



Oklahoma State Department of Health
Creating a State of Health

September 25, 2019

License Number: AL1408

Ms. Katherine Chadrick, Administrator
Arbor House Reminisce
151 48th Avenue Southwest
Norman, OK 73072

Survey Event ID: 8GGF11

Dear Ms. Chadrick:

On August 15, 2019, representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written the plan of correction (POC). The first method is to type the plan of correction and anticipated date of completion in the space provided on the right half of the STATE FORM. If additional space is needed, supplemental sheets may be attached.

The second method is to prepare your plan on the Optional Plan of Correction Template. Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at:

<http://www.ok.gov/health>. This link opens the OSDH home page. To find the optional POC, **click on Protective Health** on the left side of the home page, then **click on Long Term Care** on the right side of the page. The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

To be found acceptable by the OSDH, the plan of correction must:

- (1) Address how corrective action will be accomplished for affected residents;
- (2) Address how other residents with the potential to be affected will be identified;
- (3) Address measures or systemic changes to ensure the deficiency will not recur;
- (4) Indicate how the center plans to monitor performance to ensure corrections are sustained;
- (5) Include dates when corrective action will be completed for each violation; and
- (6) Be signed by the administrator.

Board of Health

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Your development of the evidence referenced in item 4, above, is very important for establishing the actual date your assisted living center corrected deficiencies and achieved compliance under the Continuum of Care and Assisted Living Act. If the required evidence is available when the OSDH conducts a revisit, then the earliest date of compliance shown in the evidence can be used by the OSDH to establish the effective date of correction and compliance. However, if there is no evidence of quality assurance being implemented, the correction date can be no earlier than the date of the OSDH revisit. If the required evidence is not available, the revisit may result in a repeated deficiency statement and another plan of correction may be required.

Avoid naming individuals, business firms or brand names on the enclosed form and any attachments. The document will be a public record and any such names will be available for disclosure.

Please sign, date and return the completed form, along with any attachments, supplements and templates, to this office within ten (10) OSDH business days of your receipt of this letter. OSDH business days are Monday through Friday, excluding state holidays. Failure to submit a Plan of Correction will not delay the subsequent revisit or any other phase of the enforcement process. Please retain a copy of the completed form for your files.

In accordance with O.S. 63-1-895, you have one opportunity to dispute citations of deficient practice through an informal dispute resolution (IDR) process. The IDR in no way is to be construed as a formal evidentiary hearing; it is an informal administrative process to discuss deficiencies. If you choose to contest a cited deficiency, the facility must complete an IDR Request Form (ODH Form 833AL). An explanation must be listed for each disputed deficiency. An attachment is acceptable if additional space is required for the dispute explanation. The IDR Coordinator may be contacted at (405) 271-6868 or at the address below to acquire a copy of the ODH Form 833AL and the Oklahoma IDR Process for Assisted Living Centers.

The IDR request must be submitted within 10 business days from receipt of the State Form deficiency statement. This is the same requirement for submitting an acceptable Plan of Correction (PoC). Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review or conducted in a face-to-face meeting. The facility shall receive written confirmation of the IDR results.

The facility must submit the completed IDR Request Form and supporting documentation under separate cover to:

IDR Coordinator
Long Term Care
Protective Health Services
Oklahoma State Department of Health
1000 N.E. 10th
Oklahoma City, OK 73117-1299

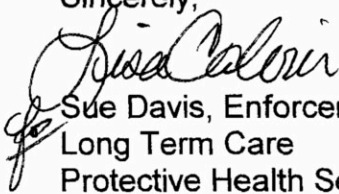
Facilities may not use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

- Remedy(ies) imposed by the Department,
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; or
- Alleged inadequacy or inaccuracy of the informal dispute resolution process

If you have any questions regarding the IDR process, please contact the IDR Coordinator via email at IDRCoordinator@health.ok.gov, or telephone at (405) 271-6868 or fax at (405) 271-2206.

If you have questions or need assistance, please feel free to send an email to LTC@health.ok.gov or call (405) 271-6868. When writing or calling, indicate whether you are asking about the enforcement process, or about the survey process and deficiencies, and your inquiry will be directed to the appropriate available staff members.

Sincerely,

A handwritten signature in black ink, appearing to read "Sue Davis", is written over the typed name and title.

Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/lde

Enclosure

INVESTIGATIVE REPORT

Facility: Arbor House Reminisce
Address: 151 48th Avenue Southwest
City, State, Zip: Norman, OK 73072
Provider #: AL1408
Complaint #: 54073
Investigation Date(s): 07/30/19, 07/31/19, 08/06/19, 08/07/19, 08/14/19 and 08/15/19

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to have and/or implement their abuse policy.	S

☐ Violation (s) unrelated to this complaint were also cited during the investigation.

An unannounced on-site investigation was initiated on Tuesday, July 30, 2019 at 9:35a.m.

A sample of 11 residents including any identified residents, was selected for the investigation based on the concerns relevant to the allegations.

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag 1512, 1914, 1951 and 1971 for details.

An investigation specific to resident abuse was conducted.

Deficient practice was unsubstantiated related to a residents fall during the night.

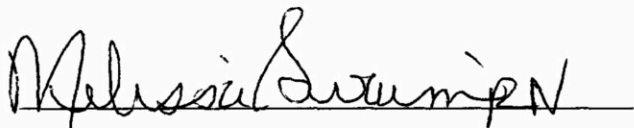
On 08/14/19 at 2:18 p.m. night shift staff was interviewed and it was determined the resident was unsteady and off balance resulting in a fall which required medical treatment. The center also provided an incident report which was also submitted the Department.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation 1. The facility will be required to submit a plan of correction (POC). The surveyor team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (S) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies.

Thank you for bringing these concerns to our attention.

A handwritten signature in black ink, appearing to read "Melissa Swaim RN", written over a horizontal line.

