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Healthcare Licensing and Surveys

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	C 08/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE HEALTH CARE CENTER	2700 E 12TH STREET CHEYENNE, WY 82001

(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 A complaint survey was conducted by Healthcare Licensing and Surveys on 8/14/17 through 8/15/17. The survey was prompted by complaint intake #WY00002459. The following common abbreviations are used throughout this document: BIMS- Brief Interview for Mental Status CNA- Certified Nurse Aide DDCS- District Director of Clinical Services DON- Director of Nursing Services LPN- Licensed Practical Nurse MDS- Minimum Data Set NHA- Nursing Home Administrator RCA- Resident Care Assistant (CNA) RN- Registered Nurse SW- Social Worker Less commonly used abbreviations will be annotated in each deficiency.	F 000	Preparation 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 of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. The plan of correction serves as the facility's allegation of compliance.	
F 223 SS=G	483.12(a)(1) FREE FROM ABUSE/INVOLUNTARY SECLUSION 483.12 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 symptoms. 483.12(a) The facility must- (a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;	F 223	**F 223** **Corrective Action** Ongoing visits of resident #2 and ~~husband~~ spouse occur with supervision by staff in public area and staff intervention if needed. The structure of these visits will be re-evaluated by the IDT as needed. The care plan for resident #2 was updated on 9/7/17 to include potential safety concerns. A BIMs Interview was conducted with resident #2 on 8/30/17.	10/13/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brenda J. Hancock — TITLE: NHA — (X6) DATE: 10/13/17

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 223	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on medical record review, resident interview, staff interview, guardian interview, incident review, and sexual abuse policy review the facility failed to ensure 1 of 3 sample residents (#2) selected to review potential abuse issues was free from abuse. This failure resulted in harm to the resident. The findings were: Medical record review showed resident #2 was admitted to the facility on 1/19/16 and had diagnoses which included hemiplegia, anxiety disorder, cerebral vascular accident, depression, and bipolar disorder. Review of the 8/1/17 quarterly MDS assessment showed the resident's BIMS (brief interview for mental status) score was 9, indicating moderate cognitive impairment, and the resident required extensive assistance of 2 staff members for transfers and bed mobility. Review of the resident's care plan showed staff were required to utilize a Hoyer lift for transfers. Further record review showed a 7/31/17 form signed by the resident's legal guardian which gave consent for the resident to engage in sexual relations with his/her spouse. Review of nursing and social services notes dated 8/3/17 showed the resident and his/her spouse utilized a room set aside in the facility for intimacy. The following concerns were identified: 1. Review of the resident's care plan showed a plan for use of the intimacy room dated 8/14/17 (11 days after the resident and his/her significant other utilized that room for intimacy). Further review of the resident's care plan revealed a 3/10/16 plan with an 8/8/17 update that showed as a focus "[The resident] has a behavior problem weeping, refusing to shower/bathe, refusing pain	F 223	**Identification of Others** There are no other residents who have requested to have private intimate time with a spouse or any other individual at this time. Should any resident choose to have private time with another individual they will be interviewed by the social worker for the desire to participate, safety risks and a safety care plan will be put in place. **Systemic Change** Education was provided to the facility staff related to Resident Abuse, Reporting Resident Abuse, Sexual Behavior with Residents and Universal Precautions and completed on 9/8/17 by the Staff Development Coordinator. Education was provided to the staff related to resident/visitor safety on 10/13/17. Residents are separated from the alleged perpetrator at the time of report to protect the resident. If the alleged perpetrator is a staff member or visitor they will not be allowed to return to the facility until the investigation is complete Reports of abuse or allegations of abuse are investigated by the NHA/designee and reported to the appropriate agencies per the CMS guidelines. **Monitoring** The NHA reports concerns related to any	

10/13/17 - This POC accepted between Ray Blevins, DON and Tony Madden, Health Surveyor with agreed to changes.

10/18/17

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F 223	Continued From page 2 medication then accusing staff of not treating [his/her] pain." Interventions included the following: "Encourage resident and spouse to interact in public areas or leave door to resident room [open] while spouse is visiting [initiated 3/10/16], "and "Intervene as necessary to protect [the resident's] rights and safety. Remove from situation as indicated [initiated 7/14/17]." Interview with the DON on 8/15/17 at 3:40 PM confirmed the care plan. The DON stated that she believed the intervention to leave the door open when the spouse visited resulted from a staff member observing the resident's spouse fondling the resident's breasts. 2. Interview with the resident's guardian on 8/16/17 at 1:05 PM revealed that she and the resident had never met. The guardian based the consent for the resident to engage in sexual relations with his/her spouse on a phone call with the resident and a phone call with the administrator. 3. Interview with LPNs #1 and #2 on 8/14/17 at 7:50 PM showed each nurse found the resident to be confused at times, and both questioned whether the resident had the cognitive ability to make an informed decision regarding sexual intimacy. They stated that administration was aware of their concerns. Interview with CNAs #1 and #2 on 8/14/17 at 8:10 PM showed each CNA felt the resident was often confused and had difficulty with simple decisions, and both felt the resident did not have the capacity to make an informed decision regarding sexual intimacy. They stated that administration was aware of their concerns. Interview with CNA #3 on 8/14/17 at 8 PM revealed the CNA felt the resident was intermittently confused. Interview with CNA #4 on	F 223	type of reported abuse to the Quality Assurance Performance Improvement Committee Monthly for their review and resolution. This process is ongoing and monitored by the NHA monthly.	

