

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365658	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
NAME OF PROVIDER OR SUPPLIER Cardinal Woods Skilled Nursing & Rehab Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 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	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** Based on record review, facility self-reported incident (SRI) review and investigation, interviews and facility policy review, the facility failed to protect Resident #96's right to be free from physical abuse by another resident. Actual harm occurred on 06/23/26 when Resident #96 sustained a fall after being struck by Resident #87 resulting in rib fractures requiring hospitalization and treatment for a pneumothorax (collapsed lung). Resident #96 remained hospitalized through 07/01/26 and then was discharged to a different facility at the request of his family. This affected one (Resident #96) of three residents reviewed for abuse. The facility census was 95. Findings include Review of the closed medical record for Resident #96 revealed an admission date of 12/03/22 with diagnoses including dementia without behavior disturbance, osteoarthritis, hypertension, age related cataract, lack of coordination, and repeated falls. Review of Resident #96's Minimum Data Set (MDS) 3.0 quarterly assessment dated [DATE] revealed the resident had highly impaired hearing and sometimes understood others. Resident #96's cognition was severely impaired. Hallucination and delusions were present with no physical or verbal behaviors towards others exhibited. The assessment revealed Resident #96 required maximum assistance for bathing, and was independent for transfers from bed to chair, independent with sit to stand and independent to walk at least 150 feet once standing. Review of the plan of care dated 05/27/26 revealed Resident #96 had a communication problem related to hearing deficit. Interventions included anticipated needs, face resident when speaking so Resident #96 could see lips and use dry erase board to write messages or hand gestures. Review of a nurse's note for Resident #96 dated 06/23/26 at 3:09 P.M. authored by the Director of Nursing (DON) revealed a staff nurse was alerted to a problem that required help. The nurse witnessed another resident (Resident #87) swinging at Resident #96. Facility staff and residents guided the other resident away from Resident #96. Resident #96 stumbled backwards into a side table. Resident #96 was unable to verbalize incident details due to impaired cognition and communication difficulties. The note included there were no apparent injuries on Resident #96. Resident #96 was assisted back to his room. Further review of the medical record for Resident #96 revealed a progress note dated 06/25/26 at 3:29 P.M. written by Nurse Practitioner (NP) #592 that stated an acute change in mental status was reported by nursing today. New non-verbal pain behaviors and high pain score. On 06/25/26 nursing notes document increased pain (moaning, grimacing with movement and guarding). Review of systems shows decreased range of motion, and weakness. Assessment and Plan included altered mental status, address pain as a contributor to mental status change, continue scheduled Aleve 220 milligrams daily, monitor response and consider alternative or additional analgesia if pain persists. Monitor for worsening symptoms of acute illness. Review of physician orders dated 06/25/26 revealed Resident #96 had an order for x-ray to (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 Level of Harm - Actual harm Residents Affected - Few	right lumber and thoracic spine, also right ribs for complaint of pain with decreased motion. Review of the Radiology Results Report, reported date 06/26/26 at 9:48 A.M., revealed Resident #96 had acute right fifth through ninth rib fractures. Up to two millimeters (MM) outward displacement distal fragments. No additional acute posterior seventh rib fracture with two MM downward displacement distal fragment. Lucency right CP (costophrenic) angle. Impression: Right pneumothorax (collapsed lung which can be caused by rib fractures) and rib fractures as stated. Review of a progress note dated 06/26/26 at 11:33 A.M. written by NP #593, revealed Resident #96's x-ray revealed rib fracture with two-millimeter displacement. Plan was to monitor vital signs every shift for three days. Schedule Tylenol 500 milligrams two tablets every eight hours for three days and send prescription Tramadol (narcotic pain medication) 50 mg every eight hours for three days. Review of the hospital records dated 06/27/26 at 6:54 P.M. revealed Resident #96 presented to the Emergency Department for altered mental status. Computed Tomography (CT) revealed large right-side pneumothorax