STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035072	A. BUILDING _____ B. WING _____	11/09/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PHOENIX MOUNTAIN POST ACUTE	13232 NORTH TATUM BLVD PHOENIX, AZ 85032

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0551 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Give the resident's representative the ability to exercise the resident's rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident and staff interviews, and policy, the facility failed to obtain signatures of the resident's court appointed guardian on advance directives and on informed consent documentation for medications and vaccines for one resident (#58). Findings include: Resident #58 was readmitted on (MONTH) 27, (YEAR), with [DIAGNOSES REDACTED]. A review of the clinical record revealed documentation that the resident had a court appointed fiduciary/guardian for medical and financial decision making. Further review of the clinical record revealed an Advance Directives dated (MONTH) 27, (YEAR) that the resident was a DNR (do not resuscitate), a decline of the influenza vaccine dated (MONTH) 27, (YEAR), an informed consent for the use of [MEDICAL CONDITION] medications ([MEDICATION NAME] and [MEDICATION NAME]) dated (MONTH) 27, (YEAR), an informed consent for the use of opioid therapy dated (MONTH) 27, (YEAR), and a consent for the Prevnar 12 and [MEDICATION NAME] 23 (pneumococcal vaccines) dated (MONTH) 29, (YEAR) that were all signed by the resident but did not include the guardian's signature. During an interview conducted with the resident on (MONTH) 6, (YEAR) at 1:54 p.m., the resident stated that a family member who lives out of state is her Power of Attorney. She stated that due to her severe medical condition, the physician wanted a local responsible party available to make medical and financial decisions on her behalf. The resident stated that the court appointed her a private fiduciary to act as her guardian for both medical and financial decisions. She stated that she currently has a private fiduciary who visits frequently and manages her care. On (MONTH) 6, (YEAR) at 2:07 p.m., an interview was conducted with the Social Services Director (staff #8). Staff #8 stated that they are aware resident #58 has an appointed guardian/fiduciary. Staff #8 further stated that if a resident has a guardian then the guardian should be the person signing consents, etc. After reviewing the clinical record, staff #8 stated that the resident's court appointed guardian's paper work is in the resident's clinical record and that the consents for psycho-active medications and opioid therapy and the resident's advance directive for DNR should have been signed by the resident's guardian and not the resident. A review of the facility's Residents' Rights policy regarding the resident representative revealed it is the policy of the facility to recognize and acknowledge the resident's representative per state and federal regulations. The policy included that a court-appointed guardian is to be recognized as the resident's representative. The policy further included that the facility would treat the decisions of the resident representative as the decisions of the resident to the extent required by the court or delegated by the resident, in accordance with applicable law.
F 0552 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that residents are fully informed and understand their health status, care and treatments.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview, and policy, the facility failed to have documented evidence that one resident (#55) was provided the risks and benefits for the use of an antidepressant. Findings include: Resident #55 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the physician's orders [REDACTED]. The Informed Consent Form for [MEDICAL CONDITION] Medications was signed and dated on 09/12/18 by the resident and a staff Registered Nurse (RN); however the form did not have the name of the medication, a [DIAGNOSES REDACTED]. The admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact. The care plan regarding depression initiated on 9/25/18 included an intervention to obtain signed consent for the use of [MEDICAL CONDITION] medications. An interview was conducted on 11/08/18 at 09:49 AM with the Director of Nursing (DON/staff #38), who stated that when there is a new physician's orders [REDACTED]. Review of the facility's policy titled Consent for Psychoactive Medications included, In order to uphold the fundamental right of all residents and/or responsible parties and exercise informed decision of their care, it is the policy of this facility to obtain consent for the use of psychoactive medications.
F 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, and documents, the facility failed to ensure one resident's (#17) call light was accessible. Findings include: Resident #17 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 6 which indicated the resident had severe cognitive impairment. The assessment included the resident required total dependence or extensive assistance of 1-2 persons for most activities. An observation was conducted of the resident on 11/05/18 at 02:46 PM The resident was observed lying in bed with a mat on the side of the bed. The resident's bed was observed against the wall with the head of the bed at the far end of the room near the window. A chair was observed at the foot of the bed with the back of the chair against the foot of the bed. A recliner was observed next to the chair in a nearly perpendicular position. The resident's call light was observed on the recliner out of the reach of the resident. During an observation conducted on 11/07/18 at 11:30 AM with the Maintenance Manager (staff #78) and the Administrator (staff #81), the resident's call light was again observed in the recliner. When the call light was extended by staff #78, the call light did not extend far enough to reach the resident's hands when in bed. It only reached approximately 2.5 feet into the bed from the bottom. The Maintenance Manager stated that if he had known, he would have ordered a longer cord. The Manager stated the call lights are checked for operation each month, not checked to see if the residents can reach them or not. An interview was conducted on 11/07/18 at 11:40 AM with a Certified Nursing Assistant (CNA/staff #164). The CNA stated that the chair at the bottom of the bed is always there because the resident wants to keep her purse here. She further stated

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

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F 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) that the bed and chairs have been in that position for quite a while. She stated that she did not realize the call light cord did not extend far enough for the resident to reach the call light when in bed. During an interview conducted on 11/07/18 at 02:55 PM with resident #17, the resident was observed in the recliner with her feet up and the call light within reach. She stated that she uses the call bell to call for assistance. She also stated that staff usually come in every so often. The resident stated that she has not wanted for anything and that she likes and wants her room and chairs the way they are. Review of facility's Call Light Checklist logs for (MONTH) (YEAR), (MONTH) (YEAR), and (MONTH) (YEAR) revealed no concerns were identified with the call light for the room of resident #17.
F 0573 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Let each resident or the resident's legal representative access or purchase copies of all the resident's records.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy and procedures, the facility failed to provide medical records within the required time frame to one resident (#354). Findings include: Resident #354 was admitted to the facility on (MONTH) 15, (YEAR) with [DIAGNOSES REDACTED]. The discharge MDS (Minimum Data Set) assessment dated (MONTH) 12, (YEAR) revealed the resident had a BIMS (Brief Interview of Mental Status) score of 13 indicating the resident was cognitively intact. Review of the Authorization for Release of Health Information form revealed the resident requested all of his medical records and signed and dated the request form on (MONTH) 13, (YEAR). However, the resident did not receive a copy of his medical records within the required time frame of two working days. An interview was conducted on (MONTH) 7, (YEAR) at 8:39 a.m. with the Medical Records Director (staff #144) who stated that the process of requesting medical records consisted of the resident informing their nurse or the medical records office of the request. Staff #144 stated that the resident then completes a release form and gives it to the medical records staff along with the fee required for the process. The Director stated that the form is then scanned to the facility's attorney for review. Staff #144 stated that after the attorney gives the okay to release the records, the resident is provided with the records requested. Staff #144 stated that a time frame for picking up the records is not stated because it depends on how long it takes for the attorney to respond. The Director stated that the estimated turnaround time for records to be ready for pick up is 2-3 weeks and that the person who made the request will be notify when the records are available for pick up. On (MONTH) 7, (YEAR) at 9:06 a.m., staff #144 stated that the resident #354 and the resident's family were not given a specific time frame when the medical record would to be ready to pick. Staff #144 stated that the request was signed on (MONTH) 13, (YEAR) and that the medical records were available for pick up on (MONTH) 7, (YEAR). The Director also stated the resident was notified the records were ready. During an interview conducted on (MONTH) 7, (YEAR) at 12:34 p.m. with staff #144, she stated that she was unaware of their facility's policy regarding the time frame for providing residents a copy of their medical records. Staff #144 stated that the current procedure of sending the request to the facility attorney was initiated by the previous administrator and has been followed since. An interview was conducted on (MONTH) 7, (YEAR) at 12: 41 p.m. with the Administrator (staff #81) who stated that the expectation of the facility would be to follow their written policy and procedure for medical records. Staff #81 stated that their current practice is to send the record request to the facility's attorney first to ensure HIPPA is followed, the attorney will send it back as quickly as they can and that medical records handles this procedure. Staff #81 stated that this process was started prior to his time at the facility and that he is unaware of why this is the current practice. Staff #81 stated that he is unsure of the turnaround time to complete medical record requests and that he was unaware of the existence of the current facility policy regarding medical records. The facility policy titled Medical Records states that the resident has the right to access personal and medical records pertaining to him or herself. It states the facility will provide the resident access, upon a written or oral request, in the form and format requested by the individual within 24 hours (excluding weekends and holidays). The policy included the facility will allow the resident to obtain a copy of the records upon request and 2 working days advance notice to the facility.
F 0583 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Keep residents' personal and medical records private and confidential.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, and facility policy review, the facility failed to ensure meal tickets containing resident information were not thrown into the trash for multiple residents. Findings include: A lunch observation was conducted on (MONTH) 5, (YEAR) at 12:56 p.m. in the 600 hall dining room. A certified nursing assistant (CNA/staff #162) was observed to take a small stack of lunch meal tickets, fold them in half, and throw them in a trash can in the dining room. The meal tickets thrown in the trash included resident information for four residents. The information on the slips included the residents' names, room numbers, allergies [REDACTED]. During an interview conducted with staff #162 on (MONTH) 8, (YEAR) at 12:32 p.m., she that stated meal tickets are collected and then put into a shred bin in the locked supply room. During an interview conducted with a CNA (staff #134) on (MONTH) 8, (YEAR) at 12:35 p.m., she stated that the meal tickets are used to ensure the proper meal is given to the resident. The CNA stated that the tickets are then collected and shredded because they contain personal resident information. An interview was conducted with the dietary manager (staff #105) on (MONTH) 8, (YEAR) at 2:02 p.m. She stated that meal tickets should be collected after the meal service and placed into a shredder bin. She also stated that staff from other dining rooms are to collect meal tickets and bring them to the kitchen in a bag which will then be disposed of properly in a shredder bin by the dietary staff. Staff #105 further stated that this is done to protect resident confidentiality of personal information. An interview was conducted with the Director of Nursing (DON/staff #38) on (MONTH) 9, (YEAR) at 11:19 a.m. She stated that the meal tickets should be collected by staff and then given to the dietary department or put into a shred bin. The DON stated that if the meal tickets are taken to the dietary department, the staff there are aware that the meal tickets are to be shredded. She further stated that the tickets need to be shredded in order to protect the privacy and confidentiality of the residents' personal information. The DON stated that nothing with a resident's name on it should be thrown in the trash, it should be shredded. Review of the facility's policy regarding medical records included, The resident has a right to personal privacy and confidentiality of his or her personal and medical records and a right to secure and confidential personal and medical records .The facility must keep confidential all information contained in the resident's records .
F 0600 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record reviews, staff and resident interviews, facility documentation and policy and procedures, the facility failed to protect three residents (#9, #10 and #58) from one resident (#56), who displayed known sexually inappropriate behaviors. As a result, the Condition of Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) were identified. The facility also failed to protect one resident (#204) from verbal abuse by a staff member.

