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F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigations #99632, #99691, and partial extended survey.	F 000		
F 223 SS=K	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: The facility had a census of 45 residents, of which 10 resided in the special care unit. Based on observation, interview, and record review the facility failed to protect the residents who resided in the special care unit from Resident #1, who inappropriately touched cognitively impaired Residents #3 and #5 in a sexual manner. The facility's failure to provide protection to the 10 residents who reside in the special care unit from Resident #1, placed the 10 residents who resided in the special care unit in immediate jeopardy for continued abuse. Findings included: - The medical record revealed the facility admitted Resident #1 on 4/15/16. The 4/20/16 physician progress note included the resident had the following diagnoses: Korsakoff's	F 223		

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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dementia (dementia caused by alcohol misuse), hallucinations (sensing things while awake that appear to be real, but the mind created), disinhibition (a lack of restraint manifested in disregard for social conventions, impulsivity, poor risk assessment, and aggressive outbursts are indicative of disinhibited instinctual drives) with frontal lobe dementia (disorders that primarily affect the frontal and temporal lobes of the brain (the areas generally associated with personality, behavior and language).

The admission (MDS) Minimum Data Set assessment was pending completion.

The 4/15/16 admission nursing assessment indicated the resident was independent with his/her (ADLs) Activities of Daily Living, alert and oriented, had no wandering behaviors, and family reported a memory problem.

The 4/15/16 admission care plan informed staff the resident was an emergency admission into the facility, and instructed staff to provide a secure unit placement. The 4/18/16 care plan update informed staff the resident had delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue), and verbally inappropriate behaviors, with no instruction for intervention. The 4/19/16 care plan update indicated the resident had sexually inappropriate behaviors, and instructed staff to provide 1 to 1 supervision. The 4/20/16 care plan update informed staff the physician ordered antidepressant medication. The 4/20/16 update informed staff the resident continued to have inappropriate verbal, physical, and sexual behaviors, and choose not to take his/her medications, or follow recommendations from the

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staff. The care plan lacked any new instruction to staff to manage the behaviors.

The 3/13/16 psychiatric consultation indicated the resident had multiple prior medication trials, and frequently refused medications and treatment. The consultation further indicated the resident's family member reported the resident heard voices and had delusional psychosis (any major mental disorder characterized by a gross impairment in reality testing), auditory and visual hallucinations, disorganized speech, and paranoia (a thought process believed to be heavily influenced by anxiety or fear to the point of irrational thinking) with a severity of 7/10 (10 being the worst).

The 4/15/16 at 4:01 PM, nurse's note indicated staff admitted the resident as an emergency admission from home and he/she had major health problems that included: organic brain syndrome (psychiatric or neurological symptoms that arise from damage to or disease in the brain)

The 4/15/16 physician orders instructed staff to administer the following medication to the resident:
- Ativan (antianxiety), 2 (mg) milligrams, every 4 hours as needed.

The 4/17/16 at 1:44 PM, nurse's note indicated the resident refused his/her medications, and rummaged through his/her roommate's belongings. The note further indicated when staff asked the resident not to go through the roommate's belongings the resident would slap his/her fist into the palm of his/her hand.

The 4/18/16 at 10:40 AM, nurse's note indicated the resident had delusional thoughts during the

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morning shift, and the resident stated he/she was a nurse, a karate expert, and not a drug addict, drunk, etc. The note indicated the resident paced around the special care unit, walked and talked with another resident, and rubbed the other resident's shoulders and arms. The note further indicated staff observed the resident hugging other residents, and staff informed the resident not to touch the other resident because the other resident may not understand his/her intentions. The note indicated the resident verbalized understanding, but stated it did not matter, he/she would do whatever he/she wanted to do. The note indicated staff informed the resident not to touch other residents, and the resident stated ok.

The 4/18/16 at 5:12 PM, nurse's note indicated in regards to the resident's recent behavior, staff implemented 15 minute checks on Resident #1 when he/she was awake.

The 4/19/16 at 12:55 AM, nurse's note indicated staff observed the resident pacing the halls in the special care unit, and at 10:30 PM, staff administered Ativan to the resident. The note further indicated staff performed 15 minute visual checks, and observed no inappropriate physical touching by the resident.

The 4/19/16 at 7:36 AM, nurse's note indicated the resident yelled in another resident's room. The note indicated staff went to the room and observed Resident #1 lying in another resident's bed, yelling at the other resident, and staff asked him/her to get out of the other resident's bed. The note further indicated staff observed the resident be verbally inappropriate to the other resident. Staff redirected the resident to his/her room, and the resident continued to yell inappropriately at

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staff.

The 4/19/16 at 2:48 PM, nurse's note indicated at 1:30 PM, staff observed Resident #1 seated next to Resident #3, and grabbed the groin of Resident #3. Staff observed Resident #1 take Resident #3's hand to place on Resident #1's chest. The note indicated Resident #3 resisted, and Resident #1 verbalized inappropriate sexual remarks to Resident #3. The note further indicated staff attempted to intervene and Resident #1 refused to remove his/her hand from Resident #3's groin area, staff moved in between the 2 chairs and Resident #1 released Resident #3 but continued to make inappropriate sexual remarks to Resident #3. The note indicated when staff attempted to talk to Resident #1 about the incident, he/she stated he/she had a black belt in karate, and attempted to kick staff unsuccessfully. The note further indicated staff provided 1 to 1 supervision to Resident #1.

