STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365629	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dixon Healthcare Center	135 Reichart Avenue Wintersville, OH 43953

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 - Immediate jeopardy to resident health or safety 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** 48565 THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on medical record review, emergency room record review, review of a facility Self-Reported Incident (SRI), review of the facility investigation, review of the news broadcast at https://wtov9.com/news, employee code of conduct review, staff interviews, resident interview and review of facility policy, the facility failed to prevent staff to resident sexual abuse. This resulted in Immediate Jeopardy and the potential for actual physical and psychosocial harm on 08/08/24 at approximately 11:10 A.M. when Hospitality Aide (HA) #286 witnessed an incident of potential sexual abuse between Maintenance Director (MD) #300 and Resident #1, a resident with a court appointed legal guardian due to mental incapacity with a known history of hypersexual tendencies. On 08/08/24 HA #286 observed Resident #1 sitting in her room on the floor, with the door closed and Maintenance Director (MD) #300 standing in front of the resident. Upon entry to the room, HA #286 observed MD #300 pulling down his shirt and his pants appeared to have been unbuttoned. The incident was reported to nursing staff and the Administrator and MD #300 was suspended pending an investigation of alleged sexual abuse. The local police department was notified of the alleged incident. On 08/08/24 at 3:45 P. M. Police Chief (PC) #306 contacted the facility Administrator and reported MD #300 confessed to receiving oral sex from Resident #1 on 08/08/24 when discovered in the resident's room. The PC also reported MD #300 confessed to having sexual interactions with Resident #1 for the last nine to 12 months (while he was employed at the facility). MD #300 was arrested and charged with sexual assault of Resident #1. This affected one resident (#1) of two residents reviewed for abuse. The facility census was 75. On 08/15/24 at 4:30 P.M. the Administrator and Regional Director of Clinical Operations (RDCO) #304 were notified Immediate Jeopardy began on 08/08/24 when Resident #1 was observed on the floor in her room with MD #300 standing in front of her. MD #300 was adjusting his shirt, and his pants appeared to be unbuttoned when discovered by HA #286. MD #300 was suspended pending an investigation and later confessed to receiving oral sex from Resident #1 and being in a sexual relationship with Resident #1 for the past nine to 12 months (while employed at the facility). The MD was arrested by police and charged with the sexual assault of Resident #1. Based on Resident #1's diagnoses and mental incapacity, there was no evidence Resident #1 was able to consent to this relationship. The deficient practice was corrected on 08/10/24 when the facility implemented the following corrective actions: (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 08/08/24 between 11:10 A.M. and 11:20 A.M., Hospitality Aide (HA) #286 entered Resident #1's room (the door was closed) and observed Resident #1 sitting on the floor and Maintenance Director (MD) #300 standing in front of her, adjusting his clothing. HA #286 ensured the resident's safety by instructing MD #300 to immediately leave the room and reported the incident to Licensed Practical Nurse (LPN) #238. On 08/08/24 at 11:30 A.M. LPN #238 reported the incident to the Administrator. On 08/08/24 at 11:33 A.M. LPN #238 completed a head to toe and pain assessment on Resident #1. On 08/08/24 at 11:34 A.M. the Administrator interviewed MD #300, who initially denied anything sexual was occurring and stated he was helping Resident #1 up off the floor. MD #300 was suspended pending the results of the investigation for suspicion of sexual abuse and escorted out of the facility by Human Resource Manager (HRC) #256. MD #300's timecard reflected an 11:45 A.M. time punch to end his shift MD #300's employment was subsequently terminated on 08/08/24. On 08/08/24 at 11:40 A.M. the Administrator notified Regional Director of Operations (RDO) #308 of the suspicion of sexual abuse by MD #300. On 08/08/24 at 11:45 A.M. the Administrator interviewed HA #286 regarding her observations. HA #286 remained with Human Resource Manager (HRM) #256 to provide a statement and then went home at 12:30 P.M. per her request. On 08/08/24 at 12:06 P.M. the Director of Nursing was notified of the incident by the Administrator. On 08/08/24 at 12:25 P.M. the Administrator notified the local police department of the incident HA #286 had reported involving MD #300. On 08/08/24 at 12:30 P.M. the Administrator asked Social Service Designee (SSD) #225 to speak with Resident #1 to determine if the resident would share any information. The resident was unable to provide meaningful information at that time, indicating MD #300 had been fixing her television. On 08/08/24 at 12:40 P.M. Police Chief #306 arrived at the facility and interviewed Resident #1. The Police Chief asked Resident #1 if she would like to go to the hospital and get checked out. Resident #1 declined at first but then stated it may be nice to get out for a little bit. The Police Chief explained to Resident #1 the hospital may complete a rape kit. Resident #1 stated she was familiar with rape kits. The resident returned to the facility on [DATE] at 5:57 P.M. No rape kit had been completed due to the resident's refusal at that time. On 08/08/24 at 1:30 P.M. Resident #1 was transported to the emergency room (ER). On 08/08/24 at 3:45 P.M. Police Chief #306 called the Administrator and reported during the interview with MD #300, MD #300 admitted to receiving oral sex from Resident #1. MD #300 was being arrested and taken to jail. On 08/08/24 at 5:12 P.M. the Administrator initiated a self-reported incident to report the incident of sexual abuse to the State agency. