

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

PRINTED: 02/23/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505151	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/19/2015
NAME OF PROVIDER OR SUPPLIER CASHMERE CONVALESCENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 817 PIONEER AVENUE CASHMERE, WA 98815		
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F 000	<p>INITIAL COMMENTS</p> <p>This amended report is the result of an unannounced Abbreviated with Partial Extended Survey conducted at Cashmere Convalescent Center on 02/04/15, 02/09/15, 02/10/15, 02/11/15, 02/12/15, 02/18/15 and 02/19/15. A sample of 12 residents was selected from a census of 64. The sample included 10 current residents and the records of 2 discharged residents.</p> <p>On 02/11/15 an immediate jeopardy was identified related to F226, Staff Treatment of Residents. The facility abated the immediate jeopardy on 02/18/15, before the completion of the Partial Extended Survey on 02/19/15.</p> <p>The following were complaints investigated as part of this survey:</p> <p>#3070691 #3074502 #3075377</p> <p>The survey was conducted by: Lisa Herke, R.D. Hermelinda Thompson, R.N. Brenda Webster, R.N.</p> <p>The survey team is from:</p> <p>Department of Social & Health Services Aging & Long-Term Support Administration Residential Care Services, Region 1, Unit D 3611 River Road, Suite 200 Yakima, WA 98902</p>	F 000		

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BY: _____

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE 3-4-15

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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F 000	Continued From page 1 Telephone: (509) 225-2800 Fax: (509) 574-5597	F 000	POC FOR CITATION RECEIVED 2/27/15 F-226 SS-J		
F 226 SS=J	<p><i>Robert L. [Signature] 2/28/15</i></p> <p>Residential Care Services Date 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>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement policies and procedures to protect 3 of 18 female residents (#s 2, 3 and 4) residing in the dementia unit from sexual abuse. Resident #1 had a change in behavior resulting in him pursuing physical sexual contact with Resident #3. The failure of the facility to identify his behavior as potential abuse and to implement effective interventions to prevent him from further inappropriate sexual contact allowed Resident #1 to sexually abuse two other residents (#s 2 and 4), which constituted an immediate Jeopardy. In addition, the facility failed to report incidents involving Resident #s 2 and 3 to the state reporting hotline per facility policy. Findings include:</p> <p>The facility "Abuse Prohibition Program," on page 5, identified, "It is the policy of the facility to</p>	F 226	<p>HOW THE NURSING HOME WILL CORRECT THE DEFICIENCY AS IT RELATES TO THE RESIDENT(S);</p> <p>Resident #1 was discharged to acute care Hospital on [REDACTED]. In addition, a policy that specifically addresses Sexual Advances Made from One Resident toward another Resident was developed on February 11, 2015 and added to the Abuse Prohibition Policy and Procedure to give staff guidelines regarding this type of behavior. The residents involved and any resident in a similar situation will be protected by improved staff knowledge and ability to intervene appropriately in the event of another situation where one resident approaches another resident in a sexual manner.</p> <p>HOW THE NURSING HOME WILL ACT TO PROTECT OTHER RESIDENTS IN SIMILAR SITUATION;</p> <p>A policy that specifically addresses Sexual Advances Made from One Resident toward another Resident was developed</p>		