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F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) Findings include: On (MONTH) 5, (YEAR) at 10:20 a.m., the Administrator (staff # 81) was informed that resident #9 reported to a surveyor that while resident #56 was shaking her hand in the hall, he stated that he was going to f--- her. Resident #9 reported that this incident occurred on (MONTH) 2, (YEAR). Two additional reports of sexually inappropriate behaviors by resident #56 were also received on (MONTH) 5, (YEAR) from resident #10 and resident #58. In addition, it was identified that staff members were aware of some of the sexually inappropriate behaviors of resident #56 and did not report these behaviors to administration or implement measures to protect the other residents. As a result, the Condition of Immediate Jeopardy and Substandard Quality of Care (SQC) were identified on (MONTH) 5, (YEAR) at 5:00 p.m. The Administrator was informed of the facility's failure to protect residents from resident #56, who exhibited sexually explicit and inappropriate behaviors. The Administrator presented a plan of correction on (MONTH) 5, (YEAR) at 6:47 p.m. The Administrator was informed that the plan of correction did not include all of the necessary components to ensure the safety of residents and provide care to those residents, who may have been affected by resident #56's sexually inappropriate behaviors. At 7:35 p.m., a revised plan of correction was presented and accepted. Observations were conducted on (MONTH) 5, (YEAR) at 7:40 p.m. of the facility implementing their plan of correction. Staff in-services were being conducted regarding abuse and sexually inappropriate behaviors. The facility also implemented 1:1 monitoring for resident #56. Additional observations were conducted on (MONTH) 6, (YEAR), of the facility continuing to implement their plan of correction. Staff in-services continued to be conducted and staff interviewed were knowledgeable of the different kinds of abuse, the reporting process, and of the measures which were being implemented to protect the residents. Resident #56 also remained on 1:1 monitoring. As a result, the Condition of Immediate Jeopardy was abated on (MONTH) 6, (YEAR) at 10:39 a.m. -Resident #56 was admitted to the facility on (MONTH) 20, 2012, with [DIAGNOSES REDACTED]. Review of the nursing monthly summaries dated (MONTH) 27, (MONTH) 24, and (MONTH) 11, (YEAR), revealed that resident #56 had moderate cognitive impairment, delusions, hallucinations, wanders in the facility, uses a wheelchair and displays sexual behaviors toward female staff. A nursing monthly summary dated (MONTH) 11, (YEAR) included that resident #56 had severe cognitive impairment, uses a wheelchair, continues to be sexually inappropriate and makes inappropriate comments to female staff and visitors. A nursing monthly summary dated (MONTH) 10, (YEAR) revealed that resident #56 has disorganized thinking and memory problems, uses a wheelchair, and is sexually inappropriate with female staff and is redirected. Review of a nursing monthly summary dated (MONTH) 10, (YEAR) revealed the resident had severe cognitive impairment, memory problems, uses a wheelchair, and that behavior monitoring is in process for sexually inappropriate behaviors at times. According to the annual Minimum Data Set (MDS) assessment dated (MONTH) 30, (YEAR), the resident had a Brief Interview for Mental Status (BIMS) score of 4, which indicated the resident had severe cognitive impairment. The MDS included the resident required extensive assistance of one person with transfers, bed mobility, bathing and eating and was able to use a wheelchair for locomotion. Under the behavior section, the documentation included that the resident did not have any physical or verbal behaviors, and did not have any behaviors which were directed toward others; such as public sexual acts.Review of an activity care plan dated (MONTH) 2, (YEAR) revealed that resident #56 was unable to complete simple program tasks and has little speech during activities, with the exception of episodes of inappropriate sexual remarks. Interventions included the following: quickly redirect at the first show of behaviors and be aware of the surroundings or seating of resident #56 related to the potential for inappropriate verbal behaviors with other residents. A care plan dated (MONTH) 3, (YEAR) included the resident has long and short term memory deficits, with poor cognitive decision making abilities related to Alzheimer's. The care plan included the resident makes sexually inappropriate gestures and comments towards female staff. Interventions were as follows: attempt to redirect the resident when sexually inappropriate gestures or comments are made towards staff by talking with him about his family, assign consistent caregivers whenever possible, and approach the resident in a calm manner. Review of a care plan dated (MONTH) 3, (YEAR) revealed the resident has a [DIAGNOSES REDACTED].e. grabbing genitals) and comments (advances for oral sex) toward female staff. Interventions listed included the following: Do not respond or react to inappropriate comments, instead distract to more appropriate conversation, if the behavior continues offer reminders of respectful talk or use sterile attention, reinforce with staff that firm and clear limits are healthy and required when the resident makes inappropriate gestures or statements, when resident #56 engages in inappropriate gestures (grabbing genitals) distract him and engage in an activity, offer a snack to occupy his hands, or escort him to his room if safe. Review of the resident assessment change of condition-alert charting dated (MONTH) 6, (YEAR), revealed documentation that the physician stated that resident #56 made sexual inappropriate comments to her, during her visit with him. A physician progress notes [REDACTED]. The physician questioned resident #56 regarding his behaviors in his room and in common areas to see if he knows right from wrong, but made sexually inappropriate comments to the female physician instead. The documentation included that the resident was alert, but was not appropriate in conversation or behaviors. -Resident #9 was admitted to the facility on (MONTH) 9, (YEAR), with [DIAGNOSES REDACTED]. Review of a quarterly MDS assessment dated (MONTH) 6, (YEAR) revealed that resident #9 had a BIMS score of 12, indicating moderate cognitive impairment. The MDS included that resident #9 walks independently with her walker. An interview was conducted on (MONTH) 5, (YEAR) at 9:26 a.m. with resident #9, who stated that last week either Thursday or Friday (November 1 or (MONTH) 2), a man (resident #56) was sitting in his wheelchair in the hallway and held out his hand to her. Resident #9 stated she thought he was being friendly and went to shake his hand, but he grabbed her hand and pulled it toward his chest and stated I'm going to F--- you. Resident #9 stated that there was a nurse in the hall at the time (staff #115) and believes the nurse witnessed the incident. Resident #9 stated that resident #56 wanders that hall in his wheelchair and has wandered into her room on multiple occasions. She stated that she now uses her wheelchair and walker to build a fence around her bed at night to feel safe. An interview was conducted on (MONTH) 5, (YEAR) at 10:20 a.m., with the Administrator (staff #81). Staff #81 stated that he became aware of the incident this morning when interviewing resident #9, and that resident #9 said she was fine. Staff #81 was informed that resident #9 felt that the incident was abuse. Another interview was conducted on (MONTH) 6, (YEAR) at 9:31 a.m., with resident #9. The resident stated that she began barricading herself in bed the night after the incident with resident #56, when he made the sexual comment to her. Resident #9 stated that she was not afraid of him prior to the incident, even though he has wandered into her room multiple times in the past. Resident #9 stated the comment that resident #56 said to her has now made her afraid of him, so she sets up her wheelchair and walker by her bed to ensure he does not come near her, while she is sleeping. An interview was conducted on (MONTH) 6, (YEAR) at 3:02 p.m. with a LPN (staff #115), who was on the hallway at the time of the incident on (MONTH) 2. Staff #115 said that she turned around and saw resident #56 holding the right forearm arm of resident #9. Staff #115 stated that she thought resident #9 was trying to pull her arm away. She said that she did not hear anything verbally, as she was standing at her medication cart which was down the hallway. She stated that she was orienting a student nurse and sent the student over to the residents, but she also went with the student. She said that resident #9 told her that she was fine, walked away and laughed. Staff #115 stated that she informed the social worker (staff #43), because she saw resident #56 holding the arm of resident #9, but she did not feel that abuse had occurred. On (MONTH) 8, (YEAR), the Administrator provided a review of the video recording of the incident which had occurred on (MONTH) 2, (YEAR) at approximately 7:27 a.m. in the 400 hallway, between resident #9 and resident #56. Per the video, resident #9 was walking down the hallway with her walker and resident #56 was sitting in his wheelchair in the hallway holding his hand out. Staff #115 was standing at the far end of the hallway by her medication cart with a student nurse. As resident #9 reached resident #56, the two residents shook hands and resident #56 pulled resident #9 close to him and talked to her. Staff #115 remained at the medication cart and the student nurse walked toward the two residents, and within a few seconds the resident's released their hands, without any staff intervention. An interview was conducted on (MONTH) 9, (YEAR) at 11:36 a.m. with Social Services (staff #43). Staff #43 stated the resident approached him Friday morning (November 2, (YEAR)) and wanted to talk with him. Staff #43 said that resident #9 stated that when she was walking past resident #56, he reached out to shake her hand and then took her hand and pulled her close to him stating I want to f--- you. Staff #43 said that resident #9 originally said she was shocked about the

