

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

PRINTED: 10/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345346	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/12/2008
NAME OF PROVIDER OR SUPPLIER FOREST VIEW REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5935 MOUNT SINAI ROAD DURHAM, NC 27705	
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F 223 SS=K	<p>483.13(b), 483.13(b)(1)(i) ABUSE</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to protect cognitively impaired residents (Resident #1 and Resident #8) from being sexually assaulted by other residents (Resident #7 and Resident #9) for 2 of 6 residents reviewed.</p> <p>Immediate Jeopardy began on 3/11/08 and is ongoing. The Immediate Jeopardy was identified on 9/8/08 at 11:30 AM and brought to the attention of the administrator. Findings include:</p> <p>1. Resident #7 was admitted to the facility on 8/4/07 and discharged on 9/1/08. The resident's cumulative diagnoses included Cerebral Vascular Disease, Aphasia and Hypertension. Review of the annual Minimum Data Set (MDS) dated 1/18/08 indicated that the resident had no short term memory loss, no long term memory problems and was independent in daily decision making abilities. Review of the most recent quarterly MDS on 7/18/08 indicated that the resident had no short term memory loss, no long term memory problems and was independent in daily decision making abilities.</p> <p>Review of the care plan for Resident #7 dated</p>	F 223		

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

TITLE

(X6) DATE

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	<p>Continued From page 1</p> <p>1/21/08 did not indicate sexually inappropriate behavior. Review of the care plan for Resident #7 indicated an entry dated 3/11/08 Problem/Need- Inappropriate sexual behavior with another resident. Goal and Target Date-Resident will not be inappropriate with other female residents times 90 days. Approaches- included 1. psych eval 2. appropriate meds as ordered 3. 1:1 staffing to monitor behaviors which were discontinued on 3-13-08 4. Counseling. On 3/14/08 15 minute checks of the resident were discontinued.</p> <p>Resident #1 was admitted to the facility on 6/22/07. The resident's cumulative diagnoses included Brain Injury, Bipolar Disorder, Schizoaffective Disorder and Hypertension. Review of the quarterly MDS dated 8/15/08 indicated that the resident had short term memory loss, long term memory loss and was moderately impaired in daily decision making abilities. The resident was non ambulatory and needed extensive assistance with dressing and bathing. The resident was incontinent of bowel and bladder. Behavioral symptoms were identified as socially inappropriate/ disruptive behavior.</p> <p>Review of the care plan for Resident #1 dated 2/26/08 indicated Problem/Need- Mood and behaviors related to brain injury and schizoaffective disorder. Resident with STM (short term memory)/LTM (long term memory) deficits with poor decision making skills. She curses, spits, kicks and yells at staff during ADL (activities of daily living) care at times, she receives antipsychotic meds. Under Problem/Need and dated 5/29/08 Resident has displayed no behavior recently but will continue CP (care plan). Approaches included in part</p>	F 223			

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F 223	<p>Continued From page 2</p> <p>Social Worker to visit frequently as needed- Approach resident warmly and positively in a calm manner-Monitor and document resident behaviors and status. Report any changes in cognition to physician. Approaches included Resident with increased agitation on 4/7/08 hit another resident. Intervention: follow up with psych with med change 4/9/08. Monitor for increased behaviors around others. 4/9/08. In the area of Comments 1) Resident with increased sexual aggression. Monitor direct supervision 1:1 until further notice 9/5/08. 2) Psych intervention as needed 3) involve in divisional activities 4) notify nurse/MD with increase in behaviors.</p> <p>Review of the Nurse's Notes for Resident #1 dated 9/1/08 at 1 PM written by Unit Coordinator (UC) #2 indicated that the UC had been notified by the resident's nurse and nurse aide (NA) that " when the assigned NA went into the resident ' s room (Resident #1) she (NA) observed a male resident (Resident #7) lying on top of her with her legs open, and apart, with her adult brief pulled to the side. The male resident was observed with his pants pulled down and that he was trying to pull his pants up quickly. The undersigned nurse (UC #2) along with her NA asked her (Resident #1) what he was doing she stated he was on me, and put his thang in me." UC #2 further indicated in her note that she remained in the room of resident #1 until the NA cleaned the resident as she had had a bowel movement and noted "some shiney [sic: shiny] substance on her perineal area." The resident appeared quiet, calm and in no apparent distress.</p> <p>During an interview on 9/4/08 at 2:25 PM UC #2 indicated that she had been called to the unit on 9/1/08 and told by NA #1 and NA #4 that they had</p>	F 223			

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F 223	<p>Continued From page 3</p> <p>seen Resident #7 in the room of Resident #1 and he was seen on top of Resident #1, that Resident #7's penis was out and his pants were down. Resident #1's legs were apart and the incontinent brief was pushed to the side. UC #2 went to Resident #1 ' s room and Resident #1 said that he (Resident # 7) was on top of me and had his thing in me. The UC then indicated that Resident #1 became confused. The UC pulled back her brief and she (Resident #1) had stool on her and a shiny substance was on the stool. UC #2 then went to Resident #7 ' s room and noticed that he had on gym pants with stool on the waistband. Resident #7 denied that he had been in the room of Resident #1.</p> <p>During an interview on 9/4/08 at 2:40 PM NA #1 indicated that on 9/1/08 while walking down the hall with NA #4 she looked in the room of Resident #1 and the curtain was pulled . NA #1 saw feet moving and entered the room. As NA #1 and NA #4 entered the room NA #1 saw Resident #7 on top of Resident #1 with his penis out. Resident #1 was just lying there and she had feces on the front of her. NA #1 indicated that Resident #7 jumped off the bed through the space between the top and bottom side rails, turned his back, placed his penis in his pants and quickly walked out of the room.</p> <p>During an interview on 9/6/08 at 3:10 PM NA #4 indicated that on 9/1/08 while walking in the hall with NA #1 they walked in the room of Resident #1. The curtain was pulled and the side rails were up on the bed of Resident #1. NA #4 saw Resident #7 on top of Resident #1. Resident #1 was not talking, the brief was pushed to the side and the resident had stool on the brief. NA #4 indicated that Resident #7 jumped off the bed and</p>	F 223			

