

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155661	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/29/2014
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NAME OF PROVIDER OR SUPPLIER OWEN VALLEY HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 920 W HWY 46 SPENCER, IN 47460
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit resulted in an Extended Survey-Immediate Jeopardy.</p> <p>This visit included the Investigation of Complaints IN00155849 and IN00155188.</p> <p>Complaint IN00155849 - Substantiated. Federal/State deficiencies related to the allegations are cited at F-225, F-226, F-323, & F-520.</p> <p>Complaint IN00155188 - Unsubstantiated due to lack of evidence.</p> <p>Survey dates: September 18, 19, 22, and 23, 2014 Extended Survey dates: 24, 25, 26, 27, 28, and 29, 2014</p> <p>Facility number: 010892 Provider number: 155661 AIM number: 200229560</p> <p>Survey team: Cheryl Mabry, RN-TC (September 18,19, 22, 23, 24, 25, 26, 27, & 29, 2014) Angela Patterson, RN</p>	F000000	<p>The submission of this plan of correction does not indicate an admission by Owen Valley Health Campus that the findings and allegations contained herein are an accurate and true representation of the quality of care provided to the residents of Owen Valley Health Campus. This facility recognizes its obligation to provide legally and medically necessary care and service to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for residential health care facilities. To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only.</p>	
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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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F000156 SS=D	<p>(September 18,19, 22, 23, 24, 25, 26, 28 & 29, 2014) Shelly Vice-Miller, RN (September 18, 19, 22, 23, 24, 25, 26, & 29, 2014) Melissa Gillis, RN (September 18, 19, 22, 23, 24, 25, 26, & 29, 2014)</p> <p>Census bed type: SNF: 10 SNF/NF: 82 Total: 92</p> <p>Census payor type: Medicare: 9 Medicaid: 64 Other: 19 Total: 92</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on October 06, 2014; by Kimberly Perigo, RN.</p> <p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and</p>			

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	<p>all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for</p>			

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	<p>Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>Based on interview and record review, the facility failed to ensure that residents</p>	F000156	F 0156 Resident #88 and #149 suffered no ill effects from the alleged deficient practice. Completion date: 10/29/14. All	10/29/2014	

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	<p>were provided 48 hours notice before their Medicare coverage ran out for 2 of 4 residents reviewed for advance beneficiary notice of Medicare noncoverage. (Resident #88, Resident #149)</p> <p>Findings include:</p> <p>On 9/22/14 at 10:33 a.m., reviewed the liability notice for Resident #88 and Resident #149.</p> <p>1. Resident #88's liability notice dated July 31, 2014; indicated Medicare coverage was ending. There was no signature from the resident nor family.</p> <p>2. Resident #149's liability notice dated April 30, 2014; indicated Medicare coverage was ending. There was no signature from the resident nor family.</p> <p>On 9/22/14 at 11:10 a.m., interview with the Administrator indicated, when asked if there was documentation to confirm Resident #88 and Resident #149 received a 48 hour notice of discontinuing of Medicare coverage of services,"I don't have anything with a signature on it. I don't have anything with a signature."</p> <p>On 9/25/14 at 1:00 p.m., interview with the Business Office Manager indicated,</p>		<p>residents who are receiving Medicare benefits have the potential to be affected by the alleged deficient practice and therefor through corrective actions the campus will ensure residents receive a minimum two day notice as required to Medicare beneficiaries who are being discharged from the Medicare Program for liability notifications and beneficiary appeal rights. Completion date 10/29/14. All department leaders who are part of interdisciplinary team have been inserviced on proper discharge planning to include giving minimum two-day notice for liability notice. Social Services has been inserviced on when and how to fill out and give to resident or repsonible party for discontinuation of Medicare benefits as back up to Business Office Manager and Executive Director. Systemic changes that the facility has made to assure a minimum two-day for liability notice will be the Director of Social Services will discuss upcoming discharges in weekly Medicare meeting giving Business Office time to ensure that a minimum two-day liability notice is given and signed by the resident or responsible party. Executive Director or designee will attend Medicare meeting and track upcoming discharges to assure all Medicare Discharge Notices for those residents ending skilled services are given</p>				

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F000157 SS=D	<p>"When asked if there was a policy for informing residents or family member of Medicare benefits endings, indicated, "No, we don't have a policy on that. We just follow federal regulations [indicating insurance benefits were expiring notice]. There was no policy and procedure provided indicating how and when to notify the resident or family of Medicare benefits ending.</p> <p>On 9/22/14 at 3:45 p.m., the Customer Service Specialist provided, "Resident Move-in Agreement" policy, dated 11-2013, and indicated that was the policy currently used by the facility. The policy indicated, "... 4. MEDICARE AND MEDICAID PROGRAMS ... If the Facility withdraws from, or its provider agreement is terminated with, the Medicaid or Medicare program, advance notice thereof will be provided that the Facility shall not be responsible to the Resident ..."</p> <p>3.1-4(a)</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving</p>		and signed a minimum two-day notices. These audits will be completed weekly in correlation with weekly Medicare meeting x 3 months and 1x monthly thereafter to ensure proper notification is followed. Any issues identified will be forwarded to QA committee for further review and suggestions/recommendations. Completion Date 10/29/14.				

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	<p>the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview the facility did not notify the family, as indicated by facility policy, of an elopement for 1 of 1 residents reviewed for elopement. (Resident #94)</p> <p>Findings include:</p> <p>On 9/18/14 at 10:15 a.m., an interview was conducted with the Administrator. The Administrator indicated Resident</p>	F000157	F 0157 Resident #94 suffered no ill effects from the alleged deficient practice. Completion Date 10/29/14. All residents have the potential to be affected by the alleged deficient practice and therefor through corrective actions and inservicing the campus will ensure residents who are at-risk for elopement or have had elopement attempt have been reviewed and responsible party have been notified of event. Systemic changes made to	10/29/2014

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	<p>#94 had eloped from the secured Legacy unit on 9/14/2014, at "noon" after a dietary delivery had been made to the unit. Resident (#94) proceeded through the Legacy unit locked doors, through the wander guard protected front doors of the facility, proceeding to the sidewalk, and was seen by the nursing staff through the windows of the Legacy unit. The Legacy unit staff, proceeded to redirect Resident #94 back onto the Legacy unit. An investigation was conducted.</p> <p>On 9/19/14 at 10:05 a.m., a record review was conducted of the form titled, "Accident/Incident Report," indicating, "...Name of person involved: [Resident #94's name] ...Date of occurrence: 9/14/14. Time of occurrence: 1140 [11:40 a.m.]. Location: LL [Legacy Lane]... did incident involve exit of building? Yes...Type of Accident/Incident...11. Elopement... Notification/Orders:...Family notified: No... no answer to phone call...."</p> <p>On 9/19/14 at 10:15 a.m., a record review was conducted of the investigation of the elopement of Resident #94. A record titled, "Exit Seeking Circumstance, Assessment and Intervention" dated 9/14/14, was reviewed indicating the family had not been notified.</p>		<p>ensure the alleged deficient practice does not reoccur: DHS or designee will re-educate the Licensed Nurses on campus guidelines for responsible party notification.DHS or designee will conduct audits during Clinical Care Meeting 1x daily x5 days for 8 weeks, and then 1x weekly for 2 weeks, and then 1x monthly for 2 months thereafter with results forwarded to the QA Committee for 3 months and quarterly thereafter for further review and suggestions/recommendations.C completion date 10/29/14.</p>	

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	<p>On 9/19/14 at 2:00 p.m., an interview was conducted with the husband of Resident #94 indicating he had not been contacted regarding the elopement. "... no, I didn't know anything about that at all... no one talked to me, and I'm her only family... no, no one from the facility has left messages or talked about that at all...."</p> <p>On 9/19/14 at 2:30 p.m., an interview was conducted with the Administrator indicating the family had not been contacted because they, "could not be reached." The Administrator could not verify if additional attempts had been made to contact the family about the elopement. No further information was provided in regard to contact being made to the family about the elopement. The Administrator indicated, "... we [the facility] have been in contact with the husband about some money issues since the elopement, but I do not recall talking about the elopement... no."</p> <p>On 9/25/2014 at 11:30 a.m., a record review was conducted of the policy and procedure of the facility titled, "Guidelines for responsible party notification....Effective date: 11/08/2010...Purpose: to ensure the resident's responsible party is aware... in change of condition in a timely manner.</p>						

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F000225 SS=D	<p>Procedure:...2. The responsible party should be notified of change in a condition... in a timely manner. 3. If the responsible party is unable to be reached a message may be left...."</p> <p>3.1-5(a)</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 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.</p> <p>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).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p>				

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	<p>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.</p> <p>Based on interview and record review, the facility failed to thoroughly investigate and report an allegation of nonconsensual sexual interaction as indicated by facility policy in that two cognitively impaired residents had two sexual interactions for 1 of 1 alleged violation of abuse reviewed. (Resident #C) (Resident #D)</p> <p>Findings include:</p> <p>A facility form titled Social Services or Physician New or Worsening Behavior Notification, dated 8/28/2014 at 10:10 p.m., for Resident #D indicated, "Res [Resident] had another Res [not identified] on his lap c [with] his hand up her shirt grabbing her breast...."</p> <p>A facility form titled Mental Health Wellness Circumstance, assessment and Inter-dated 8/28/2014 at 10:10 p.m., for Resident #D indicated, "Type of incident: Social/Sexual inhibition..."</p> <p>Social Service Progress Note dated</p>	F000225	F 0225 Resident C & D suffered no ill effects from the alleged deficient practice. The facility determined that residents with cognitive impairment have the potential to be affected and were reassessed by Social Services to determine if any other residents were at-risk for sexually acting out. Any identified resident will have their care plan updated. Systemic changes made to ensure the alleged deficient practice does not reoccur: Staff will be re-educated on the campus policy for reporting unusual occurrences. DHS/designee will conduct random audit of 5 residents 5x per week x4 weeks, then 3x week for 8 weeks, and then 1x per week for 8 weeks. The results of the audits will be reported to QA and reviewed for 6 months and quarterly thereafter for further review and suggestions/recommendations from the QA committee. Completion date 10/29/14	10/29/2014			

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	<p>9/2/2014, "Res [Resident #C] was found in a male residents [Resident #D] room with her pants off. She and the man were not making contact at the time. Male res had been in bed, where he sleeps nude. This res [Resident #C] was unable to state what happened & was unable to answer "yes" "no" questions. Res continues to interact as usual. Staff did remove her from his room...."</p> <p>A facility form titled Clinically at Risk Individual Monitoring Sheet dated 9/4/2014, for Resident #D indicated, "Reason for discussion: Behavior/altercation 8/28/2014 and 9/2/2014... 8/28/2014 res [Resident #D] had another res [not identified] on his lap c [with] his hand up her shirt grabbing her breast. res [sic] were redirected c [with] success...."</p> <p>Resident #C was dressed by CRCA (Clinical Resource Clinical Assistant/CNA), removed from Resident #D's room and was examined by LPN #4.</p> <p>Resident #C's Nurses notes dated 9/2/2014, and signed by LPN #4 indicated, "... 8:15 a.m., Nurse exam res [resident]. res. was resistant when removing pants. Noted discharge of yellow/thick const. [consistency] on pull up res also noted to</p>			

