

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

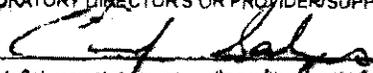
PRINTED: 11/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/24/2012
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NAME OF PROVIDER OR SUPPLIER BOYD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 12800 PRINCELAND DRIVE ASHLAND, KY 41102
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS	F 000	To the best of my knowledge and belief, as an agent of Boyd Nursing and Rehabilitation Center, the following plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid Requirements. Preparation and execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the alleged deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law.	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the job description for the Social Services Director (SSD), it was determined the facility failed to provide Social Services to attain or maintain the highest practicable physical, mental and psychosocial well-being for one (1) of six (6) sampled residents (Resident #1). On 10/06/12 at 12:30 PM Resident #2 entered Resident #1's room and made sexual comments to the resident and inappropriately touched Resident #1 in the private area. The facility failed to ensure the SSD documented follow up interviews with the alleged victim, Resident #1, or updated Resident #1's Comprehensive Plan of Care following the alleged inappropriate sexual behavior of Resident #2. The findings include:	F 250	It is the policy of Boyd Nursing and Rehabilitation Center to provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The Social Service Director has conducted followed ups on the psychosocial well-being of Resident #1 related to incident of 10/06/12 on 10/11/12, 10/18/12 and 11/01/12. No additional follow-up needed.	11/13/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	DATE 11-13-12
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 30 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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F 250	Continued From page 1 Review of the facility job description for the Social Services Director, (no date), revealed the job of the SSD is to meet the residents' and families' emotional, financial, spiritual, educational and social needs and to enhance the quality of life through individual, group and interdisciplinary activity. Further review revealed key responsibilities are to document progress and update plans of care at the interdisciplinary care conferences; assess the emotional needs of the resident and ensure those needs are met by the facility or through the use of outside agencies and acts as the resident advocate. Record review revealed the facility admitted Resident #1 on 05/20/12 with diagnoses which included Multiple Sclerosis, Cerebral Vascular Accident and Aphasia. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 10/05/12 revealed the facility assessed Resident #1 with a Brief Interview for Mental Status (BIMS) of fourteen (14) out of fifteen (15), indicating Resident #1 was oriented and cognitively intact. Review of an intake form revealed the facility self reported an allegation which stated Resident #2 entered Resident #1's room and asked him/her "to suck pussy". Review of facility's staff statements revealed a visitor (Resident #4's daughter) reported to SRNA #1 that Resident #2 was talking to and touching Resident #1 in a "private area" but was unable to hear what was being said. Interview with SRNA #1, on 10/17/12 at 11:30 AM,	F 250	Chart audits are being conducted by ICDPT including Social Service Director to be finalized by 11/30/12 to determine if all residents have received follow-up as needed for medically-related social issues and these follow-ups are documented. The Social Service Director will receive additional education by the Director of Nursing on 11/16/12 regarding the importance of follow-up and documentation of medically-related social issues. The Director of Nursing will meet with the Social Service Director weekly x 4 weeks to discuss outstanding medically-related social issues and assist with follow-up as needed. The Director of Nursing will review two charts per week for four weeks to ensure that appropriate follow-up has been completed and documented. The Director of Nursing will discuss her findings of weekly meeting with the Administrator for further monitoring and continued compliance.	