with mild leftward shift of the midsternal contents concerning for tension pneumothorax. Small right pleural effusion with significant lung collapse of the right lung. Acute fracture of lateral right sixth rib, segmental fracture of the seventh, eighth, and ninth ribs. No acute findings in the abdomen and pelvis. No intracranial hemorrhage. Resident #96 was diagnosed with tension pneumothorax (collapsed lung with tension) and altered mental status. High probability related to a fall. Resident #96 upon exam was difficult to arouse, in no apparent distress, and had a chest tube placed under moderate sedation due to the pneumothorax and some pleural effusion (fluid in the chest cavity). Pain medications and ceftriaxone and Zithromax antibiotics were given for pneumonia. The resident was discharged on 07/01/26 to another nursing facility. An interview on 07/08/26 with Resident #96's family member, (FM #586) revealed the family had Resident #96 transferred to another facility after Resident #96 was discharged from the hospital. An interview on 07/09/26 at 7:04 A.M. with Resident #96's Power of Attorney (POA) revealed the facility stated the resident who hit her husband was removed from the facility. When the family visited Resident #96 on 06/27/26 they observed Resident #96 to be lethargic so they requested Resident #96 to be sent to the hospital where he was treated for a punctured lung and broken ribs. The POA stated the Administrator told her Resident #96 was punched by Resident #87. Review of Resident #87's medical record revealed an admission date of 05/28/26 with diagnoses including dementia with behavioral disturbance, schizoaffective disorder, Parkinsonism, vascular dementia, major depressive disorder, insomnia, dementia in other disease classified elsewhere unspecified severity with other behavioral disturbance, mild neurocognitive disorder due to unknown psychological condition with behavioral disturbance, generalized anxiety disorder, and schizophrenia. Resident #87 resided on the secured unit due to wandering behaviors. Further review of the medical record for Resident #87 revealed admission documents to include a document titled Via [NAME] Psychiatric Note dated 04/23/26 from Resident #87's prior facility indicating Resident #87 had a history of behavior disturbance. Resident #87 had intermittent episodes of behavior disturbance such as agitation, verbal aggression and physical aggression towards staff that required emergency evaluation. The assessment and plan were for close interdisciplinary monitoring, behavior tracking for changes and agitation, and staff redirection strategies to maintain safety. Review of additional admission documents for Resident #87 included a care plan from the prior facility dated 12/31/25 indicating Resident #87 had a behavior problem of hitting other residents and refusing medications. Interventions included anticipating and meeting resident needs, educating the resident, explain procedures, and praise progress. Review of the comprehensive care plan for Resident #87, date revised 06/05/26 revealed Resident #87 had potential to demonstrate physically aggressive behaviors related to dementia, history of hitting other residents and taking other personal belongings. The goal (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	was to not harm self or others. Interventions included analyzing key times, places, circumstances, triggers and what de-escalation behavior to document. Assess and address for contributing sensory deficits. Assess and anticipate resident needs. Provide physical and verbal cues to alleviate anxiety. Monitor and report to physicians of danger to self and others. Psych consult as indicated. When Resident #87 becomes agitated intervene before agitation escalates, guide away from source of distress, engage calmly in conversation, staff to walk away and approach later if response was aggressive. Review of a nurse's note for Resident #87 dated 06/23/26 at 2:48 P.M. authored by the DON revealed a staff nurse was alerted to a problem that required help by an uninvolved resident. The nurse witnessed Resident #87 hitting staff and peers. Resident #87 began to approach others to continue aggression, the nurse intervened again. Resident #87 kept swearing and stated get these people out of my house. Resident #87 continued to escalate and tried to hit staff. Resident #87 was walked back to his room. NP #594 was notified who ordered a onetime dose of Olanzapine (Zyprexa) intramuscular (IM) that was administered. Staff stayed with Resident #87 for twenty minutes until resident was calm. Review of a facility Self-Reported Incident (SRI) dated 06/23/26 revealed staff reported residents on the locked unit getting into an altercation. Staff reported Resident #87 told Resident #96 