The 4/19/16 at 5:13 PM, nurse's note indicated 4 psychiatric facilities refused to admit the resident.

The 4/19/16 at 6:04 PM, nurse's note indicated 2 psychiatric facilities refused to admit the resident, and staff continued to provide 1 to 1 supervision. The note further indicated the resident was angry with the 1 to 1 staff and hit the wall 3 times.

The 4/20/16 staff in-service informed staff the resident was delusional and instructed staff to redirect inappropriate behavior. The in-service instructed staff to allow the resident to vent, and not to let the resident sit next to residents of the opposite gender.

The 4/20/16 at 9:44 AM, nurse's note indicated

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staff provided 1 to 1 supervision to the resident, and he/she required redirection 7 times, including redirection when the resident touched another resident's face. The note indicated the resident refused his/her medications, had delusions, and punched his/her fist into the other hand.

The 4/20/16 physician's order instructed staff to administer the following to the resident:
- Paxil (an antidepressant) 10 mg, daily x 1 week, then increase to 20 mg, daily.
- Seroquel (an antipsychotic) 50 mg, twice daily.

The 4/21/16 at 2:32 PM, nurse's note indicated the resident refused all medications, was very hard to redirect, and got angry when told to stay away from residents of the opposite gender. The note further indicated the resident tried to "take care of" a resident of the opposite gender.

The 4/22/16 at 2:56 AM, nurse's note indicated staff reported the resident entered the room of a resident of the opposite sex and staff observed him/her rubbing his/her back and arms. The note indicated staff instructed the resident to keep his/her hands to him/herself, and the resident appeared agitated and slapped one hand in the other. The note further indicated the resident answered the facility's phone, and told the caller he/she was a nurse. The note indicated the resident was currently pacing, and had refused his/her medications.

The 4/22/16 at 7:30 PM, nurse's note indicated the resident was outside in a secured fence and chose not to come inside the facility. The note indicated the resident stated he/she does not need to be "baby sat", and made a fist and punched his/her other hand as staff walked by.

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The note further indicated staff performed 15 minute checks, and at 8:30 PM, the resident was back in the facility.

The 4/24/16 physician's progress note indicated the provider attempted to interact with the resident and he/she would not respond, and when he/she did, it would not be useful or insightful information. The note indicated staff reported the resident will refuse his/her medications, can be a behavior problem, and became agitated or sexually inappropriate trying to grab staff and other residents genitals. The note indicated the physician planned to replace the Seroquel with Abilify for labile mood, and medications were ineffective due to the resident not taking oral medications to determine tolerability, and may consider changing to a long acting injectable due to compliance issues.

The 4/25/16 at 3:24 PM, social services admission psychological assessment indicated the resident reported he/she was angry, sad, depressed, and wanted to go home. The assessment indicated the resident refused to visit with a psychiatrist, and stated he/she had problems interacting with staff and peers.

The 4/25/16 physician's order instructed staff to discontinue the Seroquel, administer Abilify (an antipsychotic), 15 mg daily, to the resident, and to follow up in 1 month.

The 4/26/16 at 1:50 PM, social services note indicated social services visited with the resident in regards to not rummaging through his/her roommate's belongings. The note indicated social services showed the resident the belongings which belonged to his/her roommate, and the

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resident stated they were his/hers and left the room.

On 4/26/16 at 8:50 AM, observation revealed Resident #1 seated with Resident #5 at a table in the dining room of the special care unit with no staff present. Continued observation revealed at 8:54 AM, staff opened a resident's door, looked into the dining room, and shut the door again. At 8:55 AM, observation revealed staff returned to the commons area.

On 4/26/16 at 11:12 AM, observation revealed Resident #1 ambulated independently into the dining room of the special care unit, and sat in between Resident #2 and Resident #6 (both residents of the opposite gender), and across from Resident #5. Continued observation revealed, the resident was not in continuous view of staff multiple times during the meal. At 12:17 PM, Resident #1 leaned over and asked Resident #6 what his/her shirt says, and attempted to pull back his/her clothing protector to look. Observation revealed Medication Aide A stood between the 2 residents, and Resident #1 turned and made an angry face. At 12:22 PM, continuous observation revealed Resident #1 grabbed for Resident #6's hand, and Resident #6 pulled away, and scooted his/her wheelchair back. Resident #1 attempted to assist Resident #6, and he/she pushed Resident #1 away. Further observation revealed no staff intervention, and Resident #6 went from smiling, to withdrawn, and without a facial expression when Resident #1 would talk to or touch him/her.

On 4/26/16 at 1:49 PM, observation revealed Resident #1 and Resident #2 (opposite gender of Resident #1) ambulated down the hallway into the

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dining room in the special care unit. Further observation revealed the residents sat down together at a table and had iced tea. Continued observation revealed at 1:53 PM, no staff supervision of the 2 residents in the special care unit dining room for several minutes and no observations of the residents being inappropriate at this time. At 2:07 PM, observation revealed Resident #1 stood directly in front of Resident #3 seated in a recliner, looked around the room, then walked away down the hall without staff supervision.

