| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 366008 | A. Building<br>B. Wing | 12/17/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Grande Pointe Healthcare Commu | Three Merit Dr<br>Richmond Heights, OH 44143 |

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) |
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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38522<br><br>Based on record review, review of a self-reported incident (SRI), review of facility policies and interview, the facility failed to timely inform residents' attending physicians of an instance of resident-to-resident sexual abuse. This affected two residents (Resident #18 and Resident #28) out of three residents reviewed for abuse. Facility census was 158.<br><br>Findings include:<br><br>1. Review of Resident #28's medical record revealed an admitted [DATE] and diagnoses including heart disease, vascular dementia with other behavioral disturbance, depression, cognitive communication deficit, insomnia, post-traumatic stress disorder (PTSD), dysphagia, burn of unspecified degree of head, face and neck restlessness and agitation.<br><br>Review of Resident #28's guardianship documentation revealed she was deemed incompetent and had a guardian of person effective 03/13/20.<br><br>Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #28 had a brief interview for mental status (BIMS) score of nine, indicating moderate cognitive impairment and had no behaviors coded on the assessment.<br><br>Review of Resident #28's plans of care revealed a plan of care dated 08/23/21 and revised 03/24/22 for impaired cognitive function related to dementia with listed interventions including 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 and mental status.<br><br>Review of a plan of care dated 05/02/23 revealed Resident #28 required placement on a secured unit with listed interventions including notify medical provider/resident representative of behavior changes and provide diversionary activities as needed and redirect when appropriate.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Review of a SRI dated 11/26/24 revealed an allegation of resident-to-resident sexual abuse involving Resident #18 and Resident #28. Resident #18 was allegedly found to be performing oral sex on Resident #28 on 11/26/24 at approximately 8:30 P.M. Certified Nurse Aide (CNA) #396 found Resident #18 kneeling with his head in proximity of Resident #28's vagina. Both residents were separated and interviewed and reported consenting to the behavior and understanding what they were engaged in. Resident #28 also stated she was in a relationship with Resident #18. The facility determined the allegation of sexual abuse to be unsubstantiated as both residents consented to the sexual interaction.<br><br>Review of a telehealth note dated 11/27/24 at 12:00 A.M. and authored by Physician #196 revealed the following information: 'Resident #28 was seen with another resident appearing to have intimate contact. Both residents have dementia and acts were consensual per the residents. Follow with in house provider and Director of Nursing (DON).'<br><br>Review of a nurse practitioner (NP) note dated 11/27/24 at 1:00 A.M. and authored by NP #195 revealed the following information: 'Met with Resident #28 today to follow-up for nursing reports of patient having physical interaction of a sexual nature. Per nursing report and chart review, Resident #28 was seen laying in her bed with another resident/male between her legs. It is important to know that the patient is currently a resident on a locked dementia unit. Resident #28 does have a diagnosis of vascular dementia. Resident #28 is alert and oriented times one to two at baseline. Resident #28 reports she is angry she is being questioned repeatedly and repeatedly states the other resident is her boyfriend. Resident #28 denies being forced to do anything and denied wanting to press charges or file a complaint on the other resident.'<br><br>Phone interview on 12/09/24 at 3:42 P.M. with Physician #405 revealed he was the attending physician for Resident #28. Physician #405 was unaware of Resident #28 having a sexual encounter with another resident on the dementia unit.<br><br>Interview on 12/10/24 at 12:54 P.M. with the DON revealed if it was not documented, it was not done regarding physician notifications. The DON confirmed there was not evidence in Resident #28's record that her attending physician, Physician #405 had been made aware of the allegation of sexual abuse involving Resident #28.<br><br>2. Review of Resident #18's medical record revealed an admitted [DATE] and diagnoses including depression, anxiety, dementia with agitation, cognitive communication deficit and history of transient ischemic attack (TIA).<br><br>Resident #18's guardianship documentation revealed he was deemed incompetent and had a guardian of person and estate effective 07/17/23.<br><br>Review of Resident #18's annual MDS dated [DATE] revealed he was severely cognitively impaired, had no behaviors coded on the assessment and required set up for meals, dressing and toileting. Resident #18 required supervision for ambulation and was independent with most mobility.<br><br>Review of Resident #18's plans of care revealed a plan of care dated 11/23/22 for impaired cognitive function [related to] dementia and listed interventions including communicate with resident/family/caregivers regarding resident's capabilities and needs, discuss concerns about confusion, disease process and nursing home placement with resident/family/caregiver and keep routine as consistent as possible in order to decrease confusion.<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Review of a plan of care dated 11/23/22 revealed Resident #18 required a secured unit due to dementia and listed interventions included notify medical provider/resident representative of behavior changes and provide diversionary activities as needed. Redirect when appropriate.<br><br>Review of a SRI dated 11/26/24 revealed an allegation of resident-to-resident sexual abuse involving Resident #18 and Resident #28. Resident #18 was allegedly found to be performing oral sex on Resident #28 on 11/26/24 at approximately 8:30 P.M. CNA #396 found Resident #18 kneeling with his head in proximity of Resident #28's vagina. Both residents were separated and interviewed and reported consenting to the behavior and understanding what they were engaged in. Resident #28 also stated she was in a relationship with Resident #18. The facility determined the allegation of sexual abuse to be unsubstantiated as both residents consented to the sexual interaction.<br><br>Review of a nurses' note dated 11/26/24 at 11:43 P.M. and authored by Licensed Practical Nurse (LPN) #310 revealed the following information: 'Around 10:00 P.M. during rounds CNA walked into female resident room and saw Resident #18 kneeling in front of her with his head within proximity of her vagina. Residents were immediately separated. Resident #18 was interviewed and stated it was consensual, not forced and he felt safe. Guardian and physician notified as well as police.'<br><br>Review of a telehealth note dated 11/27/24 at 12:02 A.M. and authored by Physician #196 revealed the following information: 'Resident #18 was seen with another resident appearing to have intimate contact. Both residents have dementia and acts were consensual per the residents. Follow with in house provider and DON.'<br><br>Review of a nurse practitioner note dated 11/27/24 at 1:00 A.M. and authored by NP #195 revealed the following information: 'Nursing reports that patient was observed in an alleged sexual encounter with another resident. Per nursing report and chart review Resident #18 was found in another resident's room. The other patient was laying on the bed and Resident #18 was between her legs. It is important to understand that Resident #18 is on a locked dementia unit and has a diagnosis of dementia. Nursing reports that Resident #18 has a history of developing relationships, girlfriend/boyfriend intermittently with other residents since his stay at the facility. Resident #18 has been seen socializing more closely with this resident as opposed to others. There have been no other inappropriate behaviors observed or reported before this incident. Resident #18 reports he is very angry with questioning he has had to answer regarding the incident. Resident #18 was initially dismissive and would not talk but after some encouragement he reports he did nothing wrong and was with his girlfriend. Resident #18 declines being forced to do anything and declines having to force the other resident. Resident #18 reports it has been a consensual relationship.'<br><br>Phone interview on 12/09/24 at 3:57 P.M. with Physician #406 revealed he was the attending physician for Resident #18. Physician #406 stated he had heard about inappropriate behavior on the secured unit last month but indicated they did not tell me if it was consensual. Physician #406 did not have additional information to add regarding timely notification of Resident #18 having a sexual encounter with another resident on the dementia unit.<br><br>Interview on 12/10/24 at 12:54 P.M. with the Director of Nursing (DON) revealed if it was not documented, it was not done regarding physician notifications. The DON confirmed there was not evidence in Resident #18's record that his attending physician, Physician #406 had been made aware of the allegation of sexual abuse involving Resident #18.<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Review of the facility policy, Notification of Change in Condition, no date revealed the center must inform the resident, consult with the resident's physician and/or notify the residents' representative, authorized family member or legal power of attorney/guardian when there is a change requiring such notification. The practitioner is promptly notified of significant changes in condition and the medical record must reflect the notification, response and interventions implemented to address the resident's condition.