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F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 3) incident, but said no when asked if she felt abused or assaulted. Staff #43 stated that he told her if she changed her mind, the facility will need to report it and call the police. Staff #43 stated that resident #9 replied Well that's just (resident #56), but if it happens again, she would file a police report. Staff #43 stated he was surprised that the incident occurred and the language used by resident #56, but did not think any more about it. Staff #43 stated that he did not consider the incident to be abuse, because resident #9's skin was intact, and she did not seem to be offended. He said that he is aware of the care plan for resident #56 regarding comments toward staff, but has never heard anything regarding comments or actions toward peers. Staff #43 stated he informed his supervisor (the Social Service Manager/staff #8), who told him to inform the Director of Nursing (DON/staff #38) right away, which he did. Staff #43 stated he had been educated on the types of abuse and the steps of reporting abuse. He said that sexual abuse would be unwanted physical contact or innuendos, things like that. He said looking back on the incident between resident #9 and resident #56 and based on his definition of sexual abuse, that incident would be considered sexual abuse. -Resident #58 was admitted to the facility on (MONTH) 27, (YEAR), with [DIAGNOSES REDACTED]. Review of the quarterly MDS assessment dated (MONTH) 1, (YEAR) revealed the resident has a BIMS score of 15, which indicated intact cognition. The MDS included the resident required one person extensive assistance with transfers, bed mobility, bathing, dressing and was independent in her wheelchair. An interview was conducted on (MONTH) 5, (YEAR) at 3:29 p.m. with resident #58, who stated that there is a male resident (resident #56) who has been sexually inappropriate for a long time. Resident #58 stated that approximately three weeks ago, resident #56 was in the dining room during meal time, when he started to remove his shirt and started masturbating. Resident #58 stated that she had to get the attention of a staff member, who removed resident #56 from the dining room. She said that resident #56 has behaved like this for a long time and she tries not to look when he does it because it's not something she wants to see. Another interview was conducted on (MONTH) 6, (YEAR) at 9:03 a.m. with resident #58, who stated that at the time of the incident approximately three weeks ago, there were multiple female residents who were present in the dining room, when he was masturbating. Resident #58 stated that she was the one who notified a staff member, because she thinks the other female residents have dementia and are not very with it and are unable to speak for themselves. Resident #58 stated that resident #56 displays this behavior often and she wishes not to see it, so when it happens in a public area, she will take herself elsewhere. Resident #58 also recalled an incident when resident #56 was sitting close to the nurses station in his wheelchair masturbating. She could not recall the date, but stated that there were multiple staff members who saw resident #56 masturbating and they did not do anything about it, until she intervened and asked resident #56 to stop. Resident #58 stated it was only then that a staff member removed resident #56 from the nurses station area. Resident #58 stated that she feels like the staff do not care about his behavior in public, because they do not do anything to help or stop the behavior from happening. -Resident #10 was admitted to the facility on (MONTH) 12, (YEAR), with [DIAGNOSES REDACTED]. Review of the annual MDS assessment dated (MONTH) 7, (YEAR) revealed that resident #10 had a BIMS score of 14, indicating intact cognition. The MDS also revealed that resident #10 required one person limited assistance with walking and bathing, and required supervision and/or was independent with eating, transfers and bed mobility. The MDS also included that resident #10 required extensive assistance of one person while going on and off the unit. An interview was conducted on (MONTH) 5, (YEAR) at 12:53 p.m. with resident #10, who stated that approximately one month ago she was walking down the hallway going back to her room, and resident #56 was sitting in his wheelchair in the door way. Resident #10 stated that resident #56 yelled out to her that he wanted to see her tits. Resident #10 stated that she has seen resident #56 touch the nurses inappropriately and that he has behaved this way for a long time. An interview was conducted on (MONTH) 5, (YEAR) at 3:14 p.m. with a Certified Nursing Assistant (CNA/staff #18), who stated that she has witnessed resident #56 display behaviors. Staff #18 stated there was an incident in the dining room where resident #56 was saying inappropriate things and that she told resident #56 it was not okay to do that. An interview was conducted on (MONTH) 5, (YEAR) at 3:21 p.m. with a CNA (staff #82), who stated that she has worked with resident #56 for a year and he is confused and that he wanders into other resident's rooms. Staff #82 stated that some residents are fearful, because resident #56 will park himself in his wheelchair at the doorway to their rooms. Staff #82 stated that resident #56 is sometimes sexually inappropriate and will use the F word or will say to other residents come touch me. Staff #82 stated that resident #56's sexually inappropriate behaviors are directed to both staff and other residents. An interview was conducted on (MONTH) 5, (YEAR) at 4:07 p.m. with the Administrator, who stated that he had no knowledge of resident #56's sexually inappropriate behaviors. He stated that now there is a staff member with resident #56 at all times.An interview was conducted on (MONTH) 5, (YEAR), with the Director of Nursing (DON/staff #38). Staff #38 stated that she recently became aware that resident #56 had inappropriate behaviors, but did not investigate what the inappropriate behaviors consisted of. An interview was conducted on (MONTH) 5, (YEAR) at 4:47 p.m., with a LPN unit manager (staff #90). Staff #90 stated that resident #56's behaviors consist of being verbally and sexually inappropriate during care and would use phrases such as I want to F--- you or hold my privates. Staff #90 stated that last week she sat with resident #56 at the nurses station for a 1:1 and that he stated to her Let me hold your hand, take my c---. Staff #90 stated that resident #56 has been sexually inappropriate since admission to the facility in 2012. She further stated that she does feel the other residents in the facility have the right to be free from sexual verbal comments or gestures. An interview was conducted on (MONTH) 6, (YEAR) at 9:25 a.m. with a CNA (staff #93), who stated that resident #56 does say sexual comments, such as I want to touch you. She said these behaviors have been occurring for the two years that she has worked at the facility. An interview was conducted on (MONTH) 7, (YEAR) at 8:17 a.m. with a CNA (staff #119), who stated that resident #56 has displayed sexually inappropriate behaviors mostly verbal, but will occasionally start to masturbate while in the dining room and at the nurses station. Staff #119 said that she will place a blanket on his lap with his hands outside of the blanket to try and prevent this behavior from occurring. A later interview was conducted on (MONTH) 7, (YEAR) at 9:51 a.m. with staff #119. She said there was an incident approximately three weeks ago where resident #56 was in the dining room and she was assisting him to eat. She said that resident #56 yelled out F--- me and suck my c----, then proceeded to remove his shirt and brief and pulled his private parts out. She said that she immediately covered resident #56 with a blanket and removed him from the dining room. Staff #119 stated that she reported this to the nurse (staff #115), but did not report the incident to anyone else. Staff #119 stated that resident #56 has had behaviors such as masturbating in public areas and has made inappropriate sexual comments for a long time. -Resident #204 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The resident was discharged on [DATE] to Hospice. Review of a quarterly MDS assessment dated [DATE] revealed the resident had a BIMS score of 4, which indicated the resident had severe cognitive impairment. Review of the facility's investigative summary included that on 2/01/18 at approximately 9:30 a.m., three staff (CNA/staff #132, CNA/staff #187, housekeeper/staff #131) and a visitor, witnessed a Licensed Practical Nurse (LPN/staff #188) yell at resident #204 saying at least three times You can go to hell. The incident was reported to the Director of Nursing and the Administrator. Staff #188 was suspended immediately. According to the summary, staff #187 reported that she was taking the resident down the hall, when he started cursing at staff. Staff #187 reported that immediately staff #188 started yelling at the resident saying not to talk to her like that and that he is an educated man and should start to behave like one. The documentation included that the visitor who witnessed the incident reported that the nurse came up the hall saying, You don't treat people that way, I an not putting up with it and this if f--- BS. A statement by staff #131 included that staff #188 yelled at resident #204 saying, You go to hell, you go to hell. I thought you were more intelligent than that. Per the report, a statement by staff #188 included that staff #187 was taking resident #204 down the hall, when he started using profanity and she replied, Please Mr. (resident's name) you are a fine educated gentleman, so please do not speak that way to me or my staff. She said that she repeated this three times and then the resident calmed down and stopped using profanity. Review of an e-mail dated 2/1/18 at 10:29 a.m. written by the Business office Administrator (staff #54) to the Director of

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0600 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 4) Nursing (DON/staff #38) and Administrator (staff #81), revealed documentation that staff #131 came to her office on 2/1/18 around 10 a.m. to report that staff #187 was taking resident #204 by the station, and the resident told staff #187 to go to hell. Staff #188 followed them and then told resident #204 to go to hell, you are a more educated man than that. The documentation included that a family member of another resident heard the encounter. In a telephone interview on 11/06/18 at 2:13 p.m. with CNA (staff #134), she stated that resident #204 was being very loud and very disrespectful and the nurse (staff #188) lashed out and yelled at him. Staff #134 stated everybody heard it, but she did not recall the exact words said by the resident or the nurse. She said she was shocked by what the nurse had said to the resident. She said that resident #204 was very upset and he started to shake. Staff #134 stated the staff then had to comfort the resident to get him to relax. She further stated that she did witness abuse when the nurse lashed out and was disrespectful to the resident and that is wrong. An interview was conducted on 11/06/18 at 2:33 p.m. with staff #131, who stated that she was on the 300 hall buffing the floor on 2/01/18 at approximately 9:30 a.m. She stated that resident #204 was sitting on one side of her saying some things, when the nurse on the unit took her finger and pointed it at him and said, Who do you think you are. You don't F------ talk to anybody like that. You can F------ go to hell. Staff #131 stated the resident felt bad, as his head went down. Staff #131 also said that there was a family member in another room who heard the whole thing. Staff #131 stated at that point she knew she had to report it because it upset her. An interview was conducted on 11/07/18 at 8:46 a.m. with staff #54, who stated that staff #131 came to her office on 2/01/18 and reported that staff #188 had said something to resident #204. Staff #54 stated she sent an e-mail to the DON and the Administrator, but the DON never had her e-mail set up to her phone, and that she had entered the Administrator's e-mail address incorrectly, so neither of them received the e-mail. Staff #54 stated she didn't see it as abuse, but thought it was more like a dignity thing. Staff #54 stated she now knows it was abuse and that it should have been reported immediately. An interview was conducted on 11/07/18 at 8:44 a.m. with the DON, who stated that she was not notified immediately, but found out the next day (2/02/18) when she received the e-mail from staff #54. She stated that staff #188 was suspended while the investigation was completed, and after the allegation was substantiated, staff #188 was terminated. However, according to the time sheet punches, staff #188 worked her entire shift until 3:25 p.m. on 2/01/18, and was not removed from further contact from residents on the day of the verbal abuse incident with resident #204. An interview was conducted on (MONTH) 8, (YEAR) at 12:36 p.m. with the Administrator (Abuse Prohibition Officer/staff #81), who stated that part of new hire orientation and prior to staff working with residents, they receive training on abuse, abuse prevention, types of abuse and the reporting process to ensure they are keeping residents safe. Staff #81 stated if a staff member witnessed or was informed of abuse, they should protect the resident and report it immediately. Staff #81 said if a staff member is involved then that person is suspended, pending completion of the investigation. Staff #81 further stated that a report should be made to the State Agency, APS and the police. Review of the facility's policy titled, Resident Abuse Definitions and Report revealed that residents have the right to be free from mental, physical, sexual, and verbal abuse .and prohibits staff from engaging in any such conduct, as well as sets forth procedures for reporting complaints, concerns, or incidents. The policy included that Emotional/Psychological Abuse includes, but is not limited to harassment, deprivation or conduct that is demeaning, humiliating or threatening .Sexual Abuse includes: Any non consensual sexual contact of any type with a resident and includes but is not limited to sexual harassment, sexual coercion, sexual assault, sexual contact, sexual intercourse, sexual penetration with a foreign object, sexual assault or sodomy. The policy further included that verbal abuse included the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or within their hearing distance, regardless of their age, ability to comprehend or their disability. Examples of verbal abuse include, but are not limited to threats of harm, saying things to frighten a resident or cursing at them.
F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff interviews, facility documentation and policy and procedures, the facility failed to implement their abuse policy, by failing to investigate and/or report allegations of abuse involving three residents (#9, #56 and #58) to Adult Protective Services (APS) and the State Agency within two hours, by failing to report an allegation of verbal abuse immediately to the Administrator and to the State Agency within two hours for one resident (#204) and by failing to protect residents from the potential for further abuse by a staff member. Findings include: -Resident #56 was admitted to the facility on (MONTH) 20, 2012, with [DIAGNOSES REDACTED]. Review of the nursing monthly summaries dated (MONTH) 27, (MONTH) 24, and (MONTH) 11, (YEAR), revealed that resident #56 had moderate cognitive impairment, delusions, hallucinations, wanders in the facility, uses a wheelchair and displays sexual behaviors toward female staff. A nursing monthly summary dated (MONTH) 11, (YEAR) included that resident #56 had severe cognitive impairment, uses a wheelchair, continues to be sexually inappropriate and makes inappropriate comments to female staff and visitors. A nursing monthly summary dated (MONTH) 10, (YEAR) revealed that resident #56 has disorganized thinking and memory problems, uses a wheelchair, and is sexually inappropriate with female staff and is redirected. Review of a nursing monthly summary dated (MONTH) 10, (YEAR) revealed the resident had severe cognitive impairment, memory problems, uses a wheelchair, and that behavior monitoring is in process for sexually inappropriate behaviors at times. According to the annual Minimum Data Set (MDS) assessment dated (MONTH) 30, (YEAR), the resident had a Brief Interview for Mental Status (BIMS) score of 4, which indicated the resident had severe cognitive impairment. The MDS included the resident required extensive assistance of one person with transfers, bed mobility, bathing and eating and was able to use a wheelchair for locomotion. Under the behavior section, the documentation included that the resident did not have any physical or verbal behaviors, and did not have any behaviors which were directed toward others; such as public sexual acts.Review of an activity care plan dated (MONTH) 2, (YEAR) revealed that resident #56 was unable to complete simple program tasks and has little speech during activities, with the exception of episodes of inappropriate sexual remarks. Interventions included the following: quickly redirect at the first show of behaviors and be aware of the surroundings or seating of resident #56 related to the potential for inappropriate verbal behaviors with other residents. A care plan dated (MONTH) 3, (YEAR) included the resident has long and short term memory deficits, with poor cognitive decision making abilities related to Alzheimer's. The care plan included the resident makes sexually inappropriate gestures and comments towards female staff. Interventions were as follows: attempt to redirect the resident when sexually inappropriate gestures or comments are made towards staff by talking with him about his family, assign consistent caregivers whenever possible, and approach the resident in a calm manner. Review of a care plan dated (MONTH) 3, (YEAR) revealed the resident has a [DIAGNOSES REDACTED].e. grabbing genitals) and comments (advances for oral sex) toward female staff. Interventions listed included the following: Do not respond or react to inappropriate comments, instead distract to more appropriate conversation, if the behavior continues offer reminders of respectful talk or use sterile attention, reinforce with staff that firm and clear limits are healthy and required when the resident makes inappropriate gestures or statements, when resident #56 engages in inappropriate gestures (grabbing genitals) distract him and engage in an activity, offer a snack to occupy his hands, or escort him to his room if safe. Review of the resident assessment change of condition-alert charting dated (MONTH) 6, (YEAR), revealed documentation that the physician stated that resident #56 made sexual inappropriate comments to her, during her visit with him. A physician progress notes [REDACTED]. The physician questioned resident #56 regarding his behaviors in his room and in common areas to see if he knows right from wrong, but made sexually inappropriate comments to the female physician instead. The documentation included that the resident was alert, but was not appropriate in conversation or behaviors. -Resident #9 was admitted to the facility on (MONTH) 9, (YEAR), with [DIAGNOSES REDACTED]. Review of a quarterly MDS assessment dated (MONTH) 6, (YEAR) revealed that resident #9 had a BIMS score of 12, indicating moderate cognitive impairment. The MDS included that resident #9 walks independently with her walker. An interview was conducted on (MONTH) 5, (YEAR) at 9:26 a.m. with resident #9 who stated that last week, either Thursday or Friday (November 1 or (MONTH) 2, (YEAR)), a man (resident #56) was sitting in his wheelchair in the hallway and held out his hand to her. Resident #9 stated she thought he was being friendly and went to shake his hand but he grabbed her hand