Melissa Swaim RN

Date report completed: 08/23/2019

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1408	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/15/2019
NAME OF PROVIDER OR SUPPLIER ARBOR HOUSE REMINISCE		STREET ADDRESS, CITY, STATE, ZIP CODE 151 48TH AVENUE SOUTHWEST NORMAN, OK 73072			
(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) COMPLETE DATE
C 000	INITIAL COMMENTS An abbreviated survey was conducted 07/30/19, 07/31/19, 08/06/19, 08/07/19, 08/14/19 and 08/15/19 to investigate complaint #OK 00054073. Resident census was 46. Deficient practice was cited as follows.	C 000			
C1512 SS=H	310:663-15-1 & 63 OS 1-1918(B)(12) RESIDENT RIGHTS - Abuse/Neglect Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(12) (12) Every resident shall be free from mental and physical abuse and neglect, as such terms are defined in Section 10-103 of Title 43A of the Oklahoma Statutes, corporal punishment, involuntary seclusion, and from any physical and chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms, except those restraints authorized in writing by a physician for a specified period of time or as are necessitated by an emergency where the restraint may only be applied by a physician, qualified licensed nurse or other personnel under the supervision of the physician who shall set forth in writing the circumstances requiring the use of restraint. Use of a chemical or physical restraint shall require the consultation of a physician within twenty-four (24) hours of such emergency; Title 43A O.S. 10-103. Definitions 8. "Abuse" means causing or permitting: a. the infliction of physical pain, injury, sexual abuse, sexual exploitation, unreasonable restraint	C1512			

Oklahoma State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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C1512	Continued From page 1 or confinement, or mental anguish, or b. the deprivation of nutrition, clothing, shelter, health care, or other care or services without which serious physical or mental injury is likely to occur to a vulnerable adult by a caretaker or other person providing services to a vulnerable adult; 10. "Neglect" means: a. the failure to provide protection for a vulnerable adult who is unable to protect his or her own interest, b. the failure to provide a vulnerable adult with adequate shelter, nutrition, health care, or clothing, or c. negligent acts or omissions that result in harm or the unreasonable risk of harm to a vulnerable adult through the action, inaction, or lack of supervision by a caretaker providing direct services; This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Center failed to protect and prevent the physical abuse of resident #3, who experienced cognitive impairment, by resident #4, who had been diagnosed with Hypersexuality and who had been displaying inappropriate sexual behaviors for the previous three months while in the center. The Center failed to: a) Have an effective, timely, reporting system in place for reporting incidents to Administration involving alleged sexual abuse of residents; b) Update a resident's assessment after being diagnosed with heightened sexual behaviors and aggression; c) Update a resident's care plan to include interventions for monitoring, supervising and preventing a resident with inappropriate sexual	C1512			

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C1512	Continued From page 2 behaviors from having unsupervised physical access/contact with other vulnerable residents; d) Protect a cognitively impaired resident (resident #3) from sexual contact by not ensuring resident #4 did not have unsupervised personal contacts with other residents; e) Track and document the pattern of sexually inappropriate behaviors displayed by resident #4 to determine appropriate, continued placement in the Center; f) Conduct and document an investigation of inappropriate sexual contact between 2 residents; g) Complete and submit an incident report for an allegation of resident to resident sexual abuse. Due to the extended time frame from when the Center became aware of resident #4's inappropriate sexual behaviors, with no protective measures put in to place, to the day of the incident, (1/14/19 through 4/02/19), this deficient practice resulted in actual harm at a pattern. Findings: Resident #4 Resident #4 admitted to the Center 10/23/18 with diagnoses to include dementia, gastroesophageal reflux disease (GERD) and hypertension (HTN). Resident #4's Admission Assessment, conducted 10/23/18, documented, under the section "Mental/Cognitive Functional Status," resident #4 "Requires constant reorientation/redirection. No short term memory retention noted." On the assessment under "History of Abnormal Behaviors" the nurse assessed the resident to have "Anger Outburst." The Resident's admission Care Plan, dated 10/23/18, identified a problem of "increased confusion, agitation, disorientation, forgetfulness" and "wandering."	C1512		

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C1512	Continued From page 3 Staff intervention consisted of monitoring, administer medications and report changes to family and staff and report to nurse and doctor. The Resident Service Plan, dated 10/24/18, documented staff would provide reminders/cuing, assist as needed with one staff assist. On 10/24/18, the Advanced Practice Registered Nurse (APRN) documented on a progress note the resident's psychiatric judgment/insight was "NOT appropriate." The January, 2019 physician orders and medication administration record (MAR) also included insomnia and benign prostatic hypertrophy as diagnosis. The Center's licensed practical nurse/ director of nursing (LPN/DON,) reviewed and signed the physician orders. The APRN was identified as the resident's primary care provider. The History and Physical exams conducted by the APRN on 10/24/18, 12/20/18, 1/03/19 and 1/17/19 documented the resident had an "increase in behaviors." On 01/14/19, Nurses Notes document resident #4 was "pleasuring self with door open." The notes document the resident became upset with staff when they attempted to close the door (to the resident's room) to provide privacy and the resident told the staff "You don't have to close the door. I can do this anywhere I want, it's my house." Staff reported and documented the resident attempted to come out of his room "with member (penis) in hand and follow them down the hall yelling." On 1/17/19, Nurses Notes document the APRN came to assess the resident "related to increase	C1512			

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C1512	Continued From page 4 sexual behaviors." An atypical antipsychotic, Seroquel, was ordered to be administered for the behavior. As documented on the January MAR, the Seroquel was indicated for "Hypersexuality State." On 01/17/19, the APRN assessed resident #4 in the Center and documented on a Progress Note the resident's chief complaint was "increased behaviors" and the resident was having "hypersexual behaviors." The Progress Note also documented the resident "does not go into private always to conduct, sometimes is overly aggressive." The APRN added an ICD (International Classification of Diseases) Code for "Hyper Sexuality State." On 1/31/19, Nurses Notes document the resident was assessed in the home by the physician related to the resident's "hyper sexuality behaviors" and Proscar (indicated for benign prostatic hyperplasia) was ordered. On 01/31/19, the Physician documented on a Progress Note the resident was being assessed for "continued long-term assisted living care due to multiple complex medical conditions." The Physician documented "The patient was started on Seroquel for hypersexual behavior. The staff reports he masturbates in public and pleasures himself rectally with odd objects." On the Progress Note, under the section "Diagnosis, Assessment and Plan" on page 2, the Physician documented resident #4 would be started on Proscar under the ICD Code "Hyper sexuality." The Physician documented he would consider "progesterone in the future if no improvement with Proscar." The resident would be "monitored for improvement." The previous LPN/DON, who was in charge of resident care during this time	C1512		

