STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008011	A. BUILDING: _____ B. WING _____	12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORIA FALLS ASSISTED LIVING	408 E CENTRAL PO BOX 906 ANDOVER, KS 67002

(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) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of abbreviated survey with complaints #136236 and #134562 at the above named facility on 12/13/18, 12/17/18, 12/18/18, 12/19/18 and 12/20/18.	S 000		
S3028 SS=E	26-41-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the facility as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation. This REQUIREMENT is not met as evidenced	S3028		

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

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S3028	Continued From page 1 by: 5028 KAR 24-41-101(f)(3) The facility identified a census of 80 residents. The sample included 6 residents. Based on record review, observations and interviews for 2 of 6 resident sampled (#1, #2), the administrator failed to ensure each allegation of abuse was reported to the department within 24 hours, measures were put in place to prevent further potential abuse, and each allegation was thoroughly investigated with appropriate corrective action taken. Findings included: - Record review for resident #1 on 12/13/18 at 12:10 p.m. revealed an admit date of 7/3/17 with diagnoses of insulin dependent diabetic and neuropathy. The functional capacity screen dated 2/23/18, 9/22/18 and 11/12/18 recorded resident independent with bathing, dressing, toileting, transfer, walking/mobility, eating, continent of bowel and bladder, required physical assistance with management of medications/treatments, and socially inappropriate disruptive behaviors. Under comments: Resident educated on not using inappropriate language to residents and staff. Staff will report to administrator if inappropriate behaviors. The negotiated service agreement dated 2/23/18, 9/22/18 and 11/12/18 recorded resident independent with bathing, toileting, mobility/walking, grooming eating, continent bowel and bladder, staff to administer medications, resident to self-administer insulin,	S3028		

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S3028	Continued From page 2	S3028		

resident makes sexual remarks to staff, redirect to room and notify supervisor.

The record contained a HCS plan dated 2/23/18 and 9/21/18 that recorded resident independent with grooming, dressing, eating, mobility/transfers, incontinence, alert and oriented, able to make needs known, resident is a known sex offender.

The progress notes (nurses notes) recorded the following:

5/21/18 at 2:00 p.m. Writer was told by resident (#2) that he/she was having sexual relationship with resident #1. Writer did speak to resident after the conversation with resident #2 not to continue the relationship as resident #2 was upset after he/she found out resident was a sex offender and asked writer to speak to resident #1. There was an officer in the facility at the time that also spoke to both residents to make sure all was consensual, and officer also spoke to resident #1 to not bother (resident #2) anymore. Signed licensed nurse C

6/14/18 at 1:38 p.m. Resident was accused by another resident of threatening them. Supposedly resident #1 told the other resident that he/she had a [person] who would get to him/her if he/she did not pay him/her back the money he/she owed him/her. The police were called in and they went to visit (resident #2) about the incident.

The record lacked documentation of an investigation of the incident or interventions to address management of threatening behavior. Department records did not indicate the incident

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S3028	Continued From page 3	S3028		

was reported as a potential allegation of abuse.

9/27/18 at 6:10 p.m. I visited with resident #1 about a resident saying that he/she is making very specific sexual request of him/her and he/she does not like it or want him/her to bother the resident. Resident #1 got upset and said that other resident is just mad because he/she was talking to another resident in hallway and he/she told him/her not to interrupt. Resident #1 then got mad at me saying I needed to leave his/her room before he/she got up and punched me out. I told him/her I was visiting about situation and (resident #2) needed to understand about keeping the friendship only out in public areas. Resident #1 started to get up and I left. Resident #1 has made other suggestive remarks to our staff. Signed administrator A.

The record lacked documentation of an investigation of the incident and actions taken to address management of unwanted sexual requests. Department records did not indicate the incident was reported as a potential allegation of abuse.