On 4/26/16 at 2:18 PM, observation revealed staff assisted Resident #3 to his/her room to use the bathroom, and left multiple residents in the special care unit commons area unattended. Further observation revealed Resident #1 ambulated independently into the commons area, and wandered around the unit. Continued observation revealed Resident #2 and Resident #7 (both residents of the opposite gender as Resident #1), followed Resident #1 as he/she wandered the unit without staff supervision until 2:25 PM. Further observation revealed Resident #7 needed assistance, and staff went into his/her room, shut the door, and left the commons area unattended with Resident #1 and Resident #5 seated in the dining room until 2:28 PM. Further observation revealed Resident #1 continued to wander throughout the special care unit without continuous observation of the staff.

On 4/26/16 at 3:38 PM, observation revealed Resident #1 ambulated down the hallway, kicked his/her leg above his/her head, and made a karate chop move with both his/her hands at staff. Further observation revealed Resident #1 sat down in a recliner in the commons area of the

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special care unit and had a conversation with his/herself, asking and answering him/her own questions.

On 4/27/16 at 11:29 AM, observation revealed Resident #1 and a resident of the opposite gender sat in the dining room at a table next to one another. Continued observation until 11:55 AM, revealed the resident was not in continuous supervision of staff.

On 4/27/16 at 2:05 PM, observation revealed Resident #1 seated with Resident #5, and Resident #2 in the dining room of the special care unit without staff supervision. Continued observation revealed at 2:35 PM, Resident #1 and Resident #2 wandered together throughout the special care unit without direct staff supervision. At 2:40 PM, observation revealed staff assisted a resident in his/her room, shut the door, and left Resident #1, Resident #2, Resident #3, Resident #5, and Resident #6 unattended in the commons area of the special care unit. Continued observation revealed at 2:43 PM, staff checked on the residents in the commons area, and returned to the resident's room and close the door. Further observation revealed Resident #1 and Resident #2 wandered throughout the special care unit without staff supervision. At 2:49 PM, staff entered in the dining room, and Resident #5 reported to staff that Resident #1 sexually assaulted him/her last night and the night before, and he/she does not like it. Resident #5 continued to inform staff that Resident #1 will not stay out of his/her room.

On 4/26/16 at 11:12 AM, Medication Aide A stated he/she did not know what else to do with seating in the dining room, because residents sit where

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they want to. Medication Aide A stated Resident #1 is ok seated next to Resident #6 because Resident #6 will not let Resident #1 touch him/her. Medication Aide A verified Resident #1 touched Resident #6 on 4/25/16, and he/she told staff right away. Medication Aide A further verified Resident #1 got right by Resident #3 the other day, and he/she just stood in between them. Medication Aide A stated he/she did not know what else to do, and verified it was almost impossible to redirect Resident #1.

On 4/26/16 at 12:29 PM, Medication Aide A verified the day of the incident with Resident #3 on 4/19/16, Resident #1 had sat on the floor in front of Resident #3, and staff had him/her move to a recliner prior to the incident. Medication Aide A further verified Resident #1 touched Resident #6 on the belly, Resident #6 does not like it, and staff told Resident #1 to keep his/her hands to him/herself. Medication Aide A stated Resident #2 follows Resident #1 around all the time, and has written him/her love letters. Medication Aide A stated if they are only talking he/she will not interrupt unless they start touching each other. Medication Aide A verified staff do not provide 1 to 1 staff supervision for Resident #1, but do provide 15 minute checks.

On 4/26/16 at 12:35 PM, Nurse Aide C stated he/she did not witness the incident with Resident #1 and Resident #3 on 4/19/16, he/she was at the sink in the dining room. Resident #1 was seated next to Resident #3 in the living area, and had pulled his/her recliner closer to Resident #3. Nurse Aide C further stated Resident #6 tells Resident #1 not to touch him/her, and Resident #1 kissed Resident #6 on the forehead on 4/25/16. Nurse Aide C further verified the resident

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was 1 to 1 supervision on the evening shift, but stated there was not enough staff to do 1 to 1 supervision, so staff provide 15 minute checks.

On 4/26/16 at 2:45 PM, Medication Aide D stated on 4/19/16 Resident #1 told Resident #3, "you want me, you know you do?", and Resident #1 put his/her hand down Resident #3's pants. Medication Aide D verified staff try to keep a visual, but Resident #1 is not on 1 to 1 staff supervision. Medication Aide D further verified Resident #1 does not like to be redirected, and towards the evening Resident #1 and Resident #2 will walk and talk. Staff try to keep close attention to the conversation, and as long as it is appropriate, staff allow it.

On 4/26/16 at 2:50 PM, Nurse Aide E verified on 4/18/16 that Resident #1 and Resident #2 were holding hands and rubbing each other, prior to the incident.

