STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366220	A. Building B. Wing	02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Court Rehab and Nursing	6969 Glenmeadow Lane Cincinnati, OH 45237

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** Based on medical record review, staff interview, review of Self-Report Incidents (SRI) and facility policy review, the facility failed to implement their abuse policy when an allegation of sexual abuse was reported. This affected two Residents (#01 and #12) out of the three residents reviewed for abuse. The facility census was 106. 1) Review of the medical record for Resident #01 revealed the resident was admitted to the facility on [DATE]. Diagnoses included abscess of right foot, major depressive disorder, morbid obesity, hypertensive retinopathy, pulmonary embolism, insomnia, intellectual disability (ID), essential primary hypotension, and diabetes mellitus (DM). The resident was housed in the secured Memory Care Unit (MCU) and had a guardian related to mental disability. Review of physician orders for Resident #01 dated 08/16/23, revealed resident was ordered to be housed in the secured unit for safety of self and others related to major depressive disorder. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #01 was cognitively intact. The resident was independent or required minimal assistance with activities of daily living (ADL). Review of the Nurse Practitioner (NP) progress notes for Resident #01 recorded as a late entry for 01/28/26 at 5:42 P.M. and authored by NP #501on 02/09/26 at 10:48 A.M. revealed Resident #01 was assessed at the bedside for high-risk sexual behavior. The resident resides in locked men's unit and per nursing staff the resident had inappropriate behaviors like this incident involving another resident who was discharged . The resident was alert and oriented. Resident #01 was witnessed in the common area by two therapists, attempting to ejaculate another resident (Resident #12) who had severe dementia. The nurse notified Resident #12's guardian regarding Resident #01 inappropriately touching Resident #12. Resident #01 was to be put in a private room and start 15-minute checks. Resident #01 was ordered medroxyprogesterone (for high-risk sexual behavior) daily. Review of the nurse progress note for Resident #01 dated 01/28/26 at 7:10 P.M. and authored by Licensed Practical Nurse (LPN) #256, revealed Certified Nursing Assistant (CNA) #222 reported that Resident #01 was observed with hand contact to Resident #12's genital area while they were seated in the common area. The staff intervened and Resident #01 was redirected and guided away from Resident #12. All parties including Guardian were notified. Review of the physician order for Resident #01 dated 01/28/26 revealed the resident was ordered medroxyprogesterone acetate (for high-risk sexual behaviors) five milligram (mg) daily.Review of the care plans for Resident #01 created on 01/29/26, revealed he had a behavioral care plan for sexually inappropriate behaviors with other residents.Review of Interdisciplinary Team (IDT) note for Resident #01 dated 02/04/26 at 12:42 P.M., revealed Resident #01 was observed engaging in appropriate physical contact with Resident #12. Resident #01 placed his hand on another resident's perineal rea. The residents were immediately separated and Resident #01 was moved to a private room. Resident #01 was seen by psychiatric provider and started on medications. Further review of the medical record for Resident #01 revealed no documented evidence Resident #01 was evaluated by psychiatric services after the incident on 01/28/26 involving (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #12. 2) Review of the medical record for Resident #12 revealed he was admitted to the facility on [DATE]. Diagnoses included insomnia, dementia, essential primary hypertension, major depressive disorder, and DM. The resident was housed in the secured MCU.Review of the care plan for Resident #12 dated 10/07/25 revealed the resident had impaired cognition related to dementia, had short and long-term memory impairment and required assistance with decision making.Review of the MDS assessment dated [DATE] revealed Resident #12 had severely impaired cognition. Review of the Nurse Practitioner (NP) progress notes for Resident #12 recorded as a late entry for 01/28/26 at 5:48 P.M. and authored by NP #501 on 02/09/26 at 10:54 A.M., revealed Resident #12 was the receiver of another resident's (Resident #01) inappropriate behavior. Resident #12 was witnessed by two therapists being ejaculated by Resident #01 and Resident #12 did not appear to understand what