STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366170	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Sanctuary at Tuttle Crossing	4880 Tuttle Road Dublin, OH 43017

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 - 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** Based on record review, hospital record review, law enforcement interview, and facility policy review, the facility failed to ensure Resident #51 was free from abuse.Actual harm occurred to Resident #51 when Resident #21 made physical contact with Resident #51. Resident #51 fell to the ground and sustained a hematoma to the back of his head. Resident #51 was transported to the emergency room, where he was diagnosed with a falx subdural hematoma and a fracture of his C5 and C6 vertebra. This affected one (Resident #51) of three residents reviewed for abuse allegations. The facility census was 49.Findings Include:Resident #51 was admitted to the facility on [DATE]. His diagnoses were Parkinson's disease without dyskinesia, dementia, psychotic disturbance, mood disturbance, anxiety disorder, repeated falls, and major depressive disorder. Resident #21 was admitted to the facility on [DATE]. His diagnoses were bipolar disorder, schizophrenia, unspecified hearing loss, dementia, psychotic disturbance, mood disturbance, and anxiety disorder. Review of his MDS assessment, dated [DATE], revealed he was cognitively intact.Review of Resident #51's Minimum Data Set (MDS) assessment, dated [DATE], revealed he was severely cognitively impaired. Resident #51 utilized a walker and wheelchair for mobility. He was independent with rolling left and right, sit to lying, and lying to sitting mobility tasks. He needed set up assistance with sit to stand mobility task and chair to bed transfers.Review of Resident #51's progress note, dated [DATE], revealed staff heard Resident #51 yelling from his room. Resident #51 was found lying on the floor with his head and torso outside of the room and his legs inside the room. Resident #21, Resident #51's roommate, was present in the room and was standing over Resident #51 yelling. A full body assessment was completed on Resident #51 which revealed a small amount of bleeding and a raised area on the resident's scalp, consistent with possible head impact. Resident #51 appeared fearful and confused during the assessment. Physician was notified shortly after the incident on [DATE]. He was contacted by Licensed Practical Nurse (LPN) #215, and the physician gave the order to send Resident #51 to the hospital for evaluation.Review of Resident #21's progress notes, dated [DATE], revealed Resident #21 was witnessed on [DATE] standing in front of Resident #51. Resident #51 was lying on the floor looking fearful. Resident #21 was yelling profanities toward Resident #51 and staff. Resident #21 repeatedly stated, touch me again and next time you won't be able to stand back up. This incident was not witnessed by staff. Resident #21 confirmed he pushed Resident #21 because Resident #21 urinated on the toilet seat. During the morning of [DATE], Resident #21 was sent to the hospital for a psychiatric evaluation. Review of Resident #51 progress notes, dated [DATE] as a late entry, revealed emergency management services transportation was contacted to take Resident #51 to the hospital for evaluation due to a head injury.Review of Resident #51 hospital medical records, dated [DATE], revealed Resident #51 had a computed tomography (CT) scan of the head which showed he had a falx subdural hematoma, which is a small interhemispheric subdural hematoma with in the anterior interhemispheric fissure measuring a couple of millimeters. (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 - Actual harm Residents Affected - Few	There was also a fracture identified through bridging anterior osteophyte at C5-C6 extending through the body of C6. Resident #51 expired in the hospital on [DATE] at 8:52 P.M.Review of Resident #51's hospital discharge records, dated [DATE], revealed the discharge diagnoses included cardiorespiratory arrest, acute hypoxic respiratory failure, suspect aspiration with significant oropharyngeal secretions, oropharyngeal dysphagia advanced dementia, acute traumatic fall, acute traumatic C5-C6 osteophyte fracture, and acute traumatic C6 vertebral body fracture. Review of the facility Self-Reported Incident (SRI), dated [DATE], documented staff found Resident #51 lying on the floor and Resident #21 standing close by. Staff stated Resident #21 was swearing loudly and said, touch me again and next time you won't be able to stand back up. Resident #51 was fully assessed and there was a small amount of bleeding and a raised area on his scalp. Resident #51 was sent to the emergency room for assessment.During an interview on [DATE] at 1:55 P.M., the Administrator confirmed it was reported to him via Director of Nursing that Resident #21 had smacked Resident #51 across the face, which knocked him to the ground and caused an injury to the back of Resident #51 head. He confirmed it was reported to him the incident was unwitnessed, but when he interviewed Resident #21, the resident confirmed he smacked Resident #51, which caused him to fall to the ground. The Administrator confirmed Resident #51 was sent to the hospital for evaluation after the incident and was later determined to have a subdural hematoma and a fracture of the C5 and C6 vertebra. He received this information from DON but also received information from Law Enforcement Detective #600 about the extent of Resident #51's injuries and that the police department had received information about the incident and they were investigating it.During an interview on [DATE] at 9:40 A.M. with Director of Nursing confirmed it was reported to her Resident #21 had smacked Resident #51 across the face, which knocked him to the ground and caused an injury to the back of Resident #51's head. She confirmed she received a phone call from Licensed Practical Nurse (LPN) #215 shortly after the incident occurred on [DATE]. She confirmed she was told the incident was unwitnessed. She