STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145770	A. BUILDING _____ B. WING _____	C 10/20/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARROLL CO GOOD SAMARITAN CTR	**1006 NORTH LOWDEN P.O. BOX 111 MOUNT CARROLL, IL 61053**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Incident Report Investigation of 9/28/06/ IL25221 A Partial Extended Survey was conducted.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State	F 225		10/28/06

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 225	Continued From page 1 survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to conduct a thorough and systematic investigation of an incident of inappropriate sexual behavior involving 2 residents, R1 and R2. This is for 2 (R1, R2) of 3 residents in the sample. The example includes: R2 is an 84 year old confused male resident who was observed in the room of R1, a confused female resident on 9/28/06 at 2:30 PM. R2 was in his wheel chair sitting at the side of R2's bed. With one hand, R2 was attempting to pull down R1's pants and his other hand was up R1's shirt. R2 was removed from R1's room. Both residents at the time of the incident lived on the 100 hall. R2's room number was 103 and R1's room number is 108, which is 2 doors away from room 103. Neither room can be visualized from the nurses station. There are 6 alert female residents residing on the 100 wing. Review of the facility investigation of the 9/28 incident shows that none of those residents had been interviewed prior to 10/10/06, to see if they had observed or been threatened by inappropriate sexual behavior of R2. On 10/12/06 at 3:15 PM, E4(Social Service	F 225		

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F 225	Continued From page 2 Director) provided a list of 5 residents she interviewed following the incident on 9/28/06. Two of the residents (R8, R9) were not interviewed by E4 until after 10/10/06. E4 was not able to give the dates of the other interviews. Two other alert female residents (R5, R7) residing on the 100 wing, were not interviewed at all. E4 said that she randomly interviewed the residents when she would see them.	F 225		
F 324 SS=J	483.25(h)(2) ACCIDENTS The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to supervise R2 to assure the safety of a female resident by not identifying a resident's sexually inappropriate behavior and not monitoring a resident's (R2) whereabouts after staff were made aware of an incident on 9/28/06. These failures resulted in R2 touching R1 under her shirt and pulling her pants down. An Immediate Jeopardy was identified on 10/19/06 at 9:00 AM. The Immediate Jeopardy was determined to have begun on 9/28/06 at 11:30 AM. While the immediacy was removed on 10/20/06, the facility remains out of compliance at a severity level 2. Additional time is needed to monitor and evaluate the effectiveness of the facility's revised policies and procedures to ensure their implementation. This is for 1(R2) of 3 residents in the sample. The examples includes:	F 324		11/14/06

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F 324	Continued From page 3 R2 is an 84 year old male resident with the diagnosis of Depressive Disorder, according to the October 2006 Physician Order Sheet. R2's 7/26/06 Minimum Data Set(MDS) shows that the resident is moderately impaired in cognitive skills for daily decision making and that he requires supervision. The MDS also shows that R2 has short term memory deficit. According to his 7/26/06 MDS he has no range of motion limits. On 10/10/06 at 9:30 AM, E5 (Certified Nursing Assistant - CNA) said that R2 was "acting up" on 9/28/2006. She said that at about 11:30 AM R2 refused to go to the dining room for lunch. R2 made a sexual comment to E5 , "I'm hot, I need a piece of ---. I haven't had any in a long time". E5 said that R2 kept repeating the sexual comment to other residents and staff. E5 said that R2 kept going up and down the halls in his wheel chair, trying to go into the rooms of female residents. E5 said the behavior was reported to the charge nurse (E8) and the nurse caring for the resident (E9). E5 said that she was told by E8 to shut the doors of all female residents rooms. E5 said that she observed that R2 was not in his room at about 2:30 PM on 9/28 . R2 was in R1's room. He was seated in his wheel chair next to R1's bed, his chair alarm was still intact and not alarming. E5 observed R2 attempting to pull down R1's pants with one hand, and his other hand was up R1's shirt. E5 attempted to remove R2 from R1's room. R2 was resistive, grabbing onto things in the room to make it difficult for E5 to remove him. E5 summoned assistance. E3(Activity Director) helped her remove R2 from R1's room. E5 said that R2 kept saying "I'm hot, I have a date". On 10/10/06 at 9:55 AM E3 said that same day (time unknown), R2 had gone to R3's room. R3	F 324		

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F 324	Continued From page 4	F 324		

is a good friend of R2 from when they both lived outside of the facility. R2 had never gone to R3's room before. R3 had always visited R2 in his room. R3 refused to allow R2 into her room. According to E3, R3 had told an Activity Assistant that earlier in the day R2 had spoken inappropriately to her and she was upset by it.