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F 223	Continued From page 3 8/15/17 at 9:30 AM revealed the resident was confused at times and did not know what was going on. Interview with CNA #5 on 8/15/17 at 9:44 AM revealed the resident was confused at times. Interview with CNA #6 on 8/15/17 at 3:05 PM revealed she felt the resident was intermittently confused, and she felt the resident was not capable of making an informed decision regarding sexual intimacy. She added the resident would be unable to recall later in the day what s/he had eaten for breakfast. She stated that administration was aware of her concerns. 4. Interview with CNAs #1 and #2 on 8/14/17 at 8:10 PM revealed the resident utilized the intimacy room with his/her spouse on 8/3/17 around 1 PM. Medical record review showed the following documentation on 8/3/17: i. By the NHA at 13:30 (1:30 PM), "NHA received a call from the therapy director stating that one of his staff was concerned about the intimate time provided to [resident and spouse]. He was told that the staff member stated [the resident] was covered in bruises and blood. NHA immediately called the nurse on duty and told her what had been reported. Nurse [#1] asked why the therapist would think that and stated the CNA who got [the resident] up did not report anything. Requested that she conduct a head to toe assessment of [the resident] to see if there were injuries." ii. By the NHA at 19:30 (7:30 PM), "NHA received return call from nurse [#1] who reported no blood, no bruises. She did state that [the resident's] nipples looked red and that [the resident's spouse] had shaved [the resident's] pubic area. NHA interviewed both CNAs who attended [the resident] after [the spouse] left and each stated there was no blood and no bruising.	F 223		

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F 223	Continued From page 4 They did state that [resident's spouse] shaved [the resident's] pubic area. NHA notified DDCS of report. Police came to the facility and interviewed [the resident]. The police had no findings." iii. By licensed nurse (#2) at 20:00 (8 PM), "Earlier this afternoon, resident had been in the private room with [resident's spouse] who had left afterwards without anyone knowing. Resident in room staring up at the ceiling and [the resident's] face was very flush [sic]. Resident very quiet. RCAs went in to clean [the resident] and get [the resident] up. Once back in [the resident's] room, I went to speak with [the resident] and [the resident] told me [the resident's spouse] had been twisting [the resident's] nipples and it hurt and [the resident] told [the resident's spouse] to stop and [the resident's spouse] told [the resident] to be quiet or [the resident's spouse] won't be able to come back to see [the resident]. I checked [the resident's] nipples which were red but at this time there was no bruising. Also RCAs reported a lot of hair on the blankets, that [the resident] had been shaved in [his/her] pubic area. I asked resident about this and the resident stated [s/he] heard something when [s/he] asked [the resident's spouse] what it was and [the resident's spouse] told [the resident] it was none of [the resident's] concern and took [the resident's] electric razor [the resident's spouse] had brought from home and shaved [the resident's] pubic area and [the resident] had told [the resident's spouse] to stop. I did note [the resident's] pubic being shaved close and some areas showed razor burn. When asked why [the resident's spouse] did this [the resident] stated [the resident's spouse] does not like long. I asked if [the resident] knew the day and [the resident] didn't know, [the resident] did know what month it was. [The resident] also told me [his/her] mother always	F 223		

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F 223	Continued From page 5 said there would come a point in your life that you just lay there and let them have their way." iv. By licensed nurse (#3) on 8/7/17 at 20:17 (8:17 PM), "Resident voiced thank you to this nurse and on shift CNAs stating [s/he] liked [his/her] visit in the living room with [the resident's spouse] much better than alone in a room, resident stated [s/he] does not like how [the resident's spouse] acts with [the resident] when they are alone that [s/he] tells [the resident's spouse] no but [the resident's spouse] doesn't listen to [him/her]." 5. Review of an incident investigation related to the 8/3/17 use of the facility intimacy room by the resident and the resident's spouse showed the following: i. Documentation from the customer services representative on 8/3/17 at 3:30 PM included the following, "...When I returned from [unknown staff member #1's] office I saw the staff were upset at the desk, the door was open, [spouse of the resident] gone, and the staff emotions had escalated. I asked [SW #1] to talk to [the resident]. [SW #1] came back visibly upset and furious that [the resident's spouse] had shaved [the resident] and that [the resident] had a dazed look on [his/her] face. [The resident] also described the incident in great detail... The staff said they didn't know about the private room and hadn't had any education on what to do. I found out at this point that the facility had called the police in the past due to [the resident's spouse] rough fondling causing [the resident] to bleed, and [the resident] crying that [the resident's spouse] was hurting [him/her]...They said they had no training in cleaning up semen and that they have had no education on how to handle this situation. Therapy staff were very vocal about	F 223		

