STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365529	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Park Health Care Center	3536 Washington Ave Cincinnati, OH 45229

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of facility Self-Reported Incidents (SRIs), review of facility incident investigations, resident interview, staff interview, and review of the facility policy, the facility failed to report allegations of resident-to-resident sexual abuse to the state agency within 24 hours. This affected four (Residents #2, #8, #11, #36) of four residents reviewed for abuse. The facility census was 48 residents. Findings include:1.Review of the medical record for Resident #36 revealed an admission date of 03/22/22 with diagnoses including dementia, psychotic disturbance, mood disturbance, anxiety disorder, and osteoarthritis. Review of the Minimum Data Set (MDS) assessment for Resident #36 dated 07/03/25 revealed the resident was severely cognitively impaired and required staff assistance with activities of daily living (ADLs.) Review of the progress note for Resident #36 dated 07/12/25 at 6:12 P.M. revealed staff witnessed the resident sitting in the lap of another peer and kissing him. Staff separated Resident #36 removed them from the environment and educated the resident on personal space and understanding boundaries. Review of the behavior care plan for Resident #36 dated 07/16/25 revealed the resident had been sexually inappropriate with another male resident. Interventions included the following: administer medications as ordered, monitor and document side effects and effectiveness, assist the resident to develop more appropriate methods of coping and interacting, encourage the resident to express feelings appropriately, caregivers to provide opportunity for positive interaction, educate the resident, caregivers and families on successful coping and interaction strategies, intervene as necessary to protect the rights and safety of others and monitor behavior episodes and attempt to determine an underlying cause. Review of the medical record for Resident #11 revealed an admission date of 02/12/25 with diagnoses including radiculopathy, schizoaffective disorder, bipolar disorder, and congestive heart failure. (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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(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 - Some	Review of the care plan for Resident #11 dated 03/10/25 revealed the resident had altered behaviors including being verbally disruptive, resistive to care, violence, anger and noncompliance. Interventions included the following: administer prescribed medications, observe for side effects, monitor for effectiveness, allow resident to pace where he can be observed, as needed medication given after non pharmacological approach attempted, assess for internal and external contributors to rule out delirium, be careful to not invade the resident’s personal space, consult with psychiatric services if needed and as requested by the resident, family and physician, convey acceptance of the resident during periods of inappropriate behavior, and encourage family support and involvement. Review of the MDS assessment for Resident #11 dated 05/21/25 revealed the resident was moderately cognitively impaired and required staff assistance with ADLs. Review of the progress note for Resident #11 dated 07/12/25 at 6:17 P.M. revealed staff witnessed a peer sitting in the resident’s lap and started to kiss him. Staff separated the residents and educated Resident #1 on the importance of setting boundaries for personal space. Review of the facility SRI initiated 07/16/25 at 12:50 A.M. revealed the facility investigated an allegation of sexually inappropriate conduct which had occurred between Resident #36 and Resident #11 on 07/12/25 at 6:15 P.M. The facility did not substantiate abuse. Review of the undated facility investigation of the incident between Resident #36 and Resident #11 which occurred on 07/12/25 revealed the incident was mentioned in morning report meeting on 07/12/25 but the employee on duty was not sure if the incident needed to be reported to administration. The facility provided one-on-one coaching with the employee regarding immediate reporting of abuse allegations. Interview on 08/04/25 at 12:25 P.M. with Resident #11 confirmed the resident did not recall kissing or being kissed by any resident at the facility and the resident denied being sexually abused at the facility. Interview on 08/04/25 at 1:24 P.M. with Resident #36 confirmed the resident did not recall kissing or being kissed by any resident at the facility