| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| SCHOWALTER VILLA | 200 W CEDAR PO BOX 5000 HESSTON, KS 67062 |

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| F 000 | INITIAL COMMENTS<br><br>The following citations represent the findings of complaint investigation # 119151.<br><br>A revised copy of deficiencies was sent electronically to the facility on 8/23/17.<br><br>A revised copy of deficiencies was electronically sent to the facillity on 11/29/17. | F 000 | | |
| F 223 SS=D | FREE FROM ABUSE/INVOLUNTARY SECLUSION<br>CFR(s): 483.12(a)(1)<br><br>483.12<br>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 symptoms.<br><br>483.12(a) The facility must-<br>(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;<br>This REQUIREMENT is not met as evidenced by:<br>The facility reported a census of 92 residents with 3 selected for sample review of resident abuse. Based on record review and interview, the facility failed to ensure that one resident (#1) remained free from inappropriate physical contact when resident #2 touched the opposite gender resident (#1) in an inappropriate manner and asked the resident for sex.<br><br>Findings included: | F 223 | Past noncompliance: no plan of correction required. | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 08/18/2017

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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- Resident #1's POS (Physician's Order Sheet), dated 8/1/17, diagnosis included anxiety (a feeling of apprehension, worry, uneasiness or dread) disorder.

The admission Minimum Data Set, dated 3/11/17, included a Brief Interview for Mental Status of 14/15, indicating intact cognition, and the resident expressed he/she had trouble with sleep and feeling tired. The resident needed limited to extensive assistance of staff for most ADL's (activities of daily living). Review of the Care Area Assessments identified that behaviors did not trigger.

A significant change Minimum Data Set, dated 6/5/17, included a Brief Interview for Mental Status of 9/15, indicating moderately impaired cognition, without any mood, delirium or behavioral concerns. The resident needed limited to supervised assistance for most ADL's.

A comprehensive care plan, dated 8/3/17, directed staff to watch the resident for signs of upset/discomfort and seek to remedy the source as quickly as possible. The care plan lacked inclusion of the reported stop signage placed on the resident's room to possibly stop wanderers from entering the resident's room.

Nursing notes, documented on 7/29/17 at 7:04 AM, the resident called staff to his/her room, and reported resident #2 woke him/her up and had his/her hands under the blanket, and asked the resident for sex. The resident was upset and stated he/she was not hurt, but felt scared. Staff provided one to one time with the resident and offered to make a stop sign for the resident's

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door. The resident agreed to have his/her door shut completely, at that time.

Per the investigation conducted by the facility, dated 7/31/17, on 7/29/17 at 6:50 AM, resident #2 entered resident #1's room, removed his/her outer pants, and crawled into bed with resident #1. At that time the resident caressed resident #1's leg and buttocks. Resident #1 yelled out for help, and staff immediately responded and removed resident #2 from the resident #1's room.

The facility reported resident #1 was currently hospitalized due to an unrelated matter.

Resident # 2's admission Minimum Data Set, dated 7/11/17, identified the Brief Interview for Mental Status score of 10/15, indicated moderately impaired cognition. Additionally, the assessment reflected the resident exhibited inattention, had trouble with sleep and at times and exhibited rejection of care. The resident needed limited to extensive assistance of staff for most ADL's (activities of daily living) and identified the resident used a walker and a wheelchair for mobility, with limited assistance needed for ambulation.

A comprehensive care plan dated, 7/14/17 included the following instructions to staff: Should the resident become resistant/combative during care, cease the care giving and provide for the resident's safety; leave the area for 5 to 10 minutes and then return as if nothing had happened and complete the caregiving tasks.

The resident sometimes disrobed in public areas which placed the resident's personal dignity at risk. Evaluate clothing and ensure proper sizing.

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Make eye contact before speaking.

Encourage participation in neighborhood life.

Monitor for inappropriate sexual comments and behaviors; do frequent checks, every 15 minutes. Added 7/31/17.

