STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365756	A. Building B. Wing	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whitehouse Country Manor	11239 Waterville St Whitehouse, OH 43571

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 - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on medical record review, staff interview, review of the facility's Self-Reported Incident (SRI), review of the facility's investigation, and policy review, the facility failed to timely report an incident of potential sexual abuse. This affected two (#11 and #12) of three residents reviewed for abuse. The facility census was 81. Findings include: 1. Review of the medical record for Resident #11 revealed an admission date of 08/12/15 with diagnoses of bipolar disorder, schizophrenia and anxiety. Review of the quarterly Minimum Data Set (MDS) assessment, dated 03/20/25, revealed Resident #11 had intact cognition. Further review of the record revealed Resident #11 had a guardian. Review of the current care plan, updated August 2023, revealed Resident #11 displayed behaviors of showing interest in physical affection/intimacy with male peers. Review of a nursing progress note dated 05/11/25 at 2:38 A.M. revealed Resident #11 was found by staff in her room performing oral sex on a male resident. The two residents were separated. 2. Review of the medical record for Resident #12 revealed an admission date of 04/15/22 with diagnoses of schizoaffective disorder, bipolar disorder and hallucinations. Review of the comprehensive annual MDS assessment completed 04/16/25 revealed Resident #12 had impaired cognition. Review of a nursing progress note dated 05/11/25 at 2:39 A.M. revealed Resident #12 was found by staff in another resident's room receiving oral sex from a female resident. Residents were separated. Review of SRI #260263 revealed the facility initiated the investigation on 05/12/25 at 9:30 A.M. Review of the facility's investigation into SRI 260263 revealed witness statements were obtained on 05/10/25 from Certified Nursing Assistant (CNA) #101 and Registered Nurse (RN) #203. Interview on 06/04/25 at 10:04 A.M. with the Director of Nursing (DON) confirmed she initiated the investigation on 05/12/25. The DON stated the incident occurred on third shift on 05/11/25. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Few	Interview on 06/04/25 at 10:55 A.M. with RN #203, and concurrent observation of her cell phone text messages revealed she notified the Assistant Director of Nursing (ADON) via text of the incident between Resident #11 and Resident #12 on 05/11/25 at 12:01 A.M. Further interview with RN #203 confirmed the incident happened before midnight on 05/10/25 and RN #203 confirmed she and CNA #101 completed witness statements on 05/10/25. Interview on 06/04/25 at 11:21 A.M. with the ADON confirmed she received a text from RN #203 on 05/11/25 at 12:01 A.M. The ADON stated she did not see the message until later in the morning when she notified the DON of the incident. Concurrent observation of the ADON's cell phone text messages revealed she notified the DON on 05/11/25 at 10:05 A.M. Two attempts to contact the DON via telephone at the facility were unsuccessful on 06/04/25 at 4:37 P.M. and 4:52 P.M. regarding her receipt of the text message from the ADON on 05/11/25 at 10:05 A.M. and her initiation of the SRI on 05/12/25 at 9:30 A.M., reflecting a 33.5 hour time span between the incident and the initiation of an investigation. Review of the policy titled, Abuse Policy, revised 01/27/23, revealed if abuse or serious bodily injury is alleged, it should be reported to the State Agency immediately, but not later than two hours after the allegation is made. Further review revealed the Administrator or designee will notify the State Agency of all alleged violations involving Abuse, Neglect, Exploitation, Mistreatment of a resident, or Misappropriation of Resident Property and Injuries of Unknown Source as soon as possible but no later than 24 hours. The was an incidental finding during the course of the complaint investigation/ self-reported incdent investigation completed 06/04/25.