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F 000	INITIAL COMMENTS The following citations represent the findings of a partial extended survey for complaint investigation #KS00136146, KS00135467, KS00118671. Revision: A revised copy of citations were sent to the facility on 12/21/18.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: The facility reported a census of 36 residents with 3 residents reviewed for resident to resident sexual allegations. Based on observation, interview, and record review the facility failed to prevent the sexual abuse of resident #2, when the facility knew of resident #1's history of hypersexual behaviors and a prior sexual allegation from female resident #3 in July of 2018 and the facility did not implement care plan interventions to prevent another occurrence. In	F 600		

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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December 2018 resident #1 sexually abused cognitively impaired resident # 2, who was unable to provide sexual consent and displayed withdrawn behaviors and fear after the allegation.

Findings included:

- Review of resident #1's diagnoses from the signed physician's order sheet dated 11/15/18, revealed the following diagnoses: Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and psychosis (any major mental disorder characterized by a gross impairment in reality testing).

Review of the 8/18/18 significant change minimum data set (MDS) revealed resident #1 had a brief interview for mental status (BIMS) score of 15, indicating intact cognition. The resident exhibited symptoms of psychosis which included hallucinations (perceptual experiences in the absence of real external sensory stimuli) and delusions (misconceptions or beliefs that are firmly held, contrary to reality). The resident required limited assistance of one staff with walking in room and corridor, locomotion on unit, and was independent with locomotion off unit. The resident used a walker and a wheelchair for mobility. The resident received daily antipsychotic, antianxiety, and antidepressant medications.

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Review of the 11/23/18 quarterly MDS revealed resident #1 had a BIMS score of 15. The resident did not exhibit behaviors or psychosis and his/her behaviors had remained the same since the previous assessment. The resident required limited assistance of one staff with walking in room and corridor and required supervision of one staff with locomotion on and off the unit. The resident used a wheelchair for mobility and antipsychotic and antidepressant medications.

Review of the 8/18/18 activities of daily living (ADL) care area assessment (CAA) revealed the resident preferred staff to perform his/her care and required encouragement to participate with his/her care.

Review of the 8/18/18 psychotropic medication CAA revealed the resident received an antipsychotic medication and was an inpatient at the behavioral health unit.

Review of the informed consent for psychoactive medications (undated) revealed the following less restrictive non-drug approaches had proven to be ineffective for resident #1: one-on-one, distraction, redirection, relaxation, and massage. The medication intervention recommendation was Xanax (antianxiety medication) and Seroquel (antipsychotic medication). The purpose of the psychoactive medication was indicated for a list of targeted symptoms/behaviors written as: refusal to get out of bed, inappropriate sexual behavior and fixation on his/her own genitalia.

Review of the facility investigation form signed 7/6/18 described a sexual abuse allegation between resident #1 and resident #3. Resident #1 had a BIMS of 15, which indicated the resident

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had intact cognition. Resident #3 had a BIMS of 9, which indicated the resident had moderately impaired cognition. The form indicated an allegation of sexual abuse. The report described the incident as second-hand (unidentified housekeeping staff) information reported resident #1 and #3 had a sexual relationship and resident #3 did not have the cognition for consent. The signed investigation reported the incident occurred approximately 2 weeks prior. The corrective action taken by the facility in response to the incident revealed both parties were interviewed. Staff interviewed residents on the same hall as resident #1. The facility moved resident #1 to another hall. The facility placed resident #1 and #3 on 30-minute visual checks. The facility made a report to the local police department. The facility's plan for on-going monitoring for effectiveness was to send resident #1 to a behavioral health unit at a local hospital to monitor and possible adjustment to psychotropic medications.

Review of the care plan for resident #1 lacked new interventions added to his/her care plan after the 7/6/18 incident.

Review of resident #2's signed physician orders revealed the resident had the following diagnoses: weight loss, bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods), pain and weakness.

Review resident #2's admission assessment dated 11/4/18 reveled the resident had a BIMS score of 5, which indicated severely impaired cognition. The resident had inattention behavior continuously present, which did not fluctuate and

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disorganized thinking present, which fluctuated. The resident had no further behaviors identified on the assessment. The resident required extensive assistance of two staff for bed mobility and transfers. The resident did not walk between locations in his/her room or corridor.

Review of resident #2's care plan printed 12/4/18 revealed:
10/30/18 - Review of the activity problem revealed the resident was not good at expressing his/her interests/preferences.
12/24/18 - Staff would re-direct and reassure the resident as needed.
10/24/18 - Staff would monitor and redirect the resident for behaviors to determine the cause and trigger of the behaviors.
10/24/18 - Staff would provide me with care in a calm and unhurried manner.
10/24/18 - Provide, redirect, reassure, encourage activities for distraction.

Review of the resident's physician order dated 11/16/18 revealed an order for Ativan (antianxiety medication) 0.5 mg by mouth (PO) at 6:00 p.m. every day for anxiety.

Review of the facility reported investigation form revealed an incident, which occurred on 12/6/18 at 3:00 p.m. Resident #1 asked direct care staff I to get 3 items out of his/her room. Staff I handed the items to resident #1 and resident #1 reported he/she needed to go make a phone call. At 6:00 p.m., after supper Resident #1 and Resident #2 sat in the commons area of the facility visiting together. At 6:30 p.m. the two residents were witnessed dancing in resident #2's room by an unidentified direct care staff certified to administer medications. At 6:30 p.m. licensed nursing staff J

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observed resident #1 going back to his/her room in his/her wheelchair. Staff J stated that resident #1 did not come out of his/her room the remainder of the night. On December 6, 2018 at 9:25 p.m. resident #2 was found looking out of his/her room and staff J stopped to visit with the resident, at that time resident #2 voiced concern that there was a situation that made him/her uncomfortable. Resident #2 reported to Staff J that resident #1 came into his/her room and brought 3 gifts for which he/she was grateful. However, resident #2 later believed that resident #1 implied that resident #2 owed resident #1 sex for the gifts and resident #2 was uncomfortable with this. Resident #2 was worried about how to tell resident #1 that he/she was uncomfortable with the situation. The three items that resident #1 took to resident #2's room were removed by staff and taken to the nurse's station and later returned to resident #1's room. On December 6, 2018 at 10:00 p.m. staff J notified the administrative nursing staff B and administrative staff A and they discussed the following interventions to be immediately placed into effect for the remainder of the night and next morning. The facility placed the following new interventions: 1:1 monitoring to ensure resident #1 did not return to resident #2's room that night or the following day. Resident #1 was notified he/she was only allowed to interact with resident #2 in public areas. Resident #2 would be supported, and active listening was initiated. Safety would be provided as resident #1 would not be allowed to be in the presence of resident #2 privately. Provide as needed (PRN) medications as ordered for anxiety for resident #1. Skin assessments were provided by hospice and the director of nursing for resident #2. On December 7th between 8 a.m. and 9 a.m.