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	<p>be slightly red...."</p> <p>Resident #D's Nurses notes dated 9/2/2014, and signed by LPN #4 indicated, "...7:45 a.m., Housekeeping reported to CRCA that res. was sitting on side of bed naked c [with] nothing on from waist down. 7:50 a.m. CRCA note same observation from above. CRCA's noted res. acted strangely et [and] surprise when they walked in room. CRCA's removes res [Resident #C] from res. room. 8:00 a.m. Nurse notified of incident nurse reported situation to E.D. [Executive Director]...."</p> <p>On 9/22/14 at 2:04 p.m., interview with Medical Records/LPN (Licensed Practical Nurse) indicated, if sexual interaction were not consensual it is abuse. I would separate them, notify the nurse on duty, Administrator, DON, and physician. With Resident #C and Resident #D we had a little situation where her pants were off and he was fully undressed and she wandered into his room. I don't think anything happened. They're both confused and the Medical Director said she didn't think anything happened. The families were notified.</p> <p>On 9/22/14 at 2:16 p.m., interview with</p>			
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	<p>the DHS (Director of Health Services) indicated, "We consider it abuse if it was emotional distress and not consensual. If it is consensual and both parties consent we don't consider abuse. "We had an incident like that on Legacy Lane when a female went into a male room and he sleeps naked. She was found standing in the middle of his room. She had her bottoms off. We did a full assessment on her. There was no vaginal bleeding. This happened 4-6 weeks ago maybe. We did not report. It didn't appear to be any sexual assault."</p> <p>On 9/22/14 at 3:27 p.m., an interview with the Executive Director (ED) indicated, "We have a training program and corporate compliance hotline. We do abuse inservices once a year. We would have to determine if the parties were willing or not. Do an investigation, contact physician, and family, update. When asked if this would be a reportable to the state. It depends on if it were consensual. I just can't assume something happened." If two residents were not cognitively intact found in a compromising situation is that a reportable? "It depends on the investigation. We would have to investigate."</p> <p>On 9/23/2014 at 3:15 p.m., an interview</p>			

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	<p>with LPN #4 indicated a specimen was obtained from Resident #C, but the physician did not order any test to be done on the specimen and the specimen was disposed of.</p> <p>On 9/23/2014 at 10:44 a.m., an interview with the Medical Director/ personal physician (same person) for Resident #C indicated, being called about Resident #C having been found in room of a male resident. This nurse said she took some vaginal secretions. I had no intention of doing a rape kit. I didn't feel it was clinically indicated, so the specimen collected was disposed of. I think she [Resident #C] entered a room and got into the bed and he [Resident #D] probably woke up and saw her in his bed. I didn't examine the lady. I felt like it was inappropriate behavior on the residents part. She wanders around all the time. I understood she was sitting on the bed with her pants down and he was lying in the bed.</p> <p>On 9/23/2014 at 3:25 p.m., an interview with Housekeeper #1 indicated the Housekeeper found Resident #C in Resident #D's bed, both residents were awake. Resident #C was sideways on the bed and Resident #D was laying long ways on the bed. The Housekeeper informed the nurse and the CRCA of the</p>			

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	<p>event. He then indicated he filled out an incident report.</p> <p>On 9/23/2014 at 3:45 p.m., an interview with the DHS (Director of Health Services) indicated there was no incident report filled out by any staff concerning the event on 9/2/2014, in regard to Resident #C and Resident #D. The only reports related to this event were in the residents' charts filled out by nursing.</p> <p>On 9/24/2014 at 2:00 p.m., an interview with Executive Director indicated, the female resident involved in the event on 8/28/2014 and 9/2/2014, was Resident #C.</p> <p>A physicians order dated 9/2/2014, at 10:45 a.m., the order indicated, "May obtain psych [psychiatric] eval [evaluation] from Dr. [name]."</p> <p>A psychiatric evaluation titled Diagnostic & Mental Status Examination Report dated 9/10/2014, indicated, "Diagnostic Evaluation Results: ...Overall cognitive functioning appeared moderately severely impaired.... Diagnoses: Dementia of the Alzheimer's Type with Behavioral Disturbances. Recommendations: 1....Sexual behavior appears to have been instigated by female resident...."</p>			

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	<p>Resident #C and Resident #D had no nurses notes in the clinical record for the sexual interaction, which occurred on 8/28/2014.</p> <p>Resident #C had no Clinically at Risk Individual Monitoring Sheet, Mental Health Wellness Circumstance form, Social Services or Physician New or Worsening Behavior Notification, nor a Social Services progress note in the clinical record for the sexual interaction which occurred on 8/28/2014.</p> <p>Resident #C's clinical record was reviewed on 9/22/2014 at 2:24 p.m. Diagnoses included but, were not limited to, dementia with behavioral disturbances, hypertension, insomnia, constipation and osteoporosis.</p> <p>A physicians progress note dated 4/17/2014, indicated "...within a few minutes she is promptly up and we have trouble with her going into other peoples rooms lying down and taking a nap in other peoples beds, neither of which is acceptable or appropriate for the facility or for her...."</p> <p>The quarterly MDS (Minimum Data Set) assessment, completed on 6/11/2014, assessed Resident #C's BIMS (Brief Interview for Mental Status) score as 00,</p>			

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	<p>out of a score of 0-15. This score indicated the resident could not complete the interview. The delirium assessment as always having inattention and disorganized thinking. The behavior assessment, assessed Resident #C has having other behavior symptoms such as... public sexual acts, disrobing in public...for 1-3 days. Wandering was assessed as happening from 1-3 days.</p> <p>The careplan for Resident #C dated 9/23/2014 till present, indicated "I [Resident #C] have a DPOA (durable power of attorney) in place...I [Resident #C] reside on Legacy Lane, a secured venue, for my safety. I have a DX [diagnosis] of Alzheimer's Disease....Moods and Behaviors...At times I will sit on the lap of a staff member with no warning and attempt to sit on laps of my peers. I enjoy being close to others, enjoying the intimate closeness. I will at times get in beds with others as well. I will often times become somewhat intrusive of others personal space. Please redirect me....On 9/2/2014 I was found in another residents room with no pants on...Please ensure that I am wearing one piece outfits to prevent me from removing thme [sic] without staff assit [sic]. Please encourage me to stay in common areas with peers. discourage [sic] me from wandering into others</p>			

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	<p>rooms...."</p> <p>A Psychotherapy/Behavior Therapy Note dated 9/10/2014, for Resident #C indicated: "Recommendations: Patient c [with] no signs of negative sequelae [any abnormal bodily condition or disease related to or arising from a pre-existing disease] from incident. Patient has hx [history] of sitting in laps of staff or residents indiscriminately. Patient is incapable cognitively of planning & implementing multi-stage goal directed behavior. Hospitalization is clinically contraindicated as it would not enhance her current safety level & likely would drastically increase dementia related confusion, anxiety, & agitation & accelerate cognitive decline."</p> <p>On 9/18/2014 at 12:07 p.m., an interview with LPN (Licensed Practical Nurse) #4 indicated Resident #C is mostly non-verbal, rarely communicates verbally.</p> <p>Observations of Resident #C on 9/18/2014, 9/19/2014, 9/22/2014, 9/23/2014, and 9/24/2014. Multiple attempts on these days to communicate with Resident #C, no verbal communication observed.</p> <p>On 9/20/2014 an interview with Resident</p>			

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	<p>#C's spouse/DPOA indicated the Resident is mostly non-verbal. Occasionally she will say a few words, and seems to recognize the spouse and accept hugs and kisses from the spouse.</p> <p>Resident #D's clinical record was reviewed on 9/23/2014 at 11:00 a.m. Diagnoses included but, were not limited to, dementia with behavioral disturbances.</p> <p>The 14 day MDS (Minimum Data Set) assessment, completed on 9/9/2014, indicated Resident #D's BIMS (Brief Interview for Mental Status) score was a 4 out of a score of 0-15. A score of 4 indicated Resident #D's cognitive ability was severely impaired. The resident's behavior was identified has having delusions, physical behavior symptoms directed toward others...other behavioral symptoms such as...public sexual acts... for 1-3 days.</p> <p>A physicians progress note dated 8/27/2014, indicated, "Patient Profile: The patient is an 80-year old male transferred from [name] [geriatric psychiatric hospital] to OVHC [Owen Valley Health Campus]. Present Medical Illness: History is obtained almost completely from the chart as the patient is very pleasantly confused and he has a</p>			

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	<p>history of being quite difficult and obnoxious. In fact the chart reveals....Other patients were"scared" of the patient...."</p> <p>The careplan for Resident #D dated 9/23/2014 to present, indicated "I [Resident #D] have a power of attorney (POA) in place...I currently reside on legacy Lane, a secured venue, for my safety. Related to my dx [diagnosis] of Dementia with behaviors. ...On 8/28/2014 I had a behavioral expression of touching a female resident's breasts. Please encourage me to participate in group activities for diversion....I received a new order on 8/29/2014 for Prozac to reduce my libido. On 9/2/2014, my doctor increase my Prozac to decrease my sexual libido. I have a dx of dementia with behaviors. I also will wander at times....I sleep nude or only underwear per my normal routine...."</p> <p>On 9/24/2014 at 2:13 p.m., the Executive Director provided the itinerary for 9/2/2014. The itinerary indicated she was notified of the events on 9/2/2014 at approximately 7:45 a.m. "...Resident [#C] was lying in Resident [#D's] bed naked, and had been seen 15 minutes previously clothed. Resident [#D] had no pants on and was sitting on the side of the bed, he reportedly was startled when the staff member entered the room.... I asked the</p>			

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	<p>staff to start a timeline to document where Resident [#C] had been last, fifteen minute checks were started...The facts were that Resident [#C] was in his bed in his room and he was sitting on the side of the bed. Resident [#C] was not fighting or showing any signs of doing anything she did not want to do. She is capable to physically showing when she does not want to do something. Both have dementia. Resident [#D] was relatively new and staff did not know him well yet. If they had engaged sexual intercourse, neither were showing any emotional or psychological signs of trauma. Both families were made aware of incident. No allegations of abuse and/or rape were made.... Resident [#D] room is fairly close to Resident [#C's]. The week prior Resident [#C] had sat on Resident [#D's] lap. Resident [#C] may have fondness towards this particular patient. This incident did not fall into a reportable category [sic] listed on Abuse/Neglect Procedural Guidelines. Consultation with Nursing consultant and Legacy consultation with Memory Care consultant did not indicate this was a reportable incident."</p> <p>The itinerary provided by the Executive Director for 9/2/2014, indicated Resident #C and Resident #D's rooms were fairly close, no attempt made to move Resident #C nor Resident #D's room.</p>			

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	<p>An observation on 9/23/2014 at 2:00 p.m., of the distance between Resident #C's and Resident D's rooms, it was determined when standing in front of Resident C's room facing out into the hallway Resident D's room was across the hall and two rooms up from Resident C's. Resident D's room was the last room on the left next to the exit door from the unit.</p> <p>On 9/23/2014 at 3:00 p.m., the Director of Health Services provided the Reportable Event Procedural Guidelines, dated 11/2010, and indicated the policy was the one currently being used by the facility. The policy indicated: ...1. Occurrences to be report include: a. Mistreatment b. Abuse c. Neglect I. Things such as...leaving a resident unattended...</p> <p>2. The campus shall complete the appropriate "State Reporting Form" and sent to the State Agency within 24 hours of the incident discovery...."</p> <p>This Federal tag relates to Complaint IN00155849</p> <p>3.1-28(c) 3.1-28(d)</p>				

