STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365892	A. Building B. Wing	05/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burlington House Rehab & Alzheimer's Care Center	2222 Springdale Road Cincinnati, OH 45231

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and closed and open record reviews and facility policy review, the facility failed to ensure a resident was free from sexual abuse. This affected one resident (Resident #81) of one resident reviewed for sexual abuse. The facility total census was 97. Findings included: Closed record review for Resident #81 revealed the resident was admitted to the facility on [DATE] and discharged on 04/23/25 to home. Diagnoses for Resident #81 included Alzheimer ' s, dementia, heart disease, depressive disorder, and psychosis. Review of the Minimum Data Set, (MDS) comprehensive assessment dated [DATE], revealed the resident had severely impaired cognition and required partial assistance with toileting and supervision with ambulation. There were no functional impairments. The resident resided on the memory secured unit in room [ROOM NUMBER]. The resident had a guardian. Resident #81 had an emergency room visit on 03/30/25 and returned on 03/30/25. Record review of Resident Perpetrator, (RP) #11 revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #11 include dementia, hypertension, anxiety disorder, PTSD, diabetes, and heart failure. Review of the Minimum Data Set, (MDS) comprehensive assessment dated [DATE], revealed the resident had severely impaired cognition and required supervision with feeding himself and partial assistance with hygiene. The resident required partial assistance with transfers and used a wheelchair for ambulation. The resident had a guardian. Review of physician orders for Resident #11 revealed an order for progesterone at 5 milligrams for hypersexuality started on 11/02/24 and for progesterone increased to 10 milligrams on 03/04/25. There was a physician order for one-on-one staff monitoring towards female residents beginning on 03/30/25. The resident resided on the memory secured unit. There was a room move on 03/30/25. (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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the nurse progress notes dated from 03/30/25 at 3:30 P.M. revealed Registered Nurse, (RN) # 43 was notified Resident #81 entered the bathroom of RP #11 and RP #11 and had his hand inside Resident #81's brief. The residents were separated. Resident #81 had a head-to-toe assessment with no injury noted, skin clean and dry and intact. Resident #81 was peaceful and displayed no signs of agitation or distress. The physician, police and Power of Attorney were notified. Resident #81 was sent non-emergent to the hospital for a Sexual Assault Nurse Exam, (SANE) examination. Review of the facility investigation witness statement dated 03/30/25 of Licensed Social worker, (LSW), #48, revealed on 03/30/25 at approximately 10:45 A.M., Resident #81 was observed standing in RP #11 bathroom with her pants at her ankles and brief pulled up. RP #11 was in a wheelchair and had his hand inside Resident #81's brief. The residents were separated with no resistance. Resident #81 and RP #11 had no response to questioning of the incident. The police were notified and filed a report. Review of the police report dated 03/30/25 at 1:17 P.M. revealed LSW #48 reported at 10:30 A.M. she passed by RP #11 room and observed Resident #81 standing in the bathroom with the briefs intact and pants at ankles. RP #11 was seated in wheelchair with his hand down front of Resident #81's brief. LSW #48 observed no movement, and neither residents were speaking or making any sound, with blank facial expressions. The police advised the guardian to permit Resident #81 to have a SANE examination. Review of the hospital emergency department report dated 03/30/25 at 3:50 P.M. revealed the SANE examination was completed. Resident #81 had some excoriation of the perineum, likely from the use of a diaper. Review of SANE nurse documents dated 03/30/25 at 5:28 P.M., SANE nurse #200 verified LSW #48 report of seeing Resident #81 standing in the bathroom doorway with her pants around her ankles and the assailant's, RP #11, hand in her depends. Neither nursing home resident involved recalling the incident. Resident #81 did not appear in distress and respirations appeared unlabored. Resident #81 appeared clean and well-groomed upon RN #200 arrival. A large area of redness with associated tenderness was observed to the external genitalia, groin, and buttocks, consistent with incontinence associated dermatitis. There was a scant amount of thick white secretions observed to the left labia minora. The SANE RN #200 was able to evaluate the vulva and no lacerations, bruising, or bleeding was observed. There were no further findings. Review of the State Reportable Incident , (SRI) dated 03/30/25 and timed 2:55 P.M., revealed the facility completed a thorough investigation of the incident including witness statement, vulnerable resident skin assessments and staff education on resident abuse. Observations made on 04/02/25 at 11:16 P.M., 04/03/25 at 10:05 A.M., 04/03/25 at 5:55 P.M. and 04/07/2 at 9:25 A.M. and at 12:00 P.M., revealed Resident #81 was in no apparent distress related to the incident of 03/30/25. The resident was clothed, clean and had no odors. Observations made on 04/02/25 at 11:16 P.M. , 04/03/25 at 10:05 A.M. , 04/03/25 at 5:55 P.M. and 04/07/2 at 9:25 A.M. , revealed the FR #11 new room was at end of hall, two halls away from Resident #81 with one-on- one monitoring of Certified Nursing Assistants, (CNA) #100. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/02/25 at 10:00 A. M. and on 05/12/25 at 1148 A.M., witness LSW #48 verified on Sunday, 03/30/25, at approximately 10:45 A.M. Resident #81 was standing, coming out of RP #11's bathroom doorway with outwear pants at her ankles and her brief pulled up at her waist. RP #11 was facing Resident #81, sitting in his wheelchair with his hand down her brief. There was no movement of the hand and he removed his hand immediately. There were no verbalizations and flat emotions of both residents. With assistance from RN #43, the residents were separated, assessed and responsible parties were notified. LSW #48 verified Resident #81 was independently ambulatory, able to take herself to the bathroom, and wandered into other resident's rooms. LSW #48 stated RP #11's usual behavior was to sit in his wheelchair at his doorway. Interview on 04/02/25 at 9:50 A.M., the SANE RN #200 verified she completed the examination of Resident #81 on 03/30/25, and there was no evidence of sexual penetration or injury. There was a reddened rash indicative of an incontinence dermatitis. Interview on 04/07/25 at 10:00 A.M RN #43 verified he was notified of the incident between Resident #81 and RP #11 by LSW #48 on 03/30/25 at approximately 10:50 A.M. RN #43 verified the LSW #48 reported RP #11 had his hand inside Resident #81's brief. The residents were separated and assessed with no injury noted. The police and guardian were notified and the guardian agreed to a SANE examination. Interviews on 04/02/25 at 1:40 P.M., the Administrator and Director of Nursing, (DON) verified Resident #81 and RP #11 had physical contact in RP #11 room on 03/30/25 at approximately 10:45 A.M. , discovered by LSW #48. RP #11 had his hand inside Resident #81's brief. Review of facility policy titled Ohio Abuse, Neglect and Misappropriation , undated, revealed the facility intent is to prevent resident abuse. Sexual abuse is defined as non-consensual sexual contact of any type. This deficiency represents non-compliance investigated under Complaint Number OH00165513.