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F 223	Continued From page 6 what should have been done prior to any use of the private room. I advised the staff that I had told [the resident's spouse] to wait until I was finished with my meeting to continue our conversation. The staff emotions escalated to a point it had to be quieted down..." ii. Documentation on 8/4/17, unsigned, related to conversation with the resident's legal guardian, "Spoke to [the resident's] guardian explained what occurred and staff concerns. Education provided to staff. She continues to support [the resident's] wishes." iii. From the 8/3/17 Concern Form for CNA #7, "At around 3:30 PM, a staff member asked me if I could come and help her get [the resident] out of the bed in the Intimacy Room. When we went in, the first thing I noticed was the smell. It was awful. [The resident] was laying in bed. [S/he] looked terrified. We asked [the resident] if [s/he] was okay. [The resident] told us that [s/he] was sore. Then got everything set up to change [the resident]. When we pulled back the sheet that was covering [him/her], there was something on the sheets that looked like it could have either been blood or it could have been BM [bowel movement]. There was pubic hair all over the bed. [The resident] had also been shaved in [his/her] pubic area. I was told 7/21/17 that [the resident's spouse] used to be abusive towards [the resident] and had been found fondling [the resident] in their room while they were alone. 6/15/17 (ish) I was told that we shouldn't leave [the resident] and [the resident's spouse] alone in the same room because [the resident's spouse] hits [the resident]...Right before dinner I talked with [customer services representative] about what I had seen while I was in [the resident's] room. [SW #1] has walked over and was getting visibly angrier at the situation... [The resident] has	F 223		

10/12/17

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F 223	Continued From page 7 also been abused by [the resident's spouse] before. As someone who has been abused by her husband before, [the resident] isn't just going to throw [his/her] abuser under the bus if [the resident's spouse] hurts [him/her], for fear of being hurt again. At shift change we had also been told that [the resident's spouse] had told [the resident] that [s/he] had to tell us yes to them having sex or else." Further review of the Concern Form for CNA #7 showed she had marked yes for, "Have you previously voiced concern to a staff member." iv. From the 8/3/17 Concern Form for CNA #8, "On August 3, 2017 at approximately 2:00 PM [the resident] and [the resident's spouse] were together in the intimacy room. During this time [the resident's spouse] shaved [the resident's] pubic area before they proceeded to have intercourse, no cuts or wounds were found from said action... After [the resident's spouse] had left, which [s/he] did without informing anyone that they were finished and left [the resident] unattended, we found [the resident] in a state of shock, flushed, wide eyed and not talking..." Further review of the Concern Form for CNA #8 showed she had marked yes for, "Have you previously voiced concern to a staff member." 6. Review of the medical records, care plan, and 8/3/17 incident investigation failed to show any interventions for resident safety were developed or implemented after the 8/3/17 incident. 7. Review of progress notes and the 8/13/17 suspected abuse investigation showed the following: a. Review of a progress note dated 8/13/17 at 1400 (2 PM) documented by LPN #2 showed, "When walking by resident's room CNA heard	F 223		

10/17/17

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F 223	Continued From page 8 resident yelling out for help and came to get me. Went into room and [resident's spouse] was leaning over [the resident]. I asked [the resident's spouse] to step out of the room. When asking resident what was wrong [the resident] stated that '[The resident's spouse] was playing with me and [s/he] was getting rough. I asked [him/her] to stop and [s/he] said no. [The resident's spouse] didn't understand for a minute and wouldn't stop being rough.' When asked if [s/he] was in pain at the moment [the resident] stated no. I stepped out of the room and [the resident's spouse] had left the building." b. Review of a progress note dated 8/14/17 at 14:30 (2:30 PM) documented by the NHA showed, "NHA notified of resident concern from 8/13/17 at approximately 11:30 AM by [LPN #2]. NHA interviewed [the resident] who stated to the NHA that [the resident's spouse] was 'tickling me and it got rough. I asked [him/her] to stop and [s/he] said no. [The resident's spouse] didn't understand why so I waited until someone who I knew would help me and when I saw her I called out for help, she came in and [the resident's spouse] stopped.' When asked if [the resident's spouse] touching was something that [the resident] wanted [the resident's spouse] to do, [the resident] said yes. NHA notified DDCS, sent an initial report to the state and notified the police. Officer [officer's name] arrived and interviewed [the resident] with NHA present. [The resident] told the officer the same thing. [The resident] stated [s/he] welcomed [the resident's spouse's] touch, but when it got rough [the resident] wanted [the resident's spouse] to stop [the resident's spouse] didn't until the CNA entered the room. The officer was unsure at the time that she left if there was a crime with this event." c. Review of an 8/13/17 Suspected Abuse	F 223		

