STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365044	A. BUILDING _____ B. WING _____	09/15/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HYDE PARK HEALTH CENTER	4001 ROSSLYN DRIVE CINCINNATI, OH 45209

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

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F 0600 **Level of harm -** Immediate jeopardy **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** Based on medical record review, observation, staff and resident interview, review of e-mail communication, review of a witness statement, review of the hospital discharge summary, review of the facility's Abuse, Neglect and Exploitation policy, the facility failed to ensure a cognitively impaired resident (#50) was free from sexual abuse from Resident #12, who had a history of [REDACTED].#12's room and he had Resident #50's breast in his mouth. This resulted in Immediate Jeopardy for one (#50) of five residents reviewed for abuse. Additionally, this placed 14 (#02, #03, #05, #07, #08, #10, #13, #14, #15, #16, #17, #18, #20 and #21) other cognitively impaired female residents, who reside on the Fountains Unit where Resident #12 has unrestricted access, at risk for potential abuse. The facility census was 99. On 08/18/20 at 3:01 P.M., the Administrator and the Director of Nursing (DON) were notified that Immediate Jeopardy began on 07/31/20 when Resident #12, who had a history of [REDACTED].#50 and he had her breast in his mouth. The Immediate Jeopardy was removed on 08/18/20 at 8:00 P.M., when the facility implemented the following corrective actions: On 08/18/20, following the Immediate Jeopardy notification, Resident #12 was placed on one-to-one (1:1) staff supervision until appropriate placement could be found. Licensed Social Worker (LSW) #411 and Care Team Manager (CTM) #102 began actively pursing alternative placement for Resident #12 to a specialized unit. On 08/18/20 at 4:30 P.M., the Administrator and the DON conducted a meeting with the Interdisciplinary Team (IDT). Those in attendance included LSW #411, Registered Nurse (RN) #255, CTMs #102 and #641 and Human Resource Director (HRD) #408. The IDT members discussed allegations of compliance requirements and steps they needed to immediately implement for resident safety on the Fountains Unit. On 08/18/20 by 7:30 P.M., RN #255 and CTM #102 completed a physical assessment on all female residents who resided on the Fountains Unit. The assessment included assessing for any unexplained redness, bruising and/or wounds. There were no negative findings or concerns identified. On 08/18/20 by 7:30 P.M., LSW #411 completed a psychosocial assessment on all female residents who resided on the Fountains Unit. The assessment included unexplained agitation, crying for no reason and fear of other residents. There were no negative findings. LSW #411 also completed Patient Health Questionnaire (PHQ-9) assessments at the same time. This questionnaire is used to determine depression. There were no negative findings identified. On 08/18/20 by 8:00 P.M., the DON and HRD #408 completed in-service education to the staff who worked on the Fountains Unit to include seven Licensed Practical Nurses (LPNs) and 12 State tested Nursing Assistants (STNAs). The education included a review of the abuse regulation, review of the facility Abuse Program including policies, procedures and reporting responsibilities. The DON and HRD #408 also reviewed the issues with Resident #12 and #50 and the corrective action the facility was implementing. On 08/18/20, the Administrator and DON implemented an audit tool to ensure staff could define and identify abuse as well as explain the immediate actions and reporting structure requirements. These audits will be conducted randomly on the Fountains Unit three times a week for four weeks and then monthly for two months. The Quality Assurance Committee will review the audits to determine if further monitoring is needed. Although the Immediate Jeopardy was removed on 08/18/20 at 8:00 P.M., the facility remained out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility is still in the process of implementing their corrective actions and monitoring to ensure on-going compliance. Findings include: Review of the medical record revealed Resident #50 was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Review of Resident #50's Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was severely cognitively impaired and never or rarely made decisions. Resident #50 required extensive assistance with bed mobility, transfers, and dressing. Review of Resident #50's behavior care plan dated 08/01/18 revealed the resident was noted to refuse care at times. Resident #50's mood fluctuated related to decreased cognition and she had a history of [REDACTED]. Resident #50 wandered throughout the unit daily and had a history of [REDACTED]. Resident #50's behavior care plan also indicated the resident had sought out intimacy with another resident, (unable to verify when this was added to the care plan). On 08/01/20 an approach was added for staff to honor the resident's right for initiating a relationship with other residents and provide privacy during periods of intimacy. Review of a nurse's progress note dated 07/31/20 at 9:08 P.M. revealed LPN #105 documented Resident #50 was found in a male resident's (#12) room and the male resident had Resident #50's breast in his mouth while urinating on himself. STNA #01 immediately called for help and removed Resident #50 from the male's room. The physician, DON, supervisor and responsible party were notified. Review of STNA #01's witness statement dated 07/31/20 revealed STNA #01 was looking for Resident #50 to give her a shower and found her in Resident #12's room and he had his mouth on Resident #50's breast. Resident #12's hand was on Resident #50's other breast while he was urinating on himself. STNA #01 immediately assisted Resident #50 out of harm's way and reported it to the nurse at 6:50 P.M. Further review of Resident #50's progress notes revealed a late entry by CTM #102 dated 08/13/20 that indicated on 07/31/20, Resident #50 was found in Resident #12's room in the midst of a sexual act. Resident #50 was in a pleasant mood in enjoyment. The residents were immediately separated and both families were notified. Resident #50's representative laughed and stated, well I hope she enjoyed it, that's probably the most enjoyment she's had in a while. Observation of Resident #50 on 08/13/20 from 12:45 P.M. to 1:05 P.M. revealed the resident was wandering the hallway on the Fountains Unit. On 08/13/20 at 1:00 P.M., an interview was attempted with Resident #50, but she was unable to be interviewed due to her cognition. Interview with STNA #01 on 08/13/20 at 1:05 P.M. revealed STNA #01 observed Resident #12 with Resident #50's breast in his mouth. STNA #01 stated it looked consensual, but she reported the incident to the nurse and filled out a witness statement. On 08/19/20 at 7:32 A.M., care plan revision dates were requested from the Administrator and DON. Review of e-mail communication dated 08/19/20 at 2:52 P.M. from the Administrator indicated the facility could not provide edit date history for Resident #50's behavior care plan for the issue of the resident seeking out intimacy with another resident. Review of the medical record revealed Resident #05 was admitted on [DATE] and had a pertinent [DIAGNOSES REDACTED]. Review of Resident #05's MDS assessment dated [DATE] revealed the resident was severely cognitively impaired and required extensive assistance with dressing. Review of Resident #05's progress notes revealed on 05/02/20 at around 4:00 A.M. the night shift STNAs were doing rounds and observed the resident in a room with another resident (#12) and the resident was undressed. Review of Resident #05's care plan revealed Resident #05 was care planned on 05/15/20 for recent undressing with another resident. Review of the medical record revealed Resident #20 was admitted to the facility on [DATE]. Pertinent [DIAGNOSES REDACTED].#20's MDS assessment dated [DATE] revealed the resident was severely cognitively impaired and required extensive assistance with dressing. Review of Resident #20's progress notes dated 07/05/20 revealed Resident #20 was noted lying in bed with her bottoms off in a male resident's (#12) room. Resident #20 was asked what happened and the resident replied Thank god you came and got me. I was ready to go. Resident #20 was assessed with [REDACTED]. Review of Resident #20's care plan revealed Resident #20 was care planned on 07/07/20 for undressing in public and frequently taking her pants off. Closed medical record review revealed Resident #115 was admitted

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

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.

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F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) to the facility on [DATE]. Pertinent [DIAGNOSES REDACTED]. The resident discharged from the facility on 08/01/20. Review of Resident #115's MDS assessment dated [DATE] revealed the resident was severely cognitively impaired and rarely or never made decisions. Resident #115 required extensive assistance with bed mobility and dressing. Review of Resident #115's progress notes dated 06/14/20 at 6:50 P.M. revealed a resident (#12) was discovered coming out of Resident #115's room by STNAs. The incident was immediately reported to the nurse. Resident #115 was immediately checked on and was in bed with her eyes closed. The resident was easily aroused by voice and denied anyone being in her room. Review of the medical record of Resident #12 revealed he was admitted to the facility on [DATE]. Pertinent [DIAGNOSES REDACTED]. Review of Resident #12's MDS assessment dated [DATE] revealed the resident was severely cognitively impaired and required limited assistance with bed mobility, transfers, and personal hygiene. Review of Resident #12's acute care plan for alternation in behavior related to symptoms of seeking out intimacy with female residents revealed on 05/02/20 an intervention was added for the resident's rooms to be shut at night and staff were to observe the residents nightly. On 05/19/20 the intervention to provide redirection when attempting to enter another resident's room was added. On 06/09/20 the intervention of [MEDICATION NAME] (an [MEDICATION NAME] that has anti-androgen effects and reduces sexual desire in both sexes and affects arousal and orgasm), initiated by psychiatry, was added. On 07/14/20 the intervention of [MEDICATION NAME] (a mood stabilizer that is used to reduce compulsive sexual behavior) was initiated and Resident #12's [MEDICATION NAME] was discontinued. On 08/06/20 the intervention of [MEDICATION NAME] increased to 250 milligrams (mg) twice a day was added. On 08/07/20 the intervention of a door alarm to Resident #12's door was added. Review of Resident #12's care plan dated 08/05/20 revealed Resident #12 desired intimacy and a possible relationship with women. Interventions included to administer medication as ordered per the physician, communicate with the physician as needed for any increase in anxiety or discomfort, refer to mental health for evaluation and treatment, a motion activated door bell was in place to notify staff when anyone goes in or out of the resident's room, provide non pharmaceutical interventions as needed for increased anxiety, monitor resident's relationships and offer emotional support, honor the resident's right for privacy and relationships and provide privacy during periods of intimacy and communicate with resident's family as needed in regards to relationship status. Review of Resident #12's progress notes dated 04/29/20 at 6:08 A.M. revealed Resident #12 was noted to be making sexual comments towards residents and staff. On 05/02/20 around 4:00 A.M., unnamed night shift STNAs were doing rounds and observed Resident #12 in the room with a female resident (#05) who was undressed. Resident #12 was also undressed, and he stated nothing sexual had occurred. The STNAs separated the residents from each other. On 05/04/20 (two days later) Resident #12's physician was made aware of the resident's sexual behaviors. On 05/19/20, Resident #12 was in a dark room with another female resident (#50), who was fully clothed. Resident #12 was reaching out to Resident #50 attempting to touch her. The residents were separated from each other. On 06/03/20 Resident #12 was making inappropriate remarks to staff and the resident was educated. Review of Resident #12's physician's orders [REDACTED].#100 prescribed [MEDICATION NAME] 300 mg twice a day for sexually inappropriate behaviors. Review of progress notes dated 06/10/20 at 5:03 A.M. revealed Resident #12 was noted watching a sexual movie on his personal television and stated, I could watch this movie over and over again. On 06/14/20 at 7:17 P.M., Resident #12 was noted coming out of a female resident's (#115) room by STNAs #180 and #181. Resident #115 was in her bed with her eyes closed. Resident #115 was easily aroused and denied anyone ever being in the room and she appeared in no emotional distress. A physical examination was completed on Resident #115 and the physical was negative. On 07/05/20 at 6:00 A.M., Resident #12 was noted to have another female resident (#20) in his room with her bottoms off underneath the covers. Resident #12 was reported to move away from the bed when nursing staff entered the room. Resident #12 was educated on inappropriate behavior and his routine [MEDICATION NAME] was given. Review of Resident #12's psychiatric progress note dated 07/14/20 revealed the resident was seen by Psychiatric Nurse Practitioner (PNP) #101. The progress note indicated Resident #12 was followed by psychiatry for a history of dementia with behavioral disturbances (his list of active [DIAGNOSES REDACTED]. PNP #101 was requested to follow up for two reasons including a report that Resident #12's insurance would not cover the cost of [MEDICATION NAME] and a female resident was found in resident's room with her pants off. The progress note documented a unit manager indicated this female resident was known for disrobing and wandering into the other resident's rooms. There was no report that the resident was witnessed to have acted inappropriately in this instance. Review of the physician order [REDACTED]. Review of Resident #12's psychiatric progress note dated 07/29/20 revealed the resident was seen by PNP #101. The progress note indicated Resident #12 was followed by psychiatry for a history of dementia with behavioral disturbances, depression and sexual inappropriate behavior. The note indicated PNP #101's last contact with Resident #12 occurred on 07/14/20 and at that time Resident #12 was noted with continued inappropriate sexual behavior despite trial of [MEDICATION NAME]. [MEDICATION NAME] was discontinued and [MEDICATION NAME] 125 mg two times a day was started for management of sexual behavior. There was no report of the resident in any inappropriate sexual behavior since starting [MEDICATION NAME] on 07/14/20. Review of progress notes dated 07/31/20 at 7:25 P.M. revealed Resident #12 was found in his room with another female resident's (#50) breast in his mouth while urinating on himself. STNA #01 immediately called for help and removed Resident #50 from the room. The physician, DON, supervisor and responsible party were notified of the incident. Further review of the progress notes revealed transportation was contacted, and the resident was sent to the hospital around 8:30 P.M. to 9:00 P.M. Resident was being closely monitored on 1:1. Review of Resident #12's hospital discharge summary dated 08/01/20 revealed the resident was seen for increased agitation and being hypersexual with another resident. The summary indicated nursing home staff reported the resident was more agitated and hypersexual. Staff reported Resident #12 was normally sexual with staff, but it was getting worse. Staff at the nursing facility reported Resident #12 had another resident's breast in his mouth and was peeing on himself. Resident #12 was provided with community resources for counseling and psychiatry. Medically acute reasons for mental status were ruled out and the resident was evaluated by the physician, social work and psychiatry. Resident #12 was recommended to follow up with primary care physician and psychiatry in the outpatient setting for further assessment and management. Review of Resident #12's one-on-one monitoring log revealed it had blocks for 30 minute checks. The 30 minute checks were initiated on 08/01/20 at 1:00 P.M. and continued until 08/06/20 at 6:30 P.M. There were no 30 minute checks documented as being completed beginning 08/06/20 from 6:30 P.M. until 08/07/20 at 6:30 A.M. Resident #12's 30 minute checks were documented as being completed on 08/07/20 at 7:00 A.M. until 08/12/20 at 11:00 A.M. Review of progress notes dated 08/05/20 at 4:40 P.M. revealed the resident on 1:1 care, an STNA walked in and found the resident standing in front of the television jacking off. Review of progress notes dated 08/06/20, revealed CTM #102 spoke with PNP #101 regarding Resident #12's increased sexual desires. PNP #101 recommended an increase in Resident #12's [MEDICATION NAME] from 125 mg to 250 mg two times a day. Review of physician orders [REDACTED]. Review of progress notes dated 08/07/20 at 11:26 A.M., as an addendum, CTM #102 documented the resident's daughter informed CTM #102 that her father had been a Gigolo all his life. CTM #102 educated the daughter for the safety of the other residents and himself the increase in medication ([MEDICATION NAME]) was needed. CTM #102 also brought up the possibility the resident might need the services of a men's unit due to behaviors. Review of progress notes dated 08/10/20 revealed Resident #12 had a motion sensor alarm placed on his door on 08/07/20 which was used as an intervention to notify staff of residents or fell ow residents entering and exiting the residents' room. Review of Resident #12's psychiatry progress note dated 08/11/20 revealed the resident was seen by Psychiatrist #100. Resident #12 was seen due to a history of dementia with behavioral disturbance, depression and sexually inappropriate behavior. The note indicated Resident #12 was given a trial of [MEDICATION NAME] and more recently was started on [MEDICATION NAME]. The [MEDICATION NAME] dose was increased to 250 mg twice daily on 08/06/20. The note also indicated Resident #12 was currently on 15 minute checks in order to limit the potential for contact with female residents on the unit (the facility was only completing 30 minute checks). Review of the late entry progress note dated 08/17/20 indicated Resident #12's physician and family were notified of Resident #12's sexual behavior on 05/02/20, 06/14/20 and 07/05/20. Further review of the late entry progress note also indicated on 07/05/20 a large name plate was placed on Resident #12's door to alert residents not to enter and on 08/06/20, 30 minute checks were completed on third shift. Interview with Resident #12 on 08/13/20 at 1:11 P.M. revealed the resident denied having any sexual relationships or participating in any sexual acts at the facility. Interview with STNA #02 on 08/13/20 at 1:15 P.M. revealed Resident #12 had a history of [REDACTED]. Interview with the DON and Administrator on 08/13/20 at 1:25 P.M. revealed Resident #50 was found in Resident #12's room on 07/31/20. Resident #12 had Resident #50's breast in his mouth at that time. The DON stated the facility separated the residents and called Resident #12 and Resident #50's family. The DON reported Resident #12's representative stated the resident had always been a gigolo and Resident #50's resident representative stated that she was glad Resident #50 was having fun. The DON stated the facility did not suspect abuse and a Self-Reported Incident (SRI) was not completed. The DON stated Resident #12 and Resident #50 were seeking out each other. The DON stated Resident #50's cognition varied at times. The DON and the

