STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365530	A. BUILDING _____ B. WING _____	09/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DELHI POST-ACUTE	5999 BENDER ROAD CINCINNATI, OH 45233

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0607 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff and resident interviews, observation, and review of the facility's Abuse policy and procedures the facility failed to implement their policy when they failed to report an incident of a possible sexual inappropriate behavior to the state agency. This affected two Residents (#01 and #03) of three residents reviewed for abuse. The facility census was 66. Findings include: 1. Review of the medical record for Resident #01 revealed an admission date of [DATE]. His [DIAGNOSES REDACTED]. Review of his care plan initiated 03/26/20 for mood/behavioral disturbances and hypersexuality indicated he exposed himself at times and liked to be in bed with no clothes on his bottom half. Interventions included medications as ordered and to intervene as necessary to protect the rights of others. Review of his Minimum Data Set ((MDS) dated [DATE] revealed he had moderate cognitive impairment. Review of nursing progress notes dated 05/21/20 at 5:01 A.M. revealed the resident had his penis exposed and boxers down trying to have sexual relations with another resident (#03) who entered his room. Resident (#03) was removed from the residents room. Resident #01 continued to ask staff if he could see their buttocks. Review of nursing progress notes dated 05/21/20 at 4:28 P.M. revealed writer was notified of a female resident being in resident's room and the male resident appeared to be inappropriate with the female resident. It was reported that staff entered into the resident's room due to his call light being on and a female resident was noted to be directly over the resident. The male resident was lying in bed with his penis exposed. Resident frequently has his belt undone or only wears boxers while lying in bed. Female resident was noted to be fully clothed and was immediately and easily redirected from the male resident's room. When resident was questioned regarding situation, he denied being/attempting to have any type of relations with the female resident. Resident reported that many resident's come in and out of his room frequently and he pulls the call light to call for staff. Resident again was questioned about any type of relations with female resident and again denied. Resident then began speaking about his daughter being upset with him and his amount of alcohol consumption resulting in his admit to the facility. Writer then oriented resident back to original conversation and he again denied and began speaking about the church. Stop sign was placed outside of residents door to prevent wandering residents from entering resident's room. Social Worker Designee (SSD) and writer then called and spoke to residents daughter, and informed her of the situation at hand. Daughter informed SSD that resident has had previous behaviors of being verbally inappropriate sexually towards nursing staff. SSD requested that daughter sign psych consent for resident to be followed by psych to help with any medication that may be needed. SSD also questioned if daughter would be ok with allowing resident to be moved to another unit, where residents do not typically wander. Daughter was in agreement with psych and room move. Writer contacted Psych Nurse Practitioner (NP), and informed her of resident situation. New orders were received for [MEDICATION NAME] (a H2 blocker that reducing sexual desire in both sexes and affects arousal and orgasm) 400 milligram (mg) daily for hyper-sexuality and the NP will see resident on her next visit. Resident was informed that staff had spoke with daughter, guardian, and that he will begin new medication and be transferred to the 5th floor. Resident reluctant, but in agreement. Interview and observation on 09/08/20 at 12:30 P.M. revealed Resident #01 was in his room on the 6th floor, completely clothed. Resident #01 denied any sexual encounters with other residents, he stated that people had came into his room frequently and he didn't like it. Resident #01 further stated he puts on his call light to get unwelcomed people out of his room. Resident #01 then became agitated and told the surveyor to leave. 2. Review of the medical record for Resident #03 revealed an admission date of [DATE], [DIAGNOSES REDACTED]. Interventions included to intervene as appropriate and attempt to determine reason for wandering. Review of her MDS dated [DATE] revealed she had severe cognitive impairment. Review of nursing progress notes dated 05/21/20 at 5:07 A.M. revealed the resident entered another resident's (#01) room and started to straddle him. Resident was removed from the male residents' room. Resident has not complained of any pain or discomfort. Resident in room in bed asleep with call light within reach. Review of nursing progress notes dated 05/21/20 at 3:58 P.M., revealed writer was notified of situation that resident was wandering in and out of many resident's rooms during the night and not sleeping per her norm. It was reported that resident was located in