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F000226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review, the facility failed to implement their policy and procedure in regard to thoroughly report and investigate of an allegation of nonconsensual sexual interaction in that two cognitively impaired residents had two sexual encounters and were not identified for prevention, identification, investigation and reporting of abuse, for 1 of 1 alleged violation of abuse reviewed. (Resident #C) (Resident #D)</p> <p>Findings include:</p> <p>A facility form titled Social Services or Physician New or Worsening Behavior Notification, dated 8/28/2014 at 10:10 p.m., for Resident #D indicated, "Res [Resident] had another Res [not identified] on his lap c [with] his hand up her shirt grabbing her breast...."</p> <p>A facility form titled Mental Health Wellness Circumstance, assessment and Inter-dated 8/28/2014 at 10:10 p.m., for</p>	F000226	F 0226 Resident C and D suffered no ill effects from the alleged deficient practice. An investigation was conducted by the DHS and ED regarding the allegation of nonconsensual sex in regards to resident C and D. The Facility determined that residents with cognitive impairments have the potential to be affected and were reassessed by Social Services to determine if any other residents were at-risk for nonconsensual sex. Any identified resident will have their care plan updated. All staff were in-serviced by the DHS or designee on the facility policies and guidelines regarding reporting and the investigation of any allegations of abuse. The DHS or designee will conduct random audits of 5 residents 5x per week for 4 weeks and then 3x per week for 8 weeks, and then 1x per week for 8 weeks to ensure all allegations of abuse are reported and investigated per facility guidelines. The results of the audit will be reported, reviewed for compliance through the campus QA Committee for a	10/29/2014			

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	<p>Resident #D indicated, "Type of incident: Social/Sexual inhibition..."</p> <p>Social Service Progress Note dated 9/2/2014, "Res [Resident #C] was found in a male residents [Resident #D] room with her pants off. She and the man were not making contact at the time. Male res had been in bed, where he sleeps nude. This res [Resident #C] was unable to state what happened & was unable to answer "yes" "no" questions. Res continues to interact as usual. Staff did remove her from his room..."</p> <p>A facility form titled Clinically at Risk Individual Monitoring Sheet dated 9/4/2014, for Resident #D indicated, "Reason for discussion: Behavior/altercation 8/28/2014 and 9/2/2014... 8/28/2014 res [Resident #D] had another res [not identified] on his lap c [with] his hand up her shirt grabbing her breast. res [sic] were redirected c [with] success...."</p> <p>Resident #C was dressed by CRCA (Clinical Resource Clinical Assistant/CNA), removed from Resident #D's room and was examined by LPN #4.</p> <p>Resident #C's Nurses notes dated 9/2/2014, and signed by LPN #4 indicated,</p>		<p>minimum of 6 months then randomly thereafter for further recommendations. Completion date 10/29/14</p>		

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	<p>"... 8:15 a.m., Nurse exam res [resident]. res. was resistant when removing pants. Noted discharge of yellow/thick const. [consistency] on pull up res also noted to be slightly red...."</p> <p>Resident #D's Nurses notes dated 9/2/2014, and signed by LPN #4 indicated, "...7:45 a.m., Housekeeping reported to CRCA that res. was sitting on side of bed naked c [with] nothing on from waist down. 7:50 a.m. CRCA note same observation from above. CRCA's noted res. acted strangely et [and] surprise when they walked in room. CRCA's removes res [Resident #C] from res. room. 8:00 a.m. Nurse notified of incident nurse reported situation to E.D. [Executive Director]...."</p> <p>On 9/22/14 at 2:04 p.m., interview with Medical Records/LPN (Licensed Practical Nurse) indicated, if sexual interaction were not consensual it is abuse. I would separate them, notify the nurse on duty, Administrator, DON, and physician. With Resident #C and Resident #D we had a little situation where her pants were off and he was fully undressed and she wandered into his room. I don't think anything happened. They're both confused and the Medical</p>				

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	<p>Director said she didn't think anything happened. The families were notified.</p> <p>On 9/22/14 at 2:16 p.m., interview with the DHS (Director of Health Services) indicated, "We consider it abuse if it was emotional distress and not consensual. If it is consensual and both parties consent we don't consider abuse. "We had an incident like that on Legacy Lane when a female went into a male room and he sleeps naked. She was found standing in the middle of his room. She had her bottoms off. We did a full assessment on her. There was no vaginal bleeding. This happened 4-6 weeks ago maybe. We did not report. It didn't appear to be any sexual assault."</p> <p>On 9/22/14 at 3:27 p.m., an interview with the Executive Director (ED) indicated, "We have a training program and corporate compliance hotline. We do abuse inservices once a year. We would have to determine if the parties were willing or not. Do an investigation, contact physician, and family, update. When asked if this would be a reportable to the state. It depends on if it were consensual. I just can't assume something happened." If two residents were not cognitively intact found in a compromising situation is that a reportable? "It depends on the</p>			

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	<p>investigation. We would have to investigate."</p> <p>On 9/23/2014 at 3:15 p.m., an interview with LPN #4 indicated a specimen was obtained from Resident #C, but the physician did not order any test to be done on the specimen and the specimen was disposed of.</p> <p>On 9/23/2014 at 10:44 a.m., an interview with the Medical Director/ personal physician (same person) for Resident #C indicated, being called about Resident #C having been found in room of a male resident. This nurse said she took some vaginal secretions. I had no intention of doing a rape kit. I didn't feel it was clinically indicated, so the specimen collected was disposed of. I think she [Resident #C] entered a room and got into the bed and he [Resident #D] probably woke up and saw her in his bed. I didn't examine the lady. I felt like it was inappropriate behavior on the residents part. She wanders around all the time. I understood she was sitting on the bed with her pants down and he was lying in the bed.</p> <p>On 9/23/2014 at 3:25 p.m., an interview with Housekeeper #1 indicated the Housekeeper found Resident #C in Resident #D's bed, both residents were</p>			

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	<p>awake. Resident #C was sideways on the bed and Resident #D was laying long ways on the bed. The Housekeeper informed the nurse and the CRCA of the event. He then indicated he filled out an incident report.</p> <p>On 9/23/2014 at 3:45 p.m., an interview with the DHS (Director of Health Services) indicated there was no incident report filled out by any staff concerning the event on 9/2/2014, in regard to Resident #C and Resident #D. The only reports related to this event were in the residents' charts filled out by nursing.</p> <p>On 9/24/2014 at 2:00 p.m., an interview with Executive Director indicated, the female resident involved in the event on 8/28/2014 and 9/2/2014, was Resident #C.</p> <p>A physicians order dated 9/2/2014, at 10:45 a.m., the order indicated, "May obtain psych [psychiatric] eval [evaluation] from Dr. [name]."</p> <p>A psychiatric evaluation titled Diagnostic & Mental Status Examination Report dated 9/10/2014, indicated, "Diagnostic Evaluation Results: ...Overall cognitive functioning appeared moderately severely impaired.... Diagnoses: Dementia of the Alzheimer's Type with Behavioral</p>			

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	<p>Disturbances. Recommendations: 1....Sexual behavior appears to have been instigated by female resident...."</p> <p>Resident #C and Resident #D had no nurses notes in the clinical record for the sexual interaction, which occurred on 8/28/2014.</p> <p>Resident #C had no Clinically at Risk Individual Monitoring Sheet, Mental Health Wellness Circumstance form, Social Services or Physician New or Worsening Behavior Notification, nor a Social Services progress note in the clinical record for the sexual interaction which occurred on 8/28/2014.</p> <p>Resident #C's clinical record was reviewed on 9/22/2014 at 2:24 p.m. Diagnoses included but, were not limited to, dementia with behavioral disturbances, hypertension, insomnia, constipation and osteoporosis.</p> <p>A physicians progress note dated 4/17/2014, indicated "...within a few minutes she is promptly up and we have trouble with her going into other peoples rooms lying down and taking a nap in other peoples beds, neither of which is acceptable or appropriate for the facility or for her...."</p>			

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	<p>The quarterly MDS (Minimum Data Set) assessment, completed on 6/11/2014, assessed Resident #C's BIMS (Brief Interview for Mental Status) score as 00, out of a score of 0-15. This score indicated the resident could not complete the interview. The delirium assessment as always having inattention and disorganized thinking. The behavior assessment, assessed Resident #C has having other behavior symptoms such as... public sexual acts, disrobing in public...for 1-3 days. Wandering was assessed as happening from 1-3 days.</p> <p>The careplan for Resident #C dated 9/23/2014 till present, indicated "I [Resident #C] have a DPOA (durable power of attorney) in place...I [Resident #C] reside on Legacy Lane, a secured venue, for my safety. I have a DX [diagnosis] of Alzheimer's Disease....Moods and Behaviors...At times I will sit on the lap of a staff member with no warning and attempt to sit on laps of my peers. I enjoy being close to others, enjoying the intimate closeness. I will at times get in beds with others as well. I will often times become somewhat intrusive of others personal space. Please redirect me....On 9/2/2014 I was found in another residents room with no pants on...Please ensure that I am wearing one piece outfits to prevent me</p>			

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	<p>from removing thme [sic] without staff assit [sic]. Please encourage me to stay in common areas with peers. discourage [sic] me from wandering into others rooms...."</p> <p>A Psychotherapy/Behavior Therapy Note dated 9/10/2014, for Resident #C indicated: "Recommendations: Patient c [with] no signs of negative sequelae [any abnormal bodily condition or disease related to or arising from a pre-existing disease] from incident. Patient has hx [history] of sitting in laps of staff or residents indiscriminately. Patient is incapable cognitively of planning & implementing multi-stage goal directed behavior. Hospitalization is clinically contraindicated as it would not enhance her current safety level & likely would drastically increase dementia related confusion, anxiety, & agitation & accelerate cognitive decline."</p> <p>On 9/18/2014 at 12:07 p.m., an interview with LPN (Licensed Practical Nurse) #4 indicated Resident #C is mostly non-verbal, rarely communicates verbally.</p> <p>Observations of Resident #C on 9/18/2014, 9/19/2014, 9/22/2014, 9/23/2014, and 9/24/2014. Multiple attempts on these days to communicate</p>						

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	<p>with Resident #C, no verbal communication observed.</p> <p>On 9/20/2014 an interview with Resident #C's spouse/DPOA indicated the Resident is mostly non-verbal. Occasionally she will say a few words, and seems to recognize the spouse and accept hugs and kisses from the spouse.</p> <p>Resident #D's clinical record was reviewed on 9/23/2014 at 11:00 a.m. Diagnoses included but, were not limited to, dementia with behavioral disturbances.</p> <p>The 14 day MDS (Minimum Data Set) assessment, completed on 9/9/2014, indicated Resident #D's BIMS (Brief Interview for Mental Status) score was a 4 out of a score of 0-15. A score of 4 indicated Resident #D's cognitive ability was severely impaired. The resident's behavior was identified has having delusions, physical behavior symptoms directed toward others...other behavioral symptoms such as...public sexual acts... for 1-3 days.</p> <p>A physicians progress note dated 8/27/2014, indicated, "Patient Profile: The patient is an 80-year old male transferred from [name] [geriatric psychiatric hospital] to OVHC [Owen</p>			