<br><br>Review of the facility policy, Telehealth Services, no date revealed telehealth services will be utilized under the following guidelines: after hours on weekdays (5:00 P.M. to 8:30 A.M.) and weekends at all times for changes in condition. Telehealth services do not need to be utilized by the facility when the primary physician or licensed nurse practitioner is in-house to physically assess the resident and during weekdays (8:30 A.M. to 5:00 P.M.) the facility will directly contact the primary care physician or licensed nurse practitioner assigned to the resident during this timeframe for all resident care needs. The policy did not address how significant changes in resident condition, such as allegations of resident-to-resident abuse, would be communicated from the off-hours personnel to the residents' attending providers. |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38522<br><br>Based on observation, record review, self-reported incident (SRI) review, review of a police report, facility policy review and interviews, the facility failed to ensure Resident #28, who had dementia, was deemed incompetent, and unable to provide consent, was free from resident-to-resident sexual abuse. This resulted in Immediate Jeopardy and the potential for actual physical and psychosocial harm on 11/26/24 at approximately 8:20 P.M. when Resident #18, who had a history of engaging in physical activity (i.e. hand holding and touching behaviors) with Resident #28 without care planned interventions, was observed by Certified Nurse Aide (CNA) #396 engaged in an activity indicative of oral sex on Resident #28. This affected one resident (#28) of three residents reviewed for abuse. The facility census was 158.<br><br>On 12/10/24 at 4:10 P.M., the Administrator, Director of Nursing (DON) and Regional Director of Clinical Operations (RDCO)/Registered Nurse (RN) #219 were notified Immediate Jeopardy began on 11/26/24 at approximately 8:20 P.M. when CNA #396 found Resident #28 laying back on her bed with her legs wide open and Resident #18 kneeling with his face between Resident #28's legs. Resident #28, who was cognitively impaired lacked the cognitive ability to consent to the sexual activity. The facility failed to address Resident #18's prior physical aggression towards Resident #28 and a known relationship formed with Resident #28 prior to this sexual abuse incident. In addition, there was no evidence of any further behavioral assessments addressing the capacity to consent to sexual activity in addition to no documented monitoring or consistent interventions being initiated following the observed sexual encounter.<br><br>The Immediate Jeopardy was removed on 12/11/24 when the facility implemented the following corrective actions:<br><br>On 11/26/24 at 8:20 P.M. CNA #396 knocked on Resident #28's door, walked in and noticed Resident #28 laying on her back on her bed with her legs open and Resident #18 on his knees with his face in between the resident's legs. Residents #18 and #28 were immediately separated by CNA #396 and Resident #18 was placed on one-on-one (1:1) supervision with CNA #396. The 1:1 supervision ended on 12/03/24 at 7:00 A.M.<br><br>On 11/26/24 At 8:29 P.M. CNA #396 notified the Administrator of an allegation of resident-to-resident sexual abuse.<br><br>On 11/26/24 At 8:32 P.M. the Administrator notified the DON of an allegation of resident-to-resident sexual abuse.<br><br>On 11/26/24 At 8:34 P.M. the DON notified RDCO/RN #219 and Regional Director of Operations (RDO) #410 of an allegation of resident-to-resident sexual abuse.<br><br>On 11/26/24 at 9:00 P.M. the DON and RDCO/RN #219 interviewed Resident #18 and Resident #28 by phone as the staff members were not in the facility at that time.<br><br>On 11/26/24 at 10:00 P.M. the Administrator submitted a SRI report with the State Agency.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 11/26/24 at 10:20 P.M. the families of Resident #18 and Resident #28 were made aware of the allegation of resident-to-resident sexual abuse.<br><br>On 11/26/24 at 10:20 P.M. Licensed Practical Nurse (LPN) #310 called the police to report the allegation of resident-to-resident sexual abuse.<br><br>On 11/26/24 at 11:00 P.M. LPN #310 notified On-call Physician #196 of the allegation of resident-to-resident sexual abuse involving Resident #18 and Resident #28. No new orders were given and he recommended to follow up with in-house provider and DON.<br><br>On 11/26/24 at 11:27 P.M. LPN #310 attempted to check Resident #28's skin but she refused. On 11/26/24 at 11:52 P.M. LPN #310 attempted to check Resident #18's skin but he refused.<br><br>On 11/27/24 Unit Manager (UM)/LPN #368 completed skin checks on all residents on the Connections (dementia) unit.<br><br>On 11/27/24 the DON/designee provided education throughout the day to the Connections unit staff by on sexual abuse and sexual behaviors including behavior to look for such as holding hands, kissing and spending a lot of time together. Education to staff included reporting behaviors to the Administrator, DON, and/or UM/LPN #368. Any staff not there were educated their next scheduled day of work.<br><br>On 11/27/24, UM/LPN #368 placed a note at the nurses' station informing staff Resident #18 and Resident #28 were not permitted to be left alone behind closed doors due to the allegation of sexual abuse. This was communicated to staff via shift-to-shift report. Any staff not there were educated their next scheduled day of work.<br><br>On 11/27/24 at 5:30 P.M. Nurse Practitioner (NP) #195 assessed Resident #18 and Resident #28 with no new orders provided at that time.<br><br>On 12/09/24 at 10:20 A.M. Licensed Social Worker (LSW) #245 made a referral to another facility for Resident #18 per family request as the family talked about him residing on an all-male unit.<br><br>On 12/10/24 and 12/11/24 the DON/Designee interviewed all residents on the Connections unit to determine their capacity to consent to sexual behavior with the questionnaire from the facility's policy, Process for Consensual Sexual Behavior. It was determined no residents had the capacity to consent on the Connections unit including both Resident #18 and Resident #28. If a resident would have the capacity to consent to sexual activity, the facility would involve the physician, interdisciplinary team (IDT) and resident's guardian/representative and the team will discuss the risks/benefits of sexual behavior and develop a plan of care.<br><br>On 12/10/24 at 4:51 P.M. Resident #18 was immediately placed on 1:1 supervision with physician's order written by UM/LPN #368 and care plan updated by Minimum Data Set (MDS)/LPN #309 to reflect resident required 1:1. Resident #18's Kardex (care card) was also updated so staff were aware. Resident #18 would remain on 1:1 supervision until discharged from the facility. MDS/LPN #309 also reviewed Resident #28's care plan and no additional changes were made.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 12/10/24 and 12/11/24 the DON/Designee interviewed staff working on the Connections unit regarding knowledge of any residents that have a sexual relationship who lack the capacity to consent. Any resident found to be having sexual relations with other residents who lack the capacity to consent would be reviewed by the physician and IDT team to discuss the risks/benefits of sexual behavior and this would be discussed with the resident's guardian/representative and a plan of care would be developed. There were no other residents that were identified to be having a sexual relationship and there were no additional resident-to-resident sexual occurrences found. DON/Designee reviewed all charts on the unit as well with no findings.<br><br>On 12/10/24 and 12/11/24 the DON/Designee educated all staff on the facility's abuse and neglect policy which included: (a) What constitutes abuse and types of abuse and neglect; (b) Identification of signs and symptoms in residents and staff of potential abuse and abusers; (c) Actions to take when abuse is witnessed, suspected, or alleged; (d) Timely and appropriate reporting of witnessed, suspected, or alleged abuse to all responsible parties per facility policy; (e) Protection of resident while conducting a thorough investigation of alleged abuse; (f) Proper assessment of residents who have been or suspected to be abused; (g) Prevention of future incidents of abuse from occurring; (h) Sexual activity between residents including what constitutes sexual abuse per Centers for Medicare and Medicaid Services (CMS) guidelines and what to do when you identify inappropriate sexual behaviors including reporting to your supervisor, DON, or Administrator and holding a meeting with physicians, IDT and family to develop a plan of care for the resident. Staff were also educated on the facility's dementia policy as the allegation of resident-to-resident sexual abuse occurred on the Connections (dementia) unit. Additionally, staff were educated on behaviors and what to look for with residents that lack the capacity to consent to sexual behaviors. Staff on leave to be educated upon return and prior to working the floor.<br><br>On 12/11/24 from 9:30 A.M. to 2:00 P.M. the DON/Designee started additional skin checks on all residents on the Connections unit.<br><br>On 12/11/24 at 10:00 A.M. Medical Director (MD)/Physician #406 completed medication reviews for Resident #18 and Resident #28.<br><br>On 12/11/24 at 11:00 A.M. LSW #245 completed psychosocial reviews for Resident #18 and Resident #28.<br><br>On 12/11/24 at 11:00 A.M. the Administrator/designee had an ad hoc Quality Assurance/Performance Improvement (QAPI) meeting to discuss the Immediate Jeopardy and abatement plan, the facility's abuse policy and the resident-to-resident sexual abuse involving Resident #18 and Resident #28. Staff present included the Administrator, the DON, Infection Preventionist (IP)/RN #370, (MD)/Physician #406, UM/LPN #240, UM/LPN #368, LPN/UM #349, UM/RN #395, RDCO/RN #219, Regional Resident Care Coordinator (RRCC)/RN #411 and Divisional Director of Clinical Operations (DDCO)/RN #199.