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F 250	<p>Continued From page 2</p> <p>revealed he was passing lunch trays when a visitor came to him and told him of the incident occurring between Resident #2 and Resident #1. He stated when he arrived at Resident #1's room, Resident #2 was trying to back out of the room in his/her wheelchair, he returned Resident #2 to his/her room and reported the incident to LPN #1.</p> <p>Interview with LPN #1, on 10/17/12 at 9:10 AM, revealed her involvement with the incident was to report it to the House Supervisor for that day (Staff Development Nurse).</p> <p>Interview with the Staff Development Nurse (House Supervisor on the day of the alleged incident on 10/06/12), on 10/17/12 at 1:30 PM, revealed an investigation was initiated and Resident #2 was placed on 1:1 supervision, the Physician was notified and orders received to send Resident #2 for a Geriatric Psychological evaluation.</p> <p>Review of the Nurse's Notes for Resident #1, dated 10/06/12 revealed the Staff Development Nurse interviewed Resident #1 as to whether he/she felt safe or if anything was bothering him/her.</p> <p>Interview with Resident #1, on 10/19/12 at 9:45 AM, revealed Resident #2 touched him/her between the legs and made a sexually inappropriate comment.</p> <p>Review of facility Nursing Notes, dated 10/11/12 at 3:06 PM, (five days after the incident), revealed an entry by the SSD that documented her initial interview with Resident #1. Further review revealed Resident #1 was non-verbal but</p>	F 250		
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F 250	<p>Continued From page 3</p> <p>communicated with head nods, gestures and writing his/her answers. Review of the Note revealed Resident #1 indicated he/she felt safe and was not bothered or disturbed by the alleged incident. It was documented that the SSD encouraged him/her to speak with the SSD if he/she felt unsafe or disturbed by the incident in the future. Further review of the Nursing Notes revealed no further documentation to follow up on the psychosocial well-being of Resident #1 by the SSD.</p> <p>Review of the Comprehensive Plan of Care revealed there were no interventions to monitor Resident #1's psychosocial interventions put in place after the alleged incident, as indicated in the SSD's job description.</p> <p>Interview with the SSD, on 10/18/12 at 12:50 PM, revealed she had been employed by the facility following graduation and had been at the facility about eleven months. She further stated that she would document the initial interview with a resident but did not document her follow up interviews nor did she update the care plan with any interventions to promote the psychosocial well-being of Resident #1. Continued interview on 10/23/12 at 2:10 PM, revealed she was a member of the Interdisciplinary team that met weekly to update care plans as needed and Resident #1's care plan should have been revised.</p> <p>Interviews with the Director of Nursing, (DON) and the Administrator, on 10/23/12 at 1:30 PM, revealed they expected the SSD to document psycho-social interventions, follow ups and update the residents' care plans as appropriate.</p>	F 250			

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F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to periodically review and revise Comprehensive Plans of Care for one (1) of six (6) sampled residents, (Resident #2).</p> <p>On three (3) separate occasions, Resident #2 exhibited sexually inappropriate behavior towards other residents. The facility failed to identify the inappropriate behavior and failed to ensure</p>	F 280	<p>It is the policy of Boyd Nursing and Rehabilitation Center to ensure residents have a right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>The care plans for resident #2 was updated by the IDCPT on 10/31/12 to reflect the current interventions to address the inappropriate sexual behaviors.</p> <p>All care plans were reviewed by the IDCPT by 11/09/12 to determine that each care plan was updated, accurate and reflected the current needs of the resident.</p> <p>The IDCPT was re-educated by the Director of Nursing on 10/31/12 regarding the importance of reviewing and revising resident status on a daily basis to ensure that resident needs are assessed and recorded accurately and completely and interventions put in place on the current resident plan of care. The Director of Nursing will review 25% of current care plans weekly, and randomly thereafter, for four weeks to determine that care plans are accurate and reflective of current residents needs. The results will be forwarded to the monthly CQI meeting for further monitoring and continued compliance</p>	