12/7/18 at 12:38 p.m. This morning at 9:45 a.m. I along with director of operations F and activity director E went to resident #1's room and told him/her that because of recent verbal threats of bodily harm towards other residents he/she would not be allowed to go on outings with our bus and other residents. I told him/her that verbally threatening other residents is completely unacceptable. Director of operations F told resident that if we have another incident of this type we would issue a 30-day notice of eviction. Resident stated that is fine and reason he/she was saving boxes, to move. Signed Administrator

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S3028	Continued From page 4 A. The record lacked documentation of an investigation of the incident or interventions to address aggressive behavior and monitor other residents for safety. Department records did not indicate the incident was reported as a potential allegation of abuse. Interview on 12/13/18 at 1:35 p.m. with resident #1 stated, "Was probably moving out pretty quickly because if administrator barks at me again I am going to kick his ass. Resident further stated when administrator was last in his/her room he/she got up to hit administrator and he/she ran out of room. I was given a 30-day notice and will be moving out because of hugging (resident #2) and threatening to knock out (resident #7). I had a relationship with (resident #2) and he/she flipped out when I tried to hug him/her the other day. I have a large scar on my forehead from trying to kill self by shooting self in forehead. I didn't do a good job and ended up having a craniotomy." Interview on 12/13/18 at 2:45 p.m. with administrator A stated last spring resident #1 and #2 had a relationship. The family member for resident #2 preferred they not have a relationship. The police came out in May 2018 and talked to both resident #1 and #2 about relationship. Written statement from administrator A on 12//13/18 at 4:00 p.m. recorded. . .DPOA for resident #2 was informed resident #1 was going into resident #2's room and discussed moving resident #2 to a different hallway, so they would not be 3 doors apart. DPOA thought that would be fine. . . on 12/8/18 resident #1 was given a 30 day notice due to verbal threats of physical harm	S3028		

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S3028	Continued From page 5 to other residents. Interview on 12/17/18 at 12:45 p.m. with licensed nurse B stated staff have been instructed to report any concerns to this nurse or administrator A about resident #1. Licensed nurse B stated and confirmed the HCSP lacked interventions for all inappropriate verbal and physical behaviors. For resident #1, the administrator failed to ensure each allegation of abuse was reported to the department within 24 hours, measures were put in place to prevent further potential abuse, and each allegation was thoroughly investigated with appropriate corrective action taken. - Record review for resident #2 revealed an admit date of 9/29/17 with diagnoses of schizophrenia, anxiety, and drug induced akathisia. 1/14/18 Bi polar disorder see History and Physical, 11/24/18 schizophrenia with suicidal ideation see History and Physical. The functional capacity screen dated 9/21/18 recorded resident independent with toileting, transfer, walking/mobility, eating bladder continence, cognition, required physical assistance with bathing, dressing, and experienced impaired vision. The negotiated service agreement dated 9/21/18 recorded resident require physical assistance with bathing, dressing, grooming, independent with toileting, mobility/walking, cognition, bladder and bowel continence. The health care service plan dated 9/21/18	S3028		

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recorded resident required physical assistance with grooming, dressing, independent with eating, mobility/transfers, bowel/bladder care, alert and oriented, able to make needs known, and independent with transportation. Staff to administer medication.

The history and physical dated 10/14/18 recorded "diagnoses bipolar disorder, schizophrenia, and depression presents to the emergency department with suicidal ideation. The patient stated tried to cut wrist with a can opener tonight. The patient's family member stated patient was admitted here a year ago for suicidal ideation and it has been chronic since. Patient also had 12 episodes of alleged suicide attempts between 2015 and 2016. After review I do not believe patient has an emergent medical condition warranting admission and is stable to be transferred home and for further out patient psychiatric evaluation. The licensed social worker called the facility and updated them resident is stable for discharge."

The progress notes (nurses notes) recorded the following:

9/27/18 at 4:02 p.m. Resident came up to this nurse crying, upset that a male resident is coming up to him/her, "frequently wanting to have. . . (sexual relationship) after night time medication pass. I don't want him/her in my room and I want him/her to leave me alone. . . and now (male resident) wants (sexual relationship) and informed resident to tell him/her no and not to be going into his/her room or letting him/her come into (resident's) room. Resident informed could be moved to another room and he/she stated yes. Resident is now telling this nurse he/she does not want the male resident to be bothering her/him

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S3028	Continued From page 7	S3028		

anymore." Administrator A notified. Signed licensed nurse B.