8/14/17

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F 223	Continued From page 9 Investigation showed the following, "Resident stated [spouse] was 'tickling [the resident]' had fingers in the [genital] area. [The resident] stated [s/he] welcomed the touch but [the resident's spouse] got rough and [the resident] asked [him/her] to stop and [the resident's spouse] said no." d. Review of an unsigned statement dated 8/14/17 showed "[LPN #2] came into the NHA office about 11:30 AM stating [the resident] was yelling the day before and the CNA [#6] went into the room and [the resident's spouse] was leaning over [the resident]. [CNA #6] got [LPN #2] and asked [the resident's spouse] to leave the room for a moment. [LPN #2] asked [the resident] why [the resident] was yelling out. [The resident] stated, '[The resident's spouse] was playing with me and [s/he] was rough. I asked [him/her] to stop and [s/he] said no. [The resident's spouse] didn't understand for a minute and wouldn't stop being rough.' [LPN #2] asked if [the resident] was in pain and [the resident] said no. When she stepped out of the room [the resident's spouse] had left the building." e. Review of an unsigned statement dated 8/15/17 showed "[CNA #5], stated she didn't see [the resident's spouse] with [the resident] or touching [the resident], but went in the room with [LPN #2]. She stated that [the resident] told them that [the resident's spouse] was playing with [the resident] and was rough and [the resident] told [the resident's spouse] to stop and [the resident's spouse] said no. So [the resident] yelled out at someone in the hall and when she came in [the resident's spouse] stopped." f. Interview with CNA #5 on 8/15/17 at 1:23 PM revealed on 8/13/17 she was working at the facility. She stated another CNA on shift with her heard the resident "hollering" from [his/her] room,	F 223		

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F 223	Continued From page 10	F 223		

so they went in to check on the resident. The resident's spouse was seen in the room, leaning over the resident and talking. The CNAs requested the spouse to leave the room, and the CNA stated the resident made the comment that the spouse "was rough" and [his/her] hands were "down the resident's pants."

g. Interview on 8/15/17 at 3:05 PM with CNA #6 revealed she had just started her shift on the afternoon of 8/13/17 when she heard yelling coming from the resident's room. She stated she saw the resident's spouse with [his/her] hand under the resident's blanket "pushing on [the resident]," and the resident had said it hurt. She stated she went and got another CNA and the nurse, and they asked the resident's spouse to leave. She added the resident was "pretty confused" most of the time and stated she did not think "[the resident] really understands it."

8. Further review of the medical record failed to show any interventions for resident safety were developed or implemented after the 8/13/17 incident.

9. Interview with the resident on 8/14/17 at 8:29 PM revealed his/her spouse had come to visit earlier that evening, and had left "about an hour" earlier (the day after the incident of 8/13/17, and 11 days after the incident of 8/3/17).

10. Interview on 8/15/17 at 3:40 PM with the NHA and DON revealed the facility policy if a resident expressed fear, discomfort, or the desire not to be left alone with someone was to "separate those people," and if it was a staff member to do an investigation. The DON added she "would treat it very differently if it was a staff member. A [spouse] is very different than staff." They stated

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F 223	Continued From page 11 the day of 8/3/17, after the resident and spouse had utilized the intimacy room, rumors began that the resident had bruising. At that time the NHA instructed the nurse to complete a head to toe assessment of the resident. She also stated they had considered the possibility of abuse, but ultimately determined it was the personal sexual practices of the resident and his/her spouse. The NHA added that on the night of 8/14/17, staff called the DON to say the resident's spouse was in the facility, and the DON instructed staff to tell the resident and ask what s/he wanted. They revealed the resident had given conflicting statements to different staff members regarding his/her experience in the intimacy room with his/her spouse. The NHA confirmed there was no care plan in place at the time of the 8/3/17 use of the intimacy room by the resident and his/her spouse, and that they had "discussions" with staff regarding resident choices, rights, and to be respectful toward the resident. The DON stated she considered the resident to be cognitive enough to make decisions regarding sexual consent and safety, but that it was a "gray area." 11. Review of the policy titled, "Sexual Behavior" last revised on July 2016 showed the following under "Residents with Cognitive Loss": "Sexual activity between willing residents with cognitive loss is sometimes a concern among staff. Residents may not have full capacity to make decisions about all aspects of their lives, but they may have the capacity to consent to sexual relations. Residents' rights in such situations must be discussed with the resident and his or her legal surrogate and individual determinations made on a case-by-case basis." The following was noted under "Procedure": "1. Staff will identify a resident's sexual expressions and	F 223		