not to look at him. Resident #96 looked at him so Resident #87 hit Resident #96. A nurse aide intervened and she was hit and her hair was pulled. Resident #86 pulled Resident #87 off the aide. Review of a staff witness statement dated 06/23/26 written by Unit Manager #568, revealed CNA #549 stated she was working at the time of the incident and Resident #87 pushed Resident #96 then came after her and pulled her hair. An interview on 07/09/26 at 12:46 P.M. with CNA #575 revealed she witnessed Resident #87 on top of Resident #96 and with Resident #87's hands swinging at Resident #96. CNA #575 stated Resident #96 was on the floor on his buttocks and LPN #565 had to remove him out of the dining room. An interview on 07/09/26 at 12:50 P.M. with LPN #565 revealed he was the nurse on the secured unit the day of the incident between Resident #87 and #96. LPN #565 stated the day of the incident he did not directly witness Resident #96 getting hit by Resident #87 but witnessed that Resident #87 needed to be held back to calm down because Resident #87 was dangerous. LPN #565 stated no bruising was assessed on Resident #96 during the head-to-toe assessment, but a bruise appeared a few days later. LPN #565 stated he observed Resident #96 at baseline but he was not as talkative or interactive with others after the incident. An interview on 07/09/26 at 1:00 P.M. with Resident #77 revealed Resident #87 always walked the hallway on the secured unit. Resident #77 stated (on 06/23/26) she observed Resident #96 holding his arms to his face to try to block Resident #87's punches. Resident #77 stated she was scared and yelled for help. Resident #77 stated she observed Resident #96 fall from his chair in the dining room onto the floor. Resident #77 stated it looked like he got pushed. An interview on 07/09/26 at 2:00 P.M. with CNA #549 revealed she was by the dining room the day of the incident involving Resident #96 and #87 when she heard commotion. CNA #549 stated she observed Resident #96 on the floor and Resident #87 standing by him because he knocked him down. CNA #549 stated Resident #96 landed on the floor after hitting the table and chair by him. CNA #549 stated when I went to check on [Resident #96], [Resident #87] came toward me to hit me. Another resident had to pull him off me and staff had to help me. CNA #549 stated Resident #87 tried to attack LPN #565 after the incident. CNA #549 stated Resident #87 was known to walk the hallways but she denied knowledge of him harming any other resident(s) before this incident. An interview on 07/09/26 at 3:00 P.M. with Resident #37 revealed (on 06/23/26) he observed Resident #87 walk in the dining room and Resident #96 was sitting in a chair by the dining room table. Resident #37 stated he saw Resident #87 take his fist to Resident #96. Resident #37 stated he did not know why Resident #87 acted like that. Resident #37 stated he then (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	saw Resident #96 fall to the floor onto his back after getting hit by Resident #87. An interview on 07/10/26 at 2:03 P.M. with the DON revealed she heard there was a problem on the Memory Care Unit on 06/23/26 and observed Resident #87 to be agitated. The DON stated after the incident Resident #96's wife requested to have his room changed. Resident #87 was sent to a behavioral health hospital when the facility learned Resident #96 suffered an injury of rib fractures. An interview on 07/10/26 at 3:30 P.M. with the Administrator verified (on 06/23/26) Resident #87 hit Resident #96 and Resident #96 had been hospitalized with rib fractures and treated for pneumothorax. An interview on 07/15/26 at 12:45 P.M. with CNA #567 revealed (on 06/23/26) she observed Resident #87 attacking an aide and observed Resident #96 on the floor. CNA #567 stated Resident #96 looked like he was hit and looked scared, and Resident #87 continued to swing punches at staff and grabbed an aide's hair and tried to punch the aide after Resident #96 was knocked down. Review of facility policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program revised April 2021, revealed residents had the right to be free from abuse this included freedom from physical abuse. Abuse was defined as willful infliction of injury and intimidation resulting in physical harm, or pain. Willful as used in the definition of abuse was defined as the individual must act deliberately (not an accident or involuntary movement), not that the individual must have intended to inflict injury or harm. The facility management and staff would initiate measures to address the needs of residents and minimize the possibility of abuse. The facility objective was to protect residents from abuse from other residents. This deficiency represents non-compliance investigated under Complaint Number 3072031, 3074721 and 3045955.