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C1512	Continued From page 5 frame, noted the Physician's Progress Note on 2/11/19, indicating he had read the Physician's note and the Physician's plan to have the resident monitored. On 01/14/19 through 1/31/19, resident #4 was observed to have increased sexual behaviors as documented by the APRN and Physician. The LPN/DON noted the orders, where the resident was evaluated by the APRN and the Physician for the sexual behaviors, which was a change in condition from admission. The Center failed to re-assess the resident and conduct a Significant Change Assessment or update the last assessment after the resident started displaying the sexually inappropriate behaviors. The Center did not update resident #4's Care Plan with interventions concerning the resident's sexual behaviors. The care plan did not address resident #4 required increased monitoring due to sexual behaviors and aggression and to determine the effectiveness of medication; and according to staff, behavior monitoring sheets were to document the frequency and type of behaviors; nor did the care plan include interventions to be implemented by staff to ensure resident #4 would have increased supervision to ensure resident #4 was not left unsupervised and alone with other residents. No risk management agreement or other follow-up documentation was provided concerning the resident's sexual disorder and sexual behavior. The February 2019 and March 2019 physician orders had "Behavioral Disorders associated with Dementia" and "Sexual Disorder" added as diagnosis. The RN Consultant and LPN/DON reviewed and signed the physician orders, indicating they were informed and aware of the resident's "sexual disorder."	C1512		

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C1512	Continued From page 6 On 2/14/19, Nurses Notes document the APRN came to assess the resident related to "continued hypersexual behaviors." Progesterone was ordered and the Seroquel dosage was increased to three times a day. On 2/14/19, the APRN documented on a Progress Note the resident continues with "increased sexual behaviors and aggression despite the proscar." The APRN documented the resident was cooperative with the exam and documented she "reviewed behavior log." The February MAR also had "Sexual Disorder" added as a diagnosis. On 2/19/19, Nurses Notes document increased signs and symptoms of agitation and resident #4 was "exposing self on unit." The APRN was contacted and the Progesterone was discontinued and a new medication, Estradiol, was ordered. Ativan was also ordered for anxiety/agitation. On 3/11/19, Nurses Notes document multiple episodes of angry outbursts at staff with the resident "attempting to leave facility". Staff reported the resident had "been like this for several days." On 3/14/19, Nurses Notes document the APRN came to assess the resident and prescribed a new medication, Depakote. No indication for the Depakote was documented in the nurse's note. On 03/14/19, the APRN documented on a Progress Note the resident was seen for "multiple angry outbursts." (The resident) "Is agitated and aggressive at times."	C1512			

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C1512	Continued From page 7 On 3/28/19, Nurses Notes document the APRN came to assess the resident for increased behaviors in the evening. The Depakote dosage was increased On 3/29/19, Nurses Notes document the resident has an "ongoing issue of stuffing paper towel in his anus" and "it has been reported to Dr. in the past." Prior to this date, there was no documentation completed by the Center of this behavior, or reporting of this behavior. Resident #4 started exhibiting inappropriate sexual behaviors and aggression on 1/14/19. There is no indication the Center put any measures in to place to ensure resident #4's behavior did not affect or involve other residents. Resident #4 was ambulatory and had access to all residents in the Center and also shared a bathroom with another resident, resident #3. The April 2019 Physician orders and MAR had "agitation" added to the resident's diagnoses. The RN Consultant and LPN/DON reviewed and signed the physician orders and were aware of the increased agitation. On 4/02/19, an additional Nurse's Note (written out of sequence and on a separate nurses note) documented staff walked into the residents' bathroom, (shared by resident #3 and #4) and resident (#4) "was standing behind another memory impaired resident (#3) holding his erect penis." Resident #3 was observed leaning over the sink "drinking water out of the faucet." The note documented resident #4 had pulled resident #3's "pants and underwear down and was attempting to mount from behind." On 4/02/19, Nurses Notes document resident #4	C1512		

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C1512	Continued From page 8 was transferred to a Geri-psych facility for "aggressive sexual behaviors." On 04/02/19, when resident #4 was transferred to the Geri-psych facility for evaluation, the Center still had not completed a Significant Change Assessment for resident #4 up to 4/02/19, even though the behaviors were escalating. The failure to monitor, assess, and address resident #4's increasingly sexualized behaviors on a practical basis, placed all other vulnerable residents at risk of victimization by those sexually aggressive behaviors, and non-consensual sexual activity, for approximately a three month period of time that culminated in the sexual assault of resident #3 on 4/02/19. The Center also had not updated the resident's care plan with interventions specific to the resident's sexual disorder and sexual behaviors. There were no interventions added to the care plan to minimize/eliminate the observed behaviors. There was no indication the Center's staff was monitoring resident #4's whereabouts at all times and not allowing resident #4 to be alone with other residents while exhibiting the sexual behaviors. There was no documentation the Center was evaluating the appropriateness of resident #4's continued placement in the Center. On 04/03/19, the Geri-psych physician's admission note documented, resident #4 had escalating agitation and confusion being sexually inappropriate and disinhibited trying to have sex with a lower functioning client. The resident had been upset about loss of independence with no previous mental health history. The resident had episodes of hostility with auditory and visual hallucinations and paranoia. On the document "Monthly Assignment Form" for	C1512			

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ARBOR HOUSE REMINISCE

**151 48TH AVENUE SOUTHWEST
NORMAN, OK 73072**

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C1512	Continued From page 9 April 2019, there was no plan or indication for resident #4 to be more closely monitored. The form did document resident #4 walks indoors and outdoors and "gets up during the night." Highlighted on the form was staff instruction "Do not disturb" during the night. On the "Monthly Assignment Form" for May 2019, after the incident with resident #3, resident #4 was to have "2 hour checks" for toileting and "every hour wellness checks" for engagement and interests. There was no mention of the inappropriate sexual behavior identified on 4/02/19 and the resident was not even present in the facility when the May "Monthly Assignment Form" was completed. The resident was transferred from the Center on 4/02/19 and did not return to the Center. This failure to address the resident's behaviors and develop a plan of care to protect the other vulnerable residents, all diagnosed with cognitive impairment, placed the other residents at risk of being exposed to resident #4's sexual behaviors and possible nonconsensual sexual activity for approximately a 3 month time frame. On 5/07/19, resident#4 was still undergoing geropsychiatric evaluation when he expired. On 7/17/19, employee #3 hand wrote a statement of the incident as it was observed by the employee on 4/02/19. Employee #3 documented she informed the LPN/DON on 4/02/19 of what she had witnessed. Employee #3 was not asked until 7/17/19 to provide a written "statement" In the hand written statement, employee #3 documented she walked in to the shared bathroom and "resident #4 had his penis in resident #3's anus." The employee was not asked to provide a written statement on or after 4/02/19 as part of an investigation because no	C1512		

