STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365612	A. Building B. Wing	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Acres Nursing Home	44565 Sunset Road Caldwell, OH 43724

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. (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

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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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, policy review, and facility investigation report review, the facility failed to ensure residents were free from verbal abuse. This affected two (#12 and #22) of six residents reviewed. The facility census was 89. Findings include:1.Record review revealed Resident #12 was admitted to the facility on [DATE] with diagnoses including malignant neoplasm of brain and unsteadiness on feet. Review of a care plan dated 07/03/25 revealed Resident #12 had behaviors including but not limited to demanding medications and becoming upset when pain medications are not due. Review of a minimum data set (MDS) completed 07/09/25 revealed Resident #12's cognition remained intact. Review of a self-reported incident (SRI) dated 07/21/25 revealed an employee (Certified Nursing Assistant (CNA) #178) entered Resident #12's room and initiated care but also engaged in conversation which upset the resident. Resident #12 reported she is upset by CNA #178 at least a dozen times and CNA #178 had been asked to leave and not come back. The employee was suspended pending investigation and the allegation was determined to be unsubstantiated after an investigation was completed and showed CNA #178 did not willfully intend to harm the resident. Review of a witness statement dated 07/21/25 by Resident #12 transcribed by the Administrator revealed CNA #178 had entered the resident's room several times for the purpose of arguing with her for no reason at least a dozen times. Resident #12 stated she asked CNA #178 to get out and never come back several times. Resident #12 stated she did not know why CNA #178 would do that because they don't know each other outside the facility but she thought CNA #178 enjoyed upsetting her. Resident #12 stated sometimes CNA #178 would enter the room to answer the call light and then start an argument on purpose which is upsetting but there had never been physical altercations. Review of a witness statement dated 07/21/25 by CNA #178 revealed she answered Resident #12's call light with another CNA, (#301), and Resident #12 wanted her medications which were not due until 4:00 P.M. CNA #178 stated she explained countless times Resident #12 could not have her medication and had told her a previous time when she was in the room with another CNA, (#305). CNA #178 reported Resident #12 raised her voice numerous times during those visits but denied wanting to make the resident mad or antagonizing her. CNA #178 stated she tried her best to calm the resident or leave the situation. Review of a witness statement dated 07/21/25 by Registered Nurse (RN) #138 revealed she was approached by CNA #103 to ask if she would get CNA #178 out of Resident #12's room because Resident #12 did not like her and had asked her to not come back to her room. RN #138 stated Resident #12 would get upset with CNA #178 which would cause her to be upset with CNA #103. RN #138 stated she asked CNA #178 to please go to the unit while she took care of Resident #12. Resident #12 reported CNA #178 had her so upset she was shaking. Resident #12 requested pain medications. Review of a witness statement dated 07/21/25 by CNA #301 revealed at 3:30 P.M., she and CNA #178 entered Resident #12's room to answer a call light, the resident asked for her medications and was told it was not time yet and CNA #178 stated the correct time for medications was 4:30 P.M. Resident #12 then got mad and stated it was ridiculous and she was in pain. CNA #178 stated there was nothing she could do, Resident #12 stated another nurse had passed medications early before, and CNA #178 responded at some point, well if your brain isn't working, don't you think you could have forgot? The nurse then entered the room and had both aides return to their hall. Review of a care plan dated 07/26/25 revealed Resident #12 was at risk for pain related to cancer, gout, chronic pain syndrome, and diabetic neuropathy. The goal was to maintain a daily routine and verbalize they are comfortable daily by target date. Interventions included but were not limited to administer pain medications as ordered and observe for effectiveness, observe and report any side effects; coordinate with therapy as needed to provide medications as ordered and as needed by resident to promote comfort and encourage participation with therapy; observe for episodes of breakthrough pain and medicate as ordered or contact physician as needed; offer additional non-pharmacologic interventions, dim lights, soft music, position changes, music, television, and conversations/distractions; and remind resident that reporting pain early may improve effectiveness of pain medication. Interview on 12/09/25 at 4:45 P.M. with the Administrator confirmed a witness statement stated Resident #12 was so upset she was shaking and one revealed Resident #12 was told her brain is broken. During the interview, the Administrator disagreed this was abuse because there were no negative outcomes and no intent to harm the resident. 2. Record review revealed Resident #22 was admitted to the facility on [DATE] with diagnoses including autosomal dominant limb girdle muscle dystrophy and weakness. Review of

