STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25E115	A. BUILDING _____ B. WING _____	C 10/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE RETIREMENT HOME	209 OAK CIRCLE/P. O. BOX 198 DUNCAN, MS 38740

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS CI MS #16298 The State Agency (SA) conducted a complaint survey, MS #16298, on 10/16/19. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation and cited F600 related to supervision of a resident for sexual abuse behaviors. The facility's census was 60 at the time of survey, and the facility held a license for 60 beds.	F 000		
F 600 SS=E	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interviews, observations, records review, facility policy and document review, and facility investigation documents, the facility failed to prevent a male resident (Resident #1) from attempting to conduct a sexual act with two (2)	F 600	"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement is	10/30/19

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

Electronically Signed | 10/30/2019

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F 600	Continued From page 1 female residents (Resident #2 and Resident #4). Resident #1 was a registered sex offender and had a care plan for inappropriate behavior related to past sexual history and continual desires to touch females inappropriately. The goal was to maintain appropriate behaviors and remove the resident when behavior is unacceptable. The facility failed to supervise Resident #1 close enough to prevent attempted sexual contact with two (2) of four (4) residents reviewed. Findings include: Review of the "Abuse Prevention Program" policy, revised August 2006, revealed the residents had a right to be free from abuse. Review of a facility investigative report revealed on 10/8/19, the Administrator notified the Mississippi State Department of Health, Licensure and Certification (MSDH), of an allegation of Resident abuse. The notice related that Resident #1 was found to have his hand in female Resident #2's pants, near her genital area. The facility investigation report indicated that Certified Nursing Assistant (CNA) #1 was gathering supplies and turned, observing Resident #1 with his hand in Resident #2's pants. She immediately notified the Nursing Supervisor, who put Resident #1 one on one (1:1) supervision and conducted an assessment on Resident #2. The report also indicated that during the investigation, Licensed Practical Nurse (LPN) # 2 reported having seen Resident #1 with his hands under Resident #4's gown/dress the day before. On 10/16/19 at 10:55 AM, the Director of Nursing (DON) stated she had questioned Resident #1 and he had repeatedly denied the sexual	F 600	prepared and/or executed solely because it is required by provision of Federal and State Law" F600 - 483.12(a)(1) Free from Abuse and Neglect CFR(s): 483.12(a)(1) Bullet 1: Correction actions accomplished for alleged deficient practice: A. On 10/2/2019, Resident #1 was placed one on one for monitoring by nursing staff. B. On 10/2/2019, Resident #2 was assessed from head to toe by the 3-11 Nurse Supervisor with no injury or ill effects noted. C. On 10/2/2019, Sheriff Office of Bolivar County was called to investigate. As of 10/29/2019, no charges have been filed by Sheriff Office. D. On 10/2/2019, and 10/3/2019, Director of Nursing provided in-service on prevention of abuse/vulnerable adult to staff. E. On 10/3/2019, Resident #1 was transferred to Behavior Unit at Local Hospital for evaluation and treatment x14 day program or as Medical Director orders. F. On 10/3/2019, Resident #1 room changed to the hall where there are no females. G. On 10/3/2019, Attorney General's office and Miss. Department of Health was notified of incident by Administrator. H. On 10/9/2019, a facility wide mandatory in services was provided	

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F 600	Continued From page 2	F 600		

behavior. She stated that she had been at the facility since 2004, and was unaware that he had done anything like this before. She said that Resident #1 stays in his room a lot with his roommate. She stated that Resident #2 had been examined by a nurse, with no evidence of harm and that Resident #1 was put 1:1 observation until discharged.

On 10/16/19 at 11:20 AM, an interview with the Administrator revealed that the Sheriff was notified and had visited the facility twice, investigating. She stated that they have a Psych Consultant who comes in every week, and they were notified about Resident #1's behavior. Resident #1 had been transferred to a behavior unit, but arrived back to the facility on 10/16/19, and was re-assigned to a unit with all men. She stated the Social Worker is trying to find other placement for Resident #1, and that they are notifying the Sheriff's office of his readmission.

A telephone interview was conducted with LPN #1, who was on duty when the incident occurred. He stated that the CNA notified him right away, that she had immediately removed his hand from Resident #2's pants and that Resident #1 told him that he was just rubbing her leg. The LPN stated that he knew Resident #1 was a registered sex offender, but that there was no special observation conducted with him when he was around females before that, and he'd not witnessed any problems.

At 12:00 noon, on 10/16/19, the Social Worker stated she had been at the facility for three (3) years and no staff or resident had reported any inappropriate behavior prior to this incident. She stated that Resident #1 goes out of town to a sex

by Director of Nursing to staff on Sex Offenders within the facility and rights of residents to be Free from Abuse and Neglect and the Vulnerable Adult.

Bullet 2: All residents have the potential to be affected by this deficient practice.