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	<p>Valley Health Campus]. Present Medical Illness: History is obtained almost completely from the chart as the patient is very pleasantly confused and he has a history of being quite difficult and obnoxious. In fact the chart reveals....Other patients were "scared" of the patient...."</p> <p>The careplan for Resident #D dated 9/23/2014 to present, indicated "I [Resident #D] have a power of attorney (POA) in place...I currently reside on legacy Lane, a secured venue, for my safety. Related to my dx [diagnosis] of Dementia with behaviors. ...On 8/28/2014 I had a behavioral expression of touching a female resident's breasts. Please encourage me to participate in group activities for diversion....I received a new order on 8/29/2014 for Prozac to reduce my libido. On 9/2/2014, my doctor increase my Prozac to decrease my sexual libido. I have a dx of dementia with behaviors. I also will wander at times....I sleep nude or only underwear per my normal routine...."</p> <p>On 9/24/2014 at 2:13 p.m., the Executive Director provided the itinerary for 9/2/2014. The itinerary indicated she was notified of the events on 9/2/2014 at approximately 7:45 a.m. "...Resident [#C] was lying in Resident [#D's] bed naked, and had been seen 15 minutes previously</p>						

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	<p>clothed. Resident [#D] had no pants on and was sitting on the side of the bed, he reportedly was startled when the staff member entered the room.... I asked the staff to start a timeline to document where Resident [#C] had been last, fifteen minute checks were started....The facts were that Resident [#C] was in his bed in his room and he was sitting on the side of the bed. Resident [#C] was not fighting or showing any signs of doing anything she did not want to do. She is capable to physically showing when she does not want to do something. Both have dementia. Resident [#D] was relatively new and staff did not know him well yet. If they had engaged sexual intercourse, neither were showing any emotional or psychological signs of trauma. Both families were made aware of incident. No allegations of abuse and/or rape were made.... Resident [#D] room is fairly close to Resident [#C's]. The week prior Resident [#C] had sat on Resident [#D's] lap. Resident [#C] may have fondness towards this particular patient. This incident did not fall into a reportable category [sic] listed on Abuse/Neglect Procedural Guidelines. Consultation with Nursing consultant and Legacy consultation with Memory Care consultant did not indicate this was a reportable incident."</p>			

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	<p>The itinerary provided by the Executive Director for 9/2/2014, indicated Resident #C and Resident #D's rooms were fairly close, no attempt made to move Resident #C nor Resident #D's room.</p> <p>An observation on 9/23/2014 at 2:00 p.m., of the distance between Resident #C's and Resident D's rooms, it was determined when standing in front of Resident C's room facing out into the hallway Resident D's room was across the hall and two rooms up from Resident C's. Resident D's room was the last room on the left next to the exit door from the unit.</p> <p>On 9/23/2014 at 3:00 p.m., the Director of Health Services provided the Reportable Event Procedural Guidelines, dated 11/2010, and indicated the policy was the one currently being used by the facility. The policy indicated: ...1. Occurrences to be report include: a. Mistreatment b. Abuse c. Neglect I. Things such as...leaving a resident unattended... 2. The campus shall complete the appropriate "State Reporting Form" and sent to the State Agency within 24 hours of the incident discovery...."</p>			

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F000323 SS=J	<p>This Federal tag relates to Complaint IN00155849</p> <p>3.1-28(a)</p> <p>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.</p> <p>A. Based on interview and record review, the facility failed to ensure the residents' environment remained free of non-consensual sexual interactions between residents on a secured unit (Legacy Lane), which resulted in two cognitively impaired residents being involved in two sexual interactions (8/28/2014 and 9/2/2014) with each other. (Resident #C and Resident #D)</p> <p>The Immediate Jeopardy began on 8/28/2014 at 10:10 p.m., when Resident #D was observed with his hand up Resident #C's shirt and was grabbing her breast. The Executive Director, Director of Health Services, Assistant Director of Health Services and the Clinical Support Nurse were notified of the Immediate Jeopardy on 9/24/2014 at 1:30 p.m.</p> <p>B. Based on interviews and record</p>	F000323	<p>On 8/28/14, a female resident with cognitive impairment was observed sitting on the lap of a male resident. She was wearing a weighted vest based on her careplan intervention. Male resident was observed with his hand under the female's shirt. The female resident was wearing a shirt over the vest. Staff was unable to verify actual skin contact was made. Residents were separated and immediately assessed for any physical or emotional outcomes. Both residents were easily redirected. There were no negative effects observed. Notifications for both residents were made to MD and responsible parties. No new orders for the female resident. MD on 8/29/14 and orders written for 20mg Prozac by mouth to decrease libido assessed the male resident. Male resident was placed on clinically-at-risk monitoring due to his behavior.</p>	10/29/2014

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	<p>reviews the facility failed to provide supervision to prevent elopement on the secured dementia unit for 1 of 1 residents reviewed for elopement. (Resident #94)</p> <p>Findings include:</p> <p>A. The facility form titled Social Services or Physician New or Worsening Behavior Notification, dated 8/28/2014 at 10:10 p.m., for Resident #D indicated, "Res [Resident] had another Res [not identified] on his lap c [with] his hand up her shirt grabbing her breast...." Current interventions tried: redirection, ingaging [sic] in activities...Social Service or Physician order/response to communication: Will look at his meds [medication] in the AM [morning] for evaluation agree w/[with] interventions attempted...."</p> <p>A facility form titled Mental Health Wellness Circumstance, assessment and Inter-dated 8/28/2014 at 10:10 p.m., for Resident #D indicated, "Type of incident: Social/Sexual inhibition...Diagnosis which many contribute to behavior: Dementia...Prevention Update Basic approach: Engage in activities, provide exercise opportunities...Techniques: take for a walk."</p> <p>Social Service Progress Note dated</p>		<p>Careplans for both were updated. On 9/2/14 at approximately 7:45am, female resident was found partially dressed laying on bed above the blanket in male resident's room. Male resident was found partly dressed lying under blanket. Male sat up on edge of bed when female was removed by staff from bed. Both residents assessed for physical and/or emotional injuries. MD and responsible parties were notified of incident. Both were placed on one-on-one observation for approximately 3 hours until physician arrived to assess female resident. Physician did assess female resident and determined there was no evidence of penetration by the male resident. Both residents' careplans updated to reflect new interventions for each resident. Female resident was to wear a onesie to prevent inappropriate disrobing. Psychiatry consult for male resident ordered. Both residents were placed on one-on-one observation as of 9/24/14 and male resident was transferred for an inpatient psychiatric evaluation. Female resident remains one-on-one observation until psych services can evaluate. Call placed 9/25/14. As of 10/20/14, female resident has been seen by psych services. All residents on the Legacy unit were reassessed by Social Services on 9/24/14 & 9/25/14 to</p>				

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	<p>9/2/2014, "Res [Resident #C] was found in a male residents [Resident #D] room with her pants off. She and the man were not making contact at the time. Male res had been in bed, where he sleeps nude. This res [Resident #C] was unable to state what happened & was unable to answer "yes" "no" questions. Res continues to interact as usual. Staff did remove her from his room. (See nursing documentation) Also, added intervention for this res to utilize onsies outfits so she can't remove her own clothing/other residents would be unable to remove them either...."</p> <p>A facility form titled Clinically at Risk Individual Monitoring Sheet dated 9/4/2014, for Resident #D indicated, "Reason for discussion: Behavior/altercation 8/28/2014 and 9/2/2014... 8/28/2014 res [Resident #D] had another res [not identified] on his lap c [with] his hand up her shirt grabbing her breast. res [sic] were redirected c [with] success. 9/2/2014 increased Prozac [antidepressant medication] to 40 mg QD [daily] et [and] psych consult. 9/2/2014, another res [Resident #C] came into his rm [room] et [and] res were found in bed. 0 [No] injuries et [and] resident were conseal [consensual/sic]. Recommended clinical intervention: see above. Recommended physician order:</p>		<p>determine if any other residents are at-risk for sexually acting out or were involved in any situation with the above residents in question. No other residents appeared to have had any sexual encounter with other residents. Any identified residents will have their careplans updated based on the findings and interventions placed to decrease risks. The Mental Health Wellness circumstance form will be completed and behavior closely monitored for 72 hours for follow-up. Monitoring will be documented using the hourly rounding form. Each resident on a Mental Health Wellness/Behavior Management Program shall have behaviors monitored each shift via the CareTracker system. If no behaviors occur during the shift, it is not necessary to document. Any new or exacerbation of existing behavior should indicate a Social Services referral. The behaviors will be documented in terms of number of occurrences, approaches attempted, and effectiveness of interventions. When reviewing resident clinical dashboard in Clinical Care Meeting, behaviors displayed during previous 24 hours will be displayed. The Interdisciplinary Team will initiate investigation and follow-up at this time. Nursing, Dietary, Housekeeping and Department</p>	

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	<p>see above...."</p> <p>Resident #C was dressed and removed from Resident #D's room. Resident #C was examined by LPN (Licensed Practical Nurse) #4.</p> <p>Resident #C's Nurses notes dated 9/2/2014, and signed by LPN #4 indicated, "... 8:15 a.m., Nurse exam res [resident]. res. was resistant when removing pants. Noted discharge of yellow/thick const. [consistency] on pull up res also noted to be slightly red. 8:30 a.m., res. 1:1 [one on one care] c CRCA [Clinical Resource Certified Assistant/CNA] 8:40 a.m., Speciman [sic] collected from res. brief.... 10:45 a.m., Dr. [name] here stated no longer needs 1:1 et to place res. into one piece clothing. ...10:00 p.m.-6:00 a.m., signed by RN #3 indicated, Staff monitored resident closely this shift. Toileted per staff. No redness noted to periarea. No active drainage noted. No c/o's [complaints of] voiced. No S/S [signs or symptoms] of pain noted...."</p> <p>Resident #D's Nurses notes dated 9/2/2014, and signed by LPN #4 indicated,</p>		<p>leaders were educated by the DHS and ADHS on Abuse and Behavior observations with emphasis on supervision of cognitively impaired resident behavior on 9/24/14 & 9/25/14. Department leaders were educated on 9/24/14 on how to complete an investigation following incidents and follow-up to ensure no other residents are at-risk. Education was presented verbally and staff acknowledged understanding based on follow-up verbal questions and answers. Any staff not receiving education by 9/25/14 will not be allowed to work until education is completed. All changed in condition, including behavioral changes, will be monitored for 72 hours and longer if indicated. The charge nurse will initiate the Mental Health Wellness circumstance form documenting the behavior as well as initiating the follow-up. These changes and all resident incidents are reviewed during the morning Clinical Care Meeting. The Director of Health Services oversees the meeting with the Assistant Director of Health Services, MDS, Medical Records, Staff Development, Executive Director, and Therapy program manager in attendance. Any behavioral changes and/or sexual acting out will be addressed on the resident care plans/profiles by MDS Nurse and Social Services at the time of the meeting.</p>		