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of the facility self-reported incident investigation, interviews and review of facility policy, the facility failed to conduct a complete and thorough investigation for an allegation of resident-to resident physical abuse. This affected one (Resident #96) of three residents reviewed for abuse. The facility census was 95. Findings include: Review of the facility Self-Reported Incident (SRI) reported to the Ohio Department of Health by the Administrator on 06/23/26 at 12:29 P.M. and completed on 06/29/26 at 12:49 P.M. revealed Resident #87 was identified as the alleged perpetrator, Resident #87, #96 and #86 were identified as resident/victims and there were no witnesses identified. An allegation of physical abuse was sourced by staff when staff reported residents on the locked dementia unit were getting into an altercation. Staff reported Resident #87 told Resident #96 not to look at him. Resident #96 looked at him so Resident #87 hit Resident #96. A nurse aid intervened and she was hit and her hair was pulled. Resident #86 pulled Resident #87 off the aid. The facility separated the residents, placed the residents on 15-minute checks, and head-to-toe assessments were completed with no significant findings. The parties responsible were notified and no new orders were given. Staff and resident interviews were obtained. Skin, psychological and trauma assessments were completed with no negative findings. Abuse education was sent to staff. The facility unsubstantiated the allegation of physical abuse. Review of the facility SRI investigation provided by the Administrator revealed there were resident witness statements dated 06/23/26 in the investigation from Resident #44 and Resident #6. Both statements were written and signed by the Administrator. Resident #44's statement revealed the incident happened in the dining room and the description of what happened stated they were fighting. Resident #6's statement revealed he was in his room and did not know what occurred. An interview on 07/09/26 at 12:50 P.M. with Licensed Practical Nurse (LPN) #565 revealed he was the nurse on the secured unit the day of the incident between Resident #87 and #96. LPN #565 stated the day of the incident he did not directly witness Resident #96 getting hit by Resident #87 but witnessed that Resident #87 needed to be held back to calm down because Resident #87 was dangerous. LPN #565 stated that Resident #37 was in the dining room when the incident happened and confirmed the resident was able to be interviewed. Review of the medical record for Resident #37 revealed an admission date of 10/30/24. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #37 had a Brief Interview for Mental Status (BIMS) score (a score intended to determine the resident's attention, orientation, and ability to register and recall new information) of 11 indicating moderate cognitive impairment. The BIMS indicated the resident could remember the correct day, the correct year, and repeat three words after the first attempt. An interview on 07/09/26 at 3:00 P.M. with Resident #37 revealed he observed Resident #87 walking in the dining room and Resident #96 was sitting in a chair by the dining room table. Resident #37 stated he saw Resident #87 take his fist to Resident #96. Resident #37 stated he did not know why Resident #87 acted like that. Resident #37 stated he then saw Resident #96 fall to the floor onto his back after getting hit by Resident #87. An interview on 07/16/26 at 12:33 P.M. with the Administrator verified Resident #86 was interviewed for the facility SRI because Resident #86 pulled Resident #87 off the aid. The Administrator also verified Resident #44 and Resident #6 were the only other resident witness statements obtained for the investigation because of their Brief Interview for Mental Status (BIMS) score. The Administrator stated he only interviews residents with a BIMS of 13 or higher and all other residents had a skin check done. Review of the facility policy titled Abuse, Neglect, Exploitation or Misappropriation, Reporting and (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Investigating, date revised 04/2021, revealed all allegations of abuse are thoroughly investigated by facility management. The administrator initiates the investigation, and the individual conducting the investigation at a minimum interview any witnesses to the incident and documents the investigation completely and thoroughly. Witness statements are obtained in writing, signed and dated. The witness may write his/her statement, or the investigator may obtain a statement. This deficiency represents non-compliance investigated under Complaint Number 3072031, 3074721 and 3045955.		