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F 280	<p>Continued From page 5</p> <p>Resident #2's care plan was revised to include intervention to address the inappropriate sexual behaviors. (Refer to F-323)</p> <p>The findings include:</p> <p>Review of the facility's policy entitled, Comprehensive Plan of Care, dated 08/01/12, Policy number N-C-009, revealed a resident's care plan should be updated whenever a significant change occurs.</p> <p>Review of the facility's policy entitled, Behavior Changes (Resident), policy number N-B-003, dated 08/01/12, revealed the resident interdisciplinary plan of care was to be updated if there were behavior changes.</p> <p>Review of the clinical record revealed the facility admitted Resident #2, on 03/22/12, with diagnoses which included Dementia with Behavior Disorder, Depression Disorder, Anxiety and Diabetes Mellitus II.</p> <p>Review of the Admission MDS Assessment, dated 03/29/12, revealed the facility assessed Resident #2 with a Brief Interview for Mental Status (BIMS) of six (06) out of fifteen (15), indicating Resident #2 was severely mentally impaired. Further review of a Quarterly MDS, dated 09/24/12, revealed an assessed BIMS of five (5) out of fifteen (15), indicating severe cognitive impairment.</p> <p>Review of Resident #2 admission care plan, dated 03/22/12, revealed Resident #2 was known to make inappropriate sexual comments to staff with an intervention to re-direct him/her when</p>
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F 280	<p>Continued From page 6</p> <p>Inappropriate comments were made. Further review of Resident #2's care plan (dated 10/05/12), revealed he/she was known to make verbalizations of a sexual nature with interventions to observe for increased behaviors.</p> <p>Review of the SRNA care plan for Resident #2, dated 09/2012, revealed "behaviors" was an observational area noted on the care plan; however, "verbal" or "physical" was not marked as an area to monitor.</p> <p>Interview with Housekeeper #8, on 10/18/12 at 4:20 PM, revealed she had no direct knowledge of any inappropriate comments made by Resident #2- just here-say. She further stated that about two (2) days before the alleged incident involving Resident #2 and Resident #5, she had witnessed Resident #2 in the door way of Resident #5's room just wearing a T-shirt. She further stated she re-directed him/her back to his/her room, told an aide (unable to remember the name of the aide) so they could help him/her finish dressing and later told a nurse (unable to remember the name).</p> <p>Interview with Resident #5, on 10/18/12 at 4:40 PM, revealed that Resident #2 had entered his/her room several weeks ago and asked him/her if he/she wanted to have sex, did he/she miss sex and how did you get sex in here. Further interview revealed the inappropriate comments made him/her feel scared at the time. He/she further stated he/she had reported the incident to SRNA #9.</p> <p>Interview with SRNA #9, on 10/19/12 at 9:30 AM, revealed that some time around 09/01/12,</p>	F 280		
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F 280	Continued From page 7 Resident #5 told her about the incident with Resident #2 coming into his/her room and asking if he/she wanted to "make love". She further stated she was unable to remember who she reported it to; (review of facility documents, dated 10/19/12, revealed that SRNA #9 had reported the incident to Licensed Practical Nurse (LPN) #1, while she was on break). Interview with LPN #1, on 10/19/12 at 9:20 AM, revealed while they were on break, SRNA #9 had "talked" about the incident involving Resident #2 and Resident #5. Further interview revealed she assumed since it was break that SRNA #9 had reported the incident to the nurse that was not on break. She further stated that she had told the SRNAs not to report things to her while she was on break. There was no documented evidence that LPN #1 reported the incident. Review of Resident #2's Comprehensive Plan of Care, dated 03/22/12, revealed there was no documented evidence Resident #2's sexual behaviors had been assessed or that interventions had been put in place to address the sexual behaviors. Review of Nurse's Notes for Resident #6, dated 10/18/12 at 2:38 PM, revealed Resident #6 reported to an SRNA at 2:15 PM of an incident that occurred around the first of October involving Resident #2. The Note revealed Resident #6 stated he/she was in the courtyard when Resident #2 approached him/her and asked if he/she wanted to talk; when asked what he/she wanted to talk about, he/she said "sex". Resident #6 told him/her "no" and he/she went on to talk about the war.	F 280		

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F 280	<p>Continued From page 8</p> <p>Interview with Resident #6, on 10/19/12 at 12:20 PM, revealed Resident #2 approached him/her and asked if he/she wanted to talk; when asked what he/she wanted to talk about, he/she said "sex", that he/she wanted to lick him/her "all over". Resident #6 told him/her "no" and Resident #2 went on to talk about the war. Resident #6 stated he/she did not report the incident because he/she felt like Resident #2 was not in his/her right mind and would not hurt/touch, him/her.</p> <p>Review of Resident #2's Comprehensive Plan of Care, dated 03/22/12, revealed there was no documented evidence Resident #2's sexual behaviors had been assessed or that interventions had been put in place to address the sexual behaviors.</p> <p>Review of the facility's investigation, dated 10/05/12, revealed on 10/04/12 around 9:30 PM, Resident #2 entered Resident #4's room and asked if he/she could lick his/her "pussy". Resident #4 stated he/she told him/her "no", pushed the call light and told Resident #2 to leave. Further review revealed Resident #2 told Resident #4, he/she did not know what he/she was missing.</p> <p>Interview with SRNA #11, on 10/18/12 at 1:40 PM, revealed he answered Resident #4's call light around 9:30-10:00 PM. Further interview revealed he took Resident #2 back to his/her room and returned to Resident #4's room to check on him/her. He further stated Resident #4 did not relay to him what had happened, just that he/she wanted a Velcro "STOP" barrier placed on</p>	F 280		