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F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 5) and pulled her toward his chest and stated I'm going to F--- you. Resident #9 stated that there was a nurse in the hall at that time (staff #115) and believes the nurse witnessed the incident. Resident #9 stated that resident #56 wanders that hall when he is in his wheelchair and has wandered into her room before on multiple occasions, so she now uses her wheelchair and walker to build a fence by placing them up against her bed at night to feel safe while she sleeps. Following the interview with resident #9, the allegation of abuse was reported immediately to the Administrator (staff #81). Another interview was conducted on (MONTH) 6, (YEAR) at 9:31 a.m., with resident #9. The resident stated that she began barricading herself in bed the night after the incident with resident #56, when he made the sexual comment to her. Resident #9 stated that she was not afraid of him prior to the incident, even though he has wandered into her room multiple times in the past. Resident #9 stated the comment that resident #56 said to her has now made her afraid of him, so she sets up her wheelchair and walker by her bed to ensure he does not come near her, while she is sleeping. An interview was conducted on (MONTH) 9, (YEAR) at 11:36 a.m. with Social Services (staff #43). Staff #43 stated that resident #9 approached him Friday morning (November 2, (YEAR)) and wanted to talk with him. Staff #43 said the resident stated that when she was walking past resident #56, he reached out to shake her hand and then took her hand and pulled her close to him stating I want to f--- you. Staff #43 said that resident #9 originally said she was shocked about the incident, but said no when asked if she felt abused or assaulted. Staff #43 stated that he told her if she changed her mind, the facility will need to report it and call the police. Staff #43 stated that resident #9 replied Well that's just (resident #56), but if it happens again, she would file a police report. Staff #43 stated he was surprised that the incident occurred and the language used by resident #56, but did not think any more about it. Staff #43 stated that he did not consider the incident to be abuse, because resident #9's skin was intact and she did not seem to be offended. He said that he is aware of the care plan for resident #56 regarding comments toward staff, but has never heard anything regarding comments or actions toward peers. Staff #43 stated he informed his supervisor (the Social Service Manager/staff #8), who told him to inform the Director of Nursing (DON/staff #38) right away, which he did. Staff #43 stated he had been educated on the types of abuse and the steps of reporting abuse. He said that sexual abuse would be unwanted physical contact or innuendos, things like that. He said looking back on the incident between resident #9 and resident #56 and based on his definition of sexual abuse, that incident would be considered sexual abuse. The facility was unable to provide any evidence that the allegation of abuse was investigated prior to (MONTH) 5, (YEAR) or that it was reported to Adult Protective Services (APS) and the State Agency within two hours as required. The facility did not notify the State Agency until (MONTH) 5, (YEAR), which was three days after the incident. -Resident #58 was admitted to the facility (MONTH) 27, (YEAR), with [DIAGNOSES REDACTED]. An interview was conducted on (MONTH) 5, (YEAR) at 3:29 p.m. with resident #58, who stated that there is a male resident (resident #56) who has been sexually inappropriate for a long time. Resident #58 stated that approximately three weeks ago, resident #56 was in the dining room during meal time, when he started to remove his shirt and started masturbating. Resident #58 stated that she had to get the attention of a staff member, who removed resident #56 from the dining room. She said that resident #56 has behaved like this for a long time and she tries not to look when he does it because it's not something she wants to see. An interview was conducted on (MONTH) 5, (YEAR), with the Director of Nursing (DON/staff #38). Staff #38 stated that she recently became aware that resident #56 had inappropriate behaviors, but did not investigate what the inappropriate behaviors consisted of. Another interview was conducted on (MONTH) 6, (YEAR) at 9:03 a.m. with resident #58, who stated that at the time of the incident approximately three weeks ago, there were multiple female residents who were present in the dining room, when he was masturbating. Resident #58 stated that she was the one who notified a staff member, because she thinks the other female residents have dementia and are not very with it and are unable to speak for themselves. Resident #58 stated that resident #56 displays this behavior often and wishes not to see it, so when it happens in a public area, she will take herself elsewhere. Resident #58 also recalled an incident when resident #56 was sitting close to the nurses station in his wheelchair masturbating. She could not recall the date, but stated that there were multiple staff members who saw resident #56 masturbating and they did not do anything about it, until she intervened and asked resident #56 to stop. Resident #58 stated it was only then that a staff member removed resident #56 from the nurses station area. Resident #58 stated that she feels like the staff do not care about his behavior in public, because they do not do anything to help or stop the behavior from happening. An interview was conducted on (MONTH) 7, (YEAR) at 8:17 a.m. with a CNA (staff #119), who stated that resident #56 has displayed sexually inappropriate behaviors mostly verbal, but will occasionally start to masturbate while in the dining room and at the nurses station. Staff #119 said that she will place a blanket on his lap with his hands outside of the blanket to try and prevent this behavior from occurring. A later interview was conducted on (MONTH) 7, (YEAR) at 9:51 a.m. with staff #119. She said there was an incident approximately three weeks ago where resident #56 was in the dining room and she was assisting him to eat. She said that resident #56 yelled out F--- me and suck my c---, then proceeded to remove his shirt and brief and pulled his private parts out. She said that she immediately covered resident #56 with a blanket and removed him from the dining room. Staff #119 stated that she reported this to the nurse (staff #115), but did not report the incident to anyone else. Staff #119 stated that resident #56 has had behaviors such as masturbating in public areas and has made inappropriate sexual comments for a long time. The facility was unable to provide any documentation that the allegations/incidents of resident #56 exhibiting inappropriate sexual behaviors in the dining room/nurses area were investigated or reported to the State Agency. -Resident #204 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The resident was discharged on [DATE] to Hospice. Review of a quarterly MDS assessment dated [DATE] revealed the resident had a BIMS score of 4, which indicated the resident had severe cognitive impairment. Review of the facility's investigative summary revealed that on 2/01/18 at approximately 9:30 a.m., three staff members (CNA/staff #132, CNA/staff #187 and housekeeper manager/staff #131) and a visitor, witnessed a Licensed Practical Nurse (LPN/staff #188) yell at resident #204 saying at least three times You can go to hell. According to the summary, staff #187 reported that she was taking the resident down the hall when he started cursing. Staff #187 reported that immediately staff #188 started yelling at the resident saying not to talk like that and that he is an educated man and should start to behave like one. The documentation included that the visitor who witnessed the incident reported that the nurse came up the hall saying, You don't treat people that way, I am not putting up with it and this if f------ BS. A statement by staff #131 included that staff #188 yelled at resident #204 saying, You go to hell, you go to hell. I thought you were more intelligent than that. A statement by staff #188 included that staff #187 was taking resident #204 down the hall, when he started using profanity and she replied, Please Mr. (resident's name) you are a fine educated gentleman, so please do not speak that way to me or my staff. She said that she repeated this three times and then the resident calmed down and stopped using profanity. Review of an e-mail dated 2/1/18 at 10:29 a.m. written by the Business office Administrator (staff #54) to the Director of Nursing (DON/staff #38) and Administrator (staff #81), revealed documentation that staff #131 came to her office on 2/1/18 around 10 a.m. to report that staff #187 was taking resident #204 by the station, and the resident told staff #187 to go to hell. Staff #188 followed them and then told resident #204 to go to hell, you are a more educated man than that. The documentation included that a family member of another resident also heard the encounter. An interview was conducted on 11/06/18 at 2:33 p.m. with staff #131, who stated that she was on the 300 hall buffing the floor on 2/01/18 at approximately 9:30 a.m. She stated that resident #204 was sitting on one side of her saying some things, when the nurse on the unit took her finger and pointed it at him and said, Who do you think you are. You don't F------ talk to anybody like that. You can F------ go to hell. Staff #131 also said that there was a family member in another room who heard the whole thing. Staff #131 stated at that point she knew she had to report it because it upset her. An interview was conducted on 11/07/18 at 8:46 a.m. with staff #54, who stated that staff #131 came to her office on 2/01/18 and reported that staff #188 had said something to resident #204. Staff #54 stated she sent an e-mail to the DON and the Administrator, but the DON never had her e-mail set up to her phone, and that she had entered the Administrator's e-mail address incorrectly, so neither of them received the e-mail. Staff #54 stated she didn't see it as abuse, but thought it was more like a dignity thing. Staff #54 stated she now knows it was abuse and that it should have been reported

