STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365530	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delhi Post-Acute	5999 Bender Road Cincinnati, OH 45233

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. Based on medical record review, review of facility Self-Reported Incidents (SRIs), review of police reports, resident interview, observation, staff interview, and review of the facility policy, the facility failed to ensure residents were free from abuse. This affected one (Resident #5) of three residents reviewed for abuse. The facility census was 99 residents. Findings include: Review of the medical record for Resident #5 revealed an admission date of 12/06/24 with diagnoses including chronic obstructive pulmonary disease, vascular dementia, and major depressive disorder. Review of the Minimum Data Set (MDS) assessment for Resident #5 dated 01/05/26 revealed the resident had intact cognition. and required setup or cleanup assistance for bed mobility, transfers, and ambulation. Review of the facility SRI regarding Resident #5 dated 02/02/26 and timed 12:06 P.M. revealed the facility investigated and substantiated an allegation of sexual abuse per Licensed Practical Nurse (LPN) #201 towards the resident. Resident #5 reported to staff that Licensed Practical Nurse (LPN) #201 sent the resident pictures of her exposed breasts and allowed the resident to have sexual contact with her breasts. LPN #201 also videotaped the sexual contact between the nurse and Resident #5 using the resident's personal cell phone. The Director of Nursing (DON) confirmed the video which was viewable on Resident #5's personal phone lasted approximately forty-five seconds and clearly showed LPN #201's face. Interview with Resident #5 on 02/01/26 confirmed he had consented to the sexual contact and also confirmed LPN #201 had touched his genital before but could not recall the date. Interview with LPN #201 denied the allegations of sexual abuse. The local police interviewed LPN #201 on 02/03/26 and reported to the facility that LPN #201 had confessed to the allegations of sexual abuse towards Resident #5. The facility substantiated the allegation of sexual abuse and terminated LPN #201. Review of the police report dated 02/02/26 revealed the facility Director of Nursing (DON) reported Resident #5 sent them a video of the resident engaging in sexual contact with LPN #201. Review of the personnel record for LPN #201 revealed the facility emailed a written termination notice to the nurse on 02/09/26. The termination notice indicated LPN #201 was terminated due to sexual misconduct with a resident. Interview on 02/12/26 at 11:00 A.M with Detective #675 confirmed the local police were investigating LPN #201 for possible charges of sexual battery. Interview on 02/13/26 at 10:45 A.M. with Detective #675 confirmed LPN #201 had confessed she had sexual contact with Resident #5 and they were going to pursue a charge of sexual battery. Interview on 02/17/26 at 11:22 A.M. with LPN #201 confirmed she was notified on 02/01/26 by phone per LPN #301 that she was suspended due to allegation of sexual abuse towards a resident. LPN #201 denied having sexual contact with Resident #5. Observation on 02/17/26 at 12:01 P.M. revealed Resident #5 showed the Surveyor approximately two seconds of a video on his phone which showed LPN #201's face and her exposed breasts. Interview on 02/17/26 at 12:02 P.M. with Resident #5 confirmed that on a date prior to 02/01/26 LPN #201 sent him pictures of her exposed breasts and allowed the resident to suck on her breasts. LPN #201 also videotaped Resident #5 sucking on her breasts using the resident's phone. (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 - Minimal harm or potential for actual harm Residents Affected - Few	Resident #5 confirmed he consented to sexual activity with LPN #201. Resident #5 confirmed he reported LPN #201's actions to staff because he was upset as she was not spending as much time with him after the sexual incident had occurred. Interview on 02/17/26 at 12:20 P.M. with the DON, Registered Nurse Manger (RNM) #303, Assisted Director of Nursing (ADON) #306, ADON #307, and Licensed Practical Nurse Manager (LPNM) #308 confirmed the facility investigated the allegation of sexual abuse per LPN #201 towards Resident #5 and concluded abuse had occurred. Further interview revealed LPN #201 was suspended on 02/01/26, the facility did comprehensive assessments of all residents, and started all-staff education on abuse. Interview on 02/17/26 at 1:25 P.M. with the DON and the Administrator confirmed on 02/01/26 they viewed a video on Resident #5's phone of LPN #201 and Resident #5 engaging in sexual contact consisting of Resident #5 sucking on LPN #201's exposed breasts. The video was approximately 45 seconds long and both LPN #201 and Resident #5 were visible. Review of facility policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program dated April 2021 revealed the residents had the right to be free from abuse, including sexual abuse. This deficiency represents noncompliance investigated under Complaint Number 2740112 and Complaint Number 2743935.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on medical record review, review of facility Self-Reported Investigations (SRIs), staff interview, and review of the facility policy, the facility failed to ensure allegations involving resident abuse were reported to the Ohio Department of Health (ODH) in a timely manner. This affected one resident (Resident #5) of three residents reviewed for abuse. The facility census was 99 residents. Findings include:Review of the medical record for Resident #5 revealed an admission date of 12/06/24 with diagnoses including chronic obstructive pulmonary disease, vascular dementia unspecified severity with other behavioral disturbance, and major depressive disorder. Review of the Minimum Data Set (MDS) assessment for Resident #5 dated 12/12/25 revealed the resident had intact cognition and was dependent on staff for bathing. Review of the facility SRI involving Resident #5 revealed it was created on 02/02/26 at 12:06 P.M and the date of discovery of the allegation was 02/01/26.Interview on 02/18/26 P.M. at 12:24 P.M. with the Director of Nursing (DON) confirmed the facility received the notification of an alleged incident of staff to resident sexual abuse on 02/01/26 at 11:00 AM. The DON confirmed the facility did not report the incident to the state agency until over 24 hours later. Review of the facility policy tilted Abuse, Neglect, Exploitation, and Misappropriation Prevention Program dated April 2021 revealed the facility should report any allegations within timeframes required by federal requirements.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on medical record review and staff interview, the facility failed to develop comprehensive care plans for use of devices. This affected one (Resident #10) of 3 residents reviewed for falls. The facility census was 99 residents.Findings include: Review of medical record for Resident #10 revealed an admission date of 01/11/25 with diagnoses including chronic obstructive pulmonary disease, anxiety disorder, and osteoporosis and a discharge date of _____ Review of the care plan for Resident #10 dated 12/12/25 revealed the care plan did not include the use of a power wheelchair with a seatbelt. Review of the Minimum Data Set (MDS) assessment for Resident #10 dated 12/15/25 revealed the resident had intact cognition and was dependent on staff for all activities of daily living (ADLs). Review of the medical record for Resident #10 revealed it did not include an assessment regarding the appropriateness of the use of a seatbelt in the resident's power wheelchair.Interview on 02/18/25 at 11:34 A.M. with the Director of Nursing (DON) and Director of Rehabilitation (DOR) confirmed Resident #10 used a power wheelchair with a seatbelt for mobility. The DON and the DOR confirmed the facility had not conducted an assessment regarding the use of the seatbelt nor had the facility developed a care plan for the use of the seatbelt with Resident #10's power wheelchair. Further interview confirmed Resident #10's plan of care should have reflected the use of the seatbelt.