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F 280	<p>Continued From page 9</p> <p>the door and the door pulled closed a bit more. Further interview with SRNA #11 revealed he told a nurse about Resident #2 being in Resident #4's room and that he had put the Velcro barrier on the door per request.</p> <p>Interview, via telephone, with Resident #4, who had been discharged, on 10/18/12 at 2:25 PM, revealed Resident #2 had come into his/her room on the evening of 10/04/12 and made inappropriate sexual comments to him/her. Further interview revealed he/she told Resident #2 to leave and put the call light on. He/she further stated that after the SRNA had removed Resident #2 to his/her room, the SRNA came back and checked on him/her. Resident #4 stated that SRNA #11 volunteered to get a Velcro barrier for the door and to pull the door a little more. Resident #4 stated that he/she did not sleep well that night.</p> <p>Review of the twenty-four (24) report revealed Resident #2 was put on every fifteen (15) minute checks for forty-eight (48) hours; however, review of the Care Plan revealed the care plan was not revised to reflect this intervention and the intervention was only carried out for two (2) shifts.</p> <p>Interview with the Director of Nursing, on 10/24/12 at 9:35 AM, revealed she thought the care plans were a work in progress. She stated the MDS Nurse had the primary responsibility for the Care Plans. She stated the nurses could revise and update the Care Plans. She continued to stated the MDS nurse had been in that position a short time, but Resident #2's Care Plan should have been revised after each behavioral incident.</p>	F 280			

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F 280	Continued From page 10 Interview, on 10/18/12 at 9:20 AM, with the MDS Nurse revealed the facility's care plan process was messy and vague. He further stated he was new to the position but the care plans lacked individuality. He stated the care plan should have been revised to include more individualized interventions to address Resident #2's behaviors.	F 280		
F 323 SS-E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, it was determined the facility failed to ensure residents' safety through monitoring and supervision for four (4) of six (6) sampled residents. The facility failed to ensure adequate supervision was provided to prevent resident to resident sexual abuse. The facility failed to adequately assess Resident #2's inappropriate sexual history and failed to revise the Plan of Care to address Resident #2's changes in sexual behaviors that would be	F 323	It is the policy of Boyd Nursing and Rehabilitation Center to ensure that the resident environment remains as free of accident hazards as possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Resident #2 was placed on 15 minute checks for forty-eight hours following his return from the geriatric behavioral unit on 10/12/12. Resident #2 care plan was revised on 10/31/12 by IDCPT to reflect interventions to provide appropriate supervision in order to ensure other resident's safety. Behavior assessments were completed on all residents on 10/23/12 by the Staff Development Coordinator, Medical Records (LPN) and a staff LPN to ensure that any resident exhibiting behaviors that might potentially affect the safety or psychosocial well-being of other residents have been recognized.	