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resident #2 told direct care staff K that he/she did not want to take a shower or leave his/her room to eat. Resident #2 stated he/she did not want to get anyone in trouble, but he/she was touched "up there" and "lower". Resident #2 expressed concern that this was his/her fault. Staff K reassured the resident that this was not his/her fault and that no one was mad at him/her. The information was immediately shared with the charge nurse on duty. On December 7, 2018 between 8 a.m. and 9 a.m., licensed nursing staff L was informed of the statement made by resident #2. Staff L went to visit with resident #2 and the resident stated, "something happened last night" and explained that resident #1 came back into resident #2's room. Resident #2 stated that resident #1 made sexual contact by touching his/her chest area and "down there" indicating the pelvic area. Resident #2 repeated he/she did not want to cause any trouble. Staff L immediately contacted the administrative nursing staff B. Staff B then contacted administrative staff A. Both staff E and Staff H conducted interviews with resident #1 and resident #2. Immediate new care planned interventions included resident #1 to remain in the company of only same gender residents in the facility. Resident #1 was not to be in the company of resident #2 and was to be monitored when out of his/her room so that resident #1 did not have any contact with opposite gender residents. Resident #1 and resident #2 would be seen by consultant staff M. The facility looked at potential placement in a same gender facility for resident #1. Resident #1 denied any sexual advances and stated he/she never did anything that was not consensual. Resident #2 reported that resident #1 made sexual advances toward him/her. Resident #2 was descriptive in that resident #1 put his/her hand under resident #2's shirt and felt

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his/her chest area. Resident #2 stated resident #1 asked if he/she could kiss resident #2's genital area and resident #2 stated no. On December 7, 2018 at 10:00 a.m. the facility contacted local law enforcement. Resident #2 shared with the officers that resident #1 came back into his/her room and that was when the situation occurred. At that time nursing staff were able to report that resident #1 did not return to resident #2's room after he/she left around 6:30 p.m. [The facility lacked 1:1 documentation to support evidence that resident #1 did not go back into resident #2's room and per interview with Staff B on 12/11/18 - see below-the facility could not guarantee resident #1 did not go back into resident #2's room or another room occupied by an opposite gendered resident.] On December 7th at 10:00 a.m. the facility notified physician F of all current events and current investigation by local law enforcement. Physician F suggested admission for resident #1 to a local behavioral health unit (BHU). On December 7, 2018 at 1:00 p.m. the facility conducted a self-report to adult protective services of alleged sexual abuse by resident #1. Staff B reported that at that time the local law enforcement and internal investigation had been unable to substantiate sexual abuse. However, nursing care-plans were in place to protect resident #2, as well as all same gendered residents as resident #2, in the facility as the investigation continued. The staff informed the hospice company for resident #2 and the DPOA for resident #2, who stated that resident #2 had a past history of rape and that his/her past memories of past events often were mixed into current experiences. At 2:00 p.m. the facility concluded that due to inability by local law enforcement to substantiate the allegation, the internal investigation was unable to substantiate

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resident reports of sexual exploitation. However, care planned interventions remained in place for the safety of resident #2 and the other same gendered residents as resident #2. [The facility did not update resident #1's care plan with interventions mentioned in the investigation.] On December 8, 2018 Nursing documentation recorded there were no further interactions between resident #1 and resident #2. Nursing documentation indicated the residents did not have any concerns and did not voice any fears and no reports of being scared were verbalized. On December 10, 2018, resident #1 asked if he/she could visit with the administrative staff A. During the visit with the administrator resident #1 admitted to touching resident #2's chest and asked resident #2 to touch resident #1's genitalia so resident #1 could masturbate. At approximate 11:30 a.m. the facility received a call from APS following up on the original call. At 11:45 a.m. the facility called the local law enforcement with the new information and on December 10th at 2:30 p.m. resident #1 admitted to the BHU.

Review of the 12/7/18 comprehensive certified nurse aide shower review for resident #2 revealed the resident had an old healing bruise on the inner thigh which measured 0.5 centimeters (CM) by 1.5 CM.

Review of the notarized witness statement from direct care staff K dated 12/7/18 revealed on the morning 12/7/18 resident #2 refused to take a shower, eat or come out of his/her room. Staff K asked resident #2 why he/she did not want to come out of his/her room and resident #2 stated he/she was scared to come out of his/her room and did not want to get anyone in trouble.

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Resident #2 told staff K that someone touched "up here" (as he/she grabbed his/her chest) and "lower". Resident #2 asked if everyone was mad at him/her for causing trouble. Staff K stated he/she reassured resident #2 nothing was his/her fault, and no one was mad at him/her.

Review of the notarized witness statement from licensed nurse J dated 12/7/18 revealed he/she was in and out of resident #2's room throughout the night, which included extended periods between approximately 9:15 p.m. and 10:00 p.m. Staff J stated resident #2 came to the nurse's station at approximately 3:00 a.m. until 4:30 a.m. to talk and apologize "for causing so much trouble". The statement lacked evidence resident #1remained on one-on-one observation 12/6/18 and 12/7/18.

Review of the notarized witness statement from licensed nursing staff L dated 12/7/18 revealed resident #2 refused to eat or shower the morning of 12/7/18. Staff L said the resident stated, "I'm causing trouble and scared to come out of my room". Staff L asked resident #2 to tell him/her what was bothering him/her and resident #2 stated something happened last night. Resident #2 stated what happened the night prior was his/her fault because he/she did not say no. Resident #2 stated resident #1 made sexual contact by touching his/her chest and pelvic area. The resident stated he/she did not want to cause any trouble.

Review of the undated temporary care plan in-service form for resident #1 revealed a new intervention written: resident #1 was not to be in the company of resident #2. The resident was to be monitored when out of his/her room so that

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he/she did not enter any opposite gender resident rooms. The form was signed by 13 staff members, the DON and Administrator, but was undated and not located in the resident's medical chart.