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ARBOR HOUSE REMINISCE

**151 48TH AVENUE SOUTHWEST
NORMAN, OK 73072**

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C1512	Continued From page 10 investigation was conducted. According to the Administrator, the incident was not reported and the LPN/DON did not complete an incident report. On 7/31/19 at 9:32a.m., employee #3 was interviewed and asked about behavior monitoring sheets/logs. Employee #3 stated if residents start having behaviors, the staff will "start behavior sheets." On 7/31/19 at 1:52p.m., the Administrator stated the incident was not reported and she was not aware the incident of 4/02/19 had occurred. The Administrator further stated that the RN Consultant told her that no penetration occurred, but there was neither documentation nor other evidence to demonstrate how such information was obtained to contradict the eyewitness statement. Even after resident #4 was admitted to the Geri-psych facility on 4/02/19, no internal investigation was conducted. Since no investigation was conducted and documented, it could not be determined what actually occurred and there were some discrepancies regarding what was observed and what was relayed by staff internally. On 7/31/19 at 2:19p.m., the RN Consultant and Administrator were asked for the Behavior Monitoring sheets for resident #4. They both stated "the behavioral monitoring sheets were "used internally" and refused to provide the documentation. Even though the RN Consultant and Administrator would not provide behavior monitoring sheets/behavior documentation, the Center's direct care staff were interviewed and all interviewed stated there were behavior sheets for residents that were kept in the ADL books and	C1512		

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C1512	Continued From page 11 when the resident was discharged, the sheets were sent to the DON's office. On 7/31/19 at 2:43p.m., the RN Consultant was asked if an incident report had been submitted to OSDH. The RN Consultant stated there was no incident report "because residents are allowed to have relationships, it's their right; they have the right to be affectionate to each other." The RN Consultant was asked if resident #3 had the capacity to consent and she replied "yes," however there was no recent assessment of resident #3 to indicate the resident had capacity or was capable of consenting and there was no way to validate the RN Consultants response. She also stated "if don't want sex or touch, they're going to be kicking, yelling, screaming." The RN Consultant was informed resident #3 was bent over the sink drinking water with his hands when resident #4 made contact from behind. The RN Consultant stated "when inappropriate, resident lets you know." There was also no documentation the spouses of either resident were informed of the incident on 4/02/19. According to the Administrator, resident #4's spouse was only informed that resident #4 was having some sexual behaviors. On 7/31/19 at 2:54p.m., the Administrator stated she could not understand why it was not okay for these 2 residents to have a consensual sexual relationship, she felt it was consensual. She also stated "there was a different story" relayed to her. On 8/06/19 at 11:12a.m., employee #3 stated when she walked in to the bathroom, resident #4 looked at her (employee #3) but resident #3 "was trying to drink water out of (the) sink with one hand." She stated when she reported the incident	C1512		

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C1512	Continued From page 12 to the LPN/DON (employee #6) she was told to separate them (resident's #3 and #4) and the Center was going to send resident #4 to Geri-psych." Employee #3 stated the LPN/DON was in the building during the incident. Employee #3 was asked about the staff's monitoring of resident #4 and his whereabouts and employee #3 stated resident #4 would be checked on by staff to make sure "he was getting up in the morning and make sure he was taking meds." On 8/06/19 at 12:15p.m., the Administrator stated when she became aware of the incident on 7-17-19, she talked with the LPN/DON (no longer employed) and was told by the LPN/DON that "nothing had actually happened." The Administrator didn't doubt the information until she spoke with employee #8 and employee #3 and both relayed what had actually happened. The Administrator relayed that employee #3 told her she had been told by the LPN/DON "to say nothing" and the Administrator requested employee #3 prepare a written statement about "exactly what happened" which resulted in the hand written witness statement dated 7/17/19. On 8/08/19 at 12:18, the APRN was interviewed and stated she thought resident #4's behaviors were improving as reported by the Center's staff in March (2019.) When asked if all staff was aware of resident #4's sexual behaviors, she stated "2 LPN's and care aides" were aware but was not sure about the Administrator and RN (Consultant.) The APRN also stated she was aware that resident #4's sexual behaviors were recorded "consistently for several weeks" but she did not know a number. She also stated she thought the Center was monitoring resident #4 24	C1512			

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C1512	Continued From page 13 hours a day. The APRN stated she had recommended resident #4 be admitted to a Geri-psych in January (2019) but "the family wasn't interested at that time" and there was no documentation the Center was involved in the decision. On 8/08/19 at 3:34p.m., employee #6 was interviewed and stated she believed resident #3 and #4 both had the capacity to consent. She stated the Regional Consultant did not feel the incident report was required because the residents "weren't touching" and no investigation was conducted because the resident's "weren't touching." She also stated resident #4 was monitored "at times" and the wife (of resident #4) would monitor "one on one, on and off maybe two or three times due to aggression." Employee #6 stated that on 4/02/19, employees #3 and #7 informed her about the incident between resident #3 and #4 and she was told the residents were "not having sex." Employee #6 stated she "assessed resident #3" after the incident and "talked to the Administrator, families, Regional Nurse and physician." Since she was told there was no sexual contact, no investigation was conducted and when she contacted the Regional Nurse, she was told it was not reportable. On 8/13/19 at 10:34a.m., employee #8 stated resident #4 "was aggressive, he'd walk around building masturbating and he would stuff things up his bottom." Employee #8 was asked about behavior monitoring sheets and stated behavior logs are "supposed to be in the ADL's" and "if we were told	C1512		