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F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) Administrator did not report any other sexual behaviors in the facility at that time. On 08/17/20 at 4:28 P.M., capacity to consent assessments for Resident's #05, #20, #50 and #115 were requested from the administrative staff but were never provided. After the surveyor reviewed Resident #12's medical record and found other instances of possible inappropriate behavior, a telephone interview with the DON and CTM #102 was conducted on 08/17/20 at 4:29 P.M. to discuss the instances. On 05/02/20 the unnamed night shift STNAs were doing rounds and observed Resident #12 in the room with Resident #50. Both residents were undressed with their shirts off and Resident #12 stated nothing sexual had occurred, but he was separated from Resident #50. On 05/02/20 redirection was implemented, and a care plan was put in place to ensure resident rooms were shut at night and to observe residents nightly. On 05/19/20 Resident #12 was in a dark room with Resident #50 whom was fully clothed. Resident #12 was noted to be reaching out to Resident #50 and attempting to touch her. Resident #12 and Resident #50 were separated. They stated redirection was provided at the time. On 06/03/20 Resident #12 had made inappropriate sexual remarks to staff and on 06/08/20 the resident was prescribed [MEDICATION NAME] 300 mg two times a day for sexual behaviors. On 06/10/20 Resident #12 was watching a sexual movie. On 06/14/20 Resident #12 was noted coming out of Resident #115's room by STNAs. Resident #115 was in her bed with her eyes closed. Resident #115 denied anyone ever being in the room and appeared in no emotional distress and her physical exam was negative. The DON stated redirection was provided at that time. On 07/05/20 Resident #12 was noted to have another female resident (#20) in his room with her bottoms off underneath the covers. Resident #12 was noted to move away from the bed when staff entered the room. They verified education was provided to Resident #12 on inappropriate behavior. On 07/14/20 Resident #12's [MEDICATION NAME] was initiated. On 07/31/20 Resident #12 was found with Resident #50 in his room with his mouth on her breast while urinating on himself. CTM #102 stated Resident #12 was sent to the hospital and 30 minute checks were initiated upon his return from the hospital. The DON verified that 30 minute checks were not documented on third shift on 08/06/20 but she would check with staff to see if the checks were completed or documented in another area. On 08/05/20 Resident #12 had a care plan implemented for desiring intimacy and a possible relationship with women and on 08/06/20 his [MEDICATION NAME] was increased. On 08/07/20 Resident #12 also had a door alarm installed. Both the DON and CTM #102 were unable to verify if any other interventions were attempted or if the physician or responsible parties were notified for any of the above occurrences. Telephone interview with the Administrator on 08/18/20 at 8:28 A.M. revealed the resident actions were often misperceived by the direct care staff and that no one had any intent with any of the sexual incidents that occurred with Resident #12. The Administrator stated that some of the females had sought out companionship. The Administrator stated she was new at the facility and was not able to speak for what the former Administrator did regarding the above incidents. Review of an undated list of residents with sexual behaviors received on 08/13/20 revealed Resident #12 and Resident #50 were listed to exhibit sexual behaviors. Review of the facility's Abuse, Neglect and Exploitation policy dated 11/26/16 revealed the facility will protect its residents from abuse, neglect, mistreatment, exploitation and misappropriation of property. The policy also indicated sexual abuse was nonconsensual sexual contact of any type with a resident. Further review of the policy revealed a prompt and thorough investigation would be conducted. The investigation would include but not be limited to securing resident and witness interviews, gathering tangible evidence and documenting all information gathered. Any suspicions of a crime against a resident shall be reported to the appropriate state agencies. The policy also indicated the facility would monitor the resident for signs of mental, emotional, or physical abuse and notify the resident's physician and resident representatives. This deficiency substantiates Complaint Number OH 874.
F 0607 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**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, observation, staff and resident interview, review of e-mail communication, review of a witness statement, review of the hospital discharge summary, review of the facility's Abuse, Neglect and Exploitation policy the facility failed to implement their abuse policy when they failed to thoroughly investigate and report incidents of possible sexual inappropriate behavior. Resident #12 had a history of [REDACTED]. This affected five Residents (#05, #12, #20, #50 and #115) of five residents reviewed for abuse. The facility census was 99. Findings include: 1. Review of the medical record revealed Resident #50 was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Review of Resident #50's Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was severely cognitively impaired and never or rarely made decisions. Resident #50 required extensive assistance with bed mobility, transfers, and dressing. Review of Resident #50's behavior care plan dated 08/01/18 revealed the resident was noted to refuse care at times. Resident #50's mood fluctuated related to decreased cognition and she had a history of [REDACTED]. Resident #50 wandered throughout the unit daily and had a history of [REDACTED]. Resident #50's behavior care plan also indicated the resident had sought out intimacy with another resident, (unable to verify when this was added to the care plan). On 08/01/20 an approach was added for staff to honor the resident's right for initiating a relationship with other residents and provide privacy during periods of intimacy. Review of a nurse's progress note dated 07/31/20 at 9:08 P.M. revealed LPN #105 documented Resident #50 was found in a male resident's (#12) room and the male resident had Resident #50's breast in his mouth while urinating on himself. STNA #01 immediately called for help and removed Resident #50 from the male's room. The physician, DON, supervisor and responsible party were notified. Review of STNA #01's witness statement dated 07/31/20 revealed STNA #01 was looking for Resident #50 to give her a shower and found her in Resident #12's room and he had his mouth on Resident #50's breast. Resident #12's hand was on Resident #50's other breast while he was urinating on himself. STNA #01 immediately assisted Resident #50 out of harm's way and reported it to the nurse at 6:50 P.M. Further review of Resident #50's progress notes revealed a late entry by CTM #102 dated 08/13/20 that indicated on 07/31/20, Resident #50 was found in Resident #12's room in the midst of a sexual act. Resident #50 was in a pleasant mood in enjoyment. The residents were immediately separated and both families were notified. Resident #50's representative laughed and stated, well I hope she enjoyed it, that's probably the most enjoyment she's had in a while. Observation of Resident #50 on 08/13/20 from 12:45 P.M. to 1:05 P.M. revealed the resident was wandering the hallway on the Fountains Unit. On 08/13/20 at 1:00 P.M., an interview was attempted with Resident #50, but she was unable to be interviewed due to her cognition. Interview with STNA #01 on 08/13/20 at 1:05 P.M. revealed STNA #01 observed Resident #12 with Resident #50's breast in his mouth. STNA #01 stated it looked consensual, but she reported the incident to the nurse and filled out a witness statement. On 08/19/20 at 7:32 A.M., care plan revision dates were requested from the Administrator and DON. Review of e-mail communication dated 08/19/20 at 2:52 P.M. from the Administrator indicated the facility could not provide edit date history for Resident #50's behavior care plan for the issue of the resident seeking out intimacy with another resident. 2. Review of the medical record revealed Resident #05 was admitted on [DATE] and had a pertinent [DIAGNOSES REDACTED]. Review of Resident #05's MDS assessment dated [DATE] revealed the resident was severely cognitively impaired and required extensive assistance with dressing. Review of Resident #05's progress notes revealed on 05/02/20 at around 4:00 A.M. the night shift STNAs were doing rounds and observed the resident in a room with another resident (#12) and the resident was undressed. Review of Resident #05's care plan revealed Resident #05 was care planned on 05/15/20 for recent undressing with another resident. 3. Review of the medical record revealed Resident #20 was admitted to the facility on [DATE]. Pertinent [DIAGNOSES REDACTED].#20's MDS assessment dated [DATE] revealed the resident was severely cognitively impaired and required extensive assistance with dressing. Review of Resident #20's progress notes dated 07/05/20 revealed Resident #20 was noted lying in bed with her bottoms off in a male resident's (#12) room. Resident #20 was asked what happened and the resident replied Thank god you came and got me. I was ready to go. Resident #20 was assessed with [REDACTED]. Review of Resident #20's care plan revealed Resident #20 was care planned on 07/07/20 for undressing in public and frequently taking her pants off. 4. Closed medical record review revealed Resident #115 was admitted to the facility on [DATE]. Pertinent [DIAGNOSES REDACTED]. The resident discharged from the facility on 08/01/20. Review of Resident #115's MDS assessment dated [DATE] revealed the resident was severely cognitively impaired and rarely or never made decisions. Resident #115 required extensive assistance with bed mobility and dressing. Review of Resident #115's progress notes dated 06/14/20 at 6:50 P.M. revealed a resident (#12) was discovered coming out of Resident #115's room by STNAs. The incident was immediately reported to the nurse. Resident #115 was immediately checked on and was in bed with her eyes closed. The resident was easily aroused by voice and denied anyone being in her room. 5. Review of the medical record of Resident #12 revealed he was admitted to the facility on [DATE]. Pertinent [DIAGNOSES REDACTED]. Review of Resident #12's MDS assessment dated [DATE] revealed the resident was severely cognitively impaired and required limited assistance with bed mobility, transfers, and personal hygiene. Review of Resident #12's acute care plan for alternation in behavior related to symptoms of seeking out intimacy with female residents revealed on 05/02/20 an intervention was added for the resident's rooms to be shut at night and staff were to observe the residents nightly. On 05/19/20 the intervention to provide redirection when attempting to enter another resident's room was

