STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365615	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ayden Healthcare of Belle Springs.	221 North School Street Bellefontaine, OH 43311

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 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 review of the self-reported incident (SRI) investigation, review of the employee time sheets, staff interviews, and review of facility policy, the facility failed to ensure further potential abuse was prevented by removing an employee suspected of sexual abuse pending the outcome of the abuse investigation. The affected one resident (#57) of three reviewed for abuse. The facility census was 80. Findings include:Review of the medical record for Resident #57 revealed an admission date of 10/13/25. Diagnoses included respiratory failure, dysphagia, chronic obstructive pulmonary disease, muscle weakness and heart failure. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) of 15 indicating intact cognition and required substantial maximum assistance for toileting. The assessment stated the resident was continent of urine but always incontinent of bowel. Review of SRI #270483 dated 02/03/26 at 10:42 A.M. revealed Resident #57 reported CNA #64 touched his genitals during a morning check and change. He reported it happened in the past (unknown date) and reported he had not yet reported it but contacted the police to ask questions. The police informed him they were not familiar with facility policy, and he would need to check on the facility policy. Resident #57 reported the room was dark and CNA #64 did not turn on the light or state his intent to the resident before touching his genitals. Resident #57 also mentioned he had heard that a CNA had taken pictures of his genitals and shared them with someone outside the facility. The investigation found CNA #64 had last cared for Resident #57 on night shift on 01/08/26. The investigation did not mention if the staff member accused (CNA #64) was suspended or was off work during the course of the investigation or mention how the resident's safety was maintained during the course of the investigation. The investigation found that the incident was unsubstantiated. The intention of touching the incontinence wear was to complete a check and change and with the patient's own admission he stated that there was no groping, pulling or handling of his penis or genitals. Review of the timecard revealed Certified Nursing Aide (CNA) #64 worked on 02/03/26 from 6:55 A.M. to 6:58 P.M. The timecard made no indication he was suspended pending the outcome of the investigation. Interview on 05/21/26 at 1:00 P.M. with the Administrator #73 and Director of Nursing (DON) #93 confirmed they were informed of Resident #57's concern by staff who heard he had contacted the police. They reported they spoke with Resident #57 and he reported concerns related to CNA #64 coming in his room in the dark and without speaking with him, touched his genitals. He denied any groping behavior or motions occurred and relayed that it had occurred in the past but did not know a specific date. The Administrator and DON revealed CNA #64 was working in the facility at this time and he was brought to the administrator's office and interviewed and allowed to return to his assignment on a different hall where Resident #57 lived. They acknowledged the facility abuse policy stated if a staff member was accused, they shall be immediately removed from the facility. Review of facility policy titled Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property, dated 01/2026, revealed the facility shall investigate alleged violations of abuse and neglect in accordance with its policy and ensure all residents are free from retaliation. If a staff member was accused or suspected, the facility shall immediately remove that staff member from the facility and the schedule pending the outcome of the (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	investigation. The investigation shall include interviews with the resident, the accused individual and any witnesses. If no direct witnesses were identified interviews may be expanded to other employees or residents on that unit. The investigation should include documentation of all evidence, and a conclusion shall be reached by analyzing all evidence. This deficiency represents non-compliance investigated under Complaint Number 2983817.