and the resident denied being sexually abused at the facility. Interview on 08/05/25 at 11:44 A.M with the Director of Nursing (DON) confirmed the DON saw the progress notes about Resident #11 and Resident #36 kissing on 07/12/25 when she reviewed the 72-hour report on 07/14/25. The DON reported that the staff working did not report the incident to her or other administrative staff. The DON verified that the incident occurred on 07/12/25 and an SRI was not filed until 07/16/25. Interview on 08/06/25 at 11:17 A.M. with Licensed Practical Nurse (LPN) #228 confirmed the nurse could not recall the date of the incident but stated she was called to the secured unit by Certified Nursing Assistant (CNA) #211. LPN #228 stated CNA #211 reported Resident #11 and Resident #36 were at the nurses’ station and Resident #36 sat on Resident #11’s lap and started to kiss him. LPN #228 stated Resident #11 and Resident #36 were separated by CNA #211 prior to LPN #228 arriving on the unit. LPN #228 confirmed the DON was notified. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 08/06/25 at 11:24 A.M. with CNA #211 confirmed the aide could not recall the date of the incident, but she was coming out of another resident’s room when she saw Resident #11 sitting on his rollator walker by the nurse’s station. CNA #211 stated Resident #36 was standing over Resident #11 and was straddling him on his walker. CNA #211 reported Resident #36 was holding Resident #11’s head and Resident #36 was kissing Resident #11 on the lips. CNA #211 confirmed she reported the incident to the nurse. 2. Review of the medical record for Resident #8 revealed an admission date of 04/06/25 with diagnoses including cirrhosis of the liver, alcohol abuse, and cocaine abuse. Review of MDS assessment dated [DATE] for Resident #8 revealed the resident had mild cognitive impairment and was independent with ADLs with minimal set-up assistance. Review of the progress note for Resident #8 dated 06/22/25 at 8:32 A.M. revealed the resident was sitting on the porch, resident smoking area, involved in sexual activity with a female resident from another unit of the facility. Both residents were physically exposed and other residents complained. The nurse explained to Resident #8 the porch was a public area and was not an appropriate place for sexual activity. Resident #8 told the nurse he wound have sex anywhere he wanted and when he wanted and then began cursing and verbally threatening the nurse. Review of the medical record for Resident #2 revealed an admission date of 07/29/24 with a diagnosis of paraplegia. Review of the MDS assessment for Resident #2 dated 07/01/25 revealed the resident was cognitively intact and independent with ADLs. Review of the progress note for Resident #2 dated 06/22/25 at 8:30 A.M. revealed the resident was observed on the smoking porch engaged in sexual activity with another resident in the presence of other residents. The nurse explained to Resident #2 that sexual activity could not take place on the porch or other public areas, but Resident #2 laughed and stated the nurse could not stop them. Review of the facility SRIs dated 08/06/25 revealed the facility investigated an allegation of resident-to-resident sexual abuse between Residents #8 and #2. The facility did substantiate abuse. The Surveyor attempted an interview on 08/06/25 at 2:00 P.M. with Resident #8, but the resident declined the interview. Interview on 08/06/2025 at 2:51 P.M. with the Administrator confirmed staff had not reported the incident regarding Residents #8 and #2 on 06/22/25. Interview on 08/06/25 at 2:55 P.M. with the DON confirmed staff reported on 06/23/25 that Residents #8 and #2 had been kissing and talking nasty on the smoking porch on 06/22/25. The DON confirmed the facility had not investigated the incident to determine if sexual abuse had occurred nor had the facility reported the allegation immediately to the state agency as required. The DON confirmed the regional nurse told her the facility didn’t have to file an SRI because the residents were consenting adults, and the residents’ capacity to consent was presumed and was not investigated (continued on next page)

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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 - Some	Review of the facility policy titled Abuse, Neglect and Exploitation dated 01/22/25 revealed the policy defined sexual abuse as nonconsensual sexual contact of any type with a resident, and the facility would report all allegations of abuse to the state agency within required timeframes. This deficiency represents noncompliance investigated under Complaint Number 2571800.

