STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366036	A. Building B. Wing	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glendora Health Care Center	1552 North Honeytown Road Wooster, OH 44691

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, interview with the staff, and review of facility policy, the facility failed to ensure the mail was delivered daily to Resident #1. This affected one resident (#1) out of three residents reviewed for resident rights; however it had the potential to affect all the residents in the facility. The facility census was 41.Findings Include:Review of the medical record revealed Resident #1 was admitted to the facility on [DATE]. Diagnoses included borderline personality disorder, schizoaffective disorder bipolar type, asthma, obstructive sleep apnea, hypertension, obsessive compulsive disorder, insomnia, and anxiety disorder. Review of the Quarterly Minimum Data Set assessment dated [DATE] revealed Resident #1 had intact cognition and no behaviors.On 05/07/26 at 10:15 A.M, an interview with the Administrator verified the mail was passed out to the residents by the activity department. She stated Business Office Manager (BOM) #62 worked Monday, Wednesday and Friday at the other building and Tuesday and Thursday at this building. On 05/07/26 at 1:25 P.M. an interview with the BOM #62 revealed Resident #1 had been in her office daily looking for her mail. She stated she was waiting on a couple items from the bank, but they had not received anything like that for her, and they gave her all her mail when it came.On 05/11/26 at 8:45 A.M. an interview with Activity Aide #72 revealed she only passed out the mail when BOM #62 gave it to her and BOM #62 only worked on Tuesdays and Thursdays. She stated she did not pass it out every day just when there was a pile of it on her desk, but she could start doing that if that was what was required.On 05/11/26 at 10:45 A.M, an interview with Resident #1 revealed the facility did not pass the mail out every day. She stated she had to ask for her mail, and she still did not always get it when she asked for it. She stated she was waiting on her new bank card she applied for on 04/27/26. Review of the undated facility policy titled, Resident Right to Privacy in Communication, revealed it was the policy of the facility to support and facilitate a resident's right to privacy in communication with individuals and entities within and external to the facility. Promptly delivery mail or other material to the resident within 24 hours of delivery by the postal service and delivery of outgoing mail to the postal service within 24 hours, except when there was no regular scheduled postal delivery and pick-up service.This deficiency represents non-compliance investigated under Complaint Number 2998394.

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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(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 NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.Based on review of the medical record, review of the Self-Reported Incident, review of facility policy, and interview with staff, the facility failed to protect Resident #27 from abuse and video recording by an agency staff member. This affected one resident (#27) of three reviewed for abuse.Findings Include:Review of the medical record revealed Resident #27 was admitted to the facility on [DATE]. Diagnoses included diabetes, hypertension, depression, heart failure, mild dementia, neuropathy, major depressive disorder, anxiety disorder, and hyperlipidemia. The resident resided on the [NAME] Hall. Review of the Quarterly Minimum Data Set assessment dated [DATE] revealed Resident #27 had intact cognition and had physical and verbal behaviors towards others.Review of the plan of care dated 08/08/25 with a revision date of 03/18/26 revealed Resident #27 had a behavior problem, chooses to use racial slurs toward staff members, chooses to be physically aggressive with staff, make sexual comments to staff, become verbally aggressive with staff, disrupts the care environment at times and loudly expresses concerns. Interventions included administer medications as ordered, anticipate and meet the residents needs, caregivers to provide opportunities for positive interactions and attention, stop and talk with him when passing by, explain all procedures to the resident before starting and allow him to adjust to the changes, if reasonable discuss his behavior, explain and reinforce why the behavior was inappropriate, monitor behavior episodes and attempt to determine underlying causes, and praise any indication of the residence progress or improvement in behavior.Review of the Progress notes from 09/13/25 to 09/14/25 revealed no documentation of an incident between Resident #27 and Agency CNA #100 in the progress notes.Review of the statement from Resident #27 from an interview by the Director of Nursing dated 09/14/25 revealed the Director of Nursing met with