STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366415	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ohio Living Cape May	175 Cape May Drive Wilmington, OH 45177

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 - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, policy review, and review of the facilities Self-Reported Incidents (SRI) and investigations, the facility failed to complete thorough investigations into allegations of sexual and physical abuse of residents. This affected four residents (#8, #17, #67, and #68) of seven SRIs reviewed. Findings include:1. Review of the facility's SRI number 252610 dated 10/04/24 revealed an allegation of physical abuse between Residents #17 and #68. Certified Nursing Assistant (CNA) #101 was at the nursing station and heard get out, get out from a resident room. CNA #101 immediately went to Resident #17's room and Resident #17 had his fist raised to Resident #68 asking him if he wanted hit. Resident #68 wandered into Resident #17's room. Resident #17 had his hand on Resident #68's wrist. CNA #101 intervened and redirected Resident #67 out of Resident #17's room. Resident #68 was provided one-to-one supervision until his planned discharge to home on [DATE].The investigation in SRI said they got the CNA statement and no physical signs of harm. The facilities investigation did not include an assessment of Resident #68 for any injuries and there were no resident statements from Residents #17 and Resident #68 on what occurred.Interview on 04/10/26 at 2:15 P.M. with the Administrator confirmed the facility's investigation into the allegation of physical abuse between Residents #17 and #68 did not include an assessment of #68 for any injuries and there were no resident statements from Residents #17 and Resident #68 on what occurred. 2. Review of the facility's SRI number 255177 dated 12/16/24 revealed Resident #67 alleged she dreamed of someone raping her to the floor nurse. The facility's investigation revealed Certified Nursing Assistant(CNA) #100 recently toileted Resident #67 roughly 20 minutes prior to the statement being made. CNA #100 took Resident #67 to the restroom and waited outside for her to be finished. Resident #67 stated later to the nurse that she had some crazy dreams the night before. On 12/17/24, the Director of Nursing (DON) reported Resident #67 could not recall anything from the night prior (12/16/24). The investigation did not include additional staff statements and skin assessment on Resident #67. Interview on 04/10/26 at 2:15 P.M. with the Administrator confirmed the facility did not include any additional staff statements and skin assessment on Resident #67. 3. Review of the facility's SRI number 265492 dated 09/21/25 revealed Resident #8 alleged a someone hit her earlier in the day (09/21/25).The facility's investigation revealed Resident #8 refused care throughout the shift and was combative during care. Resident #8's granddaughter stated she knew Certified Nursing Assistant (CNA) 103 and CNA #103 would not hit Resident #8. Nurse #2 witnessed the incident and stated Resident #8 was combative and CNA #103 remained professional and polite during the entire interactions. The investigation did not include skin assessment on Resident #8 and staff interviews on that shift.Interview on 04/10/26 at 2:15 P.M. with the Administrator confirmed the facility's investigation into the Resident #8's allegation of physical abuse. The Administrator confirmed the facility did not include skin assessment on Resident #8 and staff interviews on that shift.Review of the facility policy titled Abuse, Neglect Misappropriation and Crime Reporting dated 04/14/1999 revealed as part of the policy, it included the investigation of allegations or suspicion of abuse. The investigation process may include all or some of the following dependent upon the situation in question: Interview the resident/victim. Examine the resident for marks/bruises/other indications of (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	abuse/neglect. Interview the alleged wrongdoer. Interview facility staff/employees/persons used by the facility, with first-hand knowledge of the incident, Interview other residents with first hand knowledge of the incident. Obtain written statements from all those interviewed. The interview may document a written record if there is a telephone interview. This was an incidental finding discovered during the complaint investigation.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, policy review, review of the Centers for Disease Control and Prevention (CDC) guidance, and record review, the facility failed to ensure staff followed appropriate enhanced barrier precautions (EBP) during high resident care activities for a resident with a wound. This affected one (Resident #4)of three residents reviewed for wound care. The facility census was 19. Findings include:Review of the medical record revealed Resident #4 was admitted to the facility on [DATE]. Diagnoses included orthopedic surgery fracture of unspecified part of neck of right femur, subsequent encounter for closed fracture with routine healing and malignant neoplasm of unspecified main bronchusReview of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #4 was cognitively intact, required substantial assistance with toileting, substantial assistance with bathing, and supervision with personal hygiene.Review of the resident record flags for Resident #4 revealed EBP were in place.Review of the care plan dated 04/07/26 revealed Resident #4's problem was EBP will be maintained per facility/organization policy related to surgical wound. Observation and interview on 04/10/26 at 10:05 A.M. to 10:16 A.M. revealed there was a sign on Resident #4's door stating EBP. Licensed Practical Nurse (LPN) #1 provided care to a skin tear on Resident #4's right arm and did not have a gown on during treatment. LPN #4 confirmed she was not wearing a gown and stated no gown needs to be worn for this type of care, only when doing the surgical wound. Interview on 04/10/26 at 1:12 P.M. with the Director of Nursing (DON) confirmed staff should be wearing gloves and gown when doing patient care for residents in EBP.Review of the policy titled Enhanced Barrier Precautions dated 01/07/26 revealed wear a gown during high contact resident care. Review of CDC guidance titled Implementation of PPE Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) found at https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html and dated 04/02/24 revealed MDRO transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs. EBP is an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP may be indicated for residents with any of the following: wounds or indwelling medical devices, regardless of MDRO colonization status. This deficiency represents non-compliance investigated under Complaint Number 2746877.