On 4/26/16 at 2:58 PM, Nurse F verified staff perform 15 minute checks, and can not keep Resident #1 and Resident #2 separated. Nurse F further verified Resident #1 kissed Resident #6 on the forehead the day before, and Resident #6 told Resident #1 to get away from him/her. Nurse F stated he/she does not know if Resident #1 is going to be inappropriate until it happens. Nurse F verified staff tried to provide 1 to 1 supervision and Resident #1 didn't like it, and they do not have enough staff to do it.

On 4/27/16 at 1:40 PM, Administrative Nurse G stated staff only performed 1 to 1 supervision right after the incident, and now staff perform 15 minute checks. Administrative Nurse G verified staff are to keep the resident in constant visual to

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keep the other residents safe in the special care unit, and verified there could be times the resident was not in constant visual. Administrative Nurse G stated staff should call for someone to come into the unit so staff can provide cares to other residents, and not leave the resident unattended. Administrative Nurse G stated the facility admitted the resident on a Friday afternoon, he/she was not involved in the admission process, and after the incident on 4/19/16, he/she felt Resident #1 was inappropriately admitted into the facility and needed medication adjustments.

On 4/27/16 at 3:10 PM, Resident #5 verified on the evening of 4/25/16, he/she was lying in bed in his/her room, and Resident #1 came in and rubbed his/her buttocks, and stated "hi sweetheart". Resident #5 stated Resident #1 kissed him/her on the cheek, and rubbed his/her arm in the past. Resident #5 stated on 4/25/16 he/she informed Nurse Aide B he/she was inappropriately touched. Resident #5 further stated Resident #1 goes into rooms of residents who are of the opposite sex, all the time. Resident #5 stated Resident #1 kisses Resident #2, and Resident #6 tells Resident #1 not touch him/her, but Resident #1 does it anyway.

On 4/27/16 at 3:32 PM, Nurse Aide B verified Resident #5 notified him/her on 4/25/16 that Resident #1 inappropriately touched him/her. Nurse Aide B further verified he/she notified the medication aide in charge that evening, so he/she could write it down on paper. Nurse Aide B further verified he/she had witnessed Resident #1 kiss Resident #2 on the cheek, walk arm and arm, and observed Resident #1 rub Resident #3's feet. Nurse Aide B stated when staff tell Resident #1

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his/her behavior is inappropriate, he/she gets upset.

On 4/27/16 at 3:38 PM, Medication Aide I stated on 4/25/16, he/she was not notified that Resident #5 reported he/she was inappropriately touched by Resident #1. Medication Aide I stated staff perform 15 minute checks on the residents to monitor for inappropriate behaviors.

On 4/27/16 at 4:06 PM, Administrative Nurse G verified he/she was not aware of an incident occurring on 4/25/16 with Resident #1 and Resident #5. Administrative Nurse G further verified he/she was aware Resident #1 approached Resident #6 and grabbed his/her hand, but did not know it went any further than that. Administrative Nurse G verified both incidents were not reported or investigated by administrative staff.

On 4/28/16 at 3:30 PM, Administrative Staff H verified he/she interviewed Resident #5 on 4/22/16, and he/she had no concerns with inappropriate behaviors of Resident #1, but reported Resident #1 kissed him/her on the cheek.

The facility's 9/2012 Preventing Resident Abuse policy instructed staff to assess a resident with signs and symptoms of a behavior problem and develop and implement a care plan to address behavioral issues.

The facility's 9/2012 Protection of Residents During Abuse Investigations policy directed staff if the alleged abuse involved another resident, the accused resident's representative and attending physician would be notified and that there may be

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F 223	Continued From page 14 restrictions on the accused resident's ability to visit in other resident rooms without supervision. If necessary, the accused resident's family members may be required to help meet this requirement. The facility's 3/2016 Reporting Abuse policy instructed staff inquiries concerning resident abuse should be referred to the director of nursing or to the administrator. The facility failed to provide protection to the 10 residents, who resided in the special care unit, from Resident #1, who displayed inappropriate sexual behaviors to residents. This deficient practice placed the 10 residents in immediate jeopardy for continued abuse. The facility abated the immediate jeopardy on 4/29/16 after completion of training of all staff regarding protection of residents after inappropriate touching in a sexual manner, by a resident, and implementation of 1 to 1 as needed. The training also included the importance of following the reviewed abuse, neglect and exploitation policy, reporting, and protection of residents. The facility also provided 1 to 1 supervision of Resident #1 and protected the residents on the unit. The facility also failed to investigate and report some of the incidents to the state agency. The deficient practice remained at the scope and severity of an E.	F 223		
F 225 SS=K	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS	F 225		

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F 225	Continued From page 15 The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 225		

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The facility had a census of 45 residents, of which 10 resided in the special care unit. Based on observation, interview, and record review the facility failed to protect the residents who resided in the special care unit from Resident #1, who inappropriately touched cognitively impaired Residents #3 and #5 in a sexual manner. The facility's failure to provide protection to the 10 residents who reside in the special care unit from Resident #1, placed the 10 residents who resided in the special care unit in immediate jeopardy.

Findings included:

- The medical record revealed the facility admitted Resident #1 on 4/15/16.