happened. The assessment / diagnoses revealed Resident #12 was the receiver of another resident's high risk sexual behavior and did not understand what happened. The plan was to notify Resident #12's guardian, keep the two residents separated and start 15-minute checks. The physician and psychiatric NP were notified. Review of the nurse progress notes for Resident #12 dated 01/28/26 at 7:12 P.M. and authored by LPN #256, revealed CNA (#222) reported that Resident #01 was observed with hand contact to Resident #12's genital area in the common area. The staff intervened and Resident #01 was redirected and guided away from Resident #12 All parties including Guardian were notified. Further review of the medical record for Resident #12 revealed no documented evidence that Resident #12 was evaluated by psychiatric services after the incident on 01/28/26 involving Resident #01. Interview on 02/09/26 at 7:37 A.M., CNA #222 stated she was the CNA on duty at the time of the incident between Resident #01 and Resident #12 on 01/28/26. CNA #222 stated she observed OTA #171 and PT #189 standing in the hallway looking into the living room area with an alarmed look on their face. The therapists stated Resident #01 had his hand on the private area of Resident #12 and was caressing it through his pants. STNA #222 stated she called Assistant Director of Nursing (ADON) #258 and reported the incident. Interview on 02/09/26 at 12:25 P.M., Occupational Therapy Assistant (OTA) #177 stated she walked toward the television room in the men's secured unit with Physical Therapist (PT) #189 when she observed Resident #01 seated to the left of Resident #12 on the couch. OTA #177 stated she observed Resident #01's hand around Resident #12's penis squeezing and rubbing it. OTA #177 stated she reported it to CNA #222. OTA #177 stated she was asked to write a statement today. Interview on 02/09/26 at 12:30 P.M., PT #189 stated on 01/28/26 she was standing in the hall with OTA #177 and observed Resident #01 on the couch sitting next to Resident #12. PT #189 stated she observed Resident #01 had his hand on the genital area of Resident #12. PT #189 stated she was asked to write a statement today. Interview on 02/09/26 at 12:49 P.M., LPN #256 stated on 01/28/26 CNA #222 reported to him that Resident #01 had his hand on Resident #12's private area and was rubbing it. LPN #256 stated two therapists (OTA #171 and PT #189) witnessed the incident. Interview on 02/09/26 at 1:15 P.M., Resident #50 (spouse and emergency contact of Resident #12) stated she was notified of the incident between Resident #01 and Resident #12 on 01/28/26. Resident #50 stated she received a call from LPN #256, and he notified her that Resident #01 was observed with his hand on Resident #12's penis and was rubbing it. Resident #50 stated she was told by LPN #256 that both Residents had their clothes on. Interview on 02/09/26 at 1:48 P.M., the Administrator stated he did not consider the incident with Resident #01 and Resident #12 to be sexual abuse. The Administrator stated both residents had their clothes on, so it was not reportable. The Administrator verified Resident #01 had a history of being sexually inappropriate. The Administrator verified Resident #01 was cognitively intact and Resident #12 was severely cognitively impaired and unable to consent to someone touching him inappropriately. The Administrator verified the (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	facility should have implemented their abuse policy, reported the incident to the state agency and completed a thorough investigation. Subsequent interview on 02/09/26 at 5:00 P.M. the Administrator verified the facility did not implement their abuse policy. The Administrator stated he did not report the incident because nothing happened to Resident #12 because the resident was fully clothed. The surveyor reviewed NP #500's documentation with the Administrator from 01/28/26, which noted Resident #01 was witnessed in the common area by two therapists, attempting to ejaculate another resident (Resident #12) who had severe dementia. The Administrator stated NP #501's note was not accurate information because NP #501 was not at the facility and did not know the details of the incident.Interview on 02/10/26 at 8:35 A.M., NP #501 stated she was at the facility on 01/28/26 when she received a call from ADON #258 related to an incident that occurred in the men's secure unit. NP #501 indicated that ADON #258 stated Resident #01 was observed by staff attempting to ejaculate Resident #12. NP #501 stated she went to the men's unit and assessed Residents #01 and #12. NP #501 stated the men were separated