On 10-10-06 at 8:30 AM, E1(Administrator) was asked what the facility had done to monitor the behavior of R2 and protect the other female residents after the incident on 9/28/06. E1 said that a yellow strip has been placed across R1's door to prevent unwanted visitors. A Psychiatric Evaluation was ordered by R2's physician and was completed. The results of the evaluation has not been returned to the facility.

On 10/10/06 at 9:00 AM, E6(CNA) said that R2 moves about the building freely. When he has inappropriate outbursts 1:1s are done with him. E6 said that R2 continues to say inappropriate things to female staff. To her knowledge he has not been inappropriate with any residents.

On 10/10/06 at 9:10 AM, E 7(CNA) said that on the day of the incident (9/28/06) R2's room (#103) was on the same wing as R1's (#108). He has since been moved to the 200 wing. E7 said that since the incident the staff watch him closely. E7 is uncertain if R2 has a Behavior Tracking Sheet.

On 10/10/06 at 9:15 AM, E4 (Social Service Director) said that the incident on 9/28/06 has been Care Planned for. When R2 is in bed he does not have the ability to transfer himself. He has a bed alarm, so if he gets out of bed the staff are aware of it. When R2 is out of bed he is

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F 324	Continued From page 5 under close supervision. When his behavior is inappropriate 1:1's are initiated. The Interdisciplinary Progress Notes dated 10/07/06 at 9:35 PM documented that R2 is out of bed and up in hall walking with a walker. On 10/10/06 at 10:00 AM E2, (Director of Nursing-DON) said that R2 was not moved to room 210 (a different hall) until 10-6-06 (8 days after the incident of 9/28/06). She said that the reason it took 8 days to move R2 to another hall is that the Interdisciplinary Team was deciding what interventions should be implemented. E2 was asked how they are certain that R2 won't be physically inappropriate with other residents. E2 said that when he is in bed, he is in a low bed with a bed alarm. He is unable to get out of the low bed without assistance. When R2 is in his wheel chair he has a personal alarm to alert staff that he is trying to get out of his wheel chair. R2's Care Plan dated 9/28/06 lists inappropriate sexual expression with other residents and staff as the problem. The interventions are: if resident is expressing sexual desires, offer him privacy in his room. If resident refuses private time in his room, do 1:1 supervision to ensure the safety of others. Review of the Certified Nursing Assistant documentation shows that since 9/29/06 R2 continues inappropriate with female staff. On 9/30/06 a female CNA was assisting R2 in getting ready for bed. R2 asked the CNA if she was going to bed with him. On 10-1-06 on the 6AM-2PM shift, R2 asked E6 (CNA) if she was married. E6 said that she was. R2 replied "well I won't do anything with you now". On 10/3/06 on the 6AM - 2PM shift E6 documented that R2 was	F 324		

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F 324	Continued From page 6 trying to get into a female resident's room. On 10/5/06 at 12:00 AM R2 was out of bed going to the Bathroom. He asked the CNA "Where is R3? I was looking to have relations". On 10/7/06 on the 2PM - 10 PM shift it is documented that the CNA was assisting R2 back into bed. R2 began grabbing at the CNA and would not let go. The CNA wrote "whenever I could get my arms free to go get help he would try to get out of the bed and get me". On 10/8/06 at 12:30 AM R2 was seated by the nurses station. R2 was talking about R3 and said that he needed to find R3 to "cool him off". When R2 was taken back to his room he asked the nurse and CNA to go to bed with him. R2 said "I'm all hot and need to be cooled down...". On 10/10/06 on the 10PM - 6AM shift a CNA wrote "Aide assisted resident to the bathroom...(R2) grabbed aide in a very inappropriate area. The aide told the resident to stop. After assisting R2 to bed, the resident grabbed aide...and attempted to pull aide down on the bed with him". On 10/11/06 aide woke resident up for the day, resident was in bed without any clothes on. He told the CNA "I gotta screw her". According to the Behavior Documentation Notes R2 "Kept on saying that". Also documented is that the resident said "he knows she's here, where is she". On 10/12/06 R2 put his hand on the CNAs knee and started "creeping fingers up aides leg. CNA put residents hand back on his lap and told the resident that wasn't nice. Resident smiled and said who would find out". On 10/16/06 at 11:30 AM the Activity Aide was doing a 1:1 visit with R2. He reached out to the activity aide attempting to touch her inappropriately. On 10/19/06 E2(Director of Nursing) said that since 10/10/06 the Interdisciplinary Team created	F 324		