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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 - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of facility Self-Reported Incidents (SRIs), review of facility incident investigations, resident interview, staff interview, and review of the facility policy, the facility failed to thoroughly and timely investigate allegations of resident-to-resident sexual abuse This affected four (Residents #2, #8, #11, #36) of four residents reviewed for abuse. The facility census was 48 residents. Findings include:1. Review of the medical record for Resident #36 revealed an admission date of 03/22/22 with diagnoses including dementia, psychotic disturbance, mood disturbance, anxiety disorder, and osteoarthritis. Review of the Minimum Data Set (MDS) assessment for Resident #36 dated 07/03/25 revealed the resident was severely cognitively impaired and required staff assistance with activities of daily living (ADLs.) Review of the progress note for Resident #36 dated 07/12/25 at 6:12 P.M. revealed staff witnessed the resident sitting in the lap of another peer and kissing him. Staff separated Resident #36 removed them from the environment and educated the resident on personal space and understanding boundaries. Review of the behavior care plan for Resident #36 dated 07/16/25 revealed the resident had been sexually inappropriate with another male resident. Interventions included the following: administer medications as ordered, monitor and document side effects and effectiveness, assist the resident to develop more appropriate methods of coping and interacting, encourage the resident to express feelings appropriately, caregivers to provide opportunity for positive interaction, educate the resident, caregivers and families on successful coping and interaction strategies, intervene as necessary to protect the rights and safety of others and monitor behavior episodes and attempt to determine an underlying cause. Review of the medical record for Resident #11 revealed an admission date of 02/12/25 with diagnoses including radiculopathy, schizoaffective disorder, bipolar disorder, and congestive heart failure. Review of the care plan for Resident #11 dated 03/10/25 revealed the resident had altered behaviors including being verbally disruptive, resistive to care, violence, anger and noncompliance. Interventions included the following: administer prescribed medications, observe for side effects, monitor for effectiveness, allow resident to pace where he can be observed, as needed medication given after non pharmacological approach attempted, assess for internal and external contributors to rule out delirium, be careful to not invade the resident’s personal space, consult with psychiatric services if needed and as requested by the resident, family and physician, convey acceptance of the resident during periods of inappropriate behavior, and encourage family support and involvement. Review of the MDS assessment for Resident #11 dated 05/21/25 revealed the resident was moderately cognitively impaired and required staff assistance with ADLs. Review of the progress note for Resident #11 dated 07/12/25 at 6:17 P.M. revealed staff witnessed a peer sitting in the resident’s lap and started to kiss him. Staff separated the residents and educated Resident #1 on the importance of setting boundaries for personal space. (continued on next page)

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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 - Some	Review of the facility SRI initiated 07/16/25 at 12:50 A.M. revealed the facility investigated an allegation of sexually inappropriate conduct which had occurred between Resident #36 and Resident #11 on 07/12/25 at 6:15 P.M. The facility did not substantiate abuse. Review of the undated facility investigation of the incident between Resident #36 and Resident #11 which occurred on 07/12/25 revealed the incident was mentioned in morning report meeting on 07/12/25 but the employee on duty was not sure if the incident needed to be reported to administration. The facility provided one-on-one coaching with the employee regarding immediate reporting of abuse allegations. The investigation did not include witness statements or witness interviews and/or staff interviews regarding the incident between Resident #11 and Resident #36 which occurred on 07/12/25. Review of the facility investigation revealed the facility interviewed seven residents related to abuse with no findings. Interview on 08/04/25 at 12:25 P.M. with Resident #11 confirmed the resident did not recall kissing or being kissed by any resident at the facility and the resident denied being sexually abused at the facility. Interview on 08/04/25 at 1:24 P.M. with Resident #36 confirmed the resident did not recall kissing or being kissed by any resident at the facility and the resident denied being sexually abused at the facility. Interview on 08/05/25 at 11:44 A.M with the Director of Nursing (DON) confirmed the DON saw the progress notes about Resident #11 and Resident #36 kissing when she reviewed the 72-hour report on 07/14/25. The