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F 223	<p>Continued From page 4 began to adjust his pants.</p> <p>Review of the Nurse's Notes dated 9/2/08 at 9:15 AM and written by the director of nurses (DON) indicated that the note was a late entry for 9/1/08 at 5PM. The DON indicated that the DON and female police officer entered the room of Resident #1. The police officer questioned the resident related to the incident with Resident #7. Resident #1 stated that the male resident had cursed her and had gotten on her. Resident #1 " stated that she did not want him to " (Resident #7). Resident #1 was cleared by the police to be sent to the emergency room.</p> <p>During an interview on 9/6/08 at 11:15 AM UC #2 indicated that because Resident #1 needed to be cleaned of stool before transport to the hospital she called the NP for the resident ' s physician and UC #2 spoke to the emergency room. UC #2 was told by the emergency room nurse to wash the stool off the resident prior to transport. UC #2 did not change the clothes of Resident #1.</p> <p>Review of the Nurse's Notes indicated that the resident was transported to the emergency room and returned to the facility on 9/1/08 at 11:30 PM.</p> <p>Review of the emergency room report dated 9/1/08 at 11:03 PM for Resident #1 indicated that the resident was examined, a rape kit was given to the police and the resident was discharged back to the facility. Diagnosis on discharge from the emergency room was Sexual Assault.</p> <p>Review of the Nurse's Notes dated 9/1/08 at 1:15 PM and completed by UC #1 for Resident #7 indicated that the resident was placed on a 1:1 monitoring by staff.</p>	F 223			

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F 223	<p>Continued From page 5</p> <p>Review of the Nurse's Notes dated 9/1/08 at 4:30 PM and completed by UC #1 for Resident #7 indicated that the resident was transported to the emergency room.</p> <p>Review of the record indicated that Resident #7 did not return to the facility. The resident was transferred to another hospital facility.</p> <p>During an observation on 9/4/08 at 12:20 PM Resident #1 was observed in her room in bed. Resident #1 was confused and asking that a carton of potato chips be ordered. The resident asked that the door be closed "to keep the glass off her body."</p> <p>During an observation on 9/5/08 at 9:10 PM Resident #1 was observed in her room in a Geri chair. Resident #1 was confused, yelling and talking about houses.</p> <p>During an observation on 9/8/08 at 10:15 AM Resident #1 was observed in her room. NA #6 indicated that she was providing care to Resident #1 and Resident #8 (her new roommate) for the day and would remain in the room. Resident #1 was confused, talking about food and family. Resident #1 then began spelling and was no longer understandable.</p> <p>During an interview on 9/8/08 at 12 PM the NP indicated that she had been seeing Resident #1 for several months for her behaviors, her vulgar behaviors and sexual aggression. The NP indicated that she was attempting to regulate her medication and because of her behaviors the resident needed to be protected but she was not sure how to do that.</p>	F 223			

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F 223	Continued From page 6 2. Resident #8 was admitted to the facility on 4/10/02. The resident's cumulative diagnoses included Cerebral Vascular Accident, Dysphagia, Aphasia and Psychosis. Review of the annual MDS dated 1/15/08 indicated that the resident had short term memory loss, long term memory loss and was moderately impaired in daily decision making abilities. The resident was non ambulatory and needed extensive assistance with dressing and bathing. The resident was incontinent of bowel and bladder. Review of the quarterly Minimum Data Set (MDS) dated 7/23/08 indicated that the resident had short term memory loss, long term memory loss and was moderately impaired in daily decision making abilities. The resident was non ambulatory and needed extensive assistance with dressing and bathing. The resident was incontinent of bowel and bladder. Review of the care plan for Resident # 8 dated 1/16/08 did not identify any sexually inappropriate behaviors. Review of the care plan for Resident #8 dated 3/11/08 indicated Problem/Need- Sexual inappropriateness with another resident. Resident had impaired judgment. Goal and Target Date-Resident will not be inappropriate with other residents (male) x (times) 90 days. Approaches- 1. Follow up medical Exam. 2. Q (every) 15 minute round and document whereabouts (discontinued) 3. Counseling. 4. Monitor for sexual behaviors every shift. 3/14/08 1 to 1 observation (discontinued). Also dated on 3/11/08 was the Problem Exhibiting sexual aggressiveness with residents. The Goal was that the resident will not exhibit sexual aggressiveness with others for 90 days. Approaches included 1) Psych consult 2) any medication as ordered 3)	F 223			

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F 223	<p>Continued From page 7</p> <p>Redirect 4)Monitor behaviors. Also listed as 4) was 1 to 1 observation which was discontinued on 3/14/08.</p> <p>Review of the nurse's notes for Resident # 7 dated 3/11/08 at 12:30 PM indicated that the resident was found in the room of a female resident (Resident # 8). The nurse's note indicated that Resident #8 was having oral sex with Resident # 7.</p> <p>During an interview on 9/11/08 at 3:30 PM Nurse #3 indicated that on 3/11/08 12:30-1PM she entered the room of Resident #8 and saw Resident #7 hovering above the wheelchair of Resident #8. Resident #7 was facing Resident #8 while she sat in the wheelchair. Resident #7 had his hands on the wheelchair, his penis was out and Resident #8 ' s brief was pushed down her legs. Nurse #3 indicated that Resident #7 jumped up and sat down on the bed when she entered the room. Nurse #3 did not remember what the residents said when she entered the room.</p> <p>Review of the former administrator ' s written report of the incident on 3/11/08 indicated that Nurse #3 entered the room of Resident #8 on 3/11/08 at " approximately 12:30-1 PM " and " opened the door and saw (name of Resident #7) with his pants down, penis out, on top of the female while she was sitting in her wheelchair. " Resident #7 was returned to his room and assigned a 1:1 (1 staff to 1 resident) coverage by nurse aides (NA ' s). The former administrator indicated that " around 1:30 PM " the administrator and the former director of nurses (DON) interviewed Resident #8 in her room. The report indicated " Through the line of questioning, the Admin and DON determined that (name of</p>	F 223			