and both were fully clothed. NP #500 stated she was told by the staff that Resident #01 had his hand around Resident #12's penis and was rubbing it up and down. NP #500 stated the staff reported Resident #12 was confused and unsure of what was going on. NP #500 stated she called Medical Director (MD) #501 and was advised on the next steps to take. MD #501 directed NP #500 to have staff contact both guardians and Resident #01 was given order for medication related to his inappropriate sexual behavior. NP #500 stated she contacted the Director of Nursing (DON) who instructed her to relay the orders to the unit managers, then the DON left the facility. NP #500 stated she was told by the staff Resident #01 had this behavior with another Resident in the past; however, this resident had been discharged . NP #500 stated after she learned of Resident #01's previous behaviors, she questioned why the resident was in the room with a resident who was severely impaired. Review of the facility policy titled, Abuse, Neglect, Misappropriation of Resident Property, injury of unknown origin dated August 2024 revealed the Administrator had a responsibility for implementation of the abuse/neglect program. Any reports of abuse will be promptly and thoroughly investigated. Additionally, the facility will immediately report such allegations to the Administrator/designee and to the Department of Health and social services. The policy indicated sexual abuse was the non-consensual sexual contact of any type with a resident and this included but not limited to, unwanted intimate touching of any kind especially of breasts or perineal area. The policy stated if there is an allegation that a resident did not consent to engage in sexual activity with another resident or may not have the capacity to consent, the facility would respond to it as an alleged violation of sexual abuse. The facility would provide for the immediate safety of the residents upon identification of suspected abuse. Means of protection include but are not limited to; provide one-on-one monitoring as appropriate and implement discharge process immediately if the resident is in danger to self or others.This deficiency represents non-compliance investigated under Complaint Number 2737505.

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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** Based on medical record review, staff interview, review of Self-Report Incidents (SRI) and facility policy review, the facility failed to report an allegation of sexual abuse. This affected two Residents (#01 and #12) out of the three residents reviewed for abuse. The facility census was 106. 1) Review of the medical record for Resident #01 revealed the resident was admitted to the facility on [DATE]. Diagnoses included abscess of right foot, major depressive disorder, morbid obesity, hypertensive retinopathy, pulmonary embolism, insomnia, intellectual disability (ID), essential primary hypotension, and diabetes mellitus (DM). The resident was housed in the secured Memory Care Unit (MCU) and had a guardian related to mental disability. Review of physician orders for Resident #01 dated 08/16/23, revealed resident was ordered to be housed in the secured unit for safety of self and others related to major depressive disorder. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #01 was cognitively intact. The resident was independent or required minimal assistance with activities of daily living (ADL). Review of the Nurse Practitioner (NP) progress notes for Resident #01 recorded as a late entry for 01/28/26 at 5:42 P.M. and authored by NP #501on 02/09/26 at 10:48 A.M. revealed Resident #01 was assessed at the bedside for high-risk sexual behavior. The resident resides in locked men's unit and per nursing staff the resident had inappropriate behaviors like this incident involving another resident who was discharged . The resident was alert and oriented. Resident #01 was witnessed in the common area by two therapists, attempting to ejaculate another resident (Resident #12) who had severe dementia. The nurse notified Resident #12's guardian regarding Resident #01 inappropriately touching Resident #12. Resident #01 was to be put in a private room and start 15-minute checks. Resident #01 was ordered medroxyprogesterone (for high-risk sexual behavior) daily. Review of the nurse progress note for Resident #01 dated 01/28/26 at 7:10 P.M. and authored by Licensed Practical Nurse (LPN) #256, revealed Certified Nursing Assistant (CNA) #222 reported that Resident #01 was observed with hand contact to Resident #12's genital area while they were seated in the common area. The