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C1512	Continued From page 14 anything or saw anything or needed to redirect we needed to put in behavior log." On 8/13/19 at 11:17a.m., employee #7 stated when she opened the shared bathroom door, "resident #4 was messing with resident #3's behind." She stated she went and reported to employee #3 what she saw and brought employee #3 back to the resident's room. Employee #7 stated she reported the incident to the LPN/DON at the time it happened and the LPN/DON would have completed the incident report. When asked if resident #3 had the ability to consent, employee #7 replied "I don't think so " The Center failed to provide Behavior Monitoring sheets after repeated requests by the surveyors during the 6 day investigation. No documentation was provided verifying resident #4 was being supervised and the resident's sexual behaviors were being monitored consistently and routinely and if resident #4's behaviors were affecting other residents. Resident #3 Resident #3 admitted to the Center on 8/24/18. The preadmission assessment, dated 08/21/18, included diagnoses of hypertension (HTN), hyperlipidemia, and gout. The resident was also diagnosed with arthropathy (disease of the joints.) The Centers assessment, for resident #3, documented resident #3 was alert, forgetful and had good judgement; good mobility, good strength, and fair gait. The assessment did not identify resident #3's orientation. The resident ambulated without assistance and was continent of both bladder and bowel and was independent	C1512		

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C1512	Continued From page 15 with toileting at admission. However, resident #3 did decline and would require staff assistance for incontinent care and hygiene. On 8/23/18, Nurses Notes documented resident #3 was admitted on 8/23/18, even though other forms documented the resident was admitted 8/24/18. The note documented the resident was accompanied by his wife and daughter and was oriented to self and family at admission. On 9/17/18, Nurses Notes documented resident #3 became agitated and was chasing and swinging at staff. Ativan was administered and was "unsuccessful." The physician was notified and ordered a Geropsychiatric evaluation. The Physician documented he contacted the Center and was informed about resident #3 being aggressive towards staff. This aggression was not addressed on the resident's assessments, in the nursing notes, or in the care plan. Resident #3's wife informed the physician this was new behavior, the resident was always "very gentle, never showing anger, until recently" and his "cognitive function has declined significantly in the last year." On 9/18/18, resident #3 was transported to the Geri-psych facility for evaluation and treatment. Resident #3 did not return to the Center until 10/11/18. On 10/11/18, resident #3 returned to the Center with new medications: Depakote for "Manic Phase of Manic-Depression," Ativan for "agitation," Namenda for "Moderate to Severe Alzheimer's Disease," Olanzapine for "behavioral disorders associated with dementia." On 10/11/18, the Center conducted a Significant	C1512		

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C1512	Continued From page 16 Change of Condition assessment due to resident #3's fall risk increasing from a 4 to a 7. The resident's communication skills also declined from "good" communication to "fair" communications. On 11/20/18, Nurses Notes documented the APRN to the Center to assess resident #3's signs and symptoms (s/s) of sedation. Olanzapine/Zyprexa, an atypical antipsychotic, had been ordered and was decreased to 5 mg (milligrams) BID (twice a day). On 1/03/19, Nurses Notes document resident #3 was noted to have problems swallowing and the diet was changed from a regular diet to a mechanical soft with chopped meat. The APRN came to the Center to assess resident #3 for signs and symptoms of dysphagia (difficulty swallowing) and recommended a swallow study and the family refused. On 01/03/19, the APRN documented on a Progress Note, "is struggling with swallowing medications. Seems to be drooling more." The APRN also ordered medications crushed. On 01/17/19, Nurses Notes document the APRN assessed resident #3 at the Center and changed the diet to mechanical soft with thickened liquids. On 01/31/19, Nurses Notes document the APRN to Center for follow up on "increased aggression" reported by care staff. On 1/31/19, the APRN documented on a Progress Note resident #3 had "Increased agitation with adl's (activities of daily living) and personal care. Facility reports more aggressive at night."	C1512		

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C1512	Continued From page 17 On 2/14/19, the APRN assessed resident #3 at the Center and discussed the results of the swallow study with wife. The swallow study "showed inability to swallow" and there was a recommendation for the resident to go NPO (nothing by mouth.) The wife had signed a dietary waiver on 2/05/19 for resident #3 to continue to consume food orally. The APRN also started dosage reductions on medications to evaluate if new medications ordered while at Geri-psych were contributing to the dysphagia (difficulty swallowing.) On 03/14/19, the APRN documented on a Progress Note resident #3 had weight loss. Resident #3's weight was 126 pounds on 1/17/19 and 115 pounds on 3/14/19. Resident #3 lost 8.7 percent body weight between 1/17/19 and 3/14/19. On 4/02/19, there was no documentation in the Nurses Notes about the incident that occurred between resident #3 and resident #4 on 4/02/19. There was no documentation in the Nurses Notes between the dates 3/14/19 and 4/04/19. On 4/04/19 at 8:30a.m., Nurses Notes document the resident "with audible congestion, decline in condition." The Center had a conversation with the wife and it was determined resident #3 would be admitted to hospice services instead of sending to the hospital. However, at 10:30a.m., on 4/04/19, resident #3 expired in the Center. The death certificate documented resident's cause of death was "aspiration pneumonia" due to "dysphagia" as a result of "end stage dementia." On 7/17/19, employee #3 was asked to provide a hand written statement, as a witness to the	C1512			

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C1512	Continued From page 18 incident that occurred on 4/02/19. Employee #3 documented "I walked into the shared bathroom (of the 2 rooms) where resident #4 had his penis in resident #3's anus." On 7/17/19, the Administrator typed a statement that documented the following: "It was brought to my attention today that two male residents (names) allegedly had anal sex on April 2, 2019." The Administrator documented she interviewed employee #3 who "allegedly saw it" and employee #3 stated she walked in on the "two men with (resident #4's) penis in (resident #3's) anus." The Administrator relayed employee #3 stated she reported the incident and she "did report it to the Director of Nursing." (That DON is no longer an employee.) On the same typed statement, the Administrator documented she interviewed three other employees and asked if they were aware of any issues, relationships, or any events with resident #3 and #4. "All three employees had never witnessed any unusual events with the two gentlemen. Both men seemed happy in demeanor during their stay at (Center's name)." The Administrator documented "I am not moving forward with any additional investigation. Both residents have passed away and there is no evidence to believe that either resident had a distressed relationship with the other." No documentation of an investigation, other than the above typed statement, was provided during the 6 days of the investigation. On 07/30/19 at 10:54a.m., employee #3 was asked about resident #3 and resident #4. She stated "on 04/02/19 around lunch time, the two male residents were located behind a closed	C1512			