Gently redirect the resident when making sexually inappropriate comments to staff. Added 8/4/17.

Assist with clothing when redressing. Remind the resident that residents are required to wear clothing in public areas, added 8/4/17.

On 6/28/17 progress notes indicated the resident with an ER (emergency room) visit, with overnight observation: related to dizziness, slurred speech and mild dehydration. The resident returned to the facility on 6/29/17, with a diagnosis of post concussive syndrome suspected due to a 6/18/17 head injury (hit in head with a baseball at a ballgame).

On 7/3/17, an emergency admission from assisted living to healthcare occurred due to the inability to manage the residents care needs (wandering) in the assisted living facility. The doctor noted the estimated length of stay to be less than 30 days.

Nursing notes on 7/18/17 at 3:30 AM, documented the licensed staff assisted the resident with toileting. During the toileting the resident reached out and stroked the licensed nurse's inner thigh. The staff removed the resident's hand and instructed the resident the behavior was inappropriate. The resident

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continued to reach out to the staff member and when the nurse assisted the resident to lie down in bed, the resident requested the nurse to lay down with him/her. The staff instructed the resident he/she was not the resident's spouse.

Nursing notes, dated 7/20/17 at 4:05 PM, recorded the resident exhibited wandering and exit seeking behaviors. The family requested the facility contact the physician for medication for dementia/memory problems. The physician declined the request, indicating the resident was experiencing delirium (sudden severe confusion, disorientation and restlessness).

On 7/24/17 the facility faxed the physician regarding the residents increasing inappropriate sexual behavior becoming more aggressive. The physician ordered Keflex, 500 milligrams, three times a day for 5 days, for a UTI (urinary tract infection).

On 7/28/17 at 4:41 AM, per nursing notes, staff found the resident up multiple times throughout the night. During one of the times up the resident wandered the hall naked, reportedly looking for the restroom. The staff assisted the resident to the toilet and then returned the resident back to bed.

On 7/28/17 at 9:53 PM, per nursing notes the resident continued with inappropriate sexual comments. However, staff easily redirected the resident.

A nursing note dated 7/29/17 at 7:06 AM, identified resident (#2) entered a neighbor's (#1) room. The neighbor reported the resident entered into his/her room without his/her pants on

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and awakened the neighbor, asking for sex. The staff returned the resident to his/her room, and placed a stop sign on the neighbor's door. Additionally, the staff provided instructions to all staff on duty, to monitor resident #2 and keep this resident away from the neighbor.

A nursing note, on 7/31/17 at 8:58 AM, identified the resident asked the social worker what to do about dreams that suddenly come true. When asked to expand the resident referenced an incident where he/she entered another resident's room and began to crawl into his/her bed. The resident thought he/she was dreaming until the other resident began screaming. The resident stated he/she went into the other resident's room, for "sex." The resident reported in the dream he/she was getting into the spouse's bed. (The resident's spouse formerly resided in this room before his/her death). Staff asked the resident if he/she had thought about sex often, reminding the resident of the multiple incidents of inappropriate behaviors with some opposite gender staff. The resident reported he/she does think about sex, but didn't think it was often. The resident denied attraction to the younger opposite gender staff, indicating his/her age. The resident stated again about often dreaming of his/her late spouse, realized that the spouse was gone and just was confused over what happened the morning of the 29th.

Multiple observations from 8/10/17 at 3:55 PM through 8/11/17 at 12:00 PM lacked identification of any inappropriate behaviors with the resident ambulating with a roller walker or staff propelling the resident in a wheelchair.

On 8/10/17 at 4:50 PM, direct care staff A

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reported the resident was independent prior to the head injury, but had been different since then, with increased confusion, especially at night. The staff reported the resident often believed what occurred was only a dream, such as the incident where he/she entered the other resident's room and crawled into the bed with the other resident. When not experiencing confusion the resident was upset about the incidents and does not understand what was happening to him/her. The resident had continued to wander and the staff were monitoring the resident closely.

