STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365979	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Community at Fairborn	789 Stoneybrook Trail Fairborn, OH 45324

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44083 Based on observation, interview ,record review, facilities investigation review, and policy review, revealed the facility failed to implement abuse policies to report allegations of resident abuse. This affected one resident, (Resident #25) of three residents reviewed for reporting abuse . The total facility census was 86. Findings Include: Record review of alleged victim Resident #25 revealed the resident was admitted to the attached skilled living facility on 11/19/20. The resident had a legal guardian and resided on the skilled living unit. Diagnoses for Resident #25 included age related physical debility, diabetes, atrial fibrillation, morbid obesity, dementia, psychosis, communication deficit, depressive disorder, muscle weakness, intellectual disabilities, and cerebrovascular disease. Review of the Minimum Data Set, (MDS) comprehensive assessment dated [DATE] revealed the resident had severely impaired cognition and required maximum assistance of one for transfers and mobility. Review of the State Reportable Incident, (SRI) dated 06/06/24 revealed the facility was notified on 06/06/24 of an alleged kissing encounter between Resident #36, the perpetrator, residing on the attached residential care unit, and Resident #25, the alleged victim, residing on the skilled care unit. Record review of Resident #36 revealed the resident was admitted to the Residential Care unit of the facility on 05/25/24 and discharged to the attached skilled living unit on 06/06/24. The resident was his own responsible party. Diagnoses for Resident # 36 include dementia, behavioral disturbance on 06/07/24, communication deficit, aphagia, reduced mobility, tachycardia, chronic kidney disease, depression, and transient cerebral attack. Review of MDS dated [DATE], revealed Resident #36 had severely impaired cognition rating a three scored out of 15 on the Brief Interview Mental Status, (BIMS) exam. The resident was independent for walking and required supervision for personal hygiene. (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: 365979	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/11/2024

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility investigation of alleged sexual encounter of Resident #36 towards Resident #25, dated 06/06/24 revealed, the Administrator was notified by State tested Nurse Aide, (STNA) #73 that STNA #60 witnessed male Resident #36 kissing female Resident #25 on 06/03/24. STNA #60 had not notified the Administrator of the incident of 06/03/24. Review of STNA #60 witness statement, dated 06/07/24, revealed on 06/03/24 at 2:30 A.M., Resident #25's roommate activated the call light. STNA #60 witnessed Resident #36 sitting on Resident #25's bed, leaning over kissing her. Review of STNA #70 statement revealed she responded after hearing STNA #60 state get off her get out of her bed. STNA #70 did not witness contact between the residents and did not hear STNA #60 report resident unwanted kissing contact to the Licensed Practical Nurses, (LPN), # 80, #90 and #50. Review of LPN #80, #90 and #50 witness statements revealed no report from STNA #60 of SR #36 contact with or kissing of Resident #25. Observation on 06/10/24 at 1:26 P.M. revealed Resident #25 on the skilled living unit in bed, in no apparent distress. Interview on 06/10/24 at 1:26 P.M. revealed Resident #25 denied having any unwanted male in her room and no male had kissed her. Observation on 06/010/24 at 2:17 P.M. revealed Resident #36 on the skilled unit in bed. Resident #36 appeared to be in no apparent distress. Interview on 06/10/24 at 2:17 P.M. with Resident #36 revealed he denied having contact with Resident #25. Interview on 06/10/24 at 2:47 P.M. STNA #60 verified she walked into Resident #25's room and witnessed Resident #36 sitting on her bed. Resident #36 was kissing Resident #25. STNA #60 revealed Resident #25 stated Resident #36 was kissing her, and the resident did not want Resident #36 in her room. STNA #60 stated she told LPN #80, #90 and #50 and STNA #70, Resident #36 was kissing Resident #25, but was not sure any staff heard her report, as there was no response from the nurses. STNA #60 stated she had received abuse reporting training, which included reporting abuse to the Administrator or Director of Nursing. STNA #60 stated she did not notify the Administrator or Director of Nursing Resident #36 was kissing Resident #25 on 06/03/24. Interview on 06/10/24 at 3:45 P.M., LPN # 50 stated on 06/03/24 at 3:00 A.M., she responded to call from STNA #60 of Resident #36 had fallen on way out of Resident #25's room. STNA #60 reported Resident #36 was previously sitting on Resident #25 bed. LPN #50 stated STNA #60 did not report physical contact between the two residents. Interview on 06/10/24 at 4:15 P.M. revealed LPN #90 responded to a call from STNA #60 of Resident #36 on floor outside of Resident #25 room. STNA #60 stated Resident #36 was trying to get into Resident #25's bed. LPN #90 interviewed Resident #25 who stated Resident #36 was pulling at her gown but denied any touching. LPN #90 denied STNA #60 reported kissing or physical contact between the residents. Interview on 06/11/24 at 1:32 P.M. the Administrator verified STNA #60 had not reported the alleged sexual abuse of Resident #36 towards Resident #25, as witnessed on 06/03/24. The Administrator verified the contact information for the Administrator and Director of Nursing was available to all staff, and the STNA #60 should have reported the incident on 06/03/24. (continued on next page)

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Abuse, Mistreatment, Neglect, Exploitation, Misappropriation of Resident Property dated 10/20/22, revealed community staff should immediately report all allegations to the Executive Director/Administrator. The community policy is to investigate all alleged violations and report to the state reporting agency. This deficiency represents non-compliance investigated under Complaint Number OH00154692.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365979	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/11/2024
NAME OF PROVIDER OR SUPPLIER Trinity Community at Fairborn		STREET ADDRESS, CITY, STATE, ZIP CODE 789 Stoneybrook Trail Fairborn, OH 45324	

