STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366403	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bath Creek Estates	186 West Bath Road Cuyahoga Falls, OH 44223

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. (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

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	**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 record review, review of a facility self-reported incident (SRI), facility, facility investigation, employee personnel file, interview and facility policy review, the facility failed to ensure Resident #95 was free from staff-to-resident abuse. This affected one resident (#95) of three residents reviewed for abuse. The facility census was 93.Findings include:Review of the medical record for Resident #95 revealed an admission date of 05/11/25 and a discharge date of 10/16/25. Diagnoses included left femur fracture, hypertension, dementia with severe psychotic disturbance, abnormal gait/mobility, Alzheimer's disease, and aphasia (language disorder that impairs a person's ability to communicate effectively). Review of the five-day Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #95 had severely impaired cognition, required assistance from staff with eating, and was dependent on staff for transfers and toileting. The assessment also indicated the resident rejected care and had physical and verbal behaviors. Review of the SRI tracking number 266123, dated 10/07/25, revealed on 10/07/25 administration was made aware that Licensed Practical Nurse (LPN) #600 slapped Resident #95 in the face. LPN #600 was immediately suspended pending investigation. A full assessment was completed on Resident #95 with no negative findings. Resident #95 remained at the facility at his baseline. Emotional support was provided. The physician and guardian were made aware. A full investigation was initiated and staff statements obtained. The facility interviewed interviewable residents with no negative findings. Skin assessments and behavior monitoring for non-interviewable residents were completed with no negative findings. The local police department was immediately notified.Review of the facility's investigation revealed an undated typed witness statement from Certified Nurse Aide (CNA) #601 revealed on 10/5/25 at approximately 7:00 P.M., LPN #600 went to Resident #95 to give medication. CNA #601 was walking by his room and heard the nurse and CNA #603 repeating [Resident #95], sit down. Sit down. CNA #601 went into the room to assist them. Resident #95 was pushing his medications away, so CNA #601 was trying to encourage him to take them. When he was putting the medications into his mouth, he dropped a couple onto his shirt. CNA #601 assisted him to pick them up and put them in his mouth, drink the water, then as CNA #601 turned her head to look away she saw water hit the floor. CNA #601 heard a sound that sounded like a slap. Resident #95 said why did you slap me? When CNA #601 turned back to look at him, Resident #95, had his hand holding his left cheek, and the nurse (LPN #600) was standing in front of him. Resident #95 was immediately tried to stand saying I'm getting out of here. The nurse made some comment about If we were in my country, people would not be allowed to behave like this. CNA #601 was focused on trying to calm Resident #95 and get him to sit back down. CNA #601 asked the nurse and other aids to leave the room so she could calm Resident #95 down. CNA #601 gave him a warm shower and laid him down in bed before she left. Review of the undated typed statement by CNA #602 revealed on 10/05/25, CNA #601 was giving Resident #95 water. CNA #603 was wiping his mouth and giving comfort to him and LPN #600 was standing by the door with him all in the room. While CNA #601 was giving him water, Resident #95 spit on her face and the room got silent for a couple of moments. CNA #601 asked Resident #95 why he did that and LPN #600 said If you spit on me, I'm smacking the dog [expletive] out of you inserting himself. Spit on me, I swear to God, LPN #600 said as he pounded on his chest a few feet in front of Resident #95, Spit on me, I dare you. Resident #95 spit at LPN #600, and LPN #600 smacked Resident #95 full palm to his right cheek. Resident #95 head moved the opposite way with the smack, and his face turned red. The room went silent, and then CNA #603 immediately tried to comfort Resident #95 who was now angry.Interview on 11/20/25 at 12:37 P.M. with the Administrator, Director of Nursing (DON), and Regional Registered Nurse (RRN) #572 revealed they learned of the incident on 10/07/25 they immediately conducted an investigation that was substantiated based on the involved staff interviews, although some were not forthcoming. The Administrator stated LPN #600 denied he had slapped Resident #95. The Administrator stated LPN #600 and CNAs #601, 602, and #603 were all terminated related to the incident. Review of the facility policy titled Ohio Resident Abuse Policy, revised 07/11/24, revealed this facility will not tolerate abuse, neglect, mistreatment, exploitation of residents, and misappropriation of resident property by anyone. It is the facility's policy to investigate all allegations, suspicions and incidents of abuse, neglect, involuntary seclusion, exploitation of residents, misappropriation of resident property and injuries of unknown source. Facility staff