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F 323	<p>Continued From page 11</p> <p>effective in managing the resident's behaviors and protecting other residents of the facility. Resident #2 was re-admitted to the facility and had a plan of care developed related to the resident making inappropriate sexual comments to staff, dated 03/22/12. Sometime between the first and second week in September 2012, Resident #2 entered Resident #5's room and asked him/her how do you get sex around here, did he/she want sex and did he/she miss sex. Resident # 5 reported the incident to State Registered Nursing Assistant (SRNA) #9. There was no evidence the facility investigated the incident or revised the Plan of Care to address the resident's sexually inappropriate comments towards residents. Sometime during the last week in September 2012, Resident #2 approached Resident #6 in the facility's courtyard outside and asked the resident if he/she wanted to talk about sex and asked him/her if he/she could lick him/her all over. On 10/04/12 at approximately 9:30 PM, Resident #2 entered Resident #4's room and asked the resident if he/she could lick his/her "pussy". Although Resident #4 only told SRNA #11 that he/she wanted Resident #2 out of his/her room and wanted a stop sign placed across the doorway, there was no evidence the facility investigated the incident to determine if there was an inappropriate sexual behavior pattern, to put interventions in place to supervise and monitor Resident #2 to prevent further incidence. On 10/05/12 at approximately 10:00 AM, Resident #4's roommate told SRNA #5 that Resident #4 had told him/her what had happened on 10/04/12. Although the facility initiated every fifteen (15) minute visual checks on Resident #2 at 2:30 PM on 10/08/12, the facility failed to revise the plan of</p>	F 323	<p>Any resident identified that exhibited these behaviors care plans were reviewed and updated by IDCPT by 11/09/12 to reflect interventions to ensure other resident's safety.</p> <p>All facility staff received additional education on 10/18/12 no later than 10/22/12 by the SDC and/or designee regarding the importance of immediately reporting resident behaviors to the supervisor as outlined in the facility Resident Advocacy Protocols. Additional education included the importance of ensuring that each resident receives adequate supervision and assistive devices to prevent accidents and ensure resident safety was given to all staff by SDC on 11/09/12 no later than 11/19/12.</p> <p>The Administrator, DON and Staff Development Coordinator will make compliance rounds at least three times per week for eight weeks in order to visually monitor resident behaviors. Additionally, these personnel will interview a total of at least five direct care staff members and five residents per week on different shifts to ensure that all resident behaviors are being reported as required so that interventions can be implemented to ensure the safety of all residents.</p>	
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F 323	Continued From page 12 care, failed to ensure staff was aware of the intervention and failed to ensure the fifteen (15) minute checks were completed. On 10/08/12 at approximately 12:30 PM, Resident #2 entered Resident #1's room and asked Resident #1 if he/she could "suck pussy" and then Resident #2 touched Resident #1 in the groin area. The facility failed to identify the incidents as abuse and failed to identify Resident #2's behavior as a risk to the other residents. The facility failed to implement interventions to ensure residents' safety and failed to provide adequate supervision to protect residents and prevent recurrence of sexually inappropriate behaviors towards residents. Additionally, the facility failed to identify other incidents of abuse/neglect through the assessment of all residents of the unit after 10/05/12 to ensure adequate supervision was provided to protect residents from further abuse. The findings include: Review of the facility's Abuse Policy, undated, revealed sexual abuse included but was not limited to sexual harassment, sexual coercion, or sexual assault. Further review of the sheet related to identification revealed the Minimum Data Set (MDS) process was used to determine residents at risk for abusing other residents, appropriate interventions would be developed to prevent occurrences utilizing the interdisciplinary Care Plan and to monitor the resident for any changes that would trigger abusive behavior. Review of the facility's policy titled "Behavior	F 323	The results of these compliance rounds and staff interviews will be discussed at the weekly Focus Meeting (a sub-committee of the monthly CQI Meeting) and forwarded to the monthly CQI Committee meeting for further monitoring and continued compliance	11/30/12	

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F 323	<p>Continued From page 13</p> <p>Changes (Resident)", dated 08/01/12, revealed residents were to be monitored for proximity to other residents, providing safety measures to prevent behavioral outburst toward others and that observations and interventions were to be objectively documented in the resident's medical record.</p> <p>Review of the clinical record revealed the facility admitted Resident #2, on 03/22/12, with diagnoses which included Dementia with Behavior Disorder, Depression Disorder, Anxiety and Diabetes Mellitus II.</p> <p>Review of the Admission MDS Assessment, dated 03/29/12, revealed the facility assessed Resident #2 with a Brief Interview for Mental Status (BIMS) of six (06) out of fifteen (15), indicating Resident #2 was severely mentally impaired. Further review of a Quarterly MDS, dated 09/24/12, revealed an assessed BIMS of five (5) out of fifteen (15), indicating severe cognitive impairment.</p> <p>Review of Resident #2 admission care plan, dated 03/22/12, revealed Resident #2 was known to make inappropriate sexual comments to staff with an intervention to re-direct him/her when inappropriate comments were made.</p> <p>Review of the SRNA care plan for Resident #2, dated 09/2012, revealed "behaviors" was an observational area noted on the care plan; however, "verbal" or "physical" was not marked as an area to monitor.</p> <p>Interview with Housekeeper #8, on 10/18/12 at 4:20 PM, revealed she had no direct knowledge</p>	F 323		
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F 323	Continued From page 14 of any inappropriate comments made by Resident #2- just here-say. She further stated that about two (2) days before the alleged incident involving Resident #2 and Resident #5, she had witnessed Resident #2 in the door way of Resident #5's room just wearing a T-shirt. She further stated she re-directed him/her back to his/her room, told an aide (unable to remember the name of the aide) so they could help him/her finish dressing and later told a nurse (unable to remember the name). Interview with Resident #5, on 10/18/12 at 4:40 PM, revealed that Resident #2 had entered his/her room several weeks ago and asked him/her if he/she wanted to have sex, did he/she miss sex and how did you get sex in here. Further interview revealed the inappropriate comments made him/her feel scared at the time. He/she further stated he/she had reported the incident to SRNA #9. Interview with SRNA #9, on 10/19/12 at 9:30 AM, revealed that some time around 09/01/12, Resident #5 told her about the incident with Resident #2 coming into his/her room and asking if he/she wanted to "make love". She further stated she was unable to remember who she reported it to; (review of facility documents, dated 10/19/12, revealed that SRNA #9 had reported the incident to Licensed Practical Nurse (LPN) #1, while she was on break). Interview with LPN #1, on 10/19/12 at 9:20 AM, revealed while they were on break, SRNA #9 had "talked" about the incident involving Resident #2 and Resident #5. Further interview revealed she assumed since it was break that SRNA #9 had	F 323			