The 4/20/16 physician progress note included the resident had the following diagnoses: Korsakoff's dementia (dementia caused by alcohol misuse), hallucinations (sensing things while awake that appear to be real, but the mind created), disinhibition (a lack of restraint manifested in disregard for social conventions, impulsivity, poor risk assessment, and aggressive outbursts are indicative of disinhibited instinctual drives) with frontal lobe dementia (disorders that primarily affect the frontal and temporal lobes of the brain (the areas generally associated with personality, behavior and language).

The admission (MDS) Minimum Data Set assessment was pending completion.

The 4/15/16 admission nursing assessment indicated the resident was independent with his/her (ADLs) Activities of Daily Living, alert and oriented, had no wandering behaviors, and family reported a memory problem.

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The 4/15/16 admission care plan informed staff the resident was an emergency admission into the facility, and instructed staff to provide a secure unit placement. The 4/18/16 care plan update informed staff the resident had delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue), and verbally inappropriate behaviors, with no instruction for intervention. The 4/19/16 care plan update indicated the resident had sexually inappropriate behaviors, and instructed staff to provide 1 to 1 supervision. The 4/20/16 care plan update informed staff the physician ordered antidepressant medication. The 4/20/16 update informed staff the resident continued to have inappropriate verbal, physical, and sexual behaviors, and choose not to take his/her medications, or follow recommendations from the staff. The care plan lacked any new instruction to staff to manage the behaviors.

The 3/13/16 psychiatric consultation indicated the resident had multiple prior medication trials, and frequently refused medications and treatment. The consultation further indicated the resident's family member reported the resident heard voices and had delusional psychosis (any major mental disorder characterized by a gross impairment in reality testing), auditory and visual hallucinations, disorganized speech, and paranoia (a thought process believed to be heavily influenced by anxiety or fear to the point of irrational thinking) with a severity of 7/10 (10 being the worst).

The 4/15/16 at 4:01 PM, nurse's note indicated staff admitted the resident as an emergency admission from home and he/she had major health problems that included: organic brain

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syndrome (psychiatric or neurological symptoms that arise from damage to or disease in the brain)

The 4/15/16 physician orders instructed staff to administer the following medication to the resident:
- Ativan (antianxiety), 2 (mg) milligrams, every 4 hours as needed.

The 4/17/16 at 1:44 PM, nurse's note indicated the resident refused his/her medications, and rummaged through his/her roommate's belongings. The note further indicated when staff asked the resident not to go through the roommate's belongings the resident would slap his/her fist into the palm of his/her hand.

The 4/18/16 at 10:40 AM, nurse's note indicated the resident had delusional thoughts during the morning shift, and the resident stated he/she was a nurse, a karate expert, and not a drug addict, drunk, etc. The note indicated the resident paced around the special care unit, walked and talked with another resident, and rubbed the other resident's shoulders and arms. The note further indicated staff observed the resident hugging other residents, and staff informed the resident not to touch the other resident because the other resident may not understand his/her intentions. The note indicated the resident verbalized understanding, but stated it did not matter, he/she would do whatever he/she wanted to do. The note indicated staff informed the resident not to touch other residents, and the resident stated ok.

The 4/18/16 at 5:12 PM, nurse's note indicated in regards to the resident's recent behavior, staff implemented 15 minute checks on Resident #1 when he/she was awake.

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The 4/19/16 at 12:55 AM, nurse's note indicated staff observed the resident pacing the halls in the special care unit, and at 10:30 PM, staff administered Ativan to the resident. The note further indicated staff performed 15 minute visual checks, and observed no inappropriate physical touching by the resident.

The 4/19/16 at 7:36 AM, nurse's note indicated the resident yelled in another resident's room. The note indicated staff went to the room and observed Resident #1 lying in another resident's bed, yelling at the other resident, and staff asked him/her to get out of the other resident's bed. The note further indicated staff observed the resident be verbally inappropriate to the other resident. Staff redirected the resident to his/her room, and the resident continued to yell inappropriately at staff.

The 4/19/16 at 2:48 PM, nurse's note indicated at 1:30 PM, staff observed Resident #1 seated next to Resident #3, and grabbed the groin of Resident #3. Staff observed Resident #1 take Resident #3's hand to place on Resident #1's chest. The note indicated Resident #3 resisted, and Resident #1 verbalized inappropriate sexual remarks to Resident #3. The note further indicated staff attempted to intervene and Resident #1 refused to remove his/her hand from Resident #3's groin area, staff moved in between the 2 chairs and Resident #1 released Resident #3 but continued to make inappropriate sexual remarks to Resident #3. The note indicated when staff attempted to talk to Resident #1 about the incident, he/she stated he/she had a black belt in karate, and attempted to kick staff unsuccessfully. The note further indicated staff

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provided 1 to 1 supervision to Resident #1.

The 4/19/16 at 5:13 PM, nurse's note indicated 4 psychiatric facilities refused to admit the resident.

The 4/19/16 at 6:04 PM, nurse's note indicated 2 psychiatric facilities refused to admit the resident, and staff continued to provide 1 to 1 supervision. The note further indicated the resident was angry with the 1 to 1 staff and hit the wall 3 times.

The 4/20/16 staff in-service informed staff the resident was delusional and instructed staff to redirect inappropriate behavior. The in-service instructed staff to allow the resident to vent, and not to let the resident sit next to residents of the opposite gender.