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 08/08/24 at 8:30 P.M. the DON/Designee interviewed 26 female residents (Resident #1, #2, #4, #5, #7, #8, #17, #21, #25, #26, #27, #33, #35, #38, #45, #46, #54, #58, #59, #62, #65, #68, #70, #71, #74 and #75) with a Brief Interview of Mental Status (BIMS) score of nine or higher (results range from 0-15) regarding MD #300. Skin sweeps were completed for 12 female residents (#3, #6, #20, #24, #32, #36, #37, #39, #40, #53, #69 and #74). unable to be interviewed Three residents (#16, #31 and #34) received both a skin sweep and interview due to their questionable BIMS score. On 08/09/24 at 9:00 A.M. the DON/Designee interviewed 28 male residents (#10, #11, #12, #14, #15, #16, #18, #19, #28, #29, #30, #41, #42, #43, #44, #47, #48, #49, #50, #55, #56, #57, #61, #64, #66, #67, #72 and #73) and skin sweeps were completed for eight non-interviewable residents (#9, #13, #22, #23, #51, #52, #60 and #63) to identify any additional sexual abuse concerns. On 08/09/24 by 1:00 P.M. the DON/Designee interviewed all 52 interviewable residents regarding abuse. Questioned asked included: Has staff, a resident or anyone else here abused you-this includes verbal, physical or sexual abuse? On 08/09/24 by 1:00 P.M. the DON/Designee interviewed 97 staff (five housekeeping staff, 35 STNAs, eight dietary staff, seven registered nurses (RN), 16 licensed practical nurses (LPN), 15 therapy staff, seven administration staff, two activity staff, one maintenance staff, and one hospitality aide) regarding MD #300 and inappropriate activity with residents. Employees were interviewed either by phone or in person. STNA #200, #219, #220, and #250 were interviewed in-person or by phone by 08/13/24 due to approved leave, leave of absence (LOA) or beginning employment. STNA #230 remained on LOA and will be interviewed on her first shift upon her return. Questions asked included: Have you witnessed or heard any inappropriateness between MD #300 and a resident? If yes, what did you hear and when? HA #286 stated she had observed Resident #1 naked in her bathroom with MD #300 present a few months prior, but this was not reported. On 08/09/24 at 3:13 P.M. Resident #1 was evaluated by Psychiatric Nurse Practitioner #307. On 08/09/24 by 2:00 P.M. the Administrator/Designee completed education with 97 staff (five housekeeping staff, 35 STNAs, eight dietary staff, seven registered nurses (RN), 16 licensed practical nurses (LPN), 15 therapy staff, seven administration staff, two activity staff, one maintenance staff, and one hospitality aide). Employees were educated either by phone or in person regarding facility's abuse policy as well as identifying residents at risk for boundary violations and recognizing warning signs of inappropriate behavior. In addition, employees were also educated via text through On-Shift. STNA #200, #219, #220, and #250 were educated in-person or by phone by 08/13/24 due to approved leave, leave of absence or beginning employment. STNA #230 remains on LOA and will be educated on her first shift upon her return. Education was related to the facility abuse policy, identification of potential/actual abuse situations and abuse reporting. On 08/09/24 at 11:30 A.M. an Ad Hoc Quality Assurance and Performance Improvement (QAPI) meeting was held. Members of the meeting included the Administrator, DON, Regional Director of Operations (RDO) #308, RDCO #304, Divisional [NAME] President of Risk #309, Medical Director #301, and Divisional President #310. As a result of the meeting, the facility-initiated interventions to have no male caregivers for Resident #1, no male staff in the resident's room without a witness and to encourage Resident #1 to leave the door open. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Beginning on 08/10/24, the DON/Designee began interviewing all interviewable residents, then implemented a plan to interview five residents weekly for four weeks regarding any abuse concerns. After four weeks, random interviews would be conducted. Beginning on 08/10/24 the Administrator/Designee began interviewing five staff members which would be done weekly for four weeks regarding any abuse concerns. Beginning on 08/10/24 Social Services and in-house counseling services would continue offering support to Resident #1 as needed. Additional residents would be identified as needed in morning clinical meeting by reviewing resident nurse's notes, discussion of grand rounds prior to morning meeting, recap from resident meetings from the therapeutic behavior specialist and psych services. On 08/10/24 the facility implemented a plan for all self-reported incidents to be reviewed by the DON/Designee within 24 hours to ensure no other residents were affected. The DON/Designee would address issues with reported incidents immediately upon identification. The facility implemented a plan for any additional staff training/re-education to be completed by the DON/Designee as needed on the facility Abuse and Neglect policy. The facility also implemented a plan for the DON/Designee to educate all new staff on the abuse policy. This would be ongoing as part of new hire orientation. Beginning in September 2024, the Administrator or DON would monitor compliance in the facility monthly QAPI meetings for three months. Then as needed for one year. The facility identified Regional Director of Clinical Operations would monitor compliance during monthly visits times beginning 08/09/2024 for three months then on an as needed basis. Findings include: Review of the Final Decree of Adjudication of Incapacity and Appointment of Plenary Guardian of the Person and Estate document dated January 15, 2003, revealed Resident #1 was adjudged and decreed an incapacitated person and her parents were appointed as guardians. Review of Resident #1's medical record revealed an admitted [DATE] with diagnoses including schizophrenia, adjustment disorder, anxiety, unspecified psychosis not due to a substance or known physiologic condition, depression, unspecified lack of coordination, difficulty walking and sleep disorder. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review revealed the facility developed a care plan (initiated 03/09/22 and revised 04/22/24) for Resident #1 related to behaviors. The care plan noted the resident had diagnoses of schizophrenia, adjustment disorder, anxiety, and psychosis as evidenced by verbal outbursts, physical outbursts, hallucinations, restlessness, irritability, disturbance in sleep patterns, inappropriate/false statements, sexual behaviors/ comments (i.e. father), taking others belongings, yells loudly throughout the building, prefers to sleep on the floor at times stating its cooler. Interventions included administer medications as ordered; Observe and document signs and symptoms of effectiveness and side effects; Educate resident/resident representative to medication effectiveness and side effects; Assist with cosmetic routine; Behavioral health consults as needed; Communicate with resident/resident representative regarding behaviors and treatment; Consult with pastoral care, Psych services and/or support groups; Encourage active support by family/resident representative; Encourage resident to express feelings; Encourage resident to participate in activities of choice; Encourage to maintain as much independence and control/decision making as possible; Intervene as necessary to protect the rights and safety of others; Minimize potential for disruptive behaviors by offering tasks that divert attention; Monitor behavioral episodes and attempt to determine underlying causes; Music of resident's choice; Offer activity of choice, offer chocolate or pop (caffeine free when possible); Notify medical provider of increase in behaviors; observe and anticipate resident's needs: thirst, food, body positioning, pain and toileting needs; Offer TV or PlayStation; Praise any indication of progress in behaviors; Send for psych evaluation if unable to redirect. A plan of care, initiated on 03/09/22 revealed Resident #1 experienced hallucinations at times related to schizophrenia as she would not answer questions appropriately at these times and might appear to have cognitive decline related to this. Interventions included administer medications as ordered, assess whether the behaviors endanger her and/or others and intervene as necessary and obtain psych consult/psychosocial therapy as needed. A plan of care, initiated on 03/09/22 revealed Resident #1 had impaired temporal orientation and recall, hallucination, disorganized thinking and poor decision-making skills related to schizophrenia. Interventions included administer medication as ordered; Discuss concerns about confusion, disease process, nursing home placement with resident/family /care giver; Keep routine as consistent as possible in order to decrease confusion; Observe/document /report to medical provider any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status; Offer two to three step instructions when competing basic tasks. Review of the resident's current physician orders revealed medications included Geodon 80 milligrams (mg) one tablet two times daily for schizophrenia, Sertraline 200 mg in the morning for depression, Wellbutrin SR 150 mg daily for depression, Amitriptyline 50 mg at bedtime for insomnia, Divalproex 500 mg in the A.M. and 1000 mg at night for schizophrenia, and Junel 1/20 daily for birth control (which had been ordered since August 2021). Review of the annual Minimum Data Set (MDS) 3.0 Assessment, dated 07/05/24, revealed a Brief Interview of Mental Status (BIMS) score of 13 (a level of 13-15 indicates intact cognition). Further review revealed the resident had delusions and indicated the resident had verbal behaviors directed toward others which occurred one to three days in the seven-day assessment period. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's nurse's note, authored by the DON, dated 08/08/24 at 12:31 P.M. revealed staff reported an alleged allegation regarding Resident #1. The staff immediately had Resident #1 separated from harm and made to feel safe. The note included a head-to-toe assessment was completed with no abnormalities noted. Review of Resident #1's nurse's note, authored by the DON, dated 08/08/24 at 1:30 P.M. revealed the facility nurse practitioner (NP), NP #312 was notified, and an order was given to send Resident #1 to the emergency room . Resident #1's father was notified. Review of Resident #1's nurse's note, authored by the DON, dated 08/08/24 at 1:45 P.M. revealed Resident #1 was transported to the emergency room per (name of transport company). Review of a facility self-reported incident (SRI), tracking number 250577 revealed an initial report, dated 08/08/24 at 4:21 P.M. related to an incident of sexual abuse involving Resident #1 (victim). The SRI listed the perpetrator as MD #300. HA #286 was identified to be a witness of the incident. HA #286 reported she walked into Resident #1's room and the resident was sitting on the floor and MD #300 was standing in front of her, adjusting his clothing; pulling his shirt down and it appeared to her that, under his shirt, his pants were unfastened. HA #286 remained in the room and called for help. State tested Nursing Assistant (STNA) #285 came in the room and assisted in standing Resident #1 up. HA #286 reported the incident because the positioning (of those involved) and the clothing adjustment when she walked into the room seemed suspicious to her. The investigation of the incident revealed on 08/08/24 between 11:10 A.M. and 11:20 A.M. HA #286 entered Resident #1's room and saw Resident #1 sitting on the floor and MD #300 standing in front of her adjusting his clothing. HA #286 ensured Resident #1's safety by asking MD #300 to immediately leave the room and reported the incident to LPN #238. At 11:30 A.M. LPN #238 reported the incident to the Administrator. At 11:33 A.M. LPN #238 assessed the resident which included a head-to-toe and pain assessment. At 11:34 A.M. the Administrator immediately met and interviewed MD #300. MD #300 denied anything sexual was going on. MD #300 stated he was helping Resident #1 up off the floor. MD #300 was sent home pending investigation. At 11:45 A.M. the Administrator interviewed HA #286. HA #286 remained with Human Resource Director #256 to complete a statement and went home after. At 12:06 P.M. the DON was notified and at 12:25 P.M. the Administrator notified the police and described the scenario as HA #286 explained. PC #306 stated he would be out. At 12:30 P.M. the Administrator asked social service staff to speak with Resident #1 and see if she would share any information. At 12:40 P.M. PC #306 arrived and interviewed Resident #1. PC #306 asked Resident #1 if she would like to go to the hospital and get checked out. Resident #1 declined at first but then stated it may be nice to get out for a little bit. PC #306 explained that the hospital may complete a rape kit. Resident #1 stated she was familiar with them (rape kits). At 1:30 P.M. Resident #1 went out to the emergency room (ER) and at 3:45 P.M. PC #306 called the administrator. PC #306 reported during their interview with MD #300, MD #300 admitted to receiving oral sex from Resident #1. MD #300 was arrested and taken to jail. At 5:57 P.M. Resident #1 returned from the ER but no rape kit was performed (resident refused). A skin check was completed upon the resident's return with no issues noted. On 08/15/24 at 4:59 P.M. the facility SRI was completed. As a result of this investigation the facility substantiated the incident of sexual abuse. Review of Resident #1's nurse's note, authored by the DON, dated 08/08/24 at 5:57 P.M. revealed Resident #1 returned from the emergency department. A head-to-toe assessment was completed with no new findings. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the emergency room Hospital discharge date d 08/08/24 revealed the resident was seen for vaginal discharge and indicated the resident was to follow up with her primary provider. No other information relevant to the visit was provided. As part of the facility investigation, a statement was obtained from HA #286. The handwritten statement dated 08/08/24 at 12:00 P.M. revealed HA #286 was going to pick up Resident #1's lunch tray. She opened the door and Resident #1 was sitting on the floor with her back to the sink. MD #300 was facing the resident. MD #300 hurried up and pulled his untucked shirt down over the front of his pants. Resident #1 was licking her lips. MD #300 wouldn't move. He said he was trying to help Resident #1 up. MD #300 wouldn't move and kept standing in front of Resident #1. HA #286 moved over a little bit and yelled out the door that they needed help. When HA #286 looked back, MD #300 was messing with the front of his pants while his shirt was still over his pants. Through his shirt, you could see that his pants were not buttoned. STNA #285 came in to help get Resident #1 up. HA #286 stated she did not leave the room. MD #300 asked, What else do you need fixed? But MD #300 did