staff intervened and Resident #01 was redirected and guided away from Resident #12. All parties including Guardian were notified. Review of the physician order for Resident #01 dated 01/28/26 revealed the resident was ordered medroxyprogesterone acetate (for high-risk sexual behaviors) five milligram (mg) daily.Review of the care plans for Resident #01 created on 01/29/26, revealed he had a behavioral care plan for sexually inappropriate behaviors with other residents.Review of Interdisciplinary Team (IDT) note for Resident #01 dated 02/04/26 at 12:42 P.M., revealed Resident #01 was observed engaging in appropriate physical contact with Resident #12. Resident #01 placed his hand on another resident's perineal rea. The residents were immediately separated and Resident #01 was moved to a private room. Resident #01 was seen by psychiatric provider and started on medications. Further review of the medical record for Resident #01 revealed no documented evidence Resident #01 was evaluated by psychiatric services after the incident on 01/28/26 involving Resident #12. 2) Review of the medical record for Resident #12 revealed he was admitted to the facility on [DATE]. Diagnoses included insomnia, dementia, essential primary hypertension, major depressive disorder, and DM. The resident was housed in the secured MCU.Review of the care plan for Resident #12 dated 10/07/25 revealed the resident had impaired cognition related to dementia, had short and long-term memory impairment and required assistance with decision making.Review of the MDS assessment dated [DATE] revealed Resident #12 had severely impaired cognition. Review of the Nurse Practitioner (NP) progress notes for Resident #12 recorded as a late entry for 01/28/26 at 5:48 P.M. and authored by NP #501 on 02/09/26 at 10:54 A.M., revealed Resident #12 was the receiver of another resident's (Resident (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#01) inappropriate behavior. Resident #12 was witnessed by two therapists being ejaculated by Resident #01 and Resident #12 did not appear to understand what happened. The assessment / diagnoses revealed Resident #12 was the receiver of another resident's high risk sexual behavior and did not understand what happened. The plan was to notify Resident #12's guardian, keep the two residents separated and start 15-minute checks. The physician and psychiatric NP were notified. Review of the nurse progress notes for Resident #12 dated 01/28/26 at 7:12 P.M. and authored by LPN #256, revealed CNA (#222) reported that Resident #01 was observed with hand contact to Resident #12's genital area in the common area. The staff intervened and Resident #01 was redirected and guided away from Resident #12 All parties including Guardian were notified. Further review of the medical record for Resident #12 revealed no documented evidence that Resident #12 was evaluated by psychiatric services after the incident on 01/28/26 involving Resident #01. Interview on 02/09/26 at 7:37 A.M., CNA #222 stated she was the CNA on duty at the time of the incident between Resident #01 and Resident #12 on 01/28/26. CNA #222 stated she observed OTA #171 and PT #189 standing in the hallway looking into the living room area with an alarmed look on their face. The therapists stated Resident #01 had his hand on the private area of Resident #12 and was caressing it through his pants. STNA #222 stated she called Assistant Director of Nursing (ADON) #258 and reported the incident. Interview on 02/09/26 at 12:25 P.M., Occupational Therapy Assistant (OTA) #177 stated she walked toward the television room in the men's secured unit with Physical Therapist (PT) #189 when she observed Resident #01 seated to the left of Resident #12 on the couch. OTA #177 stated she observed Resident #01's hand around Resident #12's penis squeezing and rubbing it. OTA #177 stated she reported it to CNA #222. OTA #177 stated she was asked to write a statement today. Interview on 02/09/26 at 12:30 P.M., PT #189 stated on 01/28/26 she was standing in the hall with OTA #177 and observed Resident #01 on the couch sitting next to Resident #12. PT #189 stated she observed Resident #01 had his hand on the genital area of Resident #12. PT #189 stated she was asked to write a statement today. Interview on 02/09/26 at 12:49 P.M., LPN #256 stated on 01/28/26 CNA #222 reported to him that Resident #01 had his hand on Resident #12's private area and was rubbing it. LPN #256 stated two therapists (OTA #171 and PT #189) witnessed the incident. Interview on 02/09/26 at 1:15 P.M., Resident #50 (spouse and emergency contact of Resident #12) stated she was notified of the incident between