9/27/18 at 6:02 p.m. Resident visited by activity director this afternoon about how resident was being pressured by a male resident to have sex with him. Resident has been told by staff not to go into this person's room and to not let him in his/her room. Family aware of their friendship but they do not want it to be sexual. Resident has some mental issues but is considered own person and able to make own decisions. Signed administrator A.
The record lacked documentation of an investigation of the incident or interventions to address management of unwanted sexual requests. Department records did not indicate the incident was reported as a potential allegation of abuse.

Interview on 12/13/18 at 3:17 p.m. with resident #2 stated he/she used to work in an office at a college years ago. Resident stated he/she liked it here. Resident stated he/she knew (resident #1) and has invited him/her into his/her room and was boyfriend/girlfriend but does not want anything to do with him/her anymore.

Interview on 12/17/18 at 4:35 p.m. with resident #2 came to me and grabbed my hand stating, I want to talk to you in my room. We went to room and resident stated he/she was very afraid of (resident #1) and afraid he/she might come into his/her room. (Resident #1) wants to have sex with him/her and he/she does not want to have sex with him/her anymore. Resident is very anxious and confirmed he/she moved to other end of facility to a room at end of hall and did not

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S3028	Continued From page 8 live by (Resident #1) anymore. For resident #2, the administrator failed to ensure each allegation of abuse was reported to the department within 24 hours, measures were put in place to prevent further potential abuse, and each allegation was thoroughly investigated with appropriate corrective action taken.	S3028		
S3155 SS=E	26-41-204 (a) Health Care Services . (a) The administrator or operator in each assisted living facility or residential health care facility shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 24-41-204 (a) The facility identified a census of 80 residents. The sample included 6 residents. Based on record review, observations and interviews for residents 3 (#1, #2, #3) of 6 resident sampled, the administrator failed to ensure no the licensed nurse provided or coordinated the provision of health care services to meet the needs of the resident.	S3155		

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S3155	Continued From page 9 Findings included: - Record review for resident #1 on 12/13/18 at 12:10 p.m. revealed an admit date of 7/3/17 with diagnoses of insulin dependent diabetic and neuropathy. The functional capacity screen dated 2/23/18, 9/22/18 and 11/12/18 recorded resident independent with bathing, dressing, toileting, transfer, walking/mobility, eating, continent of bowel and bladder, required physical assistance with management of medications/treatments, and socially inappropriate disruptive behaviors. Under comments: Resident educated on not using inappropriate language to residents and staff. Staff will report to administrator if inappropriate behaviors. The negotiated service agreement dated 2/23/18, 9/22/18 and 11/12/18 recorded resident independent with bathing, toileting, mobility/walking, grooming eating, continent bowel and bladder, staff to administer medications, resident to self-administer insulin, resident makes sexual remarks to staff, redirect to room and notify supervisor. The record contained a health care service plan (HCSP) dated 2/23/18 and 9/21/18 that recorded resident independent with grooming, dressing, eating, mobility/transfers, incontinence, alert and oriented, able to make needs known, resident is a known sex offender. The progress notes (nurses notes) recorded the following:	S3155		

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5/21/18 at 2:00 p.m. Writer was told by resident (#2) that he/she was having sexual relationship with resident #1. Writer did speak to resident after the conversation with resident #2 not to continue the relationship as resident #2 was upset after he/she found out resident was a sex offender and asked writer to speak to resident #1. There was an officer in the facility at the time that also spoke to both residents to make sure all was consensual, and officer also spoke to resident #1 to not bother (resident #2) anymore. Signed licensed nurse C

6/14/18 at 1:38 p.m. Resident was accused by another resident of threatening them. Supposedly resident #1 told the other resident that he/she had a [person] who would get to him/her if he/she did not pay him/her back the money he/she owed him/her. The police were called in and they went to visit (resident #2) about the incident.

The health care service plan lacked interventions to address management of threatening behavior.

