| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365658 | A. Building<br>B. Wing | 12/03/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Cardinal Woods Skilled Nursing & Rehab Ctr | 6831 Chapel Road<br>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<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>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.<br><br>(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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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of facility Self-Reported Incidents (SRI), review of local law enforcement reports, interviews and facility policy review, the facility failed to protect Resident #71's right to be free from abuse by Resident #93 and failed to protect Resident #64's right to be free from abuse by Resident #88. This affected two residents (#71 and #64) of four residents reviewed for abuse. Actual Harm occurred on 11/13/25 when Resident #71 reported he had been inappropriately touched and choked by another Resident (#93). Upon assessment, Resident #71 was noted to have an abrasion to his lower neck and scratches to his left shoulder. Resident #71 complained of a sore throat and rectal tenderness. The resident's rectum was assessed to be reddened. The resident was transferred to the hospital for evaluation but subsequently declined having a rape assessment completed. Findings include:1. Review of the medical record for Resident #71 revealed an admission date of 09/02/25. Resident #71 had diagnoses including senile degeneration of the brain, unspecified dementia, and generalized muscle weakness.Review of the comprehensive Minimum Data Set (MDS) assessment, dated 09/08/25, revealed Resident #71 had impaired cognition and required supervision for bed mobility, transfers, and ambulation. Review of the behavior and mood section of the MDS revealed Resident #71 experienced hallucinations and wandering behaviors. Review of the plan of care dated 09/22/25 noted Resident #71 had impaired cognitive function/impaired thought process related to dementia. Resident #71 resided on the secured unit due to behaviors of elopement and lack of personal space regarding peers. Review of a nursing progress notes dated 11/13/25 at 3:20 A.M. noted Resident #71 reported inappropriate physical touch by another resident (Resident #93). The note included staff completed a thorough assessment noting Resident #71 had a slight abrasion on to the lower neck. Resident #71 also complained of a sore throat and rectal tenderness. A nursing progress note, entered in Resident #93's medical record dated 11/13/25 at 4:13 A.M. noted Resident #93 was observed by staff standing aggressively over Resident #71 and choking him.Review of a skin check evaluation dated 11/13/25 at 5:17 A.M. noted Resident #71 had a reddened rectum and scratches on the front of his left shoulder.Review of a nurse's progress note dated 11/13/25 at 9:20 A.M. noted Resident #71 reported his rectum was burning like fire. Resident #71 was transferred to the hospital for an evaluation. A nursing progress note dated 11/13/25 at 9:33 P.M. noted Resident #71 declined all rape assessments while at the hospital and would be returning to the facility. Review of the local hospital record dated 11/13/25 noted Resident #71 received a computerized tomography (CT) scan to brain, cervical (neck), face, chest, and right elbow. The hospital record noted Resident #71 declined rape assessments. Review of a facility SRI tracking number 267485 dated 11/13/25 noted Certified Nurse Assistant (CNA) #353 heard Resident #71 yell out and immediately went into the resident's room. CNA #353 stated she observed Resident #93 leaning over Resident #71. Resident#71 stated he was woken up when Resident #93 placed his right leg on his chest and started choking him. Resident #71 stated Resident #93 inserted his finger into his rectum. Both residents were placed on 1:1 observation for safety. The facility contacted all responsible parties including the local law enforcement agency. However, review of the SRI revealed the facility unsubstantiated an incident of physical abuse citing there was not enough evidence. Review of a local law enforcement report dated 11/13/25 at 4:52 A.M. noted a report of an assault was called in from the facility. Interview with law enforcement and Resident #71 noted Resident #71 was lying down in bed when his roommate Resident #93 tried to touch him. Resident #71 said he asked Resident #93 to go to bed. Resident #71 stated Resident #93 had his hand where it should not be, and he asked Resident #93 to stop. Resident #71 stated he again asked Resident #93 to stop and go to bed. Resident #71 stated Resident #93 kept standing over and touching him. Resident #71 stated Resident #93 got him down on the bed and started choking him. Resident #71 stated he had a difficult time breathing at that point. Resident #71 continued to say Resident #93 started using his finger on his butt when he was lying on his side for approximately 15 minutes. The law enforcement agency interviewed Resident #93 who had no memory of the incident. Interview with Resident #71 on 11/25/25 at 2:05 P.M. revealed Resident #93 wanted more than he was willing to give. Resident #71 stated Resident #93 wanted to have sex and was standing over him slapping him in the face and choking him. Resident #71 then stated Resident #93 pulled his pajamas down to stick his finger in his rectum. Resident #71 stated staff came in and separated them and then removed Resident #93 the following day. (Resident #71 and Resident #93 were roommates at the time of the incident). Attempts to interview CNA #353 during the onsite investigation |