism or resident dignity. However, at times CNA #114 does provide appropriate care and can be a good caregiver. That being said, the manner in which she speaks at times is inappropriate and unprofessional. Her tone and choice of words do not align with expected standards of respectful communication towards residents and staff. Review of the written statement dated 01/19/2026 and created by LPN #342 revealed, Within the last week or two, I have witnessed CNA #114 being loud and rude to residents and staff on several occasions. Yelling in the halls and at the nurses station. Review of the Performance Improvement Plan (PIP) dated 01/22/2026 for CNA #114 revealed this PIP is being used due to ongoing concerns with poor customer service and unprofessional behavior toward residents and co-workers. These concerns have been observed and reported and are inconsistent with facility expectations, resident rights, and professional conduct standards. Examples include rude, dismissive and disrespectful tone to the residents and staff. Lack (continued on next page)</p>		

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:  365456	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/16/2026
NAME OF PROVIDER OR SUPPLIER  Circleville Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  1155 Atwater Avenue Circleville, OH 43113	
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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>of empathy and patience when providing resident care and unprofessional interactions with co-workers, yelling in the hall. Interview on 03/11/2026 at 9:39 A.M. with CNA #114 revealed she had received education multiple times by management staff related to proper customer service and that she had just completed a project improvement plan related to this same thing. Interview on 03/12/2026 at 1:30 P.M. with the Administrator revealed CNA #114 has worked at this facility for a while and everyone loves her. The Administrator revealed that on 03/24/2024 a Self-Reported Incident (SRI) was completed due to a resident reporting concern with her clothing and not getting a shower. On 09/30/2025 a resident reported that they felt CNA #114 was rushing care. On 10/03/2025 a resident claimed she was upset after CNA #114 was talking to her about her diet order. When asked what was said, the Administrator claimed she did not know. The Administrator claimed that she receives word that Resident #75 was upset over CNA #114, so she called and spoke with the resident later that evening and asked her if she felt like it was abuse and she said not but it was just poor customer services so that was why a SRI was not completed. Interview on 03/12/2026 at 2:21 P.M. with the Director of Nursing (DON) revealed CNA #114 used to work on a unit called Main Street but is no longer allowed to work this unit due to not being allowed to care for a resident who currently resides on that unit. The DON claims that she personally does not have issues with CNA #114 but other staff members do especially when they request this staff member to complete a task that she does not want to do; she will become rude and disrespectful. Review of the facility policy titled, Abuse, Neglect, exploitation or Misappropriation-Reporting and Investigation, dated 09/2022 revealed If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. The administrator or individual making the allegation immediately reports his or her suspicion to the following persons or agencies: The state licensing/certification agency responsible for surveying/licensing the facility. This deficiency represents non-compliance investigated under Complaint Number 2726246.</p>		