STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E848	A. BUILDING _____ B. WING _____	08/25/2004

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F9999	FINAL OBSERVATIONS 300.1210(a) 300.3240(b) 300.3240(f) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.	F9999		

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F9999	Continued From page 24 A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the Long-Term Care facility is the perpetrator of the abuse that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. These requirements are not met as evidenced by : Based on observation, interview, and record review the facility failed to protect one randomly sampled cognitively impaired resident, R9, from repeated episodes of sexual abuse. Facility staff failed to follow the plan of care for R13 that identified R13 as a potential sex abuser toward cognitively impaired female residents. Facility staff also failed to report the observed sexual abuse episodes against R9 to the Administrator. Staff's failure to report prevented the investigation of the observed sexual abuse episodes and prevented ongoing protection of R9 from abuse. Findings include: Observation of R9 on 8/17/04 and throughout the survey, shows an ambulatory female with a shuffling gait and a generalized flat affect.	F9999		

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F9999	Continued From page 25 Attempts to interview R9 were not successful in gaining any relevant or pertinent information. The facility has designated R9 as "Not Interviewable". Review of R9's clinical record show R9 is a 42 year old female. Record review of R9's most recent Physician's Orders dated August of 2004, indicate R9 is a resident with diagnoses of Anoxic Encephalopathy, Dementia, and Seizure Disorder . Review of a Physician's Progress Note dated 9/ 12/03 show R9 has identified behaviors. The note states, "Apparently this patient is having a lot of problems with (her) behavior. (She) has been yelling and screaming at people. The patient has also made inappropriate sexual comments with the male co-workers and the staff." Review of a nurses note dated 4/15/04 show R9 makes inappropriate sexual advances. The note states, "(Resident) has been sexually inappropriate to male Certified Nurses Assistant (CNA) this evening..." Review of R9's most recent Care Plan with a goal target date of 10/7/04 indicates R9 is at risk for abuse. Under the heading "Problems/Needs" the plan states "Risk for Abuse." Interview with Z1, R9's family member and Power of Attorney (POA) indicates a concern with the resident's safety at the facility. Z1 states in interview on 8/19/04 at approximately 8:00 AM, " The nursing home had informed me a man was in her (R9's) room trying to make her lay down. He had been in several other times. He (the man)	F9999		

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follows her down to her room." Z1 further states that "(R9) is not able to make informed consent to any sexual activity."

Record review of R13's most recent Physician's Order Sheet dated August of 2004 show diagnoses of Chronic ETOH (alcohol) abuse, Chronic Dementia, and Psychotic Mood Disorder.

Observation of R13 on 8/17/04 and throughout the survey show a male resident in a motorized wheelchair, moving about the facility at will, interacting normally with other facility residents. R 13 maintains animated expression and appears alert and oriented to his surroundings. It was also observed that R13 was allowed to carry his own cigarette lighter and was able to use his hands and arms for smoking. R13 is designated as interviewable by the facility.

Interview with R13 on 8/18/04 at approximately 10:20 AM confirm R13 is alert and oriented. R13 answers questions suitably and politely with appropriate facial expression and vocal intonations. R13 knows who he is, where he is, and the day of the week. In the course of the interview R13 expressed a desire to move out of the facility and into a highrise.

Review of nurses notes dated 3/8/04 indicates R 13 is alert and possesses a degree of normal cognitive functions. The note states, "Cognitive patterns: (R13) is alert and oriented times 3. Short (and) long term memory is good. Remembers routine well. (R13) does have a Power of Attorney (POA) but he is currently requesting to become his own POA. (R13) can make own decisions on some aspects but he

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F9999	Continued From page 27 does not always make decisions that are safe for himself." Record Review of R13's nurses notes dated 11/02/03 at approximately 6:30 PM shows the following. "(Resident) has been noted to have (R16) female (resident) (with) dementia in room. (Resident) separated x 3. Noted to be having inappropriate behaviors..." Interview with E5, Social Service Director (SSD) on 8/18/04 at approximately 5:45 PM confirms a care plan for sexually inappropriate behaviors was based on the 11/2/03 incident. The SSD states, "I was told by the Care Plan Interdisciplinary Team that (R13) had been caught - (R13) would attempt to touch inappropriately, a cognitively impaired female resident (R16 was discharged to another facility). That is where the care plan came from." Review of R13's Care Plan dated 11/06/03 shows the following need/problem. "Sexually inappropriate behavior x 1. Plan or approach #1-Do not allow him to be alone (with) confused female residents. Plan or Approach #2 - Monitor for covert or overt sexual approaches to other residents and/or female staff." Interview with E10 (CNA) on 8/19/04 at approximately 10:40AM states R13 was caught in the bathroom with R9. E10 states, "I caught them once in the bathroom. I was going past and I heard them talking so I knew he wasn't in there by himself. I knocked, no one said anything. I pushed open the door a crack and I saw (R9) she was standing up. She had her clothes on. I tried to push the door open but he (R13) was up	F9999		

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against the door (in his scooter). I went and got (E2 DON). I have seen him (R13) coming from her room (R9) when she was in there. I know he (R 13) was always around her. If you say anything to him (R13) he goes off."