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	<p>"...7:45 a.m., Housekeeping reported to CRCA that res. was sitting on side of bed naked c [with] nothing on from waist down.</p> <p>7:50 a.m. CRCA note same observation from above. CRCA's noted res. acted strangely et [and] surprise when they walked in room. CRCA's removes res [Resident #C] from res. room.</p> <p>8:00 a.m. Nurse notified of incident nurse reported situation to E.D.</p> <p>8:15 a.m., res lying in bed sleeping....</p> <p>10:45 a.m., Dr. [name] here to see stated increase Prozac to 40 mg daily to decrease libido.</p> <p>Review of Resident #C and Resident #D's Nurses Notes and the Skilled Nursing Assessment and Data Collection forms dated from 8/28/2014-9/23/2014, lacked documentation which indicated the residents were closely monitored.</p> <p>On 9/22/14 at 2:04 p.m., interview with Medical Records/LPN (Licensed Practical Nurse) indicated, if sexual interaction were not consensual it is abuse. I would separate them, notify the nurse on duty, Executive Director, Director of Health Services, and physician. With Resident #C and Resident #D we had a little situation where her pants were off and he was fully undressed and she wandered into his</p>		<p>Clinically-at-risk residents, which included behavior, are reviewed weekly at CAR meetings. Residents remain on CAR until condition stabilizes for four weeks. Resident First Meeting (Care plan meetings) is held initially within 21 days of admission and quarterly thereafter, as well as with significant changes in condition. Residents are assessed daily for behavioral changes under Medicare Part A requirements and monthly for long-term residents, as well as indicated with significant changes in condition. DHS and/or ADHS will round daily on the unit to monitor behavior for residents' identified on program. These will occur daily for 3 months, and then 3x weekly for one month and weekly thereafter until substantial Dementia Training upon hire and 3 hours annually thereafter. This includes the Aging Process, cognition changes and dealing with Residents' with difficult behaviors. Behavior Management system is also reviewed as part of company Peer Review process. Any systems out of compliance require development of Action Plan to address and that plan will be monitored monthly during QA meetings. Before frequency is decreased, QA Committee will review to determine substantial compliance has been achieved. The results of the audit</p>				

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	<p>room. I don't think anything happened. They're both confused and the Medical Director said she didn't think anything happened. The families were notified.</p> <p>On 9/22/14 at 2:16 p.m., interview with the DHS (Director of Health Services) indicated, "We consider it abuse if it was emotional distress and not consensual. If it is consensual and both parties consent we don't consider abuse. "We had an incident like that on Legacy Lane when a female went into a male room and he sleeps naked. She was found standing in the middle of his room. She had her bottoms off. We did a full assessment on her. There was no vaginal bleeding. This happened 4-6 weeks ago maybe. We did not report. It didn't appear to be any sexual assault."</p> <p>On 9/22/14 at 3:27 p.m., an interview with the Executive Director (ED) indicated, "We have a training program and corporate compliance hotline. We do abuse inservices once a year. We would have to determine if the parties were willing or not. Do an investigation, contact physician, and family. When asked if this would be a reportable to the state. It depends on if it were consensual. I just can't assume something happened." If two residents were not cognitively intact and found in a compromising</p>		<p>observations will be reported, reviewed, and trended for compliance through the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>				

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	<p>situation is that a reportable? "It depends on the investigation. We would have to investigate."</p> <p>On 9/23/2014 at 3:15 p.m., an interview with LPN #4 indicated a specimen was obtained from Resident #C, but the physician did not order any test to be done on the specimen and it was disposed of.</p> <p>On 9/23/2014 at 10:44 a.m., an interview with the Medical Director/ personal physician (same person) for Resident #C indicated, being called about Resident #C having been found in room of a male resident. This nurse said she took some vaginal secretions. I had no intention of doing a rape kit. I didn't feel it was clinically indicated, so the specimen collected was disposed of. I think she entered a room and got into the bed and he probably woke up and saw her in his bed. I didn't examine the lady. I felt like it was inappropriate behavior on the residents part. She wanders around all the time. I understood she was sitting on the bed with her pants down and he was lying in the bed.</p> <p>On 9/23/2014 at 3:25 p.m., an interview with Housekeeper #1 indicated the Housekeeper found Resident #C in Resident #D's bed, both residents were</p>			

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	<p>awake. Resident #C was sideways on the bed and Resident #D was laying long ways on the bed. The Housekeeper informed the nurse and the CRCA of the event. He then indicated he filled out an incident report.</p> <p>On 9/23/2014 at 3:45 p.m., an interview with the DHS (Director of Health Services) indicated there was no incident report filled out by any staff concerning the event on 9/2/2014, in regard to Resident #C and Resident #D. The only reports related to this event were in the residents charts filled out by nursing.</p> <p>On 9/24/2014 at 2:00 p.m., an interview with Executive Director indicated, the female resident involved in the event on 8/28/2014 and 9/2/2014, was Resident #C.</p> <p>Review on 9/29/2014 at 12:00 p.m., of the facility's training for staff indicated, "Module 4: Being with a Person with Dementia, Actions & Reactions: Why?: Goal. The goal of this lesson is to: Understand reasons that might cause a person with dementia to act, or react, in a certain way....Reasons: Health conditions, medications, communication, environment, the task, unmet needs, resident's life story, you...."</p>			

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	<p>A psychiatric evaluation titled Diagnostic & Mental Status Examination Report dated 9/10/2014, indicated, "Diagnostic Evaluation Results: ...Overall cognitive functioning appeared moderately severely impaired.... Diagnoses: Dementia of the Alzheimer's Type with Behavioral Disturbances. Recommendations: 1....Sexual behavior appears to have been instigated by female resident...."</p> <p>Resident #C and Resident #D had no nurses notes in the clinical record for the sexual interaction, which occurred on 8/28/2014.</p> <p>Resident #C had no Clinically at Risk Individual Monitoring Sheet, Mental Health Wellness Circumstance form, Social Services or Physician New or Worsening Behavior Notification, nor a Social Services progress note in the clinical record for the sexual interaction which occurred on 8/28/2014.</p> <p>Resident #C's clinical record was reviewed on 9/22/2014 at 2:24 p.m. Diagnoses included but, were not limited to, dementia with behavioral disturbances, hypertension, insomnia, constipation and osteoporosis.</p> <p>A physicians progress note dated 4/17/2014, indicated "...within a few</p>			

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	<p>minutes she is promptly up and we have trouble with her going into other peoples rooms lying down and taking a nap in other peoples beds, neither of which is acceptable or appropriate for the facility or for her...."</p> <p>The quarterly MDS (Minimum Data Set) assessment, completed on 6/11/2014, assessed Resident #C's BIMS (Brief Interview for Mental Status) score as 00, out of a score of 0-15. This score indicated the resident could not complete the interview. The delirium assessment as always having inattention and disorganized thinking. The behavior assessment, assessed Resident #C has having other behavior symptoms such as... public sexual acts, disrobing in public...for 1-3 days. Wandering...for 1-3 days.</p> <p>The careplan for Resident #C dated 9/23/2014 till present, indicated "I [Resident #C] have a DPOA (durable power of attorney) in place...I [Resident #C] reside on Legacy Lane, a secured venue, for my safety. I have a DX [diagnosis] of Alzheimer's Disease....Moods and Behaviors...At times I will sit on the lap of a staff member with no warning and attempt to sit on laps of my peers. I enjoy being close to others, enjoying the intimate</p>			

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	<p>closeness. I will at times get in beds with others as well. I will often times become somewhat intrusive of others personal space. Please redirect me....On 9/2/2014 I was found in another residents room with no pants on...Please ensure that I am wearing one piece outfits to prevent me from removing thme [sic] without staff assit [sic]. Please encourage me to stay in common areas with peers. discourage me from wandering into others rooms...."</p> <p>A Psychotherapy/Behavior Therapy Note dated 9/10/2014, for Resident #C indicated: "Recommendations: Patient c [with] no signs of negative sequelae [any abnormal bodily condition or disease related to or arising from a pre-existing disease] from incident. Patient has hx [history] of sitting in laps of staff or residents indiscriminately. Patient is incapable cognitively of planning & implementing multi-stage goal directed behavior. Hospitalization is clinically contraindicated as it would not enhance her current safety level & likely would drastically increase dementia related confusion, anxiety, & agitation & accelerate cognitive decline."</p> <p>On 9/18/2014 at 12:07 p.m., an interview with LPN (Licensed Practical Nurse) #4 indicated Resident #C is mostly non-verbal, rarely communicates</p>			

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	<p>verbally.</p> <p>Observations of Resident #C on 9/18/2014, 9/19/2014, 9/22/2014, 9/23/2014, and 9/24/2014. Multiple attempts on these days to communicate with Resident #C, no verbal communication observed.</p> <p>On 9/20/2014 an interview with Resident #C's spouse/DPOA indicated the Resident is mostly non-verbal. Occasionally she will say a few words, and seems to recognize the spouse and accept hugs and kisses from the spouse.</p> <p>Resident #D's clinical record was reviewed on 9/23/2014 at 11:00 a.m. Diagnoses included but, were not limited to, dementia with behavioral disturbances.</p> <p>The 14 day MDS (Minimum Data Set) assessment, completed on 9/9/2014, indicated Resident #D's BIMS (Brief Interview for Mental Status) score was a 4 out of a score of 0-15. A score of 4 indicated Resident #D's cognitive ability was severely impaired. The residents behavior was identified has having delusions, physical behavior symptoms directed toward others...other behavioral symptoms such as...public sexual acts... for 1-3 days.</p>			

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	<p>A physicians progress not dated 8/27/2014, indicated, "Patient Profile: The patient is an 80-year old male transferred from [name] [geriatric psychiatric hospital] to OVHC [Owen Valley Health Campus]. Present Medical Illness: History is obtained almost completely from the chart as the patient is very pleasantly confused and he has a history of being quite difficult and obnoxious. In fact the chart reveals....Other patients were "scared" of the patient...."</p> <p>The careplan for Resident #D dated 9/23/2014 to present, indicated "I [Resident #D] have a power of attorney (POA) in place...I currently reside on legacy Lane, a secured venue, for my safety. Related to my dx [diagnosis] of Dementia with behaviors. ...On 8/28/2014 I had a behavioral expression of touching a female resident's breasts. Please encourage me to participate in group activities for diversion...I received a new order on 8/29/2014 for Prozac to reduce my libido. On 9/2/2014, my doctor increase my Prozac to decrease my sexual libido. I have a dx of dementia with behaviors. I also will wander at times....I sleep nude or only underwear per my normal routine. On 9/20/2014 I was exit seeking and made way into</p>			

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	<p>shower room...."</p> <p>Resident #D had a physicians order dated 8/29/2014, at 1:30 p.m., Prozac 20 mg 1 tablet by mouth daily - decrease libido.</p> <p>According to The Lippincott's Nursing Drug Guide, copyright 2014, Prozac is an antidepressant and Interventions included, "...Monitor patient for response to therapy for up to 4 wk [week] before increasing dose...." No labeled or unlabeled use was listed to decrease libido.</p> <p>A physicians order dated 9/2/2014 at 10:45 a.m., increase Prozac to 40 mg 1 tablet by mouth daily to decrease libido.</p> <p>A physicians order dated 9/2/2014 at 10:45 a.m., the order indicated, "May obtain psych [psychiatric] eval [evaluation] from Dr. [name]."</p> <p>A psychiatric evaluation titled Diagnostic & Mental Status Examination Report dated 9/10/2014, indicated, "Diagnostic Evaluation Results: ...Overall cognitive functioning appeared moderately severely impaired.... Diagnoses: Dementia of the Alzheimer's Type with Behavioral Disturbances. Recommendations: 1....Sexual behavior appears to have been instigated by female resident...."</p> <p>On 9/24/2014 at 2:13 p.m., the Executive</p>						

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	<p>Director provided the itinerary for 9/2/2014. The itinerary indicated she was notified of the events on 9/2/2014 at approximately 7:45 a.m. "...Resident [#C] was lying in Resident [#D's] bed naked, and had been seen 15 minutes previously clothed. Resident [#D] had no pants on and was sitting on the side of the bed, he reportedly was startled when the staff member entered the room.... I asked the staff to start a timeline to document where Resident [#C] had been last, fifteen minute checks were started....The facts were that Resident [#C] was in his bed in his room and he was sitting on the side of the bed. Resident [#C] was not fighting or showing any signs of doing anything she did not want to do. She is capable to physically showing when she does not want to do something. Both have dementia. Resident [#D] was relatively new and staff did not know him well yet. If they had engaged sexual intercourse, neither were showing any emotional or psychological signs of trauma. Both families were made aware of incident. No allegations of abuse and/or rape were made.... Resident [#D] room is fairly close to Resident [#C's]. The week prior Resident [#C] had sat on Resident [#D's] lap. Resident [#C] may have fondness towards this particular patient. This incident did not fall into a reportable category [sic] listed on</p>			