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F 223	Continued From page 12 behavior and determine whether the behavior is appropriate, inappropriate, or abusive. 2. If the sexual expression or behavior is determined to be abusive: a. Nursing staff will take appropriate action to protect the alleged victim and the rights of other residents and staff as required, b. The behavior is reported to the Director of Nursing or the Administrator and the facility policies for the identification, response and reporting of abuse to the appropriate agencies are followed, c. The residents' attending physicians and the Medical Director are notified, d. A resident Incident/Accident/Report is completed and submitted using the Risk Management Information System."	F 223		
F 225 SS=G	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.	F 225	**F 225** **Corrective Action** The cited incident on 8/3/17 was reported to the Wyoming Department of Health on 8/18/17. The cited incident on 8/13/17 was reported to the Wyoming Department of Health on 8/14/17 within the 24 time frame. Ongoing visits of resident #2 and husband occur with supervision by staff in public area and staff intervention if needed. The structure of these visits will be re-evaluated by the IDT as needed. The care plan for resident #2 was updated on 9/7/17 to include potential safety concerns. A BIMs Interview was conducted with resident #2 on 8/30/17. **Identification of Others** There are no other residents who have requested to have private intimate time with a spouse or any other individual at this time. Should any resident choose to	10/3/17

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F 225	Continued From page 13 (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and	F 225	have private time with another individual they will be interviewed by the social worker for the desire to participate, safety risks and a safety care plan will be put in place. **Systemic Change** Education was provided to the facility staff related to Resident Abuse, Reporting Resident Abuse, Sexual Behavior with Residents and Universal Precautions and completed on 9/8/17 by the Staff Development Coordinator. Education was provided to the staff related to resident/visitor safety on 10/13/17. Residents are separated from the alleged perpetrator at the time of report to protect the resident. If the alleged perpetrator is a staff member or visitor they will not be allowed to return to the facility until the investigation is complete Reports of abuse or allegations of abuse are investigated by the NHA/designee and reported to the appropriate agencies per the CMS guidelines. **Monitoring** The NHA reports concerns related to any type of reported abuse to the Quality Assurance Performance Improvement Committee Monthly for their review and resolution. This process is ongoing and monitored by the NHA monthly.	

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F 225	Continued From page 14 if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on medical record review, resident interview, staff interview, incident review, sexual abuse policy review and abuse and neglect policy review, the facility failed to ensure 1 of 2 abuse investigations selected for review (regarding resident #2) was reported to the State Survey Agency. In addition, the facility failed to ensure the safety of 1 of 1 resident (#2) who was the subject of an abuse investigation. This failure resulted in harm to the resident. The findings were: Medical record review showed resident #2 was admitted to the facility on 1/19/16 and had diagnoses which included hemiplegia, anxiety disorder, cerebral vascular accident, depression, and bipolar disorder. Review of the 8/1/17 quarterly MDS assessment showed the resident's BIMS (brief interview for mental status) score was 9, indicating moderate cognitive impairment. The review showed the resident required extensive assistance of 2 staff members for transfers and bed mobility. The care plan showed staff were required to utilize a Hoyer lift for transfers. Further record review showed a 7/31/17 form signed by the resident's legal guardian which gave consent for the resident to engage in sexual relations with his/her spouse. Review of nursing and social services notes dated 8/3/17 showed the resident and his/her spouse utilized a room set aside in the facility for intimacy. The following concerns were identified: 1. Review of the resident's care plan revealed a 3/10/16 plan with an 8/8/17 update that showed	F 225		

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F 225	Continued From page 15 as a focus "[The resident] has a behavior problem weeping, refusing to shower/bathe, refusing pain medication then accusing staff of not treating [his/her] pain." Interventions included "Encourage resident and spouse to interact in public areas or leave door to resident room [open] while spouse is visiting [initiated 3/10/16]," and "Intervene as necessary to protect [the resident's] rights and safety. Remove from situation as indicated [initiated 7/14/17]." Interview with the DON on 8/15/17 at 3:40 PM confirmed the care plan. The DON stated she believed the intervention to leave the door open when the spouse visited resulted from a staff member observing the resident's spouse fondling the resident's breasts. 2. Interview with CNAs #1 and CNAs #2 on 8/14/17 at 8:10 PM revealed the resident utilized the intimacy room with his/her spouse on 8/3/17 around 1 PM. Medical record review showed licensed nurse (#2) documented the following on 8/3/17 at 8 PM: "Earlier this afternoon, resident had been in the private room with [resident's spouse] who had left afterwards without anyone knowing. Resident in room staring up at the ceiling and [the resident's] face was very flush [sic]. Resident very quiet. RCAs went in to clean [the resident] and get [the resident] up. Once back in [the resident's] room, I went to speak with [the resident] and [s/he] told me [the resident's spouse] had been twisting [the resident's] nipples and it hurt and [the resident] told [the resident's spouse] to stop and [s/he] told [the resident] to be quiet or [the resident's spouse] won't be able to come back to see [him/her]. I checked [the resident's] nipples which were red but at this time there was no bruising. Also RCAs reported a lot of hair on the blankets, that [the resident] had been shaved in [the resident's] pubic area. I	F 225		