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F 226	<p>Continued From page 2</p> <p>maintain an environment free of abuse and neglect. The resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion. Residents will not be subjected to abuse by anyone, including, but not limited to....other residents..." On page 7, sexual abuse was defined as: "This includes, but is not limited to sexual harassment, sexual coercion or sexual assault. 42 CFR 483.13 (b) and (c)" and "Sexual contact, including fondling, with a resident caused by an employee, agent, or other resident of a long term care facility by force, threat, duress, coercion, or sexual contact where the resident has no ability to consent." In the section named "Response and Reporting" on page 41, "It is the policy of this facility that all alleged violations and all substantiated incidents will be reported to the state agency and to all other agencies as required." On page 42, employees are directed, "When a mandated reporter has reasonable cause to believe an incident is abuse, neglect, involuntary seclusion, or financial exploitation, he/she must report to the DSHS [Department of Social and Health Services] Hotline within 24 hours of the incident."</p> <p>Resident #1. Admitted on [REDACTED] with diagnoses including [REDACTED] His latest comprehensive assessment dated 01/14/15 revealed he had significant cognitive impairment, and was able to transfer and to walk about the hallway.</p> <p>Resident #2. Admitted on [REDACTED] with diagnoses including [REDACTED] Her latest comprehensive assessment dated 12/05/14 revealed she had severe cognitive impairment and she was able to walk about the unit. Per a</p>	F 226	<p>February 11, 2015 and added to the Abuse Prohibition Policy and Procedure to give staff guidelines regarding this type of behavior. The residents involved and any resident in a similar situation will be protected by improved staff knowledge and ability to intervene appropriately in the event of another situation where one resident approaches another resident in a sexual manner.</p> <p>MEASURES THE NURSING HOME WILL TAKE OR THE SYSTEMS IT WILL ALTER TO ENSURE THAT THE PROBLEM DOES NOT RECUR</p> <p>All nursing staff to include Licensed Nurses, NAC's NAR's and neighborhood support staff and Activity staff will attend in-service education regarding this new policy and the concept of consent. In-service training was held on 2/17/15, 2/19/15, 2/20/15 and 2/27/15. Mandatory reporting will also be reviewed at this in-service. We will review appropriate actions to be taken in the event of this type of interaction-see attached</p> <p>HOW THE NURSING HOME PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED</p>	

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F 226	<p>Continued From page 3</p> <p>progress note dated 12/09/14, due to advancing dementia and memory loss, the resident was unable to participate in the assessment process.</p> <p>Resident #3. Admitted on [REDACTED] with diagnoses including [REDACTED]. Review of her latest comprehensive assessment dated 01/30/15 revealed she did not walk and was totally dependent on staff for transferring. The comprehensive assessment also noted significant cognitive impairment, with disorganized thinking and inattention. She was identified as having highly impaired hearing and unclear speech.</p> <p>Resident #'s 1, 2 & 3 all resided on the dementia unit.</p> <p>During an interview on 02/10/15 at approximately 11:00 a.m., Staff Member C, a housekeeper, stated on 01/16/15 in the evening after dinner she noticed Resident #1's walker was outside Resident #3's door. The housekeeper stated she left the hallway and returned a short time later. Resident #1's walker was still outside the door, so she stepped into the room to investigate. She stated Resident #1 was standing next to Resident #3's bed with his blue jeans down around his legs. She saw his genitals were exposed and Resident #1 had his hand around Resident #3's hand. Her hand was being guided by his in touching his [genitalia]. The housekeeper stated she "hollered at him to stop" and he did. She then reported the incident to Staff Member D, a licensed nurse (LN). She stated she did not hear Resident #3 say anything during the incident, but it was very hard to hear her because she had a sore throat. The housekeeper further noted the Director of Nursing (DNS or DON) was notified,</p>	F 226	<p>DNS, Social Services and Administrator (or designee) will continue to monitor the daily care and interactions between residents via 24 hour report, progress notes and Communication within our electronic medical record and follow up with staff in the event of this type of behavior/incident.</p> <p>DATE WHEN CORRECTIVE ACTION WILL BE COMPLETED</p> <p>February 27, 2015</p> <p>TITLE OF THE PERSON(S) RESPONSIBLE TO ENSURE CORRECTION</p> <p>DNS, Administrator and Social Services</p>	

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F 226	<p>Continued From page 4 but she did not call the state hotline number as per facility policy.</p> <p>During an interview on 02/10/14 at 11:45 a.m., Staff Member D, a LN, stated on 01/17/15, a nursing assistant reported to her that Resident #2 was in Resident #1's room. The LN stated she and another LN went to the room to investigate and found Resident #1 lying on his back with his private area exposed. His hands were behind his head. Resident #2 had her hand on "his private parts" and was fondling them. The LN asked Resident #2 if she wanted to be there. She said the resident replied she was tired of looking at the snow. The LN stated she directed Resident #2 out of the room, as the resident could not answer the consent question coherently.</p> <p>A progress note from Resident #1's medical record dated 01/19/15 at 4:55 a.m. by Staff Member E, a LN, noted Resident #1 was again in Resident #3's room. The LN documented Resident #1 was preparing to begin inappropriate sexual behavior. The LN removed Resident #1 from the room. Resident #3 stated to her "he was sexually abusing me." A progress note from Resident #3's medical record made by Staff Member E at 7:31 a.m. about the same incident noted Resident #3 thanked her for "taking him out of here." The note also further clarified the sexual abuse statement referred back to a previous interaction.</p> <p>Further review of progress notes revealed at 2:12 p.m. on 01/19/15, documentation by Staff Member F, a LN, noted Resident #1 tried to get Resident #2 to go to his room again.</p> <p>Review of progress notes from Resident #3</p>	F 226		