Resident #01 and Resident #12 on 01/28/26. Resident #50 stated she received a call from LPN #256, and he notified her that Resident #01 was observed with his hand on Resident #12's penis and was rubbing it. Resident #50 stated she was told by LPN #256 that both Residents had their clothes on. Interview on 02/09/26 at 1:48 P.M., the Administrator verified the facility failed to report the incident that occurred on 01/28/26 between Resident #01 and Resident #12. The Administrator stated he did not consider the incident to be sexual abuse. The Administrator stated it was not reportable because nothing happened and both residents had their clothes on. The Administrator stated the facility implemented a care plan on 01/29/26 related to Resident #01 being sexually inappropriate with another resident on 01/28/26. The Administrator verified Resident #01 had a history of being sexually inappropriate. The Administrator verified Resident #01 was cognitively intact and Resident #12 was severely cognitively impaired and unable to consent to someone touching him inappropriately. The Administrator verified the incident should have been reported the state agency via SRI and should have been thoroughly investigated.Subsequent interview on 02/09/26 at 5:00 P.M. the Administrator verified the facility did not complete a thorough investigation related to the incident that occurred on 01/28/26 between Resident #01 and Resident #12. The Administrator reported he did not report the incident because nothing happened to Resident #12 because the resident was fully clothed. The surveyor reviewed NP #500's documentation from 01/28/26, which (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	noted Resident #01 was witnessed in the common area by two therapists, attempting to ejaculate another resident (Resident #12) who had severe dementia. The Administrator stated NP #501's note was not accurate information because NP #501 was not at the facility and did not know the details of the incident.Interview on 02/10/26 at 8:35 A.M. NP #501 stated she was at the facility on 01/28/26 when she received a call from ADON #258 related to an incident that occurred in the men's secure unit. NP #501 indicated that ADON #258 stated Resident #01 was observed by staff attempting to ejaculate Resident #12. NP #501 stated she went to the men's unit and assessed Residents #01 and #12. NP #501 stated the men were separated and both were fully clothed. NP #500 stated she was told by the staff that Resident #01 had his hand around Resident #12's penis and was rubbing it up and down. NP #500 stated the staff reported Resident #12 was confused and unsure of what was going on. NP #500 stated she called Medical Director (MD) #501 and was advised on the next steps to take. MD #501 directed NP #500 to have staff contact both guardians and Resident #01 was given order for medication related to his inappropriate sexual behavior. NP #500 stated she contacted the Director of Nursing (DON) who instructed her to relay the orders to the unit managers, then the DON left the facility. NP #500 stated she was told by the staff Resident #01 had this behavior with another Resident in the past; however, this resident had been discharged . NP #500 stated after she learned of Resident #01's previous behaviors, she questioned why the resident was in the room with a resident who was severely impaired. Review of the facility policy titled, Abuse, Neglect, Misappropriation of Resident Property, injury of unknown origin dated August 2024 revealed the Administrator had a responsibility for implementation of the abuse/neglect program. Any reports of abuse will be promptly and thoroughly investigated. Additionally, the facility will immediately report such allegations to the Administrator/designee and to the Department of Health and social services. The policy indicated sexual abuse was the non-consensual sexual contact of any type with a resident and this included but not limited to, unwanted intimate touching of any kind especially of breasts or perineal area. The policy stated if there is an allegation that a resident did not consent to engage in sexual activity with another resident or may not have the capacity to consent, the facility would respond to it as an alleged violation of sexual abuse. The facility would provide for the immediate safety of the residents upon identification of suspected abuse. Means of protection include but are not limited to; provide one-on-one monitoring as appropriate and implement discharge process immediately if the resident is in danger to self or others.This deficiency represents non-compliance investigated under Complaint Number 2737505.