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F 324	Continued From page 7 a "safe zone". The safe zone is the area around the nurse's station. When R2 is verbally or physically inappropriate he would be asked to sit in this area. If he refused, 1:1 monitoring would be initiated. On 10/19/06 at 11:30 AM, E1 was asked for the policies or procedures on 1:1 resident monitoring and resident to resident abuse regarding verbal or physical inappropriate sexual behavior. E1 said that there are no such policies. On 10/19/06 at 11:30 AM, E1 was asked if the staff had received any in-services on inappropriate resident behaviors since the 9/28/06 incident. E1 stated that after R2's Care Plan was revised the staff had to read it. There was no other formal in-servicing done. 2. On 10/19/06 R13's medical record was reviewed. The Certified Nursing Assistant(CNA) Documentation for 8/08/06 on the 6AM-2:30PM shift says that the resident "threw his walker at me because I said no, I could look from the back of your underwear to see if you made a mess, resident wanted me to feel his underwear from the front". On 9/5/06 R13's Documentation notes state that on the 6AM-2PM shift R13 said to the CNA caring for him, "I'm horny...give me a kiss". Review of R13's Care Plan lists as a problem ineffective coping; occasional verbal abuse. Listed in the approaches it is said "if resident is saying inappropriate sexual comments to staff, clearly say this is not acceptable. Review of the Behavior Tracking Sheets shows that here are no tracking sheets for R13. E2 (Director of Nursing) at 10:00 AM on 10/19/06	F 324		

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F 324	Continued From page 8 said that if a resident does not display a particular behavior for a period of time, the Behavior Tracking Sheet is stopped. On 10/19/06 at 10:00 E1(Administrator) said that the inappropriate sexual comments made by R13 were only to the staff, to her knowledge he never spoke to any residents in such a manner. E 1 was informed of the Immediate Jeopardy on 10/19/06 at 8:30 AM. The surveyor confirmed the facility took the following actions to remove the immediacy of the situation: 1. All residents were reassessed for behaviors (to include physical aggression, wandering, sexual inappropriateness, verbal abuse, social inappropriateness) on 10/20/06. This was accomplished through staff interviews and chart reviews. Behavior tracking sheets and care plans were updated/changed as needed. 2. A one-to-one procedure is put into place. All staff will be given a copy of the procedure with the paychecks on Monday, October 23, 2006. 3. The staff will be in-serviced on the procedure to follow when a resident exhibits a change in behavior. The inservice will be provided by Stacy Brenton, LCSW, MSW, on Tuesday, October 24, 2006 at 10:00 AM and 2:00 PM. The Front line staff will alert the charge nurse. The Front line staff will then document on the Behavior Documentation Sheet or the Behavior Coupon in the Behavior Documentation Notebook and will communicate behavior change to the SSD (Social Service Director). The Charge nurses will be in-serviced on the new algorithm to follow when new behaviors are noted in a resident. 4. Staff will be in-serviced on how to deal with resident behaviors (to include physical aggression, verbal abuse, sexual	F 324		

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F 324	Continued From page 9 inappropriateness, etc.). The in-service is to be provided by Stacy Brenton, LCSW, MSW, on Tuesday, October 24, 2006 at 10:00 AM and 2:00 PM. The in-service is mandatory for all staff in all departments. 5. The administrator will provide a train the trainer program (regarding new policies and procedures) to the charge nurses on the day and evening shift on 10/20/06. The charge nurses will then train their staff and pass the information on to the next shift. The information will continue to be passed along through shift report throughout the weekend (10-20-06, 10-21-06, 10-22-06). All staff will be instructed to call the administrator via cell phone (number posted at the nurses station) for any and all incidents that occur between now (10/20/06) and the inservice training on Tuesday, October 24, 2006. 6. All staff were instructed on changes to R2's care plan on 10-18-06 and 10-19-06. All staff signed off that they read and understand the care plan changes. 7. Beginning on 10/20/06 audits will be completed for all incidents that occur to ensure that the one-to-one procedure and algorithm are followed. Audits will be completed by the administrator on a weekly basis. Findings will be reported to the Quality Assurance team at their monthly meeting for further recommendations.	F 324		
F9999	FINAL OBSERVATIONS Licensure Violations 300.1210a) 300.1210b)6) 300.3240a) 300.3240f)	F9999		