DON reported that the staff working did not report the incident to her or other administrative staff. The DON verified that the incident occurred on 07/12/25 and an SRI was not filed until 07/16/25. The DON confirmed the investigation of the incident did not start until 07/14/25. The DON reported she interviewed Resident #11 and Resident #36 after she discovered the incident on 07/14/25 but neither resident recalled the incident. The DON verified the facility did not obtain any staff statements related to the incident. Interview on 08/06/25 at 11:17 A.M. with Licensed Practical Nurse (LPN) #228 confirmed the nurse could not recall the date of the incident but stated she was called to the secured unit by Certified Nursing Assistant (CNA) #211. LPN #228 stated CNA #211 reported Resident #11 and Resident #36 were at the nurses’ station and Resident #36 sat on Resident #11’s lap and started to kiss him. LPN #228 stated Resident #11 and Resident #36 were separated by CNA #211 prior to LPN #228 arriving on the unit. LPN #228 confirmed the DON was notified. Interview on 08/06/25 at 11:14 A.M. with CNA #211 confirmed the aide could not recall the date of the incident, but she was coming out of another resident’s room when she saw Resident #11 sitting on his rollator walker by the nurse’s station. CNA #211 stated Resident #36 was standing over Resident #11 and was straddling him on his walker. CNA #211 reported Resident #36 was holding Resident #11’s head and Resident #36 was kissing Resident #11 on the lips. CNA #211 confirmed she reported the incident to the nurse. 2. Review of the medical record for Resident #8 revealed an admission date of 04/06/25 with diagnoses including cirrhosis of the liver, alcohol abuse, and cocaine abuse. (continued on next page)

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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 - Some	Review of MDS assessment dated [DATE] for Resident #8 revealed the resident had mild cognitive impairment and was independent with ADLs with minimal set-up assistance. Review of the progress note for Resident #8 dated 06/22/25 at 8:32 A.M. revealed the resident was sitting on the porch, resident smoking area, involved in sexual activity with a female resident from another unit of the facility. Both residents were physically exposed and other residents complained. The nurse explained to Resident #8 the porch was a public area and was not an appropriate place for sexual activity. Resident #8 told the nurse he wound have sex anywhere he wanted and when he wanted and then began cursing and verbally threatening the nurse. Review of the medical record for Resident #2 revealed an admission date of 07/29/24 with a diagnosis of paraplegia. Review of the MDS assessment for Resident #2 dated 07/01/25 revealed the resident was cognitively intact and independent with ADLs. Review of the progress note for Resident #2 dated 06/22/25 at 8:30 A.M. revealed the resident was observed on the smoking porch engaged in sexual activity with another resident in the presence of other residents. The nurse explained to Resident #2 that sexual activity could not take place on the porch or other public areas, but Resident #2 laughed and stated the nurse could not stop them. Review of the facility SRIs dated 08/06/25 revealed the facility investigated an allegation of resident-to-resident sexual abuse between Residents #8 and #2. The facility did substantiate abuse. The Surveyor attempted an interview on 08/06/25 at 2:00 P.M. with Resident #8, but the resident declined the interview. Interview on 08/06/2025 at 2:51 P.M. with the Administrator confirmed staff had not investigated the incident involving Residents #8 and #2 which had occurred on 06/22/25 until 08/06/25. Interview on 08/06/25 at 2:55 P.M. with the DON confirmed staff reported on 06/23/25 that Residents #8 and #2 had been kissing and talking nasty on the smoking porch on 06/22/25. The DON confirmed the facility had not investigated the incident to determine if sexual abuse had occurred nor had the facility reported the allegation immediately to the state agency as required. The DON confirmed the regional nurse told her the facility didn’t have to file an SRI because the residents were consenting adults, and the residents’ capacity to consent was presumed and was not investigated Review of the facility policy titled Abuse, Neglect and Exploitation dated 01/22/25 revealed an immediate investigation was warranted when a suspicion of abuse occurred. Written procedures for an investigation included the following: identify the staff responsible for the investigation, exercise caution in handling evidence that could be used in a criminal investigation, investigate different types of alleged violations, identifying and interviewing all involved persons including the alleged victim, alleged perpetrator, witnesses and others who might have knowledge of the allegations, focusing the investigation on determining if abuse occurred, the extent and the cause an providing complete and thorough documentation of the investigation. This deficiency represents noncompliance investigated under Complaint Number 2571800.