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F 323	<p>Continued From page 15</p> <p>reported the incident to the nurse that was not on break. She further stated that she had told the SRNAs not to report things to her while she was on break. There was no documented evidence that LPN #1 reported the incident.</p> <p>Interview with the Director of Nursing (DON), on 10/18/12 at 4:30 PM, revealed she had no prior knowledge of the incident between Resident #2 and Resident #5.</p> <p>Further review of Resident #2's care plan (dated 10/05/12), revealed he/she was known to make verbalizations of a sexual nature with interventions to observe for increased behaviors.</p> <p>Review of Resident #2's Comprehensive Plan of Care, dated 03/22/12, revealed there was no documented evidence Resident #2's sexual behaviors had been assessed or that interventions had been put in place to address the sexual behaviors. Review of Resident #2's eMAR (a form the facility used to document resident behaviors), dated October 2012, revealed an intervention to monitor for behaviors every shift; however, further review revealed no behaviors were marked on the eMAR document.</p> <p>Review of Nurse's Notes for Resident #6, dated 10/18/12 at 2:38 PM, revealed Resident #6 reported to an SRNA at 2:15 PM of an incident that occurred around the first of October involving Resident #2. The Note revealed Resident #6 stated he/she was in the courtyard when Resident #2 approached him/her and asked if he/she wanted to talk; when asked what he/she wanted to talk about, he/she said "sex". Resident #6 told</p>	F 323		
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F 323	<p>Continued From page 16</p> <p>him/her "no" and he/she went on to talk about the war.</p> <p>Record review of Resident #6's Admission MDS Assessment, dated 09/24/12, revealed the facility assessed the resident with a BIMS score of fourteen(14) of fifteen (15), indicating the resident was oriented with no cognitive impairment. Interview with Resident #6, on 10/19/12 at 12:20 PM, revealed Resident #2 approached him/her and asked if he/she wanted to talk; when asked what he/she wanted to talk about, he/she said "sex", that he/she wanted to lick him/her "all over". Resident #6 told him/her "no" and Resident #2 went on to talk about the war. Resident #6 stated he/she did not report the incident because he/she felt like Resident #2 was not in his/her right mind and would not hurt/touch, him/her.</p> <p>Review of Resident #2's Comprehensive Plan of Care, dated 03/22/12, revealed there was no documented evidence Resident #2's sexual behaviors had been assessed or that interventions had been put in place to address the sexual behaviors. Review of Resident #2's eMAR, dated October 2012, revealed an intervention to monitor for behaviors every shift; however, further review revealed no behaviors were marked on the eMAR document.</p> <p>On 10/18/12 at 8:00 AM, the Administrator reported an incident involving Resident #2 and Resident #4 that occurred on 10/04/12 to the investigative team.</p> <p>Review of the facility's investigation, dated 10/05/12, revealed on 10/04/12 around 9:30 PM,</p>	F 323		