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	<p>Abuse/Neglect Procedural Guidelines. Consultation with Nursing consultant and Legacy consultation with Memory Care consultant did not indicate this was a reportable incident."</p> <p>Review of the continuation of Nurses notes for Resident #C indicated, a nurses note dated: 8/22/2014 at 3:45 p.m. 8/23/2014 at 11:00 a.m. 8/24/2014 for 6:00 a.m. - 2:00 p.m., one entry 8/24/2014 for 2:00 p.m.- 10:00 p.m., one entry 8/25/2014 at 9:30 a.m.</p> <p>Review of the continuation of Nurses notes for Resident #D indicated, a nurses note dated: 8/26/2014 at 1:45 p.m., "Res [Resident] arrived at facility. 8/26/2014 10:00 p.m. - 6:00 p.m., one entry 9/9/2014 at 2:00 p.m. 9/11/14 at 1:30 p.m. 9/23/2014 at 9:45 a.m.</p> <p>Review of the Skilled Nursing Assessment and Data Collection for Resident #D dated 9/2/2014, indicated a nurses note on: 9/2/2014 at 5:00 p.m. 9/2/2014 for 10:00 p.m.-6:00 a.m., one</p>			

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	<p>entry.</p> <p>The timeline dated 9/2/2014, provided by the facility for Resident #C and Resident #D written on a nurses note indicated, an entry every fifteen minutes from 6:00 a.m.-10:45 a.m., for both residents. Review of the continuation of the timeline for Resident #C indicated, a note on: 9/2/2014 at 9:00 p.m. 9/2/2014 for 10:00 p.m. - 6:00 a.m. one entry 9/2/2014 for 6:00 a.m. - 2:00 p.m. one entry 9/6/2014 at 12:00 p.m. 9/6/2014 for 2:00 p.m. - 10:00 p.m., one entry 9/7/2014 for 6:00 a.m. - 2:00 p.m., one entry 9/21/2014 at 10:00 a.m.</p> <p>Review of the continuation of the timeline for Resident #D indicated a note on: 9/2/2014 for 10:00 p.m.- 6:00 a.m., one entry 9/3/2014 for 6:00 a.m. -2:00 p.m. one entry 9/4/2014 at 6:00 a.m.</p> <p>No other documentation in the clinical record indicating 15 minute checks nor close observation of Resident #C or</p>			

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	<p>Resident #D.</p> <p>The itinerary provided by the Executive Director for 9/2/2014, indicated Resident #C and Resident #D's rooms were fairly close, no attempt made to move Resident #C nor Resident #D's room.</p> <p>An observation on 9/23/2014 at 2:00 p.m., of the distance between Resident #C's and Resident D's rooms, it was determined when standing in front of Resident C's room facing out into the hallway Resident D's room was across the hall and two rooms up from Resident C's. Resident D's room was the last room on the left next to the exit door from the unit.</p> <p>On 9/26/2014 at 11:48 a.m., the Director of Health Services (DHS) provided the CLINICALLY AT RISK (CAR) PROGRAM GUIDELINES, dated 6/2014, and indicated the policy was the one currently being used by the facility. The policy indicated: "Program Overview...Every effort will be made to identify those residents who are clinically at risk and provide proactive interventions to manage their medical needs and minimize/eliminate further decline when possible...Criteria for residents who will be followed by CAR team:...Resident with behavior issues that</p>			

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	<p>impact their care or the care of others. Resident is to be discussed in Car unit behavior concern is manageable....Procedure: 1. The CAR team will meet weekly to discuss those resident that meet the criteria of the Clinically at Risk program.....Scribe-complete documentation on the Individual Resident Monitoring Sheet....5. The CAR team will review current interventions for effectiveness and potential changes and make recommendations based on individual resident's needs. 6. For those interventions that do not require a physician's order, i.e. dietary/nursing/clinical measures, the responsible clinician will take the appropriate action for implementation. 10. The Individual Monitoring Sheet will be filed in the resident's medical record under the assessment tab and become a permanent part of the medical record."</p> <p>The facility provided documentation dated 9/24/2014, indicating Resident #C was provided one on one care and fifteen minutes checks beginning at 2:00 p.m., and remains current.</p> <p>A physicians order dated for 9/24/2014 at 3:15 p.m., indicated Resident #D was transferred to a psychiatric hospital for evaluation and treatment.</p>						

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	<p>An interview with the ADON on 9/28/2014 at 2:00 p.m., indicated Resident #C's room had been moved to the other end of the hall, and a plan was in place to separate the female residents rooms from the male residents room. At that time, an observation of Resident #C's room indicated, the resident had been moved to the other end of the hall.</p> <p>The immediate jeopardy that began on 8/28/2014, was removed on 9/26/2014, when the facility transferred Resident #D to a psychiatric hospital for treatment and evaluation, and Resident #C was provided one on one care and documentation of 15 minutes checks were provided, The Plan of Correction, dated 9/26/14, indicated, " ...All residents on Legacy Unit were assessed by Social Services ...to determine if any other residents were at risk for sexually acting out or were involved with the above residents in question ... Any identified residents will have their care plan updated and interventions put in place ...The Mental Health Wellness Circumstance Form will be completed and behavior closely monitored for 72 hours for follow up ...Each resident on a Mental Health Wellness/Behavior Management Program shall have behaviors monitored each shift ... Any</p>			

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	<p>new or exacerbation of an existing behaviors should indicate Social Services referral ... The Interdisciplinary Team will initiate investigation and follow up...Nursing, Dietary, Housekeeping, and Department Leaders were educated by the Director of Health Services, Assistant Director of Health Services ...on Abuse and Behavior Observations, with emphasis on Supervision of cognitively impaired resident behaviors. Education was conducted on 9/24 and 9/25/14 ... Any staff not receiving education by 9/25/14 will not be allowed to work until education is completed. Systemically, all changes in condition, including behavioral changes will be monitored for 72 hours and longer if indicated ...Any behavior changes and/or sexual acting out will be addressed on the resident care plans/profiles by the MDS Nurse and Social Services at the time of the meeting. Clinically at risk residents which include behavior are reviewed weekly at CAR meetings ...DHS and/or ADHS will round daily on the unit to monitor behavior for residents identified on program. This will occur daily for 3 months, 3 times weekly for one month and weekly thereafter until substantial compliance achieved ..., " but the noncompliance remained at the lower scope and severity of isolated, no actual harm with potential for minimal</p>			

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	<p>harm/discomfort that is not immediate jeopardy, because all employees had not been inserviced.</p> <p>B. On 9/18/14 at 10:15 a.m., an interview was conducted with the Administrator. The Administrator indicated Resident #94 had eloped from the secured Legacy unit on 9/14/2014 at "noon" after a dietary delivery had been made to the unit. The Resident (#94) proceeded through the locked Legacy unit doors, through the wander guard protected front doors of the facility, proceeding to the sidewalk and was seen by the nursing staff through the windows of the Legacy unit. The Legacy unit staff, proceeded to redirect Resident #94 back onto the Legacy unit. An investigation was conducted.</p> <p>On 9/19/14 at 9:30 a.m., an observation was conducted of the secured Legacy unit. Resident #94 was located in her room, sitting in a chair with her legs crossed. A Wanderguard security bracelet was on her right wrist. The Legacy Lane (LL) unit had 3 (entrances), all to be secured by automatic locking fire doors.</p> <p>On 9/19/14 at 9:50 to 9:57 a.m. a record review was conducted of Resident #94's Clinical Medical Record (CMR.) The following were noted:</p>			

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	<p>Diagnosis were listed, but not limited to: dementia, mental disorders, depressive disorder, abnormality of gait and muscle weakness.</p> <p>The MDS (Minimum Data Set) assessment noted a BIMS (Brief Interview for Mental Status) being 4 out of 15. This indicated the Resident had a cognition deficit.</p> <p>A current Profile History Report (care plan/ service plan) indicated: "...General Information: 8/15/2014- Present: ...I currently reside on Legacy lane, a secured venue, for my safety due to my dx [diagnosis] of Dementia and exit seeking verbalizations...Elopement Risk: ... Keep an eye on my whereabouts through out your shift... I do not want to be able to wander freely and not exit the unit attended... ADL's (Activities of Daily Living) 8/15/2014- Present...Provide me with supervision... at meals... Cognition: 8/15/2014- Present: I have...poor safety awareness...."</p> <p>The Treatment Administration Record (TAR) indicated, "... Wanderguard on at all times...Dementia w/[with] exit seeking behaviors...."</p> <p>On 9/19/14 at 9:58 a.m., an interview</p>			

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	<p>was conducted with Resident #94 indicating no ability to comprehend and converse in a logical manner. "...if those people don't quit coming around here, I'm gonna have to go on down to the lake and get some fishing done... there's isn't enough milk up here to catch more fish ..." Resident #94 was unable to offer communication about the elopement.</p> <p>On 9/19/14 at 10:00 a.m., an interview was conducted with Unit Manager of the Legacy Unit in regard to the elopement of Resident #94 on 9/14/14 at noon. The Unit Manager indicated Resident #94 was an elopement risk, wore an security alarm bracelet "Wanderguard" and was demented in ability to think clearly. "...it happened at the noon meal time, [Resident #94's name] was at the end of the hallway by the locked doors, and eloped after a dietary person made a delivery to the unit. [Resident #94's name] was seen on the sidewalk outside the Legacy dining room windows. A staff immediately went to to them and brought them back..." The Unit Manager indicated the supervision of Resident #94 on 9/14/2104, was not the expectation of the facility.</p> <p>On 9/19/14 at 10:00 a.m., a record review was conducted of the Policy and Procedure titled, "Procedure Guidelines.</p>			

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F000372 SS=B	<p>Elopement Risk Procedure... Elopement Overview. Elopement occur when a resident leaves a premise or a safe are without authorization... and/or any necessary supervision to do so...."</p> <p>This Federal tag relates to Complaint IN00155849.</p> <p>3.1-4(a)(2)</p> <p>483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. Based on observation and interview, the facility failed to ensure proper disposal of garbage for 1 of 4 waste receptacles observed.</p> <p>Findings include:</p> <p>On 9/18/19 at 10:30 a.m., a tour was conducted alongside of the Dietary Service Manager (DSM) of the kitchen. An observation was made of a full, large metal trash receptacle without a lid to be overflowing with trash refuse. Large metal cans, large pieces of cardboard and other trash items were observed.</p> <p>On 9/18/19 at 10:31 a.m., an interview was conducted with the DSM. The DSM</p>	F000372	F 0372 No residents suffered ill effects from the alleged deficient practice. Receptacle was immediately removed from campus property. All trash dumpsters are in enclosed fenced area. ED/designee in-serviced all staff on appropriate disposal of waste. Audits will be completed by Environmental Services Director/Designee to assure no unauthorized recycle bins or trash receptacles are placed on campus property. Audits will be completed 5x per week for 4 weeks, 3x per week for 8 weeks, and then 1x per week for 8 weeks, and then quarterly thereafter. Any issues identified will be forwarded to QA Committee for futher review and suggestions/recommendations. Completion date 10/29/14	10/29/2014