Review of the undated temporary care plan/in-service form revealed a new intervention for resident #2, which directed staff to re-assure and provide active listening. Provide a safe environment in the company of same gender residents. The form included 14 signatures and the director of nursing's signature at the bottom of the page.

Review of resident #2's nurse's note dated 12/7/18 at 8:30 a.m. revealed the resident reported that another resident (resident #1) had sexual contact with him/her on the evening of 12/6/18. The resident reported a resident of the opposite gender came back into his/her room during the evening/night and had touched him/her. The note reported no injuries. The intervention identified in the note revealed staff provided reassurance and protection from the unnamed resident of the opposite gender and all other residents of the opposite gender as well. Staff provided care in the security of his/her room and provided active listening/reassurance. Staff initiated contact with law enforcement and an investigation.

Review of resident #2's nurse's note dated 12/9/18 at 10:55 a.m. revealed the resident alert and able to make needs known. The resident had some delusions and thought staff, residents and his/her family were making foul comments about him/her when he/she went to the dining room. He/she asked if he/she could get a room change

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to stop people from talking about him/her. The resident had no reports of fear or feelings of danger.

Review of resident #2's nurse's notes dated 12/9/18 at 11:06 p.m. revealed the resident's family talked to the nurse writer and reported the resident had 2 other rape incidents in his/her past and they were not sure he/she had not mixed past experiences with the current situation. The resident had not said anything about the situation to nursing staff that shift.

Review of resident #2's nurse's note dated 12/11/18 at 2:12 AM revealed the resident requested as needed anxiety medication.

Observation of the resident on 12/11/18 at 11:45 a.m. revealed resident #2 sleeping and awoke easily. The resident stated he/she was sleepy and had no signs of distress.

Observation on December 11, 2018 at 10:30 a.m. revealed resident #1 was in a behavioral health unit.

Interview on 12/11/18 at 11:59 a.m. with direct care staff K revealed resident #2 had been melancholy lately and had been more so, since the events with resident #1. Staff K stated the day after it happened resident #2 did not want to go take a shower, was agitated, and secluded him/herself. Staff K said the staff reassured resident #2 she was safe, but resident #2 was upset and scared and needed reassurance. Staff K provided ADL care for resident #1 and stated the resident did have behaviors that were verbally inappropriate. Staff K reported resident #1

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masturbated in his/her room and stated resident #1's curtain was usually pulled. Staff K stated resident #1 had an incident with resident #3 in July or August of 2018-and stated they were caught doing something, unsure of what, and the facility moved resident #1 to a different room.

Interview with direct care staff N on 12/11/18 at approximately 10:45 a.m. revealed resident #1 would get in a mood and act inappropriate and became angry very quickly. Staff N stated resident #2 asked during cares on Thursday or Friday if the person (resident #1) was going to sue him/her and continued to act scared of everything and refused to eat or leave his/her room.

Interview with administrative staff A on 12/11/18 at 2:59 p.m. revealed resident #1 had a prior allegation with resident #3 and stated the facility in-serviced staff after that allegation to not allow resident #1 in opposite gender resident rooms and not to be in common areas with opposite gender residents. Staff A stated he/she expected interventions to have been on the care plan regarding each incident with resident #1. Staff A stated resident #1 admitted to the allegations from 12/6/18 on the morning of 12/10/18. Staff A stated the facility put resident #1 on one-on-one after the dancing Thursday night. Staff A stated the facility did not have documentation of 15-minute checks but kept a direct care staff outside of his/her room at all times. Monitoring ended at 6:00 a.m. on Friday 12/7/18, but stated the staff did monitor resident #1 anytime he/she left the room and monitored resident #1 with resident #2 as that was where the allegation occurred. Staff A stated once the facility found out there was more to the allegation, the facility kept

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resident #1 and resident #2 separated. (The facility did not have supporting documentation to verify the 1:1 monitoring.)

Interview with administrative nursing staff B on 12/11/18 at 5:14 p.m. revealed the facility care plans were less than adequate and stated nothing was added to the care plan for either resident, but the facility did a mini in-service with one sheet for all staff to share (kept at the nurses station and not in either resident's chart) and got as many staff to sign as possible. When asked about the prior incident in July 2018 which involved resident #1, staff B reported he/she did not know much about it but stated he/she did know resident #1 had a history of sexual behaviors and had been to the BHU in the past. Staff B stated the facility did not have adequate care plan interventions in place to guide staff to respond in such situations as this one. Staff B stated he/she did not know resident #1 forced him/herself onto resident #3, prior (incident reported on 7/6/2018).

Review of the "Abuse, Prevention and Prohibition Policy" revised 11/2018 revealed each resident had the right to be free from abuse. Residents must not be subjected to abuse by other residents. The facility prohibited mistreatment, neglect and/or abuse of residents. The facility would reassess care planned interventions on a regular basis, intervention strategies based on resident screenings would be implemented to prevent occurrences of abuse. The facility would identify residents whose personal history rendered them at risk for abusing other residents through a prescreening process. The facility employee or agent, who becomes aware of abuse or neglect, including injuries of unknown origin or alleged misappropriation of resident

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property, shall immediately report the matter to the facility administrator or his designated agent. When another resident was the alleged perpetrator of the abuse, a licensed professional would immediately evaluate the resident's physical and mental status, care plan, monitor behaviors and notify the physician for a determination regarding treatment and/or discharge options. Residents would be referred for behavior management when indicated. Changes in room assignments and seating arrangements would be recommended as needed. The safety of other residents of the facility would be of primary concern.

The facility failed to prevent an occurrence of resident-to-resident sexual abuse when the facility knew resident #1 had a history of hypersexual behaviors and an allegation of sexual abuse with resident #3 and the facility did not implement interventions or care plan updated to prevent another occurrence of sexual abuse between resident #1 and resident #2. This deficient practice placed resident #2 in immediate jeopardy.