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F 223	<p>Continued From page 8</p> <p>Resident #8) had been touched in a sexual way, and she indicated that this was not what she wanted. " The administrator reported that at approximately 2 PM the police department arrived, both residents were interviewed. At 3:30 PM Resident #7 was transported to the hospital for a "psych eval " (psychiatric evaluation) and at 3:30-4 PM Resident # 8 was transported to the hospital for a physical evaluation. At 10:30 PM Resident #7 returned to the facility and was placed on 1:1 supervision.</p> <p>Review of the former administrator's written report of the incident on 3/11/08 further indicated that Resident #8 returned to the facility on 3/12/08 at 12:45 AM. The report indicated " throughout the investigation: evidence began mounting that it is (name of Resident #8) who is likely the aggressor sexually, not (name of Resident # 7). Several staff have documented that (Resident #8) is noted to entice others sexually and has been observed doing so on more than one occasion. (Name of Resident #7) did not have any documented or reported behaviors of a sexual nature prior to this event. " The entry for 3:45 PM on 3/12/08 indicated " Decided to remove (name of Resident #7) from 1:1 as soon as psych eval is completed. (Name of Resident #8) is to have 1:1 for approximately two weeks, unless psych eval determines otherwise."</p> <p>Review of the psychiatric evaluation completed on Resident #7 at the hospital on 3/11/08 indicated " Patient was found to be the recipient of oral sex by another resident of the (name of facility) and was brought to (name of the hospital) for Psychiatric Evaluation. " The assessment and recommendation of the evaluation included " Patient can return to care facility. No acute safety</p>	F 223			

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F 223	<p>Continued From page 9</p> <p>issues. Psychiatrically stable. It is suggested that staff make clear rules regarding sexual activity."</p> <p>Review of the record for Resident #7 indicated that the resident received a Psychiatric Diagnostic Evaluation by the psychiatric nurse practitioner (NP) in the facility on 3/13/08. The resident was examined by the NP on 4/14/08, 5/1/08, 5/28/08, 6/23/08, 7/2/08 and 8/5/08. The resident was receiving Celexa 20 milligrams (MG) daily until 8/5/08 when Celexa was decreased to 10 mg. daily.</p> <p>During a telephone interview on 9/8/08 at 12 PM the NP indicated that she had examined Resident #7 and followed the resident monthly. The NP indicated that the resident was alert and oriented to his surroundings, had impaired decision making, and lacked good judgment and insight. The NP indicated that the resident was reactive and did not have the judgment to say no to solicitations from female residents.</p> <p>Review of the hospital emergency room report dated 3/11/08 for Resident #8 indicated that the resident was examined by the emergency room physician and sexual assault nurse examiner (SANE). The diagnosis was "Sexual assault, Labial Laceration, Major or Minor." The resident was discharged back to the facility.</p> <p>Review of the psychiatric evaluation completed in the facility on Resident # 8 by the psychiatric NP on 3/13/08 indicated that the resident was sexually aggressive as evidenced by sexual behavior of pelvic thrusting, gesturing with her hands and masturbating in inappropriate places. The resident was thought to be soliciting sex with male residents.</p>	F 223			

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F 223	<p>Continued From page 10</p> <p>During a telephone interview on 9/8/08 at 12 PM the NP indicated that she had examined Resident #8 and found the resident alert and oriented with impaired decision making. Resident # 8 was known to be sexually aggressive, solicited sex, did not use good decision making and could not control herself. The NP indicated that Resident #8 denied being involved in sexual activity when the NP spoke to her. The NP indicated that she is trying to regulate her on medication and that there was no cure for her behavior and her sexual behaviors may continue.</p> <p>During an interview on 9/9/08 at 10:15 AM the administrator presented a written statement from the facility related to the 3/11/08 occurrence. The statement read in part " The interdisciplinary team determined through extensive investigation that the 3/11 event was consensual by both parties, facility notified law enforcement to assure that trained investigative techniques of law enforcement would not reveal otherwise. Law enforcement officials agreed with facility review of event with male resident ' s (Resident #7) accounting ultimately matching female resident ' s (Resident #8). As a post occurrence measure the 1:1 observation was discontinued for the male resident as a result of the findings of the investigation, the hospital, psychiatric services and law enforcement. All measures were taken to assure that there was no threat of immediate jeopardy, harm or adverse impact to the 2 residents involved or others within the facility. "</p> <p>3. Resident #9 was admitted to the facility on 8/14/07 and discharged on 8/27/08. The resident's cumulative diagnoses included Dementia and Hypertension. Review of the most</p>	F 223			

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F 223	<p>Continued From page 11</p> <p>recent quarterly MDS on 5/18/08 indicated that the resident had no short term memory loss, no long term memory problems and was independent in daily decision making abilities.</p> <p>Resident #8 was admitted to the facility on 4/12/02. The resident's cumulative diagnoses included Cerebral Vascular Accident, Dysphagia, Aphasia and Psychosis. Review of the annual MDS dated 1/15/08 indicated that the resident had short term memory loss, long term memory loss and was moderately impaired in daily decision making abilities. The resident was non ambulatory and needed extensive assistance with dressing and bathing. The resident was incontinent of bowel and bladder. Review of the quarterly Minimum Data Set (MDS) dated 7/23/08 indicated that the resident had short term memory loss, long term memory loss and was moderately impaired in daily decision making abilities. The resident was non ambulatory and needed extensive assistance with dressing and bathing. The resident was incontinent of bowel and bladder.</p> <p>Review of the care plan for Resident # 8 dated 1/16/08 did not identify any sexually inappropriate behaviors. Review of the care plan for Resident #8 dated 3/11/08 indicated Problem/Need- Sexual inappropriateness with another resident. Resident had impaired judgment. Goal and Target Date-Resident will not be inappropriate with other residents (male) times 90 days. Approaches- 1. Follow up medical Exam. 2. Every 15 minute round and document whereabouts (discontinued on 3/12/08) 3. Counseling. 4. Monitor for sexual behaviors every shift. Also dated on 3/11/08 was the Problem Exhibiting sexual aggressiveness with residents. The Goal</p>	F 223			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345346	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/12/2008
NAME OF PROVIDER OR SUPPLIER FOREST VIEW REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5935 MOUNT SINAI ROAD DURHAM, NC 27705		
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F 223	<p>Continued From page 12</p> <p>was that the resident will not exhibit sexual aggressiveness with others for 90 days. Approaches included 1) Psych consult 2) any medication as ordered 3) Redirect 4) Monitor behaviors. Also listed as 4) was 1 to 1 observation which was discontinued on 3/14/08.</p> <p>Review of the Nurse ' s Notes for Resident #9 dated 8/27/08 at 1:30 PM indicated that Resident #9 was in the dinning room sitting next to a female resident (identified by staff to be Resident #8). The note indicated that Resident #8 stated to Resident # 9 " she was not horny today but would be tomorrow." The female was removed from the dining room by the nurse aide.</p> <p>Review of the Nurse's Notes for Resident #9 dated 8/27/08 at 2:20 PM and written by UC #1 indicated that Resident # 9 was found in his room by the NA with Resident #8. Resident #8 was noted to have no bottoms on, in a sexual position and noted by the NA as having oral sex. When Resident # 9 was asked what he was doing he tried to push the door closed and yelled to get out (of the room). The NA removed Resident #8 from the room. The resident stated to the nurse "I' m a man and she's a women and I will not stop until I get it."</p> <p>During an interview on 9/7/08 at 10:40 AM UC #1 indicated that she had been told by the NAs that Resident #8 was in the room of Resident #9 with no brief and her pants down. Resident #9 was in his wheelchair and the recipient of oral sex.</p> <p>Review of the facility Witness Statement dated 8/27/08 and written by NA #1 indicated "at about 2:20 PM I returned from lunch and noticed (name of Resident #9) door closed. I knocked and open</p>	F 223			