On 8/11/17 at 12:14 PM, licensed nursing staff B reported the resident had been recently treated for a UTI (urinary tract infection) and thinks some of the confusion may be clearing, but not significantly. Preventive measures to ensure the residents safety included keeping the 2 residents separated, at meal times as well, every 15 minute checks, changing the care plan for all staff to be aware, and educating staff on what to do when seeing the resident acting inappropriately.

On 8/11/17 at 12:35 PM, direct care staff C reported the resident made inappropriate comments to the staff member, but when he/she told the resident he/she was married, and then the resident stopped the inappropriate comments. The staff reported that the staff monitored the resident very close, and included him/her in more activities which seemed to help keep the resident from doing so much wandering into other resident rooms.

Interview, on 8/11/17 at 1:20 PM, with social service staff D reported being made aware of the incident between the residents on 7/31/17. Staff D observed a stop sign on resident #1's door and

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went into the room to visit with resident #1 about the sign. Resident #1 informed staff D of what occurred and had requested the sign be put on the door. Staff D then reported the incident to the DON who was unaware of the incident, at that time.

On 8/11/17 at 2:07 PM, licensed nursing staff F reported that resident #2 had crawled into resident #1's bed about 6:40 AM.

The facility policy for abuse, neglect and exploitation, dated 11/28/16 directed employees of the facility in protection included removing the suspected individual form the direct care area.

The facility failed to protect this dependent resident (#1) from inappropriate physical contact, when the staff failed to recognize the signs of increasing sexual behaviors, by resident #2, and failed to implement interventions to prevent resident #2 from approaching resident #1 in a sexual manner.

The deficiency was cited as past-noncompliance when on 8/2/17 at 8:30 PM, the facility completed the following:

1.) On 7/31/17 the QAA (quality assurance and assessment) committee met and developed an educational plan, which the facility implemented on 7/31/17.

2.) Resident #2 was placed on 15 minute checks and a plan was developed to actively engage the resident in various activities keeping the resident from being alone with the opposite gender residents.

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| F 223 | Continued From page 8<br>3.) In-person education was provided to all resident care related staff in nursing, life enrichment and social services, regarding the ANE (abuse, neglect, exploitation) policy and timeliness of reporting. Additionally, staff education regarding the appropriate handling of inappropriate sexual behavior was given to the staff. The staff were educated on 7/31/17 through 8/2/17, with the last staff educated on 8/2/17 at 8:30 PM. All staff not available for these in-services will be in-serviced prior to reporting for their shift.<br><br>4.) The on-duty charge nurse received one to one counseling regarding the importance of following the ANE policy, on 8/2/17 at 7:30 PM. | F 223 | | |
| F 225 SS=K | INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS<br>CFR(s): 483.12(a)(3)(4)(c)(1)-(4)<br><br>483.12(a) The facility must-<br><br>(3) Not employ or otherwise engage individuals who-<br><br>(i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law;<br><br>(ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or<br><br>(iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or | F 225 | | |

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misappropriation of resident property.

(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.

(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

(2) Have evidence that all alleged violations are thoroughly investigated.

(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance

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| F 225 | Continued From page 10<br>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.<br>This REQUIREMENT is not met as evidenced by:<br>The facility reported a census of 92 residents with 3 selected for sample review of resident abuse. Based on record review and interview, the facility failed to ensure that the 7 opposite gender residents who resided on the skilled nursing unit of the facility remained protected from resident to resident sexual abuse when resident #2 touched an opposite gender resident (#1) in an inappropriate manner and asked the resident for sex. The facility staff failed to follow procedures for protection of the residents related to resident to resident sexual abuse, which placed 8 opposite gender residents, within the PRA (progressive recovery academy) in immediate jeopardy.<br><br>Findings included:<br><br>- Resident #1's POS (Physician's Order Sheet), dated 8/1/17, diagnosis included anxiety (a feeling of apprehension, worry, uneasiness or dread) disorder.<br><br>The admission Minimum Data Set, dated 3/11/17, included a Brief Interview for Mental Status of 14/15, indicating intact cognition, and the resident expressed he/she had trouble with sleep and feeling tired. The resident needed limited to extensive assistance of staff for most ADL's (activities of daily living). Review of the Care Area Assessments identified that behaviors did not trigger. | F 225 | Past noncompliance: no plan of correction required. | |