The facility abated the immediate jeopardy on 12/13/18 at 4:50 p.m. when the facility staff conducted a 100% audit of all care plans in the facility. The facility identified all residents with behaviors and developed a care plan which included identifying the behavior and interventions for staff to follow. The facility further added behavior monitoring to each resident identified for tracking of behaviors, for further updates and additional interventions for the resident's care plan. The facility indicated further monitoring would be completed per the Behavior Policy if indicated and staff would notify the

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physician for further evaluation and the interdisciplinary team would evaluate new or changing behavioral symptoms to identify underlying causes and address any modifiable factor that may have contributed. The facility director of nursing initialed training with all nursing staff on the abuse policy, which included notification of the abuse coordinator if staff suspected abuse, the behavior policy which included assessment, cause, management and monitoring; the care planning process of identifying problem areas, their causes and developed interventions that were targeted and meaningful to the resident, and included the need for staff to follow the care plan for each resident. The facility would educate all new hired nursing staff during orientation of the abuse, neglect, and exploitation policy, including behavior policy, and establishing/following care plans. The facility would question staff on appropriate action if a resident experienced behavior and appropriate interventions followed per the care plan. The facility administrator would randomly question at least three staff members a week on the appropriate action if staff observed a resident exhibit behavior and the proper interventions per the care plan. The facility administrator and director of nursing would randomly review residents with new behaviors daily to ensure staff followed the behavior policy and care planned interventions were in place. The facility would continue to utilize the behavior policy for residents with behaviors to ensure staff appropriately used the interventions in place. The Quality Assurance (QA) plan of action ensured staff were aware of the behavior policy and safety of other residents. The facility would implement corrective actions immediately if a concern was identified and revise the plan as needed-the plan would be reviewed

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F 600	Continued From page 16 weekly in the Compliance QA meeting. The deficient practice remained at a scope and severity of a G.	F 600		
F 610 SS=K	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey 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: The facility reported a census of 36 residents with 3 residents reviewed for resident to resident sexual allegations. Based on observation, interview, and record review the facility failed to protect the residents in the facility from potential resident to resident sexual abuse when the facility knew of resident #1's history of hypersexual behaviors and a prior sexual allegation from female resident #3 in July of 2018 and the facility did not implement care plan interventions to prevent another occurrence. In December 2018	F 610		

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resident #1 sexually abused cognitively impaired resident # 2, who was unable to provide sexual consent and displayed withdrawn behaviors after the allegation. The lack of protection had the potential to affect 23 opposite gender residents in the facility and placed them in immediate jeopardy.

Findings included:

- Review of resident #1's diagnoses from the signed physician's order sheet dated 11/15/18, revealed the following diagnoses: Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and psychosis (any major mental disorder characterized by a gross impairment in reality testing).

Review of the 8/18/18 significant change minimum data set (MDS) revealed resident #1 had a brief interview for mental status (BIMS) score of 15, indicating intact cognition. The resident exhibited symptoms of psychosis which included hallucinations (perceptual experiences in the absence of real external sensory stimuli) and delusions (misconceptions or beliefs that are firmly held, contrary to reality). The resident required limited assistance of one staff with walking in room and corridor, locomotion on unit, and was independent with locomotion off unit. The resident used a walker and a wheelchair for mobility. The resident received daily

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antipsychotic, antianxiety, and antidepressant medications.

Review of the 11/23/18 quarterly MDS revealed resident #1 had a BIMS score of 15. The resident did not exhibit behaviors or psychosis and his/her behaviors had remained the same since the previous assessment. The resident required limited assistance of one staff with walking in room and corridor and required supervision of one staff with locomotion on and off the unit. The resident used a wheelchair for mobility and antipsychotic and antidepressant medications.

Review of the 8/18/18 activities of daily living (ADL) care area assessment (CAA) revealed the resident preferred staff to perform his/her care and required encouragement to participate with his/her care.

Review of the 8/18/18 psychotropic medication CAA revealed the resident received an antipsychotic medication and had been an inpatient at the behavioral health unit.

Review of the informed consent for psychoactive medications (undated) revealed the following less restrictive non-drug approaches had proven to be ineffective for resident #1: one-on-one, distraction, redirection, relaxation, and massage. The medication intervention recommendation was Xanax (antianxiety medication) and Seroquel (antipsychotic medication). The purpose of the psychoactive medication was indicated for a list of targeted symptoms/behaviors written as: refusal to get out of bed, inappropriate sexual behavior and fixation on his/her own genitalia.

Review of the facility reported incident

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investigation form signed 7/6/18 revealed a sexual abuse allegation between resident #1 and resident #3. Resident #1 had a BIMS of 15, which indicated the resident had intact cognition. Resident #3 had a BIMS of 9, which indicated the resident had moderately impaired cognition. The form indicated an allegation of sexual abuse. The report described the incident as second-hand (unidentified housekeeping staff) information reported resident #1 and #3 had a sexual relationship and resident #3 did not have the cognition for consent. The signed investigation reported the incident occurred approximately 2 weeks prior. The corrective action taken by the facility in response to the incident revealed both parties were interviewed. Staff interviewed residents on the same hall as resident #1. The facility moved resident #1 to another hall. The facility placed resident #1 and #3 on 30-minute visual checks. The facility made a report to the local police department. The facilities plan for on-going monitoring for effectiveness was to send resident #1 to a behavioral health unit at a local hospital to monitor and possible adjustment psychotropic medications.

Review of the signed, unnotarized witness statement from licensed nursing staff C dated 7/6/18 revealed direct care staff D saw resident #1 in resident #3's room sitting on the bed.

Review of the notarized witness statement dated 7/6/18 by social service staff E revealed he/she was in the department head meeting with the director of nursing (DON) stated he/she had received a text back from physician F stating he/she had received a text about resident #1 having sexual relations. The DON then asked if staff E knew anything and staff E stated no. Then

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the unidentified housekeeping staff stated that resident #3 and resident #1 were having sexual relations. Upon hearing this staff E and activities staff H talked to resident #3, who stated he/she and resident #1 were friends and then resident #1 tried getting too close and wanted to go further but resident #3 didn't want to. Resident #3 had not been around resident #1 for a couple of weeks now. Then staff E and Staff H went and talked to resident #1. Resident #1 denied everything and stated he/she never had anyone in his/her room and stayed to him/herself. Staff E contacted family member of resident #1 to inform resident #1 would be moved to a different room. The investigation lacked any signed witness statement from the unidentified housekeeping staff who reported the residents having a sexual relationship.

Review of the medical chart revealed 30-minute visual checks for resident #1 dated 7/7/18 from 6:00 p.m. through 7/9/18 at 4:00 p.m., however documentation was missing on 7/8/18 at 6:00 p.m. through 9:30 p.m. (3.5 hours of missing 30-minute visual checks).

Review of the care plan for resident #1 lacked new interventions added to his/her care plan after the 7/6/18 incident.