<br><br>Beginning 12/11/24, LSW #245 would continue offering support to Resident #18 and Resident #28 by weekly visits for four weeks then as needed.<br><br>Beginning 12/11/24 all facility-reported incidents would be reviewed by DON/Designee immediately to ensure no other residents were affected. DON/Designee to address issues with reported incidents immediately upon identification. This would be ongoing.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Beginning 12/11/24 all allegations of abuse would be reported to the RDCO/RN #219 by the DON or Administrator as soon as the allegation was made. This would be ongoing.<br><br>Beginning on 12/11/24 the DON/Designee would educate all new staff on Abuse, Dementia and Behavioral Health management. This would be ongoing as part of new hire orientation.<br><br>Beginning on 12/11/24 the DON/Designee would observe five residents weekly for four weeks, then three residents weekly for four weeks, then two residents weekly for four weeks to look for any inappropriate sexual behaviors between residents. This would continue until compliance was achieved.<br><br>Beginning on 12/11/24, the Administrator/Designee would interview five staff members weekly for four weeks, then three staff members weekly for four weeks, then two staff members weekly for four weeks to determine if there have been any inappropriate sexual behaviors between residents. This would continue until compliance was achieved.<br><br>The Administrator or DON would monitor compliance with the above during monthly QAPI meetings for three months, then as needed for one year.<br><br>The RDCO/RN #219 would monitor compliance with the above during monthly visits times for three months then on an as needed basis.<br><br>Interviews on 12/16/24 from 7:55 A.M. to 9:07 A.M. with LPN/Medical Records #307, UM/RN/Assistant Director of Nursing (ADON) #307, CNA #390, CNA #365, CNA #382, Activities Aide (AA) #232 and RN #351 confirmed they received education on sexual abuse, dementia, sexual behaviors between residents and sexual consent.<br><br>Although the Immediate Jeopardy was removed on 12/11/24 the deficiency remained at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was in the process of implementing their corrective action plan and monitoring to ensure continued compliance.<br><br>Findings include:<br><br>Review of Resident #28's medical record revealed an admitted [DATE] with diagnoses including heart disease, vascular dementia with other behavioral disturbance, depression, cognitive communication deficit, insomnia, post-traumatic stress disorder (PTSD), dysphagia, burn of unspecified degree of head, face and neck restlessness and agitation.<br><br>Review of Resident #28's guardianship documentation revealed she was deemed incompetent and had a guardian of person effective 03/13/20.<br><br>Review of Resident #28's care plans revealed a plan of care dated 08/23/21 and revised 03/24/22 for impaired cognitive function related to dementia with listed interventions including 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 and mental status.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of a plan of care dated 05/02/23 revealed Resident #28 required placement on a secured unit with listed interventions including notify medical provider/resident representative of behavior changes and provide diversionary activities as needed and redirect when appropriate.<br><br>Review of Resident #28's physician's orders revealed an order dated 06/16/23 for behavior monitoring which included: 1. Withdrawn 2. Tearful. 3. Refusal of Care. 4. Poor appetite. Non-pharmacological intervention: 1. Redirect. 2: One-on-one. Every shift for behaviors.<br><br>Review of Resident #28's progress notes revealed a telehealth note dated 03/21/24 at 1:13 A.M. with the following information: Resident #28 was jumped on by another resident (on dementia unit). No fall to ground, unwitnessed. Noted to have small, very superficial abrasion to nose. No tenderness to palpitation. Residents are separated. Police are on site.<br><br>Review of a nurse's note dated 03/21/24 at 1:53 A.M. revealed the following information: At approximately 12:35 A.M. Resident #28 alerted this nurse that another resident jumped on her. Upon assessment resident noted to have small abrasion to nose, scratch. Resident immediately separated for safety. Vitals obtained, appropriate notifications made, and supervisor noted. Police called and on-site talking with resident. This nurse instructed resident to call for help and use call light if any residents attempted to enter room.<br><br>Review of a facility SRI dated 03/21/24 at 12:35 A.M. revealed an allegation of resident-to-resident physical abuse between Resident #18 and Resident #28. Resident #28 alleged Resident #18 hit her and/or jumped on her. Resident #18's cognition was listed as oriented times one and Resident #28's cognition was listed as oriented times one. Staff statements were included from CNA #400, the police were called, and skin sweeps were completed on like residents. The facility determined the allegation of abuse was unsubstantiated due to no witnesses.<br><br>Review of an IDT follow up note dated 03/22/24 at 11:40 A.M. revealed the following information: Resident to Resident incident. Resident #28 reported other male resident jumped on her in her room. The resident has a small, reddened area to her nose, no further injuries or complaints. Root cause: dementia. Interventions put into place: residents immediately separated, one on one with male resident and treatment given to injured area.<br><br>Review of Resident #28's medical record revealed there was no further follow up with additional interventions to address the 03/21/24 incident.<br><br>Review of a plan of care dated 04/24/24 revealed Resident #28 had a communication problem related to dementia with listed interventions including observe for declines in communication and anticipate and meet needs.<br><br>Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #28 had a brief interview for mental status (BIMS) score of nine, indicating moderate cognitive impairment and had no behaviors coded on the assessment.<br><br>Review of a plan of care dated 09/30/24 revealed Resident #28 had diagnosis of PTSD with listed interventions including observe for increased agitation, anxiety and offer quiet areas and comfort items, observe resident in group situations and prevent resident from becoming overstimulated and assist resident in identifying what triggers PTSD episodes.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of a nurses' note dated 11/26/24 at 11:28 P.M. and authored by LPN #310 revealed the following information: Around 10:00 P.M. while doing rounds, CNA entered Resident #28's room and saw the resident laying in her bed with pants down with a male resident kneeling in front of her with his head within proximity of her vagina. Residents were immediately separated. Resident #28 was interviewed, stated she consented, not forced and felt safe. Guardian notified. Physician notified. Police notified. Resident #28 resting in room, will continue to monitor.<br><br>Review of a facility SRI dated 11/26/24 revealed an allegation of resident-to-resident sexual abuse involving Resident #18 and Resident #28. Resident #18 was allegedly found to be performing oral sex on Resident #28 on 11/26/24 at approximately 8:30 P.M. CNA #396 found Resident #18 kneeling with his head in proximity of Resident #28's vagina. Both residents were separated and interviewed and reported consenting to the behavior and understanding what they were engaged in. Resident #28 also stated she was in a relationship with Resident #18. The facility determined the allegation of sexual abuse to be unsubstantiated as both residents consented to the sexual interaction.<br><br>Review of a telehealth note dated 11/27/24 at 12:00 A.M. and authored by Physician #196 revealed the following information: Resident #28 was seen with another resident appearing to have intimate contact. Both residents have dementia, and acts were consensual per the residents. Follow with in house provider and DON.<br><br>Review of a nurse practitioner note dated 11/27/24 at 1:00 A.M. and authored by NP #195 revealed the following information: Met with Resident #28 today to follow-up for nursing reports of patient having physical interaction of a sexual nature. Per nursing report and chart review, Resident #28 was seen laying in her bed with another resident/male between her legs. It is important to know that the patient is currently a resident on a locked dementia unit. Resident #28 does have a diagnosis of vascular dementia. Resident #28 is alert and oriented times one to two at baseline. Resident #28 reports she is angry she is being questioned repeatedly and repeatedly states the other resident is her boyfriend. Resident #28 denies being forced to do anything and denied wanting to press charges or file a complaint on the other resident.<br><br>Review of Resident #28's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed she was moderately cognitively impaired, required set up for eating, supervision for toileting, dressing and personal hygiene and most ambulatory tasks.<br><br>Review of a plan of care dated 12/09/24 and revised 12/09/24 revealed Resident #28 had a behavior problem with listed interventions including '11/26/24 not to be in room with male with door closed,' communicate with resident/resident representative regarding behaviors and treatment, intervene as necessary to protect the rights and safety of others and notify medical provider of increased episodes of behaviors.<br><br>Record review as of 12/09/24 revealed the facility had not assessed or developed a comprehensive or individualized plan care for Resident #28 related to human sexuality needs or preferences or the resident's capacity to consent to sexual activity.<br><br>Review of Resident #28's Kardex as of 12/10/24 had a notation under 'Monitoring' on 11/26/24 for not being in room with male with door closed.