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C1512	Continued From page 19 bathroom door. The bathroom joined both of their rooms. Resident #3 was leaned over the sink drinking water from the faucet and resident #4 was having anal sex with resident #3." She further stated the residents were separated and the LPN/DON (employee #6) was notified. She stated resident #4 was sent to the Geri-psych facility on 4/02/19 and resident #3 died (within 48 hours after the incident on 4/02/19) from aspiration (breathing fluid into the lungs). On 7/30/19 at 2:43p.m., the RN Consultant stated there was no incident report "because residents are allowed to have relationships. It's their right - they have the right to be affectionate to each other." The RN Consultant stated resident #3 and #4 had the capacity to consent. She also stated "if they don't want it done they're going to let you know." Since there was no documentation, it could not be determined how the RN Consultant determined both residents were capable of consenting. On 7/31/19 at 9:32a.m., employee #3 was asked about resident behaviors. Employee #3 stated "if they start having behaviors they have us start behavior sheets - then they get sent to Geri-psych." On 7/31/19 at 9:34a.m., employee #4 was asked about resident behaviors. Employee #4 stated when residents start having behaviors, staff "start behavioral sheets, report to nurse and (the nurse) tries to find out what's going on - different interventions - notifies physician, changes meds If no improvement, sent to psych for eval." On 7/31/19, at 1:52p.m., the Administrator stated "they (residents #3 and #4) were already passed away when (the Administrator) found out about it."	C1512		

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C1512	Continued From page 20 When asked if the families were notified of the incident on 4/02/19, the Administrator stated resident #4's wife was informed of his behaviors but "neither family would know because (Administrator) found out 2 weeks ago." The Administrator did state that she was being told different stories after she found out about the incident. When asked if an investigation was conducted, the Administrator stated "only what I put in the chart." During the interview, the Administrator was asked if an incident report was submitted to the Oklahoma State Department of Health, reporting a possible allegation of sexual abuse, and the Administrator stated there was some question whether it was a "state reportable" or was "this private" or "was it abuse" or "was it a relationship." No incident report was received by the Department after the incident on 4/02/19 or after the Administrator became aware of the incident in July 2019. On 8/13/19 at 10:34, employee #8 stated resident #3 would come out of his room and "spread his ... cheeks wanting us to look and he seemed stressed out." Employee #8 stated resident #3 did this "for about a month before the incident (on 4/2/19)" and stated resident #3 would usually "show his bottom" to employees (#3 and #7.) Employee #8 was asked if resident #3 could consent and she stated resident #3 was "too low function to be able to consent to anything at that point. (Resident #3) could not have fought against anything, could not have done anything." Employee #8 stated Behavior Monitoring Logs are "supposed to be in the ADL's" and stated she was told "if we were told anything or saw anything	C1512		

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C1512	Continued From page 21 or needed to redirect, we needed to put in the behavior log." She stated when the resident was discharged; the logs would go to the nursing office. On 8/13/19 at 11:17a.m., Employee #7 stated she had witnessed an incident between residents #3 and #4. She stated resident #3 would go in to the bathroom and drink regular water from the faucet (he was on thickened liquids.) Employee #7 stated when she walked in to the bathroom, she observed resident #3 standing up with his pants down, facing the wall. Resident #4 was behind him with his pants down. She stated (resident #4) "was messing with (resident #3's) behind. (Resident #3's) "private parts were exposed, pants were down." She immediately left the bathroom and got employee #3. Employee #3 stayed with resident #3 and employee #7 took resident #4 to the dining room. (It was lunch time.) When asked why she went to the resident's room in the first place, she stated she was getting them to come out for lunch. Employee #7 stated she did report it to the DON (employee #6) "at the time" but later she stated she only told employee #3. She stated she believed employee #3 reported it to the DON (employee #6, who is no longer employed by the Center.) Employee #7 stated she didn't think an incident report was written. She stated the DON "works incident reports." When asked if resident #3 would be able to consent, employee #7 replied, "I don't know, I don't think so, no." She stated she was not aware of resident #3 and #4 having a consensual relationship." She stated after the incident "we had to keep an eye on (resident #3) at all times."	C1512		

Oklahoma State Department of Health

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NAME OF PROVIDER OR SUPPLIER ARBOR HOUSE REMINISCE		STREET ADDRESS, CITY, STATE, ZIP CODE 151 48TH AVENUE SOUTHWEST NORMAN, OK 73072		
(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) COMPLETE DATE
C1512	Continued From page 22 Resident #3 expired after the incident, which occurred around noon on 4/02/19. The death certificate listed resident #3's cause of death at 10:19a.m., on 4/04/19, as "aspiration pneumonia." According to the Center's documentation, resident #3's health began declining in the month of January 2019; resident #4's hyper sexuality increased in the month of January 2019. The Center's failure to act and provide supervision and monitoring of resident #4 and failure to put interventions in place to protect all residents resulted in an unreasonable risk of harm to other vulnerable residents of the Center. Because the residents shared a bathroom between their two rooms, with doors entering from each room, resident #4 had access to resident #3 without leaving his room or alerting staff that he was entering another resident's room. Marketing Materials Welcome Statement: Philosophy is based on the belief that each resident is entitled to the highest quality of life through wellness services that work to promote independence, healthful lifestyles, dignity, and a sense of security. The right of each resident to determine his/her needs is respected at each level of care and promoted by providing services in ways that recognize each resident's individual needs and preferences. A partnership exists between residents and staff to promote individual independence while providing the necessary support to keep each resident functioning at his/her highest level of well-being.	C1512		

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C1512	Continued From page 23 The Finer Things in Life: Our personalized services are designed for those who desire the finer things in life. Since we believe life improves with age, we have created special services and a carefree environment that promotes independence and dignity without all of the concerns associated with maintaining a home. The array of fine services we offer reflect our goal of enhancing quality of life for our residents. Most importantly, our services are delivered with respect and sensitivity. We understand that individual needs vary, so our personalized services are tailored to meet the specific needs of each resident. Whether it be a hobby, exercise, or leisure, we offer our residents the opportunity to pursue individual desires. All the best in life in the company of good friends, the indulgence of gracious amenities, and the security of caring, personalized services await you. We invite you to become a part of our special residence dedicated to providing you with the best in life. MISSION: To give new meaning to life to seniors by providing high-quality service in a comfortable, secure environment given with a spirit promoting dignity and respect. Life Style: Our residents receive 24 hour support and caring tailored to meet your individual needs and wishes. Be relaxed in pleasant surrounding that look and feel like home. Enjoy being catered to and the personal freedom that comes from a helping hand. Memory Care: We specialize in caring for those people who are	C1512		