Review of the facility reported investigation form revealed an incident, which occurred on 12/6/18 at 3:00 p.m. Resident #1 asked direct care staff I to get 3 items out of his/her room. Staff I handed the items to resident #1 and resident #1 reported he/she needed to go make a phone call. At 6:00 p.m., after supper Resident #1 and Resident #2 were witnessed sitting in the commons area of the facility visiting together. At 6:30 p.m. the two

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residents were witnessed dancing in resident #2's room by an unidentified direct care staff certified to administer medications. At 6:30 p.m. licensed nursing staff J observed resident #1 going back to his/her room in his/her wheelchair. Staff J stated that resident #1 did not come out of his/her room the remainder of the night. On December 6, 2018 at 9:25 p.m. resident #2 was found looking out of his/her room and staff J stopped to visit with the resident, at that time resident #2 voiced concern that there was a situation that he/she was uncomfortable with. Resident #2 reported to Staff J that resident #1 came into his/her room and brought 3 gifts for which he/she was grateful for. However, resident #2 later believed that resident #1 implied that resident #2 owed resident #1 sex for the gifts and resident #2 was uncomfortable with this. Resident #2 was worried about how to tell resident #1 that he/she was uncomfortable with the situation. The three items that resident #1 took to resident #2's room were removed by staff and taken to the nurse's station and later returned to resident #1's room.

On December 6, 2018 at 10:00 p.m. staff J notified the administrative nursing staff B and administrative staff A and they discussed the following interventions to be immediately placed into effect for the remainder of the night and next morning. The facility placed the following new interventions: 1:1 monitoring to ensure resident #1 did not return to resident #2's room that night or the following day. Resident #1 was notified he/she was only allowed to interact with resident #2 in public areas. Resident #2 would be supported, and active listening was initiated. Safety would be provided as resident #1 would not be allowed to be in the presence of resident #2 privately, any longer. Provide as needed

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(PRN) medications as ordered for anxiety for resident #1. Skin assessments were provided by hospice and the director of nursing for resident #2. On December 7th between 8 a.m. and 9 a.m. resident #2 told direct care staff K that he/she did not want to take a shower or leave his/her room to eat. Resident #2 stated he/she did not want to get anyone in trouble, but he/she was touched "up there" and "lower". Resident #2 expressed concern that this was his/her fault. Staff K reassured the resident that this was not his/her fault and that no one was mad at him/her. The information was immediately shared with the charge nurse on duty. On December 7, 2018 between 8 a.m. and 9 a.m., licensed nursing staff L was informed of the statement made by resident #2. Staff L went to visit with resident #2 and the resident stated, "something happened last night" and explained that resident #1 came back into resident #2's room. Resident #2 stated that resident #1 made sexual contact by touching his/her chest area and "down there" indicating the pelvic area. Resident #2 repeated he/she did not want to cause any trouble. Staff L immediately contacted the administrative nursing staff B. Staff B then contacted administrative staff A. Both staff E and Staff H conducted interviews with resident #1 and resident #2. Immediate new care planned interventions included resident #1 to remain in the company of only same gender residents in the facility. Resident #1 was not to be in the company of resident #2 and was to be monitored when out of his/her room so that resident #1 did not have any contact with opposite gender residents. Resident #1 and resident #2 would be seen by consultant staff M. The facility looked at potential placement in a same gender facility for resident #1. Resident #1 denied any sexual advances and stated he/she never did anything that was not

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consensual. Resident #2 reported that resident #1 made sexual advances toward him/her. Resident #2 was descriptive in that resident #1 put his/her hand under resident #2's shirt and felt his/her chest area. Resident #2 stated resident #1 asked if he/she could kiss resident #2's genital area and resident #2 stated no. On December 7, 2018 at 10:00 a.m. the facility contacted local law enforcement. Resident #2 shared with the officers that resident #1 came back into his/her room and that was when the situation occurred. At that time nursing staff were able to report that resident #1 did not return to resident #2's room after he/she left around 6:30 p.m. [The facility lacked 1:1 documentation to support evidence that resident #1 did not go back into resident #2's room and per interview with Staff B on 12/11/18 - see below-the facility could not guarantee resident #1 did not go back into resident #2's room or another room occupied by an opposite gendered resident.] On December 7th at 10:00 a.m. the facility notified physician F of all current events and current investigation by local law enforcement. Physician F suggested admission for resident #1 to a local behavioral health unit (BHU). On December 7, 2018 at 1:00 p.m. the facility conducted a self-report to adult protective services of alleged sexual abuse by resident #1. Staff B reported that at that time the local law enforcement and internal investigation had been unable to substantiate sexual abuse. However, nursing care-plans were in place to protect resident #2, as well as all same gendered residents as resident #2, in the facility as the investigation continued. The staff informed the hospice company for resident #2 and the DPOA for resident #2, who stated that resident #2 had a past history of rape and that his/her past memories of past events often were mixed into

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current experiences. At 2:00 p.m. the facility concluded that due to inability by local law enforcement to substantiate the allegation, the internal investigation was unable to substantiate resident reports of sexual exploit. However, care planned interventions remained in place for the safety of resident #2 and the other same gendered residents as resident #2. [The facility did not update resident #1's care plan with interventions mentioned in the investigation] On December 8, 2018 Nursing documentation recorded there were no further interactions between resident #1 and resident #2. Nursing documentation indicated the residents did not have any concerns and did not voice any fears and no reports of being scared were verbalized. On December 10, 2018, resident #1 asked if he/she could visit with the administrative staff A. During the visit with the administrator resident #1 admitted to touching resident #2's chest and asked resident #2 to touch resident #1's genitalia so resident #1 could masturbate. At approximate 11:30 a.m. the facility received a call from APS following up on the original call. At 11:45 a.m. the facility called the local law enforcement with the new information and on December 10th at 2:30 p.m. resident #1 admitted to the BHU.

Review of the undated temporary care plan in-service form for resident #1 revealed a new intervention written: the resident was not to be in the company of resident #2. The resident was to be monitored when out of his/her room so that he/she did not enter any opposite gender resident rooms. The form was signed by 13 staff members, the DON and Administrator, but was undated and not located in the resident's medical chart.

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Review of the facility provided information and medical chart of resident #1 revealed the only monitoring documentation located were 4 nurses notes as follows:

Nurse's note dated 12/8/18 at 12:18 a.m. revealed the resident continued on follow up he/she has been in his/her room throughout this shift --will continue to monitor.