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HYDE PARK HEALTH CENTER	4001 ROSSLYN DRIVE CINCINNATI, OH 45209

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** - Some	(continued... from page 3) added. On 06/09/20 the intervention of [MEDICATION NAME] (an [MEDICATION NAME] that has anti-androgen effects and reduces sexual desire in both sexes and affects arousal and orgasm), initiated by psychiatry, was added. On 07/14/20 the intervention of [MEDICATION NAME] (a mood stabilizer that is used to reduce compulsive sexual behavior) was initiated and Resident #12's [MEDICATION NAME] was discontinued. On 08/06/20 the intervention of [MEDICATION NAME] increased to 250 milligrams (mg) twice a day was added. On 08/07/20 the intervention of a door alarm to Resident #12's door was added. Review of Resident #12's care plan dated 08/05/20 revealed Resident #12 desired intimacy and a possible relationship with women. Interventions included to administer medication as ordered per the physician, communicate with the physician as needed for any increase in anxiety or discomfort, refer to mental health for evaluation and treatment, a motion activated door bell was in place to notify staff when anyone goes in or out of the resident's room, provide non pharmaceutical interventions as needed for increased anxiety, monitor resident's relationships and offer emotional support, honor the resident's right for privacy and relationships and provide privacy during periods of intimacy and communicate with resident's family as needed in regards to relationship status. Review of Resident #12's progress notes dated 04/29/20 at 6:08 A.M. revealed Resident #12 was noted to be making sexual comments towards residents and staff. On 05/02/20 around 4:00 A.M., unnamed night shift STNAs were doing rounds and observed Resident #12 in the room with a female resident (#05) who was undressed. Resident #12 was also undressed, and he stated nothing sexual had occurred. The STNAs separated the residents from each other. On 05/04/20 (two days later) Resident #12's physician was made aware of the resident's sexual behaviors. On 05/19/20, Resident #12 was in a dark room with another female resident (#50), who was fully clothed. Resident #12 was reaching out to Resident #50 attempting to touch her. The residents were separated from each other. On 06/03/20 Resident #12 was making inappropriate remarks to staff and the resident was educated. Review of Resident #12's physician's orders [REDACTED].#100 prescribed [MEDICATION NAME] 300 mg twice a day for sexually inappropriate behaviors. Review of progress notes dated 06/10/20 at 5:03 A.M. revealed Resident #12 was noted watching a sexual movie on his personal television and stated, I could watch this movie over and over again. On 06/14/20 at 7:17 P.M., Resident #12 was noted coming out of a female resident's (#115) room by STNAs #180 and #181. Resident #115 was in her bed with her eyes closed. Resident #115 was easily aroused and denied anyone ever being in the room and she appeared in no emotional distress. A physical examination was completed on Resident #115 and the physical was negative. On 07/05/20 at 6:00 A.M., Resident #12 was noted to have another female resident (#20) in his room with her bottoms off underneath the covers. Resident #12 was reported to move away from the bed when nursing staff entered the room. Resident #12 was educated on inappropriate behavior and his routine [MEDICATION NAME] was given. Review of Resident #12's psychiatric progress note dated 07/14/20 revealed the resident was seen by Psychiatric Nurse Practitioner (PNP) #101. The progress note indicated Resident #12 was followed by psychiatry for a history of dementia with behavioral disturbances (his list of active [DIAGNOSES REDACTED]. PNP #101 was requested to follow up for two reasons including a report that Resident #12's insurance would not cover the cost of [MEDICATION NAME] and a female resident was found in resident's room with her pants off. The progress note documented a unit manager indicated this female resident was known for disrobing and wandering into the other resident's rooms. There was no report that the resident was witnessed to have acted inappropriately in this instance. Review of the physician order [REDACTED]. Review of Resident #12's psychiatric progress note dated 07/29/20 revealed the resident was seen by PNP #101. The progress note indicated Resident #12 was followed by psychiatry for a history of dementia with behavioral disturbances, depression and sexual inappropriate behavior. The note indicated PNP #101's last contact with Resident #12 occurred on 07/14/20 and at that time Resident #12 was noted with continued inappropriate sexual behavior despite trial of [MEDICATION NAME]. [MEDICATION NAME] was discontinued and [MEDICATION NAME] 125 mg two times a day was started for management of sexual behavior. There was no report of the resident in any inappropriate sexual behavior since starting [MEDICATION NAME] on 07/14/20. Review of progress notes dated 07/31/20 at 7:25 P.M. revealed Resident #12 was found in his room with another female resident's (#50) breast in his mouth while urinating on himself. STNA #01 immediately called for help and removed Resident #50 from the room. The physician, DON, supervisor and responsible party were notified of the incident. Further review of the progress notes revealed transportation was contacted, and the resident was sent to the hospital around 8:30 P.M. to 9:00 P.M. Resident was being closely monitored on 1:1. Review of Resident #12's hospital discharge summary dated 08/01/20 revealed the resident was seen for increased agitation and being hypersexual with another resident. The summary indicated nursing home staff reported the resident was more agitated and hypersexual. Staff reported Resident #12 was normally sexual with staff, but it was getting worse. Staff at the nursing facility reported Resident #12 had another resident's breast in his mouth and was peeing on himself. Resident #12 was provided with community resources for counseling and psychiatry. Medically acute reasons for mental status were ruled out and the resident was evaluated by the physician, social work and psychiatry. Resident #12 was recommended to follow up with primary care physician and psychiatry in the outpatient setting for further assessment and management. Review of Resident #12's one-on-one monitoring log revealed it had blocks for 30 minute checks. The 30 minute checks were initiated on 08/01/20 at 1:00 P.M. and continued until 08/06/20 at 6:30 P.M. There were no 30 minute checks documented as being completed beginning 08/06/20 from 6:30 P.M. until 08/07/20 at 6:30 A.M. Resident #12's 30 minute checks were documented as being completed on 08/07/20 at 7:00 A.M. until 08/12/20 at 11:00 A.M. Review of progress notes dated 08/05/20 at 4:40 P.M. revealed the resident on 1:1 care, an STNA walked in and found the resident standing in front of the television jacking off. Review of progress notes dated 08/06/20, revealed CTM #102 spoke with PNP #101 regarding Resident #12's increased sexual desires. PNP #101 recommended an increase in Resident #12's [MEDICATION NAME] from 125 mg to 250 mg two times a day. Review of physician orders [REDACTED]. Review of progress notes dated 08/07/20 at 11:26 A.M., as an addendum, CTM #102 documented the resident's daughter informed CTM #102 that her father had been a Gigolo all his life. CTM #102 educated the daughter for the safety of the other residents and himself the increase in medication ([MEDICATION NAME]) was needed. CTM #102 also brought up the possibility the resident might need the services of a men's unit due to behaviors. Review of progress notes dated 08/10/20 revealed Resident #12 had a motion sensor alarm placed on his door on 08/07/20 which was used as an intervention to notify staff of residents or fell ow residents entering and exiting the residents' room. Review of Resident #12's psychiatry progress note dated 08/11/20 revealed the resident was seen by Psychiatrist #100. Resident #12 was seen due to a history of dementia with behavioral disturbance, depression and sexually inappropriate behavior. The note indicated Resident #12 was given a trial of [MEDICATION NAME] and more recently was started on [MEDICATION NAME]. The [MEDICATION NAME] dose was increased to 250 mg twice daily on 08/06/20. The note also indicated Resident #12 was currently on 15 minute checks in order to limit the potential for contact with female residents on the unit (the facility was only completing 30 minute checks). Review of the late entry progress note dated 08/17/20 indicated Resident #12's physician and family were notified of Resident #12's sexual behavior on 05/02/20, 06/14/20 and 07/05/20. Further review of the late entry progress note also indicated on 07/05/20 a large name plate was placed on Resident #12's door to alert residents not to enter and on 08/06/20, 30 minute checks were completed on third shift. Interview with Resident #12 on 08/13/20 at 1:11 P.M. revealed the resident denied having any sexual relationships or participating in any sexual acts at the facility. Interview with STNA #02 on 08/13/20 at 1:15 P.M. revealed Resident #12 had a history of [REDACTED]. Interview with the DON and Administrator on 08/13/20 at 1:25 P.M. revealed Resident #50 was found in Resident #12's room on 07/31/20. Resident #12 had Resident #50's breast in his mouth at that time. The DON stated the facility separated the residents and called Resident #12 and Resident #50's family. The DON reported Resident #12's representative stated the resident had always been a gigolo and Resident #50's resident representative stated that she was glad Resident #50 was having fun. The DON stated the facility did not suspect abuse and a Self-Reported Incident (SRI) was not completed. The DON stated Resident #12 and Resident #50 were seeking out each other. The DON stated Resident #50's cognition varied at times. The DON and the Administrator did not report any other sexual behaviors in the facility at that time. On 08/17/20 at 4:28 P.M., capacity to consent assessments for Resident's #05, #20, #50 and #115 were requested from the administrative staff but were never provided. After the surveyor reviewed Resident #12's medical record and found other instances of possible inappropriate behavior, a telephone interview with the DON and CTM #102 was conducted on 08/17/20 at 4:29 P.M. to discuss the instances. On 05/02/20 the unnamed night shift STNAs were doing rounds and observed Resident #12 in the room with Resident #50. Both residents were undressed with their shirts off and Resident #12 stated nothing sexual had occurred, but he was separated from Resident #50. On 05/02/20 redirection was implemented, and a care plan was put in place to ensure resident rooms were shut at night and to observe residents nightly. On 05/19/20 Resident #12 was in a dark room with Resident #50 whom was fully clothed. Resident #12 was noted to be reaching out to Resident #50 and attempting to touch her. Resident #12 and Resident #50 were separated. They stated redirection was provided at the time. On 06/03/20 Resident #12 had made inappropriate sexual remarks to staff and on 06/08/20 the resident was prescribed [MEDICATION NAME] 300 mg two times a day for sexual behaviors. On 06/10/20 Resident #12 was watching a

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F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) sexual movie. On 06/14/20 Resident #12 was noted coming out of Resident #115's room by STNAs. Resident #115 was in her bed with her eyes closed. Resident #115 denied anyone ever being in the room and appeared in no emotional distress and her physical exam was negative. The DON stated redirection was provided at that time. On 07/05/20 Resident #12 was noted to have another female resident (#20) in his room with her bottoms off underneath the covers. Resident #12 was noted to move away from the bed when staff entered the room. They verified education was provided to Resident #12 on inappropriate behavior. On 07/14/20 Resident #12's [MEDICATION NAME] was initiated. On 07/31/20 Resident #12 was found with Resident #50 in his room with his mouth on her breast while urinating on himself. CTM #102 stated Resident #12 was sent to the hospital and 30 minute checks were initiated upon his return from the hospital. The DON verified that 30 minute checks were not documented on third shift on 08/06/20 but she would check with staff to see if the checks were completed or documented in another area. On 08/05/20 Resident #12 had a care plan implemented for desiring intimacy and a possible relationship with women and on 08/06/20 his [MEDICATION NAME] was increased. On 08/07/20 Resident #12 also had a door alarm installed. Both the DON and CTM #102 were unable to verify if any other interventions were attempted or if the physician or responsible parties were notified for any of the above occurrences. Telephone interview with the Administrator on 08/18/20 at 8:28 A.M. revealed the resident actions were often misperceived by the direct care staff and that no one had any intent with any of the sexual incidents that occurred with Resident #12. The Administrator stated that some of the females had sought out companionship. The Administrator stated she was new at the facility and was not able to speak for what the former Administrator did regarding the above incidents. Review of an undated list of residents with sexual behaviors received on 08/13/20 revealed Resident #12 and Resident #50 were listed to exhibit sexual behaviors. Review of the facility's Abuse, Neglect and Exploitation policy dated 11/26/16 revealed the facility will protect its residents from abuse, neglect, mistreatment, exploitation and misappropriation of property. The policy also indicated sexual abuse was nonconsensual sexual contact of any type with a resident. Further review of the policy revealed a prompt and thorough investigation would be conducted. The investigation would include but not be limited to securing resident and witness interviews, gathering tangible evidence and documenting all information gathered. Any suspicions of a crime against a resident shall be reported to the appropriate state agencies. The policy also indicated the facility would monitor the resident for signs of mental, emotional, or physical abuse and notify the resident's physician and resident representatives.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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, observation, staff and resident interview, review of e-mail communication, review of a witness statement, review of the hospital discharge summary and review of the facility policy, the facility failed to report incidents of possible sexual inappropriate behavior and resident elopements to the state agency. This affected two (Residents #18 and #10) of three residents reviewed for elopement and five (Residents #05, #12, #20, #50 and #115) of five residents reviewed for abuse. The facility census was 99. Findings include: 1. Review of the medical record revealed Resident #50 was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Review of Resident #50's Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was severely cognitively impaired and never or rarely made decisions. Resident #50 required extensive assistance with bed mobility, transfers, and dressing. Review of Resident #50's behavior care plan dated 08/01/18 revealed the resident was noted to refuse care at times. Resident #50's mood fluctuated related to decreased cognition and she had a history of [REDACTED]. Resident #50 wandered throughout the unit daily and had a history of [REDACTED]. Resident #50's behavior care plan also indicated the resident had sought out intimacy with another resident, (unable to verify when this was added to the care plan). On 08/01/20 an approach was added for staff to honor the resident's right for initiating a relationship with other residents and provide privacy during periods of intimacy. Review of a nurse's progress note dated 07/31/20 at 9:08 P.M. revealed LPN #105 documented Resident #50 was found in a male resident's (#12) room and the male resident had Resident #50's breast in his mouth while urinating on himself. STNA #01 immediately called for help and removed Resident #50 from the male's room. The physician, DON, supervisor and responsible party were notified. Review of STNA #01's witness statement dated 07/31/20 revealed STNA #01 was looking for Resident #50 to give her a shower and found her in Resident #12's room and he had his mouth on Resident #50's breast. Resident #12's hand was on Resident #50's other breast while he was urinating on himself. STNA #01 immediately assisted Resident #50 out of harm's way and reported it to the nurse at 6:50 P.M. Further review of Resident #50's progress notes revealed a late entry by CTM #102 dated 08/13/20 that indicated on 07/31/20, Resident #50 was found in Resident #12's room in the midst of a sexual act. Resident #50 was in a pleasant mood in enjoyment. The residents were immediately separated and both families were notified. Resident #50's representative laughed and stated, well I hope she enjoyed it, that's probably the most enjoyment she's had in a while. Observation of Resident #50 on 08/13/20 from 12:45 P.M. to 1:05 P.M. revealed the resident was wandering the hallway on the Fountains Unit. On 08/13/20 at 1:00 P.M., an interview was attempted with Resident #50, but she was unable to be interviewed due to her cognition. Interview with STNA #01 on 08/13/20 at 1:05 P.M. revealed STNA #01 observed Resident #12 with Resident #50's breast in his mouth. STNA #01 stated it looked consensual, but she reported the incident to the nurse and filled out a witness statement. On 08/19/20 at 7:32 A.M., care plan revision dates were requested from the Administrator and DON. Review of e-mail communication dated 08/19/20 at 2:52 P.M. from the Administrator indicated the facility could not provide edit date history for Resident #50's behavior care plan for the issue of the resident seeking out intimacy with another resident. 2. Review of the medical record revealed Resident #05 was admitted on [DATE] and had a pertinent [DIAGNOSES REDACTED]. Review of Resident #05's MDS assessment dated [DATE] revealed the resident was severely cognitively impaired and required extensive assistance with dressing. Review of Resident #05's progress notes revealed on 05/02/20 at around 4:00 A.M. the night shift STNA's were doing rounds and observed the resident in a room with another resident (#12) and the resident was undressed. Review of Resident #05's care plan revealed Resident #05 was care planned on 05/15/20 for recent undressing with another resident. 3. Review of the medical record revealed Resident #20 was admitted to the facility on [DATE]. Pertinent [DIAGNOSES REDACTED].#20's MDS assessment dated [DATE] revealed the resident was severely cognitively impaired and required extensive assistance with dressing. Review of Resident #20's progress notes dated 07/05/20 revealed Resident #20 was noted lying in bed with her bottoms off in a male resident's (#12) room. Resident #20 was asked what happened and the resident replied Thank god you came and got me. I was ready to go. Resident #20 was assessed with [REDACTED]. Review of Resident #20's care plan revealed Resident #20 was care planned on 07/07/20 for undressing in public and frequently taking her pants off. 4. Closed medical record review revealed Resident #115 was admitted to the facility on [DATE]. Pertinent [DIAGNOSES REDACTED]. The resident discharged from the facility on 08/01/20. Review of Resident #115's MDS assessment dated [DATE] revealed the resident was severely cognitively impaired and rarely or never made decisions. Resident #115 required extensive assistance with bed mobility and dressing. Review of Resident #115's progress notes dated 06/14/20 at 6:50 P.M. revealed a resident (#12) was discovered coming out of Resident #115's room by STNA's. The incident was immediately reported to the nurse. Resident #115 was immediately checked on and was in bed with her eyes closed. The resident was easily aroused by voice and denied anyone being in her room. 5. Review of the medical record of Resident #12 revealed he was admitted to the facility on [DATE]. Pertinent [DIAGNOSES REDACTED]. Review of Resident #12's MDS assessment dated [DATE] revealed the resident was severely cognitively impaired and required limited assistance with bed mobility, transfers, and personal hygiene. Review of Resident #12's acute care plan for alternation in behavior related to symptoms of seeking out intimacy with female residents revealed on 05/02/20 an intervention was added for the resident's rooms to be shut at night and staff were to observe the residents nightly. On 05/19/20 the intervention to provide redirection when attempting to enter another resident's room was added. On 06/09/20 the intervention of [MEDICATION NAME] (an [MEDICATION NAME] that has anti-androgen effects and reduces sexual desire in both sexes and affects arousal and orgasm), initiated by psychiatry, was added. On 07/14/20 the intervention of [MEDICATION NAME] (a mood stabilizer that is used to reduce compulsive sexual behavior) was initiated and Resident #12's [MEDICATION NAME] was discontinued. On 08/06/20 the intervention of [MEDICATION NAME] increased to 250 milligrams (mg) twice a day was added. On 08/07/20 the intervention of a door alarm to Resident #12's door was added. Review of Resident #12's care plan dated 08/05/20 revealed Resident #12 desired intimacy and a possible relationship with women. Interventions included to administer medication as ordered per the physician, communicate with the physician as needed for any increase in anxiety or discomfort, refer to mental health for evaluation and treatment, a motion activated door bell was in place to notify staff when anyone goes in or out of the resident's room, provide non pharmaceutical interventions as needed for increased