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A significant change Minimum Data Set, dated 6/5/17, included a Brief Interview for Mental Status of 9/15, indicating moderately impaired cognition, without any mood, delirium or behavioral concerns. The resident needed limited to supervised assistance for most ADL's.

A comprehensive care plan, dated 8/3/17, directed staff to watch the resident for signs of upset/discomfort and seek to remedy the source as quickly as possible. The care plan lacked inclusion of the reported stop signage placed on the resident's room to possibly stop wanderers from entering the resident's room.

Nursing notes, documented on 7/29/17 at 7:04 AM, the resident called staff to his/her room, and reported resident #2 woke him/her up and had his/her hands under the blanket, and asked the resident for sex. The resident was upset and stated he/she was not hurt, but felt scared. Staff provided one to one time with the resident and offered to make a stop sign for the resident's door. The resident agreed to have his/her door shut completely, at that time.

Per the investigation conducted by the facility, dated 7/31/17, on 7/29/17 at 6:50 AM, resident #2 entered resident #1's room, removed his/her outer pants, and crawled into bed with resident #1. At that time the resident caressed resident #1's leg and buttocks. Resident #1 yelled out for help, and staff immediately responded and removed resident #2 from resident #1's room.

The facility reported resident #1 was currently hospitalized due to an unrelated matter.

Resident # 2's admission Minimum Data Set,

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dated 7/11/17, identified the Brief Interview for Mental Status score of 10/15, indicated moderately impaired cognition. Additionally, the assessment reflected the resident exhibited inattention, had trouble with sleep and at times and exhibited rejection of care. The resident needed limited to extensive assistance of staff for most ADL's (activities of daily living) and identified the resident used a walker and a wheelchair for mobility, with limited assistance needed for ambulation.

A comprehensive care plan dated, 7/14/17 included the following instructions to staff: Should the resident become resistant/combative during care, cease the care giving and provide for the resident's safety; leave the area for 5 to 10 minutes and then return as if nothing had happened and complete the caregiving tasks.

The resident sometimes disrobed in public areas which placed the resident's personal dignity at risk. Evaluate clothing and ensure proper sizing.

Make eye contact before speaking.

Encourage participation in neighborhood life.

Monitor for inappropriate sexual comments and behaviors; do frequent checks, every 15 minutes. Added 7/31/17.

Gently redirect the resident when making sexually inappropriate comments to staff. Added 8/4/17.

Assist with clothing when redressing. Remind the resident that residents are required to wear clothing in public areas, added 8/4/17.

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On 6/28/17 progress notes indicated the resident with an ER (emergency room) visit, with overnight observation: related to dizziness, slurred speech and mild dehydration. The resident returned to the facility on 6/29/17, with a diagnosis of post concussive syndrome suspected due to a 6/18/17 head injury (hit in head with a baseball at a ballgame).

On 7/3/17, an emergency admission from assisted living to healthcare occurred due to the inability to manage the residents care needs (wandering) in the assisted living facility. The doctor noted the estimated length of stay to be less than 30 days.

Nursing notes on 7/18/17 at 3:30 AM, documented the licensed staff assisted the resident with toileting. During the toileting the resident reached out and stroked the licensed nurse's inner thigh. The staff removed the resident's hand and instructed the resident the behavior was inappropriate. The resident continued to reach out to the staff member and when the nurse assisted the resident to lie down in bed, the resident requested the nurse to lay down with him/her. The staff instructed the resident he/she was not the resident's spouse.