9/27/18 at 6:10 p.m. I visited with resident #1 about a resident saying that he/she is making very specific sexual request of him/her and he/she does not like it or want him/her to bother the resident. Resident #1 got upset and said that other resident is just mad because he/she was talking to another resident in hallway and he/she told him/her not to interrupt. Resident #1 then got mad at me saying I needed to leave his/her room before he/she got up and punched me out. I told him/her I was visiting about situation and (resident #2) needed to understand about keeping the friendship only out in public areas. Resident #1 started to get up and I left. Resident #1 has made other suggestive remarks to our

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S3155	Continued From page 11 staff. Signed administrator A. The HCSP lacked interventions to address management of unwanted sexual requests. 11/23/18 at 4:00 p.m. Certified staff D reported to administrator A that resident #1 was going to kick a staff member in the face and hit him/her with a newspaper. Certified staff D further stated resident #1 was going to go "Black ops" on this building and go lean a resident back in his/her wheelchair so he/she will be on back like a turtle. Certified staff D called licensed nurse B and administrator A. Signed Administrator A. The HCSP lacked interventions to address aggressive behavior and monitor other residents for safety. 12/7/18 at 7:45 a.m. Resident #1 came up to me and stated "cursing. . . if (resident #7) sits in my place on the bus today I'm going to punch him/her out. Last week when we went to Walmart (resident #7) sat in my seat on the way home from Walmart. I informed him/her we do not have assigned seating on the bus and it's not that serious. Resident #1 further stated I am telling you that old (person) want to start. . . with me I will punch (him/her) out." Signed Activity Director E. 12/7/18 at 9:04 a.m. Resident #1 called me yesterday afternoon and told me that he/she was. . . going to pick resident #7 up and throw him/her out of the seat. I told him/her you know you can't do that and resident stated, "Don't tell me what I can't do and was yelling this over the phone." I will be talking to resident about threatening comments. Signed Administrator A.	S3155		

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S3155	Continued From page 12 The HCSP lacked interventions to address aggressive behavior and monitor other residents for safety. 12/7/18 at 12:38 p.m. This morning at 9:45 a.m. I along with director of operations F and activity director E went to resident #1's room and told him/her that because of recent verbal threats of bodily harm towards other residents he/she would not be allowed to go on outings with our bus and other residents. I told him/her that verbally threatening other residents is completely unacceptable. Director of operations F told resident that if we have another incident of this type we would issue a 30-day notice of eviction. Resident stated that is fine and reason he/she was saving boxes, to move. Signed Administrator A. The HCSP lacked interventions to address aggressive behavior and monitor other residents for safety. 12/8/18 at 10:35 a.m. Resident told staff that if resident #7 talked to him/her he/she would hit (resident #7) in the mouth. I contacted director of operator of operations and was approved to proceed with giving a 30-day notice. Signed Administrator A. The HCSP lacked interventions to address aggressive behavior and monitor other residents for safety. Interview on 12/13/18 at 1:35 p.m. with resident #1 stated, "Was probably moving out pretty quickly because if administrator barks at me again I am going to kick his ass. Resident further stated when administrator was last in his/her room he/she got up to hit administrator and	S3155		

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he/she ran out of room. I was given a 30-day notice and will be moving out because of hugging (resident #2) and threatening to knock out (resident #7). I had a relationship with (resident #2) and he/she flipped out when I tried to hug him/her the other day. I have a large scar on my forehead from trying to kill self by shooting self in forehead. I didn't do a good job and ended up having a craniotomy."

Interview on 12/13/18 at 2:45 p.m. with administrator A stated last spring resident #1 and #2 had a relationship. The family member for resident #2 preferred they not have a relationship. The police came out in May 2018 and talked to both resident #1 and #2 about relationship.

Written statement from administrator A on 12//13/18 at 4:00 p.m. recorded. . .DPOA for resident #2 was informed resident #1 was going into resident #2's room and discussed moving resident #2 to a different hallway, so they would not be 3 doors apart. DPOA thought that would be fine. . . on 12/8/18 resident #1 was given a 30 day notice due to verbal threats of physical harm to other residents.