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F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 5) anxiety, monitor resident's relationships and offer emotional support, honor the resident's right for privacy and relationships and provide privacy during periods of intimacy and communicate with resident's family as needed in regards to relationship status. Review of Resident #12's progress notes dated 04/29/20 at 6:08 A.M. revealed Resident #12 was noted to be making sexual comments towards residents and staff. On 05/02/20 around 4:00 A.M., unnamed night shift STNA's were doing rounds and observed Resident #12 in the room with a female resident (#05) who was undressed. Resident #12 was also undressed, and he stated nothing sexual had occurred. The STNA's separated the residents from each other. On 05/04/20 (two days later) Resident #12's physician was made aware of the resident's sexual behaviors. On 05/19/20, Resident #12 was in a dark room with another female resident (#50), who was fully clothed. Resident #12 was reaching out to Resident #50 attempting to touch her. The residents were separated from each other. On 06/03/20 Resident #12 was making inappropriate remarks to staff and the resident was educated. Review of Resident #12's physician's orders dated 06/08/20 revealed Psychiatrist #100 prescribed [MEDICATION NAME] 300 mg twice a day for sexually inappropriate behaviors. Review of progress notes dated 06/10/20 at 5:03 A.M. revealed Resident #12 was noted watching a sexual movie on his personal television and stated, I could watch this movie over and over again. On 06/14/20 at 7:17 P.M., Resident #12 was noted coming out of a female resident's (#115) room by STNA's #180 and #181. Resident #115 was in her bed with her eyes closed. Resident #115 was easily aroused and denied anyone ever being in the room and she appeared in no emotional distress. A physical examination was completed on Resident #115 and the physical was negative. On 07/05/20 at 6:00 A.M., Resident #12 was noted to have another female resident (#20) in his room with her bottoms off underneath the covers. Resident #12 was reported to move away from the bed when nursing staff entered the room. Resident #12 was educated on inappropriate behavior and his routine [MEDICATION NAME] was given. Review of Resident #12's psychiatric progress note dated 07/14/20 revealed the resident was seen by Psychiatric Nurse Practitioner (PNP) #101. The progress note indicated Resident #12 was followed by psychiatry for a history of dementia with behavioral disturbances (his list of active [DIAGNOSES REDACTED]. PNP #101 was requested to follow up for two reasons including a report that Resident #12's insurance would not cover the cost of [MEDICATION NAME] and a female resident was found in resident's room with her pants off. The progress note documented a unit manager indicated this female resident was known for disrobing and wandering into the other resident's rooms. There was no report that the resident was witnessed to have acted inappropriately in this instance. Review of the physician order dated 07/14/20 revealed [MEDICATION NAME] was discontinued and [MEDICATION NAME] 125 mg, for sexually inappropriate behaviors, was ordered. Review of Resident #12's psychiatric progress note dated 07/29/20 revealed the resident was seen by PNP #101. The progress note indicated Resident #12 was followed by psychiatry for a history of dementia with behavioral disturbances, depression and sexual inappropriate behavior. The note indicated PNP #101's last contact with Resident #12 occurred on 07/14/20 and at that time Resident #12 was noted with continued inappropriate sexual behavior despite trial of [MEDICATION NAME]. [MEDICATION NAME] was discontinued and [MEDICATION NAME] 125 mg two times a day was started for management of sexual behavior. There was no report of the resident in any inappropriate sexual behavior since starting [MEDICATION NAME] on 07/14/20. Review of progress notes dated 07/31/20 at 7:25 P.M. revealed Resident #12 was found in his room with another female resident's (#50) breast in his mouth while urinating on himself. STNA #01 immediately called for help and removed Resident #50 from the room. The physician, DON, supervisor and responsible party were notified of the incident. Further review of the progress notes revealed transportation was contacted, and the resident was sent to the hospital around 8:30 P.M. to 9:00 P.M. Resident was being closely monitored on 1:1. Review of Resident #12's hospital discharge summary dated 08/01/20 revealed the resident was seen for increased agitation and being hypersexual with another resident. 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The note also indicated Resident #12 was currently on 15 minute checks in order to limit the potential for contact with female residents on the unit (the facility was only completing 30 minute checks). Review of the late entry progress note dated 08/17/20 indicated Resident #12's physician and family were notified of Resident #12's sexual behavior on 05/02/20, 06/14/20 and 07/05/20. Further review of the late entry progress note also indicated on 07/05/20 a large name plate was placed on Resident #12's door to alert residents not to enter and on 08/06/20, 30 minute checks were completed on third shift. Interview with Resident #12 on 08/13/20 at 1:11 P.M. revealed the resident denied having any sexual relationships or participating in any sexual acts at the facility. Interview with STNA #02 on 08/13/20 at 1:15 P.M. revealed Resident #12 had a history of [REDACTED]. Interview with the DON and Administrator on 08/13/20 at 1:25 P.M. revealed Resident #50 was found in Resident #12's room on 07/31/20. Resident #12 had Resident #50's breast in his mouth at that time. The DON stated the facility separated the residents and called Resident #12 and Resident #50's family. The DON reported Resident #12's representative stated the resident had always been a gigolo and Resident #50's resident representative stated that she was glad Resident #50 was having fun. The DON stated the facility did not suspect abuse and a Self-Reported Incident (SRI) was not completed. The DON stated Resident #12 and Resident #50 were seeking out each other. The DON stated Resident #50's cognition varied at times. The DON and the Administrator did not report any other sexual behaviors in the facility at that time. On 08/17/20 at 4:28 P.M., capacity to consent assessments for Resident's #05, #20, #50 and #115 were requested from the administrative staff but were never provided. After the surveyor reviewed Resident #12's medical record and found other instances of possible inappropriate behavior, a telephone interview with the DON and CTM #102 was conducted on 08/17/20 at 4:29 P.M. to discuss the instances. On 05/02/20 the unnamed night shift STNA's were doing rounds and observed Resident #12 in the room with Resident #50. Both residents were undressed with their shirts off and Resident #12 stated nothing sexual had occurred, but he was separated from Resident #50. On 05/02/20 redirection was implemented, and a care plan was put in place to ensure resident rooms were shut at night and to observe residents nightly. On 05/19/20 Resident #12 was in a dark room with Resident #50 whom was fully clothed. Resident #12 was noted to be reaching out to Resident #50 and attempting to touch her. Resident #12 and Resident #50 were separated. They stated redirection was provided at the time. On 06/03/20 Resident #12 had made inappropriate sexual remarks to staff and on 06/08/20 the resident was prescribed [MEDICATION NAME] 300 mg two times a day for sexual behaviors. On 06/10/20 Resident #12 was watching a sexual movie. On 06/14/20 Resident #12 was noted coming out of Resident #115's room by STNA's. Resident #115 was in her bed with her eyes closed. Resident #115 denied anyone ever being in the room and appeared in no emotional distress and her physical exam was negative. The DON stated redirection was provided at that time. On 07/05/20 Resident #12 was noted to have another female resident (#20) in his room with her bottoms off underneath the covers. Resident #12 was noted to move away from the bed when staff entered the room. They verified education was provided to Resident #12 on inappropriate behavior. On 07/14/20 Resident #12's [MEDICATION NAME] was initiated. On 07/31/20 Resident #12 was found with Resident #50 in his room with his mouth on her breast while urinating on himself. CTM #102 stated Resident #12 was sent to the hospital and 30 minute checks were

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	365044	A. BUILDING _____ B. WING _____	09/15/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HYDE PARK HEALTH CENTER	4001 ROSSLYN DRIVE CINCINNATI, OH 45209

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 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 6) initiated upon his return from the hospital. The DON verified that 30 minute checks were not documented on third shift on 08/06/20 but she would check with staff to see if the checks were completed or documented in another area. On 08/05/20 Resident #12 had a care plan implemented for desiring intimacy and a possible relationship with women and on 08/06/20 his [MEDICATION NAME] was increased. On 08/07/20 Resident #12 also had a door alarm installed. Both the DON and CTM #102 were unable to verify if any other interventions were attempted or if the physician or responsible parties were notified for any of the above occurrences. Telephone interview with the Administrator on 08/18/20 at 8:28 A.M. revealed the resident actions were often misperceived by the direct care staff and that no one had any intent with any of the sexual incidents that occurred with Resident #12. The Administrator stated that some of the females had sought out companionship. The Administrator stated she was new at the facility and was not able to speak for what the former Administrator did regarding the above incidents. Review of an undated list of residents with sexual behaviors received on 08/13/20 revealed Resident #12 and Resident #50 were listed to exhibit sexual behaviors. 6. Medical record review for Resident #18 revealed an admission date of [DATE]. Medical [DIAGNOSES REDACTED]. The resident required limited supervision for bed mobility, transfers, and toileting. He required supervision for eating, and locomotion on and off the unit with one-person assistance. He used a Wanderguard daily, because he was at a significant risk of getting to a potentially dangerous place and the wandering significantly intruded on the privacy of others. Review of the facility investigation dated 07/20/20 for Resident #18 revealed it was reported at 6:00 P.M. he was missing from the facility. A search began inside and outside the facility grounds. The Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), Licensed Social Worker (LSW) #629 and Activity Director (AD) #1 responded to the call. The resident's family was notified. The police were notified and within minutes the resident was found across the street. He was not injured. The resident had a Wanderguard in place on his ankle. Review of the facility Self-Reported Incidents (SRI) revealed no SRI was filed with the State Agency for this elopement involving Resident #18. During interview on 08/27/20 at 1:15 P.M., the DON stated Resident #18 was reported missing on 07/20/20 at around 6:00 P.M. and he was wearing a Wanderguard at the time. She said either the staff didn't hear the alarm because they were busy, the system malfunctioned, or the alarm could have been possibly turned down. She stated interviews with the staff revealed no one heard the alarm. She said a search was done as soon as possible inside the building and when they didn't find him, the search began outside. She stated it was dry and warm and Resident #18 was found across the street and it only took about 20 minutes to find him and he was found to be uninjured. When asked why this elopement wasn't reported to the State Agency, she said she was told by the Administrator she didn't have to report it. 7. Medical record review for Resident #10 revealed an admission date of [DATE]. Medical [DIAGNOSES REDACTED]. Review of the quarterly MDS assessment, dated 07/15/20, revealed Resident #10 was severely cognitively impaired. She required extensive assistance for bed mobility, transfers, toileting and required supervision for eating. She used a Wanderguard daily. Review of progress notes dated 07/18/20 at 6:59 P.M., written by Licensed Practical Nurse (LPN) #651, revealed Resident #10 was exit seeking throughout the entire shift. At 6:45 P.M. it was reported the resident was in the front parking lot on the ground. Resident was assessed by LPN #651. It was determined there were no injuries and vital signs were stable. Resident #10 stated she was going home. She was last seen 10 minutes prior to incident looking for exits. Review of investigation for Resident #10 revealed on 07/18/20 it was reported to the charge nurse Resident #10 had attempted to leave the property. An investigation interview with STNA #180 reported that she pulled into the parking lot in front of the facility at approximately 6:50 P.M. and saw Resident #10 outside the Newberry Unit exit door. She immediately called the supervisor phone and reported Resident #10 was found on the sidewalk. Review of the facility SRI's revealed no SRI was filed with the State Agency for this elopement involving Resident #10. Interview with DON on 09/01/20 at 2:10 P.M. revealed Resident #10 took her wheelchair and exited a door out into the parking lot. A staff member was pulling into the parking lot around the same time and discovered the resident. She stated she asked her Administrator at the time if she needed to file an SRI and he said no, she didn't need to report the incident to the State Agency. Review of policy titled Abuse, Neglect, Exploitation, dated 11/26/16, revealed it is the policy of the facility to protect residents from neglect. Neglect means the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. The policy also indicated sexual abuse was nonconsensual sexual contact of any type with a resident. Further review of the policy revealed a prompt and thorough investigation would be conducted. The investigation would include but not be limited to securing resident and witness interviews, gathering tangible evidence and documenting all information gathered. Any suspicions of a crime against a resident shall be reported to the appropriate state agencies. The policy also indicated the facility would monitor the resident for signs of mental, emotional, or physical abuse and notify the resident's physician and resident representatives. A prompt and thorough investigation will be conducted, and a report should be made to the appropriate State Agencies. This deficiency substantiates Complaint Number OH 874.
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 medical record review, observation, staff and resident interview, review of e-mail communication, review of a witness statement, review of the hospital discharge summary, review of the facility's Abuse, Neglect and Exploitation policy the facility failed to thoroughly incidents of possible sexual inappropriate behavior. Resident #12 had a history of [REDACTED]. This affected five Residents (#05, #12, #20, #50 and #115) of five residents reviewed for abuse. The facility census was 99. Findings include: 1. Review of the medical record revealed Resident #50 was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Review of Resident #50's Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was severely cognitively impaired and never or rarely made decisions. Resident #50 required extensive assistance with bed mobility, transfers, and dressing. Review of Resident #50's behavior care plan dated 08/01/18 revealed the resident was noted to refuse care at times. Resident #50's mood fluctuated related to decreased cognition and she had a history of [REDACTED]. Resident #50 wandered throughout the unit daily and had a history of [REDACTED]. Resident #50's behavior care plan also indicated the resident had sought out intimacy with another resident, (unable to verify when this was added to the care plan). On 08/01/20 an approach was added for staff to honor the resident's right for initiating a relationship with other residents and provide privacy during periods of intimacy. Review of a nurse's progress note dated 07/31/20 at 9:08 P.M. revealed LPN #105 documented Resident #50 was found in a male resident's (#12) room and the male resident had Resident #50's breast in his mouth while urinating on himself. STNA #01 immediately called for help and removed Resident #50 from the male's room. The physician, DON, supervisor and responsible party were notified. Review of STNA #01's witness statement dated 07/31/20 revealed STNA #01 was looking for Resident #50 to give her a shower and found her in Resident #12's room and he had his mouth on Resident #50's breast. Resident #12's hand was on Resident #50's other breast while he was urinating on himself. STNA #01 immediately assisted Resident #50 out of harm's way and reported it to the nurse at 6:50 P.M. Further review of Resident #50's progress notes revealed a late entry by CTM #102 dated 08/13/20 that indicated on 07/31/20, Resident #50 was found in Resident #12's room in the midst of a sexual act. Resident #50 was in a pleasant mood in enjoyment. The residents were immediately separated and both families were notified. Resident #50's representative laughed and stated, well I hope she enjoyed it, that's probably the most enjoyment she's had in a while. Observation of Resident #50 on 08/13/20 from 12:45 P.M. to 1:05 P.M. revealed the resident was wandering the hallway on the Fountains Unit. On 08/13/20 at 1:00 P.M., an interview was attempted with Resident #50, but she was unable to be interviewed due to her cognition. Interview with STNA #01 on 08/13/20 at 1:05 P.M. revealed STNA #01 observed Resident #12 with Resident #50's breast in his mouth. STNA #01 stated it looked consensual, but she reported the incident to the nurse and filled out a witness statement. On 08/19/20 at 7:32 A.M., care plan revision dates were requested from the Administrator and DON. Review of e-mail communication dated 08/19/20 at 2:52 P.M. from the Administrator indicated the facility could not provide edit date history for Resident #50's behavior care plan for the issue of the resident seeking out intimacy with another resident. 2. Review of the medical record revealed Resident #05 was admitted on [DATE] and had a pertinent [DIAGNOSES REDACTED]. Review of Resident #05's MDS assessment dated [DATE] revealed the resident was severely cognitively impaired and required extensive assistance with dressing. Review of Resident #05's progress notes revealed on 05/02/20 at around 4:00 A.M. the night shift STNAs were doing rounds and observed the resident in a room with another resident (#12) and the resident was undressed. Review of Resident #05's care plan revealed Resident #05 was care planned on 05/15/20 for recent undressing with another resident. 3. Review of the medical record revealed Resident #20 was admitted to the facility on [DATE]. Pertinent [DIAGNOSES REDACTED].#20's MDS assessment dated [DATE] revealed the resident was severely cognitively impaired and required extensive assistance with dressing. Review of Resident #20's progress notes dated 07/05/20 revealed Resident #20 was noted lying in bed with her bottoms off in a male resident's (#12) room. Resident #20 was asked what