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, interview, and facility policy review. The facility failed to investigate an allegation of abuse. This affected two Residents (#01, #12) out of three residents (#01, #03, #12) reviewed. The facility census was 106. 1) Review of the medical record for Resident #01 revealed the resident was admitted to the facility on [DATE]. Diagnoses included abscess of right foot, major depressive disorder, morbid obesity, hypertensive retinopathy, pulmonary embolism, insomnia, intellectual disability (ID), essential primary hypotension, and diabetes mellitus (DM). The resident was housed in the secured Memory Care Unit (MCU) and had a guardian related to mental disability. Review of physician orders for Resident #01 dated 08/16/23, revealed resident was ordered to be housed in the secured unit for safety of self and others related to major depressive disorder. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #01 was cognitively intact. The resident was independent or required minimal assistance with activities of daily living (ADL). Review of the Nurse Practitioner (NP) progress notes for Resident #01 recorded as a late entry for 01/28/26 at 5:42 P.M. and authored by NP #501on 02/09/26 at 10:48 A.M. revealed Resident #01 was assessed at the bedside for high-risk sexual behavior. The resident resides in locked men's unit and per nursing staff the resident had inappropriate behaviors like this incident involving another resident who was discharged . The resident was alert and oriented. Resident #01 was witnessed in the common area by two therapists, attempting to ejaculate another resident (Resident #12) who had severe dementia. The nurse notified Resident #12's guardian regarding Resident #01 inappropriately touching Resident #12. Resident #01 was to be put in a private room and start 15-minute checks. Resident #01 was ordered medroxyprogesterone (for high-risk sexual behavior) daily. Review of the nurse progress note for Resident #01 dated 01/28/26 at 7:10 P.M. and authored by Licensed Practical Nurse (LPN) #256, revealed Certified Nursing Assistant (CNA) #222 reported that Resident #01 was observed with hand contact to Resident #12's genital area while they were seated in the common area. The staff intervened and Resident #01 was redirected and guided away from Resident #12. All parties including Guardian were notified. Review of the physician order for Resident #01 dated 01/28/26 revealed the resident was ordered medroxyprogesterone acetate (for high-risk sexual behaviors) five milligram (mg) daily.Review of the care plans for Resident #01 created on 01/29/26, revealed he had a behavioral care plan for sexually inappropriate behaviors with other residents.Review of Interdisciplinary Team (IDT) note for Resident #01 dated 02/04/26 at 12:42 P.M., revealed Resident #01 was observed engaging in appropriate physical contact with Resident #12. Resident #01 placed his hand on another resident's perineal rea. The residents were immediately separated and Resident #01 was moved to a private room. Resident #01 was seen by psychiatric provider and started on medications. Further review of the medical record for Resident #01 revealed no documented evidence Resident #01 was evaluated by psychiatric services after the incident on 01/28/26 involving Resident #12. 2) Review of the medical record for Resident #12 revealed he was admitted to the facility on [DATE]. Diagnoses included insomnia, dementia, essential primary hypertension, major depressive disorder, and DM. The resident was housed in the secured MCU.Review of the care plan for Resident #12 dated 10/07/25 revealed the resident had impaired cognition related to dementia, had short and long-term memory impairment and required assistance with decision making.Review of the MDS assessment dated [DATE] revealed Resident #12 had severely impaired cognition. Review of the Nurse Practitioner (NP) progress notes for Resident #12 recorded as a late entry for 01/28/26 at 5:48 P.M. and authored by NP #501 on 02/09/26 at 10:54 A.M., revealed Resident #12 was the receiver of another resident's (Resident #01) inappropriate behavior. Resident #12 was witnessed by two therapists being ejaculated by Resident #01 and (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #12 did not appear to understand what happened. The assessment / diagnoses revealed Resident #12 was the receiver of another resident's high risk sexual behavior and did not understand what happened. The plan was to notify Resident #12's guardian, keep the two residents separated and start 15-minute checks. The physician and psychiatric NP were