

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366171	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/03/2025
NAME OF PROVIDER OR SUPPLIER Cridersville Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 603 East Main Street Cridersville, OH 45806	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>Based on medical record reviews, staff, resident and resident representative interviews, review of Self-Reported Incidents (SRI's), and policy review, the facility failed to ensure a resident was free from sexual abuse. This affected one (#12) out of three residents reviewed for abuse. The facility census was 39.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #12 revealed an admission date of 02/18/25 with medical diagnoses of cerebral infarction, dementia with other behavioral disturbance, psychotic disorder with delusions, and hypertension.</p> <p>Review of the medical record for Resident #12 revealed a quarterly Minimum Data Set (MDS) assessment, dated 05/20/25, which indicated Resident #12 had severely impaired cognition and required supervision with eating and toilet hygiene, substantial/maximum staff assistance for bathing, and partial/moderate staff assistance with bed mobility and transfers. Review of Resident #12's medical record revealed the resident resided on a secured/locked unit at the facility.</p> <p>Review of the medical record for Resident #12 a nurses' note, dated 05/17/25 at 5:48 P.M. which stated Resident #12 was observed with her curtain pulled in her room with another resident. The note stated Resident #12 was observed with her pants below her waist line and the other resident was seen touching her when this writer questioned Resident #12. Resident #12 stated he wasn't doing nothing but making her feel good. The note stated the residents were immediately separated and the nurse was notified. The note continued to stated a head to toe assessment was completed, and no injuries were noted. The note stated the family and physician were notified and Resident #12 declined to seek medical attention.</p> <p>2. Review of the medical record for Resident #07 revealed an admission date of 07/27/22 with medical diagnoses of Intellectual Disabilities, diabetes mellitus, end stage renal disease, and depression.</p> <p>Review of the medical record revealed an annual MDS assessment, dated 04/24/25, which indicated Resident #07 was cognitively intact and was independent with eating and required supervision with showers, toilet hygiene, bed mobility, and transfers. Review of Resident #07's medical record revealed the resident resided on a secured/locked unit at the facility.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the medical record for Resident #07 revealed a nurses' note, dated 05/17/25 at 6:10 P.M., which stated Resident #07 was observed in another resident's room touching her while her pants were down. The note stated the writer questioned Resident #07 about what was going on and Resident #07 stated he was talking to the female resident about outside. The note stated Resident #07 was his own person and the Administrator was notified.</p> <p>Review of the facility SRI, dated 05/17/25, revealed the facility investigated a sexual abuse allegation against Resident #12 by Resident #07. The SRI revealed staff reported finding Resident #07 in Resident #12's room with his hand on her peri-area. The investigation included staff interviews, physical assessment for Resident #12, and notification to the Resident #12's family and the police department.</p> <p>Interview on 06/03/25 at 11:06 A.M. with Certified Nursing Assistant (CNA) #102 stated she walked into Resident #12's room and observed Resident #12 lying on her bed with her pants to her knees and Resident #07 sitting in his wheelchair next to her bed with his hand in her peri-area. CNA #102 stated she immediately separated the residents and notified the nurse. CNA #102 stated she asked Resident #12 what was going on and Resident #12 stated he was making her feel good. CNA #102 confirmed Resident #12 had impaired cognition and resided on a secured unit.</p> <p>Interview on 06/03/25 at 11:28 A.M. with Director of Nursing (DON) confirmed Resident #07 was found in Resident #12's room with his hand on her peri-area. DON confirmed the facility had not provided education to all staff on abuse or follow-up audits/monitoring of concerns for abuse.</p> <p>Interview on 06/03/25 at 11:44 A.M. with Licensed Practical Nurse (LPN) #105 stated he was notified by CNA #102 that Resident #07 was observed in Resident #12's room with her hand in her peri-area. LPN #105 confirmed CNA #102 immediately separated the residents and the Administrator was notified. LPN #105 stated a head to toe assessment was completed on Resident #12 with no apparent injuries.</p> <p>Interview on 06/03/25 at 11:55 A.M. with Resident #12's son stated he was not Resident #12's power of attorney (POA) but he was not aware of any allegation of abuse. Resident #12's son stated at times Resident #12 is alert and oriented but other times Resident #12 has no idea what was going on or where she was at.</p> <p>Interview on 06/03/25 at 1:05 P.M. with Resident #07 stated he and Resident #12 were friends and denied touching Resident #12 in her peri-area.</p> <p>Interview on 06/03/25 at 2:08 P.M. with Social Service Director (SSD) #110 stated Resident #12 had moderately impaired cognition and was able to answer some questions appropriately but stated she was not sure if Resident #12 was able to comprehend everything that was told to her. SSD #110 stated Resident #12 did not have the cognitive capacity to consent to a sexual encounter.</p> <p>Interview on 06/03/25 at 3:05 P.M. with Resident #12 revealed she was alert to person, place, and year. Resident #12 stated she recalled Resident #07 touching her in her peri-area but could not recall if she consented to allowing Resident #07 touch her.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 06/03/25 at 3:15 P.M. with Administrator confirmed he initiated a SRI and completed an investigation into the sexual abuse allegation for Resident #12. Administrator stated after speaking with staff he did not feel there was a sexual assault by Resident #07 because he felt the sexual encounter was a mutual decision by Resident #12 and Resident #07. Administrator stated Resident #07 was put on 15-minute checks after the incident until the investigation was completed. Administrator stated at times Resident #12 will seek out Resident #07 and speak to him inappropriately. Administrator stated the police department were contacted but did not investigate the incident. Administrator confirmed the facility completed the investigation and did not substantiate the allegation of abuse.</p> <p>Review of the facility policy titled, Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property, stated the residents have a right to be free from abuse, neglect, exploitation, and misappropriation of resident property. This included, but was not limited to, freedom from corporal punishment, involuntary seclusion, and any physician or chemical restraint that was not required to treat the resident's medical symptoms. The policy stated sexual abuse was non-consensual sexual contact of any type with a resident. The policy stated the facility would investigate all alleged violations involving Abuse, Neglect, Misappropriation of Resident Property, Exploitation or Mistreatment, including injuries of unknown source. The policy stated abuse included verbal abuse, sexual abuse, physical abuse, and mental abuse, including abuse facilitated or enabled through the use of technology, such as photographs and recording devices to demean or humiliate a resident. The policy continued to state if a resident was accused or suspected the facility would ensure other residents are protected as determined by the circumstances, which may include but are not limited to, increased supervision of the alleged perpetrator and/or other residents, room or staffing changes, and immediate transfer or discharge, if indicated.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00166012 and OH00165956.</p>		