Resident #27 to discuss the incident from the night before. Resident #27 stated he could not remember all the events that happened but stated Agency CNA #100 was behind the nurse's station when he wheeled himself up to the nurse's station. He stated they were yelling back and forth and at one point the Agency CNA had made a comment about his mother, but he did not remember what it was exactly. Resident #27 stated he was so upset about the comment that he stood up, knocked a basket off the nurse's station, and that was when the Agency CNA #100 stood up, swung at him, hit him in the face, and knocked his glasses off his face. Resident #27 stated he did not remember much after that because the nurse assisted him to his room shortly after, assessed him and he went to bed. Resident #27 was noted to have two scratches down his forehead and one on the bridge of his nose that the resident stated was from the Agency CNA hitting him.Review of the facility's Self-Reported Incident dated 09/14/25 revealed the Former Administrator received a call from the charge nurse at midnight with concerns that a resident was unable to be redirected and a nursing assistant was behind the nurse's station, preparing to leave the facility. Upon answering the call, the resident was yelling at the nursing assistant [Agency CNA #100] from in front of the nurse's station. The nurse was able to get another nursing assistant to come to the nurse's station to sit with the resident while Former Administrator and the nurse spoke with the Agency CNA. The nurse immediately separated Agency CNA #100 and the resident prior to the phone call to the Former Administrator. The Agency CNA was on the phone with nine-one-one (911) dispatch as the nurse tried to interview her regarding what happened. As the nurse was attempting to interview, the resident yelled she hit me!, pointing at Agency CNA #100. The Agency CNA stated that she did not hit him, and wanted to wait until the police arrived, stating that she had captured the entire event on camera. The Former Administrator directed the Agency CNA to remove herself from facility and wait for police arrival. The police arrived and collected statements from Agency CNA #100, the resident, the nurse, and the Former Administrator. A (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	police report was made regarding the incident. The resident was interviewed immediately, the day following, and twice more by the Former Administrator, Director of Nursing, and Social Services Director. The resident stated in the immediate interview that Agency CNA #100 was taunting him by sticking her tongue out, and that was when she allegedly kicked him, then he went after her. The resident stated when he got to the nurse's station, that was when the Agency CNA swatted at him. The resident denied at this time being aggressive towards her. Resident #27 had two scratch-like marks down the left side of his forehead and nose. In the following interview on 09/14/25 in the afternoon, the resident forgot what happened during the event and could not recall the series of events and how they unfolded. During the interview on 09/15/25, resident stated that the Agency CNA had not kicked him, but did smack him across the forehead, the opposite direction of the marks on resident's face. The resident was unsure of how these marks appeared but then stated they were not from her. The resident also had glasses on during this event, but they were now unable to be located. The Agency CNA was interviewed immediately by the Former Administrator on 09/14/25 and stated that she did not kick the resident, but rather created distance from him by holding her leg out, as he was in the wheelchair. She denied hitting the resident in any capacity and stated the resident was very aggressive towards her, trying to hit and kick her, following her down the hallway to nurses' station while calling racial slurs at her. She stated she then began recording [on her phone] for her safety and then called 911 from behind the nurse's station. She stated she wished to say nothing more as she would discuss it with the officer and her lawyer but denied any contact with resident on her behalf. The nurse was interviewed during the incident and stated she witnessed most of the occurrence and did not see the Agency CNA #100 hit the resident, but witnessed the resident being aggressive towards Agency CNA #100. Other staff were interviewed immediately that were on-site and stated they did not witness the event, or anyone being hit. Other staff were interviewed during the following days regarding the incident, and no other findings were noted. Other residents were interviewed at time of event and there was no witness to the event. Residents were interviewed during the following days and stated no concerns about safety, care, abuse, or regarding this nursing assistant.Review of the skin assessment dated [DATE] at 2:51 A.M. revealed Resident #27 had two four-centimeter scratches to the face and one