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F 225	Continued From page 16 asked resident about this and the resident stated [s/he] heard something when [s/he] asked [the resident's spouse] what it was and [the resident's spouse] told [the resident] it was none of [his/her] concern and took [the resident's] electric razor [the resident's spouse] had brought from home and shaved [the resident's] pubic area and [the resident] had told [the resident's spouse] to stop. I did note [the resident's] pubic being shaved close and some areas showed razor burn. When asked why [the resident's spouse] did this [the resident] stated [the resident's spouse] does not like long. I asked if [the resident] knew the day and [the resident] didn't know, [the resident] did know what month it was. [The resident] also told me [the resident's] mother always said there would come a point in your life that you just lay there and let them have their way." 3. Review of the note written by licensed nurse (#3) on 8/7/17 at 8:17 PM showed "Resident voiced thank you to this nurse and on shift CNAs stating [the resident] liked [the resident] visit in the dining room with [the resident's spouse] much better than alone in a room, resident stated [s/he] does not like how [the resident's spouse] acts with [the resident] when they are alone that [the resident] tells [the resident's spouse] no but [the resident's spouse] doesn't listen to [the resident]." 4. Review of an incident investigation related to the 8/3/17 use of the facility intimacy room by the resident and the resident's spouse showed the following: i. From the 8/3/17 Concern Form for CNA #7, "At round 3:30 PM, a staff member asked me if I could come and help her get [the resident] out of the bed in the Intimacy Room. When we went in, the first thing I noticed was the smell. It was	F 225		

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F 225	Continued From page 17	F 225		

awful. [The resident] was laying in bed. [The resident] looked terrified. We asked [the resident] if [s/he] was okay. [The resident] told us that [s/he] was sore. When got everything set up to change [the resident]. When we pulled back the sheet that was covering [the resident], there was something on the sheets that looked like it could have either been blood or it could have been BM [bowel movement]. There was pubic hair all over the bed. [The resident] had also been shaved in [his/her] pubic area. I was told 7/21/17 that [the resident's spouse] used to be abusive towards [the resident] and had been found fondling [the resident] in their room while they were alone. 6/15/17 (ish) I was told that we shouldn't leave [the resident] and [the resident's spouse] alone in the same room because [the resident's spouse] hits [the resident]...Right before dinner I talked with [Customer Services Representative] about what I had seen while I was in [the resident's] room. [SW #1] has walked over and was getting visibly angrier at the situation...[The resident] has also been abused by [the resident's spouse] before. As someone who has been abused by [their spouse] before, [the resident] isn't just going to throw [his/her] abuser under the bus if [the resident's spouse] hurts [him/her], for fear of being hurt again. At shift change we had also been told that [the resident's spouse] had told [the resident] that [s/he] had to tell us yes to them having sex or else." Further review of the Concern Form for CNA #7 showed she had marked yes for, "Have you previously voiced concern to a staff member."

ii. From the 8/3/17 Concern Form for CNA #8, "On August 3, 2017 at approximately 2:00 PM [the resident] and [the resident's spouse] were together in the intimacy room. During this time [the resident's spouse] shaved [the resident's]

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F 225	Continued From page 18	F 225		

pubic area before they proceeded to have intercourse, no cuts or wounds were found from said action. However, before consent could be verified it was told by another CNA that [the resident's spouse] was in [the resident's] room telling [him/her] that [s/he] had to say yes and give consent or else. Therefore, [the resident] gave consent to have intercourse with [the resident's spouse].

5. Review of the medical record, care plan and the 8/3/17 incident investigation failed to show any interventions for resident safety were developed or implemented after the 8/3/17 incident.

6. Interview on 8/15/17 at 3:40 PM with the NHA and DON revealed the facility policy if a resident expressed fear, discomfort, or the desire not to be left alone with someone was to "separate those people," and if it was a staff member to do an investigation. During the interview, they each agreed that an abuse investigation had been done regarding the 8/3/17 incident. However, they confirmed the facility had failed to notify the State Survey Agency of the allegation. In addition, they both confirmed there was no plan in place before or after 8/3/17 until 8/14/17 (1 day after a second incident) to ensure the resident was made safe.

