

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365716	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/16/2025
NAME OF PROVIDER OR SUPPLIER Grafton Oaks Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 405 Grafton Avenue Dayton, OH 45406	

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)
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Based on medical record review, review of a Self-Reported Incident (SRI), review of facility investigation documents, staff interview, resident interview, police detective interview, and facility policy review, the facility failed to ensure residents were free from sexual abuse. This resulted in Actual Harm on 08/29/25 for Resident #12, a severely cognitively impaired resident, was sexually abused when Resident #10 entered Resident #12's room, lifted the resident's top, and began touching and sucking on her breasts. Staff witnessed the sexual abuse per Resident #10 towards Resident #12 but did not intervene to stop the abuse. This affected one (Resident #12) of six residents reviewed for abuse. The facility census was 75 residents. Findings include: Review of the medical record for Resident #10 revealed an admission date of 04/18/25 with diagnoses including myocardial infarction, peripheral vascular disease, hypertension, type two diabetes, and anxiety disorder. Resident #10 was discharged from the facility on 08/29/25 to a local law enforcement agency. Review of the care plan for Resident #10 dated 04/20/25 revealed the resident was compliant with care, could make his needs known and displayed no negative behaviors. Resident #10 was receiving rehabilitation services with a goal to return to the community. Review of a check of the national sex offender public website on 06/25/25 revealed Resident #10 was not listed as a sex offender. Review of the Minimum Data Set (MDS) assessment for Resident #10 dated 07/24/25 revealed the resident was cognitively intact, used a walker for mobility, and required limited assistance with activities of daily living (ADLs). Review of the facility incident report regarding Resident #10 dated 08/29/25 at 4:38 P.M. revealed Resident #10 was in female Resident #12's room touching her breasts. Resident #10 stated he was trying to make friends with Resident #12. He was removed from Resident #12's room and immediately moved to a different unit on another floor with one-on-one supervision. Review of the medical record for Resident #12 revealed an admission date of 05/03/23 with diagnoses including schizophrenia, bipolar disorder, diabetes, anxiety disorder, and dementia. Review of the MDS assessment for Resident #12 dated 08/13/25 revealed the resident was severely cognitively impaired and required staff assistance with ADLs. Review of the care plan for Resident #12 dated 08/13/25 revealed the resident had an ADL self-care performance deficit related to confusion and dementia. Resident #12 required prompts, cues and direction for all tasks and was compliant with care. Review of the facility incident report regarding Resident #12 dated 08/29/25 at 4:38 P.M. revealed Resident #12 was lying in bed, and a staff member witnessed a male, Resident #10, touching Resident #12's breasts. Resident #12 stated that she had not seen a male in her room, and she had been asleep all morning when staff asked why Resident #10 was in her room. Review of the facility SRI dated 08/29/25 administration was notified of an allegation of sexual abuse per Resident #10 towards Resident #12. Housekeepers (HKs) #110 and #115 stated on 08/29/25 they walked into Resident #12's room and observed Resident #10 touching Resident #12's breasts with his hands and also had his mouth on the resident's breasts. Both witnesses stated Resident #12 was lying still in her bed and was not moving, fighting or attempting to move out of the presence of Resident #10. HKs #110 and #115 stated they were not sure if they were witnessing a consensual event or a nonconsensual event so they decided one of them would stay in the room for safety and the other would go and seek immediate assistance. While HK #115 was in the room, Resident #10 stopped the touching and proceeded to adjust Resident #12's clothing and walk away from her bed. Physician #120 examined Resident #12 on 08/29/25 following the incident and found no injuries. Registered Nurse (RN) #105 assessed Resident #12 and noted the resident showed no verbal or non-verbal signs of pain or discomfort. When staff interviewed Resident #12 she did not recall the incident and stated that she had been sleeping in bed all day. The facility notified the local police department of the incident on 08/29/25. Police interviewed Resident #12 who was pleasant and cooperative and lacked any distress during the interview, but she could not provide any meaningful information. Police interviewed Resident #10 who was also cooperative and told police he was trying to start a friendship with Resident #12 when and he thought the sexual contact with her was consensual. Resident #10 was monitored by the staff after the incident until he was removed and taken into custody by the police. Review of an interview statement dated 08/29/25 with Resident #12 conducted by Social Service Designee (SSD) #200 revealed the resident did not remember a man coming into her and she had been sleeping all day. Review of an interview statement dated 08/29/25 with Resident #10 conducted by SSD#200 revealed Resident #10 acknowledged he had touched Resident #12, because he was trying to make friends with her. Review of HK #110's witness statement dated 08/29/25 revealed she was coming down the hall to clean a room when she noticed Resident #10 in Resident #12's</p>		