Nursing notes, dated 7/20/17 at 4:05 PM, recorded the resident exhibited wandering and exit seeking behaviors. The family requested the facility contact the physician for medication for dementia/memory problems. The physician declined the request, indicating the resident was experiencing delirium (sudden severe confusion, disorientation and restlessness).

On 7/24/17 the facility faxed the physician

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regarding the residents increasing inappropriate sexual behavior becoming more aggressive. The physician ordered Keflex, 500 milligrams, three times a day for 5 days, for a UTI (urinary tract infection).

On 7/28/17 at 4:41 AM, per nursing notes, staff found the resident up multiple times throughout the night. During one of the times up the resident wandered the hall naked, reportedly looking for the restroom. The staff assisted the resident to the toilet and then returned the resident back to bed.

On 7/28/17 at 9:53 PM, per nursing notes the resident continued with inappropriate sexual comments. However, staff easily redirected the resident.

A nursing note dated 7/29/17 at 7:06 AM, identified the resident (#2) entered a neighbor's (#1) room. The neighbor reported the resident entered into his/her room without his/her pants on and awakened the neighbor, asking for sex. The staff returned the resident to his/her room, and placed a stop sign on the neighbor's door. Additionally, the staff provided instructions to all staff on duty, to monitor resident #2 and keep this resident away from the neighbor.

A nursing note, on 7/31/17 at 8:58 AM, identified the resident asked the social worker what to do about dreams that suddenly come true. When asked to expand the resident referenced an incident where he/she entered another resident's room and began to crawl into his/her bed. The resident thought he/she was dreaming until the other resident began screaming. The resident stated he/she went into the other resident's room,

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for "sex." The resident reported in the dream he/she was getting into the spouse's bed. (The resident's spouse formerly resided in this room before his/her death). Staff asked the resident if he/she had thought about sex often, reminding the resident of the multiple incidents of inappropriate behaviors with some opposite gender staff. The resident reported he/she does think about sex, but didn't think it was often. The resident denied attraction to the younger opposite gender staff, indicating his/her age. The resident stated again about often dreaming of his/her late spouse, realized that the spouse was gone and just was confused over what happened the morning of the 29th.

Multiple observations from 8/10/17 at 3:55 PM through 8/11/17 at 12:00 PM lacked identification of any inappropriate behaviors with the resident ambulating with a roller walker or staff propelling the resident in a wheelchair.

On 8/10/17 at 4:50 PM, direct care staff A reported the resident was independent prior to the head injury, but had been different since then, with increased confusion, especially at night. The staff reported the resident often believed what occurred was only a dream, such as the incident where he/she entered the other resident's room and crawled into the bed with the other resident. When not experiencing confusion the resident was upset about the incidents and does not understand what was happening to him/her. The resident had continued to wander and the staff were monitoring the resident closely.

On 8/11/17 at 12:14 PM, licensed nursing staff B reported the resident had been recently treated for a UTI (urinary tract infection) and thinks some

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of the confusion may be clearing, but not significantly. Preventive measures, to ensure the residents safety included keeping the 2 residents separated, at meal times as well, every 15 minute checks, changing the care plan for all staff to be aware, and educating staff on what to do when seeing the resident acting inappropriately.

On 8/11/17 at 12:35 PM, direct care staff C reported the resident made inappropriate comments to the staff member, on various occasions.

Interview on 8/11/17 at 1:20 PM, with social service staff D reported being made aware of the incident between the residents on 7/31/17. Staff D observed the stop sign on resident #1's door and went in to the room to visit with resident #1 about the sign. Resident #1 informed staff D of what occurred and had requested the sign be put on the door. Staff D then reported the incident to the DON, who was unaware of the incident, at that time.