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F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 7) happened and the resident replied Thank god you came and got me. I was ready to go. Resident #20 was assessed with [REDACTED]. Review of Resident #20's care plan revealed Resident #20 was care planned on 07/07/20 for undressing in public and frequently taking her pants off. 4. Closed medical record review revealed Resident #115 was admitted to the facility on [DATE]. Pertinent [DIAGNOSES REDACTED]. The resident discharged from the facility on 08/01/20. Review of Resident #115's MDS assessment dated [DATE] revealed the resident was severely cognitively impaired and rarely or never made decisions. Resident #115 required extensive assistance with bed mobility and dressing. Review of Resident #115's progress notes dated 06/14/20 at 6:50 P.M. revealed a resident (#12) was discovered coming out of Resident #115's room by STNAs. The incident was immediately reported to the nurse. Resident #115 was immediately checked on and was in bed with her eyes closed. The resident was easily aroused by voice and denied anyone being in her room. 5. Review of the medical record of Resident #12 revealed he was admitted to the facility on [DATE]. Pertinent [DIAGNOSES REDACTED]. Review of Resident #12's MDS assessment dated [DATE] revealed the resident was severely cognitively impaired and required limited assistance with bed mobility, transfers, and personal hygiene. Review of Resident #12's acute care plan for alternation in behavior related to symptoms of seeking out intimacy with female residents revealed on 05/02/20 an intervention was added for the resident's rooms to be shut at night and staff were to observe the residents nightly. On 05/19/20 the intervention to provide redirection when attempting to enter another resident's room was added. On 06/09/20 the intervention of [MEDICATION NAME] (an [MEDICATION NAME] that has anti-androgen effects and reduces sexual desire in both sexes and affects arousal and orgasm), initiated by psychiatry, was added. On 07/14/20 the intervention of [MEDICATION NAME] (a mood stabilizer that is used to reduce compulsive sexual behavior) was initiated and Resident #12's [MEDICATION NAME] was discontinued. On 08/06/20 the intervention of [MEDICATION NAME] increased to 250 milligrams (mg) twice a day was added. On 08/07/20 the intervention of a door alarm to Resident #12's door was added. Review of Resident #12's care plan dated 08/05/20 revealed Resident #12 desired intimacy and a possible relationship with women. Interventions included to administer medication as ordered per the physician, communicate with the physician as needed for any increase in anxiety or discomfort, refer to mental health for evaluation and treatment, a motion activated door bell was in place to notify staff when anyone goes in or out of the resident's room, provide non pharmaceutical interventions as needed for increased anxiety, monitor resident's relationships and offer emotional support, honor the resident's right for privacy and relationships and provide privacy during periods of intimacy and communicate with resident's family as needed in regards to relationship status. Review of Resident #12's progress notes dated 04/29/20 at 6:08 A.M. revealed Resident #12 was noted to be making sexual comments towards residents and staff. On 05/02/20 around 4:00 A.M., unnamed night shift STNAs were doing rounds and observed Resident #12 in the room with a female resident (#05) who was undressed. Resident #12 was also undressed, and he stated nothing sexual had occurred. The STNAs separated the residents from each other. On 05/04/20 (two days later) Resident #12's physician was made aware of the resident's sexual behaviors. On 05/19/20, Resident #12 was in a dark room with another female resident (#50), who was fully clothed. Resident #12 was reaching out to Resident #50 attempting to touch her. The residents were separated from each other. On 06/03/20 Resident #12 was making inappropriate remarks to staff and the resident was educated. Review of Resident #12's physician's orders [REDACTED].#100 prescribed [MEDICATION NAME] 300 mg twice a day for sexually inappropriate behaviors. Review of progress notes dated 06/10/20 at 5:03 A.M. revealed Resident #12 was noted watching a sexual movie on his personal television and stated, I could watch this movie over and over again. On 06/14/20 at 7:17 P.M., Resident #12 was noted coming out of a female resident's (#115) room by STNAs #180 and #181. Resident #115 was in her bed with her eyes closed. Resident #115 was easily aroused and denied anyone ever being in the room and she appeared in no emotional distress. A physical examination was completed on Resident #115 and the physical was negative. On 07/05/20 at 6:00 A.M., Resident #12 was noted to have another female resident (#20) in his room with her bottoms off underneath the covers. Resident #12 was reported to move away from the bed when nursing staff entered the room. Resident #12 was educated on inappropriate behavior and his routine [MEDICATION NAME] was given. Review of Resident #12's psychiatric progress note dated 07/14/20 revealed the resident was seen by Psychiatric Nurse Practitioner (PNP) #101. The progress note indicated Resident #12 was followed by psychiatry for a history of dementia with behavioral disturbances (his list of active [DIAGNOSES REDACTED]. PNP #101 was requested to follow up for two reasons including a report that Resident #12's insurance would not cover the cost of [MEDICATION NAME] and a female resident was found in resident's room with her pants off. The progress note documented a unit manager indicated this female resident was known for disrobing and wandering into the other resident's rooms. There was no report that the resident was witnessed to have acted inappropriately in this instance. Review of the physician order [REDACTED]. Review of Resident #12's psychiatric progress note dated 07/29/20 revealed the resident was seen by PNP #101. The progress note indicated Resident #12 was followed by psychiatry for a history of dementia with behavioral disturbances, depression and sexual inappropriate behavior. The note indicated PNP #101's last contact with Resident #12 occurred on 07/14/20 and at that time Resident #12 was noted with continued inappropriate sexual behavior despite trial of [MEDICATION NAME]. [MEDICATION NAME] was discontinued and [MEDICATION NAME] 125 mg two times a day was started for management of sexual behavior. There was no report of the resident in any inappropriate sexual behavior since starting [MEDICATION NAME] on 07/14/20. Review of progress notes dated 07/31/20 at 7:25 P.M. revealed Resident #12 was found in his room with another female resident's (#50) breast in his mouth while urinating on himself. STNA #01 immediately called for help and removed Resident #50 from the room. The physician, DON, supervisor and responsible party were notified of the incident. Further review of the progress notes revealed transportation was contacted, and the resident was sent to the hospital around 8:30 P.M. to 9:00 P.M. Resident was being closely monitored on 1:1. Review of Resident #12's hospital discharge summary dated 08/01/20 revealed the resident was seen for increased agitation and being hypersexual with another resident. The summary indicated nursing home staff reported the resident was more agitated and hypersexual. Staff reported Resident #12 was normally sexual with staff, but it was getting worse. Staff at the nursing facility reported Resident #12 had another resident's breast in his mouth and was peeing on himself. Resident #12 was provided with community resources for counseling and psychiatry. Medically acute reasons for mental status were ruled out and the resident was evaluated by the physician, social work and psychiatry. Resident #12 was recommended to follow up with primary care physician and psychiatry in the outpatient setting for further assessment and management. Review of Resident #12's one-on-one monitoring log revealed it had blocks for 30 minute checks. The 30 minute checks were initiated on 08/01/20 at 1:00 P.M. and continued until 08/06/20 at 6:30 P.M. There were no 30 minute checks documented as being completed beginning 08/06/20 from 6:30 P.M. until 08/07/20 at 6:30 A.M. Resident #12's 30 minute checks were documented as being completed on 08/07/20 at 7:00 A.M. until 08/12/20 at 11:00 A.M. Review of progress notes dated 08/05/20 at 4:40 P.M. revealed the resident on 1:1 care, an STNA walked in and found the resident standing in front of the television jacking off. Review of progress notes dated 08/06/20, revealed CTM #102 spoke with PNP #101 regarding Resident #12's increased sexual desires. PNP #101 recommended an increase in Resident #12's [MEDICATION NAME] from 125 mg to 250 mg two times a day. Review of physician orders [REDACTED]. Review of progress notes dated 08/07/20 at 11:26 A.M., as an addendum, CTM #102 documented the resident's daughter informed CTM #102 that her father had been a Gigolo all his life. CTM #102 educated the daughter for the safety of the other residents and himself the increase in medication ([MEDICATION NAME]) was needed. CTM #102 also brought up the possibility the resident might need the services of a men's unit due to behaviors. Review of progress notes dated 08/10/20 revealed Resident #12 had a motion sensor alarm placed on his door on 08/07/20 which was used as an intervention to notify staff of residents or fell ow residents entering and exiting the residents' room. Review of Resident #12's psychiatry progress note dated 08/11/20 revealed the resident was seen by Psychiatrist #100. Resident #12 was seen due to a history of dementia with behavioral disturbance, depression and sexually inappropriate behavior. The note indicated Resident #12 was given a trial of [MEDICATION NAME] and more recently was started on [MEDICATION NAME]. The [MEDICATION NAME] dose was increased to 250 mg twice daily on 08/06/20. The note also indicated Resident #12 was currently on 15 minute checks in order to limit the potential for contact with female residents on the unit (the facility was only completing 30 minute checks). Review of the late entry progress note dated 08/17/20 indicated Resident #12's physician and family were notified of Resident #12's sexual behavior on 05/02/20, 06/14/20 and 07/05/20. Further review of the late entry progress note also indicated on 07/05/20 a large name plate was placed on Resident #12's door to alert residents not to enter and on 08/06/20, 30 minute checks were completed on third shift. Interview with Resident #12 on 08/13/20 at 1:11 P.M. revealed the resident denied having any sexual relationships or participating in any sexual acts at the facility. Interview with STNA #02 on 08/13/20 at 1:15 P.M. revealed Resident #12 had a history of [REDACTED]. Interview with the DON and Administrator on 08/13/20 at 1:25 P.M. revealed Resident #50 was found in Resident #12's room on 07/31/20. Resident #12 had Resident #50's breast in his mouth at that time. The DON stated the facility separated the residents and called Resident #12 and Resident #50's family. The DON reported Resident #12's representative stated the resident had always been a gigolo