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F 226	<p>Continued From page 5</p> <p>documented concerns Resident #3 had about Resident #1, asking on 01/19/15 if Resident #1 was still living here, and, on 01/20/15, "did that man move out?" (the writer of the note assured her he was not allowed in her room any longer).</p> <p>Review of Resident #1's care plan revealed it was updated on 01/19/15 to identify a behavior problem with sexual advances. The behaviors were to be managed with removing him from the situation and re-directing him from other resident's rooms immediately.</p> <p>Further review of progress notes revealed on 01/21/15 at 9:32 a.m., Staff Member F, a LN, noted Resident #1 was trying to go into Resident #3's room again, and a nursing aide (NA) had to re-direct him from entering the room. A later progress note by Staff Member F at 2:06 p.m. noted an interaction witnessed by an NA, between Resident #1 and Resident #2, where he pulled her hands to his groin area. Resident #2 pulled her hands away from him, and stated "you are being a little rough with me." The NA made eye contact with Resident #1 and he walked away.</p> <p>During an interview on 02/10/15 at 8:20 a.m., Staff Member B, the Activities Director, stated she was in the Pioneer dining room on the morning of 01/22/15 helping with breakfast. She stated she heard Resident #1 say, "I am a dirty old man and you all like it." She stated it made other residents in the dining room uncomfortable. Resident #5, a cognitively alert resident who does not reside on the dementia unit, expressed discomfort with the conversation and told her, "I don't want to be here." The Activity Director took her back to her room. She stated Resident #6, a cognitively alert</p>	F 226	<p>POC For Citation F 250</p> <p>How the nursing home will correct the deficiency as it relates to the resident(s):</p> <ol style="list-style-type: none"> 1. Resident #1 was discharged to acute care hospital on [REDACTED]. A policy that specifically addresses 'Sexual Advances Made from One Resident toward Another Resident' was developed on February 11, 2015 and amended on 03/03/15. The policy was added to the Abuse Prohibition Policy and Procedure in an effort to give staff guidelines regarding this type of incident. The residents involved and any resident in a similar situation will be protected by improved staff knowledge of ability to intervene, protect, and assess appropriately in the event of a future situation during which a resident makes sexual advances towards another resident. 	

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F 226	<p>Continued From page 6</p> <p>resident who is mobile, got up and left on her own. Staff Member B stated she told the DNS, and the DNS talked with Resident #1, but the conversation with Resident #1 "didn't do any good." She said the DNS told her there isn't anything we can do until he "crosses the line."</p> <p>During an interview on 02/10/15 at 4:10 p.m., Staff Member A, the DNS, stated she had a conversation with Resident #1 on 01/22/15, after the incident in the dining room. She stated she asked him to stop the inappropriate sexual comments and behaviors, and he told her he could not promise to do that.</p> <p>Review of progress notes revealed continued inappropriate behaviors by Resident #1, including being in Resident #3's room again on 01/27/15, inviting Resident #2 back to his room so he could "give her some of his exercises" on 01/29/15, and inviting Resident #7, a cognitively impaired resident of the dementia unit to "come and share my bed" on 01/29/15.</p> <p>In a 02/10/15 interview conducted with printed questions because of her impaired hearing, Resident #3 stated she did not feel safe here. "They let him play with me. I didn't like it." She further stated she thought he (Resident #1) was still here and it bothered her he could come into her room again.</p> <p>The facility failed to recognize the incidents that occurred between 01/16/15 through 01/29/15 as sexual abuse or sexual harassment. There was no evidence of an effective plan to protect residents from Resident #1's abusive behaviors, thus residents continued to be at risk.</p>	F 226	<p>2. An 'Acute Change in Behavior' Assessment was developed. The residents involved and any resident in a similar situation will be protected by improved interdisciplinary team assessment of potential contributing factors to, and the creation, of individualized interventions and/or recommendations in response to a resident's change in behavior.</p> <p>How the nursing home will act to protect other residents in similar situations:</p> <p>1. A policy that specifically addresses 'Sexual Advances Made from One Resident toward Another Resident' was developed on February 11, 2015 and added to the Abuse Prohibition Policy and Procedure in an effort to give staff guidelines regarding this type of incident. The policy was amended on (date) with the following addition to Procedure #1 (please note the addition is</p>		