Interview on 12/17/18 at 12:45 p.m. with licensed nurse B stated staff have been instructed to report any concerns to this nurse or administrator A about resident #1. Licensed nurse B stated and confirmed the HCSP lacked interventions for all inappropriate verbal and physical behaviors.

For resident #1, the administrator failed to ensure no the licensed nurse provided or coordinated the provision of health care services to meet the needs of the resident.

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	N008011	A. BUILDING: _____ B. WING _____	12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORIA FALLS ASSISTED LIVING	408 E CENTRAL PO BOX 906 ANDOVER, KS 67002

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S3155	Continued From page 14 - Record review for resident #2 revealed an admit date of 9/29/17 with diagnoses of schizophrenia, anxiety, and drug induced akathisia. Bi polar disorder (added 1/14/18) and schizophrenia with suicidal ideation (added 11/24/18) The functional capacity screen dated 9/21/18 recorded resident independent with toileting, transfer, walking/mobility, eating bladder continence, cognition, required physical assistance with bathing, dressing, and experienced impaired vision. The negotiated service agreement dated 9/21/18 recorded resident require physical assistance with bathing, dressing, grooming, independent with toileting, mobility/walking, cognition, bladder and bowel continence. The health care service plan dated 9/21/18 recorded resident required physical assistance with grooming, dressing, independent with eating, mobility/transfers, bowel/bladder care, alert and oriented, able to make needs known, and independent with transportation. Staff to administer medication. The history and physical dated 10/14/18 recorded diagnoses bipolar disorder, schizophrenia, and depression presents to the emergency department with suicidal ideation. The patient stated tried to cut wrist with a can opener tonight. The patient's family member stated patient was admitted here a year ago for suicidal ideation and it has been chronic since. Patient also had 12 episodes of alleged suicide attempts between 2015 and 2016. After review I do not believe patient has an emergent medical condition warranting admission and is stable to be	S3155		

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transferred home and for further out patient psychiatric evaluation. The licensed social worker called the facility and updated them resident is stable for discharge.

The progress notes (nurses notes) recorded the following:

9/27/18 at 4:02 p.m. Resident came up to this nurse crying, upset that a male resident is coming up to him/her, "frequently wanting to have. . . (sexual relationship) after night time medication pass. I don't want him/her in my room and I want him/her to leave me alone. . . and now (male resident) wants (sexual relationship) and informed resident to tell him/her no and not to be going into his/her room or letting him/her come into (resident's) room. Resident informed could be moved to another room and he/she stated yes. Resident is now telling this nurse he/she does not want the male resident to be bothering her/him anymore." Administrator A notified. Signed licensed nurse B.

9/27/18 at 6:02 p.m. Resident visited by activity director this afternoon about how resident was being pressured by a male resident to have sex with him. Resident has been told by staff not to go into this person's room and to not let him in his/her room. Family aware of their friendship but they do not want it to be sexual. Resident has some mental issues but is considered own person and able to make own decisions. Signed administrator A.
The HCSP lacked interventions to address unwanted sexual requests.

10/14/18 at 7:00 p.m. Resident attempting to cut wrist using a can opener, stated "I want to kill myself", staff remained with resident and called

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VICTORIA FALLS ASSISTED LIVING	408 E CENTRAL PO BOX 906 ANDOVER, KS 67002

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licensed nurse B, resident crying and yelling, "I am going to kill myself, had can opener in hand trying to cut wrist, this nurse notified and instructed staff to call family and 911. Emergency Medical Services and police stated there was no reason to take resident in as by the time they arrived resident answered all questions they gave him/her appropriately and would not take in. When family arrived resident began yelling and crying again that he/she was trying to kill self. Family took resident to hospital for evaluation and later family brought resident back and stayed the night with him/her." Signed licensed nurse B. The HCSP lacked interventions to address suicidal behavior.

Interview on 12/13/18 at 3:17 p.m. with resident #2 stated he/she used to work in an office a college years ago. Resident stated he/she liked it here. Resident stated he/she knew (resident #1) and has invited him/her into his/her room and was boyfriend/girlfriend but does not want anything to do with him/her anymore.