Bullet 3: Measures put in place to ensure the alleged deficient practice does not reoccur:

A. The facility currently has two (2) residents with history of sex offender within the building. All current staff in serviced by Director of Nursing on 10/9/2019, on residents with Sex Offender history and on resident's rights to be Free from Abuse and Neglect. All new employees will be in-serviced upon hire regarding any resident(s) with Sex Offender history within the facility.

B. Administrator/Director of Nursing/Social Worker will visit Sex Offender residents weekly X6, then monthly X4, then prn within the facility to ensure compliance on resident's rights beginning week of, October 16, 2019.

C. Resident(s)with a history of Sex Offender will be seen by Mental Health Nurse Practitioner and/or Physician monthly X6 and prn visits beginning, October 22, 2019.

D. Resident(s) with a history of Sex Offender will be seen by Mental Health Therapist weekly X6 weeks and the prn with visits in facility beginning week of, October 16,2019.

E. Monitoring and documentation

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F 600	Continued From page 3	F 600		

offender meeting every three (3) months or more often if indicated.

Certified Nursing Assistant (CNA) #1, who initially dealt with the incident, was interviewed by telephone. She stated that Resident #2 was due for a shower, so she had pushed her in a Geri-chair down by the dining area and had gone to the linen room to collect supplies. She said she noticed Resident #2 stroking her head, so she went back toward her and noticed Resident #1 next to her with his hand inside her pants. The CNA said she yelled "What are you doing?" and he jerked his hand back, saying he was just rubbing her leg. The CNA said Resident #2's brief was still on and intact.

At 2:30 PM, on 10/16/19, Resident #4 was interviewed in her room. When queried about any man touching her inappropriately, she said that only one man did, but she stated, "I have to say I asked for it; don't blame him".

During an interview, on 10/16/19 at 2:40 PM, Resident #1 adamantly denied the incident. He stated that they had already tried to get him to say he did it, but stated, "I never touched her".

At 3:10 PM, on 10/16/19, LPN #2, who had reported to the DON, per facility report, that he had observed Resident #1 with Resident #4 was interviewed. He stated that at about 8:00 PM, the night before this incident with Resident #1 and Resident #2, he was going to give another resident an insulin shot and saw Resident #1 with his hand up Resident #4's dress, but she was not telling him to stop. He stated that he sees the two (2) of them together a lot. He stated that he was not aware that Resident #1 was a registered sex

every 2 hours for 3 months, then weekly X4 weeks, and then prn by licensed nursing staff on resident #1 and others with Sex Offender history in Medical Records beginning, October 16, 2019.

F. Activity Director will ensure documentation on inappropriate behavior of any resident with Sex Offender history during activities and their location beginning, October 16, 2019.

G. Ongoing teachings with staff by Director of Nursing and Social Worker on daily rounds to immediately report any finding or incidence involving inappropriate behavior of sex offenders.

H. Conference will be held with Medical Director and Responsible Party by Social Worker/Administrator/Director of Nursing for immediate discharge with inappropriate behavior occurrences when necessary.

J. Administrator/Director of Nursing/Social Worker will review all referrals prior to acceptance of a new admission into the facility for sex offender history.

K. Resident #1 and other registered sex offenders will continue to report every 90 days to the Sex Offender Registry office as directed.

Bullet 4: Administrator will monitor this deficient practice for six months, by reviewing compliance in documentation and behavior monitoring by Mental Health Nurse Practitioner, Mental Health Therapist, Director of Nursing, Social Workers, Nurses, and Activity Director. The Administrator will report to Quality

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F 600	Continued From page 4 offender. The facility admitted Resident #1 on 5/4/16, with a re-admission date of 2/24/17. Resident #1's diagnoses included Hypertension, Diabetes Mellitus and Anxiety Disorder. Medications included insulin, Digoxin, Sinemet, Klonopin, and Cymbalta. His Brief Interview for Mental Status (BIMS) score on 5/16/19, was 14, which indicated no cognitive impairment. The facility admitted Resident #2 on 4/26/17, with diagnoses which included Unspecified Mental Disabilities, Anxiety, Psychotic Disorder, and Adjustment Disorder. Medication included Melatonin at bedtime for sleep and Risperdal for psychosis. Her BIMS score was 99, indicating she could not take the test. A nurse's note dated 10/8/19, reflected they were unable to assess memory. A nurse's note by an LPN on 10/3/19, revealed Resident #2 was inappropriately touched by another resident, promptly removed from the situation, and a thorough assessment did not reveal any harm. The facility admitted Resident #4 on 8/2/12, with diagnoses which included Psychotic Disorder with Hallucinations, Chronic Anxiety, Hypertension and Eating Disorder. Medications included Cardizem, Remeron, Risperdol, Zanax and Valium daily. Her BIMS score was 15 on 3/19/19, which indicated no cognitive impairment. The Administrator presented signed in-service documents for all staff, acknowledging they have been trained in Freedom of Abuse and Neglect and the Vulnerable Adult, dated 10/9/19.	F 600	Assurance (QA) committee on a monthly basis for six months. The Quality Assurance Committee will review and evaluate findings for potential concerns and address changes as the needs develops.	