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F 226	<p>Continued From page 7</p> <p>Review of an incident investigation revealed on 02/02/15 at 5:00 p.m., Staff Member H, a NA, observed Resident #1 remove the Pioneer dining room key from a tray box next to the door. He unlocked the door. When she next passed by the dining room, she noted the dining room door was closed and lights were off. She entered the dining room, observed Resident #4's blouse and t-shirt "entangled lying on the floor next to some water" and "Resident #1's hands on Resident #4's breasts." The NA immediately put the t-shirt on Resident #4 and removed her from the area. The investigation concluded Resident #4 was a victim of sexual abuse by Resident #1.</p> <p>On 02/09/15 at 3:40 p.m., Staff member I, a LN, stated Resident #1's behavior changed "3 or 4 weeks ago," when he went from being "flirty" to more sexually aggressive. She stated they [the staff] watched him closely and tried to intervene to keep him out of other resident rooms. On 02/11/15 at 2:45, she further noted she was at the opposite end of the hall from the dining room on 02/02/15 when Resident #1 was in the dining room with Resident #4, so she did not hear or see the incident. She stated the NA's were all busy with meal time cares, so no one was in the vicinity to see Resident #1 go into the dining room.</p> <p>Resident #4. Admitted on [REDACTED] with diagnoses including [REDACTED]. Her latest comprehensive assessment dated 01/09/15 revealed she was severely cognitively impaired (the mental status test could not be completed), with disorganized thinking and inattention. She required staff assistance to walk, but could move about in her wheel chair independently.</p> <p>On 02/09/15 at 12:35, Resident #4 was observed</p>	F 226	<p>italized): "When a resident is observed making sexual advances toward another resident such as inappropriate touching, sexual harassment, sexual coercion or sexual assault , intervene immediately and remove the initiating resident. Ensure all residents safety. Assess the non-initiating resident for physical injury and/or psychosocial distress immediately. Complete the "Capacity to Consent" assessment for each resident." The interdisciplinary team will include the information gathered in the "Capacity to Consent" assessment in Procedures #'s 6 and 7. The residents involved and any resident in a similar situation will be protected by improved staff knowledge of ability to intervene, protect, and assess appropriately in the event of a future situation during which a resident makes sexual advances towards another resident.</p> <p>2. An 'Acute Change in Behavior Assessment' was developed to assess potential contributing</p>		

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F 226	<p>Continued From page 8</p> <p>in her wheelchair coming out of the Vista dining room. She was propelling her wheelchair independently and was humming to herself. She was unable to be interviewed.</p> <p>On 02/10/15 at 4:10 p.m., the DNS stated she did not notify the state hotline about the incident with Resident #3 on 01/16/15 and with Resident #2 on 01/17/15 because she thought the behaviors were consensual, as the two female residents did not object to Resident #1's behavior. She further stated Resident #1 has rights that couldn't be denied, too, including sexual gratification and intimacy needs. She stated when the incident with Resident #4 happened, it was definitely "over the line," and she asked to have the resident transported to a local hospital and she reported the incident.</p> <p>Review of medical records for Resident #s 2, 3 and 4 revealed all had Power of Attorney representatives for care decisions and financial decisions. Care plans for all three women identified impaired cognitive function with moderate receptive and expressive language deficits, which limited decision making abilities, but there was not an assessment in the records of capacity to consent.</p>	F 226	<p>factors and create individualized interventions and/or recommendations in the event of a resident demonstrating an acute change in behavior. The assessment will be completed by the interdisciplinary team. The assessment will be initiated when a resident is placed on alert charting for change in behavioral symptoms. The residents involved and any resident in a similar situation will be protected by improved interdisciplinary team assessment of potential contributing factors to and the creation of individualized interventions and/or recommendations in response to a resident's change in behavior.</p> <p>Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur:</p>	
F 250 SS=G	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p>	F 250	<p>Licensed nursing will be provided an in-service education regarding the 'Capacity to Consent' and 'Acute Change in Behavior Assessment'. Activity Director will be provided an in-service education regarding the 'Acute Change in Behavior Assessment'.</p>	

