STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365658	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cardinal Woods Skilled Nursing & Rehab Ctr	6831 Chapel Road Madison, OH 44057

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 - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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** 44461 Based on record review, review of the facility self-reported incident (SRI) and investigation, review of facility policy, observation and interview, the facility failed to ensure Resident #12 was free from physical abuse by Resident #40. Actual harm occurred on 03/16/25 when Resident #40, who had known verbal and physical aggressive behaviors towards others, punched Resident #12 in the face, head, and neck approximately 20 times resulting in facial and scalp contusions, headache and neck pain requiring evaluation and treatment in the hospital emergency room (ER). Resident #12 had X-rays, and a Computed Axial Tomography (CAT) scan performed while in the ER which indicated there were no broken bones. Resident #12 was diagnosed with physical assault, head, face, and neck contusions. Resident #12 returned to the facility on [DATE] with orders to see a concussion specialist on 03/26/25 at 2:30 P.M. This affected one resident (Resident #12) out of six residents reviewed for abuse. The facility census was 94. Findings include: 1. Review of the medical record for Resident #12 revealed an admitted [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease (COPD), adult failure to thrive, chronic pain syndrome, neurogenic bladder, anxiety disorder, type two diabetes mellitus, opioid abuse, viral hepatitis, hypertension, and quadriplegia. Review of Resident #12's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had intact cognition, required setup or clean up assistance for eating, and oral hygiene, required partial to moderate assistance for toileting hygiene and dressing, and required substantial to maximal assistance for showers, personal hygiene, and bed mobility. Resident #12 used a motorized wheelchair and required substantial to maximal assist for transfer into their wheelchair then were independent with wheelchair mobility. Review of the plan of care for Resident #12 dated 01/05/25 revealed Resident #12 was set up to dependent assist with their Activities of Daily Living (ADL), mobility and functions. Resident #12 utilized an electric wheelchair. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of Resident #12's progress notes revealed on 03/16/25 at 1:47 A.M. Resident #12 was physically assaulted by Resident #40 when Resident #40 punched Resident #12 approximately 20 times in the head, neck and face. The two residents were separated, and 911 emergency services were called to the facility. Resident #12 stated he wanted to press charges against Resident #40. Resident #12 was sent to the ER for further evaluation and treatment of apparent facial and scalp contusions and reported headache and neck pain. Review of the hospital records dated 03/16/25 revealed Resident #12 had X-rays, and a CAT scan performed which indicated there were no broken bones. Resident #12 was diagnosed with physical assault, head, face, and neck contusions. Resident #12 returned to the facility on [DATE] with orders to see a concussion specialist on 03/26/25 at 2:30 P.M. Review of the pain scales (zero being no pain to 10 being the most severe pain on a scale of zero to 10) in the medical record for Resident #12 from 03/16/25 and 03/17/24 revealed after the assault on 03/16/25 Resident #12 had intermittent pain scores ranging from six to 10 with relief achieved after use of ordered pain medication as evidenced by scores of zero after the administration of oxycodone (narcotic pain medication) five milligrams (mg) every eight hours. 2. Review of the medical record for Resident #40 revealed an admitted [DATE] with diagnoses including COPD, vascular dementia with behavioral disturbances and agitation, Post-Traumatic Stress Disorder (PTSD), anxiety, and impulse disorder. Resident #40 was sent to the hospital on 03/16/25 for a psychiatric evaluation and did not return to the facility. Review of the emergency discharge notice dated 03/24/25 revealed Resident #40 was discharged from the facility as of 03/16/25 due to the welfare and needs of the resident could not be met in the facility. Review of the admission documentation dated 01/29/25 revealed Resident #40 had transferred to the facility from out of state and had known behaviors including confusion, mood swings, drug and alcohol use, physically abusive and aggression, wanders mentally and physically, short- and long-term forgetfulness and has difficulty concentrating. Resident #40 had diagnoses of PTSD, vascular dementia with behavioral disturbances and agitation, anxiety and impulse disorder. Review of Resident #40's baseline care plan dated 01/31/25 revealed under the Social Services section that mental health needs was checked but there was no additional information related to what the mental health needs were for Resident #40. The section for behavior concerns was also checked but there was no additional information related to what the behavioral concerns were for Resident #40. For both sections, no identified interventions were documented. The baseline care plan was silent for any plan of care, triggers or interventions for Resident #40's diagnoses of PTSD, impulse disorder or dementia with behavioral disturbances and agitation. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of a progress note dated 02/05/25 at 2:36 A.M. revealed Resident #40 wanted to go smoke and when staff stated it was not time, he became aggressive and began yelling profanities and verbal threats to hurt staff. He was attempting to get to the nurse who told him it was not time for smoke break and additional nursing staff stood between the nurse and Resident #40 to protect the nurse. 