one-centimeter skin tear to the nose.Review of the handwritten, signed, witness statement by Registered Nurse #102 from the police report dated 09/14/25 revealed she was in the doorway of a neighboring resident's room when she heard Resident #27 start yelling about the noise. The nursing assistant let him know that they were working and trying to get things finished. Resident #27 said something under his breath and then she heard a loud, [expletive] you. She tried to de-escalate the resident by telling him they were almost finished with majority of the work, and she got back to her tasks. She heard loud voices again and when she came out in the hallway Resident #27 was getting up out of his wheelchair and walking towards the nursing assistant [Agency CNA #100] trying to kick at her. She stated she sat him down in the wheelchair and told the nursing assistant to leave the area. She indicated Resident #27 kept trying to get up and the nursing assistant would not stop verbally replying to Resident #27's racial slurs/language. The nursing assistant went behind the nurse's station and called the police and Resident #27 threw a cup and the cigarette tote at her. She called the administrator.Review of the handwritten, signed, witness statement by Agency CNA #100 from the police report dated 09/14/25 revealed she encountered Resident #27 on the [NAME] Wing Hallway complaining about the noise that staff were making so she closed the door to his room. She indicated Resident #27 open the door back up and started calling her racial slurs and continued taunting her as she retreated to the nurse's station, at that time he began swinging at her and slapped her. He threw a box of cigarettes and lighters at her face and that was when she got her telephone slapped out of her hand, but she was still able to get video of the altercation. She stated she was asked to leave the property by the administration in defense of the resident. When asked if she made contact with Resident #27 at any time she indicated she was able to create distance by using her foot before walking behind the nurse's station for her safety.Review (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of the police report by Officer #200 on 09/14/25 at 8:37 P.M. revealed Officer #200 was dispatched to the facility for a threat complaint. The caller was identified as Agency CNA #100 who stated she worked for an agency and a resident had become violate with her. She stated Resident #27 had slapped her in the face and slapped away her telephone. Agency CNA #100 told dispatch that Resident #27 had been calling her racial slurs and making several comments towards her. Prior to the officer's arrival Agency CNA #100 advised that she was now separated from Resident #27 and would be waiting in the parking lot in her vehicle. Officer #200 made contact with Agency CNA #100 in the parking lot outside the nursing home. Agency CNA #100 explained to the officer that Resident #27 became angry because the staff were being too loud in the hallways. Due to his complaint of the noise in the hallway, she decided to shut the door to his room which caused Resident #27 to become very angry. She stated he opened the door and came towards her calling her racial slurs. Agency CNA #100 stated the resident stood up from his wheelchair and came towards her as she backed towards the nurses station which was located across the hall from his room however, before making it behind the nurses station Resident #27 had attempted to swing at her several times and she had pushed Resident #27 back from her by using her foot to push against him to create distance. She stated Resident #27 continued to advance towards her and began reaching over the nurse's station continuing to swing at her. She stated Resident #27 was able to slap her on the left side of her face on her cheek, threw a box of cigarettes and lighters at her and smacked her telephone out of her hand while she was attempting to videotape his behavior. Agency CNA #100 allowed Officer #200 to view the video of Resident #27 coming towards her and attempting to swing and smack at her during the video. Officer #200 indicated viewing the video revealed that no injuries were observed on Resident #27's face however, scratch marks were observed on Resident #27 face that had occurred sometime after the video had ended. Officer #200 then went inside the facility to attempt to speak to Resident #27. He observed Resident #27 sitting calmly in front of the nurse's station across from his room. When the officer was speaking to Resident #27, he was able to observe scratch marks on his forehead and his nose. The resident was calm throughout the time the officer was speaking to him. He indicated Resident #27 stated he had become angry that Agency CNA #100 was out in the hallway acting like a [expletive], sticking her tongue out of him, taunting him, and being loud and obnoxious. He stated he became angry, went after her, calling her racial slurs and said that he began swinging