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F9999	Continued From page 10 Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological 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. b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. f) 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. (Section 3-612 of the Act)	F9999		

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F9999	Continued From page 11 These requirements were not met as evidenced by the following: Based on interview and record review the facility failed to supervise R2 to assure the safety of a female resident by not identifying a resident's sexually inappropriate behavior and not monitoring a resident's (R2) whereabouts after staff were made aware of an incident on 9/28/06. These failures resulted in R2 touching R1 under her shirt and pulling her pants down. This is for 1 of 3 residents in the sample. The findings includes: R2 is an 84 year old male resident with the diagnosis of Depressive Disorder, according to the October 2006 Physician Order Sheet. R2's 7/26/06 Minimum Data Set (MDS) shows that the resident is moderately impaired in cognitive skills for daily decision making and that he requires supervision. The MDS also shows that R2 has short term memory deficit. According to his 7/26/06 MDS he has no range of motion limits. On 10/10/06 at 9:30 AM, E5 (Certified Nursing Assistant-CNA) said that R2 was "acting up" on 9/28/06. She said that at about 11:30 AM R2 refused to go to the dining room for lunch. R2 made a sexual comment to E5 , "I'm hot, I need a piece of ---. I haven't had any in a long time." E5 said that R2 kept repeating the sexual comment to other residents and staff. E5 said that R2 kept going up and down the halls in his wheel chair, trying to go into the rooms of female residents. E5 said the behavior was reported to the charge nurse (E8) and the nurse caring for the resident (E9). E5 said that she was told by E8 to shut the doors of all female residents' rooms. E5 said that	F9999		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 12	F9999		

she observed that R2 was not in his room at about 2:30 PM on 9/28. R2 was in R1's room. He was seated in his wheel chair next to R1's bed, his chair alarm was still intact and not alarming. E5 observed R2 attempting to pull down R1's pants with one hand, and his other hand was up R1's shirt. E5 attempted to remove R2 from R1's room. R2 was resistive, grabbing onto things in the room to make it difficult for E5 to remove him. E5 summoned assistance. E3 (Activity Director) helped her remove R2 from R1's room. E5 said that R2 kept saying "I'm hot, I have a date."

On 10/10/06 at 9:55 AM E3 said that same day (time unknown), R2 had gone to R3's room. R3 is a good friend of R2 from when they both lived outside of the facility. R2 had never gone to R3's room before. R3 had always visited R2 in his room. R3 refused to allow R2 into her room. According to E3, R3 had told an Activity Assistant that earlier in the day R2 had spoken inappropriately to her and she was upset by it.

On 10-10-06 at 8:30 AM, E1 (Administrator) was asked what the facility had done to monitor the behavior of R2 and protect the other female residents after the incident on 9/28/06. E1 said that a yellow strip has been placed across R1's door to prevent unwanted visitors. A Psychiatric Evaluation was ordered by R2's physician and was completed. The results of the evaluation have not been returned to the facility.

On 10/10/06 at 9:00 AM, E6 (CNA) said that R2 moves about the building freely. When he has inappropriate outbursts 1:1s are done with him. E6 said that R2 continues to say inappropriate things to female staff. To her knowledge he has not been inappropriate with any residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145770	A. BUILDING _____ B. WING _____	C 10/20/2006

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F9999	Continued From page 13 On 10/10/06 at 9:10 AM, E7 (CNA) said that on the day of the incident (9/28/06) R2's room (#103) was on the same wing as R1's (#108). He has since been moved to the 200 wing. E7 said that since the incident the staff watch him closely. E7 is uncertain if R2 has a Behavior Tracking Sheet. On 10/10/06 at 9:15 AM, E4 (Social Service Director) said that the incident on 9/28/06 has been Care Planned for. When R2 is in bed he does not have the ability to transfer himself. He has a bed alarm, so if he gets out of bed the staff are aware of it. When R2 is out of bed he is under close supervision. When his behavior is inappropriate 1:1's are initiated. The Interdisciplinary Progress Notes dated 10/07/06 at 9:35 PM documented that R2 is out of bed and up in hall walking with a walker. On 10/10/06 at 10:00 AM E2, (Director of Nursing-DON) said that R2 was not moved to room 210 (a different hall) until 10/6/06 (8 days after the incident of 9/28/06). She said that the reason it took 8 days to move R2 to another hall is that the Interdisciplinary Team was deciding what interventions should be implemented. E2 was asked how they are certain that R2 won't be physically inappropriate with other residents. E2 said that when he is in bed, he is in a low bed with a bed alarm. He is unable to get out of the low bed without assistance. When R2 is in his wheel chair he has a personal alarm to alert staff that he is trying to get out of his wheel chair. R2's Care Plan dated 9/28/06 lists inappropriate sexual expression with other residents and staff as the problem. The interventions are: if resident	F9999		