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of Resident #18's medical record revealed an admitted [DATE] with diagnoses including depression, anxiety, dementia with agitation, cognitive communication deficit and history of transient ischemic attack (TIA).<br><br>Review of Resident #18's care plans revealed a plan of care dated 11/23/22 for impaired cognitive function [related to] dementia and listed interventions including communicate with resident/family/caregivers regarding resident's capabilities and needs, discuss concerns about confusion, disease process and nursing home placement with resident/family/caregiver and keep routine as consistent as possible in order to decrease confusion.<br><br>Review of a plan of care dated 11/23/22 revealed Resident #18 required a secured unit due to dementia and listed interventions included notify medical provider/resident representative of behavior changes and provide diversionary activities as needed. Redirect when appropriate.<br><br>Review of a plan of care dated 11/25/22 revealed Resident #18 wandered aimlessly from place to place, and listed interventions included notify medical provider, resident representative of behavior changes and notify staff of wandering risk.<br><br>Review of a plan of care dated 11/30/22 and revised 10/16/24 revealed Resident #18 had a behavior problem [related to] disease process, nursing home admission, refusal of medication, banging on exit doors, history of refusing labs, screaming at others, cursing at others, layers clothing, refuses to change daily including socks/underwear, refuses shower feels doesn't needs it and hoards personal care items (personal/private bought) with listed interventions including '11/26/24 not be in room with female with door closed (initiated 12/09/24),' behavioral health consults as needed, communicate with resident/resident representative regarding behaviors and treatment, intervene as necessary to protect the rights and safety of others, monitor behavioral episodes and attempt to determine underlying causes and notify medical provider of increased episodes of behaviors.<br><br>Review of a plan of care dated 11/30/22 and revised 10/16/24 revealed Resident #18 had a communication problem due to other disease process/condition usually understands and is usually understood with listed interventions including observe for declines in communication and anticipate and meet needs.<br><br>Review of Resident #18's physician's orders revealed an order dated of 06/16/23 for behavior monitoring which included: 1. Withdrawn 2. Tearful. 3. Resists Care. 4. Agitation. Non-pharmacological intervention: 1. One-on-one. 2: Calm quiet environment. 3. Activity. 4. Meet Needs Every shift for behaviors as well as an order dated 12/05/24 for monitor resident for exit-seeking behaviors and document each shift twice a day.<br><br>Resident #18's guardianship documentation revealed he was deemed incompetent and had a guardian of person and estate effective 07/17/23.<br><br>Review of Resident #18's progress notes revealed a telehealth note dated 03/21/24 at 1:49 A.M. revealed the following information: 'Patient on dementia unit, allegedly hit another resident. Police were on site. Reports have been filed. Residents immediately separated. Resident #18 now calm. No change in behavior from baseline.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of a nurse's note dated 03/21/24 at 2:16 A.M. revealed the following information: At approximately 12:35 A.M. this shift another resident alleged Resident #18 jumped on her. Residents immediately separated for safety and Resident #18 instructed to stay in his room. Vitals obtained, abrasion noted to right hand, appears to be a scratch. Appropriate notifications were made, and the police were called and were onsite taking statement.<br><br>Review of a facility SRI dated 03/21/24 at 12:35 A.M. revealed an allegation of resident-to-resident physical abuse between Resident #18 and Resident #28. Resident #28 alleged Resident #18 hit her and/or jumped on her. Resident #18's cognition was listed as 'oriented times one' and Resident #28's cognition was listed as 'oriented times one.' Staff statements were included from CNA #400, the police were called, and skin sweeps were completed on like residents. The facility determined the allegation of abuse was unsubstantiated due to no witnesses.<br><br>Review of a nurse practitioner note dated 03/22/24 at 1:00 A.M. and authored by NP #194 revealed the following information: Resident #18 resides on the dementia unit due to the condition. It was reported he was involved in an altercation with another female resident yesterday and the female member sustained a small scratch to the nose. Resident #18 denies any such incident occurring. Today, Resident #18 was observed acting well with the other resident. He is alert and oriented times one to two and ambulates independently.<br><br>Review of an IDT follow-up note dated 03/22/24 at 11:44 A.M. revealed the following information: Resident to Resident incident. It was reported by female resident; Resident #18 jumped on her in her room causing a small abrasion to his hand. No further injuries or complaints. Root cause: dementia. Interventions put into place: residents immediately separated, one on one with male resident and treatment given to injured area.<br><br>Review of Resident #18's medical record revealed no evidence of the one-on-one supervision or additional interventions adding to his comprehensive care plan to address the incident.<br><br>Review of Resident #18's annual MDS assessment dated [DATE] revealed the resident was severely cognitively impaired, had no behaviors coded on the assessment and required set up for meals, dressing and toileting. Resident #18 required supervision for ambulation and was independent with most mobility.<br><br>Review of a nurses' note dated 11/26/24 at 11:43 P.M. and authored by LPN #310 revealed the following information: Around 10:00 P.M. during rounds CNA walked into female resident room and saw Resident #18 kneeling in front of her with his head within proximity of her vagina. Residents were immediately separated. Resident #18 was interviewed and stated it was consensual, not forced and he felt safe. Guardian and physician notified as well as police.<br><br>Review of a telehealth note dated 11/27/24 at 12:02 A.M. and authored by Physician #196 revealed the following information: Resident #18 was seen with another resident appearing to have intimate contact. Both residents have dementia and acts were consensual per the residents. Follow with in house provider and DON.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of a nurse practitioner note dated 11/27/24 at 1:00 A.M. and authored by NP #195 revealed the following information: Nursing reports that patient was observed in an alleged sexual encounter with another resident. Per nursing report and chart review Resident #18 was found in another resident's room. The other patient was laying on the bed and Resident #18 was between her legs. It is important to understand that Resident #18 is on a locked dementia unit and has a diagnosis of dementia. Nursing reports that Resident #18 has a history of developing relationships, girlfriend/boyfriend intermittently with other residents since his stay at the facility. Resident #18 has been seen socializing more closely with this resident as opposed to others. There have been no other inappropriate behaviors observed or reported before this incident. Resident #18 reports he is very angry with questioning he has had to answer regarding the incident. Resident #18 was initially dismissive and would not talk but after some encouragement he reports he did nothing wrong and was with his girlfriend. Resident #18 declines being forced to do anything and declines having to force the other resident. Resident #18 reports it has been a consensual relationship.<br><br>Review of Resident #18's nurse's notes from March 2024 through November 2024 did not contain any documentation regarding Resident #18 holding hands with other residents, putting his arm around other residents or developing a relationship with other residents.<br><br>Review of a facility SRI dated 11/26/24 revealed an allegation of resident-to-resident sexual abuse involving Resident #18 and Resident #28. Resident #18 was allegedly found to be performing oral sex on Resident #28 on 11/26/24 at approximately 8:30 P.M. CNA #396 found Resident #18 kneeling with his head in proximity of Resident #28's vagina. Both residents were separated and interviewed and reported consenting to the behavior and understanding what they were engaged in. Resident #28 also stated she was in a relationship with Resident #18. The facility determined the allegation of sexual abuse to be unsubstantiated as both residents consented to the sexual interaction.<br><br>Review of a witness statement dated 11/26/24 and authored by LPN #310 revealed the following information: Since beginning of shift on 11/26/24 both residents (#18, #28) were acting normal, at their baseline, in a good mood, no change in condition, no behaviors, no issues or complaints.<br><br>Review of a witness statement dated 11/26/24 and authored by CNA #396 revealed the following information: I was doing rounds and noticed Resident #24 was not in her room so I knocked on Resident #28's door and walked in and saw Resident #28 laying back on her bed with her legs wide open and Resident #18 on his knees with his face in between her legs.<br><br>Review of a staff schedule for 11/26/24 7:00 P.M. to 7:00 A.M. identified three staff working on the Connections secured unit: LPN #310, CNA #396 and CNA #358. No witness statement was available for CNA #358.<br><br>Review of a typed, unauthored interview dated 11/27/24 with Resident #28 revealed the following information: Resident #28 shared she and the gentleman were in an average relationship and that no sexual contact occurred. Resident #28 stated she is not married, just an average relationship and reported other patient did not have a spouse. Resident #28 stated sexual intimacy occurred between people that care for one another and that she was not taken advantage of. Resident #28 indicated she could say no to sexual contact. Resident #28 stated she was aware one of them may move but that did not mean their relationship will end.