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F000441 SS=E	<p>indicated, "...that is emptied by our trash service, [local trash dump service name], I'm not sure why they don't empty that one, they empty the other ones... that ones been out there like that for a long time...."</p> <p>On 9/18/19 at 11:30 a.m., an interview was conducted with the Administrator in regard to the trash receptacle observed upon tour of the kitchen to be overly full and not covered. The Administrator indicated, "... I'm not sure to why... yes, it should be covered and needs emptied..."</p> <p>On 9/19/19 at 9:00 a.m., an interview was conducted with the Administrator indicating the trash receptacle is to be covered and emptied per the facility's expectations.</p> <p>3.1-21(i)(5)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it -</p>			
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	<p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>A). Based on observation, interview, and record review, the facility failed to ensure infection control practices were followed related to hand washing and glove use during medication pass as indicated by facility policy for 6 of 6 randomly observed residents for medication pass. (Licensed Practical Nurse (LPN #2) (Resident #3, Resident #8, Resident #12, Resident #23, Resident #62, Resident #100)</p>	F000441	F 0441 Resident #39 suffered no ill effects from the alleged deficient practice. Res #39 incontinence product was immediately disposed of by the Certified Resident Care Assistant. LPN #2 was provided verbal education. All residents residing within the facility have potential to be affected by alleged deficient practice. DHS or designee will re-educate the Licensed Nurses on the following campus guidelines. 1) Handwashing and glove use	10/29/2014

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	<p>B). Based on observation and interview, the facility failed to ensure a resident's soiled brief were discarded in the proper trash can and not placed in a resident's chair for 1 randomly observed resident. (Resident #39)</p> <p>Findings Include:</p> <p>A. 1.) Observation on 9/23/14 at 2:55 p.m., indicated LPN #2 used hand sanitizer and gathered the medications for Resident #8. LPN #2 entered Resident #8's room and gave Resident #8 her pills. After her pills were given, LPN #2 administered Resident #8 her eye drops. She was observed not to wash her hands before or after giving the eye drops to Resident #8. LPN #2 was observed not to wear gloves when administering eye drops to Resident #8. She walked back to the medication cart and wrote in the Medication Administration Record (MAR). She then gathered the medications for Resident #3. LPN #2 passed the medications for Resident #3 and was observed not to wash her hands. LPN #2 then answered a residents's light and went into Resident # 45's room. LPN #2 walked out of Resident # 45's room and went back to the medication cart. LPN #2 was observed not to wash her hands. LPN #2 proceeded to give medications to Resident #12 and walked</p>		<p>during medication pass. 2) Proper disposal of incontinence products. DHS or designee will re-educate the Certified Nursing Assistants on the following campus guidelines: proper disposal of incontinence products. Education will be completed by 10/29/14. The DHS, or designee, will complete random Medication Administration Competency checklists with Licensed nurses who administer medication. The DHS or designee, will complete random pericare competency checklists with the Licensed Nurses and Certified Nursing Assistants who provide direct resident care to ensure Licensed nurses and Certified Nursing Assistants are performing the procedures in accordance with our facility's guidelines, random monitoring will occur daily across all shifts for 5x per week for 4 weeks, 3x per week for 8 weeks, 1x per week for 8 weeks, and then quarterly thereafter. The results of the audit observations will be reported, reviewed, and trended for compliance through the campus QA Committee for a minimum of 6 months then randomly thereafter for further recommendations.</p>				

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	<p>back to the medication cart and was observed not to wash her hands. LPN #2 gave medications to Resident #62 and after medications were given, LPN #2 did use the hand sanitizer at the medication cart.</p> <p>A. 2). LPN #2 then passed medications for Resident #23 and was observed not to wash her hands after medication pass. LPN #2 gathered the medications for Resident #100 and entered his room. LPN #2 passed medications to this resident and went into the bathroom. LPN #2 was observed not to wash her hands. LPN #2 then went back to the medication cart and administered insulin to Resident #12. LPN #2 was observed to hand sanitize after she cleaned the glucose monitor.</p> <p>Interview on 9/23/14 at 3:15 p.m., with Director of Health Services (DHS), indicated when asked what she expects of her nurses when they pass medications, "I want them to hand sanitize or wash their hands before and after patient care. They are to hand sanitize only three times and then wash their hands."</p> <p>On 9/24/14 at 11:02 a.m., the DHS provided copies of "Guidelines for Handwashing", dated 10/2004, and "Preparation and General Guidelines for</p>			

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	<p>Medication Administration", dated 2/1/10, and indicated it was the policies currently being used by the facility. The "Guidelines for Handwashing" policy indicated, "Purpose: Handwashing is the single most important factor in preventing transmission of infections...Procedure: 1. All health care workers shall wash their hands frequently and appropriately...3...c. Before/after having direct physical contact with residents..." The "Preparation and General Guidelines for Medication Administration" policy indicated, "...B. Administration...8) Hands are washed before and after administration of topical, ophthalmic, otic, parenteral, enteral...Gloves are worn when administering these medications..."</p> <p>B). Resident #39's clinical record was reviewed on 9/23/14 at 12:05 p.m. Diagnoses included, but were not limited to: hypertension, coronary artery disease, neurogenic bladder with retention and cerebrovascular attack.</p> <p>The current Minimum Data Set (MDS) assessment dated 8/18/14, indicated Brief Interview Mental Status (BIMS) score was 9. When 8-15 was cognitively intact and interviewable. The MDS indicated Resident #39 required extensive assistance of 2 staff members for bed</p>			

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	<p>mobility, dressing and toileting use.</p> <p>On 9/18/14 at 2:23 p.m., observed a dirty brief in a chair by the window. Certified Resident Care Assistant #7 was called into Resident #39's room to identify the item. When asked if that brief was soiled, Certified Resident Care Assistant (CRCA/CNA #7) indicated, " I don't know." Observed CRCA #7 to open brief and there was brownish liquid stains in the brief. When asked if that brief should be in the chair CRCA #7 indicated, "No." CRCA #7 was observed to place the brief in a plastic bag and removed it from the room.</p> <p>On 9/23/14 at 2:27 p.m., CRCA #1 was interviewed and indicated when asked if at anytime should a dirty brief be placed in a chair, "No, it should be thrown in trash. It can be at the end of the bed and then you throw it away." [chuckling] "No, there's no reason to put in a chair.'</p> <p>On 9/23/14 at 2:33 p.m., CRCA #2 was interviewed and indicated when asked what should be done with a dirty brief once removed from a resident, "You put it in the trash can." When asked if a dirty brief be placed in a chair at any time? "No.'</p> <p>On 9/23/14 at 2:40 p.m., the Unit</p>						

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F000464 SS=E	<p>Manager for the Skilled unit was interviewed and indicated when asked should a dirty brief at any time be placed in a residents chair, "No, and if it does [indicating dirty brief in a chair] it would need to sanitized."</p> <p>On 9/24/14 at 11:02 a.m., the Director of Nursing provided "Perineal Care for the Incontinent Guideline", undated, and indicated that was the one currently used by the facility. The guideline provided steps in clean an incontinent resident and it did not contain information on discarding soiled items. There was no other policy presented.</p> <p>3.1-18(a) 3.1-18(l)</p> <p>483.70(g) REQUIREMENTS FOR DINING & ACTIVITY ROOMS The facility must provide one or more rooms designated for resident dining and activities.</p> <p>These rooms must be well lighted; be well ventilated, with nonsmoking areas identified; be adequately furnished; and have sufficient space to accommodate all activities.</p> <p>Based on observation, interview and record review, the failed to ensure sufficient space as indicated by facility Dining Program in the Restorative dining room as evidenced by moving residents</p>	F000464	F 0464 Resident # 126 and #62 suffered no ill effects from the alleged deficient practice. Resident #126 discharged. All residents who require assistive dining services have been re-evaluated to determine if they	10/29/2014

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	<p>out of the way in order to maneuver new residents into the dining room and no walking space for 15 of 15 residents served in the Restorative dining room. (Resident #70, Resident #7, Resident #52, Resident #44, Resident #62, Resident #32, Resident #11, Resident #58, Resident #126, Resident #40, Resident #104, Resident #81, Resident #47, Resident #64, Resident #18)</p> <p>Findings include:</p> <p>On 9/18/14 at 12:45 p.m., observed Qualified Resident Medical Assistant (QRMA#1) to push Resident #40 into the front doors of the assisted dining room. QRMA #1 was observed to look inside the dining room and ask where is she going to place the resident. QRMA #1 was then observed to push the chair with Resident #40 around to the hallway entrance. At that time CRCA #1 moved a couple residents chairs out of the way and QRMA #1 pushed Resident #40's chair in front of a table and left her there. There was no where to position or place Resident #40's chair at that time.</p> <p>CRCA #1 was observed to move a chair and position Resident #40's chair sideways against the table. There was no walking room left between Resident #40 and Resident #47's wheelchair that was</p>		<p>are appropriately placed in assistive dining services. Residents found to require cueing only have been moved to the main dining room, in designated cueing table area. All residents that require assistance with eating have the potential to be at-risk for this alleged deficient practice. Residents that require assistive dining services will be re-evaluated to determine level of need daily under Medicare Part A requirements and monthly for long-term care residents, as well as indicated with significant changes in condition. DHS or designee will educate Licensed nursing staff and department leaders on sufficient spacing for assistive dining room. Education will be completed by 10/29/14. Department leader will be assigned to dining room daily. Department leader will perform random audits of resident spacing and maximum room capacity, randomly auditing during breakfast, lunch, and dinner in assistive dining room. The audit will be conducted daily 5x per week for 4 weeks, then 3x per week for 8 weeks, then 1x per week for 8 weeks, and quarterly thereafter. The results of the audits will be reported and reviewed in QA Committee meetings for a minimum of 6 months and then randomly thereafter for further recommendations.</p>				

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	<p>beside her. The assisted dining room was very crowded. No walking room was left in the area by Resident #40. There was no room to maneuver any chairs around without moving other residents out of the way.</p> <p>On 9/18/14 at 12:45 p.m., an observation was made of the following residents in the Restorative dining room from 12:45 p.m. to 12:55 p.m.: [Resident #70, Resident #7, Resident #52, Resident #44, Resident #62 Resident #32, Resident #11, Resident #58, Resident #126, Resident #40, Resident # 104, Resident # 81, Resident #47, Resident #64 and Resident #18 The residents were being assisted to eat their lunch meals by the following staff: CRCA #4, CRCA #5, and CRCA #1.</p> <p>On 9/18/14 at 12:50 p.m., an interview with CRCA #1 indicating the room was too small to adequately position the residents for meal service.</p> <p>On 9/18/14 at 12:51 p.m., an interview with CRCA #5 indicating the room was too small to adequately position the residents for meal service.</p> <p>On 9/18/14 at 12:52 p.m., an interview with CRCA #4 indicating the room was too small to adequately position the</p>			

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F000520 SS=D	<p>residents for meal service.</p> <p>On 9/23/14 at 3:00 p.m., the Director of Health Service (DON provided policy and procedure "BILL OF RESIDENT RIGHTS," revised date 10/2004, and indicated that was the one currently used by the facility. The policy indicated, "5. All Dining areas and service provision will be observed for: ...E. Sufficient space ..."</p> <p>On 9/25/14 at 12:45 p.m., observation of the Restorative dining room indicated Resident #64's chair back had no room between Resident #126's table and still no walking room. There were less residents dining at that time.</p> <p>3.1-19(v)(1)</p> <p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are</p>			