The 4/20/16 at 9:44 AM, nurse's note indicated staff provided 1 to 1 supervision to the resident, and he/she required redirection 7 times, including redirection when the resident touched another resident's face. The note indicated the resident refused his/her medications, had delusions, and punched his/her fist into the other hand.

The 4/20/16 physician's order instructed staff to administer the following to the resident:
- Paxil (an antidepressant) 10 mg, daily x 1 week, then increase to 20 mg, daily.
- Seroquel (an antipsychotic) 50 mg, twice daily.

The 4/21/16 at 2:32 PM, nurse's note indicated the resident refused all medications, was very hard to redirect, and got angry when told to stay away from residents of the opposite gender. The note further indicated the resident tried to "take care of" a resident of the opposite gender.

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The 4/22/16 at 2:56 AM, nurse's note indicated staff reported the resident entered the room of a resident of the opposite sex and staff observed him/her rubbing his/her back and arms. The note indicated staff instructed the resident to keep his/her hands to him/herself, and the resident appeared agitated and slapped one hand in the other. The note further indicated the resident answered the facility's phone, and told the caller he/she was a nurse. The note indicated the resident was currently pacing, and had refused his/her medications.

The 4/22/16 at 7:30 PM, nurse's note indicated the resident was outside in a secured fence and chose not to come inside the facility. The note indicated the resident stated he/she does not need to be "baby sat", and made a fist and punched his/her other hand as staff walked by. The note further indicated staff performed 15 minute checks, and at 8:30 PM, the resident was back in the facility.

The 4/24/16 physician's progress note indicated the provider attempted to interact with the resident and he/she would not respond, and when he/she did, it would not be useful or insightful information. The note indicated staff reported the resident will refuse his/her medications, can be a behavior problem, and became agitated or sexually inappropriate trying to grab staff and other residents genitals. The note indicated the physician planned to replace the Seroquel with Abilify for labile mood, and medications were ineffective due to the resident not taking oral medications to determine tolerability, and may consider changing to a long acting injectable due to compliance issues.

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The 4/25/16 at 3:24 PM, social services admission psychological assessment indicated the resident reported he/she was angry, sad, depressed, and wanted to go home. The assessment indicated the resident refused to visit with a psychiatrist, and stated he/she had problems interacting with staff and peers.

The 4/25/16 physician's order instructed staff to discontinue the Seroquel, administer Abilify (an antipsychotic), 15 mg daily, to the resident, and to follow up in 1 month.

The 4/26/16 at 1:50 PM, social services note indicated social services visited with the resident in regards to not rummaging through his/her roommate's belongings. The note indicated social services showed the resident the belongings which belonged to his/her roommate, and the resident stated they were his/hers and left the room.

On 4/26/16 at 8:50 AM, observation revealed Resident #1 seated with Resident #5 at a table in the dining room of the special care unit with no staff present. Continued observation revealed at 8:54 AM, staff opened a resident's door, looked into the dining room, and shut the door again. At 8:55 AM, observation revealed staff returned to the commons area.

On 4/26/16 at 11:12 AM, observation revealed Resident #1 ambulated independently into the dining room of the special care unit, and sat in between Resident #2 and Resident #6 (both residents of the opposite gender), and across from Resident #5. Continued observation revealed, the resident was not in continuous view of staff multiple times during the meal. At 12:17

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PM, Resident #1 leaned over and asked Resident #6 what his/her shirt says, and attempted to pull back his/her clothing protector to look. Observation revealed Medication Aide A stood between the 2 residents, and Resident #1 turned and made an angry face. At 12:22 PM, continuous observation revealed Resident #1 grabbed for Resident #6's hand, and Resident #6 pulled away, and scooted his/her wheelchair back. Resident #1 attempted to assist Resident #6, and he/she pushed Resident #1 away. Further observation revealed no staff intervention, and Resident #6 went from smiling, to withdrawn, and without a facial expression when Resident #1 would talk to or touch him/her.

On 4/26/16 at 1:49 PM, observation revealed Resident #1 and Resident #2 (opposite gender of Resident #1) ambulated down the hallway into the dining room in the special care unit. Further observation revealed the residents sat down together at a table and had iced tea. Continued observation revealed at 1:53 PM, no staff supervision of the 2 residents in the special care unit dining room for several minutes and no observations of the residents being inappropriate at this time. At 2:07 PM, observation revealed Resident #1 stood directly in front of Resident #3 seated in a recliner, looked around the room, then walked away down the hall without staff supervision.

On 4/26/16 at 2:18 PM, observation revealed staff assisted Resident #3 to his/her room to use the bathroom, and left multiple residents in the special care unit commons area unattended. Further observation revealed Resident #1 ambulated independently into the commons area, and wandered around the unit. Continued

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observation revealed Resident #2 and Resident #7 (both residents of the opposite gender as Resident #1), followed Resident #1 as he/she wandered the unit without staff supervision until 2:25 PM. Further observation revealed Resident #7 needed assistance, and staff went into his/her room, shut the door, and left the commons area unattended with Resident #1 and Resident #5 seated in the dining room until 2:28 PM. Further observation revealed Resident #1 continued to wander throughout the special care unit without continuous observation of the staff.