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of a typed, unauthored interview dated 11/27/24 with Resident #18 revealed the social worker read the questions and Resident #18 responded 'no' to the first four questions relating to who initiated the sexual contact, did the patient believe the other person was a spouse, what level of sexual intimacy was he comfortable with and if the behavior was consistent with formerly held beliefs/values. Resident #18 stated he could say no to sexual contact. Resident #18 said he would be fine when the relationship ends, and he would just not see her anymore.<br><br>Review of a typed interview completed by the DON and RDCO/RN #219 on 11/26/24 at 9:00 P.M. with Resident #28 revealed she knew what was happening in her room with Resident #18 and thought they were alone in here. Resident #18 stated she was not forced during this episode, no one put a gun to my head, stated she felt safe and was not hurt.<br><br>Review of a typed interview completed by the DON and RDCO/RN #219 on 11/26/24 at 9:00 P.M. with Resident #18 revealed he understood what was happening in his room with Resident #28, he was not forced, felt safe and was not hurt, and leave me alone.<br><br>Review of a police report dated 11/26/24 at 10:11 P.M. revealed LPN #310 placed a call for a sex offense at the facility. Comments on the report read: Needs to report sexual abuse between two patients on the dementia unit. Both parties say it was consensual but because it is the dementia unit staff was advised they need to make a report. Parties involved: Resident #18 and Resident #28.<br><br>Record review as of 12/09/24 revealed the facility had not assessed or developed a comprehensive or individualized plan care for Resident #18 related to human sexuality needs or preferences or the resident's capacity to consent to sexual activity.<br><br>Review of Resident #18's Kardex as of 12/10/24 had a notation under 'Monitoring' on 11/26/24 for not being in room with female with door closed.<br><br>Observation on 12/09/24 at 9:19 A.M. with Resident #28 revealed she was sitting in bed in her room eating breakfast without issue. When the surveyor introduced herself to attempt an interview, Resident #28 nodded when her name was said and said I don't know as several questions were asked about how long she had lived at the facility and if she had friends or boyfriends at the facility. The interview was terminated due to Resident #28's decreased cognitive ability.<br><br>Interview on 12/09/24 at 9:30 A.M. with Resident #18 revealed he had been at the facility for one month and was going home soon. Resident #18 denied having any female friends at the facility, denied any intimate relationships with any of the female residents on the unit and denied sexual interactions with Resident #28 as he did not spend time with her. Resident #18 then voi [TRUNCATED] |

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| F 0606<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Not hire anyone with a finding of abuse, neglect, exploitation, or theft.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38522<br><br>Based on personnel file review, interview, review of facility policies and review of the Ohio Revised Code (ORC), the facility failed to hire staff free of disqualifying offenses. This affected one out of seven personnel files reviewed and had the potential to affect all 158 residents residing in the facility.<br><br>Findings include:<br><br>Review of personnel files on 12/11/24 starting at 2:20 P.M. with Employee Lifecycle Manager (ELM) #246 and Regional Employee Engagement Specialist ([NAME]) #197 revealed the following area of concern:<br><br>Review of Maintenance Staff (MS) #385's personnel file revealed a date of hire of 04/28/23. MS #385 was on the Bureau of Criminal Investigation (BCI) log as having a background check sent on 04/27/23 and the results returning on 05/11/23 with no findings. ELM #246 and [NAME] #197 were asked to provide the background check report. Further review of MS #385's background check report dated 05/12/23 revealed charges for domestic violence (2919.25) on 12/28/95. No personal care standards were located within MS #385's personnel file.<br><br>Interview with [NAME] #197 verified the above findings at the time of discovery and confirmed MS #385 did not have personal care standards completed within his personnel file or background check reports.<br><br>Review of the facility policy, Background Checks/Abuse Checks Under Ohio Law, effective 10/01/00 revealed if an individual had convictions you will see a printout that will list all convictions for that individual not just convictions for disqualifying crimes. You will need to review the printout to determine whether any of the convictions are disqualifying. The printout will also include arrests for which the Bureau of Criminal Investigation (BCII) or the Federal Bureau of Investigation (FBI) has no record of disposition (i.e. they do not know how the matter turned out in the courts). If a job applicant has been arrested for what would be a disqualifying crime but there is no disposition listed, you will have to investigate yourself to find out what the result was. You may put the burden on the applicant to provide you with evidence of what the disposition of the offense was you are not required to hire someone with a prohibited offense regardless of whether they can meet personal care standards or not Any individual found not eligible to work may not be employed.<br><br>Review of the policy, Ohio Prohibited Offenses, dated 10/01/19 revealed applicants coming under final consideration for employment with the facility's corporation may not have been convicted of, plead guilty to or plead no contest to the listed offenses including 2919.25 domestic violence.<br><br>Review of ORC Rule 3701-13-05, Disqualifying Offenses, dated 12/08/23 revealed except as set forth in the personal character standards established in rule 3701-13-06 of the Administrative Code, no Direct Care Provider is allowed to employ a person in a position that involves providing direct care to an older adult if the person has been convicted of or pleaded guilty to a violation of any of the following sections of the Revised Code . including 2919.25 domestic violence. |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Develop and implement policies and procedures to prevent abuse, neglect, and theft.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38522<br><br>Based on personnel record review, facility policy review, and interview, the facility failed to implement their abuse policy and procedure regarding checking potential applicants against the Ohio Nurse Aide Registry (NAR) prior to working with residents as well as completing background checks as required. This affected six out of seven personnel files reviewed and had the potential to affect all 158 residents who resided in the facility.<br><br>Findings include:<br><br>Review of personnel files on 12/11/24 starting at 2:20 P.M. with Employee Lifecycle Manager (ELM) #246 and Regional Employee Engagement Specialist ([NAME]) #197 revealed the following areas of concern:<br><br>Review of Certified Nurse Aide (CNA) #365's personnel file revealed a date of hire of 11/29/23. CNA #365 was checked against the NAR on 12/19/23, after she had already been working with residents. CNA #365 was not on the facility's background check log and her file contained no envelope with background checks available for further review.<br><br>Review of Dietary Aide (DA) #338's personnel file revealed a date of hire of 08/08/24. DA #338's file lacked evidence she was checked against the NAR. DA #338 was not on the background check log and a copy of her background checks was present dated 12/11/24.<br><br>Review of CNA #384's personnel file revealed a date of hire of 08/14/24. CNA #384 was checked against the NAR on 09/03/24, after she had already been working with residents.<br><br>Review of Licensed Practical Nurse (LPN) #324's personnel file revealed a date of hire of 04/03/24. LPN #324's file lacked evidence she was checked against the NAR.<br><br>Review of Maintenance Staff (MS) #385's personnel file revealed a date of hire of 04/28/23. MS #385's personnel file lacked evidence he was checked against the NAR.<br><br>Review of Receptionist #224's personnel file revealed a date of hire of 06/16/23. Receptionist #224's personnel file lacked evidence she was checked against the NAR. Receptionist #224 was on the facility's background check log, however, her file contained no envelope with background checks available for further review.<br><br>Interview with [NAME] #197 verified the above findings at the time of discovery and confirmed the NAR was to be checked and background checks were to be run for all potential employees before they were hired to ensure no applicant had a finding of abuse, neglect, misappropriation or other disqualifying offenses.<br><br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Review of the policy, Background Checks/Abuse Checks Under Ohio Law, dated 10/01/00 revealed it was policy of the facility's corporation to assure a check of the Ohio NAR registry was completed on all candidates for employment prior to a job offer being made. When hiring or rehiring any employee, including contract employees, to any position within an Ohio facility, you must conduct an Ohio Bureau of Criminal Identification and Investigation (BCII) and Federal Bureau of Investigation (FBI) check prior to date of hire.<br><br>Review of the facility policy, Ohio Abuse, Neglect and Misappropriation, no date revealed following the personal interview and upon recommendation of the interviewer, background checks will be performed. A pre-hire criminal background check will be performed for all potential Ohio staff. Licensure/registry checks will be performed after the interview to verify the NAR. All checks will be managed by the facility Human Resources manager/designee and results will be reviewed with the appropriate department head and administration. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 366008 | A. Building<br>B. Wing | 12/17/2024 |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38522<br><br>Based on interview, review of a self-reported incident (SRI), review of the facility investigation and review of the facility policy, the facility failed to thoroughly investigate allegations of resident-to-resident sexual abuse. This affected one resident (#28) of three residents reviewed for abuse. Facility census was 158.<br><br>Findings include:<br><br>Review of Resident #28's medical record revealed an admitted [DATE] with diagnoses including heart disease, vascular dementia with other behavioral disturbance, depression, cognitive communication deficit, insomnia, post-traumatic stress disorder (PTSD), dysphagia, burn of unspecified degree of head, face and neck restlessness and agitation.<br><br>Review of Resident #28's guardianship documentation revealed she was deemed incompetent and had a guardian of person effective 03/13/20.<br><br>Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #28 had a brief interview for mental status (BIMS) score of nine, indicating moderate cognitive impairment and had no behaviors coded on the assessment.<br><br>Review of Resident #28's care plans revealed a plan of care dated 08/23/21 and revised 03/24/22 for impaired cognitive function related to dementia with listed interventions including 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 and mental status.<br><br>Review of a plan of care dated 05/02/23 revealed Resident #28 required placement on a secured unit with listed interventions including notify medical provider/resident representative of behavior changes and provide diversionary activities as needed and redirect when appropriate.<br><br>Review of a nurses' note dated 11/26/24 at 11:28 P.M. and authored by Licensed Practical Nurse (LPN) #310 revealed the following information: Around 10:00 P.M. while doing rounds, Certified Nurse Aide (CNA) entered Resident #28's room and saw the resident laying in her bed with pants down with a male resident kneeling in front of her with his head within proximity of her vagina. Residents were immediately separated. Resident #28 was interviewed, stated she consented, not forced and felt safe. Guardian notified. Physician notified. Police notified. Resident #28 resting in room, will continue to monitor.<br><br>Review of Resident #18's medical record revealed an admitted [DATE] with diagnoses including depression, anxiety, dementia with agitation, cognitive communication deficit and history of transient ischemic attack (TIA).<br><br>Resident #18's guardianship documentation revealed he was deemed incompetent and had a guardian of person and estate effective 07/17/23.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident #18's annual MDS assessment dated [DATE] revealed the resident was severely cognitively impaired, had no behaviors coded on the assessment and required set up for meals, dressing and toileting. Resident #18 required supervision for ambulation and was independent with most mobility.<br><br>Review of Resident #18's care plans revealed a plan of care dated 11/23/22 for impaired cognitive function [related to] dementia and listed interventions including communicate with resident/family/caregivers regarding resident's capabilities and needs, discuss concerns about confusion, disease process and nursing home placement with resident/family/caregiver and keep routine as consistent as possible in order to decrease confusion.<br><br>Review of a plan of care dated 11/23/22 revealed Resident #18 required a secured unit due to dementia and listed interventions included notify medical provider/resident representative of behavior changes and provide diversionary activities as needed. Redirect when appropriate.<br><br>Review of a nurses' note dated 11/26/24 at 11:43 P.M. and authored by LPN #310 revealed the following information: Around 10:00 P.M. during rounds CNA walked into female resident room and saw Resident #18 kneeling in front of her with his head within proximity of her vagina. Residents were immediately separated. Resident #18 was interviewed and stated it was consensual, not forced and he felt safe. Guardian and physician notified as well as police.<br><br>Review of a facility SRI dated 11/26/24 revealed an allegation of resident-to-resident sexual abuse involving Resident #18 and Resident #28. Resident #18 was allegedly found to be performing oral sex on Resident #28 on 11/26/24 at approximately 8:30 P.M. CNA #396 found Resident #18 kneeling with his head in proximity of Resident #28's vagina. Both residents were separated and interviewed and reported consenting to the behavior and understanding what they were engaged in. Resident #28 also stated she was in a relationship with Resident #18. The facility determined the allegation of sexual abuse to be unsubstantiated as both residents consented to the sexual interaction.<br><br>Review of a witness statement dated 11/26/24 and authored by LPN #310 revealed the following information: Since beginning of shift on 11/26/24 both residents (#18, #28) were acting normal, at their baseline, in a good mood, no change in condition, no behaviors, no issues or complaints.<br><br>Review of a witness statement dated 11/26/24 and authored by CNA #396 revealed the following information: I was doing rounds and noticed Resident #24 was not in her room so I knocked on Resident #28's door and walked in and saw Resident #28 laying back on her bed with her legs wide open and Resident #18 on his knees with his face in between her legs.<br><br>Review of a staff schedule for 11/26/24 7:00 P.M. to 7:00 A.M. identified three staff working on the Connections secured unit: LPN #310, CNA #396 and CNA #358. No witness statement was available for CNA #358.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of a typed, unauthored interview dated 11/27/24 with Resident #28 revealed the following information: Resident #28 shared she and the gentleman were in an average relationship and that no sexual contact occurred. Resident #28 stated she is not married, just an average relationship and reported other patient did not have a spouse. Resident #28 stated sexual intimacy occurred between people that care for one another and that she was not taken advantage of. Resident #28 indicated she could say no to sexual contact. Resident #28 stated she was aware one of them may move but that did not mean their relationship will end.<br><br>Review of a typed, unauthored interview dated 11/27/24 with Resident #18 revealed the social worker read the questions and Resident #18 responded 'no' to the first four questions relating to who initiated the sexual contact, did the patient believe the other person was a spouse, what level of sexual intimacy was he comfortable with and if the behavior was consistent with formerly held beliefs/values. Resident #18 stated he could say no to sexual contact. Resident #18 said he would be fine when the relationship ends, and he would just not see her anymore.<br><br>Review of a typed interview completed by the Director of Nursing (DON) and Regional Director of Clinical Operations (RDCO)/Registered Nurse (RN) #219 on 11/26/24 at 9:00 P.M. with Resident #28 revealed she knew what was happening in her room with Resident #18 and thought they were alone in here. Resident #18 stated she was not forced during this episode, no one put a gun to my head, stated she felt safe and was not hurt.<br><br>Review of a typed interview completed by the DON and RDCO/RN #219 on 11/26/24 at 9:00 P.M. with Resident #18 revealed he understood what was happening in his room with Resident #28, he was not forced, felt safe and was not hurt, and leave me alone.<br><br>A telephone interview on 12/10/24 at 8:33 A.M. and 2:09 P.M. with CNA #396 revealed on 11/26/24 around 8:30 P.M. she had identified Resident #24 was not in her bed so she went to her (Resident #24's old room (which was Resident #28's current room) to look for the resident. When she arrived to this room, she witnessed Resident #18 giving Resident #28 oral sex. CNA #396 stated both residents did not have pants on and Resident #18 was on his knees and his head was between Resident #28's legs. CNA #396 called LPN #310 down and reported what she saw to the Administrator. CNA #396 stated they separated both residents at that time. CNA #396 explained both Resident #18 and Resident #28 felt they were boyfriend and girlfriend and would put their arms around each other and sit next to each other and this had been going on for maybe nine months to one year. CNA #396 stated Family Member (FM) #192 saw them often sitting at the table together and Resident #18 would introduce Resident #28 as his girlfriend. CNA #396 shared the night of the incident, a staff member had called off, so it was her, LPN #310 and CNA #358 on the dementia unit from 7:00 P.M. to 7:00 A.M. When asked about when both residents had been last seen (as her witness statement did not contain this information), CNA #396 stated 15 minutes prior, both residents were sitting at the table together on the unit.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A telephone interview on 12/10/24 at 9:31 A.M. and 2:11 P.M. with CNA #358 revealed she was aware of the sexual interaction that had occurred between Resident #18 and Resident #28 but was providing patient care to other residents at the time it was discovered. CNA #358 stated the nurse, and the other CNA were communicating with administration. CNA #358 stated she was present when Resident #28 was being questioned by staff (not named) and Resident #28 was aggravated, said she consented to the activity and was asking why people were in her business. When asked when she last saw Resident #18, CNA #358 stated he had been upset at his roommate and was sitting in the dining room before 12:00 A.M. but did not recall further. When asked when she last saw Resident #28, CNA #358 stated she put her roommate to bed before 8:00 P.M.