Nurse's note 12/8/18 at 9:03 a.m. (almost 6 hours later) revealed the resident was doing his/her normal routine today and showed no ill effects for the incident.

Nurse's note dated 12/8/18 at 10:23 p.m. (over 12 hours later) revealed the resident remained in his/her room throughout the shift, with no complaints of distress and no signs of anxiety-- will continue to monitor.

Nurse's note dated 12/9/18 at 10:57 a.m. (over 12 hours later) revealed the resident had no reports of fear or danger and was up and about per his/her normal.

Nurse's note dated 12/9/18 at 11:07 a.m. revealed the resident had remained in his/her room since before 6pm.

Observation on December 11, 2018 at 10:30 a.m. revealed resident #1 was in a behavioral health unit.

Interview with direct care staff K on 12/11/18 at 11:59 a.m. revealed the nurse documented the behaviors of residents. Staff K had provided ADL care for resident #1 and stated the resident did have behaviors that were verbally inappropriate.

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Staff K reported resident #1 masturbated in his/her room and stated resident #1's curtain was usually pulled. Staff K stated resident #1 had an incident with resident #3 in July or August of 2018-and stated they were caught doing something, unsure of what, and the facility moved resident #1 to a different room.

Interview with direct care staff N on 12/11/18 at approximately 10:45 a.m. revealed resident #1 would get in a mood and act inappropriate and became angry very quickly. Staff N stated resident #2 asked during cares on Thursday or Friday if the person (resident #1) was going to sue him/her and continued to act scared of everything and refused to eat or leave his/her room.

Interview with administrative staff A on 12/11/18 at 2:59 p.m. revealed resident #1 had a prior allegation with resident #3 and stated the facility in-serviced staff after that allegation to not allow resident #1 in opposite gender resident rooms and not to be in common areas with opposite gender residents and stated resident #1. Staff A stated he/she would have expected interventions to have been on the care plan regarding each incident with resident #1. Staff A stated resident #1 admitted to the allegations from 12/6/18 on the morning of 12/10/18. Staff A stated the facility put resident #1 on one-on-one after the dancing Thursday night. Staff A stated the facility did not have documentation of 15-minute checks but had kept a direct care staff outside of his/her room at all times but monitoring ended at 6:00 a.m. on Friday 12/7/18, but stated the staff did monitor resident #1 anytime he/she left the room and monitored resident #1 with resident #2 as that was where the allegation was. Staff A stated once

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the facility found out there was more to the allegation, the facility kept resident #1 and resident #2 separated. (The facility did not have supporting documentation to verify the 1:1 monitoring)

Interview with administrative nursing staff B on 12/11/18 at 5:14 p.m. revealed the facility was not sure the allegation was valid. Staff B reported no one specific staff member was designated to keep an eye on resident #1. Staff B reported he/she did not know for sure resident #1 did not get into another resident's room or go back to the room of resident #2. Staff B just received assurance from the direct care staff who said resident #1 did not go into other resident's room's that night. (The facility lacked documentation to support consistent monitoring as referenced). Staff B stated he/she did know resident #1 had a history of sexual behaviors and had been to the BHU before. Staff B stated the facility did not have adequate care plan interventions in place to guide staff to respond in such situations as this one. Staff B stated at this time there was no one in the facility that would pose this type of threat, but when staff B looked back on it now, staff B would not have considered resident #1 a threat, either. Staff B stated he/she did not know resident #1 had forced himself onto resident #3, prior (incident reported on 7/6/2018).

Review of the "Abuse, Prevention and Prohibition Policy" revised 11/2018 revealed each resident had the right to be free from abuse. Residents must not be subjected to abuse by other residents. The facility prohibited mistreatment, neglect and/or abuse of residents. The facility would reassess care planned interventions on a regular basis, intervention strategies based on

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resident screenings would be implemented to prevent occurrences of abuse. The facility would identify residents whose personal history rendered them at risk for abusing other residents through a prescreening process. The facility employee or agent, who becomes aware of abuse or neglect, including injuries of unknown origin or alleged misappropriation of resident property, shall immediately report the matter to the facility administrator or his designated agent. When another resident was the alleged perpetrator of the abuse, a licensed professional would immediately evaluate the resident's physical and mental status, care plan, monitor behaviors and notify the physician for a determination regarding treatment and/or discharge options. Residents would be referred for behavior management when indicated. Changes in room assignments and seating arrangements would be recommended as needed. The safety of other residents of the facility would be of primary concern.

The facility failed to protect the residents in the facility from potential resident-to-resident sexual abuse from resident #1, with an established history of hypersexualized behaviors and an allegation of sexual abuse with resident #3 and the facility did not implement protective measures to prevent another occurrence of sexual abuse between resident #1 and resident #2. This deficient practice placed 23 opposite gender residents in immediate jeopardy.

The facility abated the immediate jeopardy on 12/13/18 at 4:50 p.m. when the facility staff conducted a 100% audit of all care plans in the facility. The facility identified all residents with behaviors and developed a care plan which

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included identifying the behavior and interventions for staff to follow. The facility further added behavior monitoring to each resident identified for tracking of behaviors, for further updates and additional interventions for the resident's care plan. The facility indicated further monitoring would be completed per the Behavior Policy if indicated and staff would notify the physician for further evaluation and the interdisciplinary team would evaluate new or changing behavioral symptoms to identify underlying causes and address any modifiable factor that may have contributed. The facility director of nursing initialed training with all nursing staff on the abuse policy, which included notification of the abuse coordinator if staff suspected abuse, the behavior policy which included assessment, cause, management and monitoring; the care planning process of identifying problem areas, their causes and developed interventions that were targeted and meaningful to the resident, and included the need for staff to follow the care plan for each resident. The facility would educate all new hired nursing staff during orientation of the abuse, neglect, and exploitation policy, including behavior policy, and establishing/following care plans. The facility would question staff on appropriate action if a resident experienced behavior and appropriate interventions followed per the care plan. The facility administrator would randomly question at least three staff members a week on the appropriate action if staff observed a resident exhibit behavior and the proper interventions per the care plan. The facility administrator and director of nursing would randomly review residents with new behaviors daily to ensure staff followed the behavior policy and care planned interventions were in place. The facility would

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F 610	Continued From page 30 continue to utilize the behavior policy for residents with behaviors to ensure staff appropriately used the interventions in place. The Quality Assurance (QA) plan of action ensured staff were aware of the behavior policy and safety of other residents. The facility would implement corrective actions immediately if a concern was identified and revise the plan as needed-the plan would be reviewed weekly in the Compliance QA meeting. The deficient practice remained at a scope and severity of an E.	F 610		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.	F 657		

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(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 36 residents with 3 residents reviewed for resident to resident sexual allegations. Based on observation, interview, and record review the facility failed to update resident #1's care plan with interventions address the resident's history of hypersexual behaviors and a prior sexual allegation from female resident #3 in July of 2018 and the facility did not implement care plan interventions to prevent another occurrence.