confirmed Resident #51 was sent to the hospital, and after testing and assessment at the hospital, it was determined that Resident #51 had a subdural hematoma and a fracture of the C5 and C6 vertebra. She confirmed she reported this to the administrator after being informed by the hospital.During an interview on [DATE] at 11:02 AM., Law Enforcement Detective #600 stated he was contacted by Resident #51's family two or three days after Resident #51 expired. He stated he was collecting information to determine if there were any issues with the incident that happened at the facility between Resident #51 and Resident #21.During an interview on [DATE] at 12:30 PM, Licensed Practical Nurse (LPN) #215 stated she was working the hallway in which Resident #51 and Resident #21 lived. She stated she heard a loud noise on the evening of [DATE], went to their room, and found Resident #51 lying on the floor and Resident #21 near him, saying, He always does this. She later found out that Resident #21 said he always does this because he was accusing Resident #51 of urinating on their toilet seat. LPN #215 stated Resident #21 told her he pushed Resident #51 to the ground. She fully assessed Resident #51 and found a laceration to his right arm and a raised, reddened area with a small amount of blood to the back of his head. She got an order from the physician to send Resident #51 to the hospital for further evaluation.During an interview on [DATE] at 12:52 P.M., LPN #225 stated she was working the opposite hallway to where Resident #51 and Resident #21's room was located. She heard a loud noise back their hallway and went toward that area. She found Resident #51 lying halfway in and out of his room, on the floor, and Resident #21 over top of Resident #51, saying, I promise next time, you won't get up. She did not physically assess Resident #51 but was told about the injury to his forearm and the back of his head. Review of facility policy titled Abuse, Neglect, and Exploitation, dated [DATE], revealed it is the policy of this (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. Abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. This deficiency represents non-compliance investigated regarding complaint number 2709090.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and facility policy review, the facility failed to report an allegation of abuse in a timely manner. This affected one (Resident #51) of three residents reviewed for abuse. The census was 49.Findings Include: Resident #51 was admitted to the facility on [DATE]. His diagnoses were Parkinson's disease without dyskinesia, dementia, psychotic disturbance, mood disturbance, anxiety disorder, repeated falls, and major depressive disorder. Review of his minimum data set (MDS) assessment, dated 12/02/25, revealed he had a severe cognitive impairment.Review of Resident #51 progress notes, dated 12/13/25, revealed staff heard Resident #51 yelling from his room on 12/12/25. He was found lying on the floor with his head and torso outside of the room and his legs inside the room. Resident #21 (Resident #51 roommate) was present in the room and was standing over Resident #51 yelling. A full body assessment was completed on Resident #51 with the following found: small amount of bleeding and a raised area on the resident's scalp, consistent with possible head impact. Resident #51 appeared fearful and confused during the assessment.Review of Resident #51 progress notes, dated 12/14/25, revealed Resident #51 was still in the hospital.Review of Resident #51 progress notes, dated 12/15/25 (late entry meant to have been documented on 12/13/25), revealed emergency management services transportation was contacted to take Resident #51 to the hospital for evaluation due to a head injury.Review of Facility Reported Incident (FRI) number 268571, dated 12/13/25 at 10:06 A.M., confirmed on 12/12/25 at 8:00 P.M. there was an allegation of physical abuse between Resident #21 and Resident #51. Staff found Resident #51 lying on the floor and Resident #21 standing close by. Staff stated Resident #21 was swearing loudly and said, touch me again and next time you won't be able to stand back up. Resident #51 was fully assess and found a small amount of bleeding and a raised area on his scalp. He was sent to the emergency room for assessment.Interview with Administrator and Director of Nursing (DON) on 01/06/26 at 1:55 P.M. and 01/07/26 at 9:40 A.M. both confirmed they were notified of the incident between Resident #21 and Resident #51 on 12/12/25. They confirmed they were told that when Resident #51 was found on the ground, Resident #21 was standing near/over top him, stating that, I promise next time, you won't get up. Administrator confirmed he interviewed Resident #21, who told him that he smacked Resident #51, which caused him to fall to the ground. Administrator stated he reported the incident the next day because he initially thought it was an unwitnessed fall. DON and Administrator both confirmed they knew Resident #21 had stated he smacked Resident #51, knocking him to the ground, on the night of the incident. Interview with Licensed Practical Nurse (LPN) #215 on 01/07/26 at 12:30 P.M. confirmed she reported the incident between Resident #21 and Resident #51 to the DON shortly after the incident happened on 12/12/25. She confirmed she told the DON that Resident #21 had indicated he was the one that smacked Resident #51 and knocked him to the ground.Review of facility Abuse, Neglect, and Exploitation policy, dated 08/01/25, revealed it is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. Abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. The facility will have written procedures that include: reporting all alleged violations to the administrator, state agency, adult protective services, and to all other required agencies within specified time frames: immediately, but no later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury. This deficiency represents non-compliance investigated (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	regarding complaint number 2709090.