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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	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** 44083 Based on observation, interviews, record review, facility investigation report, and policy review, revealed the facility failed to report allegations of abuse. This affected one resident, (Resident #25) of three residents reviewed for reporting abuse. The total facility census was 86. Findings Include: Record review of alleged victim Resident #25 revealed the resident was admitted to the attached skilled living facility on 11/19/20. The resident had a legal guardian and resided on the skilled living unit. Diagnoses for Resident #25 included age related physical debility, diabetes, atrial fibrillation, morbid obesity, dementia, psychosis, communication deficit, depressive disorder, muscle weakness, intellectual disabilities, and cerebrovascular disease. Review of the Minimum Data Set, (MDS) comprehensive assessment dated [DATE] revealed the resident had severely impaired cognition and required maximum assistance of one for transfers and mobility. Review of the State Reportable Incident, (SRI) dated 06/06/24 revealed the facility was notified on 06/06/24 of an alleged kissing encounter between Resident #36, the perpetrator, residing on the attached residential care unit, and Resident #25, the alleged victim, residing on the skilled care unit. Record review of Resident #36 revealed the resident was admitted to the Residential Care unit of the facility on 05/25/24 and discharged to the attached skilled living unit on 06/06/24. The resident was his own responsible party. Diagnoses for Resident # 36 include dementia, behavioral disturbance on 06/07/24, communication deficit, aphagia, reduced mobility, tachycardia, chronic kidney disease, depression, and transient cerebral attack. Review of the MDS dated [DATE], revealed Resident #36 had severely impaired cognition rating a three scored out of 15 on the Brief Interview Mental Status, (BIMS) exam. The resident was independent for walking and required supervision for personal hygiene. Review of the facility investigation of alleged sexual encounter of Resident #36 towards Resident #25, dated 06/06/24 revealed, the Administrator was notified by State tested Nurse Aide, (STNA) #73 that STNA #60 witnessed male Resident #36 kissing female Resident #25 on 06/03/24. STNA #60 had not notified the Administrator of the incident of 06/03/24. Review of STNA #60 witness statement, dated 06/07/24, revealed on 06/03/24 at 2:30 A.M., Resident #25's roommate activated the call light. STNA #60 witnessed Resident #36 sitting on Resident #25's bed, leaning over kissing her. Review of STNA #70 statement revealed she responded after hearing STNA #60 state get off her get out of her bed. STNA #70 did not witness contact between the residents and did not hear STNA #60 report resident unwanted kissing contact to the Licensed Practical Nurses, (LPN), # 80, #90 and #50. Review of LPN #80, #90 and #50 witness statements revealed no report from STNA #60 of SR #36 contact with or kissing of Resident #25. (continued on next page)

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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	Observation on 06/10/24 at 1:26 P.M. revealed Resident #25 on the skilled living unit in bed, in no apparent distress. Interview on 06/10/24 at 1:26 P.M. revealed Resident #25 denied having any unwanted male in her room and no male had kissed her. Observation on 06/010/24 at 2:17 P.M. revealed Resident #36 on the skilled unit in bed. Resident #36 appeared to be in no apparent distress. Interview on 06/10/24 at 2:17 P.M. with Resident #36 revealed he denied having contact with Resident #25. Interview on 06/10/24 at 2:47 P.M. STNA #60 verified she walked into Resident #25's room and witnessed Resident #36 sitting on her bed. Resident #36 was kissing Resident #25. STNA #60 revealed Resident #25 stated Resident #36 was kissing her, and the resident did not want Resident #36 in her room. STNA #60 stated she told LPN #80, #90 and #50 and STNA #70, Resident #36 was kissing Resident #25, but was not sure any staff heard her report, as there was no response from the nurses. STNA #60 stated she had received abuse reporting training, which included reporting abuse to the Administrator or Director of Nursing. STNA #60 stated she did not notify the Administrator or Director of Nursing Resident #36 was kissing Resident #25 on 06/03/24. Interview on 06/10/24 at 3:45 P.M., LPN # 50 stated on 06/03/24 at 3:00 A.M., she responded to call from STNA #60 of Resident #36 had fallen on way out of Resident #25's room. STNA #60 reported Resident #36 was previously sitting on Resident #25 bed. LPN #50 stated STNA #60 did not report physical contact between the two residents. Interview on 06/10/24 at 4:15 P.M. revealed LPN #90 responded to a call from STNA #60 of Resident #36 on floor outside of Resident #25 room. STNA #60 stated Resident #36 was trying to get into Resident #25's bed. LPN #90 interviewed Resident #25 who stated Resident #36 was pulling at her gown but denied any touching. LPN #90 denied STNA #60 reported kissing or physical contact between the residents. Interview on 06/11/24 at 1:32 P.M. the Administrator verified STNA #60 had not reported the alleged sexual abuse of Resident #36 towards Resident #25, as witnessed on 06/03/24. The Administrator verified the contact information for the Administrator and Director of Nursing was available to all staff, and the STNA #60 should have reported the incident on 06/03/24. Review of the facility policy titled, Abuse, Mistreatment, Neglect, Exploitation, Misappropriation of Resident Property dated 10/20/22, revealed community staff should immediately report all allegations to the Executive Director/Administrator. The community policy is to investigate all alleged violations and report to the state reporting agency. This deficiency represents non-compliance investigated under Complaint Number OH00154692.