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F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 8) and Resident #50's resident representative stated that she was glad Resident #50 was having fun. The DON stated the facility did not suspect abuse and a Self-Reported Incident (SRI) was not completed. The DON stated Resident #12 and Resident #50 were seeking out each other. The DON stated Resident #50's cognition varied at times. The DON and the Administrator did not report any other sexual behaviors in the facility at that time. On 08/17/20 at 4:28 P.M., capacity to consent assessments for Resident's #05, #20, #50 and #115 were requested from the administrative staff but were never provided. After the surveyor reviewed Resident #12's medical record and found other instances of possible inappropriate behavior, a telephone interview with the DON and CTM #102 was conducted on 08/17/20 at 4:29 P.M. to discuss the instances. On 05/02/20 the unnamed night shift STNAs were doing rounds and observed Resident #12 in the room with Resident #50. Both residents were undressed with their shirts off and Resident #12 stated nothing sexual had occurred, but he was separated from Resident #50. On 05/02/20 redirection was implemented, and a care plan was put in place to ensure resident rooms were shut at night and to observe residents nightly. On 05/19/20 Resident #12 was in a dark room with Resident #50 whom was fully clothed. Resident #12 was noted to be reaching out to Resident #50 and attempting to touch her. Resident #12 and Resident #50 were separated. They stated redirection was provided at the time. On 06/03/20 Resident #12 had made inappropriate sexual remarks to staff and on 06/08/20 the resident was prescribed [MEDICATION NAME] 300 mg two times a day for sexual behaviors. On 06/10/20 Resident #12 was watching a sexual movie. On 06/14/20 Resident #12 was noted coming out of Resident #115's room by STNAs. Resident #115 was in her bed with her eyes closed. Resident #115 denied anyone ever being in the room and appeared in no emotional distress and her physical exam was negative. The DON stated redirection was provided at that time. On 07/05/20 Resident #12 was noted to have another female resident (#20) in his room with her bottoms off underneath the covers. Resident #12 was noted to move away from the bed when staff entered the room. They verified education was provided to Resident #12 on inappropriate behavior. On 07/14/20 Resident #12's [MEDICATION NAME] was initiated. On 07/31/20 Resident #12 was found with Resident #50 in his room with his mouth on her breast while urinating on himself. CTM #102 stated Resident #12 was sent to the hospital and 30 minute checks were initiated upon his return from the hospital. The DON verified that 30 minute checks were not documented on third shift on 08/06/20 but she would check with staff to see if the checks were completed or documented in another area. On 08/05/20 Resident #12 had a care plan implemented for desiring intimacy and a possible relationship with women and on 08/06/20 his [MEDICATION NAME] was increased. On 08/07/20 Resident #12 also had a door alarm installed. Both the DON and CTM #102 were unable to verify if any other interventions were attempted or if the physician or responsible parties were notified for any of the above occurrences. Telephone interview with the Administrator on 08/18/20 at 8:28 A.M. revealed the resident actions were often misperceived by the direct care staff and that no one had any intent with any of the sexual incidents that occurred with Resident #12. The Administrator stated that some of the females had sought out companionship. The Administrator stated she was new at the facility and was not able to speak for what the former Administrator did regarding the above incidents. Review of an undated list of residents with sexual behaviors received on 08/13/20 revealed Resident #12 and Resident #50 were listed to exhibit sexual behaviors. Review of the facility's Abuse, Neglect and Exploitation policy dated 11/26/16 revealed the facility will protect its residents from abuse, neglect, mistreatment, exploitation and misappropriation of property. The policy also indicated sexual abuse was nonconsensual sexual contact of any type with a resident. Further review of the policy revealed a prompt and thorough investigation would be conducted. The investigation would include but not be limited to securing resident and witness interviews, gathering tangible evidence and documenting all information gathered. Any suspicions of a crime against a resident shall be reported to the appropriate state agencies. The policy also indicated the facility would monitor the resident for signs of mental, emotional, or physical abuse and notify the resident's physician and resident representatives.
F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NONCOMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on medical record review, observation, staff interview, family interview, review of written statements by staff, review of a police report and review of a facility policy, the facility failed to provide adequate supervision to prevent the elopement of a resident. This resulted in Immediate Jeopardy when one resident (Resident #18) was placed at risk for potential serious harm and injury when the resident eloped from the facility, without staff knowledge, and was missing for approximately two and a half hours. The resident was found across the street from the facility by the police about 200 feet from the facility. The resident was walking back to the facility with a 35 mile per hour speed limit, and two lanes of moving traffic with a blind turn. This affected one (#18) of three residents reviewed for risk of elopement. Additionally, the facility failed to prevent the elopement of another cognitively impaired resident (Resident #10) from a secured care unit placing the resident at risk for potential harm that did not rise to the level of Immediate Jeopardy when she left the secured unit and eloped from the facility, unknown to staff, and fell out of her wheelchair and onto the curb in the facility parking lot. The facility identified eight (#10, #18, #50, #55, #68, #70, #90 and #131) residents at high risk for elopement. The facility census was 99. On 09/02/20 at 2:51 P.M., the Administrator and Director of Nursing (DON) were notified Immediate Jeopardy began on 07/20/20 at 7:00 P.M. when Resident #18 left his room, went through a double door and a sliding glass door and eloped from the facility, unknown to staff. At approximately 8:57 P.M., the resident was located walking back to the facility across the street. The Immediate Jeopardy was removed on 07/24/20 when the eight residents at risk for elopement were reassessed, their Wanderguard alarms were checked for functionality, and staff were educated on the facility's elopement policy. The deficiency was corrected on 07/24/20 when the facility implemented the following corrective actions: On 07/20/20, Resident #18 was moved to the secured memory support unit. On 07/20/20, all Wanderguard alarms for Residents #10, #18, #50, #55, #68, #70, #90 and #131 were checked for functionality by the DON. On 07/20/20, the status of the locking systems on all doors were checked daily by Plant Supervisor (PS) #639 and Plant Maintenance Staff (PMS) #637 and #642. On 07/20/20, all new hires were being provided education during orientation. The facility's Elopement Policy as well as a course entitled Wandering: Elopement Prevention will be provided by Human Resource Director #408. On 07/21/20, an elopement drill was completed by the DON and PS #639 with no identified concerns. On 07/21/20, a meeting with the interdisciplinary team was directed by the DON to discuss safety compliance requirements and steps that were immediately implemented for the safety of the residents who were at risk for elopement in the facility. On 07/22/20, elopement risks were completed. Registered Nurse (RN) #634, who was involved in the incident with Resident #18, was counseled by the Assistant Director of Nursing (ADON) #200. On 07/24/20, all staff were inserviced on the facility's elopement policy. On 07/24/20, all residents were assessed for elopement by ADON #200 and Care Team Managers (CTM) #641 and #102. Findings include: Medical record review for Resident #18 revealed an admission date of [DATE]. The resident had medical [DIAGNOSES REDACTED].#18 was at risk for elopement/or unsafe wandering. Review of the baseline care plan, dated 07/17/20, for Resident #18 revealed he was admitted with behavior concerns related to wandering. The interventions were to place a Wanderguard and maintain the current alarm as ordered. Review of Resident #18's admission Minimum Data Set (MDS) assessment, dated 07/24/20, revealed the resident's cognitive status was moderately impaired. He required limited supervision for bed mobility, transfers, and toileting. He required supervision for eating, and locomotion on and off the unit with one-person assistance. He used a Wanderguard daily, because he was at a significant risk of getting to a potentially dangerous place and the wandering significantly intruded on the privacy of others. Review of the exit door checks documentation dated 07/20/20 at 4:00 P.M. revealed the Terrace Unit double sliding glass doors were unlocked. Review of the facility's incident summary, dated 07/20/20, revealed it was reported at 6:00 P.M. that Resident #18 was missing from the facility. A search began inside and outside the facility grounds. The Administrator, DON, ADON #200, Licensed Social Worker (LSW) #629 and Activity Director (AD) #01 responded to the call. Family was notified. The police were notified and within minutes the resident was found across the street. He was assessed for injuries and none were found. The resident was wearing the Wanderguard. The physician was notified of the incident and agreed to place the resident on a secured unit. The evening maintenance staff checked the egress doors and adjusted the alarm to make it more sensitive. Resident #18 was moved to the secured unit and the Wanderguard remained on the resident. All door alarms were checked with no fault noted. All Wanderguards were checked, all were in place and were functioning. Review of the interview statement with RN #634 on 07/20/20, no time documented and typed by the DON, revealed when making rounds towards the end of her shift, RN #634 could not locate Resident #18. The DON explained the elopement procedure over the phone. RN #634 stated

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	365044	A. BUILDING _____ B. WING _____	09/15/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HYDE PARK HEALTH CENTER	4001 ROSSLYN DRIVE CINCINNATI, OH 45209

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 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 9) she and State tested Nursing Assistant (STNA) #252 looked on the unit but couldn't find him. They alerted other units and they joined in the search. She reported that neither she nor STNA #252 heard a door alarm. RN #634 called the resident's family and reported the incident. The police were called when staff could not find the resident. The statement stated the resident was returned to the facility by the police and had been across the street from the facility. Review of the interview statement with STNA #252, no date or time documented and typed by the DON, revealed she was notified by RN #634 that Resident #18 could not be found. She proceeded to check all rooms, closets, bathrooms, and offices and could not locate him. She reported back to the charge nurse. Review of the 911 incident detail report dated 07/20/20 for Resident #18 revealed RN #634 called 911 on 07/20/20 at 8:47 P.M. and reported Resident #18, with [DIAGNOSES REDACTED]. He was wearing a brown brimmed straw hat, peach colored shirt, and a blue short sleeved shirt underneath, gray pants, and white gym shoes. According to the report, Resident #18 was found across the street from the facility at a business, walking back to the facility at 8:57 P.M. Review of a late entry progress note, dated 07/21/20 at 8:56 P.M. and written by RN #634, revealed Resident #18 was observed in the facility on 07/20/20 at 6:30 P.M. eating in the common area. The note revealed he was not present in his room on walking rounds. Room checks were initiated along with a search of the facility grounds. The facility supervisor, the resident's Power of Attorney (POA), and physician were notified. The resident was found by STNA #252 and redirected back to his room without difficulty. The resident was placed on a memory care unit at 9:00 P.M. Observation of the street in front of the facility on 08/27/20 at 12:13 P.M. revealed it was a 35 mile per hour speed zone on the street. There was a blind turn before you pass the facility. A half a block from the entrance to the facility, there was a building that was part of the facility. Two hundred feet across the street was an industrial building with a parking lot. The traffic was light, and the cars came quickly around the blind turn by the facility entrance. Interview with the DON on 08/27/20 at 1:15 P.M. revealed Resident #18 was reported missing on 07/20/20 at around 6:00 P.M. He was wearing a Wanderguard at the time. She said either the staff didn't hear the Wanderguard alarm because they were busy, the system malfunctioned, or the alarm could have been possibly turned down. She stated interviews with the staff said they didn't hear the alarm. She said a search was done as soon as possible inside the building and when they didn't find him, the search began outside. She stated it was dry and warm and Resident #18 was found across the street. It only took about 20 minutes to find him and he was not injured. She said the police were with the resident but since he was found so quickly, they didn't write a report about it. Interview with PS #639 on 08/27/20 at 1:33 P.M. revealed it was about 6:00 P.M. or so when Resident #18 eloped from the facility. He stated he had just arrived at the facility and the resident was in the lobby and was not injured. He stated he walked Resident #18 in and out of the doors but when he walked him out of the doors, the alarms didn't sound. When he walked him into the facility, the alarms sounded. He stated he adjusted the sensitivity of the alarm and walked the resident in and out and the alarm sounded every time. Observation of Resident #18 on 08/27/20 at 2:19 P.M. revealed he was lying in bed and said hello. During observation on 08/27/20 at 2:43 P.M., Resident #18's prior room was examined with the DON. He lived on the Terrace Unit at the time of the elopement. He walked approximately 500 feet to a set of double doors. There was a posting on the door stating the alarm would sound if the door was opened longer than 15 seconds. When tested , the door alarmed after being opened for 15 seconds. To the immediate left, there was a set of sliding double doors that were not locked. According to the DON, the staff wouldn't be able to hear those doors alarm. She said it was discovered the doors were pried open and off the track. Across the street, adjacent to the doors of the facility, about 200 feet away, was the parking lot of an industrial building where Resident #18 was found. During an interview on 08/31/20 at 12:29 P.M., RN #634 stated the incident happened on 07/20/20 in the evening. She charted a late entry on 07/21/20. She stated Resident #18 was sitting in the common area by the nursing station eating dinner about 6:40 P.M. and she was asked by an STNA, who she couldn't remember the name, to help check and change a resident. She stated she felt like Resident #18 eloped when she was in the other resident's room. She stated she did not hear the door alarm sound. At 7:00 P.M. she was doing walking rounds and went into the resident's room and he wasn't there. She said she alerted staff to search for the resident and alerted the DON, POA and physician. She stated he wasn't found in the facility and so the search ensued outside. He was found at 7:30 P.M. across the street because he thought he worked there. She assessed him and he was uninjured. During an interview on 08/31/20 at 2:55 P.M., STNA #252 stated they noticed about 6:40 P.M. Resident #18 wasn't in his room. She stated she did not hear an alarm sound. They did a search, and everyone was looking for him. They couldn't figure out how he got out of the facility. She said it was at shift change and everyone was looking for him in the facility and moved to the outside of the facility too. She stated she was walking to her car about 7:30 P.M. and the officers had a man detained across the street in the parking lot. She remembered what clothes the resident was wearing. She walked over and discovered it was Resident #18. She said she handed Resident #18 over to the nurse. Review of STNA #252's timecard revealed on 07/20/20 she punched out at 8:40 P.M. Interview with Police Officer #300 on 09/01/20 at 11:15 A.M. revealed there wasn't an officer's report filed for the elopement for Resident #18. She revealed there was a call that came into the precinct of a trespasser in the parking lot of a business across the street from the facility, which was identified as Resident #18. She stated the call came in at 8:29 P.M. and he was located at 9:02 P.M. Interview with the DON on 09/01/20 at 3:42 P.M. revealed she thought the incident with Resident #18 happened around 6:00 P.M., even though the documentation stated he was last seen at 6:30 P.M. in the common area. The DON was informed of the time frame that was received from the police department did not match what the facility documented. She stated, I guess the police would be correct on the timing of the incident. She stated she instructed RN #634 to call the police when the nurse informed her the resident was missing but didn't know what time that was. She said she left the faciity on [DATE] at 9:00 P.M. and the resident was in the facility safe. Subsequent interview with the DON on 09/02/20 at 10:29 A.M. revealed RN #634 called 911 on 07/20/20 past the time she stated to the DON. The DON stated she was out in her car looking for the resident and perhaps the nurse was waiting to hear from her if he was found, to determine if she needed to call 911. When asked why she reported in her investigation he was found within 20 minutes of eloping, she said she didn't know why. When asked why she put in her investigation the incident happened at 6:00 P.M. when it was clearly documented in the medical record he was last seen at 6:30 P.M., she said it was an error. 2. Medical record review for Resident #10 revealed an admission date of [DATE]. Medical [DIAGNOSES REDACTED]. Review of the quarterly MDS assessment, dated 07/15/20, revealed Resident #10 was severely cognitively impaired. She required extensive assistance for bed mobility, transfers and toileting. She required supervision for eating. She used a Wanderguard daily. Review of the Elopement/Unsafe Wandering Risk assessment dated [DATE] revealed Resident #10 was at risk for elopement/or unsafe wandering. Review of the care plan for Resident #10, dated 06/22/20, revealed she was an elopement risk as evidenced by history of resident wandering aimlessly and impaired safety awareness. Interventions were for resident to wear identification bracelet at all times, utilize and check Wanderguard placement as indicated, redirect resident from exit doors, maintain calm attitude when redirecting the resident during a behavior, make sure all staff are aware of elopement risk and the resident resided on the secured unit. Review of the investigation for Resident #10 revealed on 07/18/20 it was reported to the charge nurse Resident #10 had attempted to leave the property. The nurse reported she last saw Resident #10 at 6:45 P.M. Staff were alerted, and the resident was found in the front of the building on facility property. The resident stated she was going home. Resident #10 was assessed and there were no injuries found. She had her Wanderguard on. The physician and family were notified of the incident and one-on-one supervision was initiated. Review of a witness statement from STNA #180, dated 07/18/20, revealed on that date at 6:50 P.M., she pulled into the facility parking lot and saw Resident #10 just outside the Newberry Unit exit door. She immediately called the supervisor's phone and reported the resident was on the sidewalk. Review of the witness statement from STNA #437, dated 07/18/20, reported she was working on the unit for Resident #10 but was with another resident and didn't see or hear anything. Review of the witness statement from Licensed Practical Nurse (LPN) #651, dated 07/18/20, revealed she notified the DON of Resident #10 being outside on this date a little before 7:00 P.M. She stated she saw the resident 15 minutes prior to her being found outside. She was exit seeking all day. There were four nurses and STNA's outside when LPN #651 arrived at the resident. She stated the wheelchair was on the sidewalk and the resident was sitting on the curb. No injuries were noted, and vital signs were within normal limits. Three nurses helped assist the resident to her wheelchair. The Wanderguard was working and setting off the alarms on the way back in the facility. The resident had no complaints of pain. Neurological checks were initiated, and a full body assessment was completed with no abnormal findings. On 07/19/20, Licensed Social Worker (LSW) #629 documented a conversation with the resident's family regarding placement on the secured unit. The family declined to move her at that time and one-on-one continued. On 07/22/20, she was moved to the secured unit. Observation of Resident #10 on 08/27/20 at 2:22 P.M. from the hallway revealed she was lying in bed asleep. Interview with LSW #629 on 09/01/20 at 4:15 P.M. revealed Resident #10 was admitted to the skilled unit on admission, because she came from another facility and had to be in 14-day quarantine because of Covid-19. She stated the family of the resident