at her. Resident #27 stated when he was trying to swing at her he was attempting to smack her with his hand and he would have been okay with smacking her. However, he stated he had not touched her at any time. Officer #200 indicated it should be noted Agency CNA #100 stated Resident #27 had smacked her, but the officer was unable to observe any injuries to her person. Resident #27 also stated Agency CNA #100 had kicked at him and pushed him back by kicking towards his right hip with her foot. Resident #27 stated he had not smacked her telephone out of her hand and had not touched her at any time. Resident #27 explained he was advancing towards Agency CNA #100, she went behind the nurse's station, and he continued to attempt to smack at her, he eventually grabbed a basket of cigarettes and lighters and threw it at her. Resident #27 stated that after he had thrown the basket of items at her she had scratched him across the face causing the visible injuries on his forehead and nose. The officer indicated he had checked her nails to see if there was any blood under her nails however he was unable to observe any. There also were no visible cameras in the area where the altercation had occurred. An interview on 05/11/26 at 9:55 A.M. with the Director of Nursing (DON) confirmed the details of the incident related to the altercation with Resident #27 and Agency CNA #100, and that Resident #27 was videotaped by the CNA. She stated she remembered seeing the scratches on the resident's face. An interview on 05/11/26 at 10:20 A.M. with Resident #27 revealed the night of the incident, the aides were being loud, and he told them to be quiet. He stated the aide [Agency CNA #100] got mouthy with him and he got mouthy back and she did not like it. He stated he got up out of the wheelchair and went after her, but he never touched her because he would never hit a woman. He stated she swung at him and scratched his face and knocked his new (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	glasses off his face and shattered them. He stated he did throw the cigarette case at her. He stated she kicked him in the right hip when he got up out of his wheelchair. Resident #27 stated he felt safe at the facility but in general he wanted to leave.A second interview on 05/11/26 at 10:29 A.M. with the DON revealed she verified the glasses Resident #27 had on in the video screen shot prior to the incident, were not the same glasses he had on now. She stated she did not know what had happened to them that night.Review of the undated facility policy titled, Abuse, Neglect, and Exploitation, revealed it was the facility policy to provide protections for the health welfare and rights of each residents by developing and implementing written policies and procedure that prohibits and prevents abuse neglect exploitation and misappropriation of resident property.The deficiency was corrected on 09/15/25 after the facility implemented the following corrective actions: -On 09/14/25 at 12:00 A.M. Registered Nurse #102 notified the Former Administrator.-On 09/14/25 at 12:05 A.M. the Former Administrator advised Agency CNA #100 that she was released for the remainder of shift.-On 09/14/25 at 1:21 A.M. the Former Administrator notified the Director of Nursing and Former Social Services Director #104 of the incident.-On 09/14/25 from 12:20 A.M. to 1:00 A.M. the Former Administrator and Former Social Services Director #104 interviewed all staff working via telephone.-On 09/14/25 from 1:00 A.M, to 4:00 A.M. Registered Nurse #102 interviewed all residents on the [NAME] Hall who had a Brief Interview for Mental Status greater than 12 on abuse and performed skin and pain assessments on all residents located on [NAME] Hall.-On 09/14/25 at 10:00 A.M. the Director of Nursing was at the facility and educated all staff on the Abuse policy, and updated the power of attorney, medical director and psychiatric services of the incident. The Director of Nursing also notified Clipboard Health of the incident that involved their staff member and requested Agency CNA #100 be placed on the Do Not Return list.-On 09/14/25 at 11:00 A.M. the Director of Nursing reviewed the incident and statements. Resident #27's orders and care plan were updated as needed.-On 09/14/25 at 12:00 P.M. the Director of Nursing interviewed Resident #27.-On 09/14/25, a Root Cause Analysis was completed to determine the potential cause of the incidentOn 09/15/25, a Quality Assurance Performance Improvement (QAPI) meeting was held to discuss the incident. -On 09/15/25 at 1:00 P.M. Former Social Service Director #104 met with Resident #27 to follow up and discuss the weekend incident.-From 09/15/25 through 09/18/25, Resident #27's pain medications and psychiatric medications were adjusted per a psychiatric evaluation and the psychiatric nurse practitioners orders. -On 09/19/25, Agency CNA #100 was reported to the nurse aide registry. This deficiency represents non-compliance investigated under Complaint Number 2998394.