7. Review of a progress note dated 8/13/17 at 1400 (2 PM) documented by LPN #2 showed, "When walking by resident's room CNA heard resident yelling out for help and came to get me. Went into room and [resident's spouse] was leaning over [the resident]. I asked [the resident's spouse] to step out of the room. When asking resident what was wrong [the resident] stated that '[The resident's spouse] was playing with me and

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F 225	Continued From page 19 [the resident's spouse] was getting rough. I asked [him/her] to stop and [s/he] said no. [The resident's spouse] didn't understand for a minute and wouldn't stop being rough.' When asked if [the resident] was in pain at the moment [the resident] stated no. I stepped out of the room and [the resident's spouse] had left the building." 8. Review of a progress note dated 8/14/17 at 14:30 (2:30 PM) documented by the NHA showed, "NHA notified of resident concern from 8/13/17 at approximately 11:30 AM by [LPN #2]. NHA interviewed [the resident] who stated to the NHA that [the resident's spouse] was 'tickling me and it got rough. I asked [the resident's spouse] to stop and [the resident's spouse] said no. [The resident's spouse] didn't understand why so I waited until someone who I knew would help me and when I saw her I called out for help, she came in and [the resident's spouse] stopped.' When asked if [the resident's spouse] touching was something that [the resident] wanted [the resident's spouse] to do, [the resident] said yes. NHA notified DDCS, sent an initial report to the state and notified the police. Officer [officer's name] arrived and interviewed [the resident] with NHA present. [The resident] told the officer the same thing. [The resident] stated [the resident] welcomed [the resident's spouse's] touch, but when it got rough [the resident] wanted [the resident's spouse] to stop [the resident's spouse] didn't until the CNA entered the room. The officer was unsure at the time that she left if there was a crime with this event." 9. Review of the 8/13/17 Suspected Abuse Investigation showed the following: "Resident stated [spouse] was 'tickling [the resident]' had fingers in the [genital area]. [The resident] stated	F 225		

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F 225	Continued From page 20 [s/he] welcomed the touch but [the resident's spouse] got rough and [the resident] asked [the resident's spouse] to stop and [the resident's spouse] said no." 10. Review of an unsigned statement dated 8/14/17 showed the following: "[LPN #2] came into the NHA office about 11:30 AM stating [the resident] was yelling the day before and the CNA [#6] went into the room and [the resident's spouse] was leaning over [the resident]. [CNA #6] got [LPN #2] and asked [the resident's spouse] to leave the room for a moment. [LPN #2] asked [the resident] why [the resident] was yelling out. [The resident] stated, '[The resident's spouse] was playing with me and [the resident's spouse] was rough. I asked [the resident's spouse] to stop and [the resident's spouse] said no. [The resident's spouse] didn't understand for a minute and wouldn't stop being rough. [LPN #2] asked if [the resident] was in pain and [the resident] said no. When she stepped out of the room [the resident's spouse] had left the building." 11. Interview with CNA #5 on 8/15/17 at 1:23 PM revealed she was working at the facility on 8/13/17. She stated another CNA on shift with her heard the resident "hollering" from his/her room, so they went in to check on the resident. The resident's spouse was seen in the room, leaning over the resident and talking. The CNAs requested the spouse to leave the room, and the CNA stated the resident made the comment that the spouse "was rough" and his/her hands were "down the resident's pants." 12. Interview on 8/15/17 at 3:05 PM with CNA #6 revealed she had just started her shift on the afternoon of 8/13/17 when she heard yelling	F 225		

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F 225	Continued From page 21 coming from the resident's room. She stated she saw the resident's spouse with his/her hand under the resident's blanket "pushing on [the resident]," and the resident had said it hurt. She stated she went and got another CNA and the nurse, and they asked the resident's spouse to leave. She added the resident was "pretty confused" most of the time and stated she did not think "[the resident] really understands it." 13. Further review of the medical record failed to show any interventions were put into place for resident safety after the 8/13/17 incident. 14. Interview with the resident on 8/14/17 at 8:29 PM revealed his/her spouse had come to visit earlier that evening, and had left "about an hour" earlier (the day after the incident of 8/13/17, and 11 days after the incident of 8/3/17). 15. Interview on 8/15/17 at 3:40 PM with the NHA and DON confirmed the resident's spouse was not told to stay away from the facility after the 8/3/17 incident or the 8/13/17 incident, until 8/14/17 after 8 PM (State surveyors entered the facility on 8/14/17 at 7:48 PM). They further confirmed staff had called the DON on 8/14/17 when the resident's spouse entered the facility. The DON stated she told the staff to ask the resident if s/he wanted a visit from his/her spouse and the resident said yes. 16. Review of the policy titled, "Sexual Behavior" last revised on July 2016 showed the following under "Residents with Cognitive Loss", "Sexual activity between willing residents with cognitive loss is sometimes a concern among staff. Residents may not have full capacity to make decisions about all aspects of their lives, but they	F 225		