not have any tools with him. MD #300 left the room but stood in the hallway while HA #286 was in the room. MD #300 eventually left the hall. By the time MD #300 left the room, the staff had Resident #1 off the floor. Resident #1 did not admit to anything. HA #286 tried to ask Resident #1 if MD #300 made her do something and she said no. HA #286 documented she told Resident #1 we are all human, but we are supposed to protect her. Review of a police report dated 08/08/24 and completed by Police Chief (PC) #306, incident #24-08-000247 revealed the police were contacted by the facility related to an incident of sexual abuse involving Resident #1. During the initial police investigation, MD #300 admitted to receiving oral sex from Resident #1. MD #300 stated to PC #306 sexual relations with Resident #1 had been going on for nine months to a year. The prosecutor was contacted, and MD #300 was transported to a local county jail. MD #300 was charged with sexual assault. Review of the news broadcast at https://wtov9. com/news/local/[NAME]-healthcare-worker-charged-with-sexual-assault-of-a-resident on 08/13/24 at 5:08 P. M. revealed a maintenance worker employed by [NAME] Healthcare Center had been charged with sexual assault after an incident last week at the facility. MD #300 was arrested after an investigation and had since bonded out. The PC involved with the case stated he received a call from the facility Administrator on 08/08/24 that an incident was reported to her regarding a staff member that may have sexually assaulted a resident. Allegedly, another employee witnessed MD #300 engaging in sexual activity with a patient. On 08/15/24 at 8:18 A.M. an interview with PC #306 revealed MD #300 was arrested and charged related to the above incident with Resident #1 as the result of a police investigation. PC #306 indicated Resident #1 lacked the cognitive ability to report accurately what had or was occurring (with MD #300) due to her diagnoses. PC #306 stated based on their investigation, witness, suspect confession- the incident of sexual abuse had occurred. Further interview revealed the PC was aware of some rumors that MD #300 had been engaging in sexual activity for a number of years, but stated none of the staff felt had enough evidence or had witnessed anything specific prior to this incident on 08/08/24. On 08/15/24 at 9:35 A.M. an attempted interview with Resident #1 revealed the resident was unable to describe any physical interactions with MD #300. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 08/15/24 at 11:56 A.M. an interview with the Administrator revealed she was notified of the incident involving Resident #1 and MD #300 on 08/08/24 at 11:30 A.M. The Administrator stated she immediately brought MD #300 to the office, and he was notified at that time of a suspension pending investigation (into an allegation of sexual abuse). The Administrator stated she asked MD #300 if anything sexual had occurred with Resident #1 to which MD #300 denied. At that point MD #300 became angry and threw his keys on the desk. MD #300 was escorted out of the building. During the interview, the Administrator shared about a year ago, there was report of MD #300 coming to the building at off hours frequently however, she stated the incident was investigated without findings. On 08/15/24 at 12:21 P.M. an interview with HA #286 revealed on 08/08/24 between 11:10 A.M. and 11:20 A.M. she walked into Resident #1's room. The main door to the room was closed and Resident #1 only closed the door when looking for clothing or when she was sleeping. HA stated MD #300 was in Resident #1's bathroom and Resident #1 was sitting on the bathroom floor. HA #286 stated after she entered the room, MD #300 pulled down his shirt to cover the front of himself. HA #286 stated she asked MD #300 what he was doing in the room, and he told her he was helping Resident #1 get off the floor. HA #286 shared MD #300 would never assist a resident off the floor prior to this incident but would ask staff to assist a resident. HA #286 stated, at that point, MD #300 was told to leave the room and she stated she called for help. HA #286 stated MD #300 turned away from her and adjusted his pants and left the room but stayed in the hallway outside of the door. HA #286 further revealed there was an incident with MD #300 within the last year where he was in Resident #1's bathroom with Resident #1 and the resident was without clothing. HA #286 stated she did not report the incident because she did not think anyone would do anything about her observation. HA #286 also stated Resident #1 would often call out MD #300's name. On 08/15/24 at 12:55 P.M. interview with STNA #294 revealed she was working on a different hall on 08/08/24 and HA #286 had reported concerns involving Resident #1 directly to her. STNA #294 stated HA #286 was distraught and looked like she had just seen a ghost. STNA #294 stated HA #286 told her she walked into Resident #1's room for a food tray and Resident #1 was on the floor with her back up against the sink. HA #286 described MD #300 was standing over Resident #1 and had his shirt untucked. STNA #294 was told by HA #286 MD #300 then pulled down his shirt to cover his front. STNA #294 stated this was unusual for MD #300 as he always had his shirt tucked in with a belt on. At that point they were approached by LPN #238 and HA #286 was removed from the area to talk privately with LPN #238. Further interview with STNA #294 revealed MD #300 spent a lot of time with Resident #1 behind closed doors. STNA #294 also shared Resident #1 would call out MD #300 by name in a sweet manner but would call out to other staff with anger and would curse. STNA #294 indicated in her opinion, the facility failed Resident #1 by not reporting feelings staff had that MD #300 gave a creepy vibe regarding Resident #1. (continued on next page)