notified. Review of the nurse progress notes for Resident #12 dated 01/28/26 at 7:12 P.M. and authored by LPN #256, revealed CNA (#222) reported that Resident #01 was observed with hand contact to Resident #12's genital area in the common area. The staff intervened and Resident #01 was redirected and guided away from Resident #12 All parties including Guardian were notified. Further review of the medical record for Resident #12 revealed no documented evidence that Resident #12 was evaluated by psychiatric services after the incident on 01/28/26 involving Resident #01. Interview on 02/09/26 at 7:37 A.M., CNA #222 stated she was the CNA on duty at the time of the incident between Resident #01 and Resident #12 on 01/28/26. CNA #222 stated she observed OTA #171 and PT #189 standing in the hallway looking into the living room area with an alarmed look on their face. The therapists stated Resident #01 had his hand on the private area of Resident #12 and was caressing it through his pants. STNA #222 stated she called Assistant Director of Nursing (ADON) #258 and reported the incident. Interview on 02/09/26 at 12:25 P.M., Occupational Therapy Assistant (OTA) #177 stated she walked toward the television room in the men's secured unit with Physical Therapist (PT) #189 when she observed Resident #01 seated to the left of Resident #12 on the couch. OTA #177 stated she observed Resident #01's hand around Resident #12's penis squeezing and rubbing it. OTA #177 stated she reported it to CNA #222. OTA #177 stated she was asked to write a statement today. Interview on 02/09/26 at 12:30 P.M., PT #189 stated on 01/28/26 she was standing in the hall with OTA #177 and observed Resident #01 on the couch sitting next to Resident #12. PT #189 stated she observed Resident #01 had his hand on the genital area of Resident #12. PT #189 stated she was asked to write a statement today. Interview on 02/09/26 at 12:49 P.M., LPN #256 stated on 01/28/26 CNA #222 reported to him that Resident #01 had his hand on Resident #12's private area and was rubbing it. LPN #256 stated two therapists (OTA #171 and PT #189) witnessed the incident. Interview on 02/09/26 at 1:15 P.M., Resident #50 (spouse and emergency contact of Resident #12) stated she was notified of the incident between Resident #01 and Resident #12 on 01/28/26. Resident #50 stated she received a call from LPN #256, and he notified her that Resident #01 was observed with his hand on Resident #12's penis and was rubbing it. Resident #50 stated she was told by LPN #256 that both Residents had their clothes on. Interview on 02/09/26 at 1:48 P.M., the Administrator stated he did not consider the incident to be sexual abuse. The Administrator stated it was not reportable because nothing happened and both residents had their clothes on. The Administrator verified Resident #01 had a history of being sexually inappropriate. The Administrator verified Resident #01 was cognitively intact and Resident #12 was severely cognitively impaired and unable to consent to someone touching him inappropriately. The Administrator verified the incident should have been thoroughly investigated.Subsequent interview on 02/09/26 at 5:00 P.M. the Administrator verified the facility did not complete a thorough investigation related to the incident that occurred on 01/28/26 between Resident #01 and Resident #12. The Administrator reported he did not report the incident because nothing happened to Resident #12 because the resident was fully clothed. The surveyor reviewed NP #500's documentation from 01/28/26,which noted Resident #01 was witnessed in the common area by two therapists, attempting to ejaculate another resident (Resident #12) who had severe dementia. The Administrator stated NP #501's note was not accurate information because NP #501 was not at the facility and did not know the details of the incident.Interview on 02/10/26 at 8:35 A.M. NP #501 stated she was at the facility on 01/28/26 when she received a call from ADON #258 related to an incident that occurred (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366220	A. Building B. Wing	02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Court Rehab and Nursing	6969 Glenmeadow Lane Cincinnati, OH 45237