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

PRINTED: 10/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345346	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/12/2008
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F 223	<p>Continued From page 13</p> <p>and saw (name of Resident #8) with her clothes down coming up from (name of Resident #9) with her mouth full of spit she started to spit into a bedside basin. I (NA #1) asked her what she was doing she said she was taking a test for the doctor. (Resident #9) started to shout out at me this is my room I brought her in here she is in here with a man. I sent someone to get the nurse and reported it to the nurse. (Name of Resident #8) had just taken her mouth up from his penis."</p> <p>During an interview on 9/8/08 at 10 AM NA #1 indicated that on 8/27/08 she knocked on the door of Resident #9 and when she opened the door she saw Resident #8 standing with no brief on and her pants down to her ankles. Resident #8 said that she was doing a test for the doctor and had a mouth full of spit. NA #1 indicated that Resident #8 spit a lot. NA #1 did not enter the room right away as Resident #9 began to yell that he brought her in there (the room) and he was going to keep doing it and that he was doing a man and a women thing. Resident #8 kept saying that she was doing a test for the doctor. NA #1 then entered the room with Nurse #1 who told Resident #9 that she (Resident #8) was not in her right mind. Resident #8 was then removed from the room.</p> <p>Review of the facility Witness Statement dated 8/27/08 and written by NA #5 Indicated " NA call me to room (#). Patient was in there with her pants down halfway her legs trying to pull pants up. "</p> <p>During an interview on 9/8/08 at 9:45 AM NA #5 indicated that when she was called to the room she did not see Resident #9 as he was behind the door in his wheelchair. NA #5 saw Resident #8</p>	F 223			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345346	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/12/2008
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F 223	<p>Continued From page 14</p> <p>standing up facing the NA and pulling up her pants. NA #5 indicated that Resident #8 could stand when she wanted to stand</p> <p>During an interview on 9/6/08 at 3:30 PM Nurse #1 indicated that she had been told by the NAs that Resident #8 was giving Resident # 9 oral sex and she did not see that occur. As Nurse #1 entered the room she saw the crotch of Resident #9 pants all wet and he was yelling that no one should come in the room and that he was going to have sex with Resident #8. Nurse #1 indicated that she spoke to Resident # 9 about his STD and the resident denied having a STD. Nurse #1 told Resident #9 that he could not have sex with Resident #8 as Resident #8 was not on the same cognitive level as he was. Nurse #1 spoke with Resident #8 who denied that she had oral sex with Resident #9. Nurse #1 indicated that when she later spoke to Resident #8 the resident would not look at her and only looked out the window. Nurse #1 indicated that Resident #8 was not independent in decision making.</p> <p>Review of the SW Progress Note dated 8/27/08 at 2:45 PM indicated that the SW spoke with Resident #9 who denied having sex with Resident #8. Resident #9 told the SW that he was going to have sex but people came into his room. Resident #9 was asked by the SW if Resident #9 understood the seriousness of the incident. The SW note indicated that the resident was transferred to the hospital.</p> <p>During an interview on 9/6/08 at 2 PM the SW indicated that he had spoken to Resident #9 and Resident #8 on 8/27/08 after the incident. The SW indicated that when he spoke to Resident #8 she had denied a sexual encounter with Resident</p>	F 223			

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

PRINTED: 10/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345346	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/12/2008
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F 223	Continued From page 15 #9. Review of the Progress note (undated) written by the physician of Resident #9 indicated that Resident had a STD who was witnessed having oral sex with a mentally incompetent patient (Resident #8). The physician indicated that Resident #9 asserted that he will continue sexual activity in the future with the same patient. The physician indicated " Because he is a danger to an incompetent female resident and other patients we can no longer safely care for (name of Resident #9) in a safe environment for all of our residents. " During an interview on 9/9/08 at 10:15 AM the administrator provided a written statement of the 8/27/08 occurrence. The statement read in part "The interdisciplinary team determined through the investigative process that (name of Resident #8) sought out the company of (name of Resident #9) and was, in fact, found in his room. On observation, it was she (Resident #8) who was engaging in oral sex with (name of Resident # 9). There was no behavior observed that would indicate that there was any abuse or feeling of discomfort by either party until they were in fact separated in order to make that determination.. Hospital was notified of the event with (name of Resident #9) transferred to the hospital for further evaluation related to his verbalizations, not for the act itself."	F 223			
F 323 SS=K	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323			

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

PRINTED: 10/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345346	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/12/2008
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F 323	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to prevent alert and oriented residents (Resident #7 and #9) from having sexual contact with two cognitively impaired resident (Residents #8 and Resident # 1) for 2 of 6 residents reviewed. Immediate Jeopardy began on 3/11/08 and is ongoing. The Immediate Jeopardy was identified on 9/8/08 at 11:30 AM and brought to the attention of the administrator. Findings include: 1. Resident #7 was admitted to the facility on 8/4/07 and discharged on 9/1/08. The resident's cumulative diagnoses included Cerebral Vascular Disease, Aphasia, Sexually Transmitted Disease (STD) and Hypertension. Review of the care plan for Resident #7 dated 1/21/08 did not indicate sexually inappropriate behavior. Review of the care plan for Resident #7 indicated an entry dated 3/11/08 Problem/Need- Inappropriate sexual behavior with another resident. Goal and Target Date-Resident will not be inappropriate with other female residents times 90 days. Approaches- included 1. psych eval 2. appropriate meds as ordered 3. 1:1 staffing to monitor behaviors which were discontinued on 3-13-08 4. Counseling. On 3/14/08 15 minute checks of the resident were discontinued. Resident #1 was admitted to the facility on 6/22/07. The resident's cumulative diagnoses included Brain Injury, Bipolar Disorder,	F 323			