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F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 6) immediately. An interview was conducted on 11/07/18 at 8:44 a.m. with the DON, who stated that she was not notified immediately, but found out the next day (on 2/02/18) when she received the e-mail from staff #54. She stated that staff #188 was suspended while the investigation was completed and after the allegation was substantiated, staff #188 was terminated. However, according to the time sheet punches, staff #188 worked her entire shift until 3:25 p.m. on 2/01/18, and was not removed from further contact with residents, immediately following the incident. An interview was conducted on (MONTH) 8, (YEAR) at 12:36 p.m. with the Administrator (Abuse Prohibition Officer/staff #81), who stated that part of new hire orientation and prior to staff working with residents, they receive training on abuse, abuse prevention, types of abuse and the reporting process to ensure they are keeping residents safe. Staff #81 stated if a staff member witnessed or was informed of abuse, they should protect the resident and report it immediately. Staff #81 said if a staff member is involved then that person is suspended, pending completion of the investigation. Staff #81 further stated that a report should be made to the State Agency, APS and the police. Per the facility's documentation, the incident occurred on 2/1/18 and the Director of Nursing was not notified until 2/02/18, and it was not reported to the State Agency until 2/02/18 at 8:06 a.m. The facility was unable to provide evidence that the staff to resident verbal abuse was reported immediately to the Administrator/designee and to the State Agency within two hours after the allegation was made. Review of the facility's policy regarding Resident Abuse Definitions and Report revealed that residents have the right to be free from mental, physical, sexual, and verbal abuse .and prohibits staff from engaging in any such conduct, as well as sets forth procedures for reporting complaints, concerns or incidents. The policy included to promote a resident's right to be free from verbal, sexual, physical, and mental abuse .by anyone, including .facility staff, other Residents .All allegations, observations, or suspected cases of Abuse .will be thoroughly investigated by the facility. Any staff member .suspected of any kind of Resident Abuse, Neglect, misappropriation of property, Exploitation, or any other form of Resident mistreatment will be placed on administrative leave and restricted from duty pending the outcome of the investigation. The Procedure section included: 2. .when a staff member .reasonable suspects Abuse, Neglect, misappropriation of property, or Exploitation of a Resident, has received a report or complaint from a Resident of such treatment, or has actual knowledge a Resident has been a victim of such treatment; he/she shall report it immediately to the Administrator . The Administrator will then initiate an investigation, maintain documentation of the investigation and report it in a timely manner to the appropriate authorities. Allegations that involve Abuse will be reported immediately, but not more than two (2) hours after the allegation is made. Failure to make any report required by this policy is a violation of facility policy and may result in disciplinary action up to, and including termination of employment. According to a policy titled Investigative Process, the facility will conduct a thorough investigation of incidents affecting Resident care. The policy included that an investigation will be conducted for any allegation of abuse. The policy included that self-reporting of abuse or neglect to state agencies is mandatory .If after hours, fax an investigative form to the appropriate state agency and contact the agency at the earliest time the next business day . Any staff member suspected of abuse will be placed on administrative leave and restricted from duty pending the outcome of the investigation. A policy regarding Staff treatment of [REDACTED].Staff is made aware of liability and information related to reporting abuse and notified to report any sign or evidence of abuse to their supervisor immediately .Preventative measures to prevent further abuse initiated.
F 0608 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures to ensure (1) employees report any suspicion of a crime against any resident, according to timelines; (2) post the notice of employee rights; and (3) prohibit and prevent retaliation for reporting.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff interviews and policy and procedures, the facility failed to report suspicion of a crime to law enforcement regarding an incident of abuse between resident (#56) and resident (#58). Findings include: -Resident #56 was admitted to the facility on (MONTH) 20, 2012, with [DIAGNOSES REDACTED]. Review of the nursing monthly summaries dated (MONTH) 27, (MONTH) 24, and (MONTH) 11, (YEAR), revealed that resident #56 had moderate cognitive impairment, delusions, hallucinations, wanders in the facility, uses a wheelchair and displays sexual behaviors toward female staff. A nursing monthly summary dated (MONTH) 11, (YEAR) included that resident #56 had severe cognitive impairment, uses a wheelchair, continues to be sexually inappropriate and makes inappropriate comments to female staff and visitors. A nursing monthly summary dated (MONTH) 10, (YEAR) revealed that resident #56 has disorganized thinking and memory problems, uses a wheelchair, and is sexually inappropriate with female staff and is redirected. Review of a nursing monthly summary dated (MONTH) 10, (YEAR) revealed the resident had severe cognitive impairment, memory problems, uses a wheelchair, and that behavior monitoring is in process for sexually inappropriate behaviors at times. According to the annual Minimum Data Set (MDS) assessment dated (MONTH) 30, (YEAR), the resident had a Brief Interview for Mental Status (BIMS) score of 4, which indicated the resident had severe cognitive impairment. The MDS included the resident required extensive assistance of one person with transfers, bed mobility, bathing and eating and was able to use a wheelchair for locomotion. Under the behavior section, the documentation included that the resident did not have any physical or verbal behaviors, and did not have any behaviors which were directed toward others; such as public sexual acts.Review of an activity care plan dated (MONTH) 2, (YEAR) revealed that resident #56 was unable to complete simple program tasks and has little speech during activities, with the exception of episodes of inappropriate sexual remarks. Interventions included the following: quickly redirect at the first show of behaviors and be aware of the surroundings or seating of resident #56 related to the potential for inappropriate verbal behaviors with other residents. A care plan dated (MONTH) 3, (YEAR) included the resident has long and short term memory deficits, with poor cognitive decision making abilities related to Alzheimer's. The care plan included the resident makes sexually inappropriate gestures and comments towards female staff. Interventions were as follows: attempt to redirect the resident when sexually inappropriate gestures or comments are made towards staff by talking with him about his family, assign consistent caregivers whenever possible, and approach the resident in a calm manner. Review of a care plan dated (MONTH) 3, (YEAR) revealed the resident has a [DIAGNOSES REDACTED].e. grabbing genitals) and comments (advances for oral sex) toward female staff. Interventions listed included the following: Do not respond or react to inappropriate comments, instead distract to more appropriate conversation, if the behavior continues offer reminders of respectful talk or use sterile attention, reinforce with staff that firm and clear limits are healthy and required when the resident makes inappropriate gestures or statements, when resident #56 engages in inappropriate gestures (grabbing genitals) distract him and engage in an activity, offer a snack to occupy his hands, or escort him to his room if safe. Review of the resident assessment change of condition-alert charting dated (MONTH) 6, (YEAR), revealed documentation that the physician stated that resident #56 made sexual inappropriate comments to her, during her visit with him. A physician progress notes [REDACTED]. The physician questioned resident #56 regarding his behaviors in his room and in common areas to see if he knows right from wrong, but made sexually inappropriate comments to the female physician instead. The documentation included that the resident was alert, but was not appropriate in conversation or behaviors. -Resident #9 was admitted to the facility on (MONTH) 9, (YEAR), with [DIAGNOSES REDACTED]. Review of a quarterly MDS assessment dated (MONTH) 6, (YEAR) revealed that resident #9 had a BIMS score of 12, indicating moderate cognitive impairment. The MDS included that resident #9 walks independently with her walker. An interview was conducted on (MONTH) 5, (YEAR) at 9:26 a.m. with resident #9, who stated that last week either Thursday or Friday (November 1 or (MONTH) 2), a man (resident #56) was sitting in his wheelchair in the hallway and held out his hand to her. Resident #9 stated she thought he was being friendly and went to shake his hand, but he grabbed her hand and pulled it toward his chest and stated I'm going to F--- you. Resident #9 stated that there was a nurse in the hall at the time (staff #115) and believes the nurse witnessed the incident. Resident #9 stated that resident #56 wanders that hall in his

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	035072	A. BUILDING _____ B. WING _____	11/09/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PHOENIX MOUNTAIN POST ACUTE	13232 NORTH TATUM BLVD PHOENIX, AZ 85032

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0608 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 7) wheelchair and has wandered into her room on multiple occasions. She stated that she now uses her wheelchair and walker to build a fence around her bed at night to feel safe. Following the interview with resident #9, the allegation of abuse was reported immediately to the Administrator (staff #81). Another interview was conducted on (MONTH) 6, (YEAR) at 9:31 a.m. with resident #9, who stated that she began barricading herself in bed the night after the incident with resident #56, when he made the sexual comment to her. Resident #9 stated that the comment resident #56 said to her has now made her afraid of him, so she sets up her wheelchair and walker by her bed to ensure he does not come near her bed, while she is sleeping. An interview was conducted on (MONTH) 9, (YEAR) at 11:36 a.m. with Social Services (staff #43). Staff #43 stated that resident #9 approached him Friday morning (November 2, (YEAR)) and wanted to talk with him. Staff #43 said the resident stated that when she was walking past resident #56, he reached out to shake her hand and then took her hand and pulled her close to him stating I want to f--- you. Staff #43 said that resident #9 originally said she was shocked about the incident, but said no when asked if she felt abused or assaulted. Staff #43 stated that he told her if she changed her mind, the facility will need to report it and call the police. Staff #43 stated that resident #9 replied Well that's just (resident #56), but if it happens again, she would file a police report. Staff #43 stated he was surprised that the incident occurred and the language used by resident #56, but did not think any more about it. Staff #43 stated that he did not consider the incident to be abuse, because resident #9's skin was intact, and she did not seem to be offended. Staff #43 stated he informed his supervisor (the Social Service Manager/staff #8), who told him to inform the Director of Nursing (DON/staff #38) right away, which he did. Staff #43 stated he had been educated on the types of abuse and the steps of reporting abuse. He said that sexual abuse would be unwanted physical contact or innuendos, things like that. He said that looking back on the incident between resident #9 and resident #56, and based on his definition of sexual abuse, that incident would be considered sexual abuse. The facility was unable to provide any documentation that this incident was reported to law enforcement. Review of a policy titled, Resident Abuse Definitions and Reporting revealed that when a staff member suspects abuse of a resident, has received knowledge of a report or complaint from a resident of such treatment, or has actual knowledge a resident has been a victim of such treatment, he/she shall report it immediately to the Administrator. The Administrator will initiate an investigation and report it to the appropriate authorities in a timely manner. The report of abuse will be made to the State Survey Agency and may result in reports to law enforcement.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff interviews, facility documentation and policy and procedures, the facility failed to report allegations of abuse involving three residents (#9, #56 and #58) to Adult Protective Services (APS) and/or the State Agency within two hours after the allegation was made, failed to report an allegation of verbal abuse immediately to the Administrator and to the State Agency within two hours after the allegation was made for one resident (#204). Findings include: -Resident #56 was admitted to the facility on (MONTH) 20, 2012, with [DIAGNOSES REDACTED]. Review of the nursing monthly summaries dated (MONTH) 27, (MONTH) 24, and (MONTH) 11, (YEAR), revealed that resident #56 had moderate cognitive impairment, delusions, hallucinations, wanders in the facility, uses a wheelchair and displays sexual behaviors toward female staff. A nursing monthly summary dated (MONTH) 11, (YEAR) included that resident #56 had severe cognitive impairment, uses a wheelchair, continues to be sexually inappropriate and makes inappropriate comments to female staff and visitors. A nursing monthly summary dated (MONTH) 10, (YEAR) revealed that resident #56 has disorganized thinking and memory problems, uses a wheelchair, and is sexually inappropriate with female staff and is redirected. Review of a nursing monthly summary dated (MONTH) 10, (YEAR) revealed the resident had severe cognitive impairment, memory problems, uses a wheelchair, and that behavior monitoring is in process for sexually inappropriate behaviors at times. Review of an activity care plan dated (MONTH) 2, (YEAR) revealed that resident #56 was unable to complete simple program tasks and has little speech during activities, with the exception of episodes of inappropriate sexual remarks. Interventions included the following: quickly redirect at the first show of behaviors and be aware of the surroundings or seating of resident #56 related to the potential for inappropriate verbal behaviors with other residents. A care plan dated (MONTH) 3, (YEAR) included the resident has long and short term memory deficits, with poor cognitive decision making abilities related to Alzheimer's. The care plan included the resident makes sexually inappropriate gestures and comments towards female staff. Interventions were as follows: attempt to redirect the resident when sexually inappropriate gestures or comments are made towards staff by talking with him about his family, assign consistent caregivers whenever possible, and approach the resident in a calm manner. Review of a care plan dated (MONTH) 3, (YEAR) revealed the resident has a [DIAGNOSES REDACTED].e. grabbing genitals) and comments (advances for oral sex) toward female staff. Interventions listed included the following: Do not respond or react to inappropriate comments, instead distract to more appropriate conversation, if the behavior continues offer reminders of respectful talk or use sterile attention, reinforce with staff that firm and clear limits are healthy and required when the resident makes inappropriate gestures or statements, when resident #56 engages in inappropriate gestures (grabbing genitals) distract him and engage in an activity, offer a snack to occupy his hands, or escort him to his room if safe. Review of the resident assessment change of condition-alert charting dated (MONTH) 6, (YEAR), revealed documentation that the physician stated that resident #56 made sexual inappropriate comments to her, during her visit with him. A physician progress notes [REDACTED]. The physician questioned resident #56 regarding his behaviors in his room and in common areas to see if he knows right from wrong, but made sexually inappropriate comments to the female physician instead. The documentation included that the resident was alert, but was not appropriate in conversation or behaviors. -Resident #9 was admitted to the facility on (MONTH) 9, (YEAR), with [DIAGNOSES REDACTED]. An interview was conducted on (MONTH) 5, (YEAR) at 9:26 a.m. with resident #9 who stated that last week, either Thursday or Friday (November 1 or (MONTH) 2, (YEAR)), a man (resident #56) was sitting in his wheelchair in the hallway and held out his hand to her. Resident #9 stated she thought he was being friendly and went to shake his hand but he grabbed her hand and pulled her toward his chest and stated I'm going to F--- you. Resident #9 stated there was a nurse in the hall at that time (staff #115) and believes the nurse witnessed the incident. Resident #9 stated that resident #56 wanders that hall in his wheelchair and has wandered into her room on multiple occasions. She stated that she now uses her wheelchair and walker to build a fence around her bed at night to feel safe. Following the interview with resident #9, the allegation of abuse was reported immediately to the Administrator (staff #81). An interview was conducted on (MONTH) 5, (YEAR) at 10:20 a.m., with the Administrator (staff #81). Staff #81 stated that he became aware of the incident this morning when interviewing resident #9, and that resident #9 said she was fine. Staff #81 was informed that resident #9 felt that the incident was abuse. Another interview was conducted on (MONTH) 6, (YEAR) at 9:31 a.m. with resident #9, who stated that she began barricading herself in bed the night after the incident with resident #56, when he made the sexual comment to her. Resident #9 stated that the comment resident #56 said to her has now made her afraid of him, so sets up her wheelchair and walker by her bed to ensure he does not come near her bed, while she is sleeping. An interview was conducted on (MONTH) 9, (YEAR) at 11:36 a.m. with Social Services (staff #43). Staff #43 stated that resident #9 approached him Friday morning (November 2, (YEAR)) and wanted to talk with him. Staff #43 said the resident stated that when she was walking past resident #56, he reached out to shake her hand and then took her hand and pulled her close to him stating I want to f--- you. Staff #43 said that resident #9 originally said she was shocked about the incident, but said no when asked if she felt abused or assaulted. Staff #43 stated that he told her if she changed her mind, the facility will need to report it and call the police. Staff #43 stated that resident #9 replied Well that's just (resident #56) but if it happens again, she would file a police report. Staff #43 stated he was surprised that the incident occurred and the language used by resident #56, but did not think any more about it. Staff #43 stated that he did not consider the incident to be abuse, because resident #9's skin was intact and she did not seem to be offended. Staff #43