On 4/26/16 at 3:38 PM, observation revealed Resident #1 ambulated down the hallway, kicked his/her leg above his/her head, and made a karate chop move with both his/her hands at staff. Further observation revealed Resident #1 sat down in a recliner in the commons area of the special care unit and had a conversation with his/herself, asking and answering him/her own questions.

On 4/27/16 at 11:29 AM, observation revealed Resident #1 and a resident of the opposite gender sat in the dining room at a table next to one another. Continued observation until 11:55 AM, revealed the resident was not in continuous supervision of staff.

On 4/27/16 at 2:05 PM, observation revealed Resident #1 seated with Resident #5, and Resident #2 in the dining room of the special care unit without staff supervision. Continued observation revealed at 2:35 PM, Resident #1 and Resident #2 wandered together throughout the special care unit without direct staff supervision. At 2:40 PM, observation revealed staff assisted a resident in his/her room, shut the

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door, and left Resident #1, Resident #2, Resident #3, Resident #5, and Resident #6 unattended in the commons area of the special care unit. Continued observation revealed at 2:43 PM, staff checked on the residents in the commons area, and returned to the resident's room and close the door. Further observation revealed Resident #1 and Resident #2 wandered throughout the special care unit without staff supervision. At 2:49 PM, staff entered in the dining room, and Resident #5 reported to staff that Resident #1 sexually assaulted him/her last night and the night before, and he/she does not like it. Resident #5 continued to inform staff that Resident #1 will not stay out of his/her room.

On 4/26/16 at 11:12 AM, Medication Aide A stated he/she did not know what else to do with seating in the dining room, because residents sit where they want to. Medication Aide A stated Resident #1 is ok seated next to Resident #6 because Resident #6 will not let Resident #1 touch him/her. Medication Aide A verified Resident #1 touched Resident #6 on 4/25/16, and he/she told staff right away. Medication Aide A further verified Resident #1 got right by Resident #3 the other day, and he/she just stood in between them. Medication Aide A stated he/she did not know what else to do, and verified it was almost impossible to redirect Resident #1.

On 4/26/16 at 12:29 PM, Medication Aide A verified the day of the incident with Resident #3 on 4/19/16, Resident #1 had sat on the floor in front of Resident #3, and staff had him/her move to a recliner prior to the incident. Medication Aide A further verified Resident #1 touched Resident #6 on the belly, Resident #6 does not like it, and staff told Resident #1 to keep his/her hands to

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him/herself. Medication Aide A stated Resident #2 follows Resident #1 around all the time, and has written him/her love letters. Medication Aide A stated if they are only talking he/she will not interrupt unless they start touching each other. Medication Aide A verified staff do not provide 1 to 1 staff supervision for Resident #1, but do provide 15 minute checks.

On 4/26/16 at 12:35 PM, Nurse Aide C stated he/she did not witness the incident with Resident #1 and Resident #3 on 4/19/16, he/she was at the sink in the dining room. Resident #1 was seated next to Resident #3 in the living area, and had pulled his/her recliner closer to Resident #3. Nurse Aide C further stated Resident #6 tells Resident #1 not to touch him/her, and Resident #1 kissed Resident #6 on the forehead on 4/25/16. Nurse Aide C further verified the resident was 1 to 1 supervision on the evening shift, but stated there was not enough staff to do 1 to 1 supervision, so staff provide 15 minute checks.

On 4/26/16 at 2:45 PM, Medication Aide D stated on 4/19/16 Resident #1 told Resident #3, "you want me, you know you do?", and Resident #1 put his/her hand down Resident #3's pants. Medication Aide D verified staff try to keep a visual, but Resident #1 is not on 1 to 1 staff supervision. Medication Aide D further verified Resident #1 does not like to be redirected, and towards the evening Resident #1 and Resident #2 will walk and talk. Staff try to keep close attention to the conversation, and as long as it is appropriate, staff allow it.

On 4/26/16 at 2:50 PM, Nurse Aide E verified on 4/18/16 that Resident #1 and Resident #2 were holding hands and rubbing each other, prior to

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the incident.

On 4/26/16 at 2:58 PM, Nurse F verified staff perform 15 minute checks, and can not keep Resident #1 and Resident #2 separated. Nurse F further verified Resident #1 kissed Resident #6 on the forehead the day before, and Resident #6 told Resident #1 to get away from him/her. Nurse F stated he/she does not know if Resident #1 is going to be inappropriate until it happens. Nurse F verified staff tried to provide 1 to 1 supervision and Resident #1 didn't like it, and they do not have enough staff to do it.

On 4/27/16 at 1:40 PM, Administrative Nurse G stated staff only performed 1 to 1 supervision right after the incident, and now staff perform 15 minute checks. Administrative Nurse G verified staff are to keep the resident in constant visual to keep the other residents safe in the special care unit, and verified there could be times the resident was not in constant visual. Administrative Nurse G stated staff should call for someone to come into the unit so staff can provide cares to other residents, and not leave the resident unattended. Administrative Nurse G stated the facility admitted the resident on a Friday afternoon, he/she was not involved in the admission process, and after the incident on 4/19/16, he/she felt Resident #1 was inappropriately admitted into the facility and needed medication adjustments.