911 emergency medical services (EMS) were called, and police arrived at the facility. The situation was explained to the police, and staff insisted the other residents and staff were not safe at the facility and Resident #40 needed to go to the hospital. Police then notified EMS they were needed to transport the resident to the ER for a psychiatric evaluation and treatment. The progress note dated 02/05/25 at 2:49 P.M. revealed Resident #40 returned to the facility with no new orders and was actively trying to exit the facility. Further review of progress notes indicated the resident calmed and was observed to be resting in bed at 6:11 P.M. Review of Resident #40's admission MDS 3.0 assessment dated [DATE] revealed the resident had impaired cognition, required supervision or touching assistance for showers and was independent with eating, oral hygiene, toileting hygiene, dressing, personal hygiene, bed mobility and walking. The behaviors noted on this MDS included physical behaviors including hitting, kicking, pushing, scratching, grabbing marked as behaviors occurring one to three days, verbal behaviors directed towards others including threatening others, screaming at others, cursing at others marked as behavior occurring one to three days, other behavioral symptoms not directed towards others including physical symptoms such as hitting or scratching self, pacing, rummaging, verbal/vocal symptoms like screaming or disruptive sounds and rejection of care occurring one to three days. Review of Resident #40's comprehensive care plan, date initiated 02/13/25, revealed Resident #40 had fluctuating behaviors related to affects of alcohol dependence, dementia, PTSD and impulse disorder. Resident #40 displayed both verbal and physical aggression towards staff and disrupted his environment. Interventions included administer medication as ordered and monitor for side effects, anticipate and meet needs as much as possible, assist to develop more appropriate methods of coping and interacting, caregivers to provide positive interaction by stopping to talk to him when passing by, explain all procedure before starting and allow time to adjust, discuss behavior and explain why inappropriate, intervene to protect the rights and safety of others by approach and speak in a calm manner, divert attention, remove from situation and take to alternate location, monitor behavior episodes and attempt to determine underlying cause. On 03/16/25 an additional intervention was added to include place resident on one-to-one during episodes of increased pacing and aggressive behaviors. Review of Resident #40's physician orders dated March 2025 revealed orders for Duloxetine 30 mg (selective serotonin and norepinephrine reuptake inhibitor) daily for depression, Chlorpromazine 25 mg (give three tablets to equal 75 mg) (antipsychotic) three times a day for impulse disorder, Propranolol 10 mg (beta blocker to treat high blood pressure) every 12 hours as needed for anxiety, Haloperidol 2 mg (antipsychotic) every eight hours as needed for anxiety/agitation, and Buspirone 15 mg (anxiolytic to treat anxiety) every 12 hours for anxiety. Review of progress notes for Resident #40 dated 03/16/25 revealed no documentation of the assault involving Resident #40 and Resident #12, however, there was a progress note entry on 03/16/25 at 4:01 P. M. stating the social worker from the hospital reached out to the facility and notified them Resident #40 was being transferred to Ohio Hospital for Psychiatry in Columbus. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the facility SRI and investigation dated 03/16/25 revealed the facility substantiated that resident-to-resident abuse had occurred with Resident #40 being listed as the perpetrator and Resident #12 the victim. Resident #40 made contact with his hand/fist to Resident #12's face and head. Resident #12 was transferred to a hospital ER for evaluation and treatment of apparent facial and scalp contusion and reported neck pain and headache. Resident #40 was transferred to an intensive psychiatric facility. Review of the witness statement dated 03/16/25 and authored by Certified Nurse Aide (CNA) #811 revealed CNA #811 was sitting at the nurses' station next to Resident #12. Resident #40 approached and asked for a sleeping pill. CNA #811 told Resident #40 she was just an aid so he would have to go back to his own unit and ask the nurse. Resident #12 stated yeah bud your nurse can help you. Resident #40 looked and pointed at Resident #12 then walked up to him and started punching him with a closed fist in his head. CNA #811 tried to intervene but could not get Resident #40 to stop hitting Resident #12. A nurse (not identified) came from a room and was able to get Resident #40 to stop. Review of the incident report dated 03/16/25 and authored by Licensed Practical Nurse (LPN) #808 revealed LPN #808 walked out of a resident room to find Resident #40 hitting Resident #12 with a closed fist and wrote he must have hit him at least 20 times. The residents were separated, and 911 EMS was called to the facility. Resident #12 had injuries to his scalp, right ear and face. Resident #12 indicated he wanted to press charges against Resident #40. Resident #40 was sent to the hospital. An interview with the Administrator and LPN #799 on 03/24/25 at 10:45 A.M. revealed Resident #40 was in the hospital and would not be returning to the facility due to his behaviors. They both confirmed Resident #40 assaulted Resident #12 on 03/16/25 causing facial and scalp contusions and reported headache and neck pain. They confirmed Resident #12 required an ER visit and follow up with a concussion specialist. Interviews were attempted with the responsible party for Resident #40 on 03/24/25 at 2:45 P.M. and 03/27/25 at 11:00 A.M. but no return contact was made. An interview on 03/24/25 at 10:45 A.M. with LPN #801 and LPN #802 revealed they were informed Resident #40 punched Resident #12 in the head, neck, and face approximately 20 times causing swelling and bruising and a possible concussion. They stated this was not the first time Resident #40 had been physically aggressive. They stated Resident #40 would become verbally and physically aggressive with staff. An interview on 03/26/25 at 12:55 P.M. with LPN #803 revealed Resident #40 was not appropriately placed in the facility and needed a facility that was better suited to handle his behaviors. Interviews on 03/26/25 at 2:15 P.M. with CNA #804 and CNA #806 revealed they were afraid of Resident #40 due to his aggressive behavior and verified he had a history of aggressive behaviors prior to the incident involving Resident #12. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	An interview on 03/27/25 at 11:39 A.M. with LPN #808 revealed they were working the night Resident #40 assaulted Resident #12. LPN #808 stated Resident #40 punched Resident #12 approximately 20 times in the head, neck and face. The two residents were separated and 911 was called. LPN #808 stated she notified the physician and responsible party for Resident #40. They stated Resident #12 was alert and oriented to person, place, time, and situation. LPN #808 stated Resident #12 was their own responsible party. Resident #12 stated to the nurse he wanted to press charges against Resident #40. Resident #12 was sent to the ER for further evaluation and treatment of apparent facial and scalp contusions and reported headache and neck pain. LPN #808 stated she was afraid of Resident #40, and this was not his first incident of physical aggression. An interview on 03/27/25 at 12:35 P.M. with the facility Psychiatric Nurse Practitioner (PNP) revealed she was aware Resident #40 was sent to theER on [DATE] due to a confrontation with another resident. The PNP verified Resident #40 punched Resident #12 approximately 20 times and required a discharge to a psychiatric hospital. When asked if she felt Resident #40's behaviors were well managed at the facility, the PNP stated it was hard to answer due to the situation that occurred on 03/16/25. Interview on 03/27/25 at 2:55 P.M. with LPN #805 and Registered Nurse (RN) #807 revealed Resident #40 assaulted Resident #12 causing visible bruising and swelling to his head, neck, and face. They stated Resident #12 had to go to the emergency room where he had X-rays and a CAT scan done which showed no broken bones, but he had to follow up with a concussion specialist. Observation was conducted and interviews attempted with Resident #12 on 03/24/25 at 12:38 P.M, 03/25/24 at 11:00 A.M. and on 03/27/25 at 2:35 P.M. who was alert and up in his motorized wheelchair. He had slight yellow bruising to his face. He demonstrated no signs of pain. During attempts to interview him, Resident #12 would start to drive off while yelling he contacted the police and they will handle it! An interview was conducted on 03/31/25 at 11:52 A.M. with Police Department Employee (PDE) #919 to try to obtain a copy of the police report related to the abuse incident on 03/16/25 involving Resident #12. PDE #919 stated they were unable to supply the police report associated with Resident #40 assaulting Resident #12 because it was an open investigation with Resident #12 wanting to press charges against Resident #40. Review of the facility policy titled Abuse and Neglect Clinical Protocol, date revised 03/2018, revealed abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. The policy stated facility management and staff will institute measures to address the needs of residents and minimize the possibility of abuse, and address appropriate causes of problematic resident behaviors. This deficiency represents non-compliance investigated under Complaint Number OH00163841 and OH00163683.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44461 Based on resident and staff interviews, record review, and review of the facility Self Reported Incident (SRI) and investigation, the facility failed to ensure the misappropriation of narcotic pain medication did not occur for Resident #80. This affected one resident (Resident #80) out of six residents reviewed for misappropriation. The facility census was 94. Findings include: Review of the medical record for Resident #80 revealed an admitted [DATE] with diagnoses including rheumatoid arthritis, chronic pain syndrome, peripheral vascular disease, history of morbid obesity, rheumatoid arthritis, and gout. Review of Resident #80's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had intact cognition. They required setup or clean up assistance with eating and were independent with all other Activities of Daily Living (ADLs) including toileting hygiene, showers, dressing, personal hygiene, bed mobility and transfers. Review of Resident #80's care plan dated 03/07/25 revealed Resident #80 had chronic pain related to peripheral vascular disease, history of morbid obesity, rheumatoid arthritis, and gout. Goals and interventions included the resident would voice that adequate comfort and pain control was maintained daily, staff would administer pain medications per physician orders, encourage activity and movement within tolerance, monitor, document side effects of pain medications, observe for constipation, new onset or increased agitation, restlessness, confusion, hallucinations, dysphoria, nausea, vomiting, dizziness and falls. Staff to report any findings to the physician. Staff were to offer comfort measures every shift and as needed. Review of Resident #80's physician orders dated February 2025, revealed the resident was ordered Tylenol 650 milligrams (mg) every six hours for pain as needed, Baclofen 10 mg every 12 hours as needed for muscle pain, and Oxycodone (a narcotic pain medication) 5-325 mg every eight hours as needed for severe pain rated a seven or higher on the numerical pain scale. Review of Resident #80 Medication Administration Record (MAR) dated February 2025 revealed the resident received a dose of Oxycodone 5-325 mg on 02/11/25 at 6:00 P.M., 02/12/25 at 1:00 A.M., and on 02/12/25 at 6:20 A.M. administered by Licensed Practical Nurse (LPN) #797. There were no administrations of Tylenol documented for these dates. Review of the facility SRI dated 02/12/25 for misappropriation revealed Resident #80 accused LPN #797 of stealing remaining doses of Oxycodone 5-325 mg. The previous facility Administrator completed the investigation and unsubstantiated the allegation of misappropriation. After review of the investigation, it was determined that misappropriation occurred. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the SRI investigation revealed a witness statement provided by LPN #797. LPN #797 stated he started his medication pass as usual with residents lined up at this cart. Resident #80 was at the cart and was medicated with his normal medications and a pain medication except his sleeping pill, which he usually requested around 10:00 P.M. to 10:30 P.M LPN #797 stated the resident was at his medication cart and witnessed him pull the medications and were given at this time. LPN #797 stated he completed his medication pass at approximately 9:30 P.M. to 9:45 P.M Resident #80 next came to the nurse's station and asked for his sleeping pill, which again the resident was present and witnessed the nurse pull the medication. LPN #797 stated he then was approached by Resident #80 around 6:00 A.M. to 6:15 A.M. on 02/12/25 asking for another pain pill which was the Oxycodone 5-325 mg. LPN #797 stated the resident was present when medications were pulled from the cart. LPN #797 stated he did tell Resident #80 this was his last pill in the card, and he was worried about this. LPN #797 stated he would re-order the medication. LPN #797 then pulled