On 8/11/17 at 1:45 PM, administrative staff E verified the incident involving the sexual encounter between resident #1 and #2 was not reported to the administrative staff as expected and/or per the policy. The administrative staff lacked awareness of the incident for approximately 2 days and 2 hours, after the occurrence.

On 8/11/17 at 2:07 PM, licensed nursing staff F reported that resident #2 had crawled into resident #1's bed about 6:40 AM. The staff member ensured that both residents were not injured then had gone off shift and did not even think about calling the on-call staff member for

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reporting of a reportable incident. Staff F stated, he/she had many different trainings on abuse and neglect, but at that time it did not even cross his/her mind to report the incident.

The facility policy for abuse, neglect and exploitation, dated 11/28/16 directed all employees of the facility would receive education regarding policies and prevention of abuse during initial orientation and annually during mandatory in-services. Additionally, the policy included all alleged violations involving abuse, neglect, exploitation, or mistreatment were to be reported immediately to the supervisor, charge nurse, Director of Nursing, or the Executive Director. The policy directed that upon notification of a possible abuse situation the supervisor would remove the suspected individual from the direct care area.

The facility failed to timely and thoroughly investigate and report to the state agency, an incident of resident to resident sexual abuse, when the staff on duty failed to notify the administration of the event. Furthermore, the facility failed to ensure protection of all the opposite gender residents, a total of 7 of the PRA, when the policy for ANE was not followed.

This deficient practice placed 7 opposite gender residents, in immediate jeopardy from 7/29/17 at 6:40 AM until 8/2/17 at 8:30 PM (3 days, 14 hours and 50 minutes) when the on-duty staff failed to notify the administrative team of an incident of sexual abuse.

The deficiency was cited as past-noncompliance when on 8/2/17 at 8:30 PM, the facility completed the following:

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| F 225 | Continued From page 18<br><br>1.) On 7/31/17 the QAA (quality assurance and assessment) committee met and developed an educational plan, which the facility implemented on 7/31/17.<br><br>2.) Resident #2 was placed on 15 minute checks and a plan was developed to actively engage the resident in various activities keeping the resident from being alone with the opposite gender residents.<br><br>3.) In-person education was provided to all resident care related staff in nursing, life enrichment and social services, regarding the ANE (abuse, neglect, exploitation) policy and timeliness of reporting. Additionally, staff education regarding the appropriate handling of inappropriate sexual behavior was given to the staff. The staff were educated on 7/31/17 through 8/2/17, with the last staff educated on 8/2/17 at 8:30 PM. All staff not available for these in-services will be in-serviced prior to reporting for their shift.<br><br>4.) The on-duty charge nurse received one to one counseling regarding the importance of following the ANE policy, on 8/2/17 at 7:30 PM. | F 225 | | |
| F 226 SS=F | DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES<br>CFR(s): 483.12(b)(1)-(3), 483.95(c)(1)-(3)<br><br>483.12<br>(b) The facility must develop and implement written policies and procedures that:<br><br>(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of | F 226 | | |

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| F 226 | Continued From page 19<br>resident property,<br><br>(2) Establish policies and procedures to investigate any such allegations, and<br><br>(3) Include training as required at paragraph §483.95,<br><br>483.95<br>(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on-<br><br>(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12.<br><br>(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property<br><br>(c)(3) Dementia management and resident abuse prevention.<br>This REQUIREMENT is not met as evidenced by:<br>The facility reported a census of 92 residents. Based on interview and record review, the facility failed to implement the policy on abuse when the facility failed to protect 1 resident (#1) from sexual abuse and failed to ensure protection of potential sexual abuse to 7 residents (identified as the opposite gender residents). Additionally, the facility failed to ensure the investigation of the incident was timely, and failed to ensure all staff were trained adequately in reporting of abuse.<br><br>Findings included: | F 226 | Past noncompliance: no plan of correction required. | |

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- Resident #1's POS (Physician's Order Sheet), dated 8/1/17, diagnosis included anxiety (a feeling of apprehension, worry, uneasiness or dread) disorder.