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

PRINTED: 10/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345346	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/12/2008
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F 323	<p>Continued From page 17</p> <p>Schizoaffective Disorder and Hypertension. Review of the quarterly Minimum Data Set (MDS) dated 8/15/08 indicated that the resident had short term memory loss, long term memory loss and was moderately impaired in daily decision making abilities. The resident was non ambulatory and needed extensive assistance with dressing and bathing. The resident was incontinent of bowel and bladder. Behavioral symptoms were identified as socially inappropriate/ disruptive behavior.</p> <p>Review of the care plan for Resident #1 dated 2/26/08 indicated Problem/Need- Mood and behaviors related to brain injury and schizoaffective disorder. Resident with STM (short term memory)/LTM (long term memory) deficits with poor decision making skills. She curses, spits, kicks and yells at staff during ADL (activities of daily living) care at times, she receives antipsychotic meds. Under Problem/Need and dated 5/29/08 Resident has displayed no behavior recently but will continue CP (care plan). Approaches included in part Social Worker to visit frequently as needed- Approach resident warmly and positively in a calm manner-Monitor and document resident behaviors and status. Report any changes in cognition to physician. Approaches included Resident with increased agitation on 4/7/08 hit another resident. Intervention: follow up with psych with med change 4/9/08. Monitor for increased behaviors around others. 4/9/08. In the area of Comments 1) Resident with increased sexual aggression. Monitor direct supervision 1:1 until further notice 9/5/08. 2) Psych intervention as needed 3) involve in divisional activities 4) notify nurse/MD with increase in behaviors.</p>	F 323			

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

PRINTED: 10/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345346	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/12/2008
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F 323	<p>Continued From page 18</p> <p>Review of the Nurse's Notes for Resident #1 dated 9/1/08 at 1 PM written by Unit Coordinator (UC) #2 indicated that the UC had been notified by the resident's nurse and nurse aide (NA) that " when the assigned NA went into the resident's room (Resident #1) she (NA) observed a male resident (Resident #7) lying on top of her with her legs open, and apart, with her adult brief pulled to the side. The male resident was observed with his pants pulled down and that he was trying to pull his pants up quickly. The undersigned nurse (UC #2) along with her NA asked her (Resident #1) what he was doing she stated he was on me, and put his thang in me." UC #2 further indicated in her note that she remained in the room of resident #1 until the NA cleaned the resident as she had had a bowel movement and noted " some shiney [sic: shiny] substance on her perineal area." The resident appeared quiet, calm and in no apparent distress.</p> <p>During an interview on 9/4/08 at 2:25 PM UC #2 indicated that she had been called to the unit on 9/1/08 and told by NA #1 and NA #4 that they had seen Resident #7 in the room of Resident #1 and he was seen on top of Resident #1, that Resident #7 ' s penis was out and his pants were down. Resident #1 ' s legs were apart and the incontinent brief was pushed to the side. UC #2 went to Resident #1 ' s room and Resident #1 said that he (Resident # 7) was on top of me and had his thing in me. The UC then indicated that Resident #1 became confused. The UC pulled back her brief and she (Resident #1) had stool on her and a shiny substance was on the stool. UC #2 then went to Resident #7 ' s room and noticed that he had on gym pants with stool on the waistband. Resident #7 denied that he had been in the room of Resident #1.</p>	F 323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345346	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/12/2008
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F 323	Continued From page 19 During an interview on 9/4/08 at 2:40 PM NA #1 indicated that on 9/1/08 while walking down the hall with NA #4 she looked in the room of Resident #1 and the curtain was pulled . NA #1 saw feet moving and entered the room. As NA #1 and NA #4 entered the room NA #1 saw Resident #7 on top of Resident #1 with his penis out. Resident #1 was just lying there and she had feces on the front of her. NA #1 indicated that Resident #7 jumped off the bed through the space between the top and bottom side rail, turned his back, placed his penis in his pants and quickly walked out of the room. During an interview on 9/6/08 at 3:10 PM NA #4 indicated that on 9/1/08 while walking in the hall with NA #1 they walked in the room of Resident #1. The curtain was pulled and the side rails were up on the bed of Resident #1. NA #4 saw Resident #7 on top of Resident #1. Resident #1 was not talking, the brief was pushed to the side and the resident had stool on the brief. NA #4 indicated that Resident #7 jumped off the bed and began to adjust his pants. Review of the Nurses ' Notes dated 9/2/08 at 9:15 AM and written by the director of nurses (DON) indicated that the note was a late entry for 9/1/08 at 5PM. The DON indicated that the DON and female police officer entered the room of Resident #1. The police office questioned the resident related to the incident with Resident #7. Resident #1 stated that the male resident had cursed her and had gotten on her. Resident #1 " stated that she did not want him to " (Resident #7). Resident #1 was cleared by the police to be sent to the emergency room.	F 323			

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

PRINTED: 10/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345346	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/12/2008
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F 323	<p>Continued From page 20</p> <p>During an interview on 9/6/08 at 11:15 AM UC #2 indicated that because Resident #1 needed to be cleaned of stool before transport to the hospital she called the NP for the resident ' s physician and UN #2 spoke to the emergency room. UC #2 was told by the emergency room nurse to wash the stool off the resident prior to transport. UC #2 did not change the clothes of Resident #1.</p> <p>Review of the Nurse ' s Notes indicated that the resident was transported to the emergency room and returned to the facility on 9/1/08 at 11:30 PM.</p> <p>Review of the emergency room report dated 9/1/08 at 11:03 PM for Resident #1 indicated that the resident was examined, a rape kit was given to the police and the resident was discharged back to the facility. Diagnosis on discharge from the emergency room was Sexual Assault.</p> <p>Review of the Nurse's Notes dated 9/1/08 at 1:15 PM and completed by UC #1 for Resident #7 indicated that the resident was placed on a 1:1 monitoring by staff.</p> <p>Review of the Nurse's Notes dated 9/1/08 at 4:30 PM and completed by UC #1 for Resident #7 indicated that the resident was transported to the emergency room.</p> <p>Review of the record indicated that Resident #7 did not return to the facility and was transferred to another hospital.</p> <p>During an observation on 9/4/08 at 12:20 PM Resident #1 was observed in her room in bed. Resident #1 was confused and asking that a carton of potato chips be ordered. The resident asked that the door be closed "to keep the glass</p>	F 323			