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F 323	<p>Continued From page 17</p> <p>Resident #2 entered Resident #4's room and asked if he/she could lick his/her "pussy". Resident #4 stated he/she told him/her "no", pushed the call light and told Resident #2 to leave. Further review revealed Resident #2 told Resident #4, he/she did not know what he/she was missing.</p> <p>Interview with SRNA #11, on 10/18/12 at 1:40 PM, revealed he answered Resident #4's call light around 9:30-10:00 PM. Further interview revealed he took Resident #2 back to his/her room and returned to Resident #4's room to check on him/her. He further stated Resident #4 did not relay to him what had happened, just that he/she wanted a Velcro "STOP" barrier placed on the door and the door pulled closed a bit more. Further Interview with SRNA #11 revealed he told a nurse about Resident #2 being in Resident #4's room and that he had put the Velcro barrier on the door per request.</p> <p>Interview, via telephone, with Resident #4, who had been discharged, on 10/18/12 at 2:25 PM, revealed Resident #2 had come into his/her room on the evening of 10/04/12 and made inappropriate sexual comments to him/her. Further interview revealed he/she told Resident #2 to leave and put the call light on. He/she further stated that after the SRNA had removed Resident #2 to his/her room, the SRNA came back and checked on him/her. Resident #4 stated that SRNA #11 volunteered to get a Velcro barrier for the door and to pull the door to a little more. Resident #4 stated that he/she did not sleep well that night.</p> <p>Interview with the Administrator, on 10/18/12 at</p>	F 323			

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F 323	<p>Continued From page 18</p> <p>8:20 AM, revealed she had investigated the incident involving Resident #2 and Resident #4 but did not report it because she felt it was an isolated incident and there was no willful intent due to Resident #2's cognition. She further stated Resident #2 was placed on every fifteen (15) minute checks for forty eight (48) hours.</p> <p>Review of the (15) minute check sheet revealed the checks were started on 10/05/12 at 2:30 PM and continued until 5:45 AM on 10/06/12. There was no documented evidence the (15) minute checks were carried out past 5:45 AM on 10/06/12.</p> <p>Interview with LPN #1, on 10/19/12 around 1:45 PM, revealed she did not remember the night shift nurse passing along the (15) minute checks for Resident #2 and admitted she did not look at the twenty four (24) hour report sheet until later on 10/06/12.</p> <p>Although Resident #2 was supposed to be supervised and on every fifteen minute visual checks on 10/06/12, Resident #2 entered Resident #1's room sometime around noon and asked him/her "to suck pussy" and touched Resident #1 in the groin area. Review of facility's staff statements revealed a visitor (Resident #4's daughter) reported to SRNA #1 that Resident #2 was talking to and touching Resident #1 in a "private area" but was unable to hear what was being said.</p> <p>Interview with SRNA #1, on 10/17/12 at 11:30 AM, revealed he was passing lunch trays when a visitor came to him and told him of the incident occurring between Resident #2 and Resident #1.</p>	F 323		
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F 323	<p>Continued From page 19</p> <p>He stated when he arrived at Resident #1's room, Resident #2 was trying to back out of the room in his/her wheelchair, he returned Resident #2 to his/her room and reported the incident to LPN #1.</p> <p>Interview with LPN #1, on 10/17/12 at 9:10 AM, revealed her involvement with the incident was to report it to the House Supervisor for that day (Staff Development Nurse).</p> <p>Interview with the Staff Development Nurse (House Supervisor on the day of the alleged incident on 10/06/12), on 10/17/12 at 1:30 PM, revealed an investigation was initiated and Resident #2 was placed on 1:1 supervision, the Physician was notified and orders received to send Resident #2 for a Geriatric Psychological evaluation.</p> <p>Review of the Nurse's Notes for Resident #1, dated 10/06/12 revealed the Staff Development Nurse interviewed Resident #1 as to whether he/she felt safe or if anything was bothering him/her.</p> <p>Interview with Resident #1, on 10/19/12 at 9:45 AM, revealed Resident #2 touched him/her between in the groin area between his/her legs and stated he/she wanted to "suck pussy". Further interview revealed she was embarrassed by the incident.</p> <p>Review of Resident #2's clinical record revealed no documented evidence of the sexually inappropriate behaviors being documented on the behavior logs and there was no documented evidence that behaviors were charted in the Nurse Notes, as per facility policy. Further</p>	F 323			

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F 323	Continued From page 20 review of SRNA Care Card revealed no documented evidence the Care Card was updated to monitor for behaviors. There was no documented evidence the facility revised the Plan of Care to include increased supervision or monitoring to ensure safety of other residents.	F 323			