Findings included:

- Review of resident #1's diagnoses from the signed physician's order sheet dated 11/15/18, revealed the following diagnoses: Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and psychosis (any major mental disorder characterized by a gross impairment in reality testing).

Review of the 8/18/18 significant change minimum data set (MDS) revealed resident #1 had a brief interview for mental status (BIMS) score of 15, indicating intact cognition. The resident exhibited symptoms of psychosis which

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included hallucinations (perceptual experiences in the absence of real external sensory stimuli) and delusions (misconceptions or beliefs that are firmly held, contrary to reality). The resident required limited assistance of one staff with walking in room and corridor, locomotion on unit, and was independent with locomotion off unit. The resident used a walker and a wheelchair for mobility. The resident received daily antipsychotic, antianxiety, and antidepressant medications.

Review of the 11/23/18 quarterly MDS revealed resident #1 had a BIMS score of 15. The resident did not exhibit behaviors or psychosis and his/her behaviors had remained the same since the previous assessment. The resident required limited assistance of one staff with walking in room and corridor and required supervision of one staff with locomotion on and off the unit. The resident used a wheelchair for mobility and antipsychotic and antidepressant medications.

Review of the 8/18/18 activities of daily living (ADL) care area assessment (CAA) revealed the resident preferred staff to perform his/her care and required encouragement to participate with his/her care.

Review of the 8/18/18 psychotropic medication CAA revealed the resident received an antipsychotic medication and was an inpatient at the behavioral health unit.

Review of the informed consent for psychoactive medications (undated) revealed the following less restrictive non-drug approaches had proven to be ineffective for resident #1: one-on-one, distraction, redirection, relaxation, and massage.

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The medication intervention recommendation was Xanax (antianxiety medication) and Seroquel (antipsychotic medication). The purpose of the psychoactive medication was indicated for a list of targeted symptoms/behaviors written as: refusal to get out of bed, inappropriate sexual behavior and fixation on his/her own genitalia.

Review of the facility investigation form signed 7/6/18 described a sexual abuse allegation between resident #1 and resident #3. Resident #1 had a BIMS of 15, which indicated the resident had intact cognition. Resident #3 had a BIMS of 9, which indicated the resident had moderately impaired cognition. The form indicated an allegation of sexual abuse. The report described the incident as second-hand (unidentified housekeeping staff) information reported resident #1 and #3 had a sexual relationship and resident #3 did not have the cognition for consent. The signed investigation reported the incident occurred approximately 2 weeks prior. The corrective action taken by the facility in response to the incident revealed both parties were interviewed. Staff interviewed residents on the same hall as resident #1. The facility moved resident #1 to another hall. The facility placed resident #1 and #3 on 30-minute visual checks. The facility made a report to the local police department. The facility's plan for on-going monitoring for effectiveness was to send resident #1 to a behavioral health unit at a local hospital to monitor and possible adjustment to psychotropic medications.

Review of the care plan for resident #1 lacked new interventions added to his/her care plan after the 7/6/18 incident.

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Review of the facility reported investigation form revealed an incident, which occurred on 12/6/18 at 3:00 p.m. Resident #1 asked direct care staff I to get 3 items out of his/her room. Staff I handed the items to resident #1 and resident #1 reported he/she needed to go make a phone call. At 6:00 p.m., after supper Resident #1 and Resident #2 sat in the commons area of the facility visiting together. At 6:30 p.m. the two residents were witnessed dancing in resident #2's room by an unidentified direct care staff certified to administer medications. At 6:30 p.m. licensed nursing staff J observed resident #1 going back to his/her room in his/her wheelchair. Staff J stated that resident #1 did not come out of his/her room the remainder of the night. On December 6, 2018 at 9:25 p.m. resident #2 was found looking out of his/her room and staff J stopped to visit with the resident, at that time resident #2 voiced concern that there was a situation that made him/her uncomfortable. Resident #2 reported to Staff J that resident #1 came into his/her room and brought 3 gifts for which he/she was grateful. However, resident #2 later believed that resident #1 implied that resident #2 owed resident #1 sex for the gifts and resident #2 was uncomfortable with this. Resident #2 was worried about how to tell resident #1 that he/she was uncomfortable with the situation. The three items that resident #1 took to resident #2's room were removed by staff and taken to the nurse's station and later returned to resident #1's room. On December 6, 2018 at 10:00 p.m. staff J notified the administrative nursing staff B and administrative staff A and they discussed the following interventions to be immediately placed into effect for the remainder of the night and next morning. The facility placed the following new

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interventions: 1:1 monitoring to ensure resident #1 did not return to resident #2's room that night or the following day. Resident #1 was notified he/she was only allowed to interact with resident #2 in public areas. Resident #2 would be supported, and active listening was initiated. Safety would be provided as resident #1 would not be allowed to be in the presence of resident #2 privately. Provide as needed (PRN) medications as ordered for anxiety for resident #1. Skin assessments were provided by hospice and the director of nursing for resident #2. On December 7th between 8 a.m. and 9 a.m. resident #2 told direct care staff K that he/she did not want to take a shower or leave his/her room to eat. Resident #2 stated he/she did not want to get anyone in trouble, but he/she was touched "up there" and "lower". Resident #2 expressed concern that this was his/her fault. Staff K reassured the resident that this was not his/her fault and that no one was mad at him/her. The information was immediately shared with the charge nurse on duty. On December 7, 2018 between 8 a.m. and 9 a.m., licensed nursing staff L was informed of the statement made by resident #2. Staff L went to visit with resident #2 and the resident stated, "something happened last night" and explained that resident #1 came back into resident #2's room. Resident #2 stated that resident #1 made sexual contact by touching his/her chest area and "down there" indicating the pelvic area. Resident #2 repeated he/she did not want to cause any trouble. Staff L immediately contacted the administrative nursing staff B. Staff B then contacted administrative staff A. Both staff E and Staff H conducted interviews with resident #1 and resident #2. Immediate new care planned interventions included resident #1 to remain in the company of only same gender residents in the