Interview on 12/17/18 at 4:35 p.m. with resident #2 came to me and grabbed my hand stating, I want to talk to you in my room. We went to room and resident stated he/she was very afraid of (resident #1) and afraid he/she might come into his/her room. (Resident #1) wants to have sex with him/her and he/she does not want to have sex with him/her anymore. Resident is very anxious and confirmed he/she moved to other end of facility to a room at end of hall and did not live by (Resident #1) anymore.

Interview on 12/17/18 at 4:45 p.m. with licensed nurse B stated resident went to (resident #1's) table in dining room and tried talking to (resident #1). Staff asked resident to go back to table and

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S3155	Continued From page 17 to not talk to resident #1 and not to go to his/her room to visit. For resident #2, the administrator failed to ensure the licensed nurse provided or coordinated the provision of health care services to meet the needs of the resident. - Record review for resident #3 revealed an admit date of 8/29/13 with diagnosis of impulse disorder, anxiety, diabetes mellitus, schizoaffective disorder, panic disorder, psychoactive substance dependence, hypertension, depression, and rheumatoid arthritis. The functional capacity screen dated 9/21/18 recorded resident independent with eating, cognition, required physical assistance with bathing, dressing, toileting, transfer, walking/mobility, bladder continence, and experienced falls/unsteadiness. Under comments: ½ rail for positioning and transfer, seizure precautions. The negotiated service agreement dated 9/21/18 recorded resident required physical assistance with bathing, dressing, toileting, mobility/walking, grooming, needs ½ side rail for bed mobility, seizure precautions, and independent with cognition. The health care service plan dated 9/21/18 recorded resident to have physical assistance with shower three times a week, assistance with dressing, mobility/transfer, encourage to wear	S3155		

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seatbelt while in electric scooter, assistance with bowel and bladder due to incontinence. Resident able to make needs known and is alert and oriented.

The progress notes (nurses notes) recorded the following:

12/6/18 at 7:51 a.m. Resident came up to this nurse crying and stating that he/she was seeing another resident here at the facility and just found out he/she was a registered sex offender. Resident was upset that no one from the facility told him/her about resident being a sex offender. Resident also found out resident (#1) was seeing 5 other residents and is, "extremely upset and humiliated, his/her family is aware and concerned that resident will continue to bother him/her and he/she had told him/her to stay away from him/her." This nurse told resident if the resident continued to bother him/her after he/she told resident to stop that he/she can get a restraining order against him/her. This nurse notified the administrator. Signed licensed nurse B.
The HCSP lacked interventions to address unwanted sexual advances.
Written statement from administrator A on 12/13/18 at 4:00 p.m. recorded resident #3 was in a relationship with resident #1 until he/she heard from another person that resident #1 had been in prison as a sexual offender. Resident #3 was devastated and did not want anything to do with resident #1. I advised resident to tell resident #1 he/she did not want to see him/her and to keep his/her door locked. All the female relationships that resident #1 has engaged in have been with consenting adults. There has never been any report of sexual abuse. Signed administrator A.

Interview on 12/13/18 at 4:05 p.m. with resident

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S3155	Continued From page 19 #3 stated thought he/she was dating (resident #1) until family member pulled up a record that showed he/she had three felonies of molesting 14-year-old girls. Resident #1 is seeing 3 other residents. He/she was shocked and could not believe what he/she observed in writing and no longer looks at him/her or has any contact. I keep my door locked at night as he/she comes to door and knocks on door. I went to his/her room yesterday to see if he/she would tell me he/she had a sexual offense. He/she stated resident #1 lied to him/her and did not tell him/her the truth. As soon as I stopped seeing him/her, he/she informed resident #2 that they could start seeing each other again. I am upset because the administrator or nurse did not tell me that resident had a record of sexual offense. I also hate having to keep my door locked at night to keep him/her out. For resident #3, the administrator failed to ensure no the licensed nurse provided or coordinated the provision of health care services to meet the needs of the resident.	S3155		