STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366248	A. Building B. Wing	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apostolic Christian Home Inc	10680 Steiner Road Rittman, OH 44270

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45442 Based on observation, interviews, record review, review of facility staff statements, review of a facility self reported incident, and review of the facility's Abuse policy and procedure, the facility failed to ensure Resident #263 was free from an incident of resident to resident sexual abuse when staff failed to prevent unwanted sexual contact. This affected one resident (#263) of three residents reviewed for abuse. The facility census was 74. Actual harm occurred on 03/30/24 at approximately 5:30 P.M. when Resident #264,who was severely cognitively impaired, was observed with his hands inside the pants of his roommate, Resident #263, who was also severely cognitively impaired and dependent on staff for mobility. The facility failed to implement effective safety measures to protect Resident #263 when Resident #264 began displaying sexual behaviors towards Resident #263 on 03/29/24. Resident #263's impaired cognition placed him at risk for actual physical and/or psychosocial harm as a result of the incident. The reasonable person concept also applies in this situation and involves the resident's ability to understand the potential consequences and choose a course of action for a given situation. Findings include: Review of the medical record for Resident #263 revealed an admitted [DATE]. Diagnoses included but were not limited to frontotemporal neurocognitive disorder, anxiety disorder, debility, peripheral vascular disease, and polyneuropathy. Review of Resident #263's care plan dated 03/26/22 revealed Resident #263 was non-ambulatory and dependent upon one to two staff for mobility and required a stand-up lift to move between surfaces. The care plan indicated Resident #263 was dependent on staff for meeting emotional, intellectual, physical and social needs related to cognitive deficits. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #263 had severe cognitive impairment with disorganized thinking, was non-ambulatory, required one to two staff for mobility, required a mechanical lift to move between surfaces, and required the assistance of one to two staff for bed mobility. (continued on next page)

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

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the nursing progress note dated 03/29/24 timed at 8:45 P.M. revealed Resident #263 recalled his roommate, Resident #264, was next to his bed but he did not know what his roommate was doing. A head to toe assessment was completed with no observed concerns and Resident #263's bedding and clothing were clean and dry. Staff reported Resident #263 had his head covered with his blanket (which was normal behavior for him) when they entered the room. The note did not include information regarding why Resident #263 was asked about his roommate, why the assessment was completed, or why the bed linens and clothing were checked. Review of the nursing progress note dated 03/30/24 timed at 6:45 P.M. revealed a head to toe assessment which the Director of Nursing (DON) requested to be completed on Resident #263 revealed no sign of injury or distress. No soiling was noted on bed or clothing. The note did not indicate why the assessment was requested or why the bed linens and clothing were checked. Review of the medical record for Resident #264 revealed an admitted [DATE]. Diagnoses included but were not limited to myasthenia gravis with exacerbation, metabolic encephalopathy, nonpyrogenic thrombosis of intracranial venous system, Alzheimer's dementia, history of falls, vascular dementia with agitation and mood disturbance, spinal stenosis, and dementia with behavioral disturbances. Review of the discharge MDS 3.0 assessment dated [DATE] revealed Resident #264 had severe cognitive impairment, and was independent for toileting and walking 50 feet. Review of the care plan initiated on 01/10/24 revealed Resident #264 had impaired cognitive function/dementia related to diagnoses of Alzheimer's dementia, metabolic encephalopathy, and intracerebral hemorrhage with recent flare up of myasthenia gravis. Interventions included cue, reorient, and supervise as needed. The care plan was updated on 03/29/24 to included Resident #264 was noted to have agitation and sexually inappropriate behavior. Intervention included 15-minute checks. On 03/30/24 an intervention of one-on-one supervision was added following additional inappropriate behavior being observed. The care plan indicated Resident #264 was transferred to the hospital on 03/30/24 and remained on one-on-one supervision upon his return from the hospital on 03/31/24 until he was sent out for geriatric-psych evaluation on 04/01/24. Review of the nursing progress note dated 03/29/24 timed at 3:20 P.M. revealed Resident #264 was found by Environmental Aide (EA) #14 crouching next to Resident #263's bed. Registered Nurse (RN) #10 asked Resident #264 what he was doing, and he stated he was looking for coins. Resident #264 appeared short of breath, stated he had not fallen and was not in pain. RN #10 assessed Resident #264 and found no concerns and assisted him to lay down in his bed. No concerns were noted related to Resident #263 who was sleeping in his bed. Review of the nursing progress note dated 03/29/24 timed at 7:45 P.M. revealed Resident #264 was standing by Resident #263's bed with his pants down. Resident #264 left the side of the bed and walked to close the door when staff knocked at the door. When staff asked what he was doing, Resident #264 stated he was getting ready for bed and went over to Resident #263's bed to answer a question. The Director of Nursing (DON) was notified, and 15-minute checks were initiated. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the facility self reported incident (SRI) dated 03/29/24 and timed at 8:48 P.M. revealed two staff members observed Resident #264 standing by Resident #263's bed partially disrobed, and Resident #264 was touching his own penis. A head to toe assessment was completed on both residents and no evidence of injury was found and no bodily fluids or soiling was observed. The physician was contacted and 15-minute checks were initiated. There was no SRI from the touching incident on 03/30/24. Review of the nursing progress note dated 03/29/24 timed at 9:00 P.M. revealed the physician returned call, behaviors and medications were reviewed and Vistaril 25 milligram (mg) one half or one tablet was ordered every six hours as needed for restlessness or agitation. Review of the nursing progress note dated 03/30/24 timed at 3:51 P.M. revealed at 3:35 P.M. RN #10 observed Resident #264 disrobing next to the window by Resident #263's bed. Resident #264 stated he was looking out the window to see if it was snowing and rushed from the window to his chair. RN #10 assisted Resident #264 to lay down in his bed. At 3:40 P.M. RN #10 came back with RN #11 and found Resident #264 pulling on the covers covering Resident #263's head. Resident #264 was fully clothed and stated they wanted ice cream. The DON was notified at 3:48 P.M. Review of the nursing progress note dated 03/30/24 timed at 7:58 P.M. revealed Resident #264 went to the hospital for evaluation. Review of the nursing progress note dated 03/31/24 timed at 1:35 A.M. revealed the hospital staff stated since Resident #264 did not cause any physical harm they could not keep him and were sending him back to the facility. Review of the nursing progress note dated 03/31/24 timed at 2:17 A.M. revealed Resident #264 returned to the facility. The nurse placed a fall alarm mat next to Resident #264's bed and staff stayed outside the room for one-on-one monitoring of any attempts of getting out of bed. Review of the nursing progress noted dated 04/01/24 timed at 10:58 A.M. revealed Resident #264 was accepted for inpatient geriatric psychiatric evaluation and one-on-one monitoring continued. Review of the nursing progress note dated 04/01/24 timed at 6:00 P.M. revealed Resident #264 was sent to hospital for inpatient geriatric psychiatric evaluation. At time of survey Resident #264 remained in the hospital's geriatric psych unit. (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 0600 Level of Harm - Actual harm Residents Affected - Few	Interview on 04/02/24 at 8:30 A.M. with the DON revealed she received a call on 03/29/24 at 7:45 P.M. from RN #10 stating Resident #264 was standing by Resident #263's bed and Resident #264 had his hand on his own genitals. Resident #264 stated he was getting ready for bed and Resident #263 had asked a question, so he went over to his bed to answer him. Following assessment of Resident #263 they found no concerns and no noted bodily fluids or soiling. Resident #263 stated he recalled Resident #264 was near his bed but had his head covered with the sheet and did not know what Resident #264 was doing. It was also reported that earlier in the day, Resident #264 was found by a State tested Nurse Aide (STNA) crouching down with his pants partially pulled down next to the window by Resident #263's bed. The STNA thought he may have fallen. Resident #264 stated he had not fallen and was looking out the window for snow and appeared confused. The DON stated she contacted the physician, obtained an order for an as needed medication for agitation/restlessness, initiated the self-reported incident investigation, and placed Resident #264 and every 15- minute checks. The DON received another call on 03/30/24 at 6:04 P.M. from RN #10 stating Resident #264 was observed next to Resident #263's bed with his hand on the inside of Resident #263's pants. The DON called the physician at 7:05 P.M. and obtained an order to send out Resident #264 for a psychiatric evaluation. The DON instructed the nurse to complete a head-to-toe assessment of both Resident #263 and #264. Resident #264 was kept one-on-one supervision with staff until he left for the hospital around 8:00 P. M. Resident #264 returned to the facility on [DATE] at 2:30 A.M. Staff placed an alarming fall mat next to Resident #264's bed to alert when he was getting out of bed and staff were stationed outside of the room until morning. Staff or family continued to sit one-on-one with Resident #264 until he was sent to the hospital's geriatric psych unit for inpatient evaluation on 04/01/24. Resident #264 had not returned to the facility. Interview on 04/02/24 at 10:00 A.M. with Deputy #15 revealed Deputy #15 was at the facility to investigate the allegation of sexual abuse which was called in by the DON. Deputy #15 said an investigation was not completed because Resident #263 could not provide a statement related to his cognitive impairment and Resident #264 could not be interviewed because he was currently in a geriatric psychiatric unit. A police report had not been completed at the time of the survey. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Phone interview on 04/02/24 at 11:20 A.M. with RN #10 revealed on 03/29/24 around 3:30 P.M. two staff (STNA #12 and EA #14) reported to her that they observed Resident #264 crouched near Resident #263's bed. They reported they did not observe Resident #264 touching Resident #263. They thought Resident #264 had fallen but he said he did not fall, he seemed out of breath and they assisted him back to bed. RN #10 assessed Resident #264 immediately and no concerns were identified. On 03/29/24 around 7:30 P.M. STNA #10 reported she saw Resident #264 near Resident #263's bed and Resident #264 had his hand on his own penis but was not touching Resident #263. RN #10 performed a head-to-toe assessment of both residents, found no observed concerns, and then called the DON who instructed her to start 15-minute checks. On 03/30/24 around 2:45 P.M., RN #10 observed Resident #264 standing by the window near Resident #263's bed with his pants down and underwear in place; he was not touching Resident #263. RN #10 went to get RN #11 and they both re-entered the room to find Resident #264 lifting the covers off of Resident #263's head and Resident #263 pulling to keep the covers over his head. Resident #264 was fully clothed and was removed from the room to be monitored by staff. Around 5:20 P.M. on 03/30/24, STNA #13 reported to RN #10 that he observed Resident #264 by Resident #263's bed and Resident #264 had his hand inside of Resident #263's pants. RN #10 reported this immediately to the DON and obtained an order to send Resident #264 out for evaluation. Resident #264 was transferred out of the facility around 9:00 P.M. When RN #10 reported to work on 04/01/24, Resident #264 had been moved to another room, had an alarm mat next to his bed and one-on-one monitoring was completed by staff or his daughter until he was sent out again for psychiatric evaluation on 04/01/24 around 6:00 P.M. Interview on 04/02/24 at 11:42 A.M. with RN #11 revealed RN #10 asked her to come to Resident #264's room with her. When they entered the room, Resident #264 was observed on the far side of the room by the window standing over Resident #263's bed attempting to pull back the blanket covering Resident #263's face. Resident #264 appeared confused and when asked what he was doing, he stated they wanted ice cream. Resident #263 was observed pulling the blanket in an attempt to keep the blanket over his face. They removed Resident #264 from the room and continued to monitor Resident #264. Observation of Resident #263 on 04/02/24 at 11: 51 A.M. revealed he was sitting in the dining room with a blanket covering him up to his neck. An attempt to interview Resident #263 was unsuccessful related to cognitive impairment; he was unable to provide meaningful responses to questions that were asked. Phone interview on 04/02/24 at 11:55 A.M. with STNA #12 revealed on 03/29/24 around 7:30 P.M. she entered Resident #264's room and found the privacy curtain pulled. STNA #12 witnessed Resident #264 hovering over Resident #263's bed with his pants down to his ankles including his underwear. Resident #264 had his hand on his penis. STNA #12 asked him what he was doing, and he didn't respond but started to walk to his side of the room. Resident #264 took a couple steps and then pulled up his pants and walked to his recliner and sat down. STNA #12 reclined Resident #264 in his recliner and left to report her observation to RN #10. On 03/29/24 around 7:45 P.M., as EA #14 was exiting Resident #264's room EA #14 told STNA #12 she observed Resident #264 standing over Resident #263's bed with his pants down. EA #14 stated Resident #264 was not touching himself or Resident #263, he was just standing there. EA #14 and STNA #12 reported this observation to RN #10. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Phone interview on 04/02/24 at 2:15 P.M. with EA #14 revealed on 03/29/24 at approximately 3:10 P.M. she opened the door to Resident #264's room and observed Resident #264 next to Resident #263's bed crouched with his pants unzipped and partially down with his underwear fully on. EA #14 thought he had fallen and appeared to be out of breath. Resident #264 stated he had not fallen. EA #14 told STNA #12, and they went to tell RN #10. RN #10 went to assess Resident #264. On 03/29/24 around 7:40 P.M., EA #14 was passing the room and observed Resident #264 with his pants down standing over Resident #263's bed but was not touching himself or Resident #263, he was just standing there. EA #14 and STNA #12 reported this to RN #10. Interview on 04/02/24 at 3:26 P.M. with STNA #13 revealed on 03/30/24 at approximately 5:20 P.M. he was doing 15-minute checks on Resident #264 and observed him at the side of Resident #263's bedside pulling at the covers of Resident #263. Resident #264 stated he was looking out the window. STNA #13 assisted Resident #264 back to his chair and left the room to assist another aide. When he returned less than 15-minutes later, he observed Resident #264 standing over Resident #263 with his hand inside of Resident #263's pants; it appeared he had his hand on Resident #263's genitals. When asked what he was doing, Resident #264 stated he was folding the blanket. STNA #13 walked Resident #264 down to the common area and staff monitored him until he left for the hospital on 03/30/24 at about 8:00 P.M. Follow up interview on 04/02/24 at 4:05 P.M. with the DON revealed she initiated the 15-minute checks upon becoming aware of concerns related to Resident #264 on 03/29/24 at about 8:00 P.M. One-on-one staff monitoring of Resident #264 was initiated after the second reported incident occurred with Resident #264 on 03/30/24 at around 5:30 P.M. and continued until he went to the hospital on 03/30/24 around 8:00 P.M. One-on-one monitoring continued when he returned from the hospital on 03/31/24 around 2:30 A.M. until he was sent back out for an inpatient geriatric psych evaluation on 04/01/24 around 5:30 P.M. The DON confirmed Resident #263 and #264 occupied the same room and 15-minute checks were not an effective intervention to protect Resident #263 from unwanted sexual contact. The DON confirmed Resident #263 was not capable of protecting himself. Review of the facility policy Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property with a revision date of the 01/01/23 revealed the residents had the right to be free from abuse including non-consensual sexual contact of any type with another resident. The facility would monitor residents with behaviors including inappropriate touching and care plan for appropriate interventions to ensure all residents safety. This deficiency represents non-compliance investigated under Control Number OH00152568.