Record review of a nurses note for R13 dated 7/ 23/04 confirms the interview with E10 (CNA). The note states,"Res (resident) noted to be in south hall shower room with a female res (R9) (with) altered mental status. She (R9) was on the toilet. Res (R13) had doorway to (bathroom) blocked (and) res (R13) would not allow entrance (after) 2 attempts to enter. Res (R13) finally came out of (bathroom) stating 'nothing happened I was just waiting on her to finish using the (bathroom).' After female (R9) exited the restroom writer observed Res (R13) talking quietly (with) the female resident..."

Incident/accident reports show no mention of the above incident. Interview with E1 Administrator, and E2 DON on numerous occasions throughout the survey confirm an abuse investigation for the above incident was not done.

Interview with E12 (CNA) on 8/19/04 at approximately 3:45 PM shows staff were aware of R13's attraction for R9. E12 states, "I have observed (R13) whispering to (R9) and after that (R9) walking to her room and (R13) following her. I (E12) talked to (R9) to ask what (R13) was saying. (R9) said (R13) told her he loved her and they were going to be together. Last Saturday (8/ 14/04), (E14, CNA) and I went to (R9's) room and witnessed (R13) was in his wheelchair and (R9) was in her recliner. After I walked (R13) out of the room and back to the nurses station I went back

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F9999	Continued From page 29 to (R9's) room. She had a low cut shirt on and I saw her bra was above her breasts - and her breasts were bare under the shirt. I have seen him (R13) follow her 3 or 4 times since his girlfriend left about 1 month ago. His activity toward (R9) has increased. (I told E8 Licensed Practical Nurse (LPN) that I caught R13 in R9's room)." Record review of R13's and R9's nurses notes show no record of the above incident. Record review of the incident/accident reports show no mention of the above incident. Interview with E1 Administrator, and E2 DON on numerous occasions confirmed they had no knowledge of the above incident. Interview with E6 (CNA) on 8/18/04 at approximately 5:45 PM confirms the above incident and another incident that took place in the TV lounge. E6 states, "I saw (R9) sitting in her chair in her room. Then I heard (R13's) (motorized) wheelchair go into (R13's) room. She was bent over him with her hand reaching toward his britches. (E12) CNA observed this - we were concerned - (E12 CNA) ran him (R13) out of her (R9's) room. There was an incident 2 weeks ago where he (R13) was fondling (R9's) butt. This was in the dining room. The impression I am getting is the nurses know about this." Interview with E6 on 8/19/04 at approximately 2: 00 PM indicates initial reporting of the dining room incident. E6 states "I documented the actions (R13 sexually patting R9 on the buttocks) on the back of his (R13's) behavior sheet. The charge nurse was aware." Record review of nurses notes and incident/accident reports find	F9999		

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no reports of this incident. Interview with the Administrator and the DON on 8/19/04 at approximately 4:00 PM indicates they had no knowledge of the incident.

Interview with a confidential source on 8/18/04 at approximately 5:15 PM, confirms knowledge of R 13's behaviors toward R9. The source states, "He (R13) would often go to her (R9's) room 2 -3 times a week. I saw him come out of her room with his pants unzipped. We told (E9, RN)."

Record review of nurses notes dated 8/14/04 at 2 :30 PM show another instance of sexual abuse on the part of R13 toward R9. The notes state, " Res (R13) noted to have younger female resident (R9) in a corner kissing her on the mouth, neck, and face..." Review of another note of the same date at 4:20PM states, "Res (R13) continues to remain near to young female res (R9) will continue to monitor."

Interview with the Administrator and the DON on 8/19/04 at approximately 2:00 PM confirm neither had knowledge of the 8/14/04 incident or of any occasion when R13 had left R9's room with his pants unzipped. In both episodes an investigation was not initiated.

Interview with E9 RN on 8/19/04 at approximately 9:40 AM confirmed a knowledge of some activity on R13's part. E9 states, "I heard a few things that they (CNAs) had found him down in her room. They (CNAs) had a concern that something was going on. The aides told me that ." At the time of the interview E9 was asked about R13's care plan and the need to keep R13 separated from cognitively impaired females. E9

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F9999	Continued From page 31 states, "I have never checked his careplan. I would have watched him closer had I known." E9 further states, "She (R9) is definitely not able to give sexual consent." Interviews with the DON and the Administrator on 8/19/04 at approximately 2:00 PM confirm R9 is not cognitively intact enough to give informed consent to sexual relations. Interview with E5, Social Service Director (SSD) on 8/18/04 at approximately 5:45 PM also confirm that R9 is not cognitively intact enough to give consent to sexual relations. The facility is still in the process of educating management and staff on the importance of reporting allegations of abuse immediately, and investigating the allegations thoroughly.	F9999		