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in the men's secure unit. NP #501 indicated that ADON #258 stated Resident #01 was observed by staff attempting to ejaculate Resident #12. NP #501 stated she went to the men's unit and assessed Residents #01 and #12. NP #501 stated the men were separated and both were fully clothed. NP #500 stated she was told by the staff that Resident #01 had his hand around Resident #12's penis and was rubbing it up and down. NP #500 stated the staff reported Resident #12 was confused and unsure of what was going on. NP #500 stated she called Medical Director (MD) #501 and was advised on the next steps to take. MD #501 directed NP #500 to have staff contact both guardians and Resident #01 was given order for medication related to his inappropriate sexual behavior. NP #500 stated she contacted the Director of Nursing (DON) who instructed her to relay the orders to the unit managers, then the DON left the facility. NP #500 stated she was told by the staff Resident #01 had this behavior with another Resident in the past; however, this resident had been discharged . NP #500 stated after she learned of Resident #01's previous behaviors, she questioned why the resident was in the room with a resident who was severely impaired. Review of the facility policy titled, Abuse, Neglect, Misappropriation of Resident Property, injury of unknown origin dated August 2024 revealed the Administrator had a responsibility for implementation of the abuse/neglect program. Any reports of abuse will be promptly and thoroughly investigated. Additionally, the facility will immediately report such allegations to the Administrator/designee and to the Department of Health and social services. The policy indicated sexual abuse was the non-consensual sexual contact of any type with a resident and this included but not limited to, unwanted intimate touching of any kind especially of breasts or perineal area. The policy stated if there is an allegation that a resident did not consent to engage in sexual activity with another resident or may not have the capacity to consent, the facility would respond to it as an alleged violation of sexual abuse. The facility would provide for the immediate safety of the residents upon identification of suspected abuse. Means of protection include but are not limited to; provide one-on-one monitoring as appropriate and implement discharge process immediately if the resident is in danger to self or others.This deficiency represents non-compliance investigated under Complaint Number 2737505.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview the facility failed to ensure physician visits were signed and dated in a timely manner. This affected two Residents (#01, #12) out of two residents reviewed. The facility census was 106. 1) Review of the medical record for Resident #01 revealed the resident was admitted to the facility on [DATE]. Diagnoses included abscess of right foot, major depressive disorder, morbid obesity, hypertensive retinopathy, pulmonary embolism, insomnia, intellectual disability (ID), essential primary hypotension, and diabetes mellitus (DM). The resident was housed in the secured Memory Care Unit (MCU) and had a guardian related to mental disability. Review of the Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #01 was cognitively intact. The resident was independent or required minimal assistance with activities of daily living (ADL). Review of the Nurse Practitioner (NP) progress note for Resident #01 recorded as a late entry for 01/28/26 at 5:42 P.M. and authored and signed by NP #501 on 02/09/26 at 10:48 A.M. revealed Resident #01 was assessed at the bedside for high-risk sexual behavior. Review of the NP progress note for Resident #01 recorded as a late entry for 02/03/26 at 5:38 P.M. and authored and signed by NP #501 on 02/07/26 at 5:42 P.M. revealed a provider visit related to his diabetes and morbid obesity.2) Review of the medical record for Resident #12 revealed he was admitted to the facility on [DATE]. Diagnoses included insomnia, dementia, essential primary hypertension, major depressive disorder, and DM. The resident was housed in the secured MCU.Review of the MDS assessment dated [DATE] revealed Resident #12 had severely impaired cognition. Review of the NP progress note for Resident #12 recorded as a late entry for 01/28/26 at 5:48 P.M. and authored and signed by NP #501 on 02/09/26 at 10:54 A.M., revealed Resident #12 was the receiver of another resident's (Resident #01) inappropriate behavior. Review of the NP progress note for Resident #12 recorded as a late entry for 01/31/26 at 6:46 A.M. and authored and signed by NP #502 on 02/02/26 at 6:46 A.M., revealed Resident #12 was seen for rash.Interview on 02/10/26 at 8:35 A.M., NP #501 verified she created and signed the late entry progress notes from 01/28/26 involving Residents #01 and #12 on 02/09/26. NP #501 verified the other provider visits were not being created and signed on the days the residents were being seen. NP #501 stated she was behind on her documentation because of the workload.