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

PRINTED: 10/13/2008
FORM APPROVED
OMB NO. 0938-0391

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F 323	<p>Continued From page 21 off her body."</p> <p>During an observation on 9/5/08 at 9:10 PM Resident #1 was observed in her room in a Geri chair. Resident #1 was confused, yelling and talking about houses.</p> <p>During an observation on 9/8/08 at 10:15 AM Resident #1 was observed in her room. NA #6 indicated that she was providing care to Resident #1 and Resident #8 (her new roommate) for the day and would remain in the room. Resident #1 was confused, talking about food and family. Resident #1 then began spelling and was no longer understandable.</p> <p>During an interview on 9/8/08 at 12 PM the NP indicated that she had been seeing Resident #1 for several months for her behaviors, her vulgar behaviors and sexual aggression. The NP indicated that she was attempting to regulate her medication and because of her behaviors the resident needed to be protected but she was not sure how to do that.</p> <p>2. Resident #8 was admitted to the facility on 4/12/02. The resident's cumulative diagnoses included Cerebral Vascular Accident, Dysphagia, Aphasia and Psychosis. Review of the annual MDS dated 1/15/08 indicated that the resident had short term memory loss, long term memory loss and was moderately impaired in daily decision making abilities. The resident was non ambulatory and needed extensive assistance with dressing and bathing. The resident was incontinent of bowel and bladder. Review of the quarterly Minimum Data Set (MDS) dated 7/23/08 indicated that the resident had short term memory loss, long term memory loss and was moderately</p>	F 323			

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

PRINTED: 10/13/2008
FORM APPROVED
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F 323	<p>Continued From page 22</p> <p>impaired in daily decision making abilities. The resident was non ambulatory and needed extensive assistance with dressing and bathing. The resident was incontinent of bowel and bladder.</p> <p>Review of the care plan for Resident # 8 dated 1/16/08 did not identify any sexually inappropriate behaviors. Review of the care plan for Resident #8 dated 3/11/08 indicated Problem/Need- Sexual inappropriateness with another resident. Resident had impaired judgment. Goal and Target Date-Resident will not be inappropriate with other residents (male) times 90 days. Approaches- 1. Follow up medical Exam. 2. Every 15 minute round and document whereabouts (discontinued) 3. Counseling. 4. Monitor for sexual behaviors every shift. 3/14/08 1 to 1 observation (discontinued).Also dated on 3/11/08 was the Problem -Exhibiting sexual aggressiveness with residents. The Goal was that the resident will not exhibit sexual aggressiveness with others for 90 days. Approaches included 1) Psych consult 2) any medication as ordered 3) Redirect 4)Monitor behaviors. Also listed as 4) was 1 to 1 observation which was discontinued on 3/14/08.</p> <p>Review of the nurse's notes for Resident # 7 dated 3/11/08 at 12:30 PM indicated that the resident was found in the room of a female resident (Resident # 8). The nurse ' s note indicated that Resident #8 was having oral sex with Resident #7.</p> <p>Review of the former administrator's written report of the incident on 3/11/08 indicated that Nurse #3 entered the room of Resident #8 on 3/11/08 at " approximately 12:30-1 PM " and " opened the door and saw (name of Resident #7) with his</p>	F 323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345346	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/12/2008
NAME OF PROVIDER OR SUPPLIER FOREST VIEW REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5935 MOUNT SINAI ROAD DURHAM, NC 27705		
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F 323	Continued From page 23 pants down, penis out, on top of the female while she was sitting in her wheelchair. " Resident #7 was returned to his room and assigned a 1:1 (1 staff to 1 resident) coverage by nurse aides (NAs). The former administrator indicated that " around 1:30 PM " the administrator and the former director of nurses (DON) interviewed Resident #8 in her room. The report indicated " Through the line of questioning, the Admin and DON determined that (name of Resident #8) had been touched in a sexual way, and she indicated that this was not what she wanted. " The administrator reported that at approximately 2 PM the police department arrived, both residents were interviewed. At 3:30 PM Resident #7 was transported to the hospital for a " psych eval " (psychiatric evaluation) and at 3:30-4 PM Resident # 8 was transported to the hospital for a physical evaluation. At 10:30 PM Resident #7 returned to the facility and was placed on 1:1 supervision. The report indicated that Resident #8 returned to the facility on 3/12/08 at 12:45 AM. The report indicated " throughout the investigation: evidence began mounting that it is (name of Resident #8) who is likely the aggressor sexually, not (name of Resident # 7). Several staff have documented that (Resident #8) is noted to entice others sexually and has been observed doing so on more than one occasion. (Name of Resident #7) did not have any documented or reported behaviors of a sexual nature prior to this event." The entry for 3:45 PM on 3/12/08 indicated " Decided to remove (name of Resident #7) from 1:1 as soon as psych eval is completed. (Name of Resident #8) is to have 1:1 for approximately two weeks, unless psych eval determines otherwise. " Review of the psychiatric evaluation completed on	F 323			

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

PRINTED: 10/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345346	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/12/2008
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F 323	<p>Continued From page 24</p> <p>Resident #7 at the hospital on 3/11/08 indicated " Patient was found to be the recipient of oral sex by another resident of the (name of facility) and was brought to (name of the hospital) for Psychiatric Evaluation. " The assessment and recommendation of the evaluation included " Patient can return to care facility. No acute safety issues. Psychiatrically stable. It is suggested that staff make clear rules regarding sexual activity. "</p> <p>Review of the record for Resident #7 indicated that the resident received a Psychiatric Diagnostic Evaluation by the psychiatric nurse practitioner (NP) in the facility on 3/13/08. The resident was examined by the NP on 4/14/08, 5/1/08, 5/28/08, 6/23/08, 7/2/08 and 8/5/08. The resident was receiving Celexa 20 milligrams (MG) daily until 8/5/08 when Celexa was decreased to 10 mg. daily.</p> <p>During a telephone interview on 9/8/08 at 12 PM the NP indicated that she had examined Resident #7 and followed the resident monthly. The NP indicated that the resident was alert and oriented to his surroundings, had impaired decision making, and lacked good judgment and insight. The NP indicated that the resident was reactive and did not have the judgment to say no to solicitations from female residents.</p> <p>Review of the hospital emergency room report dated 3/11/08 for Resident #8 indicated that the resident was examined by the emergency room physician and sexual assault nurse examiner (SANE). The diagnosis was " Sexual assault, Labial Laceration, Major or Minor. " The resident was discharged back to the facility.</p> <p>Review of the psychiatric evaluation completed in</p>	F 323			

