STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366028	A. Building B. Wing	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodside Village Care Center	841 W Marion Rd Mount Gilead, OH 43338

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. Based on observation, interview and record review, the facility failed to ensure residents were free from abuse by Certified Nursing Assistant (CNA) #102. This affected one (Resident #12) of seven residents reviewed for abuse. The facility census was 67. Findings include: Review of the medical record for the Resident #12 revealed an admission date of 05/23/25. Diagnoses included dementia, encephalopathy, hypertension, diabetes mellitus, and end stage renal disease. Review of the quarterly Minimum Data Set (MDS) assessment, dated 04/13/25, revealed the resident had impaired cognition. The resident required assistance for mobility, transfers, bathing and feeding. Review of the nursing progress notes dated from 03/01/25 to 06/02/25 revealed Resident #12 had increased agitation and observed behaviors of hitting and kicking facility staff members when they were performing care. Review of the plan of care dated 06/02/25 revealed she was receiving antipsychotic medication to control her behavioral disturbances and sundowning. Review of the facility's investigation file, completed by the Director of Nursing (DON) dated 05/27/25 and timed 11:00 A.M., revealed on 05/27/25, Certified Nursing Assistant (CNA) #102 was assisting Resident #12 during breakfast. Resident #12 was swinging her arms and attempting to kick CNA #102. CNA #102 held down Resident #12's arms to restrain Resident #12 from punching CNA #102. Resident #12 then leaned her head down toward CNA #102's right arm and attempted to bite CNA #102. CNA #102 took her open left hand and struck Resident #12 in the face, intending to thrust Resident #12's head back so she did not bite CNA #102. During an interview on 06/02/25 at 09:57 A.M., Resident #14 stated he had witnessed a CNA hit a resident in the face about one week prior. He states he observed the resident repeatedly hit the CNA first and then the CNA hit the resident back. During an interview on 06/02/25 at 01:30 P.M., with CNA#110 confirmed on 05/27/25 she witnessed CNA #102 push Resident #12's head back with CNA #102's left hand. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/02/25 at 2:20 P.M., CNA #102 stated she did hit Resident #12 in the face on 05/27/27 during breakfast in the dining room. She had a knee-jerk reaction to Resident #12 attempting to bite her arm and she pushed Resident #12's head away from her. Review of the facility policy titled Abuse Prevention Program Policy & Procedure, revised June 2023, revealed it is not acceptable for a staff member to strike a resident in response to any situation, regardless of whether harm was intended. Staff will held accountable to their actions to meet the Medicare and Medicaid requirements for participation by providing care in a safe environment. Atrium will not consider striking a combative resident an appropriate response in any situation. It is also not acceptable for any staff member to claim his/her action was 'reflexive or a 'knee-jerk reaction'' and was not intended to cause harm. Retaliation by staff is abuse, regardless of whether harm was intended, is unacceptable and must be cited. This deficiency represents non-compliance investigated under Complaint Number OH00166122.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on observation, interview and record review, the facility failed to report the results of an allegation of abuse to the State Survey Agency. This affected one (Resident #12) of seven residents reviewed for abuse. The facility census was 67. Findings include: Review of the medical record for Resident 12 revealed an admission date of 05/23/25. Diagnoses included dementia, encephalopathy, hypertension, diabetes mellitus, and end stage renal disease. Review of the quarterly Minimum Data Set (MDS) assessment, dated 04/13/25, revealed the resident had impaired cognition. The resident required supervision for bed mobility, transfers, ambulation. Review of behavior and mood. Review of the nursing progress notes dated from 03/01/25 to 06/02/25 revealed Resident #12 had increased agitation and observed behaviors of hitting and kicking facility staff members when they were performing care. Review of the facility's investigation file, completed by the Director of Nursing (DON) dated 05/27/25 and timed 11:00 A.M. revealed on 05/27/25, CNA #102 was assisting Resident #12 during breakfast. Resident #12 was swinging her arms and attempting to kick CNA #102. CNA #102 held down Resident #12 arms to restrain Resident #12 from punching CNA #102. Resident #12 then leaned her head down toward CNA #102's right arm and attempted to bite CNA #102. CNA #102 took her open left hand and struck Resident #12 in the face, intending to thrust Resident #12's head back so she did not bite CNA #102. During an interview on 06/02/25 at 09:57 A.M., Resident #14 stated he had witnessed a Certified Nursing Assistant (CNA), hit Resident #12 in the face about one week prior. He states he observed the resident repeatedly hit the CNA first and then the CNA hit the resident back. During an interview on 06/02/25 at 01:30 P.M., CNA #110 stated on 05/27/25 she witnessed CNA #102 push Resident#12's head back with her left hand. She stated she did not report the abuse to any management staff. During an interview on 06/02/25 at 2:20 P.M., CNA #102 stated she hit Resident #12 in the face on 05/27/27 during breakfast in the dining room. She had a knee-jerk reaction to Resident #12 attempting to bite her arm and she pushed Resident #12's head away from her. CNA #102 confirmed that she did not report the incident to any members of management. During an interview on 06/02/25 at 2:44 P.M., the Director of Nursing (DON) stated she was notified about the alleged incident, which occurred on the morning of 05/27/25, by LPN #135 soon after it took place. The DON stated she immediately notified the Administrator and initiated an internal investigation on 05/27/25 to determine if abuse against Resident #12 did occur. The DON stated she did confirm that CNA #102 did hit Resident #12, but did not believe the intention of CNA #102 was to harm Resident #12. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/02/25 at 2:52 P.M., the Administrator confirmed that she was notified about the alleged incident on the morning of 05/27/25. She stated after reviewing the investigation information she did not believe abuse occurred because CNA #102 did not intend to harm Resident #12. The Administrator confirmed that she had not reported the incident to the State Survey Agency. Review of the facility policy titled Abuse Prevention Program Policy & Procedure, revised June 2023, stated reporting results of all investigations to required officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This deficiency represents non-compliance investigated under Complaint Number OH00166122.

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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. Based on observation, interview and record review, the facility failed to ensure a staff member was removed from resident care while an allegation of abuse was being investigated. This affected one (Resident #12) of seven residents reviewed for abuse. The facility census was 67. Findings include: Review of the medical record for Resident #12 revealed an admission date of 05/23/25. Diagnoses included dementia, encephalopathy, hypertension, diabetes mellitus, and end stage renal disease. Review of the facility's investigation file, completed by the DON dated 05/27/25 and timed 11:00 a.m. revealed on 05/27/25 CNA #102 was assisting Resident #12 during breakfast. Resident #12 was swinging her arms and attempting to kick CNA #102. CNA #102 held down Resident #12 arms to restrain Resident #12 from punching CNA #102. Resident #12 then leaned her head down toward CAN #102's right arm and attempted to bite CNA #102. CNA #102 took her open left hand and struck Resident #12 in the face, intending to thrust Resident #12's head back so she did not bite CNA #102. Review of the time punch card dated 05/27/25 revealed the CNA #102 was not instructed to clock out and did continue to work during the facility's incident investigation. During an interview on 06/02/25 at 2:52 P.M., the Administrator confirmed that she was notified about the alleged incident on the morning of 05/27/25. She confirmed that after reviewing the investigation information she did not believe abuse occurred because CNA #102 did not intend to harm Resident #12. The Administrator confirmed CNA #102 continued to work after the alleged abuse occurred. Review of the facility policy titled Abuse Prevention Program Policy & Procedure, revised June 2023, revealed to identify alleged perpetrator, remove from resident care area immediately, suspend pending investigation conclusion, obtain statement. This deficiency represents non-compliance investigated under Complaint Number OH00166122.