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	365044	A. BUILDING _____ B. WING _____	09/15/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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F 0689 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 10) did mention the resident may need to be placed on a more secured unit. LSW #629 said the facility didn't see any behaviors when she came in and there were no conversations with the family that would suggest elopement. During interview on 09/02/20 at 7:08 A.M., STNA #180 revealed as she was pulling into the driveway of the facility at the Transitional Care Unit emergency door in front of the building on 07/18/20 at about 6:25 P.M., Resident #10 was sitting sideways in her wheelchair on the curb right outside of the facility. She said since the resident was a large woman, she ran into the building to get help from another staff member and both went back outside. The resident had fallen out of the wheelchair and was sitting on her buttocks and was not injured. She stated the resident said she was going home and was angry with staff for trying to help her. She stated the resident had her Wanderguard on and the staff members couldn't figure out how she got out of the facility. Interview with LPN #651 on 09/02/20 at 10:34 A.M. revealed Resident #10 had a history of [REDACTED]. She said on 07/18/20 the resident was exit seeking all day and had set off the alarm earlier in the day and the nurse wheeled her back to her room. She stated at 6:30 P.M. she saw the resident and at approximately 6:45 P.M., a nurse came to get her and said the resident was out in the parking lot. She stated she went to assess the resident and she had fallen out of her wheelchair and was sitting on her buttocks with her legs out straight and was up against the curb and the wheelchair was on the curb. She said she didn't have any injuries and the nurse had staff help her get the resident back to her room and called the physician and the POA. She said the POA had voiced to her she wanted the resident to be placed on the secured unit upon admission and was told the facility would have to see the behaviors for themselves before placing her on a secured unit. She stated the POA told her she had a history of [REDACTED]. Review of the facility policy titled Missing Residents, no date, stated if an employee discovers a resident missing from the facility, he/she shall determine if the resident is out on an authorized leave; if not, initiate a search of the buildings and premises. If the resident is not located, notify the Administrator and the Director of Nursing, the resident's legal representative, the attending physician, law enforcement officials and as necessary, volunteer agencies. Provide search teams with resident identification information and initiate an extensive search of the surrounding areas. When the resident returns to the facility, the DON or Charge Nurse shall examine the resident for injuries, contact the attending physician and report findings, notify the resident's legal representative, notify search teams the resident has been located, complete and fill and incident report and document relevant information in the resident's medical record. This deficiency substantiates Complaint Number OH 310.
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** Based on medical record review, investigation review, statement interviews, and staff interview, the facility failed to document accurate information in an investigation related to an elopement. This affected one (Resident #18) of three residents reviewed for elopement. The facility identified eight residents at risk for elopement. The census was 99. Findings included: Medical record review for Resident #18 revealed an admission date of [DATE]. Medical [DIAGNOSES REDACTED].M. that Resident #18 was missing from the facility. A search began inside and outside the facility grounds. The Administrator, DON, ADON #200, Licensed Social Worker (LSW) #629 and Activity Director (AD) #1 responded to the call. Family was notified. The police were notified and within minutes the resident was found across the street. He was assessed for injuries and none were found. The resident was wearing the Wanderguard. The physician was notified of the incident and agreed to place the resident on a secured unit. The evening maintenance staff checked the egress doors and adjusted the alarm to make it more sensitive. Resident #18 was moved to the secured unit and the Wanderguard remained on the resident. All door alarms were checked with no fault noted. All Wanderguards were checked, all were in place and were functioning. Review of the interview statement with RN #634 on 07/20/20, no time documented and typed by the DON, revealed when making rounds towards the end of her shift, RN #634 could not locate Resident #18. The DON explained the elopement procedure over the phone. RN #364 stated she and State tested Nursing Assistant (STNA) #252 looked on the unit but couldn't find him. They alerted other units and they joined in the search. She reported that neither she nor STNA #252 heard a door alarm. RN #634 called the resident's family and reported the incident. The police were called when staff could not find the resident. The statement stated the resident was returned to the facility by the police and had been across the street from the facility. Review of the interview statement with STNA #252, no date or time documented and typed by the DON, revealed she was notified by RN #634 that Resident #18 could not be found. She proceeded to check all rooms, closets, bathrooms, and offices and could not locate him. She reported back to the charge nurse. Review of the 911 incident detail report dated 07/20/20, identifier number CPD 71 for Resident #18 revealed RN #634 called 911 on 07/20/20 at 8:47 P.M. and reported Resident #18, with [DIAGNOSES REDACTED]. He was wearing a brown brimmed straw hat, peach colored shirt, and a blue short sleeved shirt underneath, gray pants, and white gym shoes. According to the report, Resident #18 was found across the street from the facility at a business, walking back to the facility at 8:57 P.M. Review of a late entry progress note, dated 07/21/20 at 8:56 P.M. and written by RN #634, revealed Resident #18 was observed in the facility on 07/20/20 at 6:30 P.M. eating in the common area. The note revealed he was not present in his room on walking rounds. Room checks were initiated along with a search of the facility grounds. The facility supervisor, the resident's Power of Attorney (POA), and physician were notified. The resident was found by STNA #252 and redirected back to his room without difficulty. The resident was placed on a memory care unit at 9:00 P.M. Interview with the DON on 08/27/20 at 1:15 P.M. revealed Resident #18 was reported missing on 07/20/20 at around 6:00 P.M. He was wearing a Wanderguard at the time. She said either the staff didn't hear the Wanderguard alarm because they were busy, the system malfunctioned, or the alarm could have been possibly turned down. She stated interviews with the staff said they didn't hear the alarm. She said a search was done as soon as possible inside the building and when they didn't find him, the search began outside. She stated it was dry and warm and Resident #18 was found across the street. It only took about 20 minutes to find him and he was not injured. She said the police were with the resident but since he was found so quickly, they didn't write a report about it. Interview with Plant Maintenance (PM) #639 on 08/27/20 at 1:33 P.M. revealed it was about 6:00 P.M. or so when Resident #18 eloped from the facility. He stated he had just arrived at the facility and the resident was in the lobby and was not injured. He stated he walked Resident #18 in and out of the doors but when he walked him out of the doors, the alarms didn't sound. When he walked him into the facility, the alarms sounded. He stated he adjusted the sensitivity of the alarm and walked the resident in and out and the alarm sounded every time. During interview on 08/31/20 at 12:29 P.M., RN #634 stated the incident happened on 07/20/20 in the evening. She charted a late entry on 07/21/20. She stated Resident #18 was sitting in the common area by the nursing station eating dinner about 6:40 P.M. and she was asked by an STNA, who she couldn't remember the name, to help check and change a resident. She stated she felt like Resident #18 eloped when she was in the other resident's room. She stated she did not hear the door alarm sound. At 7:00 P.M. she was doing walking rounds and went into the resident's room and he wasn't there. She said she alerted staff to search and alerted the DON, POA and physician. She stated he wasn't found in the facility and so the search ensued outside. He was found at 7:30 P.M. across the street because he thought he worked there. She assessed him and he was uninjured. During interview on 08/31/20 at 2:55 P.M., STNA #252 stated they noticed about 6:40 P.M. Resident #18 wasn't in his room. She stated she did not hear an alarm sound. They did a search, and everyone was looking for him. They couldn't figure out how he got out of the facility. She said it was at shift change and everyone was looking for him in the facility and moved to the outside of the facility too. She stated she was walking to her car about 7:30 P.M. and the officers had a man detained across the street in the parking lot. She remembered what clothes the resident was wearing. She walked over and discovered it was Resident #18. She said she handed Resident #18 over to the nurse. Review of STNA #252's timecard revealed on 07/20/20 she punched out at 8:40 P.M. Interview with Police Officer #300 on 09/01/20 at 11:15 A.M. revealed there wasn't an officer's report filed for the elopement for Resident #18. She revealed there was a call that came into the precinct of a trespasser in the parking lot of a business across the street from the facility, which was identified as Resident #18. She stated the call came in 8:29 P.M. and he was located at 9:02 P.M. Interview with the DON on 09/01/20 at 3:42 P.M. revealed she thought the incident with Resident #18 happened around 6:00 P.M., even though the documentation stated he was last seen at 6:30 P.M. in the common area. The DON was informed of the time frame that was received from the police department did not match what the facility documented. She stated, I guess the police would be correct on the timing of the incident. She stated she instructed RN #634 to call the police when the nurse informed her the resident was missing but didn't know what time that was. She said she left the faciity on [DATE] at 9:00 P.M. and the resident was in the facility safe. Subsequent interview with the DON on 09/02/20 a

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	365044	A. BUILDING _____ B. WING _____	09/15/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HYDE PARK HEALTH CENTER	4001 ROSSLYN DRIVE CINCINNATI, OH 45209