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

PRINTED: 10/13/2008
FORM APPROVED
OMB NO. 0938-0391

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F 323	<p>Continued From page 25</p> <p>the facility on Resident # 8 by the psychiatric NP on 3/13/08 indicated that the resident was sexually aggressive as evidenced by sexual behavior of pelvic thrusting, gesturing with her hands and masturbating in inappropriate places. The resident was thought to be soliciting sex with male residents.</p> <p>During a telephone interview on 9/8/08 at 12 PM the NP indicated that she had examined Resident #8 and found the resident alert and oriented with impaired decision making. Resident # 8 was known to be sexually aggressive, solicited sex, did not use good decision making and could not control herself. The NP indicated that Resident #8 denied being involved in sexual activity when the NP spoke to her. The NP indicated that she is trying to regulate her on medication and that there was no cure for her behavior and her sexual behaviors may continue.</p> <p>During an interview on 9/9/08 at 10:15 AM the administrator presented a written statement from the facility related to the 3/11/08 occurrence. The statement read in part " The interdisciplinary team determined through extensive investigation that the 3/11 event was consensual by both parties, facility notified law enforcement to assure that trained investigative techniques of law enforcement would not reveal otherwise. Law enforcement officials agreed with facility review of event with male resident ' s (Resident #7) accounting ultimately matching female resident ' s (Resident #8). As a post occurrence measure the 1:1 observation was discontinued for the male resident as a result of the findings of the investigation, the hospital, psychiatric services and law enforcement. All measures were taken to assure that there was no threat of immediate</p>	F 323			

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

PRINTED: 10/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345346	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/12/2008
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F 323	<p>Continued From page 26</p> <p>jeopardy, harm or adverse impact to the 2 residents involved or others within the facility. "</p> <p>3. Resident #9 was admitted to the facility on 8/14/07 and discharged on 8/27/08. The resident's cumulative diagnoses included Dementia and Hypertension. Review of the most recent quarterly MDS on 5/18/08 indicated that the resident had no short term memory loss, no long term memory problems and was independent in daily decision making abilities.</p> <p>Resident #8 was admitted to the facility on 4/12/02. The resident's cumulative diagnoses included Cerebral Vascular Accident, Dysphagia, Aphasia and Psychosis. Review of the annual MDS dated 1/15/08 indicated that the resident had short term memory loss, long term memory loss and was moderately impaired in daily decision making abilities. The resident was non ambulatory and needed extensive assistance with dressing and bathing. The resident was incontinent of bowel and bladder. Review of the quarterly Minimum Data Set (MDS) dated 7/23/08 indicated that the resident had short term memory loss, long term memory loss and was moderately impaired in daily decision making abilities. The resident was non ambulatory and needed extensive assistance with dressing and bathing. The resident was incontinent of bowel and bladder.</p> <p>Review of the care plan for Resident # 8 dated 1/16/08 did not identify any sexually inappropriate behaviors. Review of the care plan for Resident #8 dated 3/11/08 indicated " Problem/Need- Sexual inappropriateness (symbol for with) another resident. Resident had impaired judgment. Goal and Target Date-Resident will not</p>	F 323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345346	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/12/2008
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F 323	<p>Continued From page 27</p> <p>be inappropriate (symbol for with) with other residents (male) x (times) 90 days. Approaches- 1. Follow up medical Exam. 2. Q (every) 15 minute round and document whereabouts (with a line through it) 3. Counseling. 4. Monitor for sexual behaviors every shift. 3/14/08 1 to 1 observation DC ' d. (with a line through it)." Also dated on 3/11/08 was the Problem -Exhibiting sexual aggressiveness with residents. The Goal was that the resident will not exhibit sexual aggressiveness with others for 90 days.</p> <p>Approaches included 1) Psych consult 2) any medication as ordered 3) Redirect 4) Monitor behaviors. Also listed as 4) was 1 to 1 observation which was discontinued on 3/14/08.</p> <p>Review of the Nurse ' s Notes for Resident #9 dated 8/27/08 at 1:30 PM indicated that Resident #9 was in the dinning room sitting next to a female resident (identified by staff to be Resident #8). The note indicated that Resident #8 stated to Resident # 9 " she was not horny today but would be tomorrow. " The female was removed from the dining room by the nurse aide.</p> <p>Review of the Nurse ' s Notes for Resident #9 dated 8/27/08 at 2:20 PM and written by UC #1 indicated that Resident # 9 was found in his room by the NA with Resident #8. Resident #8 was noted to have no bottoms on, in a sexual position and noted by the NA as having oral sex. When Resident # 9 was asked what he was doing he tried to push the door closed and yelled to get out (of the room). The NA removed Resident #8 from the room. The resident stated to the nurse "I'm a man and she' s a women and I will not stop until I get it."</p> <p>During an interview on 9/7/08 at 10:40 AM UC #1</p>	F 323			

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

PRINTED: 10/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345346	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/12/2008
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F 323	<p>Continued From page 28</p> <p>indicated that she had been told by the NAs that Resident #8 was in the room of Resident #9 with no brief and her pants down. Resident #9 was in his wheelchair and the recipient of oral sex.</p> <p>Review of the facility Witness Statement dated 8/27/08 and written by NA #1 indicated " at about 2:20 PM I returned from lunch and noticed (name of Resident #9) door closed. I knocked and open and saw (name of Resident #8) with her clothes down coming up from (name of Resident #9) with her mouth full of spit she started to spit into a bedside basin. I (NA #1) asked her what she was doing she said she was taking a test for the doctor. (Resident #9) started to shout out at me this is my room I brought her in here she is in here with a man. I sent someone to get the nurse and reported it to the nurse. (Name of Resident #8) had just taken her mouth up from his penis. "</p> <p>During an interview on 9/8/08 at 10 AM NA #1 indicated that on 8/27/08 she knocked on the door of Resident #9 and when she opened the door she saw Resident #8 standing with no brief on and her pants down to her ankles. Resident #8 said that she was doing a test for the doctor and had a mouth full of spit. NA #1 indicated that Resident #8 spit a lot. NA #1 did not enter the room right away as Resident #9 began to yell that he brought her in there (the room) and he was going to keep doing it and that he was doing a man and a women thing. Resident #8 kept saying that she was doing a test for the doctor. NA #1 then entered the room with Nurse #1 who told Resident #9 that she (Resident #8) was not in her right mind. Resident #8 was then removed from the room.</p> <p>Review of the facility Witness Statement dated</p>	F 323			

