STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366313	A. Building B. Wing	09/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Scioto Pointe	740 Canonby Place Columbus, OH 43223

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 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** 47990 Based on observation, staff, resident, and Guardian interviews, Sexual Assault Nurse Examiner (SANE) interview, record review, review of a facility Self-Reported Incident (SRI), review of facility investigation, and policy review, the facility failed to initiate a timely investigation of alleged staff to resident sexual abuse. This affected one (Resident #80) of three residents reviewed for abuse. The facility census was 91. Findings include: Review of the medical record for Resident #80 revealed an admitted [DATE]. Medical diagnoses included paranoid schizophrenia, anxiety, depression, type II diabetes mellitus, chronic kidney disease, insomnia, chronic pain, and chronic obstructive pulmonary disease (COPD). Review of Resident #80's Quarterly Minimum Data Set (MDS) assessment, dated 06/26/24, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Resident #80 had no signs or symptoms of depression, no hallucinations, and no delusions. Review of Resident #80's interdisciplinary progress notes, dated 08/01/24 to 09/03/24, revealed no mention or description of an alleged staff-to resident sexual abuse incident recorded on 08/25/24. The only related note was an entry dated 08/26/24 at 5:30 P.M., authored by the Administrator, indicating he received a call from Social Services Director (SSD) #276 informing him Resident #80 had phoned the police to report a sexual abuse allegation against a staff member. The Administrator spoke with the police officers and informed them a SRI had been filed with the State Agency, and the facility's investigation was underway. The officer stated he would open a case. There were no progress notes describing the alleged incident, no record of Resident #80 being assessed for any injury , nor was there any psychosocial follow up or monitoring recorded by nursing or social services. There was no entry detailing any discussion with Resident #80's Guardian or physician regarding the incident and a decision to transport the resident to the local hospital for evaluation. The only mention of a hospital transport was a note dated 08/27/24 at 6:11 P.M. indicating Resident #80 returned to the facility from a local hospital with no new orders, and a quote from Resident #80 indicating they swabbed my mouth and talked to me. (continued on next page)

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an SRI initiated on 08/25/24 at 8:59 P.M. by the Director of Nursing (DON) revealed an allegation of sexual abuse. The SRI revealed Resident #80 approached Activities Aide (AA) #336 on 08/25/24 around 3:00 P.M. and alleged that Licensed Practical Nurse (LPN) #200 pulled her into the shower room, placed blue gloves on his hands and put his penis in her mouth around 5:15 A.M. Resident #40 was standing near area and stated that LPN #200 had also placed his penis in her mouth on several occasions. Resident #40 never told anyone because she thought he was her ex-boyfriend. Resident #08 was also standing in the area and stated LPN #200 had done the same thing to her. AA #336 reported the allegations to the staff Registered Nurse (RN) #320 who notified the Director of Nursing (DON) and the Administrator via phone. The DON created an SRI immediately and informed LPN #200 of an immediate suspension. The police were notified on 08/26/24 at approximately 530 P.M. by Resident #20. The facility submitted their final report on 08/30/24 and unsubstantiated the sexual abuse allegation. Review of the facility's investigation file revealed an incident report dated 08/26/24 and completed by the DON, which noted Resident #80 reported an incident allegedly occurring on 08/25/24 at approximately 5:15 A.M. in the shower room on second avenue. Resident #80 reported to staff (AA #336) that a nurse (LPN #200) sexually abused her in the shower. The incident report notes Resident #80 as alert and oriented to person, place, time, and situation, and with no apparent injuries. The incident report contained a summary of the incident, which contained instructions to include names and positions of persons that witnessed the incident, timelines, and specifics of the incidents. The summary described in the early morning of 08/25/24, the resident somehow ended up in the second avenue shower room where a nurse orally sexually assaulted her. The resident reported she ended up back in bed but had no knowledge of how she got into the shower room, or back to bed. The incident report contained no additional details of the alleged perpetrator or alleged event. A form included in the incident report packet titled Skilled Nursing notes dated 08/26/24 at 9:15 A.M. revealed Resident #80 was assessed by the DON and was found to be alert and oriented, responsive, in a pleasant mood. The resident had no medication or treatment change, and no laboratory testing recorded. A review of the Emergency Department (ED) After Visit Summary, dated 08/27/24, indicating Resident #20 was seen for an examination, and the diagnosis was listed as sexual assault of adult. Follow up instructions and information were given which included following up with the