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F 250	<p>Continued From page 9</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide medically related social services for 2 of 3 (#s 2 and 3) residents sampled for sexual harassment or sexual touching when Resident #1 became sexually aggressive toward the residents. Failure to advocate for Resident #s 2 and 3 by assessing their decision making capacity and ability to consent to sexual overtures and protecting them while the assessment was ongoing caused harm to those residents, who were subjected to sexual abuse. Additionally, failure to assess the circumstances around Resident #1's change in behavior placed all female residents in the dementia unit at risk for sexual harassment or assault. Findings include:</p> <p>Resident #1. Admitted on [REDACTED] with diagnoses including [REDACTED]. His latest comprehensive assessment dated 01/14/15 revealed he had severe cognitive impairment. The assessment also revealed he was able to walk about the facility with no assistance from staff.</p> <p>In an interview on 02/09/15 at 12:35 p.m., Staff Member F, a licensed nurse (LN), stated Resident #1 had some anger issues since admission, but until recently, he had no sexually inappropriate behaviors. The LN described 3 to 4 weeks ago, Resident #1 began demonstrating sexually inappropriate behaviors, including inappropriate verbal statements to residents and staff, multiple attempts to go into rooms occupied by female residents on the dementia unit and inappropriate touching of female residents.</p>	F 250	<p>F 250 How the nursing home plans to monitor its performance to make sure that the solutions are sustained:</p> <p>Administrator (or designee), SSD, and DNS will continue to monitor the daily care and interactions between residents via 24H report, progress notes, and Communication within our electronic medical record to ensure compliance.</p> <p>Date when correction action will be completed:</p> <p>03/03/15</p> <p>Title of person(s) responsible to ensure correction:</p> <p>Administrator, Director of Social Services, Director of Nursing Services</p> <p>F-490 The Administrator failed to administer operations in an effective and efficient manner</p> <p>How the nursing home will correct the deficiency as it relates to the resident(s):</p> <ol style="list-style-type: none"> 1. Resident #1 was discharged to acute care hospital on February 	

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F 250	<p>Continued From page 10</p> <p>Resident #3. Admitted on [REDACTED] with diagnosis including [REDACTED]. Review of her latest comprehensive assessment revealed she had severe cognitive impairment, scoring 5 out of 15 on a Brief Interview for Mental Status (BIMS) exam. The assessment also revealed she had highly impaired hearing, did not walk and was dependent on staff for transferring.</p> <p>On 01/16/15, Staff Member C, a housekeeper, observed Resident #1 in Resident #3's room. The housekeeper noted Resident #1's pants were down. He was holding Resident #3's hand and guiding her hand in touching his private parts. The housekeeper immediately intervened, separated the two residents and called the nurse.</p> <p>Review of progress notes in Resident #3's medical record following the incident revealed expressions of discomfort from the resident about the incident. On 01/18/15, Staff Member E, a LN, documented Resident #1 was in Resident #3's room again. The LN documented she removed Resident #1 and Resident #3 told her "thank you for taking him out." On 01/20/15, Staff Member E documented Resident #3 was still concerned about Resident #1, asking "did that man move out?"</p> <p>In an interview on 02/10/15 with Staff Member A, the Director of Nursing Services (DNS), she stated she felt the incident was consensual and Resident #1 had a right to pursue intimacy.</p> <p>Review of Resident #3's medical record revealed she had a Power of Attorney (POA) for health care and for financial decisions. Her care plan described her as having impaired cognitive function, compounded by severe hearing loss. It</p>	F 250	<p>2, 2015. A policy that specifically addresses 'Sexual Advances Made from One Resident toward Another Resident' was developed on February 11, 2015 and amended on (date). The policy was added to the Abuse Prohibition Policy and Procedure in an effort to give staff guidelines regarding this type of incident. The residents involved and any resident in a similar situation will be protected by improved staff knowledge of ability to intervene, protect, and assess appropriately in the event of a future situation during which a resident makes sexual advances towards another resident.</p> <p>2. An 'Acute Change in Behavior' Assessment was developed. The residents involved and any resident in a similar situation will be protected by improved interdisciplinary team assessment of potential contributing factors to, and the creation, of individualized interventions and/or</p>		