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

PRINTED: 10/13/2008
FORM APPROVED
OMB NO. 0938-0391

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F 323	<p>Continued From page 29</p> <p>8/27/08 and written by NA #5 Indicated " NA call me to room (#). Patient was in there with her pants down halfway her legs trying to pull pants up. "</p> <p>During an interview on 9/8/08 at 9:45 AM NA #5 indicated that when she was called to the room she did not see Resident #9 as he was behind the door in his wheelchair. NA #5 saw Resident #8 standing up facing the NA and pulling up her pants. NA #5 indicated that Resident #8 could stand when she wanted to stand</p> <p>During an interview on 9/6/08 at 3:30 PM Nurse #1 indicated that she had been told by the NAs that Resident #8 was giving Resident # 9 oral sex and she did not see that occur. As Nurse #1 entered the room she saw the crotch of Resident #9 pants all wet and he was yelling that no one should come in the room and that he was going to have sex with Resident #8. Nurse #1 indicated that she spoke to Resident # 9 about his STD and the resident denied having a STD. Nurse #1 told Resident #9 that he could not have sex with Resident #8 as Resident #8 was not on the same cognitive level as he was. Nurse #1 spoke with Resident #8 who denied that she had oral sex with Resident #9. Nurse #1 indicated that when she later spoke to Resident #8 the resident would not look at her and only looked out the window. Nurse #1 indicated that Resident #8 was not independent in decision making.</p> <p>Review of the SW Progress Note dated 8/27/08 at 2:45 PM indicated that the SW spoke with Resident #9 who denied having sex with Resident #8. Resident #9 told the SW that he was going to have sex but people came into his room. Resident #9 was asked by the SW if Resident #9</p>	F 323			

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

PRINTED: 10/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345346	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/12/2008
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F 323	<p>Continued From page 30</p> <p>understood the seriousness of the incident. The SW note indicated that the resident was transferred to the hospital.</p> <p>During an interview on 9/6/08 at 2 PM the SW indicated that he had spoken to Resident #9 and Resident #8 on 8/27/08 after the incident. The SW indicated that when he spoke to Resident #8 she had denied a sexual encounter with Resident #9.</p> <p>Review of the Progress note (undated) written by the physician of Resident #9 indicated that Resident had a STD who was witnessed having oral sex with a mentally incompetent patient (Resident #8). The physician indicated that Resident #9 asserted that he will continue sexual activity in the future with the same patient. The physician indicated " Because he is a danger to an incompetent female resident and other patients we can no longer safely care for (name of Resident #9) in a safe environment for all of our residents. "</p> <p>During an interview on 9/9/08 at 10:15 AM the administrator provided a written statement of the 8/27/08 occurrence. The statement read in part " The interdisciplinary team determined through the investigative process that (name of Resident #8) sought out the company of (name of Resident #9) and was, in fact, found in his room. On observation, it was she (Resident #8) who was engaging in oral sex with (name of Resident # 9). There was no behavior observed that would indicate that there was any abuse or feeling of discomfort by either party until they were in fact separated in order to make that determination.. Hospital was notified of the event with (name of Resident #9) transferred to the hospital for further</p>	F 323			

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

PRINTED: 10/13/2008
FORM APPROVED
OMB NO. 0938-0391

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F 323	Continued From page 31	F 323			
F 354 SS=C	<p>evaluation related to his verbalizations, not for the act itself. "</p> <p>483.30(b) NURSING SERVICES - REGISTERED NURSE</p> <p>Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.</p> <p>Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.</p> <p>The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staffing review and staff interviews, the facility failed to have a registered nurse (RN) in the facility for 8 consecutive hours on 8/16/08 and 8/17/08. Findings include:</p> <p>Review of the staffing schedule for 8/16/08 and 8/17/08 indicated that there was no RN on duty for the day, evening or night shifts. The resident census was 109 for both 8/16/08 and 8/17/08.</p> <p>During an interview on 9/4/08 at 3:15 PM unit coordinator #1 indicated that the RN supervisor who worked 7 AM to 7 PM on weekends was on vacation on 8/16/08 and 8/17/08.</p> <p>During an interview on 9/4/08 at 5:30 PM the director of nurses (DON) indicated that the RN</p>	F 354			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345346	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/12/2008
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F 354	Continued From page 32 supervisor thought she had vacation days. The DON indicated that she had been told on 8/17/08 that there was no RN in the building. The DON indicated that on Sunday 8/17/08 she had come in to the facility at 4 PM and worked on staffing issues until 9 PM. The DON indicated that she did not think about RN coverage for the day. The DON indicated that she had spoken with the weekend supervisor regarding the correct procedure to request vacation time.	F 354		
F 490 SS=K	483.75 ADMINISTRATION A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review staff interviews, the facility failed to protect cognitively impaired residents (Resident #1 and Resident #8) from being sexually assaulted by another residents (Resident #7 and Resident # 9) for 2 of 6 residents reviewed. The facility also failed to prevent alert and oriented residents (Resident #7 and Resident #9) from having sexual contact with two cognitively impaired resident (Resident #1 and Resident # 8) for 2 of 6 residents reviewed. Immediate Jeopardy began on 3/11/08 and is ongoing. The Immediate Jeopardy was identified on 9/8/08 at 11:30 AM and brought to the attention of the administrator. Findings include: 1. Cross reference F 223. The facility failed to protect residents from sexual abuse.	F 490		

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

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F 490	Continued From page 33 2. Cross reference F 323. The facility failed to develop effective interventions to protect residents from inappropriate sexual behaviors.	F 490			