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F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 8) stated he informed his supervisor (the Social Service Manager/staff #8), who told him to inform the Director of Nursing (DON/staff #38) right away, which he did. Staff #43 stated he had been educated on the types of abuse and the steps of reporting abuse. He said that sexual abuse would be unwanted physical contact or innuendos, things like that. He said that looking back on the incident between resident #9 and resident #56, and based on his definition of sexual abuse, that incident would be considered sexual abuse. The facility was unable to provide any evidence that the allegation of abuse was reported to APS and the State Agency within two hours as required. The facility did not notify the State Agency until (MONTH) 5, (YEAR), which was three days after the incident. -Resident #58 was admitted to the facility (MONTH) 27, (YEAR), with [DIAGNOSES REDACTED]. An interview was conducted on (MONTH) 5, (YEAR) at 3:29 p.m. with resident #58, who stated that there is a male resident (resident #56) who has been sexually inappropriate for a long time. Resident #58 stated that approximately three weeks ago, resident #56 was in the dining room during meal time, when he started to remove his shirt and started masturbating. Resident #58 stated that she had to get the attention of a staff member, who removed resident #56 from the dining room. She said that resident #56 has behaved like this for a long time and she tries not to look when he does it because it's not something she wants to see. An interview was conducted on (MONTH) 5, (YEAR), with the Director of Nursing (DON/staff #38). Staff #38 stated that she recently became aware that resident #56 had inappropriate behaviors, but did not investigate what the inappropriate behaviors consisted of. Another interview was conducted on (MONTH) 6, (YEAR) at 9:03 a.m. with resident #58, who stated that at the time of the incident approximately three weeks ago, there were multiple female residents who were present in the dining room, when he was masturbating. Resident #58 stated that she was the one who notified a staff member, because she thinks the other female residents have dementia and are not very with it and are unable to speak for themselves. Resident #58 stated that resident #56 displays this behavior often and wishes not to see it, so when it happens in a public area, she will take herself elsewhere. Resident #58 also recalled an incident when resident #56 was sitting close to the nurses station in his wheelchair masturbating. She could not recall the date, but stated that there were multiple staff members who saw resident #56 masturbating and they did not do anything about it, until she intervened and asked resident #56 to stop. Resident #58 stated it was only then that a staff member removed resident #56 from the nurses station area. Resident #58 stated that she feels like the staff do not care about his behavior in public, because they do not do anything to help or stop the behavior from happening. An interview was conducted on (MONTH) 7, (YEAR) at 8:17 a.m. with a CNA (staff #119), who stated that resident #56 has displayed sexually inappropriate behaviors mostly verbal, but will occasionally start to masturbate while in the dining room and at the nurses station. Staff #119 said that she will place a blanket on his lap with his hands outside of the blanket to try and prevent this behavior from occurring. A later interview was conducted on (MONTH) 7, (YEAR) at 9:51 a.m. with staff #119. She said there was an incident approximately three weeks ago where resident #56 was in the dining room and she was assisting him to eat. She said that resident #56 yelled out F--- me and suck my c---, then proceeded to remove his shirt and brief and pulled his private parts out. She said that she immediately covered resident #56 with a blanket and removed him from the dining room. Staff #119 stated that she reported this to the nurse (staff #115), but did not report the incident to anyone else. Staff #119 stated that resident #56 has had behaviors such as masturbating in public areas and has made inappropriate sexual comments for a long time. The facility was unable to provide any documentation that the allegations of abuse/incidents were reported to the State Agency within two hours. -Resident #204 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The resident was discharged on [DATE] to Hospice. Review of the facility's investigative summary revealed that on 2/01/18 at approximately 9:30 a.m., three staff members (CNA/staff #132, CNA/staff #187 and housekeeper manager/staff #131) and a visitor, witnessed a Licensed Practical Nurse (LPN/staff #188) yell at resident #204 saying at least three times You can go to hell. According to the summary, staff #187 reported that she was taking the resident down the hall when he started cursing. Staff #187 reported that immediately staff #188 started yelling at the resident saying not to talk like that and that he is an educated man and should start to behave like one. The documentation included that the visitor who witnessed the incident reported that the nurse came up the hall saying, You don't treat people that way, I am not putting up with it and this if f------ BS. A statement by staff #131 included that staff #188 yelled at resident #204 saying, You go to hell, you go to hell. I thought you were more intelligent than that. A statement by staff #188 included that staff #187 was taking resident #204 down the hall, when he started using profanity and she replied, Please Mr. (resident's name) you are a fine educated gentleman, so please do not speak that way to me or my staff. She said that she repeated this three times and then the resident calmed down and stopped using profanity. Review of an e-mail dated 2/1/18 at 10:29 a.m. written by the Business office Administrator (staff #54) to the Director of Nursing (DON/staff #38) and Administrator (staff #81), revealed documentation that staff #131 came to her office on 2/1/18 around 10 a.m. to report that staff #187 was taking resident #204 by the station, and the resident told staff #187 to go to hell. Staff #188 followed them and then told resident #204 to go to hell, you are a more educated man than that. An interview was conducted on 11/07/18 at 8:44 a.m. with the DON, who stated that she was not notified immediately, but found out the next day (02/02/18) when she received an e-mail from staff #54. An interview was conducted on 11/07/18 at 8:46 a.m. with staff #54, who stated that staff #131 came to her office on 2/01/18 and said that staff #188 said to resident #204 to go to hell, you are a more educated man that that Staff #54 stated that she sent an e-mail to the DON and the Administrator, but the DON never had her e-mail set up to her phone and she had entered the Administrator's e-mail address incorrectly, so neither of them received the e-mail that day. An interview was conducted on (MONTH) 8, (YEAR) at 12:36 p.m. with the Administrator (Abuse Prohibition Officer/staff #81), who stated if a staff member witnessed or was informed of abuse, they should report it immediately. Staff #81 also stated that a report should be made to the State Agency. Per the facility's documentation, the incident occurred on 2/1/18 and the Director of Nursing was not notified until 2/02/18, and it was not reported to the State Agency until 2/02/18 at 8:06 a.m. The facility was unable to provide evidence that the staff to resident verbal abuse was reported immediately to the Administrator/designee and to the State Agency within two hours after the allegation was made. Review of the Resident Abuse Definitions and Report policy revealed the resident has the right to be free from mental, physical, sexual, and verbal abuse .and prohibits staff from engaging in any such conduct, as well as sets forth procedures for reporting complaints, concerns or incidents. The Procedure section included: when a staff member reasonably suspects Abuse, Neglect, misappropriation of property or exploitation of a resident, or has received a report or complaint from a resident of such treatment or has actual knowledge that a resident has been a victim of such treatment; he/she shall report it immediately to the Administrator .The Administrator will make a timely report to the appropriate authority. The policy included that allegations that involve Abuse will be made immediately, but not more than two (2) hours after the allegation is made. Failure to make any report required by this policy is a violation of facility policy and may result in disciplinary action up to, and including termination of employment.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff interviews, facility documentation and policy and procedures, the facility failed to ensure that allegations of abuse involving three residents (#56, #58 and #204) were thoroughly investigated. Findings include: -Resident #56 was admitted to the facility on (MONTH) 20, 2012, with [DIAGNOSES REDACTED]. Review of the nursing monthly summaries dated (MONTH) 27, (MONTH) 24, and (MONTH) 11, (YEAR), revealed that resident #56 had moderate cognitive impairment, delusions, hallucinations, wanders in the facility, uses a wheelchair and displays sexual behaviors toward female staff. A nursing monthly summary dated (MONTH) 11, (YEAR) included that resident #56 had severe cognitive impairment, uses a