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	365629	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dixon Healthcare Center	135 Reichart Avenue Wintersville, OH 43953

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	On 08/15/24 at 1:52 P.M. interview with LPN # 238 revealed on 08/08/24, HA #286 pulled her into a private area and informed her of an incident between Resident #1 and MD #300. LPN #238 stated she then reported the incident to the Administrator and HRM #256. After reporting the incident, LPN #238 stated she completed an assessment of Resident #1 for injury and there were no physical or mental issues. When asked what was meant by that, LPN #238 stated Resident #1 was confused at times with delusions. LPN #238 further revealed Resident #1 could not make safe decisions which all staff were aware of. LPN #238 shared Resident #1 would call out MD #300's name but stated this did not seem suspicious to her. LPN #238 stated she had not witnessed any unusual behaviors with MD #300 prior to this incident. LPN #238 stated there was a time MD #300 was reported to be coming in early (for work) but she stated this had been investigated, and nothing was found out of the ordinary. Lastly, LPN #238 stated Resident #1 was not capable of consenting to a sexual relationship with MD #300 due to her cognition. On 08/15/24 at 2:50 P.M. an interview with Physician #301 (also the facility medical director) revealed he was Resident #1's primary care physician. Physician #301 stated Resident #1 could not make safe decisions. Physician #301 further stated Resident #1 could say something sensible at one minute then something nonsensical the next. Physician #301 stated he was aware of the incident involving MD #300 that had occurred on 08/08/24 and had participated in the facility corrective plan following the incident. On 08/15/24 at 3:52 P.M. an interview with Resident #1's mother, who was a named guardian for the resident, revealed Resident #1 could, in no way make safe decisions. Resident #1's mother further stated Resident #1 often fixated on sex and would not stop fixating. Resident #1's mother revealed she had been notified of the incident that had occurred with MD #300 on 08/08/24. On 08/15/24 at 3:52 P.M. an interview with Ombudsman #303 revealed knowledge of the incident that occurred on 08/08/24. Ombudsman #303 stated she saw Resident #1 on 08/09/24 and at that time Resident #1 had denied the incident. Ombudsman #303 further stated she interviewed staff, and many were creeped out by MD #300 and advances he had made toward staff in the past. On 08/15/24 at 3:57 P.M. an interview with Nurse Practitioner (NP) #302 revealed she saw all residents in the building for psychiatric care except for Resident #65. NP #302 stated she was made aware of the incident that occurred on 08/08/24 on the day it happened and gave the order to send Resident #1 to the emergency room to have a rape kit completed. NP #302 stated Resident #1 was unable to make safe, informed decisions. The NP stated she felt MD #300 knew the status (cognitive and behavioral) of Resident #1 (he attended morning clinical meetings) including the resident being fixated on sex, her mental status, that she was on birth control and believed MD #300 likely felt no one would believe the resident if she reported sexual incidents. The NP stated the resident was on birth control as an intervention to prevent pregnancy if she was sexually active. She described it as the perfect storm. On 08/19/24 at 12:48 P.M. an interview with Social Service Designee (SSD) #225 revealed she was notified of the incident between Resident #1 and MD #300 on 08/08/24 and attempted to speak to Resident #1 about the incident. SSD #225 revealed Resident #1 was unable to tell her what MD #300 had done or why MD #300 was in the room. SSD #225 stated during the interview, Resident #1 denied any incidents regarding MD #300. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 08/22/24 at 11:20 A.M. an attempt to reach MD #300 via phone was made. The phone number was not in service. An interview with the Administrator revealed she was told MD #300's phone was confiscated by the police. On 08/22/24 at 11:30 A.M. an interview with STNA #285 revealed she was the STNA who assisted HA #286 to get Resident #1 off of the floor on 08/08/24. STNA #285 stated she went to Resident #1's room because she heard HA #286 call for help. STNA #285 stated she witnessed Resident #1 on the floor in the bathroom with her back against the wall. STNA #285 stated Resident #1 was clothed. STNA #285 revealed MD #300 (who was present in the room) stated he was helping Resident #1 get off the floor. STNA #285 stated she thought that was odd because MD #300 never assisted with any resident needs before. STNA #285 stated that in the past if any resident expressed a need to MD #300, he would tell the resident he would get someone. STNA stated she did not personally witness MD #300's pants being undone nor, did she see MD #300 adjust his clothing. STNA #285 stated after she and HA #286 assisted Resident #1 off the floor and walked out of the room. HA #286 stated to her, I think I just saw something bad. Review of MD #300's personnel file revealed the employee was hired on 10/13/17. An Employee Corrective Action Form dated 08/08/24 revealed MD #300 was terminated from employment on 08/08/24. The reason for termination included performance/policy violation and abuse. The document was signed by the Administrator and HRM #256. Review of the facility's undated Code of Conduct for Contract with Attestation revealed the company was committed to maintaining the highest professional and et [TRUNCATED]

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48565 Based on record review, self-reported incident review, and staff interview the facility failed to timely report an allegation of sexual abuse and failed to report an allegation of misappropriation to the state survey agency. This affected two residents (Resident #1 and Resident #50) of three residents reviewed for abuse. The facility census was 75. Findings include: 1. Review of the Final Decree of Adjudication of Incapacity and Appointment of Plenary Guardian of the Person and Estate document dated January 15, 2003, revealed Resident #1 was adjudged and decreed an incapacitated person and her parents were appointed as guardians. Review of Resident #1's medical record revealed an admitted [DATE] with diagnoses including schizophrenia, adjustment disorder, anxiety, unspecified psychosis not due to a substance or known physiologic condition, depression, unspecified lack of coordination, difficulty walking and sleep disorder. Review of the annual Minimum Data Set (MDS) 3.0 Assessment, dated 07/05/24, revealed a Brief Interview of Mental Status (BIMS) score of 13 (a level of 13-15 indicates intact cognition). Further review revealed the resident had delusions and indicated the resident had verbal behaviors directed toward others which occurred one to three days in the seven-day assessment period. Review of Resident #1's nurse's note, authored by the DON, dated 08/08/24 at 12:31 P.M. revealed staff reported an alleged allegation regarding Resident #1. The staff immediately had Resident #1 separated from harm and made to feel safe. The note included a head-to-toe assessment was completed with no abnormalities noted. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility self-reported incident (SRI), tracking number 250577 revealed an initial report, dated 08/08/24 at 4:21 P.M.and related to an incident of sexual abuse involving Resident #1 (victim). The SRI listed the perpetrator as MD #300. HA #286 was identified to be a witness of the incident. HA #286 reported she walked into Resident #1's room and the resident was sitting on the floor and MD #300 was standing in front of her, adjusting his clothing; pulling his shirt down and it appeared to her that, under his shirt, his pants were unfastened. HA #286 remained in the room and called for help. State tested Nursing Assistant (STNA) #285 came in the room and assisted in standing Resident #1 up. HA #286 reported the incident because the positioning (of those involved) and the clothing adjustment when she walked into the room seemed suspicious to her. The investigation of the incident revealed on 08/08/24 between 11:10 A.M. and 11:20 A.M. HA #286 entered Resident #1's room and saw Resident #1 sitting on the floor and MD #300 standing in front of her adjusting his clothing. HA #286 ensured Resident #1's safety by asking MD #300 to immediately leave the room and reported the incident to LPN #238. At 11:30 A.M. LPN #238 reported the incident to the Administrator. At 11:33 A.M. LPN #238 assessed the resident which included a head-to-toe and pain assessment. At 11:34 A.M. the Administrator immediately met and interviewed MD #300. MD #300 denied anything sexual was going on. MD #300 stated he was helping Resident #1 up off the floor. MD #300 was sent home pending investigation. At 11:45 A.M. the Administrator interviewed HA #286. HA #286 remained with Human Resource Director #256 to complete a statement and went home after. At 12:06 P.M. the DON was notified and at 12:25 P.M. the Administrator notified the police and described the scenario as HA #286 explained. PC #306 stated he would be out. At 12:30 P.M. the Administrator asked social service staff to speak with Resident #1 and see if she would share any information. At 12:40 P.M. PC #306 arrived and interviewed Resident #1. PC #306 asked Resident #1 if she would like to go to the hospital and get checked out. Resident #1 declined at first but then stated it may be nice to get out for a little bit. PC #306 explained that the hospital may complete a rape kit. Resident #1 stated she was familiar with them (rape kits). At 1:30 P.M. Resident #1 went out to the emergency room (ER) and at 3:45 P.M. PC #306 called the administrator. PC #306 reported during their interview with MD #300, MD #300 admitted