primary care provider. The After Visit Summary form did not contain any additional results, information, or findings. An interview on 08/29/24 at 8:27 A.M. with the Administrator, revealed Resident #80, with paranoid schizophrenia, had reported being sexually assaulted by a nurse. The resident reported the alleged assault hours after the alleged incident occurred on Sunday 08/25/24. The nurse in question, LPN #200 was not on duty at the time of Resident #80's report but was contacted by the DON and placed on suspension pending the outcome of the investigation. The Administrator indicated Resident #80 phoned the police herself on Monday 08/26/24, stating she had been raped. Officers responded to the building, a detective responded, and on 08/27/24 Resident #80 went out to a local hospital for an examination. The Administrator stressed Resident #80 wanted to leave the facility and discharge to a lower level of care and believed this was the reason for the allegation of sexual abuse. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 08/29/24 at 9:03 A.M. with SANE RN #464 revealed she worked at a local hospital system and evaluated Resident #80 on Tuesday evening, 08/27/24. SANE RN #464 interviewed Resident #80 in detail, and completed an oral swab, as the resident reported being orally sexually assaulted by a facility nurse. SANE RN #464 found Resident #80 to be credible, and described Resident #80 as being alert and oriented, able to answer questions and communicate effectively and noted the resident wanted to press charges against the facility nurse. Upon the conclusion of the exam, the complainant phoned the facility, spoke to a staff member and was told the nurse in question was suspended pending the outcome of the investigation. SANE RN #464 shared Resident #80 felt safe to and did return to the facility following the examination. The complainant provided the name and phone number of an assigned detective from the local police department who was assigned to follow up. An interview on 08/29/24 at 9:48 A.M. with the DON, revealed Resident #80 was seen at a local freestanding Emergency Department on 08/27/24. The DON was familiar with Resident #80's allegation and recounted the resident went to the hospital after the resident phoned the police herself and stated she was raped and wanted to press charges. The police shared with the facility and the resident that to press charges, they should do a test. Resident #80 went to the local freestanding Emergency Department and per the resident's report, had an oral swab and an interview. An interview on 08/29/24 at 10:26 A.M. with Resident #80 revealed on the night of Saturday 08/24/24, she had gone to bed around 10:00 P.M. She had no idea how she got there, but when she awoke, she was in the shower room where LPN #200 sat her down into the shower chair. LPN #200 untied the string of his maroon-colored scrub pants, applied blue gloves, removed his genitals out of his pants and underwear, grabbed her head and shoved his genitals into her mouth. Resident #80 recounted the alleged incident lasted approximately three minutes, but it felt longer. Resident #80 reported LPN #200 had big hands, and she tried to pull away from him, but he had a strong hold on the back of her head. She stated after a few minutes, she was finally able to pull away. Resident #80 estimated this happened on Sunday 08/25/24 at 5:15 A.M. Resident #80 was tearful, and her voice cracked as she recounted the alleged incident. Resident #80 shared she waited until a staff member she trusted, AA #336, arrived to work around 3:00 P.M. to report what had happened. Resident #80 reported everyone believed she was lying about the allegation. Resident #80 had spoken to the Administrator, DON, Assistant Director of Nursing (ADON) #368 and SSD #276 all together during a meeting held on the morning of 08/26/24. Resident #80 stated she felt ganged up on, as there were four staff members versus her, and felt she was not believed by staff, and they were attempting to get her to change her mind or state the event did not occur. Resident #80 reported during the meeting, the facility staff never offered to phone the police to report the alleged sexual assault, never offered an examination at a hospital, nor had a staff member even assessed her for any physical injuries following the event. Resident #80 stated she decided to phone the police herself in the late afternoon of 08/26/24 as no one had taken her seriously. Resident #80 stated the police arrived at the facility and took her statement and contacted a detective to further investigate the case. Resident #80 reiterated she wanted to press charges, and the detective recommended a sexual assault examination as part of the process. Resident #80 reported she went to a local hospital in the late afternoon hours of 08/27/24, approximately two and a half days after the alleged incident. At the hospital, the hospital nurses thoroughly swabbed her mouth, interviewed her at length, and took photographs. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 08/29/24 at 1:47 P.M. with RN #320, revealed she was the nurse on day shift on Sunday 08/25/24, when Resident #80 reported the sexual abuse incident. RN #320 stated she was approached by AA #336 who reported Resident #80's allegation of a sexual assault. RN #320 phoned the Administrator and DON and found a statement form for AA #336. RN #320 reported she did not write a statement as she had no knowledge of the event. RN #320 confirmed she did not record the allegation in the resident's medical record, nor did she initiate an incident report or assess Resident #80. RN #320 described the alleged sexual assault as a false allegation and reported this was unusual for Resident #80 as she did not know the resident as having a history of making any type of false reports. RN #320 questioned if maybe the resident watched a scary or science fiction movie that could have caused her to have weird dreams. RN #320 stated she did not believe Resident #80's allegation as she had never heard any complaints against LPN #200. An interview on 08/29/24 at 1:56 P.M. with Resident #41, revealed she was Resident #80's at the time of the alleged incident on 08/25/24. Resident #41 reported in the middle of the night, approximately 3:00 A.M., she was awakened by a knock on the door and heard a male voice asking Resident #80 if she wanted a shower. Resident #41 reported the room was dark, she did not see faces, but stated aloud don't wake her up, referring to Resident #80. Resident #41 reported she felt uncomfortable as a male voice asking about a shower at 3:00 A.M. was unusual. That night, she only saw the one male nurse, LPN #200, who was the one who brought the medicine, but identified the aides as the ones who gave showers. A telephone interview on 08/29/24 at 2:36 P.M. with Resident #80's Guardian, revealed Resident #80 was always alert and oriented, she never knew the resident to have any hallucinations or delusions. Resident #80 had left the Guardian a few voicemails, but she calls her frequently, and many times does not leave what she needed on the voicemail, so she did not speak to the resident until Tuesday 08/27/24 where she recounted the event and stated she wanted to press charges. The Guardian also reported having a message from the facility on Monday 08/26/24 and spoke to the DON on Tuesday 08/27/24. The Guardian asked the facility if they filed a police report and was told they only open a report with state. A telephone interview on 09/03/24 at 9:26 A.M. via phone with LPN #200, revealed he was familiar with Resident #80 and had cared for her for years but had never heard her make allegations. LPN #200 vehemently denied all acts of sexual abuse against Resident #80, or any other resident. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 09/03/24 at 11:11 A.M. with SSD #276 revealed she became aware of Resident #80's allegation on Monday 08/26/24 when she was called back to the Administrator's office for a meeting. Present at the meeting was the Administrator, DON, ADON #368, and herself. They asked Resident #80 to describe the incident and asked her questions. The resident was unable to recall how she got to the shower room. The resident denied previous problems with LPN #200. The resident denied the possibility this incident could have been a dream. SSD #276 stated during the meeting with Resident #80 on 08/26/24, it never came up to phone the police or to send the resident to the hospital for an examination. On Monday evening, 08/26/24, Resident #80 phoned the police herself, and she was still working when the police responded to the building. The police questioned her, asking why the police had not been called earlier when first aware of the allegation, and questioned at which point would the facility phone the police. SSD #276 recalled that was a good question, and one she asked the Administrator and was told if we really thought it happened. Officers took statements from Resident #80, called a supervisor, and informed her they would treat this as a potential rape. The detective ended up suggesting a sexual assault exam, and she went to the local freestanding Emergency Department on Tuesday. SSD #276 stated she still needed to write a note about the alleged event. She stated she was hesitant to document it sooner, she didn't want to just assume it was a behavior in the chance that it was not and could hinder an investigation. SSD #276 stated she would never want to document something that could lead someone to not believe Resident #80's account of the event. An interview on 09/03/24 at 12:00 P.M. with AA #336 via phone revealed she received the initial report of Resident #80 being sexually assaulted on 08/25/24 around 3:00 P.M. and immediately reported the incident to RN #320, who was Resident #80's nurse on Sunday 08/25/24. An interview on 09/03/24 at 1:34 P.M. with the DON revealed he was contacted on Sunday 08/25/24 in the afternoon and informed of Resident #80's allegations. The DON indicated he completed the initial SRI to the State Agency and notified LPN #200 he was suspended pending the investigation outcome. When asked if Resident #80 was assessed following the incident, the DON proceeded to check Resident #80's documentation in the electronic health record. The DON verified there was no progress note or assessment revealing she was assessed, and that was where it would be recorded. There was no record of an assessment for injuries in the resident's hard chart. The DON confirmed the only assessment recorded would be in the incident report he initiated and completed on 08/26/24, but nothing was recorded in the medical record to indicate the resident had been assessed on the day she reported the sexual assault allegation. The DON verified the only record of the incident was a note the Administrator put in after the police were notified and present in the building on 08/26/24, noting an investigation was in progress, but no mention of when the alleged incident occurred or was made, nor any actions or steps taken by the facility to assess and ensure Resident #80's safety. The DON confirmed the facility does not phone the police for sexual abuse allegations, as they only notify the State Agency. The DON stated the police notification was likely something they should be doing but had not done in the past. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 09/03/24 at 2:07 P.M. with the Administrator, revealed he unsubstantiated the sexual abuse allegation against LPN #200 as he had nothing to go on but Resident #80's word. The Administrator indicated Resident #20 had no history of making false abuse claims against any staff members. The Administrator stated the resident's story did not seem realistic. The Administrator confirmed he did not offer to notify the Police Department or send Resident #80 to the hospital for a SANE exam, as it was not his practice to inform the local Police Department or send residents out to the hospital for examinations after allegations of sexual abuse. The Administrator stated, at the moment, he did not think to call the police as he did not think a crime had been committed. The Administrator confirmed the initial allegation of sexual abuse is listed as a reportable crime to law enforcement. Additionally, the Administrator confirmed that staff should be documenting the allegation and any assessment and actions taken in the resident's medical record, and documentation should include psychosocial follow up by both nursing and social services. Review of the facility policy titled Abuse Investigation and Reporting, revised July 2017, revealed all reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment, and/or injuries of unknown sources shall be promptly reported to local state and federal agencies (as defined by current regulations) and timely and thoroughly investigated by facility management. Findings of abuse investigations will also be reported. Review of the facility policy titled Abuse and Neglect - Clinical Protocol, undated, revealed the nurse will assess the individual and document related findings. Assessment data will include injury assessment, pain assessment, current behavior, vital signs, and behavior over the last 24 hours. The nurse will report findings to the physician. As indicated, the physician will evaluate the resident or refer him or her for evaluation; for example, to rule out sexual assault. The facility management and staff will institute measures to address the needs of residents and minimize the possibility of abuse and neglect. The management and staff, with physician support, will address situations of suspected or identified abuse and repot them in a timely manner to appropriate agencies, consistent with applicable laws and regulations.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47990 Based on observation, staff and resident interview, record review, and policy review, the facility failed to document an allegation of staff-to-resident sexual abuse and record follow-up action taken in Resident #80's medical record. This affected one (Resident #80) of three residents reviewed for abuse. The facility census was 91. Findings include: Review of the medical record for Resident #80 revealed an admitted [DATE]. Medical diagnoses included paranoid schizophrenia, anxiety, depression, type II diabetes mellitus, chronic kidney disease, insomnia, chronic pain, and chronic obstructive pulmonary disease (COPD). Review of Resident #80's Quarterly Minimum Data Set (MDS) assessment, dated 06/26/24, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Resident #80 had no signs or symptoms of depression, no hallucinations, and no delusions. Review of Resident #80's interdisciplinary progress notes, dated 08/01/24 to 09/03/24, revealed no mention or description of an alleged staff-to resident sexual abuse incident recorded on 08/25/24. The only related note was an entry dated 08/26/24 at 5:30 P.M., authored by the Administrator, indicating he received a call from Social Services Director (SSD) #276 informing him Resident #80 had phoned the police to report a sexual abuse allegation against a staff member. The Administrator spoke with the police officers and informed them a Self-reported Incident (SRI) had been filed with the State Agency, and the facility's investigation was underway. There were no progress notes describing the alleged incident, no record of Resident #80 being assessed for any injury , nor was there any psychosocial follow up or monitoring recorded by nursing or social services. There was no entry detailing any discussion with Resident #80's Guardian or physician regarding the incident and a decision to transport the resident to the local hospital for evaluation. The only mention of a hospital transport was a note dated 08/27/24 at 6:11 P.M. indicating Resident #80 returned to the facility from a local hospital with no new orders, and a quote from Resident #80 indicating they swabbed my mouth and talked to me. Review of an SRI initiated on 08/25/24 at 8:59 P.M. by the Director of Nursing (DON) revealed an allegation of sexual abuse. The SRI revealed Resident #80 approached Activities Aide (AA) #336 on 08/25/24 around 3:00 P.M. and alleged that Licensed Practical Nurse (LPN) #200 pulled her into the shower room, placed blue gloves on his hands and put his penis in her mouth around 5:15 A.M. AA #336 reported the allegations to the staff Registered Nurse (RN) #320 who notified the Director of Nursing (DON) and the Administrator via phone. The DON created an SRI immediately and informed LPN #200 of an immediate suspension. The police were notified on 08/26/24 at approximately 530 P.M. by Resident #20. The facility submitted their final report on 08/30/24 and unsubstantiated the sexual abuse allegation. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's investigation file revealed an incident report dated 08/26/24 and completed by the DON, which noted Resident #80 reported an incident allegedly occurring on 08/25/24 at approximately 5:15 A.M. in the shower room on second avenue. Resident #80 reported to staff (AA #336) that a nurse (LPN #200) sexually abused her in the shower. The incident report contained a summary of the incident, which contained instructions to include names and positions of persons that witnessed the incident, timelines, and specifics of the incidents. The incident report contained no additional details of the alleged perpetrator or alleged event. A review of the Emergency Department (ED(After Visit Summary, dated 08/27/24, indicating Resident #20 was seen for an examination, and the diagnosis was listed as sexual assault of adult. Follow up instructions and information were given which included following up with the primary care provider. An interview on 08/29/24 at 8:27 A.M. with the Administrator, revealed Resident #80, with paranoid schizophrenia, had reported being sexually assaulted by a nurse. The resident reported the alleged assault hours after the alleged incident occurred on Sunday 08/25/24. The nurse in question, LPN #200 was not on duty at the time of Resident #80's report but was contacted by the DON and placed on suspension pending the outcome of the investigation. The Administrator indicated Resident #80 phoned the police herself on Monday 08/26/24, stating she had been raped. Officers responded to the building, a detective responded, and on 08/27/24 Resident #80 went out to a local hospital for an examination. The Administrator stressed Resident #80 wanted to leave the facility and discharge to a lower level of care and believed this was the reason for the allegation of sexual abuse. An interview on 08/29/24 at 9:48 A.M. with the DON, revealed Resident #80 was seen at a local freestanding ED on 08/27/24. The DON was familiar with Resident #80's allegation and recounted the resident went to the hospital after the resident phoned the police herself and stated she was raped and wanted to press charges. The DON provided a generic report indicating the resident was seen at the freestanding ED. There was no notation on what the resident was seen for, any testing that was completed, nor any results of any testing. The DON stated that was the only record received from the local Emergency Department and the facility had not attempted to get any additional records. The DON verified there was no documentation regarding the sexual abuse allegations in the resident's record. An interview on 08/29/24 at 10:26 A.M. with Resident #80 revealed on the night of Saturday 08/24/24, she had gone to bed around 10:00 P.M. She had no idea how she got there, but when she awoke, she was in the shower room where LPN #200 sat her down into the shower chair. LPN #200 untied the string of his maroon-colored scrub pants, applied blue gloves, removed his genitals out of his pants and underwear, grabbed her head and shoved his genitals into her mouth. Resident #80 estimated this happened on Sunday 08/25/24 at 5:15 A.M. Resident #80 shared she waited until a staff member she trusted, Activity Aide (AA) #336, arrived to work around 3:00 P.M. to report what had happened. Resident #80 reported everyone believed she was lying about the allegation. Resident #80 had spoken to the Administrator, DON, Assistant Director of Nursing (ADON) #368 and SSD #276 all together during a meeting held on the morning of 08/26/24. Resident #80 reported during the meeting, facility staff never offered to phone the police to report the alleged sexual assault, never offered an examination at a hospital, nor had a staff member even assessed her for any physical injuries following the event. Resident #80 stated she decided to phone the police herself in the late afternoon of 08/26/24 as no one had taken her seriously. Resident #80 stated the police arrived at the facility and took her statement and contacted a detective to further investigate the case. Resident #80 reported she went to a local hospital in the late afternoon hours of 08/27/24, approximately two and a half days after the alleged incident. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 08/29/24 at 1:47 P.M. with RN #320, revealed she was the nurse on day shift on Sunday 08/25/24, when Resident #80 reported the sexual abuse incident. RN #320 stated she was approached by AA #336 who reported Resident #80's allegation of a sexual assault. RN #320 phoned the Administrator and DON and found a statement form for AA #336. RN #320 reported she did not write a statement as she had no knowledge of the event. RN #320 confirmed she did not record the allegation in the resident's medical record, nor did she initiate an incident report or assess Resident #80. RN #320 described the alleged sexual assault as a false allegation and reported this was unusual for Resident #80 as she did not know the resident as having a history of making any type of false reports. RN #320 questioned if maybe the resident watched a scary or science fiction movie that could have caused her to have weird dreams. RN #320 stated she did not believe Resident #80's allegation as she had never heard any complaints against LPN #200. An interview on 09/03/24 at 11:11 A.M. with SSD #276 revealed she became aware of Resident #80's allegation on Monday 08/26/24 when she was called back to the Administrator's office for a meeting. Present at the meeting was the Administrator, DON, ADON #368, and herself. They asked Resident #80 to describe the incident and asked her questions. SSD #276 stated during the meeting with Resident #80 on 08/26/24, it never came up to phone the police or to send the resident to the hospital for an examination. On Monday evening, 08/26/24, Resident #80 phoned the police herself, and she was still working when the police responded to the building. The police questioned her, asking why the police had not been called earlier when first aware of the allegation, and questioned at which point would the facility phone the police. SSD #276 recalled that was a good question, and one she asked the Administrator and was told if we really thought it happened. Officers took statements from Resident #80, called a supervisor, and informed her they would treat this as a potential rape. The detective ended up suggesting a sexual assault exam, and she went to the local freestanding Emergency Department on Tuesday. SSD #276 stated she still needed to write a note about the alleged event. She stated she was hesitant to document it sooner, she didn't want to just assume it was a behavior in the chance that it was not and could hinder an investigation. SSD #276 stated she would never want to document something that could lead someone to not believe Resident #80's account of the event. An interview on 09/03/24 at 12:00 P.M. with AA #336 via phone revealed she received the initial report of Resident #80 being sexually assaulted on 08/25/24 around 3:00 P.M. and immediately reported the incident to RN #320, who was Resident #80's nurse on Sunday 08/25/24. An interview on 09/03/24 at 1:34 P.M. with the DON, revealed he was contacted on Sunday 08/25/24 in the afternoon and informed of Resident #80's allegations. The DON indicated he completed the initial SRI to the State Agency and notified LPN #200 he was suspended pending the investigation outcome. When asked if Resident #80 was assessed following the incident, the DON proceeded to check Resident #80's documentation in the electronic health record. The DON verified there was no progress note or assessment revealing she was assessed, and that was where it would be recorded. There was no record of an assessment for injuries in the resident's hard chart. The DON confirmed the only assessment recorded would be in the incident report he initiated and completed on 08/26/24, but nothing was recorded in the medical record to indicate the resident had been assessed on the day she reported the sexual assault allegation. The DON verified the only record of the incident was a note the Administrator put in after the police were notified and present in the building on 08/26/24, noting an investigation was in progress, but no mention of when the alleged incident occurred or was made, nor any actions or steps taken by the facility to assess and ensure Resident #80's safety. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366313	A. Building B. Wing	09/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Scioto Pointe	740 Canonby Place Columbus, OH 43223

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 09/03/24 at 2:07 P.M. with the Administrator, revealed the staff should be documenting allegations of abuse and any assessment and actions taken in the resident's medical record, and documentation should include psychosocial follow up by both nursing and social services. Review of the facility policy titled Abuse Investigation and Reporting, revised July 2017, revealed all reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment, and/or injuries of unknown sources shall be promptly reported to local state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported. Review of the facility policy titled Abuse and Neglect - Clinical Protocol, undated, revealed the nurse will assess the individual and document related findings. Assessment data will include injury assessment, pain assessment, current behavior, vital signs, and behavior over the last 24 hours. The nurse will report findings to the physician. As indicated, the physician will evaluate the resident or refer him or her for evaluation; for example, to rule out sexual assault. The facility management and staff will institute measures to address the needs of residents and minimize the possibility of abuse and neglect. The management and staff, with physician support, will address situations of suspected or identified abuse and repot them in a timely manner to appropriate agencies, consistent with applicable laws and regulations.