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 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 11) 10:29 A.M. revealed RN #634 called 911 on 07/20/20 past the time she stated to the DON. The DON stated she was out in her car looking for the resident and perhaps the nurse was waiting to hear from her if he was found, to determine if she needed to call 911. When asked why she reported in her investigation he was found within 20 minutes of eloping, she said she didn't know why. When asked why she put in her investigation the incident happened at 6:00 P.M. when it was clearly documented in the medical record he was last seen at 6:30 P.M., she said it was an error. This is an incidental deficiency found during the investigation of Complaint Number OH 310.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, interview with staff and local health department (LHD), review of new admissions, review of staffing schedule, review of infection control log, review of hospital lab results, review of facility policy, review of Centers of Disease Control (CDC) and review of Centers for Medicare and Medicare Services (CMS) guidance, the facility failed to create an observation unit or use appropriate personal protective equipment (PPE) with residents who were newly admitted to the facility within the last 14 days in order to prevent the spread of the coronavirus (COVID 19). The facility also failed to utilize a designated COVID 19 unit and designated staff for a resident who tested positive for COVID 19. This directly affected two residents (#98 and #100) and had the potential to affect 12 other residents (#95, #96, #97, #99, #101, #102, #103, #104, #105, #106, #107 and #108) that resided on the Terrace Unit of the facility. The facility identified two residents (#96 and #98) who were quarantined because of being newly admitted and one resident (#100) who had a positive COVID 19 test. The facility census was 99. Findings include: 1. Review of the Medical record revealed Resident #98 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #98's entry Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was newly admitted to the facility. Review of Resident #98's baseline care plan dated 08/11/20 revealed the resident was alert and cognitively intact. Resident #98 required assistance with bed mobility and transfers. No assistance was noted for toileting, eating, bathing or grooming. Resident #98's baseline care plan indicated the resident was quarantined. Review of Resident #98's progress notes revealed the resident was admitted from the hospital on [DATE]. The resident was noted with abnormal lung sounds on 08/13/20. Observation of the Terrace Unit on 08/13/20 at 10:50 A.M. revealed STNA #251 and STNA #252 went into Resident #98's room without a gown, gloves, goggles/face shield or N95 mask. STNA #251 told STNA #252 that she had been in Resident #98's room three times prior to assist the resident with dressing. There was no PPE cart or sign indicating Resident #98 was on precautions. After entering the room, STNA #251 and STNA #252 came back out of his room and when asked if Resident #98 was on precautions, both STNA #251 and STNA #252 stated they were unaware if Resident #98 was on precautions. STNA #251 and STNA #252 proceeded to go to another resident's room on the same hallway and take the PPE cart that was in front of that room and moved it in front of Resident #98's room. STNA #251 and STNA #252 then donned a gown, gloves and goggles before proceeding back into Resident #98's room. Neither STNA #251 or STNA #252 were wearing an N95 mask when they re-entered Resident #98's room. Interview with STNA #251 and STNA #252 at the time of the observation verified Resident #98 did not have a PPE cart or sign on his door and both STNAs stated they were previously unaware that Resident #98 was on precautions due to him being newly admitted to the facility. STNA #251 stated she had previously went into Resident #98's room three times and provided assistance with dressing and other personal care with only a surgical mask and gloves. STNA #251 stated she did not wear an N95 mask, gown or eye protection because she was previously unaware Resident #98 was on precautions. Observation of PPE carts on the Terrace Unit on 08/13/20 at 12:00 P.M. with Registered Nurse (RN) Unit Manager #255 revealed the PPE in front of Resident #98's room had no N95 masks and no goggles or face shields. The cart only had three gowns in it. Observation of the PPE cart in front of Resident #100's room revealed there were goggles, gowns and gloves in the carts. No N95 masks were in the carts. 2. Review of the medical record revealed Resident #100 was admitted from the hospital on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #100's hospital labs (prior to admission) revealed Resident #100 tested positive for COVID 19 on 07/02/20 and was negative for COVID 19 on 07/08/20 and 07/09/20. Review of Resident #100's admission MDS assessment dated [DATE] revealed the resident was severely cognitively impaired and required limited assistance with bed mobility and personal hygiene. Resident #100 also required extensive assistance with transfers, dressing and toileting and supervision with eating. Review of Resident #100's progress note dated 07/13/20 revealed Resident #100 was admitted from the hospital on [DATE] and Resident #100 had positive COVID 19 results (while in the hospital) Review of Resident #100's progress notes dated 08/08/20 revealed the facility was notified that resident tested positive for COVID 19. Resident #100 was not showing signs of COVID 19. Review of Resident #100's labs revealed Resident #100 was retested for COVID 19 on 08/12/20 and the labs were pending. Observation of the front receptionist desk on 8/13/20 at 9:19 A.M. revealed Administrative Assistant #10 was standing at the desk talking to a mobile x ray vendor with her mask below her chin. Observation of the chapel on 08/13/20 at 9:22 A.M. revealed five staff members were in the chapel for a meeting with two of the staff members having their masks pulled down around their chins. Observation of Assistant Director of Nursing (ADON) #200 on 08/13/20 at 9:24 A.M. revealed ADON #200 came out of the chapel wearing a cloth face mask. Interview with ADON #200 at the time of the observation verified he was in the chapel but stated he was not aware of any staff members with their masks below their chins. ADON #200 verified he was wearing a cloth face covering. Observation of the facility during initial tour with the Director of Nursing (DON) on 08/13/20 at 9:28 A.M. revealed the Newberry Unit was designated as the facility's COVID 19 unit but the unit was vacant. Licensed Practical Nurse (LPN) #201 and Dietician #202 were observed on the Willow Unit wearing a cloth face mask. LPN #205 was observed on the Fountains Unit wearing a cloth mask and State tested Nursing Assistant (STNA) #203 was observed on the Terrace Unit wearing a cloth face mask. Further observation of the Terrace Unit revealed Resident #100 was in a private room with a PPE cart and a droplet precautions sign on the door. Interview with the DON during initial tour verified LPN #201, Dietician #202, LPN #205 and STNA #203 were wearing cloth face masks. The DON stated that the Newberry Unit was vacant and dedicated for COVID 19 residents. The DON reported Resident #100 was originally admitted from the hospital for a short term stay and planned to be discharged to an assisted living. The DON reported Resident #100 tested positive on a rapid test that was given by the assisted living and was being retested for COVID 19. The DON verified that Resident #100 remained on the Terrace Unit in a private room on droplet precautions because the facility did not have the staff to place Resident #100 on the Newberry Unit with designated staff. The DON verified staff that provided care to Resident #100 also cared for all other residents on the Terrace Unit. Interview with ADON #200 on 08/19/20 at 10:05 A.M. revealed ADON #200 was designated as the infection control preventionist at the facility. ADON #200 stated the facility had no trouble getting PPE except gowns but they had enough gowns at that time. ADON #200 stated rooms 1001 to 1008 were designed for new admissions. ADON #200 stated the facility used the same staff to care for the new admissions, COVID 19 residents and other residents on the Terrace Unit and stated staff only have to use PPE such as a gown, gloves, N95 mask and goggles if doing invasive procedures. Interview on 08/13/20 at 10:24 A.M. with LPN #250 revealed LPN #250 took care of all residents on Terrace Unit including new admissions who were on quarantine, Resident #100 who was on droplet precautions for COVID 19 and other residents that resided on the unit. LPN #250 stated Resident #100 was in a private room with a bathroom but that he had to shower in the common shower room on the unit. Interview with RN Unit Manager #255 at the time of the observation verified there were no N95 masks in either PPE cart in from of Resident #98 and Resident #100's rooms. RN Unit Manager #255 stated she had N95 masks in her office. RN Unit Manager #225 also verified Resident #95, #97, #98 and #99 still resided on the Terrace Unit in rooms designated for new admissions under 14 days but were no longer in isolation as they had resided at the facility for over 14 days. Interview with ADON #200 on 08/13/20 at 12:05 P.M. verified that there were no N95 masks in the carts and stated the facility assigned certain staff members N95 masks but did not put N95 masks on the unit due to theft. ADON #200 stated staff did not have to wear N95 masks when going into Resident #100's room unless they were doing an aerosol generating procedure. ADON #200 reported that cloth face masks were not PPE because they were worn to protect the resident and not the employee. ADON #200 stated the facility only had 50 surgical masks available in the facility due to the supplier denying their orders. Interview with on 08/13/20 at 12:12 P.M. with LPN #250 revealed LPN #250 had went into Resident #100's room while only wearing a surgical mask on 08/13/20. When asked if LPN #250 had a N95 mask available, LPN #250 stated she could get one from central supply in the front of the building. LPN #250 verified Resident #100 was on droplet precautions for COVID 19. Interview with STNA #252 on 08/13/20 at 12:22 P.M. revealed STNA #252 wore a gown, gloves and two surgical masks into Resident #100's room. STNA #252 stated she was assigned an N95 mask, but she kept it in her locker and would wear it if she could get to it. STNA #252 verified she had been in Resident #100's room on that date while only wearing a surgical mask. STNA #252 verified Resident #100 was on droplet precautions. Observation of Terrace Unit on 08/13/20 at 12:46 P.M. revealed STNA #252 delivered Resident #100's lunch tray. STNA #252 looked through the PPE cart and made a statement to STNA

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 12) #251 that RN Unit Manager #255 told her she was going to put N95 masks in the cart. STNA #252 then went into the break room and returned while wearing an N95 mask. STNA #252 sanitized her hands and donned her gown and her gloves. She also wore her personal glasses. STNA #252 doffed her gown and gloves while in Resident #100's room and came out wearing her N95 mask. STNA #252 asked the surveyor what she should do with the N95 mask as she was taking it off outside of Resident #100's room. STNA #252 put the N95 mask in a plastic bag that she had previously gotten her gown out of and put the bag with the N95 mask in her in pocket and sanitized her hands with hand sanitizer. STNA #252 went back to the break room to get her surgical mask and proceeded to pass lunch trays to other residents on the unit. Interview with the DON, Administrator and Unit Manager #105 on 08/18/20 at 9:57 A.M. revealed Resident #100 had COVID 19 while at the hospital and that he tested negative two times prior to being admitted to the facility. The DON reported Resident #100 was supposed to be discharged to an assisted living but tested positive for COVID 19 9 on 08/08/20. The DON stated the facility placed Resident #100 on precautions on the Terrace Unit and retested Resident #100 on 08/10/20 but the sample was insufficient. Resident #100 was retested for COVID 19 on 08/13/20 and was positive for COVID 19. The DON stated that a former resident (#500) had tested positive for COVID 19 on 07/29/20 after being tested because of having a fever. Resident #500 was also placed in isolation in a private room on the Terrace Unit but discharged from the facility on 08/07/20. The DON verified neither Resident #100 or Resident #500 were moved to the COVID 19 Newberry Unit. Interview with Local Health Department (LHD) #300 on 8/18/20 at 1:42 P.M. revealed the facility informed LHD #300 that they had enough PPE and the facility had not reported any PPE shortages. LHD #300 reported she provided the facility with a list of resources to help them obtain PPE, if needed. LHD #300 reported she recommended they move all residents that test positive for COVID 19 to a separate COVID 19 unit and that they wear full PPE including a gown, gloves, face shield, booties and N95 mask when in close contact with residents with COVID 19. Review of the facility's infection control log from 07/01/20 to 08/13/20 revealed Resident #100 was the only resident in the facility with COVID 19 Review of staffing schedules from 07/30/20 to 08/13/20 revealed no designated staff were assigned to Resident #100 (who was on droplet precautions for COVID 19), on the Terrace Unit. Review of the facility census revealed 14 Residents (#95, #96, #97, #98, #99, #100, #101, #102, #103, #104, #105, #106, #107 and #108) resided on the Terrace Unit. Review of the facility's undated list of new admissions provided on 08/13/20 revealed two residents (#96 and #98) were quarantined due to being new admissions. Review of the facility's Behaviors of Staff, Visitors and Vendors to Prevent to Spread of COVID 19 Virus policy dated September 2017 revealed care staff must wear appropriate PPE for the setting and staff working in an area of COVID 19 must wear a mask, goggles and gown. The policy indicated staff assigned to a unit which has COVID 19 residents will remain on the unit and be assigned to that unit each day they work at the facility. Review of the facility's Staff training to prevent the spread of COVID 19 throughout the building policy dated 04/06/20 revealed nursing staff will be trained specific to nursing and COVID 19 with an emphasis on hand hygiene, PPE use, infection control and monitoring for conditions related to COVID 19. Review of the facility's To prevent the spread of COVID 19 virus through admissions policy dated 04/06/20 revealed admits from the hospital will be sent to Terrace rooms 1001 to 1008. Admissions will remain in that location for 14 days. After 14 days and 72 hours without symptoms and fever reducing mediation, the admit can be relocated to another unit. If the new admit continues to need therapy, they may remain on the unit and be transferred to another room on the Terrace Unit. If they do not need therapy, then they may be transferred to another unit. The policy also indicated that after admission all residents will be put on droplet isolation. All staff must wear gowns, gloves, masks and goggles or appropriate PPE when entering rooms. Review of the facility's Isolation Policy for COVID 19 undated revealed anyone who has tested positive will be placed on droplet isolation per the CDC. Residents who test positive will be placed on an isolation wing or an isolation area with dedicated staff who will provide care only to these residents. If staffing is not adequate to allow for dedicated unit, residents will isolate in assigned rooms with appropriate isolation protocols to promote infection control and safety. Droplet isolation precautions will be maintained for 14 days following collection of their COVID 19 test. N95 masks are to be worn when providing a COVID 19 positive patient with any aerosol generating procedures. Otherwise a surgical mask may be worn. Review of CMS and CDC's COVID 19 Long Term Care Facility Guidance (https://www.cms.gov/files/document/4220-covid-19-long-term-care-facility-guidance.pdf) dated 04/02/20 revealed full PPE should be worn per CDC guidelines for care of any resident with known or suspected COVID 19 per CDC guidance on conservation of PPE. The guidance also reported long term care facilities should separate resident who have COVID 19 from residents who are COVID 19 negative. Further review of the guidance revealed facilities should use separate staffing teams for COVID 19 positive residents to the best of their ability to avoid transmission within long term care facilities. Review of an online resource from the CDC (https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html) entitled Responding to COVID 19 in nursing homes dated 04/30/20 revealed if a resident is confirmed to have COVID 19 regardless of symptoms, they should be transferred to the designated COVID 19 care unit. Further review of the guidance revealed cohorting residents on the same unit based on symptoms alone could result in inadvertent mixing of infected and non-infected residents. HCP should use all recommended PPE to care for all residents on affected units including both symptomatic and asymptomatic residents. Further review of the guidance revealed dedicated HCP should be assigned to work only the COVID 19 care unit. The guidance also stated the facility should create a plan for managing new admissions and readmissions whose COVID 19 status is unknown. Options include placement in a single room or in a separate observation area so the resident can be monitored for evidence of COVID 19. The article also indicated all recommended COVID 19 PPE should be worn during care of residents under observation, which includes use of an N95 or higher-level respirator, eye protection, gloves, and gown. Further review of the article revealed a single negative test upon admission does not mean that the resident was not exposed or will not become infected in the future. Newly admitted or readmitted residents should still be monitored for evidence of COVID 19 for 14 days after admission and cared for using all recommended COVID 19 PPE. Review of the CDC's article Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the COVID 19 Pandemic article (https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Finfection-control%2Fcontrol-recommendations.html) dated 06/15/20 revealed staff who enter the room of a patient with suspected or confirmed COVID 19 infection should adhere to Standard Precautions and use a National Institute for Occupational Safety and Health (NIOSH) approved N95 or equivalent or higher-level respirator, gown, gloves, and eye protection. Review of an online resource from the CDC (https://www.cdc.gov/Coronavirus/2019-ncov/hcp/long-term-care-strategies.html) dated 06/25/20 revealed the following guidance regarding facemask's: ensure all healthcare care personnel (HCP) wear a facemask or cloth face covering for source control while in the facility. Cloth face coverings are not considered personal protective equipment (PPE) because their capability to protect HCP is unknown. Cloth face coverings should not be worn instead of a respirator or facemask if more than source control is required. Review of an online resource from the CDC (https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/how-to-wear-cloth-face-coverings.html) dated 07/06/20 revealed the following guidance regarding proper wearing of face coverings: put it over your nose and mouth and secure it under your chin.