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facility. Resident #1 was not to be in the company of resident #2 and was to be monitored when out of his/her room so that resident #1 did not have any contact with opposite gender residents. Resident #1 and resident #2 would be seen by consultant staff M. The facility looked at potential placement in a same gender facility for resident #1. Resident #1 denied any sexual advances and stated he/she never did anything that was not consensual. Resident #2 reported that resident #1 made sexual advances toward him/her. Resident #2 was descriptive in that resident #1 put his/her hand under resident #2's shirt and felt his/her chest area. Resident #2 stated resident #1 asked if he/she could kiss resident #2's genital area and resident #2 stated no. On December 7, 2018 at 10:00 a.m. the facility contacted local law enforcement. Resident #2 shared with the officers that resident #1 came back into his/her room and that was when the situation occurred. At that time nursing staff were able to report that resident #1 did not return to resident #2's room after he/she left around 6:30 p.m. [The facility lacked 1:1 documentation to support evidence that resident #1 did not go back into resident #2's room and per interview with Staff B on 12/11/18 - see below-the facility could not guarantee resident #1 did not go back into resident #2's room or another room occupied by an opposite gendered resident.] On December 7th at 10:00 a.m. the facility notified physician F of all current events and current investigation by local law enforcement. Physician F suggested admission for resident #1 to a local behavioral health unit (BHU). On December 7, 2018 at 1:00 p.m. the facility conducted a self-report to adult protective services of alleged sexual abuse by resident #1. Staff B reported that at that time the local law enforcement and internal investigation had been

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unable to substantiate sexual abuse. However, nursing care-plans were in place to protect resident #2, as well as all same gendered residents as resident #2, in the facility as the investigation continued. The staff informed the hospice company for resident #2 and the DPOA for resident #2, who stated that resident #2 had a past history of rape and that his/her past memories of past events often were mixed into current experiences. At 2:00 p.m. the facility concluded that due to inability by local law enforcement to substantiate the allegation, the internal investigation was unable to substantiate resident reports of sexual exploitation. However, care planned interventions remained in place for the safety of resident #2 and the other same gendered residents as resident #2. [The facility did not update resident #1's care plan with interventions mentioned in the investigation.] On December 8, 2018 Nursing documentation recorded there were no further interactions between resident #1 and resident #2. Nursing documentation indicated the residents did not have any concerns and did not voice any fears and no reports of being scared were verbalized. On December 10, 2018, resident #1 asked if he/she could visit with the administrative staff A. During the visit with the administrator resident #1 admitted to touching resident #2's chest and asked resident #2 to touch resident #1's genitalia so resident #1 could masturbate. At approximate 11:30 a.m. the facility received a call from APS following up on the original call. At 11:45 a.m. the facility called the local law enforcement with the new information and on December 10th at 2:30 p.m. resident #1 admitted to the BHU.

Review of the 12/7/18 comprehensive certified

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nurse aide shower review for resident #2 revealed the resident had an old healing bruise on the inner thigh which measured 0.5 centimeters (CM) by 1.5 CM.

Review of the undated temporary care plan in-service form for resident #1 revealed a new intervention written: resident #1 was not to be in the company of resident #2. The resident was to be monitored when out of his/her room so that he/she did not enter any opposite gender resident rooms. The form was signed by 13 staff members, the DON and Administrator, but was undated and not located in the resident's medical chart.

Observation on December 11, 2018 at 10:30 a.m. revealed resident #1 was in a behavioral health unit.

Interview on 12/11/18 at 11:59 a.m. with direct care staff K revealed resident #2 had been melancholy lately and had been more so, since the events with resident #1. Staff K stated the staff looked to the care plan pocket aide to know the cares for each resident. Staff K stated the day after it happened resident #2 did not want to go take a shower, was agitated, and secluded him/herself. Staff K said the staff reassured resident #2 she was safe, but resident #2 was upset and scared and needed reassurance. Staff K provided ADL care for resident #1 and stated the resident did have behaviors that were verbally inappropriate. Staff K reported resident #1 masturbated in his/her room and stated resident #1's curtain was usually pulled. Staff K stated resident #1 had an incident with resident #3 in July or August of 2018-and stated they were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	C 12/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW OF DERBY	445 N WESTVIEW DR DERBY, KS 67037

(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 657	Continued From page 39	F 657		

caught doing something, unsure of what, and the facility moved resident #1 to a different room.

Interview with direct care staff N on 12/11/18 at approximately 10:45 a.m. revealed he/she looked at the pocket care plan to know the cares for each resident. Staff N said resident #1 would get in a mood and act inappropriate and became angry very quickly. Staff N stated resident #2 asked during cares on Thursday or Friday if the person (resident #1) was going to sue him/her and continued to act scared of everything and refused to eat or leave his/her room.

Interview with administrative staff A on 12/11/18 at 2:59 p.m. revealed resident #1 had a prior allegation with resident #3 and stated the facility in-serviced staff after that allegation to not allow resident #1 in opposite gender resident rooms and not to be in common areas with opposite gender residents. Staff A stated he/she expected interventions to have been on the care plan regarding each incident with resident #1.

Interview with administrative nursing staff B on 12/11/18 at 5:14 p.m. revealed the facility care plans were less than adequate and stated nothing was added to the care plan for either resident, but the facility did a mini in-service with one sheet for all staff to share (kept at the nurses station and not in either resident's chart) and got as many staff to sign as possible.

Review of the policy regarding behavioral assessment, intervention and monitoring reviewed on 01/2017 revealed the interdisciplinary team would evaluate behavioral symptoms in residents to determine the degree of severity, distress and potential safety risk to the

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F 657	Continued From page 40 resident, and develop a plan of care accordingly. Safety strategies would be implemented immediately if necessary to protect the resident and others from harm. The facility failed to updated the care plan of resident #1 with interventions to prevent an occurrence of resident-to-resident sexual abuse when the facility knew resident #1 had a history of hypersexual behaviors and an allegation of sexual abuse with resident #3 and the facility did not implement interventions or care plan updated to prevent another occurrence of sexual abuse between resident #1 and resident #2.	F 657		