The admission Minimum Data Set, dated 3/11/17, included a Brief Interview for Mental Status of 14/15, indicating intact cognition, and the resident expressed he/she had trouble with sleep and feeling tired. The resident needed limited to extensive assistance of staff for most ADL's (activities of daily living). Review of the Care Area Assessments identified that behaviors did not trigger.

A significant change Minimum Data Set, dated 6/5/17, included a Brief Interview for Mental Status of 9/15, indicating moderately impaired cognition, without any mood, delirium or behavioral concerns. The resident needed limited to supervised assistance for most ADL's.

A comprehensive care plan, dated 8/3/17, directed staff to watch the resident for signs of upset/discomfort and seek to remedy the source as quickly as possible. The care plan lacked inclusion of the reported stop signage placed on the resident's room to possibly stop wanderers from entering the resident's room.

Nursing notes, documented on 7/29/17 at 7:04 AM, the resident called staff to his/her room, and reported resident #2 woke him/her up and had his/her hands under the blanket, and asked the resident for sex. The resident was upset and stated he/she was not hurt, but felt scared. Staff provided one to one time with the resident and offered to make a stop sign for the resident's

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door. The resident agreed to have his/her door shut completely, at that time.

Per the investigation conducted by the facility, dated 7/31/17, on 7/29/17 at 6:50 AM, resident #2 entered resident #1's room, removed his/her outer pants, and crawled into bed with resident #1. At that time the resident caressed resident #1's leg and buttocks. Resident #1 yelled out for help, and staff immediately responded and removed resident #2 from the resident #1's room.

Resident # 2's admission Minimum Data Set, dated 7/11/17, identified the Brief Interview for Mental Status score of 10/15, indicated moderately impaired cognition. Additionally, the assessment reflected the resident exhibited inattention, had trouble with sleep and at times and exhibited rejection of care. The resident needed limited to extensive assistance of staff for most ADL's (activities of daily living) and identified the resident used a walker and a wheelchair for mobility, with limited assistance needed for ambulation.

A comprehensive care plan dated, 7/14/17 included the following instructions to staff: Should the resident become resistant/combative during care, cease the care giving and provide for the resident's safety; leave the area for 5 to 10 minutes and then return as if nothing had happened and complete the caregiving tasks.

The resident sometimes disrobed in public areas which placed the resident's personal dignity at risk. Evaluate clothing and ensure proper sizing.

Encourage participation in neighborhood life.

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Monitor for inappropriate sexual comments and behaviors; do frequent checks, every 15 minutes. Added 7/31/17.

Gently redirect the resident when making sexually inappropriate comments to staff. Added 8/4/17.

Assist with clothing when redressing. Remind the resident that residents are required to wear clothing in public areas, added 8/4/17.

On 6/28/17 progress notes indicated the resident with an ER (emergency room) visit, with overnight observation: related to dizziness, slurred speech and mild dehydration. The resident returned to the facility on 6/29/17, with a diagnosis of post concussive syndrome suspected due to a 6/18/17 head injury (hit in head with a baseball at a ballgame).

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Nursing notes, dated 7/20/17 at 4:05 PM, recorded the resident exhibited wandering and exit seeking behaviors. The family requested the facility contact the physician for medication for dementia/memory problems. The physician declined the request, indicating the resident was experiencing delirium (sudden severe confusion, disorientation and restlessness).

On 7/24/17 the facility faxed the physician regarding the residents increasing inappropriate sexual behavior becoming more aggressive. The physician ordered Keflex, 500 milligrams, three times a day for 5 days, for a UTI (urinary tract infection).

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resident away from the neighbor.