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on medical record review, observation, staff interview, and review of facility policy, the facility failed to provide appropriate hand and nail hygiene for dependent residents. This affected one (Resident #15) of four residents reviewed for hand and nail care. The facility census was 48 residents.Findings include: Review of medical record for Resident #15 revealed an admission date of 12/28/23 with diagnoses including included cerebral infarction, diabetes, hypertension, and aphasia. Review of the Minimum Data Set (MDS) assessment for Resident #15 dated 02/13/25 revealed the resident had moderately impaired cognition and required staff assistance with bathing and personal hygiene. Observation on 08/06/25 at 8:44 A.M. of Resident #15 revealed the resident communicated via an iPad but had difficulty using the device because his fingernails were too long. The resident's nails also had debris underneath them. Interview on 08/06/25 at 8:47 A.M. with Resident #25 confirmed his nails were too long and staff had not offered to cut them, and the length of the nails made it difficult for him to use his communication device. Interview on 08/07/25 at 9:49 A. M. with the Director of Nursing (DON) confirmed nail care was to be done in conjunction with showers which were offered, at minimum, twice weekly to each resident. The DON confirmed there was no set schedule for hand or nail care outside the bathing schedule. Interview on 08/07/25 at 10:31 A.M. with Assistant Director of Nursing (ADON) #235 confirmed nail care should be occurring on shower days. Nurses were instructed to do the nail clipping of any resident who is diabetic. ADON #235 confirmed Certified Nursing Assistants (CNAs) should be charting if residents refused nail care or personal hygiene. Interview on 08/07/25 at 10:48 A.M. with Licensed Practical Nurse (LPN) #231 confirmed Resident #15 was in need of nail care to his hands due to the length of the nails and the dirt under his fingernails. Review of facility policy titled Care of Fingernails/Toenails dated October 2010 revealed nail care includes daily cleaning and regular trimming to prevent skin problems around the nail bed. This deficiency represents noncompliance investigated under Complaint Number OH00166418 (iQIES 1339328)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interview, and review of the facility policy, the facility failed to ensure resident fall prevention interventions were in place as ordered by the physician and per the resident care plan. This affected one (Resident #31) of four residents reviewed for falls. The facility census was 48. Findings include: Review of the medical record for Resident #31 revealed an admission date of 04/07/25 with diagnoses including type two diabetes mellitus, chronic kidney disease, depression, and spastic hemiplegia. Review of the fall risk assessment for Resident #31 dated 04/10/25 revealed the resident had one to two falls in the past three months and was at risk for falls. Review of the fall care plan for Resident #31 dated 06/04/25 revealed the resident had a potential for injuries and falls related to a balance deficit and a history of falls. The intervention of adding a fall mat to the right side of the bed was added to the care plan on 07/16/25. Review of the interdisciplinary team (IDT) progress note for Resident #31 dated 07/11/25 at 3:39 P. M. revealed the resident fell on [DATE] while attempting to reposition himself in his bed and rolled out of bed. An intervention was to add a fall mat to the right side of the bed. Review of the Minimum Data Set (MDS) assessment for Resident #31 dated 07/15/25 revealed the resident was cognitively intact, required staff assistance with activities of daily living (ADLs.) Review of the physician's orders for Resident #31 revealed an order dated 07/16/25 for a fall mat to the right side of the bed at all times when the resident was in bed. Observation on 08/05/25 at 11:31 A.M. of Resident #31 revealed the resident was lying in bed and did not have a fall mat next to his bed. Interview on 08/05/25 at 11:31 A.M. with Certified Nursing Assistant (CNA) #213 verified Resident #31 was lying in bed and the resident's fall mat was not in place. Observation on 08/06/25 at 11:26 A.M. of Resident #31 revealed the resident was lying in bed and did not have a fall mat next to his bed. Interview on 08/06/25 at 11:26 A.M with CNA #212 verified Resident #31 was lying in bed and the resident's fall mat was not in place. Interview on 08/06/25 at 11:28 A.M. with Licensed Practical Nurse (LPN) #228 confirmed Resident #31's care plan indicated the resident was to have a fall mat to the side of his bed. LPN #228 verified Resident #31's fall mat was not in place while Resident #31 was lying in bed. Review of the facility policy titled Managing Falls and Falls Risk undated revealed the staff would identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to minimize complications from falling. This deficiency represents noncompliance investigated under Complaint Number OH00167474 (iQIES 1339329).