to receiving oral sex from Resident #1. MD #300 was arrested and taken to jail. At 5:57 P.M. Resident #1 returned from the ER but no rape kit was performed (resident refused). A skin check was completed upon the resident's return with no issues noted. On 08/15/24 at 4:59 P.M. the facility SRI was completed. As a result of this investigation the facility substantiated the incident of sexual abuse. On 08/15/24 at 11:56 A.M. an interview with the Administrator revealed she was notified of the incident involving Resident #1 and MD #300 on 08/08/24 at 11:30 A.M. The Administrator stated she immediately brought MD #300 to the office, and he was notified at that time of a suspension pending investigation (into an allegation of sexual abuse). The Administrator stated she asked MD #300 if anything sexual had occurred with Resident #1 to which MD #300 denied. At that point MD #300 became angry and threw his keys on the desk. MD #300 was escorted out of the building. On 08/15/24 at 1:52 P.M. interview with LPN # 238 revealed on 08/08/24, HA #286 pulled her into a private area and informed her of an incident between Resident #1 and MD #300. LPN #238 stated she then reported the incident to the Administrator and HRM #256. After reporting the incident, LPN #238 stated she completed an assessment of Resident #1 for injury and there were no physical or mental issues. When asked what was meant by that, LPN #238 stated Resident #1 was confused at times with delusions. LPN #238 further revealed Resident #1 could not make safe decisions which all staff were aware of. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/19/24 at 11:22 A.M. an interview with the Administrator revealed she did not file a Self-Reported Incident (SRI) with the state survey agency until 08/08/24 at 4:21 P.M., exceeding the two hour reporting requirement. The Administrator stated she did not file the SRI initially as she was investigating a reported clothing adjustment. The Administrator reported that on 08/08/24 at 4:21 P.M., after she heard from PC #306 regarding MD #300's admission to receiving oral sex from Resident #1, she then filed the SRI 2. Review of the document titled; Health Care Power of Attorney dated 04/08/24 revealed Resident #50 had Licensed Practical Nurse (LPN) #241 as healthcare power of attorney. There were no Durable Power of Attorney documents for finances on file at the facility. Review of the medical record for Resident #50 revealed an initial date of admission as 06/17/24 and a readmitted [DATE]. Significant diagnoses included, heart failure, chronic obstructive pulmonary disease, presence of aortocoronary bypass graft, presence of heart-valve replacement, aneurism of artery of lower extremity and deep vein thrombosis of lower extremity. An admission Minimum Data Set (MDS) assessment dated [DATE] revealed a BIMS of 15 (cognitively intact). A review of Resident #50's demographic information revealed Resident #50 was his own responsible party. Review of a progress note dated 06/21/24 at 2:31 P.M., authored by Social Service Designee (SSD) #225, revealed SSD #225 spoke with the resident's medical power of attorney (MPOA) regarding Resident #50's Direct Express card (Social Security pre-paid debit card). SSD #225 provided information to MPOA to help assist with expenses. On 08/15/24 at 9:27 A.M. an interview with Resident #50 revealed he managed his own money. Resident #50 stated he has a MPOA (LPN #241) to help make decisions. Resident #50 denied having money taken from him. On 08/15/24 at 12:18 P.M. an interview with LPN #241 revealed she has been MPOA for Resident #50 for four months. LPN #241 denied knowledge of anyone seeking durable power of attorney for finances. On 08/19/24 at 12:48 P.M. an interview with SSD #225 revealed she had been approached by the MPOA and the spouse of the MPOA regarding Resident #50's bank card. SSD #225, MPOA and the spouse of MPOA approached Resident #50. Resident #50 disclosed a family member has card numbers and is making unauthorized purchases. SSD #225 advised MPOA and Resident #50 to cancel cards and order a bank investigation to get funds reinstated. SSD #225 stated she did not report the incident to administration. On 08/19/24 at 3:21 P.M. an interview with Regional Director of Clinical Operations (DCO) #304 revealed the misappropriation of resident property for Resident #50 as it was reported to SSD #225 should have been reported to administration. The DCO also stated an SRI should have been filed as well. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the policy titled; Ohio Abuse, Neglect and Misappropriation revealed misappropriation as deliberate misplacement, exploitation, or wrongful, temporary or permanent use of belongings or money without consent. The policy defined sexual abuse as non-consensual sexual contact of any type with a resident. The policy stated all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury. The policy also stated for alleged violations of neglect, exploitation, misappropriation of resident property or mistreatment that do not result in serious bodily injury, the facility must report the allegation no later than 24 hours. This deficiency represents non-compliance investigated under Master Complaint Number OH00156731 and Complaint Number OH00155753.