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F9999	Continued From page 14 is expressing sexual desires, offer him privacy in his room. If resident refuses private time in his room, do 1:1 supervision to ensure the safety of others. Review of the Certified Nursing Assistant documentation shows that since 9/29/06 R2 continues inappropriate behavior with female staff. On 9/30/06 a female CNA was assisting R2 in getting ready for bed. R2 asked the CNA if she was going to bed with him. On 10/1/06 on the 6AM-2PM shift, R2 asked E6 (CNA) if she was married. E6 said that she was. R2 replied "well I won't do anything with you now." On 10/3/06 on the 6AM - 2PM shift E6 documented that R2 was trying to get into a female resident's room. On 10/5/06 at 12:00 AM R2 was out of bed going to the Bathroom. He asked the CNA "Where is R3? I was looking to have relations". On 10/7/06 on the 2PM - 10 PM shift it is documented that the CNA was assisting R2 back into bed. R2 began grabbing at the CNA and would not let go. The CNA wrote "whenever I could get my arms free to go get help he would try to get out of the bed and get me." On 10/8/06 at 12:30 AM R2 was seated by the nurses station. R2 was talking about R3 and said that he needed to find R3 to "cool him off." When R2 was taken back to his room he asked the nurse and CNA to go to bed with him. R2 said "I'm all hot and need to be cooled down...." On 10/10/06 on the 10PM - 6AM shift a CNA wrote "Aide assisted resident to the bathroom...(R2) grabbed aide in a very inappropriate area. The aide told the resident to stop. After assisting R2 to bed, the resident grabbed aide...and attempted to pull aide down on the bed with him." On 10/11/06 aide woke resident up for the day, resident was in bed without any clothes on. He told the CNA "I	F9999		

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F9999	Continued From page 15 gotta screw her." According to the Behavior Documentation Notes R2 "Kept on saying that." Also documented is that the resident said "he knows she's here, where is she." On 10/12/06 R2 put his hand on the CNA's knee and started "creeping fingers up aides leg. CNA put residents hand back on his lap and told the resident that wasn't nice. Resident smiled and said who would find out." On 10/16/06 at 11:30 AM the Activity Aide was doing a 1:1 visit with R2. He reached out to the activity aide attempting to touch her inappropriately. On 10/19/06 E2 (Director of Nursing) said that since 10/10/06 the Interdisciplinary Team created a "safe zone." The safe zone is the area around the nurse's station. When R2 is verbally or physically inappropriate he would be asked to sit in this area. If he refused, 1:1 monitoring would be initiated. On 10/19/06 at 11:30 AM, E1 was asked for the policies or procedures on 1:1 resident monitoring and resident to resident abuse regarding verbal or physical inappropriate sexual behavior. E1 said that there are no such policies. On 10/19/06 at 11:30 AM, E1 was asked if the staff had received any in-services on inappropriate resident behaviors since the 9/28/06 incident. E1 stated that after R2's Care Plan was revised the staff had to read it. There was no other formal in-servicing done. 2. On 10/19/06 R13's medical record was reviewed. The Certified Nursing Assistant(CNA) Documentation for 8/08/06 on the 6AM-2:30PM shift says that the resident "threw his walker at me because I said no, I could look from the back	F9999		

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F9999	Continued From page 16 of your underwear to see if you made a mess, resident wanted me to feel his underwear from the front." On 9/5/06 R13's Documentation notes state that on the 6AM-2PM shift R13 said to the CNA caring for him, "I'm horny...give me a kiss." Review of R13's Care Plan lists as a problem ineffective coping; occasional verbal abuse. Listed in the approaches it is said "if resident is saying inappropriate sexual comments to staff, clearly say this is not acceptable. Review of the Behavior Tracking Sheets shows that here are no tracking sheets for R13. E2 (Director of Nursing) at 10:00 AM on 10/19/06 said that if a resident does not display a particular behavior for a period of time, the Behavior Tracking Sheet is stopped. On 10/19/06 at 10:00, E1 (Administrator) said that the inappropriate sexual comments made by R13 were only to the staff, to her knowledge he never spoke to any residents in such a manner. (A)	F9999		