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C1512	Continued From page 24 walking the journey with a dementia causing disease such as Alzheimer's. We are committed to supporting both the person with the diagnosis and all those affected by it. What Makes Us the Best? Memory Care Specialized Community Care and Caring is delivered by trusted Friends! Our team members get to know your loved one as more than a resident or patient, but as a Friend! This concept of the Best Friends Approach to Caring described by Troxell & Bell, allows your loved one to develop a trusting relationship with a particular few team members that will eat meals with them, plant a garden with them, sing with them, and of course, play bingo with them. These same team members will also oversee their medication and personal needs. The friendship that develops during engagement helps reduce stress and paranoia during time of care...often reducing the need for medications which are designed to do the same thing! POLICY: Protecting and Ensuring Resident Rights The Director will be an advocate for resident rights. Protecting Vulnerable Adults: To Identify and immediately report suspected abuse of vulnerable adults. 1. "Vulnerable adult" means an individual who is an incapacitated person or who, because of physical or mental disability, incapacity, or other disability, is substantially impaired. For example, a resident of the memory-care unit would be considered a vulnerable adult. 2. Vulnerable adults are afforded special	C1512		

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C1512	Continued From page 25 protections by Oklahoma law. 3. Team members must immediately report to the Director suspected abuse of a vulnerable adult. 4. Any team member who knowingly and willfully fails to promptly report any abuse, neglect, or exploitation may face civil and criminal penalties. CONTRACT: The resident admission agreement documented: 4. ADMISSIONS A. Admission Criteria for residents at the Community include: g) Behaviors. May have behavior problems if these problems can be controlled as a result of behavior management, medication, family, home health agency, or mental health interventions 8. TERMINATION OF AGREEMENT B. By the Community The Community may terminate this Agreement by transferring or discharging the Resident if: i. transfer is for the Resident's welfare and the Resident's needs cannot be met by the Community; or ii. Resident's health and safety of the health and safety of another resident would be endangered if the transfer or discharge was not made Anytime the Community believes that the Resident is at unusual risk due to a Resident, Responsible Party and/or Resident's health care representative's decision or preference, a Negotiated Risk Agreement will be required. ADDENDUM: Resident Discharge Criteria: a) Care for residents whose needs exceed the care or services available in the Community. b) Care for residents who pose a threat to self or	C1512		

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C1512	Continued From page 26 others. c) Care for residents if unable to meet the resident's needs for privacy or dignity. EXHIBIT A STATEMENT OF RESIDENT'S RIGHTS To ensure that resident rights are respected and protected To inform residents of their rights and provide an environment in which they can be exercised Our residents have the right to... 1. Be treated with dignity and respect. 4. Privacy. 6. Be treated fairly, courteously, and with respect by all staff. 11. Be free of physical or psychological abuse from staff, family, and other residents. 21. Be consulted and encouraged to have input into their assistance/service plan, which guides the services delivered to the resident.	C1512		
C1914 SS=G	310:663-19-1(d) REPORTS TO THE DEPARTMENT (d) Each assisted living center shall report to the Department those incidents specified in 310:663-19-1(b). An assisted living center may use the Department's Long Term Care Incident Report Form. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to prepare an internal incident report and submit the required incident report to the Oklahoma State Department of Health (OSDH) for 2 (#3 and #4)	C1914		

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C1914	Continued From page 27 of 2 residents who were allegedly involved in resident to resident abuse. Because the Center's Registered Nurse believed the sexual contact was consensual and not an incident, an incident report was not completed. This failure to complete an incident report internally also resulted in the Center not conducting an investigation. This failed practice resulted in isolated actual harm. Findings: On 04/02/19 there was an incident between two cognitively impaired residents involving resident to resident sexual assault. Resident #4 was sent to a Geri-psych facility on 4/02/19 for medical evaluation and treatment after being observed in a sexually inappropriate situation with resident #3 on 4/02/19. Resident #3 died within 48 hours after the incident (04/04/19) after the resident had aspirated (breathed fluid into the lungs). On 07/31/19 at 1:52 p.m. the Registered Nurse (RN) and Administrator stated no Incident Report was submitted to the Department because it was believed the sexual contact was consensual. At 1:55 p.m. the Administrator was asked if the family of each resident were notified. She stated there would have been nothing to gain, except upsetting two families. At 2:54 p.m. the Administrator was asked how the Center determined sexual contact between 2 cognitively impaired residents was considered to be consensual. She stated in the past, she, the RN and the Chief Operating Officer (COO) would visit with the resident's power of attorneys, but there was no documentation, no updated	C1914		

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C1914	Continued From page 28 assessments, no updated care plans for either resident. There was no training/in-service for staff about residents' capacity to consent to sexual relationships. Even though the Administrator stated the incident had been consensual, at the time of the incident the residents were immediately separated, resident #3's private area was assessed, and resident #4 was transferred to a Geri-psych facility for medical evaluation, treatment and one on one supervision. POLICY Incidents/Accidents 1. If an occurrence or event leads to unintentional consequences or an unfortunate happening to a resident, visitor, or team member, an Incident/Accident Report must be completed. 2. Notify the Director as soon as possible. 3. When in doubt, complete the incident report. If the form has been completed, the Director should be notified. Notify Regional Support. 4. Incidents requiring report. The Community must prepare a written report for the following incidents: a. allegations and incidents of resident abuse; b. allegations and incidents of resident neglect; c. allegations and incidents of misappropriation of resident's property; f. deaths by unusual occurrence, including accidental deaths or deaths other than by natural causes; j. incidents that result in fractures, spinal cord injury, head injury or require treatment at a hospital; - l situations arising where a criminal act is	C1914		

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C1914	Continued From page 29 suspected. Such situations shall also be reported to local law enforcement. Make every effort to preserve the scene until law enforcement has arrived. 6. Timeline for reporting. All reports to the Department shall be made via facsimile or by telephone within one (1) business day of the reportable incident's discovery. A follow-up report of the incident shall be submitted via facsimile or mail to the Department within five (5) days after the incident. The final report shall be filed with the Department within ten (10) days after the incident.	C1914		
C1951 SS=G	310:663-19-3(a) MAINTENANCE OF RECORDS (a) There shall be an organized, accurate, clinical record, typewritten, electronic, or legibly written with pen and ink, for each resident admitted. The resident's record shall document all services provided under the direction of a licensed health care professional consistent with professional standards of practice. This Rule is not met as evidenced by: Based on interview and record review it was determined the Center failed to provide an organized and accurate clinical record for #3 and resident #4. The Center failed to: a. update a resident assessment after a significant change; b. develop an accurate care plan with interventions for 1 (#4) of 1 resident who had a documented sexual disorder and sexually acted	C1951		