On 4/27/16 at 3:10 PM, Resident #5 verified on the evening of 4/25/16, he/she was lying in bed in his/her room, and Resident #1 came in and rubbed his/her buttocks, and stated "hi sweetheart". Resident #5 stated Resident #1 kissed him/her on the cheek, and rubbed his/her

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arm in the past. Resident #5 stated on 4/25/16 he/she informed Nurse Aide B he/she was inappropriately touched. Resident #5 further stated Resident #1 goes into rooms of residents who are of the opposite sex, all the time. Resident #5 stated Resident #1 kisses Resident #2, and Resident #6 tells Resident #1 not touch him/her, but Resident #1 does it anyway.

On 4/27/16 at 3:32 PM, Nurse Aide B verified Resident #5 notified him/her on 4/25/16 that Resident #1 inappropriately touched him/her. Nurse Aide B further verified he/she notified the medication aide in charge that evening, so he/she could write it down on paper. Nurse Aide B further verified he/she had witnessed Resident #1 kiss Resident #2 on the cheek, walk arm and arm, and observed Resident #1 rub Resident #3's feet. Nurse Aide B stated when staff tell Resident #1 his/her behavior is inappropriate, he/she gets upset.

On 4/27/16 at 3:38 PM, Medication Aide I stated on 4/25/16, he/she was not notified that Resident #5 reported he/she was inappropriately touched by Resident #1. Medication Aide I stated staff perform 15 minute checks on the residents to monitor for inappropriate behaviors.

On 4/27/16 at 4:06 PM, Administrative Nurse G verified he/she was not aware of an incident occurring on 4/25/16 with Resident #1 and Resident #5. Administrative Nurse G further verified he/she was aware Resident #1 approached Resident #6 and grabbed his/her hand, but did not know it went any further than that. Administrative Nurse G verified both incidents were not reported or investigated by administrative staff.

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On 4/28/16 at 3:30 PM, Administrative Staff H verified he/she interviewed Resident #5 on 4/22/16, and he/she had no concerns with inappropriate behaviors of Resident #1, but reported Resident #1 kissed him/her on the cheek.

The facility's 9/2012 Preventing Resident Abuse policy instructed staff to assess a resident with signs and symptoms of a behavior problem and develop and implement a care plan to address behavioral issues.

The facility's 9/2012 Protection of Residents During Abuse Investigations policy directed staff if the alleged abuse involved another resident, the accused resident's representative and attending physician would be notified and that there may be restrictions on the accused resident's ability to visit in other resident rooms without supervision. If necessary, the accused resident's family members may be required to help meet this requirement.

The facility's 3/2016 Reporting Abuse policy instructed staff inquiries concerning resident abuse should be referred to the director of nursing or to the administrator.

The facility failed to provide protection to the 10 residents, who resided in the special care unit, from Resident #1, who displayed inappropriate sexual behaviors to residents. This deficient practice placed the 10 residents in immediate jeopardy.

The facility abated the immediate jeopardy on 4/29/16 after completion of training of all staff

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F 225	Continued From page 30 regarding protection of residents after inappropriate touching in a sexual manner, by a resident, and implementation of 1 to 1 as needed. The training also included the importance of following the reviewed abuse, neglect and exploitation policy, reporting, and protection of residents. The facility also provided 1 to 1 supervision of Resident #1 and protected the residents on the unit. The facility also failed to investigate and report some of the incidents to the state agency. The deficient practice remained at the scope and severity of an E.	F 225		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility had a census of 45 residents. The sample included 4 residents. Based on observation, interview, and record review the facility failed to provide appropriate supervision to 1 resident during a tornado drill by leaving him/her unattended in the special care unit during the tornado drill. (#7) Findings included:	F 323		

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- On 4/27/16 at 3:21 PM, observation revealed no staff on the special care unit because all residents had been relocated for a tornado drill. Further observation revealed Resident #7, ambulated in his/her room, and placed his/her pillow on the floor in the hallway multiple times and laid down. Continued observation revealed staff returned to the special care unit at 3:26 PM.

On 4/27/16 at 3:30 PM, Medication Aide D verified the resident was left in the special care unit without staff supervision during the tornado drill. Medication Aide D further verified he/she did not know the resident was left behind until he/she returned to the unit and observed him/her lying on the floor in the hallway. Medication Aide D stated he/she had a list of residents he/she was responsible for, and is unsure how he/she was left behind.

On 4/27/16 at 4:06 PM, Administrative Nurse G verified he/she would had expected staff to have taken the resident out of the special care unit with the other residents for the tornado drill. Administrative Nurse G further verified he/she did not check the special care unit during the tornado drill because he/she was informed Medication Aide D was in the unit.

The facility's undated Admission and Continuing Care Requirements for Secured Units policy indicated the special care unit provided each resident who required low stimuli, a safe and structured environment to meet physical, emotional, social, and spiritual needs.

The facility failed to provide appropriate supervision to Resident #7 during a tornado drill,

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F 323	Continued From page 32 and left him/her unattended by staff in the special care unit.	F 323		