<br><br>An interview was attempted with LPN #310 on 12/10/24 at 8:32 A.M. but was not successful.<br><br>Interview on 12/10/24 at 11:56 P.M. with Licensed Social Worker (LSW) #245 revealed FM #192 had left her a voicemail about the sexual encounter between Resident #18 and Resident #28. Resident #18 was in Resident #28's room during rounds the evening of 11/26/24 and was found in a sexual position kneeling in front of Resident #28. LSW #245 confirmed she completed the typed, unauthored interviews as part of the facility's SRI and related investigation and shared Resident #18 said nothing and Resident #28 felt she was in a relationship with Resident #18.<br><br>Interview on 12/10/24 at 12:41 P.M. with the DON and RDCO/RN #219 revealed the DON indicated she was not sure how long Resident #18 and Resident #28 had been friends and was made aware of multiple staff reports Resident #18 and Resident #28 were holding hands on the unit and were quite close which was not documented in either resident's medical record. The DON indicated she had learned from staff interviews during the SRI investigation that both residents would walk together and hold hands but this was not documented within the SRI. The DON was questioned regarding the lack of detail in both staff statements for the SRI on 11/26/24 including times and she indicated both residents were last seen not much before the time of the encounter walking together and did not have further documentation to provide on the matter.<br><br>A follow up interview on 12/11/24 at 8:24 A.M. with the DON, the Administrator and Divisional Director of Clinical Operations (DDCO)/RN #199 revealed no statement was collected from CNA #358 even though she was working on the unit at the time of the sexual encounter with Resident #18 and Resident #28, as the DON and the Administrator indicated they could not get ahold of her. When asked about establishing a timeline, including interviewing staff from the shift before an incident occurred to see if there were any precursors to this behavior, the Administrator stated they did not obtain a timeline as they got a first-hand account from CNA #396 and they would only establish a timeline if the incident was not witnessed. When asked why LPN #310's statement lacked information regarding this incident including times, the DON stated that it reflected that LPN #310 saw the residents at the beginning of the shift but to determine when LPN #310 last saw both residents, they would have to interview her again.<br><br>Follow-up interview on 12/11/24 at 8:40 A.M. with DDCO/RN #199 during a review of the sexual abuse SRI with the surveyor confirmed the SRI lacked a timeline and the two available staff statements were not clear, complete and did not contain time details to help with establishing a timeline.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the undated facility policy, Ohio Abuse, Neglect and Misappropriation, revealed the accurate and timely identification of any event which would place our residents at risk is a primary concern of the facility. Each occurrence of alleged abuse will be identified and reported to the supervisor and investigated timely. The DON and Administrator receive reports of resident incidents. The Administrator determines when an investigation is required and directs the investigation. Statements will be obtained from the resident or from the reporter of the incident in writing whenever possible by the Administrator or Designee. Statements will be obtained from staff related to the incident including victim, person reporting incident, accused perpetrator and witnesses. The statement should be in writing, signed and dated at the time it is written. Statements should include the following: first-hand knowledge of the incident and a description of what was witnessed, seen or heard. Following the initial report of the alleged violation, the facility will complete a thorough investigation and put measures in place to prevent other incidents from occurring during the course of the investigation. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38522<br><br>Based on record review, fall investigation review, interview and review of the facility policy, the facility failed to thoroughly investigate falls to ensure appropriate safety interventions were in place for Resident #160. This affected one resident (#160) of three residents reviewed for falls. Facility census was 158.<br><br>Findings include:<br><br>Review of Resident #160's closed medical record revealed an admitted [DATE] and diagnoses including type two diabetes, repeated falls, hypertension, obesity, aphasia following cerebral infarction and hemiplegia and hemiparesis following non-traumatic intracerebral hemorrhage affecting left non-dominant side. Resident #160 discharged to the hospital on 09/06/24 and did not return to the facility.<br><br>Review of Resident #160's physician's orders revealed an order dated 09/04/24 for low bed with bilateral mats to floor every shift and an order dated 09/04/24 for physical therapy (PT) and occupational therapy (OT) to evaluate.<br><br>Review of Resident #160's admission nursing evaluation dated 09/04/24 revealed Resident #160's fall history was unknown prior to admission but Resident #160 had poor recall and judgement and required a wheelchair and/or ambulation assistance. The assessment indicated Resident #160 was at risk for falls.<br><br>Review of a discharge-return anticipated Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #160 had intact memory, no behaviors documented, required substantial/maximal assistance for bed mobility and transfers and was dependent on staff for toileting. Resident #160 had one fall with minor injury and one fall with major injury coded on the assessment.<br><br>Review of Resident #160's care plans revealed a plan of care dated 09/04/24 for risk of falls due to cerebrovascular accident with left hemiparesis and diabetes mellitus with listed interventions including physical therapy evaluation; move closer to nursing station when returns; assess for risk for falls on admission/readmission, quarterly and as needed; educate resident or resident representative how to operate bed controls/call light/television; ensure resident is wearing appropriate non-skid footwear; ensure resident's room is free of potential visible hazards; ensure the bed locks are engaged; initiate neurological checks if a fall is unwitnessed or if the head is involved; low bed with bilateral mats to floor; observe medication for side effects that may increase risk for falls; place call bell within reach and remind resident to call for assistance.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Review of Resident #160's progress note dated 09/06/24 at 6:33 A.M. and was authored by Licensed Practical Nurse (LPN) #356 and contained the following information: 'Resident #160 was found on the floor next to bed at approximately 4:10 A.M. by laboratory technician. Resident #160 was assessed for pain and injury, Resident #160 complained of headache and stated that he hit his head upon landing on the floor. Resident #160's bed was found in high position and Resident #160 stated he had lifted the bed up for reasons he did not know. Nurse practitioner contacted and recommended sending Resident #160 [to the hospital] due to hitting his head and being on blood thinners. Vitals were obtained and emergency contact informed of incident.' The progress note did not indicate when LPN #356 last saw Resident #160 prior to the fall and in what capacity.<br><br>Review of a progress note dated 09/06/24 at 6:43 A.M. and authored by LPN #356 revealed Resident #160 was picked up [by emergency medical services] at 6:00 A.M. headed to Euclid Hospital.<br><br>Review of a progress note dated 09/06/24 at 7:56 A.M. and authored by Unit Manager (UM)/RN #395 revealed Resident #160 was transferring to University Hospitals main campus with diagnosis intracranial hemorrhage.<br><br>Review of a post-fall investigation dated 09/06/24 revealed Resident #160 fell from the bed to the floor at 4:10 A.M. Resident #160 was found sitting on the floor next to bed unable to verbalize how he came to be on the floor. A new intervention was listed as move Resident #160 closer to the nurses' station upon return from hospital. Follow-up was listed as 'sent to hospital via 9-1-1.' Appropriate notifications were made. Staff on duty were identified at LPN #356, Certified Nurse Aide (CNA)#198 and CNA #383.<br><br>Review of an incident report for Resident #160's fall on 09/06/24 reported by LPN #356 timed the fall at 4:10 A.M. revealed Resident #160's emergency contact was notified on 09/06/24 at 4:30 A.M., the telehealth physician was notified on 09/06/24 at 4:31 A.M., an ambulance was called on 09/06/24 at 5:00 A.M. and Resident #160 was sent to the hospital on 09/06/24 at 6:00 A.M. Notes on the incident report were added by UM/RN #396 on 12/09/24 to include what happened: 'Per nurse, Resident #160 found on the floor by laboratory technician and did not witness fall;' and resident statement of what happened: 'Per patient, raised bed for unknown reasons and fell , states that he hit his head.' The incident report section, Care Prior to Fall, listed a visually observed time of 09/06/24 at 4:10 A.M. with no further information provided as to who saw Resident #160 and in what capacity prior to his fall. The report indicated mattresses were on the floor and the call light was off at the time of discovery.<br><br>Review of a witness statement dated 09/06/24 for CNA #198 revealed the following information: 'Verbal- did not witness incident.' The statement did not indicate when CNA #198 last saw Resident #160.<br><br>Review of a witness statement dated 09/06/24 for CNA #383 revealed the following information: 'Verbal- did not witness incident.' The statement did not indicate when CNA #383 last saw Resident #160.<br><br>Review of bowel and bladder tracking for 09/06/24 revealed Resident #160 was checked for incontinence at 2:17 A.M. by CNA #383 but this information was not within the facility investigation.