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	<p>necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on interview and record review the facility failed to ensure the Quality Assurance and Assessment (QAA) team identified and implemented a plan of action to ensure resident supervision on a secure unit to prevent nonconsensual sexual interactions and elopement for 3 of 28 residents who resided on the Legacy Unit. (Resident #C) (Resident #D) (Resident #96)</p> <p>Findings include:</p> <p>1. A facility form titled Social Services or Physician New or Worsening Behavior Notification, dated 8/28/2014 at 10:10 p.m., for Resident #D indicated, "Res [Resident] had another Res [not identified] on his lap c [with] his hand up her shirt grabbing her breast...." Current interventions tried: redirection, engaging [sic] in activities...Social Service or Physician order/response to</p>	F000520	F 0520 Investigations completed for residents C & D and root causes established and interventions established. Investigation completed for root cause of resident #96's elopement. Residents with cognitive impairment can be identified at-risk. ED or designee will re-educate the Quality Assurance Committee on the following guideline: Quality Assessment and Assurance Process. ED/Designee to complete monthly audits 1x per month for 6 months of QA attendees sign-in and QA minutes to assure completion of meetings.	10/29/2014

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	<p>communication: Will look at his meds in the AM for evaluation agree w/[with] interventions attempted...."</p> <p>A facility form titled Mental Health Wellness Circumstance, assessment and Inter-dated 8/28/2014 at 10:10 p.m., for Resident #D indicated, "Type of incident: Social/Sexual inhibition...Diagnosis which many contribute to behavior: Dementia...Prevention Update Basic approach: Engage in activities, provide exercise opportunities...Techniques: take for a walk."</p> <p>Social Service Progress Note dated 9/2/2014, "Res [Resident #C] was found in a male residents [Resident #D] room with her pants off. She and the man were not making contact at the time. Male res had been in bed, where he sleeps nude. This res was unable to state what happened & was unable to answer "yes" "no" questions. Res continues to interact as usual. Staff did remove her from his room. (See nursing documentation) Also, added intervention for this res to utilize onsies outfits so she can't remove her own clothing/other residents would be unable to remove them either...."</p> <p>A facility form titled Clinically at Risk Individual Monitoring Sheet dated 9/4/2014, for Resident #D indicated,</p>			

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	<p>"Reason for discussion: Behavior/altercation 8/28/2014 and 9/2/2014... 8/28/2014 res [Resident #D] had another res [not identified] on his lap c [with] his hand up her shirt grabbing her breast. res [sic] were redirected c [with] success. 9/2/2014 increased Prozac to 40 mg QD [daily] et [and] psych consult. 9/2/2014, another res [Resident #C] came into his rm [room] et [and] res were found in bed. 0 injuries et [and] resident were conseal [consensual/sic]. Recommended clinical intervention: see above. Recommended physician order: see above...."</p> <p>Resident #C's Nurses notes dated 9/2/2014, and signed by LPN #4 indicated, "... 8:15 a.m., Nurse exam res [resident]. res. was resistant when removing pants. Noted discharge of yellow/thick const. [consistency] on pull up res also noted to be slightly red. 8:30 a.m., res. 1:1 [one on one care] c CRCA (Clinical Resource Certified Assistant) 8:40 a.m., Speciman [sic] collected from res. brief.... 10:45 a.m., Dr. [name] here stated no longer needs 1:1 et to place res. into one piece clothing. ...10:00 p.m.-6:00 a.m., signed by RN #3 indicated, Staff monitored resident</p>			

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	<p>closely this shift. Toileted per staff. No redness noted to periarea. No active drainage noted. No c/o's [complaints of] voiced. No S/S [signs or symptoms] of pain noted...."</p> <p>Resident #D's Nurses notes dated 9/2/2014, and signed by LPN #4 indicated, "...7:45 a.m., Housekeeping reported to CRCA that res. was sitting on side of bed naked c [with] nothing on from waist down. 7:50 a.m. CRCA note same observation from above. CRCA's noted res. acted strangely et [and] surprise when they walked in room. CRCA's removes res [Resident #C] from res. room. 8:00 a.m. Nurse notified of incident nurse reported situation to E.D. 8:15 a.m., res lying in bed sleeping.... 10:45 a.m., Dr. [name] here to see stated increase Prozac to 40 mg daily to decrease libido.</p> <p>Review of Resident #C and Resident #D's Nurses Notes and the Skilled Nursing Assessment and Data Collection forms dated from 8/28/2014-9/23/2014, lacked documentation which indicated the residents were closely monitored.</p> <p>On 9/22/14 at 2:04 p.m., interview with Medical Records/LPN (Licensed</p>			

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	<p>Practical Nurse) indicated, if sexual interaction were not consensual it is abuse. I would separate them, notify the nurse on duty, Admission, DON, and physician. With Resident #C and Resident #D we had a little situation where her pants were off and he was fully undressed and she wandered into his room. I don't think anything happened. They're both confused and the Medical Director said she didn't think anything happened. The families were notified.</p> <p>On 9/22/14 at 2:16 p.m., interview with the DHS (Director of Health Services) indicated, "We consider it abuse if it was emotional distress and not consensual. If it is consensual and both parties consent we don't consider abuse. "We had an incident like that on Legacy Lane when a female went into a male room and he sleeps naked. She was found standing in the middle of his room. She had her bottoms off. We did a full assessment on her. There was no vaginal bleeding. This happened 4-6 weeks ago maybe. We did not report. It didn't appear to be any sexual assault."</p> <p>On 9/22/14 at 3:27 p.m., an interview with the Executive Director (ED) indicated, "We have a training program and corporate compliance hotline. We do abuse inservices once a year. We would</p>			

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	<p>have to determine if the parties were willing or not. Do an investigation, contact physician, and family, update. When asked if this would be a reportable to the state. It depends on if it were consensual. I just can't assume something happened." If two residents were not cognitively intact found in a compromising situation is that a reportable? "It depends on the investigation. We would have to investigate."</p> <p>On 9/23/2014 at 10:44 a.m., an interview with the Medical Director/ personal physician (same person) for Resident #C indicated, being called about Resident #C having been found in room of a male resident. This nurse said she took some vaginal secretions. I had no intention of doing a rape kit. I didn't feel it was clinically indicated, so the specimen collected was disposed of. I think she entered a room and got into the bed and he probably woke up and saw her in his bed. I didn't examine the lady. I felt like it was inappropriate behavior on the residents part. She wanders around all the time. I understood she was sitting on the bed with her pants down and he was lying in the bed.</p> <p>On 9/23/2014 at 3:25 p.m., an interview with Housekeeper #1 indicated the</p>			

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	<p>Housekeeper found Resident #C in Resident #D's bed, both residents were awake. Resident #C was sideways on the bed and Resident #D was laying long ways on the bed. The Housekeeper informed the nurse and the CRCA of the event. He then indicated he filled out an incident report.</p> <p>On 9/23/2014 at 3:45 p.m., an interview with the DHS (Director of Health Services) indicated there was no incident report filled out by any staff concerning the event on 9/2/2014, in regard to Resident #C and Resident #D. The only reports related to this event were in the residents charts filled out by nursing.</p> <p>On 9/24/2014 at 2:00 p.m., an interview with Executive Director indicated, the female resident involved in the event on 8/28/2014 and 9/2/2014, was Resident #C.</p> <p>On 9/25/2014 at 3:15 p.m., an interview with DHS indicated the sexual encounters on 8/28/2014 and 9/2/2014, between Residents #C and Resident #D were reviewed during the QAA meeting but, was not identified as an issue.</p> <p>2. On 9/18/2014 at 10:15 a.m., an interview was conducted with the Administrator. The Administrator</p>			

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	<p>indicated Resident #94 had eloped from the secured Legacy unit on 9/14/2014, at "noon" after a dietary delivery had been made to the unit. The Resident (#94) proceeded through the locked Lagacy unit doors, through the wander guard protected front doors of the facility, proceeded to the sidewalk, and was seen by nursing staff through the windows of the Legacy unit. The Legacy unit staff, proceeded to redirect Resident #94 back onto the Legacy unit. An investigation was conducted.</p> <p>On 9/19/14 at 9:30 a.m., an observation was conducted of the secured Legacy unit. Resident #94 was located in her room, sitting in a chair with her legs crossed. A wanderguard security bracelet was on her right wrist. The Legacy Lane unit had 3 entrances, all to be secured by automatic locking fire doors.</p> <p>On 9//19/2014 from 9:50 a.m., to 9:57 a.m., a record review was conducted of Resident #94's Clinical Medical Record (CMR). The following were noted:</p> <p>Diagnoses included but, were not limited to: dementia, mental disorders, depressive disorder, abnormality of gait and muscle weakness.</p> <p>The MDS (Minimum Data Set)</p>						

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	<p>assessment, assessed Resident #94's BIMS (Brief Interview for Mental Status) as being a 4 out of a score of 0-15. This score indicated Resident #94 was severely cognitively impaired.</p> <p>A current Profile History Report (care plan/service plan) indicated "...General Information: 8/15/2014-Present: ...I currently reside on Legacy lane, a secured venue, for my safety due to my dx [diagnosis] of dementia and exit seeking verbalizations...Elopement Risk: ...Keep an eye on my whereabouts through out your shift...I do not want to be able to wander freely and not exit the unit attended...ADL's [Activities of Daily Living] 8/15/2014-Present...Provide me with supervision...at meals...cognition: 8/15/2014-Present: I have...poor safety awareness...."</p> <p>On 9/19/2014 at 10:00 a.m., an interview was conducted with Unit Manager of the Legacy Unit in regard to the elopement of Resident #94 on 9/14/2014 at 12:00 p.m., The Unit Manager indicated Resident #94 was an elopement risk, wore a security alarm bracelet "Wanderguard" and was demented in ability to think clearly."...it happened at the noon meal time, Resident #94 [name] was at the end of the hallway by the locked doors, and eloped after a dietary person made a</p>			

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	<p>delivery to the unit. Resident #94 [name] was seen on the sidewalk outside the Legacy dining room windows. A staff immediately went to them and brought them back..." The Unit Manager indicated the supervision of resident #94 had not occurred on 9/14/2014, and was not the expectation of the facility.</p> <p>On 9/19/2014 at 10:00 a.m., a record review was conducted of the Policy and Procedure titled, "Procedure Guidelines. Elopement Risk Procedure...Elopement Overview. Elopement occur when a resident leaves a premise or a safe are without authorization...and/or any necessary supervision to do so..."</p> <p>On 9/18/2014 at 10:58 a.m., the Executive Director provided the Quality Assessment and Assurance Meeting policy, undated, and indicated the policy was the one currently being used by the facility. The policy indicated: "Purpose: To establish and maintain the integrity of care and services provided at THS (Trilogy Health Services) campuses. and protecting the health and welfare of the residents and staff.....Meetings: ...This committee is responsible for identifying issues that necessitate action of the committee, such as issues which negatively affect the quality of care and services provided to the residents. The</p>			

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	<p>committee will develop and implement plans of action to correct identified quality deficiencies....Action Plans: Action plans shall be developed for each area identified in need of correction. These action plans will be followed, communicated with appropriate staff, monitored, and reassess for effectiveness....Areas to be reviewed...9. Behaviors 20. Other areas of concern...."</p> <p>This Federal tag relates to Complaint IN00155849.</p> <p>3.1-52 (b)(2)</p>						