STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365973	A. Building B. Wing	05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birchaven Retirement Village	15100 Birchaven Lane Findlay, OH 45840

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NONCOMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on medical record review, Self-Reported Incident (SRI) review, staff interview, and policy review, the facility failed to ensure residents were free from physical abuse. This affected one (#96) of three residents reviewed for abuse. The facility census was 90. Findings included: Review of Former Resident (FR) #96's medical record revealed an admission date of [DATE]. The resident expired under Hospice care on [DATE]. Diagnoses included Lewy Bodies dementia, Parkinson's disease, and a cognitive communication deficit. Review of FR #96's significant change in status Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was unable to complete the test for cognitive function levels. The resident had physical behaviors such at hitting others one to three times weekly. This was documented as significant in interfering with the resident's care. Review of the SRI dated [DATE] revealed on [DATE] at 9:30 A.M. the charge nurse reported to the Assistant Director of Nursing (ADON) and Administrator that during morning care being delivered to FR #96, Certified Nursing Assistant (CNA) slapped the resident on the arm. This was done in front of the charge nurse and another CNA. Associate delivered no further care to the residents or other residents in the area. Associate was interviewed by the ADON and Administrator and placed on administrative leave pending the outcome of the review of the allegation. Associates in the resident room during the alleged action were requested to document statements and were then interviewed by the ADON and Administrator. The charge nurse completed skin assessments on the resident and all other residents in the work area. No negative outcomes were noted. Social Service Designee interviewed 13 residents living in the area of the alleged abuse. Residents interviewed did not report any allegations of abuse. Upon completion of the review, it was determined that the allegation was substantiated and that the test ready nurse aide did slap the resident during routing care. The associate was terminated. Review of Registered Nurse (RN) #121's witness statement dated [DATE] revealed staff were providing care for FR #96 and changing his shirt. Certified Nursing Assistant (CNA) #120 and Registered Nurse (RN) #121 were on the left side of the bed. CNA #118 was attempting to place a new brief under the resident. RN #121 had the resident's right hand and CNA #120 was holding his left hand. As staff were rolling him sideways FR #96 squeezed CNA #120's finger and she yelled out ow, ow and then she slapped his left arm because he didn't let go of her. RN #121 informed CNA #120 that they did not hit residents and stopped her from providing any further care to FR #96. FR #96 did not appear to be in any distress and no injury was noted. Review of CNA #118's witness statement dated [DATE] revealed herself and CNA #120 went into FR #96's room to wash him, check his brief, and turn him in bed. At that time RN #121 entered the room to administer the resident his medication. CNA #118 asked RN #121 to remain in the room to assist with the resident's care because CNA #120 didn't want to get hit. They were holding the resident's hands and CNA #118 went to roll him. As she rolled him the resident grabbed CNA #120's pointer finger and squeezed. CNA #120 began to yell and then she smacked his left arm to get him to let go of her finger. RN #121 immediately corrected CNA #120 and (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 - Minimal harm or potential for actual harm Residents Affected - Few	informed her that they do not hit residents. The former CNA was excused from care at that time. Witness interview with former CNA #120 was completed by the Administrator and the Assistant Director of Nursing (ADON) on [DATE]. FR #96 was pulling her finger back and she placed her hand on his arm. The CNA demonstrated how she placed her hand on the resident's arm and slid forward to push the resident's hand off her finger. CNA #120 was immediately sent home until further investigation was completed. Interview with the Administrator on [DATE] at 9:35 A.M. verified CNA #120 slapped FR #96 on the arm during routine care. The Administrator verified the facility completed an SRI and substantiated abuse. As a result of the incident, the facility took the following actions to correct the deficient practice by [DATE]: -On [DATE] at 9:30 A.M. an allegation of physical abuse was reported by RN #121 and CNA #118 to the DON and Administrator. CNA #120 was removed from care for residents by RN #121. -On [DATE] at 9:40 A.M. a full-body skin assessment was completed for FR #96 and found negative. -On [DATE] at 10:55 A.M. CNA #120 was interviewed by the ADON and Administrator and placed on administrative leave pending further investigation. -On [DATE] human resources and scheduling notified of the situation. -On [DATE] at 11:15 A.M. the Certified Nurse Practitioner (CNP) was notified of the situation. -On [DATE] at 2:35 P.M. FR #96's representative was notified by the ADON. -On [DATE] at 2:35 P.M. the Administrator began educating staff regarding the definition of physical and verbal abuse. -On [DATE] between 10:00 A.M. and 2:00 P.M. skin assessments were completed on 14 residents in the same unit. -On [DATE] at 4:56 P.M. FR #96 and 13 like residents were interviewed and had no concerns by Social Service Designee #107. -On [DATE] through [DATE] care audits were completed by the ADON. -On [DATE] at 3:32 P.M. staff education was completed regarding abuse reporting. -On [DATE] at 4:25 P.M. CNA #120 was terminated by the Administrator, ADON, and human resources. -On [DATE] at 5:07 P.M. the Administrator report to the Ohio Nursing Assistant Registry (ONAR) the abuse. A return call was received on [DATE]. -The ONAR informed the Administrator that since CNA #120 had not taken her test yet the abuse notification would come up when she applied. -0n [DATE] and [DATE] dementia training was completed for all CNAs working with memory care residents by the DON and ADON. -Interviews with staff on [DATE] between 8:45 A.M. and 1:57 P.M. revealed the staff were trained on the abuse policy and knowledgeable regarding reporting witnessed abuse. The staff included Medication Aides #103, #108, and #111, CNA #101, #105, and #113, Licensed Practical Nurses (LPN) #110, and RN #102. This deficiency represents non-compliance investigated under Complaint Number 3012988.