the empty card out of the cart, ripped off the top of the card, wrote down the prescription number, pulled the narcotic count sheet, and threw the card in the shred box. LPN #797 stated he placed the narcotic count sheet aside. LPN #797 stated the resident still seemed worried about not having his medication and explained it would be ok due to the fact they could call the pharmacy and get authorization to pull doses from the starter box if needed. LPN #797 stated he spoke with the other nurse on duty about Resident #80 not having any Oxycodone left, and the other nurse stated, didn't you order that last week?, LPN #797 stated yes, but it was not delivered yet. LPN #797 sent in an addendum to his original witness statement saying Resident #80 was up and about around 12:00 A.M. after his guest left and wanted medicated. LPN #797 thought this was odd because the lady guest was there late which she also seen him at the cart when she was leaving. Review of the witness statement provided by Resident #80's female guest revealed she visited with Resident #80 every evening at the facility and on 02/11/25 she visited from 8:00 P.M. to 11:30 P.M. and LPN #797 did not offer Resident #80 any medication. Review of the witness statement provided by LPN #815 revealed Resident #80 approached the nurse asking to call the pharmacy for authorization to pull Oxycodone because he was out and his nurse would pull it. When LPN #815 called the pharmacy they stated the Resident should have enough pills for the day, which would have been three pills and his next card was not due to be sent to the facility until 02/14/25. The resident stated to the nurse that he only asked for one Oxycodone during the 7:00 P.M. to 7:30 A.M. shift on 02/11/25. LPN #815 stated she saw the medication was signed out by LPN #797 three times, and Resident #80 stated he was given Tylenol instead of Oxycodone. LPN #815 looked for the narcotic count sheet and empty card, and neither could be located. The card was signed out of the cart as empty on 02/11/25 by LPN #797. Review of the witness statement provided by Registered Nurse (RN) #813 who relieved LPN #797 on 02/12/25 at 7:00 A.M. revealed she came in for her shift and spoke with LPN #797 who gave a hurried report, and appeared anxious to get out. Before they counted the narcotics LPN #797 stated Resident #80 was out of Oxycodone, it still had not come in from the pharmacy and LPN #797 stated he had to pull a dose from the starter box during the night shift. Review of the facility fax to the pharmacy revealed on 02/13/25 the facility contacted the pharmacy for authorization to pull three tablets of Oxycodone form the starter box for Resident #80. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Shift Change Controlled Substance Inventory Count Sheet dated 02/09/25 to 02/12/25 revealed on 02/12/25 at 7:00 A.M. LPN #797 removed Resident #80's Oxycodone card and narcotic count sheet indicating they were empty. Interview on 03/26/25 at 2:49 P.M. with RN #813 revealed LPN #797 was in a hurry to leave on 02/12/25 and rushed through report, they counted the narcotics and count was correct. RN #813 stated before they counted the narcotics, LPN #797 pointed out Resident #80 was out of Oxycodone, and it had not come in from the pharmacy yet. RN #813 stated LPN #797 told her they had to pull a dose for the starter box during the night. Interview on 03/26/25 at 3:45 P.M. with Resident #80 revealed on 02/11/25 at approximately 10:15 P.M. he asked LPN #797 for his Oxycodone 5-325 mg pain medication and a sleeping pill. Resident #80 stated he received one pain medication and his sleeping pill. The resident stated he then went to sleep and slept until 6:00 A.M. on 02/12/25. He stated at 6:15 A.M. he asked LPN #797 for a pain pill and LPN #797 gave him a medication cup with two white tablets in them and then LPN #797 stated to him I threw a Baclofen in for you. Resident #80 stated he was surprised as he does not ask for Baclofen at that time. Resident #80 stated he knows what Tylenol looks like and stated the nurse gave him two Tylenol and not his Oxycodone as requested. Resident #80 stated he knew how he felt when he takes his Oxycodone, and he knows he did not get it as he did not have any pain relief. Resident #80 stated LPN #797 told him he was running out of his Oxycodone, Resident #80 stated he asked LPN #797 how many pills he had left, and LPN #797 stated he had two pills left. On 02/12/25 Resident #80 stated he asked Registered Nurse (RN) #813 for an Oxycodone and she replied, he did not have any left. Resident #80 stated he then went to go find the Director of Nursing (DON) to report the missing medications. Resident #80 stated he did not ask for or receive a dose of his Oxycodone at 6:00 P.M. on 02/11/25. Resident #80 stated he knows when his medications were given and knows he can only have his Oxycodone every eight hours, and it was not due at that time. Resident #80 stated he did not ask for a dose of Oxycodone at 12:00 A.M. either due to having it at 10:15 P.M. and it was not due to be taken. Interview on 03/27/25 at 12:15 P.M. with LPN #815 revealed Resident #80 approached her regarding his Oxycodone and wanted her to call the pharmacy for authorization to pull a dose of his medication from the starter box due to not having any at the facility. When LPN #815 called the pharmacy they stated the Resident should have enough pills for the day, which would have been three pills, and his next card was not due to be sent to the facility until 02/14/25. The resident stated to the nurse that he only asked for one Oxycodone during the 7:00 P.M. to 7:30 A.M. shift on 02/11/25. LPN #815 stated she saw the medication was signed out by LPN #797 three times, and Resident #80 stated he was given Tylenol instead of Oxycodone. LPN #815 looked for the narcotic count sheet and empty card, and neither could be located. The card was signed out of the cart as empty on 02/11/25 by LPN #797. Interview on 03/27/25 at 1:48 P.M. with the Regional Director of Clinical Operations (RDCO) revealed they had to replace three Oxycodone 5/325 mg tablets for Resident #80 due to LPN #797 stealing them. They stated LPN #797 denied stealing the medication when asked, however through investigation it was discovered there were three tablets unaccounted for, the narcotic count sheet was missing and was unable to be found. The RDCO stated there was an ongoing investigation with the Ohio Board of Nursing, Attorney General's Office, the Bureau of Regulatory Operations, and local Police Department. The RDCO stated the previous Administrator completed the SRI without the help or guidance of the Corporate team and unsubstantiated the SRI but should have Substantiated the allegation of Misappropriation. The RDCO stated Resident #80 did not miss a dose of their pain medication due to the facility replacing the three missing doses at no cost to the resident. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was not able to be conducted with LPN #797, as he no longer worked at the facility. Review of the undated facility policy titled Resident Right to Freedom of Abuse, Neglect, and Exploitation Policy and Procedure revealed the facility explicitly and expressly prohibits and will take steps to prevent, any associates from engaging in any behavior or actions that may result in the abuse, neglect, and exploitation of residents and misappropriation of resident's property. This deficiency represents non-compliance identified during investigation of Complaint Number OH00163841 and OH00163683.

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	365658	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cardinal Woods Skilled Nursing & Rehab Ctr	6831 Chapel Road Madison, OH 44057

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44461 Based on interviews and record reviews, the facility failed to develop and implement a baseline care plan that included instructions needed to provide effective and person-centered care for Resident #40. This affected one resident (Resident #40) out of six residents revealed for care plans. The facility census was 94. Findings include: Review of the Resident #40's medical record revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), vascular dementia with behavioral disturbances and agitation, Post-Traumatic Stress Disorder (PTSD), anxiety, and impulse disorder. Resident #40 was discharged to the hospital on 03/16/25 and did not return to the facility. Review of the admission documentation dated 01/29/25 revealed Resident #40 had transferred to the facility from out of state and had known behaviors including confusion, mood swings, drug and alcohol use, physically abusive and aggression, wanders mentally and physically, short- and long-term forgetfulness and has difficulty concentrating. Resident #40 had diagnoses of PTSD, vascular dementia with behavioral disturbances and agitation, anxiety and impulse disorder. Review of Resident #40's baseline care plan dated 01/31/25 revealed under the Social Services section that mental health needs was checked but there was no additional information related to what the mental health needs were for Resident #40. The section for behavior concerns was also checked but there was no additional information related to what the behavioral concerns were for Resident #40. For both sections, no identified interventions were documented. The baseline care plan was silent for any plan of care, triggers or interventions for Resident #40's diagnoses of PTSD, impulse disorder or dementia with behavioral disturbances and agitation. Review of a progress note dated 02/05/25 at 2:36 A.M. revealed Resident #40 wanted to go smoke and when staff stated it was not time, he became aggressive and began yelling profanities and verbal threats to hurt staff. He was attempting to get to the nurse who told him it was not time for smoke break and additional nursing staff stood between the nurse and Resident #40 to protect the nurse. 911 emergency medical services (EMS) were called, and police arrived at the facility. The situation was explained to the police, and staff insisted the other residents and staff were not safe at the facility and Resident #40 needed to go to the hospital. Police then notified EMS they were needed to transport the resident to the ER for a psychiatric evaluation and treatment. The progress note dated 02/05/25 at 2:49 P.M. revealed Resident #40 returned to the facility with no new orders and was actively trying to exit the facility. Further review of progress notes indicated the resident calmed and was observed to be resting in bed at 6:11 P.M. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #40's admission MDS 3.0 assessment dated [DATE] revealed the resident had impaired cognition, required supervision or touching assistance for showers and was independent with eating, oral hygiene, toileting hygiene, dressing, personal hygiene, bed mobility and walking. The behaviors noted on this MDS included physical behaviors including hitting, kicking, pushing, scratching, grabbing marked as behaviors occurring one to three days, verbal behaviors directed towards others including threatening others, screaming at others, cursing at others marked as behavior occurring one to three days, other behavioral symptoms not directed towards others including physical symptoms such as hitting or scratching self, pacing, rummaging, verbal/vocal symptoms like screaming or disruptive sounds and rejection of care occurring one to three days. An interview on 03/24/25 at 10:45 A.M. with Licensed Practical Nurse (LPN) #801 and LPN #802 revealed baseline care plans were to be completed on the first day of admission. LPN #801 and #802 both revealed Resident #40 was verbally and physically aggressive. An interview on 03/26/25 at 12:55 P.M. with LPN #803 revealed Resident #40 was not appropriately placed in the facility and needed a facility that was better suited to handle his behaviors. LPN #803 verified a baseline care plan should have been completed for Resident #40 on his date of admission to the facility. LPN #803 confirmed Resident #40's baseline care plan was dated 01/31/25 and was not filled out appropriately to include information under the Social Services section to direct staff about Resident #40's mental health needs, and behavior concerns. LPN #803 stated there should have been information including diagnosis, goals and behavior interventions listed. Review of the facility policy titled Care Plans-Baseline, last revised March 2022, revealed the baseline care plan was to include instructions needed to provide effective, person-centered care of the resident which meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident including, but not limited to the following: A. initial goals based on admission orders and discussion with the resident/representative, B. physician orders, C. Dietary orders, D. therapy services, E. Social Services; and F. PASARR recommendations if applicable. This deficiency represents non-compliance investigated under Complaint Number OH00163841.