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F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 9) wheelchair, continues to be sexually inappropriate and makes inappropriate comments to female staff and visitors. A nursing monthly summary dated (MONTH) 10, (YEAR) revealed that resident #56 has disorganized thinking and memory problems, uses a wheelchair, and is sexually inappropriate with female staff and is redirected. Review of a nursing monthly summary dated (MONTH) 10, (YEAR) revealed the resident had severe cognitive impairment, memory problems, uses a wheelchair, and that behavior monitoring is in process for sexually inappropriate behaviors at times. Review of an activity care plan dated (MONTH) 2, (YEAR) revealed that resident #56 was unable to complete simple program tasks and has little speech during activities, with the exception of episodes of inappropriate sexual remarks. Interventions included the following: quickly redirect at the first show of behaviors and be aware of the surroundings or seating of resident #56 related to the potential for inappropriate verbal behaviors with other residents. A care plan dated (MONTH) 3, (YEAR) included the resident has long and short term memory deficits, with poor cognitive decision making abilities related to Alzheimer's. The care plan included the resident makes sexually inappropriate gestures and comments towards female staff. Interventions were as follows: attempt to redirect the resident when sexually inappropriate gestures or comments are made towards staff by talking with him about his family, assign consistent caregivers whenever possible, and approach the resident in a calm manner. Review of a care plan dated (MONTH) 3, (YEAR) revealed the resident has a [DIAGNOSES REDACTED].e. grabbing genitals) and comments (advances for oral sex) toward female staff. Interventions listed included the following: Do not respond or react to inappropriate comments, instead distract to more appropriate conversation, if the behavior continues offer reminders of respectful talk or use sterile attention, reinforce with staff that firm and clear limits are healthy and required when the resident makes inappropriate gestures or statements, when resident #56 engages in inappropriate gestures (grabbing genitals) distract him and engage in an activity, offer a snack to occupy his hands, or escort him to his room if safe. Review of the resident assessment change of condition-alert charting dated (MONTH) 6, (YEAR), revealed documentation that the physician stated that resident #56 made sexual inappropriate comments to her, during her visit with him. A physician progress notes [REDACTED]. The physician questioned resident #56 regarding his behaviors in his room and in common areas to see if he knows right from wrong, but made sexually inappropriate comments to the female physician instead. The documentation included that the resident was alert, but was not appropriate in conversation or behaviors. -Resident #58 was admitted to the facility (MONTH) 27, (YEAR), with [DIAGNOSES REDACTED]. An interview was conducted on (MONTH) 5, (YEAR) at 3:29 p.m. with resident #58, who stated that there is a male resident (resident #56) who has been sexually inappropriate for a long time. Resident #58 stated that approximately three weeks ago, resident #56 was in the dining room during meal time, when he started to remove his shirt and started masturbating. Resident #58 stated that she had to get the attention of a staff member, who removed resident #56 from the dining room. She said that resident #56 has behaved like this for a long time and she tries not to look when he does it because it's not something she wants to see. An interview was conducted on (MONTH) 5, (YEAR), with the Director of Nursing (DON/staff #38). Staff #38 stated that she recently became aware that resident #56 had inappropriate behaviors, but did not investigate what the inappropriate behaviors consisted of. Another interview was conducted on (MONTH) 6, (YEAR) at 9:03 a.m. with resident #58, who stated that at the time of the incident approximately three weeks ago, there were multiple female residents who were present in the dining room, when he was masturbating. Resident #58 stated that she was the one who notified a staff member, because she thinks the other female residents have dementia and are not very with it and are unable to speak for themselves. Resident #58 stated that resident #56 displays this behavior often and wishes not to see it, so when it happens in a public area, she will take herself elsewhere. Resident #58 also recalled an incident when resident #56 was sitting close to the nurses station in his wheelchair masturbating. She could not recall the date, but stated that there were multiple staff members who saw resident #56 masturbating and they did not do anything about it, until she intervened and asked resident #56 to stop. Resident #58 stated it was only then that a staff member removed resident #56 from the nurses station area. Resident #58 stated that she feels like the staff do not care about his behavior in public, because they do not do anything to help or stop the behavior from happening. An interview was conducted on (MONTH) 7, (YEAR) at 8:17 a.m. with a CNA (staff #119), who stated that resident #56 has displayed sexually inappropriate behaviors mostly verbal, but will occasionally start to masturbate while in the dining room and at the nurses station. Staff #119 said that she will place a blanket on his lap with his hands outside of the blanket to try and prevent this behavior from occurring. A later interview was conducted on (MONTH) 7, (YEAR) at 9:51 a.m. with staff #119. She said there was an incident approximately three weeks ago where resident #56 was in the dining room and she was assisting him to eat. She said that resident #56 yelled out F--- me and suck my c---, then proceeded to remove his shirt and brief and pulled his private parts out. She said that she immediately covered resident #56 with a blanket and removed him from the dining room. Staff #119 stated that she reported this to the nurse (staff #115), but did not report the incident to anyone else. Staff #119 stated that resident #56 has had behaviors such as masturbating in public areas and has made inappropriate sexual comments for a long time. The facility was unable to provide any documentation that the allegations of abuse/incidents had been investigated. -Resident #204 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The resident was discharged on [DATE] to Hospice. Review of the facility's investigative summary revealed that on 2/01/18 at approximately 9:30 a.m., three staff members (CNA/staff #132, CNA/staff #187 and housekeeper manager/staff #131) and a visitor, witnessed a Licensed Practical Nurse (LPN/staff #188) yell at resident #204 saying at least three times You can go to hell. According to the summary, staff #187 reported that she was taking the resident down the hall when he started cursing. Staff #187 reported that immediately staff #188 started yelling at the resident saying not to talk like that and that he is an educated man and should start to behave like one. The documentation included that the visitor who witnessed the incident reported that the nurse came up the hall saying, You don't treat people that way, I am not putting up with it and this if f------ BS. A statement by staff #131 included that staff #188 yelled at resident #204 saying, You go to hell, you go to hell. I thought you were more intelligent than that. A statement by staff #188 included that staff #187 was taking resident #204 down the hall, when he started using profanity and she replied, Please Mr. (resident's name) you are a fine educated gentleman, so please do not speak that way to me or my staff. She said that she repeated this three times and then the resident calmed down and stopped using profanity. Further review of the facility's investigative documentation revealed that it was not thorough, as it did not include any interviews with other residents who were in the area at the time of the incident, nor interviews with other residents who may have been cared for by staff #188. An interview was conducted on 11/07/18 at 8:44 a.m. with the DON (staff #38), who stated that she interviewed the staff which were present and the Social Worker interviewed residents. The DON stated that it is her policy to interview 5-10 residents, however, the Social Worker was terminated and there are no records of other resident interviews. An interview was conducted on (MONTH) 8, (YEAR) at 12:36 p.m. with the Administrator (Abuse Prohibition Officer/staff #81), who stated a thorough investigation included an interview with the resident involved, other residents in the vicinity or who had contact with or was provided care by the alleged perpetrator, and staff that worked with the alleged perpetrator. The Resident Abuse Definitions and Report policy revealed to promote a resident's right to be free from verbal, sexual, physical, and mental abuse by anyone, including facility staff and other residents. All allegations, observations, or suspected cases of Abuse will be thoroughly investigated by the facility. The Procedure section included that the Administrator will initiate an investigation of the report and maintain documentation of the investigation, including the date of the incident, a description of the incident, resident(s) involved, and the identity of the person(s) alleged to be responsible for the potential misconduct towards a resident. Review of the policy titled, Investigative Process revealed the facility will conduct a thorough investigation of incidents affecting resident care. The policy included that an investigation will be conducted for any allegation of abuse. The Procedure section of the policy included that each witness will be interviewed and that each person interviewed is asked to write a narrative statement describing the incident on a facility approved form. The policies did not address the need to interview other residents who are in the vicinity at the time of an incident, or of the need to interview other residents who may have been cared for by the staff member who is named in an allegation.

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F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 10)
F 0756 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview, and policy and procedure, the facility failed to ensure a Medication Regimen Review (MRR) was reviewed by a pharmacist within the required time frame of at least once a month for one resident (#79). Findings include: Resident #79 was admitted to the facility on (MONTH) 5, (YEAR), with [DIAGNOSES REDACTED]. Review of the physician's admission orders [REDACTED]. Review of the clinical record revealed no evidence that the resident's medication regimen had been reviewed by a pharmacist. An interview was conducted on (MONTH) 9, (YEAR) at 12:18 pm with the Director of Nursing (DON/staff #38). She stated that normally the pharmacist would review the resident's medication regimen right after the resident was admitted to the facility. Later that day, at 1:48 pm, the DON stated that she contacted the pharmacy and confirmed that a MRR had not been conducted for the resident from the date of admission to the facility until the current date. The facility's Medication Regimen Review policy stated that each resident's medication regimen would be reviewed at least monthly or more frequently depending upon the resident's condition. The policy included that the medication regimen would be reviewed by a pharmacist at times of transitions in care, such as from the hospital to the facility, for all residents with an expected stay of less than 30 days. The policy further included that medications would be reviewed by a pharmacist at the time of dispensing and with modifications in dosages.
F 0757 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy, the facility failed to ensure one resident's (#55) drug regimen was free from unnecessary drugs, by failing to ensure there was adequately monitoring in place for an antidepressant medication. Findings include: Resident #55 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the physician's orders [REDACTED]. A laboratory (lab) result obtained on 09/15/18 included that the resident had a CrCl (creatinine clearance) of 22 ml/minute. The normal reference range for CrCl is greater than or equal to 61 for the laboratory used for the testing. The admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact. The assessment also included the resident had no mood changes or behaviors. Review of the Mood State care plan for depression initiated on 09/25/18, revealed the following interventions: use Duloxetine and monitor for adverse side effects; educate resident on anger management techniques and the benefits and risks of refusal of care; monitor for refusal of care and document on the Behavior Monitoring Flow Sheet; [MEDICAL CONDITION] medications to be reviewed quarterly and as needed by the Interdisciplinary Team, Physician, and Pharmacist to evaluate for ongoing need and for potential gradual dose reduction. A lab result obtained on 10/06/18 included that the resident had a low CrCl of 17 ml/minute. A Pharmacist Medication Regimen Review (MRR) dated 10/09/18 included a manufacturer statement to avoid the use of Duloxetine with a CrCl of <30 ml/minute. The Pharmacist recommended discontinuing the use of Duloxetine. The Physician signed the agreement to discontinue the Duloxetine on 10/28/18 and it was noted by the Unit Manager. A lab result obtained on 10/10/18 included that the resident had a low CrCl of 18 ml/minute. A lab result obtained on 10/25/18 included that the resident had a low CrCl of 19 ml/minute. Review of the Behavior/Intervention Monthly Flow Record for (MONTH) (YEAR) revealed no identified behaviors of depression AEB refusing care and only one day shift with identified behaviors of depression AEB refusing care in (MONTH) (YEAR). A review of the Medication Administration Record [REDACTED]. No Behavior/Intervention Monthly Flow Record was initiated to monitor the resident's behavior for depression for the month of November. An interview was conducted on 11/08/18 at 9:31 AM with the Licensed Practical Nurse (LPN/staff #13), who stated that the resident was receiving the Duloxetine for depression and refusing care. The LPN stated that the resident should be monitored for those behaviors as well as adverse effects of the medication. Staff #13 stated that there was no behavior monitoring done for (MONTH) 1-7, (YEAR). The LPN stated that it is important to monitor the behaviors so that even a slight change in behavior would be captured. An interview was conducted on 11/08/18 at 09:49 AM with the Director of Nursing (DON/staff #38), who stated that when there is a new physician's orders [REDACTED]. The DON stated that a couple of days prior to a new month starting, the order recapitulation (recap) sheets are distributed to the Nurse Managers to review and verify. Staff #38 stated that if a resident is receiving a medication that requires monitoring, the Nurse Manager will prepare the appropriate monitoring sheet to include with the MARs. The DON stated that she receives the MRRs and distributes them to the Nurse Managers, who ensures the physician reviews and responds to any recommendations. She stated that if the Physician has agreed to the recommendation, the Nurse Manager will write the order for the recommendation. An interview was conducted on 11/08/18 at 10:04 AM with the Unit Manager (staff #23), who stated there should have been a behavior monitoring sheet included with the MAR for the month of November. Staff #23 further stated it is important to monitor residents receiving [MEDICAL CONDITION] medications because if the behaviors are decreasing, attempts can be made to decrease the medication or stop the medication. He stated that once he is given the MRR reports; he gives them to the physicians for review. He stated that once the physician has reviewed the MRR, he would write any needed orders. Staff #23 stated that his signature is on the MRR as having reviewed it and that the recommendation was missed. Review of the facility's policy titled Medication Regimen Review revealed It is the policy of this facility that each resident's medications will be reviewed at least monthly by the Consulting Pharmacist or more frequently depending on the resident's condition and the risks or adverse consequences related to the current medication(s) .the DON or designee will ensure all recommendations are reconciled. The policy included that the pharmacists identifies irregularities through a variety of sources including laboratory results and behavior monitoring. The policy included the Pharmacist will review medications for medical condition and response to drug therapy. The policy also included, The Director of Nursing will forward all findings to the respective nurse manager for timely follow-up/contact with the attending physician .The attending physician must address the issues identified .by accepting and ordering recommended alterations in medication regimen or by providing justification for the decision to not accept.
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, clinical record review, and policy review, the facility failed to ensure one resident (#79) had adequate indication for the use of an antipsychotic medication. Findings include: Resident #79 was admitted to the facility on (MONTH) 5, (YEAR), with [DIAGNOSES REDACTED]. Review of the physician's admission orders [REDACTED].