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C1951	Continued From page 30 out; c. have staff monitor and document all aggressive and sexually inappropriate behaviors displayed by resident #4, in the clinical record or on behavior monitoring logs; d. complete an incident report when resident #4 was observed in a sexually inappropriate situation with resident #3 e. document the incident in resident #3's clinical record; e. conduct and document an investigation to determine if the relationship/sexual contact was voluntary or if resident #4 sexually abused resident #3. This failed practice resulted in isolated actual harm. Findings: Resident #4 admitted to the center 10/23/18 with diagnoses to include dementia, gastroesophageal reflux disease (GERD) and hypertension (HTN). The January 2019 physician order and medication administration record (MAR) also included insomnia, benign prostatic hypertrophy and dementia as diagnoses. The registered nurse reviewed and signed that she had reviewed the physicians orders. The Center, the Advanced Practice Registered Nurse/APRN and Physician ncontinued to document resident #4's increase in aggressive behaviors and sexually inappropriate behaviors from January 14, 2019 until April 2, 2019. The center's floor staff stated there were behavior sheets, but when the Registered Nurse and Administrator were asked to provide this documentation on 07/31/19 at 2:19 p.m., they stated the behavioral monitoring sheets were used internally and not part of the resident's chart	C1951		

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C1951	Continued From page 31 and would not provide the behavior logs even with repeat requests. Without an organized, accurate, clinical record, it could not be communicated to all staff the level of care the resident needed or how the Center could or could not meet the needs of this resident or protect and keep all other cognitively impaired residents safe if unable to protect themselves. Due to lack of documentation, it could not be determined if the Center was proactive and protecting other residents or actually negligent and not increasing supervision and monitoring of resident #4, with resulting harm and/or unreasonable risk of harm to resident #3 and the other vulnerable adults residents. POLICY Resident Records 2. Daily documentation in a shift-to-shift report is necessary. Documentation shall be from direct team members reporting only their shift's activity. Documentation will be made of an activity, event, incident that is not usual for the resident or change in level of assistance occurs. If nothing unusual happens, the team member will enter N/C for No Complaints. Assessments To assure the proper level of care is being provided, and the resident's needs can be met under assisted living licensure. 1 The Community shall use the results of the resident's assessment for the following: a. to assist in determining the appropriateness of the resident's placement;	C1951		

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C1951	Continued From page 32 c. to develop a care plan for the resident in consultation with the resident and POA (power of attorney).	C1951		
C1971 SS=G	310:663-19-4(b) POLICIES (b) The administrator of the assisted living center who becomes aware of abuse or neglect of a resident or misappropriation of a resident's property shall immediately act to rectify the problem and shall make a report of the incident and its correction to the Department. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to immediately act to rectify the problem and follow their written policy and report an allegation of resident abuse to the appropriate authorities for 2 (#3 and #4) of 2 residents after being aware of a resident to resident alleged sexual abuse incident. Per staff interviews, the LPN/DON was informed at the time of the incident, but no Incident Report was completed. The Center failed to complete and submit an Incident Report to the Department and conduct and document an investigation, after becoming aware of the incident 3 months later This failed practice resulted in isolated actual harm. Findings: On 07/30/19 employees were asked about resident #3 and resident #4. Two employees stated they were present 04/02/19, around lunch time, after locating the two residents behind a closed bathroom door that joined both of their rooms. Resident #3 was leaned over the sink	C1971		

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C1971	Continued From page 33 drinking water from the faucet with his hand and resident #4 appeared to be having anal sex with resident #3 while bent over drinking water. The residents were separated and the LPN/DO was notified. Resident #4 was sent to Geri-psych and resident #3 died within 48 hours later after aspirating (breathing fluid into the lungs). On 07/31/19 at 2:00 p.m. the Administrator was asked if she had done an investigation. She stated, "Only what I put in the chart." This document was a one page narrative documenting staff had been interviewed about resident #3 and #4's relationship. The LPN/DON did no investigation 04/02/19 after the incident was reported to her by staff. The one page narrative, dated, 07/17/19, and signed by the Administrator documented, "At this time, I am not moving forward with any additional investigation. Both residents have passed away and there is no evidence to believe that either resident had a distressed relationship with the other." No documentation was provided to indicate a complete investigation had been conducted to determine if there was involvement with other residents and no incident report was provided. POLICY PREVENTION: The Management Team is required to accept all allegations of abuse and conduct a complete investigation including reporting to the proper authorities. All reports whether from family, residents or team members will be reported immediately to the administrator and D.O.N. (director of nursing). NO team	C1971		

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C1971	Continued From page 34 member, resident or visitor shall receive reprisals from the reporting of allegations of abuse. Team members are required to intervene, identify and correct situations where any type of abuse may occur. After the allegations of abuse are reported to the D.O.N. and the Administrator, an incident report is completed, and forwarded to the Safety Committee and Quality Improvement Committee. INVESTIGATION: 1. Any accused team member will be immediately removed from contact with the resident suspected of being abused and the resident's safety will be protected. 2. The Administrator and the D.O.N. will conduct an investigation. 3. Other team members may be consulted. 4. The investigation team will interview all parties concerned: witnesses, the victim, team members and the accused. 5. The investigation will proceed and conclude by fact-finding, root cause analysis and comparison of information. 6. The results of the investigation will be provided to the proper authorities, Quality Improvement Committee, Attending Physician, Resident and family members of the resident with five (5) days of the reported incident. 7. Appropriate steps will be taken to assure the abuse situations do not reoccur in the future. 8. The Administrator or D.O.N. will report all allegations of abuse, alleged violation and substantiated incidents to the state agency. The Administrator or D.O.N. will report the incident to the licensing board if the Community determines that actions by a court of law against an employee indicate that the individual is unsuited to work in a nursing home. Protecting and Ensuring Resident Rights	C1971			