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Interview on 12/11/24 at 11:12 A.M. with UM/RN #395 revealed Resident #160's fall on 09/06/24 was unwitnessed. When asked when Resident #160 was seen prior to falling as it was not stated in the facility's fall investigation, UM/RN #395 stated staff should have seen him at the 2:00 A.M. checks. UM/RN #395 confirmed the time of 4:10 A.M. on the fall investigation is when the laboratory technician found Resident #160, not the actual time he fell or was seen last by staff. The floor nurse was supposed to do an incident report when a resident fell and gather witness statements; these witness statements would tell what staff were doing at the time of the fall and when they last observed the resident which UM/RN #395 confirmed was not done in this case. UM/RN #395 also confirmed the incident report was not done at the time of the fall and this was the reason why she placed notes in the incident report on 12/09/24.<br><br>Interview on 12/11/24 at 12:11 P.M. with the Director of Nursing (DON) revealed she had no further information regarding Resident #160's fall on 09/06/24 aside from the content of the fall investigation and incident report provided other than he was found by the laboratory technician at 4:10 A.M. The DON confirmed witness statements and fall investigations were to include more details including the last time a staff member saw the resident and the last time the resident was toileted or cared for. The DON explained the facility's unit managers were to complete the post-fall investigation with a completed incident report and witness statements within seven days following the fall for discussion at the weekly risk meeting. The DON indicated in this case, LPN #356 was responsible for obtaining complete and accurate witness statements post-fall and UM/RN #395 should have asked further questions about the witness statements that did not provide adequate information as required. The DON acknowledged she did not like how these witness statements were done and confirmed she needed to continue to educate staff.<br><br>Phone interview on 12/11/24 at 1:56 P.M. with CNA #198 revealed she no longer worked for the facility and did not recall Resident #160's fall.<br><br>Phone interview on 12/11/24 at 1:58 P.M. with LPN #356 revealed on 09/06/24 during night shift, the lab staff found Resident #160 on the floor. When asked when she last saw Resident #160 as the progress notes and report did not contain this information, LPN #356 stated she saw Resident #160 an hour prior, maybe under an hour prior to his fall and she and CNA #383 had repositioned him at that time in a low bed. When asked if staff had entered the room after she had prior to Resident #160's fall, LPN #356 claimed she and CNA #383 had just been in there.<br><br>Phone interview on 12/11/24 at 2:04 P.M. with CNA #383 revealed he did not recall Resident #160's fall.<br><br>Review of the facility policy, Fall Prevention and Management, no date revealed once the resident is safely transferred a fall investigation should begin. Ask the resident what they were doing when the fell . Identify if there were witnesses to the fall. Ask them what they saw, have them write a statement if possible. Immediately written statements provide much more detail than asking later.<br><br>This deficiency represents noncompliance investigated under Complaint Number OH00159828. |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38522<br><br>Based on record review, review of the facility assessment, self-reported incident (SRI) review and interview the facility failed to maintain sufficient levels of staff on the secured care unit to meet the supervisory needs of all residents. This affected two residents (#18 and #28) and had the potential to affect the 41 residents residing on the facility's secured memory care unit. Facility census was 158.<br><br>Findings include:<br><br>Review of the facility assessment dated [DATE] revealed based on the facility resident population and their needs for care and support, our approach to staffing is to ensure that each of our nursing facility residents has the minimum direct care staff to meet the needs of the residents at any given time. We work to assure necessary staff based on the model shown. For the Connections (secured) unit on night shift, there were to be one to two licensed nurses and two to three nurse aides. The facility assessment did not delineate what would determine more or less nurses or aides or at what point staffing would change on the Connections unit.<br><br>Review of a staff schedule for 11/26/24 from 7:00 P.M. to 7:00 A.M. identified three staff working on the Connections secured unit: Licensed Practical Nurse (LPN) #310, Certified Nurse Aide (CNA) #396 and CNA #358.<br><br>In addition, concerns for Resident #18 and Resident #28 were identified which correlated to a lack of staffing and resident supervision on 11/26/24:<br><br>Review of a facility SRI dated 11/26/24 revealed an allegation of resident-to-resident sexual abuse involving Resident #18 and Resident #28. Resident #18 was allegedly found to be performing oral sex on Resident #28 on 11/26/24 at approximately 8:30 P.M. CNA #396 found Resident #18 kneeling with his head in proximity of Resident #28's vagina. Both residents were separated and interviewed and reported consenting to the behavior and understanding what they were engaged in. Resident #28 also stated she was in a relationship with Resident #18. The facility determined the allegation of sexual abuse to be unsubstantiated as both residents consented to the sexual interaction.<br><br>Review of a witness statement dated 11/26/24 and authored by LPN #310 revealed the following information: Since beginning of shift on 11/26/24 both residents (#18, #28) were acting normal, at their baseline, in a good mood, no change in condition, no behaviors, no issues or complaints.<br><br>Review of a witness statement dated 11/26/24 and authored by CNA #396 revealed the following information: I was doing rounds and noticed Resident #24 was not in her room so I knocked on Resident #28's door and walked in and saw Resident #28 laying back on her bed with her legs wide open and Resident #18 on his knees with his face in between her legs.<br><br>No witness statement was available for CNA #358.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 366008 | A. Building<br>B. Wing | 12/17/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Grande Pointe Healthcare Commu | Three Merit Dr<br>Richmond Heights, OH 44143 |

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 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A telephone interview on 12/10/24 at 8:33 A.M. and 2:09 P.M. with CNA #396 revealed on 11/26/24 around 8:30 P.M. she had identified Resident #24 was not in her bed so she went to her (Resident #24's old room (which was Resident #28's current room) to look for the resident. When she arrived to this room, she witnessed Resident #18 giving Resident #28 oral sex. CNA #396 stated both residents did not have pants on and Resident #18 was on his knees and his head was between Resident #28's legs. CNA #396 called LPN #310 down and reported what she saw to the Administrator. CNA #396 stated they separated both residents at that time. CNA #396 shared the night of the incident, a staff member had called off, so it was only her, LPN #310 and CNA #358 on the dementia unit from 7:00 P.M. to 7:00 A.M. When asked about when both residents had been last seen (as her witness statement did not contain this information), CNA #396 stated 15 minutes prior, both residents were sitting at the table together on the unit.<br><br>A telephone interview on 12/10/24 at 9:31 A.M. and 2:11 P.M. with CNA #358 revealed she was aware of the sexual interaction that had occurred between Resident #18 and Resident #28 but was providing patient care to other residents at the time it was discovered. CNA #358 stated the nurse and the other CNA were the only other staff on the unit at the time. When asked when she last saw Resident #18, CNA #358 stated he had been upset at his roommate and was sitting in the dining room before 12:00 A.M. but did not recall further. When asked when she last saw Resident #28, CNA #358 stated she put her roommate to bed before 8:00 P. M.<br><br>An interview was attempted with LPN #310 on 12/10/24 at 8:32 A.M. but was not successful.<br><br>Interview on 12/16/24 at 2:09 P.M. with the Administrator revealed for staffing schedules, the facility's corporation utilized an outside company based in Dubai that made the schedules and she, the Director of Nursing (DON) and Human Resources (HR) got on daily calls with their point person to discuss the schedule. The Administrator stated since she had starting working at this facility in January 2024, the facility did not utilize staffing agencies to meet staffing needs. The Administrator explained they had a dedicated call-off specialist that would help to fill holes in the schedule 72 hours out, but the DON and Unit Managers would help to fill scheduling needs when changes occurred more last minute. The on-call manager would call staff to try to get the call-off replaced and if it could not be covered, staff could be pulled from a unit with less acuity and if the situation was really bad the on-call manager would have to come in to work. The Administrator was asked regarding the facility assessment and what determined two versus three aides on the Connections unit on night shift as the facility assessment did not specify and she indicated that census as well as resident behaviors or need to have a one-on-one staff would impact how many staff were needed on the unit at any given time. The Administrator explained that there was a staffing ladder for the whole building which was based on census number and would give how many total CNAs could be in the building but confirmed this did not break down further into units, including the Connections unit. The Administrator confirmed the schedule provided for 11/26/24 was accurate and as-worked with one LPN and two CNAs working at the time the sexual abuse between Resident #18 and Resident #28 occurred. |