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F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 11) Review of the physician's admission History and Physical (H & P) dated (MONTH) 8, (YEAR), revealed the resident was alert with pleasant affect, and that the resident was oriented to month, year, general place, and room. The H & P stated that the resident had been taking [MEDICATION NAME] twice daily and [MEDICATION NAME] (antipsychotic) 0.5 mg at bedtime. The H & P stated [MEDICATION NAME] would be discontinued, and the resident would continue to take [MEDICATION NAME] twice daily. The H & P did not include the rationale for the continued use of [MEDICATION NAME]. A nursing note dated (MONTH) 9, (YEAR) revealed the resident has not exhibited any unsafe behaviors and appears to be adjusting to the facility well. The admission Minimum Data Set (MDS) assessment dated (MONTH) 14, (YEAR), revealed a Brief Interview for Mental Status (BIMS) score of 8 which indicated the resident had moderate cognitive impairment. In addition, the MDS assessment included the resident was assessed to have no symptoms of [MEDICAL CONDITION] such as hallucinations and/or delusions, and that she did not display behaviors of physical aggression, verbal aggression, or other behavioral symptoms. Review of the care plan initiated (MONTH) 18, (YEAR) regarding the resident's mood state revealed interventions that included administering [MEDICATION NAME] as ordered, observing for side effects, and monitoring for targeted behaviors including agitation, refusing medications, and dysphoria. The interventions also included that [MEDICAL CONDITION] medications would be reviewed quarterly to evaluate for ongoing need and for potential gradual dose reductions. The Medication Administration Record [REDACTED]. The MAR indicated [REDACTED]. From (MONTH) 6, (YEAR) through (MONTH) 9, (YEAR), the resident had zero documented episodes of dysphoria, one episode of refusing medications, and five episodes of agitation. Review of the Medication Regimen Review (MRR) conducted on (MONTH) 9, (YEAR), revealed the resident was receiving [MEDICATION NAME] for [MEDICAL CONDITION] with mood features as evidenced by agitation, refusing medications, [MEDICAL CONDITION], and dysphoria. The review included a request to clarify how the resident exhibited agitation. The review further included the resident's behaviors would be monitored and a Gradual Dose Reduction (GDR) would be considered at the next evaluation. Additional review of the clinical record revealed no adequate indication for the continued use of [MEDICATION NAME]. An observation of the resident was conducted on (MONTH) 9, (YEAR) at 9:51 am. The resident was observed seated in her wheelchair in her room. She appeared neatly groomed with a calm affect. She appeared to be engaging in conversation with her guest. An interview was conducted on (MONTH) 9, (YEAR) at 10:16 am with a Certified Nursing Assistant (CNA/staff #119). The CNA described the resident's only behaviors as acting grumpy, and insisting on trying to independently perform her own activities of daily living. The CNA stated that the resident would occasionally yell, Leave me alone, but that the resident would calm down if given a little time and space. During an interview conducted on (MONTH) 9, (YEAR) at 10:21 am with a Licensed Practical Nurse (LPN/staff #41), the LPN stated that the resident's only behaviors consisted of acting confused and stating that she wanted to go home. The LPN also stated he had not witnessed the resident yelling, striking out, or showing aggression. Review of the facility's policy regarding psychoactive medication administration revealed the following: -it is the policy of the facility to provide psychoactive medications for only those residents diagnosed or identified with conditions indicated. -Behaviors with physical symptoms will be monitored.
F 0842 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a clinical record review, staff and resident interviews, and policies review, the facility failed to ensure the medical record for one resident #22 was accurately documented. Findings include: Resident #22 was admitted to the facility on (MONTH) 2, (YEAR) and readmitted on (MONTH) 12, (YEAR) with [DIAGNOSES REDACTED]. An advance directive form sign by the resident's representative on (MONTH) 11, (YEAR) revealed the resident was a full code indicating the resident's representative elected to have all emergency resuscitation efforts for the resident. Further review of the clinical record revealed a second advance directive form electing Do not resuscitate signed by the resident's representative on (MONTH) 28, (YEAR). Review of the recapitulation of physician orders [REDACTED]. Review of the admission Minimum Data Set (MDS) assessment dated (MONTH) 19, (YEAR) revealed a Brief Interview for Mental Status score of 12 which indicated the resident had moderate cognitive impairment. An interview was conducted on (MONTH) 7, (YEAR) at 10:11 a.m. with a registered nurse (RN/staff #101). She stated that upon admission the nurse obtains a completed advance directive from the resident and/or the power of attorney. After reviewing the clinical record she stated that the resident has a full code order dated (MONTH) 11, (YEAR) and an advance directive for do not resuscitate dated (MONTH) 28, (YEAR). During an interview conducted on (MONTH) 7, (YEAR) at 10:18 a.m. with the MDS coordinator (staff #153), he stated that advance directives are obtained on admission by the nurse and that the unit manager will review the physician orders [REDACTED].#22 has a health care power of attorney that signed a do not resuscitate advance directive (MONTH) 28, (YEAR) and that the most recent advance directive order is for a full code status. He stated that advance directives should match the physician's orders [REDACTED].>An interview was conducted on (MONTH) 7, (YEAR) at 10:27 a.m. with the Director of Nursing (DON/staff #38). She stated that upon admission advance directives are explained to the resident and/or the resident's representative and that the form is completed and signed. She stated that the unit managers are to write clarification orders if the advance directives do not match physician's orders [REDACTED]. She stated that there is a full code order dated (MONTH) 11, 1018 and there is a do not resuscitate form signed (MONTH) 28, (YEAR). The DON further stated that there was no clarification order to change the advance directive order to a do not resuscitate in the chart. An interview was conducted on (MONTH) 7, (YEAR) at 10:41 a.m. with resident #22. He stated that on admission he was given an opportunity to elect advance directives and elected not to be resuscitated. The facility's policy titled Advance Directives revealed the facility is to determine on admission whether the resident has an advance directives and, if not, determine whether the resident wishes to formulate an advance directive. The policy included the facility must identify, clarify, and periodically review as a part of the compressive care planning process, the existing care instructions and whether the resident wishes to change or continue these instructions. Review of the facility's policy titled Medical Records revealed the facility is to maintain medical records on each resident that are in accordance with accepted professional standards and practices and that are complete and accurately documented.
F 0867 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.** Based on concerns identified during the survey, staff interview, facility documentation and policy and procedures, the Quality Assessment and Assurance (QAA) committee failed to develop and implement an appropriate plan of action to correct concerns regarding abuse. Findings include: The facility's Abuse Prohibition Officer/Administrator (staff #81) and the Director of Nursing (DON/staff #38) were notified of a staff to resident verbal abuse incident on 02/02/18 that occurred on 02/01/18, which resulted in failure to protect residents, a delay in reporting, and an incomplete investigation. As a result, the facility initiated a Process Improvement plan (PIP) for correction on 02/09/18 regarding the two-hour reporting requirement for abuse. The action plan items included in-servicing nursing staff on the new rules and presenting the new rules during orientation. The responsible

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F 0867 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 12) persons were the DON, Administrator, and the Nurse Managers. Review of the plan on 11/05/18 revealed the following documentation on the Follow-Up Date section: 1. 02/19/18, 02/21/18, then as needed and yearly; 2. On-going. The plan did not reflect any root cause analysis, scope of the problem or plan, and any documentation of follow-up actions, other than in-service sign-in sheets. The State Agency received multiple facility self-reports regarding allegations of abuse since the initiation of the PIP and none were reflected on the PIP as being reviewed for compliance. The PIP regarding abuse did not include the failure to protect residents as soon as a suspicion of abuse is identified and the lack of staff knowledge as to what constitutes abuse. The facility then provided a copy of the plan that now contained handwritten notes under the follow-up date section that included the following: -02/02/18 In-service -02/05/18 All staff meeting -April (YEAR) Annual in-service with test to all staff. See staff development -April 5 General staff In-service and Kahoot Quiz -April 27, (YEAR) In-service by Social Service -11/05/18-11/09/18. 11/06/18 Abuse In-service The supporting documentation for the above plan included: -An in-service sheet with no date, title/topic with one Registered Nurse Signature -A partial copy of the Kahoot Quiz that contained 10 questions, of which only 2 were related to abuse that asked when reporting should occur and the acceptable form of communication when reporting abuse to the Administrator or DON -A copy of the Resident Rights & Abuse Quiz used at the annual in-service in (MONTH) (YEAR) of which approximately half of the 14 questions were on abuse and 10 questions under the Elder Justice Act were regarding reporting a crime. -A copy of the one page document titled Social Service Orientation on Abuse/Neglect and Reporting with handwritten dates of (MONTH) 23 at 2:30 and (MONTH) 27 at 2:30 -A copy of the outdated federal regulations regarding abuse and resident rights (pre (MONTH) (YEAR)) -A copy of the Elder Justice Act Notice -Mandatory Meeting for (MONTH) (YEAR) that included 4 bullet points to report immediately and regarding the 2-hour time frame. -Staff in-service sign-in sheets from 02/17/18 (x 2) and 02/21/18 (x 2), and all staff that signed in are from the nursing area and no other departments in the facility. An interview was conducted on 11/09/18 at 12:50 PM with the Administrator (staff #81) and the DON (staff #38). The Administrator stated that the QAA Committee meets monthly and that if a concern is presented that requires monitoring and improvement, a Process Improvement Plan (PIP) is initiated. Staff #81 stated that the sub-committee working on the concern would identify the problem using root cause analysis (RCA) and the documentation would include identification of the problem, possible causes, responsible person, outcomes, on-going monitoring, and identification of changes to be expected. The administrator stated that the goal is to have a PIP completed in 3-6 months. Staff #81 stated that if something failed after the PIP was completed; the QAA Committee would open a new PIP. The facility's policy regarding Quality Assurance-Performance Policy revealed the following statement It is the policy of this facility to utilize the principles of Quality Assurance (QA) and Performance Improvement (PI) to create systems to provide care and achieve compliance with state and federal regulations; track, investigate, and try to prevent recurrence of adverse events . The policy also included The activities of QAPI involves members from all levels of the organization to: -identify opportunities for improvement; -address gaps in systems or processes; -develop and implement an improvement or corrective plan; -and continuously monitor effectiveness of interventions.