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F 250	<p>Continued From page 11</p> <p>directed staff to use short clear questions in writing to communicate with the resident.</p> <p>In an interview on 02/10/15 with Resident #3's POA, she stated she had not been notified of the 01/16/15 incident, but had been called by facility staff recently because the resident had lost weight and had "quit eating." The POA thought perhaps the appetite decline was related to being upset about the incident. She further noted Resident #3 was not competent to consent to a proposed intimate encounter.</p> <p>Resident #2. Admitted on [REDACTED] with diagnoses including [REDACTED]. Her latest comprehensive assessment dated 12/05/14 revealed she had severe cognitive impairment, scoring 3 out of 15 on a BIMS exam. The assessment also noted she was able to walk about the unit.</p> <p>On 01/17/15, Resident #2 was observed by a nursing assistant (NA) being in Resident #1's room. The NA summoned Staff Member D, a LN, who observed Resident #1 lying on his back with his private parts exposed. Resident #2 was touching his private parts. The LN asked Resident #2 if she wanted to be there (in the room with Resident #1). Resident #2 responded she was tired of looking at the snow. The LN stated she directed the resident out of the room, because she could not answer the question about consent.</p> <p>Review of progress notes revealed further interaction between Resident #1 and #2. On 01/21/15, a note documented Resident #1 took Resident #2's hand and placed it on his groin area. Resident #2 pulled her hand away and</p>	F 250	<p>recommendations in response to a resident's change in behavior.</p> <p>How the nursing home will act to protect other residents in similar situations:</p> <p>3. A policy that specifically addresses 'Sexual Advances Made from One Resident toward Another Resident' was developed on February 11, 2015 and added to the Abuse Prohibition Policy and Procedure in an effort to give staff guidelines regarding this type of incident. The policy was amended on (date) with the following addition to Procedure #1 (please note the addition is italicized): "When a resident is observed making sexual advances toward another resident such as inappropriate touching, sexual harassment, sexual coercion or sexual assault , intervene immediately and remove the initiating resident. Ensure all residents safety. Assess the non-initiating resident for physical injury and/or psycho-social distress immediately.</p>		

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F 250	<p>Continued From page 12 complained he was being rough.</p> <p>Review of Resident #2's medical record revealed she had a POA for healthcare and finance. Her care plan included issues with cognitive impairment and indicated she had trouble making herself understood and confusion was evident. It noted she needed to be cued to her own room, the dining room and to the bathroom. The care plan was not updated following the incident.</p> <p>Further review of the medical record for Resident #'s 2 and 3 revealed the residents were placed on alert charting by nursing for possible distress related to the incidents, but there was no evidence of a Social Service evaluation to determine their ability to make an informed decision about a sexual encounter or evidence of support for these two residents following a difficult resident to resident interaction.</p> <p>In an interview on 02/18/15, Staff Member K, the Social Service Director (SSD), stated her role is to advocate for residents and families. She stated they focused on Resident #1's need to have intimacy and, in hindsight, the facility did not do all they could have for Resident #2 and #3 to be safe. She further noted nursing took the lead with these incidents and she should have been more involved.</p> <p>By viewing Resident #1's behavior as a pursuit of intimacy instead of potential sexual abuse, the facility failed to advocate for Resident #2 and #3's safety and well-being. This caused harm for Resident #2 and #3 by subjecting them to further abuse. Further, this placed all female residents residing on the dementia unit at risk for sexual abuse or harassment.</p>	F 250	<p>Complete the "Capacity to Consent" assessment for each resident." The interdisciplinary team will include the information gathered in the "Capacity to Consent" assessment in Procedures #'s 6 and 7. The residents involved and any resident in a similar situation will be protected by improved staff knowledge of ability to intervene, protect, and assess appropriately in the event of a future situation during which a resident makes sexual advances towards another resident.</p> <p>4. An 'Acute Change in Behavior Assessment' was developed to assess potential contributing factors and create individualized interventions and/or recommendations in the event of a resident demonstrating an acute change in behavior. The assessment will be completed by the interdisciplinary team. The assessment will be initiated when a resident is placed on alert charting for change in behavioral symptoms. The residents involved and any resident in a</p>	