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, policy review, and facility investigation report review, the facility failed to ensure allegations of abuse were thoroughly investigated. This affected one (#22) of two residents reviewed for abuse. The facility census was 89. Findings include:Record review revealed Resident #22 was admitted to the facility on [DATE] with diagnoses including autosomal dominant limb girdle muscle dystrophy and weakness. Review of an minimum data set (MDS) assessment dated [DATE] revealed Resident #22's cognition remained intact. Review of a self-reported incident (SRI) dated 09/19/25 revealed an allegation of verbal abuse from Dietary Coordinator (DC) #310 to Resident #22. Witnesses stated DC #310 cussed and yelled at Resident #22 after the resident cussed and insulted her about his missing lunch tray. After the exchange, DC #310 left the room and continued to cuss under her breath as she went up the hallway passing residents and staff. A thorough investigation was completed and the allegation of verbal abuse was unsubstantiated due to lack of willful intention to harm to Resident #22, however DC #310 was terminated for unprofessional behavior or conduct. Review of a witness statement dated 09/19/25 by DC #310 revealed she received a call stating Resident #22 did not get a tray, but she knew good and well he received a tray. DC #310 went to check the cart when Resident #22 called her into his room and yelled at her for always getting his tray wrong. DC #310 explained she did not get his tray wrong, but Resident #22 called her an expletive (f**king b*tch) and she told him to shut up. DC #310 stated she knew she should not have said that but she reached her boiling point. Review of a witness statement dated 09/19/25 by the Assistant Director of Nursing (ADON) #155 revealed she was standing in the dining area speaking with staff members during lunch time, witnessed DC #310 walk into the dining area stating she made the food Resident #22 requested and you guys need to find the f**king tray. DC #310 then walked into Resident #22's room and ADON #155 was not able to hear the entire conversation but did hear DC #310 use the word f*ck and the resident began screaming in response. DC #310 left the resident's room and walked back through the dining area stating I'm over this f**king place loud enough for family members and residents in the area to hear. Resident #22 continued screaming after DC #310 left his room so ADON #155 entered the room to ensure he was safe and to attempt therapeutic communication. Resident #22 stated nobody is going to come in here and talk to me like that calling me f**king stupid. ADON #155 did not hear DC #310 call Resident #22 stupid and only heard the profanity. Review of a witness statement dated 09/19/25 by certified nursing assistant (CNA) #224 revealed she was coming back to a resident room to fix food and DC #310 headed towards Resident #22's room, they began fighting and Resident #22 called DC #310 a f**king bitch then she said f*ck you to him. CNA #224 stated she was standing at Resident #22's door way then left to get another resident their food. Resident #22 would always complain his food was messed up. Review of a witness statement dated 09/19/25 by Licensed Practical Nurse (LPN) #177 revealed while passing medications, she heard yelling and saw DC #310 come out of a room yelling, f*ck this place, I'm over it. Review of a witness statement dated 09/19/25 by Resident #22 transcribed by the Administrator revealed the resident had no issues at lunch, did not need anything, and had no issues with DC #310. There was no evidence additional residents were interviewed regarding allegations of abuse despite staff statements indicating family and residents were in the dining area while DC #310 walked away cussing on 09/19/25 during the interaction with Resident #22. Interview on 12/09/25 at 3:51 P.M. with the Administrator revealed staff did witness DC #310 yelling and cussing in the facility and DC #310 admitted to telling Resident #22 to shut up but because there was no willful intention to abuse, it would not substantiated as an allegation of verbal abuse. The Administrator stated Resident #22 could not recall an incident or did not feel bothered enough to discuss it. The Administrator stated DC #310 was fired for unprofessionalism and misconduct. The Administrator confirmed no additional residents were interviewed because no additional residents were affected since the incident happened in Resident #22's room and in the hallway. Review of an undated policy titled Abuse, Mistreatment, Neglect, Injuries of Unknown Source, and Misappropriation of Resident Property revealed the facility will not tolerate abuse by anyone. Abuse is defined by the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Allegations of abuse should be investigated and the investigation should be completed within five working days which do not include weekends or legal holidays. The investigation should include interviewing the resident, the accused and all witnesses. Witnesses generally include anyone who witnessed or heard the incident; came