A nursing note, on 7/31/17 at 8:58 AM, identified the resident asked the social worker what to do about dreams that suddenly come true. When asked to expand the resident referenced an incident where he/she entered another resident's room and began to crawl into his/her bed. The resident thought he/she was dreaming until the other resident began screaming. The resident stated he/she went into the other resident's room, for "sex." The resident reported in the dream he/she was getting into the spouse's bed. (The resident's spouse formerly resided in this room before his/her death). Staff asked the resident if he/she had thought about sex often, reminding the resident of the multiple incidents of inappropriate behaviors with some opposite gender staff. The resident reported he/she does think about sex, but didn't think it was often. The resident denied attraction to the younger opposite gender staff, indicating his/her age. The resident stated again about often dreaming of his/her late spouse, realized that the spouse was gone and just was confused over what happened the morning of the 29th.

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On 8/11/17 at 12:14 PM, licensed nursing staff B reported the resident had been recently treated for a UTI (urinary tract infection) and thinks some of the confusion may be clearing, but not significantly.

On 8/11/17 at 12:35 PM, direct care staff C reported the resident made inappropriate comments to the staff member, at various times.

Interview on 8/11/17 at 1:20 PM, with social service staff D reported being made aware of the incident between the residents on 7/31/17. Staff D observed the stop sign on resident #1's door and went in to the room to visit with resident #1 about the sign. Resident #1 informed staff D of what occurred and had requested the sign be put on the door. Staff D then reported the incident to the DON, who was not aware of the incident, at that time.

On 8/11/17 at 1:45 PM, administrative staff E verified the incident involving the sexual encounter between resident #1 and #2 was not reported to the administrative staff as expected and/or planned per policy, timely.

On 8/11/17 at 2:07 PM, licensed nursing staff F reported that resident #2 had crawled into resident #1's bed about 6:40 AM.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175386 | A. BUILDING _____ B. WING _____ | C 08/18/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SCHOWALTER VILLA | 200 W CEDAR PO BOX 5000 HESSTON, KS 67062 |

| (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 226 | Continued From page 26 | F 226 | | |

The facility policy for abuse, neglect and exploitation, dated 11/28/16 indicated residents had the right to be free from sexual abuse. Residents must not be subjected to abuse by anyone, including but not limited to other residents. The policy further directed all employees of the facility would receive education regarding policies and prevention of abuse during initial orientation and annually during mandatory in-services. Additionally, the policy included all alleged violations involving abuse, neglect, exploitation, or mistreatment were to be reported immediately to the supervisor, charge nurse, Director of Nursing, or the Executive Director for investigation and reporting to the state agency.

The facility failed to follow their policy for ANE when they failed to timely and thoroughly investigate and report to the state agency, this incident of resident to resident sexual abuse, when the staff on duty failed to immediately notify the administration of the event. Furthermore, the facility failed to ensure protection of the 7 opposite gender residents of the PRA (progressive recovery academy unit).

The deficiency was cited as past-noncompliance when on 8/2/17 at 8:30 PM, the facility completed the following:

1.) On 7/31/17 the QAA (quality assurance and assessment) committee met and developed an educational plan, which the facility implemented on 7/31/17.

2.) Resident #2 was placed on 15 minute checks and a plan was developed to actively engage the resident in various activities keeping the resident from being alone with the opposite gender

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| F 226 | Continued From page 27<br>residents.<br><br>3.) In-person education was provided to all resident care related staff in nursing, life enrichment and social services, regarding the ANE (abuse, neglect, exploitation) policy and timeliness of reporting. Additionally, staff education regarding the appropriate handling of inappropriate sexual behavior was given to the staff. The staff were educated on 7/31/17 through 8/2/17, with the last staff educated on 8/2/17 at 8:30 PM. All staff not available for these in-services will be in-serviced prior to reporting for their shift.<br><br>4.) The on-duty charge nurse received one to one counseling regarding the importance of following the ANE policy, on 8/2/17 at 7:30 PM. | F 226 | | |