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F 490 SS=J	<p>483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING</p> <p>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to administer operations in an effective and efficient manner to ensure resident safety, health, and well-being related to implementing policies to prevent sexual abuse. This failure resulted in harm to Resident #s 2, 3 and 4. An Immediate Jeopardy situation was identified on 02/11/15, as this issue was not recognized by the facility administration as causing serious harm to residents. Findings include but are not limited to:</p> <p>1) On 01/16/15 in the evening, Resident #1 (a male residing on the dementia unit), was observed by Staff Member C, a housekeeper, in Resident #3's (a female also residing in the dementia unit) room. Resident #1 had his pants down and was guiding Resident #3's hands in touching his private area. The housekeeper stated, in an interview on 02/10/15, she immediately intervened to stop the behavior and reported the incident to the licensed nurse (LN) and the Director of Nursing (DNS).</p> <p>During an interview on 02/10/15, Staff Member F, a LN, stated Resident #3 was fearful after the incident. She explained the resident told her she did not want "that man" (Resident #1) in her room any more.</p>	F 490	<p>similar situation will be protected by improved interdisciplinary team assessment of potential contributing factors to and the creation of individualized interventions and/or recommendations in response to a resident's change in behavior.</p> <p>Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur:</p> <p>Licensed nursing will be provided an in-service education regarding the 'Capacity to Consent' and 'Acute Change in Behavior Assessment'. Activity Director will be provided an in-service education regarding the 'Acute Change in Behavior Assessment'.</p> <p>How the nursing home plans to monitor its performance to make sure that the solutions are sustained:</p> <p>Administrator (or designee), SSD, and DNS will continue to monitor the daily care and interactions between residents via 24H report, progress notes, and Communication within our electronic medical record to ensure compliance.</p>		

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F 490	<p>Continued From page 14</p> <p>In an interview on 02/10/15 with the DNS, she stated she felt the incident was consensual and Resident #3 was not in distress so she "let it go" (did not investigate or report the incident to the state hotline).</p> <p>2) On 01/17/15, Staff Member D, a LN, was summoned to Resident #1's room by a nursing assistant (NA). The LN observed Resident #1 lying on his bed and noted Resident #2, a female resident of the dementia unit, was also in the room and was touching Resident #1's exposed "private parts." In an interview with Staff Member D on 02/10/15, she stated she asked Resident #2 if she wanted to be in the room. She stated the resident was unable to voice her preference so she re-directed the resident from the room and notified the DNS of the incident.</p> <p>In an interview on 02/10/15, Staff Member J, a NA, stated Resident #1 tried several more times to get Resident #2 and other female residents to come to his room after the 01/17/15 incident. The NA stated she was uncomfortable with the situation because Resident #2 was "not with it at all."</p> <p>In an interview with the DNS on 02/10/15, she stated she did not report or investigate the incident because it was consensual, and Resident #1 had the right to pursue intimacy and sexual gratification.</p> <p>3) Review of an incident investigation report revealed Resident #1 was found in the dining room with Resident #4, a female resident of the dementia unit, on 02/02/15 at approximately 5:00 p.m. The investigation concluded Resident #1</p>	F 490	<p>Date when correction action will be completed: <i>02/15/15 3-5-15</i></p> <p>Title of person(s) responsible to ensure correction: Administrator, Director of Social Services, Director of Nursing Services</p> <p>Please also see the POC for F-226</p> <p>F-597 The facility failed to ensure at least 12 hours of annual in-service was completed for 6 of 6 staff</p> <p>How the nursing home will correct the deficiency as it relates to the resident(s): A review of the annual in-service schedule has been completed and revised to include adequate meaningful opportunities for nursing assistances to fulfill the 12 hours per year minimum requirement per regulation. In addition, all CNA in-service records have been reviewed to determine if adequate in-service hours have completed.</p> <p>How the nursing home will act to protect other residents in similar situations:</p>	