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44461 Based on observation, medical record review, review of the hospital records, review of the fall incident, facility policy review and family, staff and resident interview, the facility failed to ensure the physician was notified immediately of an unwitnessed fall with injury, and failed to timely update the physician on increased, severe pain and delay transferring the resident in and out of bed until further orders from the physician were obtained to prevent further injury and pain for Resident #57. Actual harm occurred beginning on 02/21/25 when Resident #57, who was severely cognitively impaired had an unwitnessed fall in his room with evidence of left foot rotation and increasing complaints of pain in his hips without timely and adequate treatment. The resident subsequently developed severe hip pain after being repeatedly transferred in and out of bed without obtaining orders from the physician throughout 02/21/25 and 02/22/25 with the resident yelling out, it hurts at the top while pointing to his bilateral hip area. The resident was also noted to have a problem bearing weight and had a decline in his ability to transfer from one person assistance to three-person assistance. On 02/22/25 at 2:44 P.M. Resident #57 was transported to the hospital emergency room (ER) per order by Physician #814 due to increased pain and difficulty with transfers where he was diagnosed with an acute displaced femoral neck fracture. Resident #57 had to be transferred from the ER to another hospital able to complete a left hip hemiarthroplasty surgery. Resident #57 was readmitted to the facility on [DATE] with orders for physical therapy, narcotic pain medication and treatments to the surgical incision. This affected one resident (#57) of six residents reviewed for pain/quality of care and treatment. The facility census was 94. Findings include: Review of the medical record for Resident #57 revealed an initial admitted [DATE] with diagnoses including chronic kidney disease, muscle wasting and atrophy, Alzheimer dementia, and type two diabetes mellitus. Resident #57 was discharged to a hospital on 02/22/25 after a fall incident occurring on 02/21/25 and readmitted to the facility on [DATE] with new diagnoses including displaced fracture of left femur and presence of left artificial hip joint. Review of the facility document titled Clinical Admission, dated 01/24/25 revealed Resident #57 was admitted from another facility, was alert to person with confusion, disorganized thinking and short-term memory loss. The resident had no pain upon admission, no functional limitations to his upper or lower extremities and used a walker and manual wheelchair for mobility devices. Review of the facility document titled Fall Risk Evaluation, dated 01/24/25, revealed the resident had no falls in the last three months. A predisposing factor to fall risk was that the resident had been hospitalized within the last 30 days. The fall risk score was two out of 10. Review of Resident #57's five-day admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had severely impaired cognition and required one-person physical assistance for bed mobility, toileting hygiene and transfers. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #57's care plan, initiated on 01/24/25 revealed the resident had a high fall risk related to poor safety awareness due to dementia, unsteady gait and use of psychotropic medications. Goals included Resident #57 would be at a reduced risk for injury related to fall risk. Interventions included keep frequently used items in reach at bed side, maintain call light within reach at all times, monitor for acute signs and symptoms of infection or pain which may precipitate a fall, monitor for potential hazards such as untied shoes, spills on the floor, clutter and correct situation, monitor for signs of adverse effects of medication and notify physician, observe for decrease or loss of functional status and notify physician and observe for gait unsteadiness and intervene as necessary. Review of a physician's order dated 01/24/25 revealed an order for acetaminophen (non-narcotic pain medication) 325 milligram give two tablets by mouth every six hours as needed for pain and monitor for pain every shift. Further review of the care plan, initiated on 02/05/25 revealed Resident #57 had potential for pain related to age and diabetes. Goals included the resident would not have an interruption in normal activities due to pain. Interventions included administer analgesics per physician orders, anticipate needs for pain relief and respond immediately to any complaint of pain, encourage the resident to report pain, monitor/record/report to nurse any complaints of pain, notify physician if current interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain. Review of the progress notes for Resident #57 dated 01/24/25 through 02/09/25 revealed he had no indication of pain. There was no progress note entries documented for the date range of 02/11/25 to 02/20/25. Review of the February 2025 Medication Administration Record (MAR) revealed Resident #57 had no complaints of any pain from 02/01/25 through 02/20/25. Review of a facility document titled Fall, dated 02/21/25 at 12:00 A.M. and authored by Licensed Practical Nurse (LPN) #798 revealed an incident description including that a nurse aid informed the nurse she had seen Resident #57 by his counter trying to pull himself up. She did not witness him on the floor but treated it like a fall considering it was unwitnessed. The resident was in his chair sitting with both feet on the floor when the nurse entered the room. The resident stated he was alright and stated I fell . Immediate action taken was the nurse assessed vital signs and skin. A small skin tear was noted on the left elbow. When the nurse and aid asked the resident to stand the resident showed signs of pain and discomfort on his left side. The nurse assessed the left leg and noticed that while the resident was standing his left foot would go outward. The aid stated that was not normal for him. The resident's mental status was oriented to person and place. The physician was notified at 4:26 A.M., family was notified at 4:27 A.M. The document stated the Director of Nursing (DON) was notified but no time was noted. Review of the vitals and pain note dated 02/21/25 at 4:28 A.M. and authored by LPN #798 revealed Resident #57 was having aching pain in his left elbow and grimacing when he stood up. As needed, medication was administered. There were no details in the note regarding the fall incident. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of a physician's order dated 02/21/25 at 8:00 A.M. revealed an order for an x-ray of the left femur due to complaint of pain after unwitnessed fall which was entered into the electronic medical record by LPN #798. Review of the x-ray report dated 02/21/25 and electronically signed at 10:04 A.M. by the interpreting physician revealed there was no acute visualized fracture of the left femur. Review of a nursing note dated 02/21/25 at 2:58 P.M. revealed the resident continued on neurological checks due to status post fall. The neurological checks were within normal limits for him. An x-ray completed showed no acute fracture visualized femur and was sent to the doctor with no new orders. The resident was able to sit up in his wheelchair. Tylenol was given with good effects for signs of pain. Spoke with son in New Mexico for update after x-rays. Review of a late entry nursing note with an effective date of 02/16/25 at 9:52 P.M. (this date is incorrect, as the fall occurred on 02/21/25) and created date of 02/23/25 at 10:14 P.M. and authored by LPN #808 revealed the resident complained of pain to his left hip when rolling resident to change him. X-ray was done today of femur per MDS but no hip x-ray was obtained. Left foot was turned out. Left hip x-ray was ordered at 7:00 P.M. with no ETA (estimated time of arrival). Another nurse (not identified) came and assessed the resident also, at this time, DON was called and did not want the resident sent out. Wanted a pain eval done (8) and wanted to give resident Tylenol. The resident was not transferred to the hospital for additional evaluation/care at this time. Review of a physician's order dated 02/21/25 at 7:45 P.M. revealed an order for a left hip x-ray due to pain after a fall. Review of a vitals and pain note entry dated 02/21/25 at 8:51 P.M. revealed Resident #57 was having severe pain (rated) of eight (on a scale of 1 to 10) in the left hip which worsened with any movement. The pain was constant and non-medication intervention did not provide relief. Scheduled medication was provided. Review of an orders administration note dated 02/22/25 at 8:40 A.M. and authored by LPN #809 revealed acetaminophen 325 mg two tablets given for pain. Resident had visual signs and symptoms of pain. He was guarding his left hip area and had a noted decrease in range of motion related to transferring into his wheelchair. Does have left hip x-ray scheduled to be completed today. Review of an orders administration note and nurse's note dated 02/22/25 at 9:40 A.M. and authored by LPN #809 revealed the acetaminophen was effective and the pain was now at a zero and resident showing no signs of pain. He was having problems transferring and weight bearing. Three staff were needed for transfers this morning. He ate his meals with good intake and fed himself with set-up. Care was ongoing. Review of a nursing note dated 02/22/25 at 10:48 A.M. and authored by LPN #809 revealed the resident was transferred back to bed with three staff assisting and he was yelling out in pain with the transfer it hurts at the top and pointing to his bilateral hip area. The nurse called ALL STAT X-ray Services who revealed this resident was on the schedule today for a left hip/pelvis x-ray but unable to give an estimated time of arrival. Call was placed to Physician #814 for further instruction as resident requested to go to the hospital. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of a nursing note dated 02/22/25 at 1:12 P.M. and authored by LPN #809 revealed Physician #814 called back with new orders to send Resident #57 out to the ER. The resident had become non-weight bearing at this time and required three staff assistance for transfer. He had been medicated for his pain complaints per orders. Staff was laying him down after each meal this day to assist with pressure relief and pain control. Son was updated and notified of transfer. The ambulance service was called and will be at the facility approximately 2:00 P.M. Review of a nursing note dated 02/22/25 at 2:25 P.M. authored by LPN #809 revealed the resident had bilateral lower leg pitting edema times two and remains with pain and discomfort to hip area. Ambulance transport called with an arrival time of five minutes for transfer to ER. Review of a nursing note dated 02/22/25 at 2:44 P.M. authored by LPN #809 revealed Emergency Medical Services (EMS) arrived at the facility. LPN #809 and three paramedics lifted Resident #57 onto the gurney. Prior to leaving the resident room, the paramedics started an IV (intravenous line) and administered a dose of Fentanyl (narcotic used to treat pain) pain medication and completed an EKG (electrocardiogram test that measures heart activity) due to the severe pain of the resident. Review of hospital documentation dated 02/22/25 through 02/26/25 revealed the resident was diagnosed with an acute impacted femoral neck fracture with impaction and cephalad (toward the head/anterior) displacement of 1.2 centimeters after sustaining a fall at the facility. The operative note dated 02/24/25 listed the pre-operative diagnosis as closed the left displaced femoral neck fracture. Resident #57 was placed under general anesthesia and a left hip hemiarthroplasty was performed. The surgeon noted the resident tolerated the procedure well and was stable. An interview was conducted on 03/19/25 at 2:30 P.M. with Resident #57's son who reported the facility called to tell him Resident #57 fell at the facility. The son said his dad was sent to the hospital two days later and at the hospital he was diagnosed with a hip fracture and needed hip surgery. Interview on 03/24/25 at 10:45 A.M. with LPN #802 revealed they cared for Resident #57 on 02/21/25 from 7:00 A.M. to 7:30 P.M. and stated the resident's pain related to the fall was being treated with Tylenol. LPN #802 stated the resident would cry out anytime they had to move him with transfers or in bed to provide incontinence care. LPN #802 stated prior to the fall on 02/21/25 at 12:00 A.M. the resident required assist by one staff member for transfers to the wheelchair or bed. However, after the fall the resident was requiring maximal assistance by three to four staff members with a notable deformity of position on the left foot and when standing it would turn outward. LPN #802 stated it became more and more difficult to transfer the resident throughout the day until he was non-weight bearing on his left lower extremity. LPN #802 did not say why they continued to transfer the resident having pain with an outward turn of the left foot position. Interview on 03/26/25 at 2:15 P.M. with Certified Nursing Assistant (CNA) #806 revealed Resident #57 had complaints of left leg pain when transferring on 02/22/25 from his wheelchair to his bed. CNA #806 stated he screamed in pain with transfers, so they requested assistance by two additional staff members to get him in the bed. CNA #806 stated prior to the fall the resident was a minimal assist by one staff member for transfers to the wheelchair or the bed. CNA #806 stated they felt Resident #57's pain was not ceasing and should have been sent to the hospital sooner than he was. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Interview on 03/27/25 at 11:26 A.M. with Resident #57 revealed when asked if he knew where he was, he stated no. When asked if he remembered falling, he stated yes and he was unsure what happened but his leg hurt after the fall. When asked what he was trying to do at the time of fall he stated, I do not know, I think I just fell over. Resident #57 did not show any verbal or nonverbal signs of pain during the interview. Interview on 03/27/25 at 11:39 A.M. with LPN #808 confirmed Resident #57 fell on [DATE] at 12:00 A.M. and that notification was not made to the Physician until 4:26 A.M. LPN #808 provided no explanation as to why the delay in notification. LPN #808 stated Resident #57 complained of left hip pain when rolling the resident to provide incontinence care. Resident #57's left foot was turned out. LPN #808 stated the left femur x-ray was negative for fracture and a left hip x-ray was ordered on 02/21/25 at 7:00 P.M. but was not completed yet and there was no estimated time of arrival for x-ray company. LPN #808 stated another nurse (not identified) came and assessed the resident also. At this time, they notified the DON who did not want the resident sent to the hospital instead instructed them to complete a pain evaluation with results of the resident's pain being an 8 out 10 on the pain scale and to medicate the resident with Tylenol. LPN #808 stated they did not feel Resident #57's pain was controlled on the Tylenol. LPN #808 gave no explanation of why they continued to move the resident before the hip x-ray was completed. Observation made on 03/27/25 at 11:45 A.M. and on 03/31/25 at 10:37 A.M. of Resident #57 revealed he was up in his wheelchair sitting with other residents in the dining room located on the secure dementia unit. There were no overt signs or symptoms of pain at the time of the observations. Interview on 03/27/25 at 2:15 P.M. with LPN #809 revealed the LPN was assigned to care for Resident #57 on 02/22/25 and had observed signs and symptoms of severe pain throughout their shift and had medicated the resident with Tylenol as needed for pain. LPN #809 confirmed Resident #57 was guarding his left hip area and noted a decrease in range of motion when transferring into their wheelchair. LPN #809 stated they notified the physician on 02/22/25 at 10:48 A.M. of the resident's continued pain, increase in need for assistance, swelling to legs, decrease in pedal pulses and wanted to notify the physician about the x-ray company unsure of when they would be out to do hip x-ray. LPN #809 stated the physician did not return the call until 02/22/25 at 1:12 P.M. and gave orders to transfer the resident to the local ER for evaluation and treatment. LPN #809 stated she notified EMS of need for transportation. EMS arrived around 2:44 P.M., assisted the staff with the transfer to the gurney. LPN #809 stated the paramedics immediately started an IV and medicated the resident with Fentanyl for pain prior to leaving the resident's room. LPN #809 stated Resident #57 was sent to the local ER where they found the resident had an acute displaced femoral neck fracture which required a left hip hemiarthroplasty. LPN #809 stated they had to transfer the resident from the local ER to a hospital equipped to complete the surgery. Interview attempts with LPN #798 were made on 03/27/25 at 11:37 A.M., on 03/27/25 at 2:58 P.M., on 04/09/25 at 11:23 A.M. and 04/09/25 at 1:45 P.M. but the calls were not answered, and no return call was received. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A follow-up interview was conducted on 04/09/25 at 3:40 P.M. with LPN #808 who revealed the LPN spoke with the DON regarding Resident #57's pain, negative femur x-ray, and foot being rotated out. LPN #808 stated the DON instructed her to not send the resident to the hospital and gave orders for a hip x-ray. When asked why the DON instructed her to not send the resident to the hospital, LPN #808 stated the DON told her she was told by corporate to not send residents to the hospital that they would get in trouble for it. LPN #808 stated she was instructed to not call the physician by the DON. An interview on 04/09/25 at 3:49 P.M. with Physician #814 revealed the physician was not aware the facility waited four hours and 26 minutes after the fall to notify him. Physician #814 stated he was aware the resident was in pain but not that it continued or that Resident #57 was having difficulty with transfers. Physician #814 stated he was not informed the resident's foot was turned outward. Physician #814 stated it was not ok for the DON to instruct the staff to not send the resident to the hospital and it was not ok for the DON to order a hip x-ray. He stated the staff should have called him for further orders. Physician #814 stated the facility staff should not have been transferring the resident from his bed to his chair after the fall. The DON resigned employment with the facility on 03/24/25 with last day worked on 03/18/25 and was not available for an interview. Review of the facility policy titled Change in a Resident Condition or Status, revised 02/2021, revealed the facility promptly notifies the resident's attending physician of changes in the residents' medical condition or status. The nurse will notify the residents' physician or physician on call when there has been an accident or incident involving the resident. Review of the facility policy titled Falls Clinical Protocol, revised 03/2018, revealed the staff, with the physicians' guidance, with follow-up on any fall with an associated injury until the resident is stable and delayed complications such as late fracture have been ruled out or resolved. This deficiency represents non-compliance investigated under complaint number OH00163683.