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F 225	Continued From page 22 may have the capacity to consent to sexual relations. Residents' rights in such situations must be discussed with the resident and his or her legal surrogate and individual determinations made on a case-by-case basis." The following was noted under "Procedure", "1. Staff will identify a resident's sexual expressions and behavior and determine whether the behavior is appropriate, inappropriate, or abusive. 2. If the sexual expression or behavior is determined to be abusive: a. Nursing staff will take appropriate action to protect the alleged victim and the rights of other residents and staff as required, b. The behavior is reported to the Director of Nursing or the Administrator and the facility policies for the identification, response and reporting of abuse to the appropriate agencies are followed, c. The residents' attending physicians and the Medical Director are notified, d. A resident Incident/Accident/Report is completed and submitted using the Risk Management Information System." 17. Review of the policy titled, "Abuse and Neglect Prohibition" revised January 2017 showed the following under "Protection", "1. The facility will protect residents from harm during the investigation." Under "Reporting and Response" showed the following, "The facility will report all allegations and substantiated occurrences of abuse...to the administrator, State Survey Agency, and law enforcement officials and adult protective services...in accordance with State law through established procedures. Timeline for reporting is as follows: a. If the events that caused the allegation involve abuse or result in serious bodily injury, a report is made not later than 2 hours after the management staff becomes aware of the allegation..."	F 225		

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	535025	A. BUILDING _____ B. WING _____	C 08/15/2017

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F 226 SS=E	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, concern form review, and review of staff education documentation, the facility failed to	F 226	**F 226** **Corrective Action** Education was provided to the staff related to the resident's right to share intimate time together, resident consent, sexual coercion, sexual abuse, universal precautions and completed on 9/8/17 by the SDC. **Identification of Others** Any resident who chooses to share intimate time with another person has the potential to be affected. **Systemic Change** Education was provided to the staff related to the resident's right to share intimate time together, resident consent, sexual coercion, sexual abuse, universal precautions and completed on 9/8/17 by the SDC. Education related to the resident's right to share intimate time together, resident consent and sexual coercion have been added to general orientation of new employees. The topics of abuse (sexual or other) and universal precautions continue to be part of general orientation with new employees. Education was provided to the staff regarding the changes in the safety care plan for resident #2 on 10/13/17. **Monitoring**	10/13/17

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F 226	Continued From page 24 ensure staff were educated in a timely manner regarding implementation of a room to be utilized for resident and significant other intimacy. The findings were: Review of a 7/27/17 Training Attendance document showed that staff were informed about a "private room" to be set aside in order to provide residents with a private area for general privacy and sexual engagement. At that time the document provided information about resident comfort and protection from sexually transmitted diseases, but no education on related issues such as consent, sexual coercion or sexual abuse was included. Review of nursing and social services notes dated 8/3/17 showed that a facility resident and spouse utilized a room set aside in the facility for intimacy. The following concerns were identified: a. Interview on 8/14/17 at 8 PM with CNA #3 revealed she had "no idea" what her role was concerning utilization of the room set aside for resident privacy and intimacy at the time the room was utilized on 8/3/17. Interview with CNAs #1 and #2 on 8/14/17 at 8:10 PM showed each CNA felt expectations concerning what to do if issues arose when residents and their significant others utilized the room set aside for privacy were not made clear at the time the room was utilized on 8/3/17 by a resident and his/her spouse. Documentation from the customer services representative on 8/3/17 at 3:30 PM included the following, ..."The staff said they didn't know about the private room and hadn't had any education on what to do...They said they had no training in cleaning up semen and that they have had no education on how to handle this situation. b. Review of an 8/3/17 Concern Form from CNA #7 after the 8/3/17 incident regarding the	F 226	The NHA reports and concerns related to abuse training or related information to the Quality Assurance Performance Improvement Committee Monthly for their review and resolution. These reports will continue for 3 months unless the Committee deems it prudent.	

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F 226	Continued From page 25 resident's use of a private room revealed the following: "I brought up the question of why we hadn't been trained on any of this or been told of any protocol we had to follow before this was put into place." c. Review of a 8/4/17 Training Attendance document (1 day after a resident and his/her spouse utilized the private room) showed staff were educated on use of the private room set aside for privacy and intimacy. d. Interview on 8/15/17 at 3:40 PM with the NHA and DON revealed they felt the staff should have known what to do when the private room was utilized by residents and their significant others because they had talked about it. However, they confirmed that the formal education occurred on 8/4/17, the day after the room was utilized by a facility resident and spouse.	F 226		

10/17/18