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F 490	Continued From page 15 turned off the lights, closed the door and removed a t-shirt and a blouse from Resident #4. The NA who discovered the incident observed Resident #1 touching Resident #4's breasts. The facility administration did not recognize the 01/16/15 and 01/17/15 incidents as sexual abuse, and thus did not implement an effective plan to protect all female residents on the dementia unit from further abuse. On 02/10/15, when initial findings were presented to the DNS, she continued to define the first two incidents as consensual, demonstrating a lack of recognition of the immediacy of the situation and the risk of harm to other residents. Refer to F226 and F250 for additional information.				
F 497 SS=E	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced				
F 490			CNA staff were notified of the federal regulation requirement for continuing education credit. All CNA staff reviewed during survey were directly notified of their insufficient in-service hours. CNA staff will be notified quarterly of their status. Education opportunities for CNA staff will be offered at monthly general staff meetings, monthly licensed nursing staff meetings, departmental meetings and if that is not sufficient CNA staff will be assigned in-service courses utilizing our video library and other outside resources. Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur:		
F 497			All CNA staff has been notified of the federal regulation requirement for continuing education and the HR department will track the CNA progress in fulfilling the 12 hour requirement. CNA staff will be notified quarterly of their accumulated in-service hours for their individual license year. Education opportunity for CNA staff will be offered at the monthly general staff meetings, monthly licensed staff meetings, departmental meetings and if that is not sufficient CNA staff will be assigned in-service courses utilizing our video library.		

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F 497	<p>Continued From page 16</p> <p>by: Based on interview and record review the facility failed to ensure at least 12 hours of annual in-service education was completed for 6 of 6 sampled Certified Nursing Assistants (NAC) (Staff Members N, O, P, Q, R and S) who provided direct resident care. This failure had the potential to affect the quality of care provided to residents. Findings include:</p> <p>Review of the education records on 02/19/15 revealed the following staff, all NACs, completed the following education during their latest 12 month cycle based on their hire date:</p> <p>Staff Member N completed approximately 8.5 hours of education between 05/06/13 and 05/06/14.</p> <p>Staff Member O completed approximately 10.5 hours between 03/30/13 and 03/30/14.</p> <p>Staff Member P completed approximately 8.75 hours between 03/08/13 and 03/08/14.</p> <p>Staff Member Q completed approximately 5.5 hours between 02/28/13 and 02/28/14.</p> <p>Staff Member R completed approximately 7.5 hours between 10/28/13 and 10/28/14.</p> <p>Staff Member S completed approximately 6.5 hours between 11/11/13 and 11/11/14.</p> <p>On 02/19/15 at approximately 2:00 p.m., Staff Member L, an office worker, stated she was responsible for documenting the continued education the staff received in their files. She explained there was no system in place to</p>	F 497	<p>How the nursing home plans to monitor its performance to make sure that the solutions are sustained:</p> <p>The HR Department will track individual progress of in-service education requirements. The Administrator, Director of Nursing and/or their assistants will ensure in-service education is scheduled, attendance taken and delivered to the HR Department.</p> <p>Date when correction action will be completed:</p> <p>Corrected 3/5/15</p> <p>Title of person(s) responsible to ensure correction:</p> <p>The Administrator and the Director of Nursing will monitor this finding for continued compliance.</p>		

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F 497	<p>Continued From page 17</p> <p>monitor the amount of education each staff member had received. She further explained she was not aware of the continued education requirement for nursing assistants.</p> <p>On 02/19/15 at approximately 2:15 p.m., Staff Member M, the Assistant Director of Nursing Services, stated she was responsible for tracking the amount of continued education for all staff until September of 2014 when she switched positions. When asked about a current system to monitor the continuing education hours, she stated, "Nobody's at the helm."</p>	F 497		