male resident's (#01) room, fully dressed, and leaning over the other resident that was reported to be lying in bed at the time. Resident was redirected from room and monitored closely throughout the night and was later noted to be resting quietly in her bed with eyes closed. SSD called and spoke with resident's power of attorney (POA), concerning the situation. POA was understanding of situation and also gave permission via phone for resident to be seen by psych services. Writer spoke with psych NP, regarding resident appearing to not sleep well at night and continue to wander. NP reported that she would see her at next visit and agreed that a urinalysis with culture and sensitivity should be checked since the resident's behavior was slightly off per resident's norm. POA notified of new order. Interview on 09/08/20 at 12:45 P.M. with Administrator In Training (AIT) revealed on 05/21/20 during the night shift, Resident #01 was in a compromising situation with Resident #03, where Resident #03 was found fully dressed and astride Resident #01, who had his pants down. AIT indicated the facility had investigated and found no evidence of any misconduct. AIT confirmed the facility did not self-report this incident to the state agency. Interview on 09/08/20 at 1:10 P.M., Resident #03 denied any recollection of an incident with Resident #01. Interview by phone on 09/08/20 at 3:40 P.M. Licensed Practical Nurse (LPN) #201 stated she was on break when the incident occurred on 05/21/20 between Resident #01 and Resident #03. When she came back from break, State tested Nursing Assistant (STNA) #200 informed her that Resident #03 was in Resident #01's room straddling him. LPN #201 stated Resident #01 used his call light frequently that night, but he was known to use it to get help to remove other residents from his room. LPN #201 stated that Resident #01 had a history of [REDACTED]. Resident #01 was not on the unit when she returned to work two days after this situation occurred. LPN #201 was able to verbalize what to do to address a sexual encounter and stated she informed her supervisor about the situation. Interview by phone on 09/08/20 at 3:55 P.M., STNA #200 stated the situation between Resident #01 and Resident #03 occurred on her first night shift working in the facility. She reported the situation to LPN #201. Resident #01 was sexually forward, and he put his call light on frequently that night. She thought it was because he knew she was new. STNA #200 saw Resident #03 wandering on the far end of the unit, near Resident #01's room. STNA #200 went down the hallway where Resident #03 had been wandering and Resident #01's call light came on. When STNA #200 entered the room she saw Resident #03 was straddling Resident #01, who was lying in bed. Resident #03 was completely clothed; Resident #01 had his pants on but they were unbuttoned and his penis was exposed. No intercourse or contact was noted. STNA #200 immediately removed Resident #03 from Resident #01's room and the resident's were closely monitored the rest of the shift. Review of Abuse Prohibition Policy and Procedure, undated, revealed sexual abuse includes but not limited to sexual harassment, sexual coercion or sexual assault. Further review revealed the Administrator, or designee, who is in charge of the facility shall report any instances of suspected abuse, neglect or misappropriation of resident property to the Department of Health as required. Review of Abuse Policy dated 12/2016 revealed the facility will investigate and report any allegations of abuse within timeframes as required by federal requirements. This is an incidental finding discovered during the investigation of Complaint Number OH 567.
F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Timely report suspected abuse, neglect, or theft and report the results of the**

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

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F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) **investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff and resident interviews, observation, and review of the facility's Abuse policy and procedured the facility failed to report an incident of a possible sexual inappropriate behavior to the state agency. This affected two Residents (#01 and #03) of three residents reviewed for abuse. The facility census was 66. Findings include: 1. Review of the medical record for Resident #01 revealed an admission date of [DATE]. His [DIAGNOSES REDACTED]. Review of his care plan initiated 03/26/20 for mood/behavioral disturbances and hypersexuality indicated he exposed himself at times and liked to be in bed with no clothes on his bottom half. 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Further review revealed the Administrator, or designee, who is in charge of the facility shall report any instances of suspected abuse, neglect or misappropriaton of resident property to the Department of Health as required. Review of Abuse Policy dated 12/2016 revealed the facility will investigate and report any allegations of abuse within timeframes as required by federal requirements. This is an incidental finding discovered during the investigaton of Complaint Number OH 567.