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F9999	Continued From page 61 LICENSURE VIOLATIONS 300.610a) 300.1210a) 300.3240a) 300.3240b) 300.3240c) 300.3240d) 300.3240f) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative	F9999		

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F9999	Continued From page 62 measures shall include at a minimum the following procedures: Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act) c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative. (Section 3-610 of the Act) d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (Section 3-610 of the Act) f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act) These Regulations were not met as evidenced	F9999		

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F9999	Continued From page 63 by: Based on observation, interview, and record review, the facility failed to protect and provide interventions for 10 out of 10 known residents sexually abused (R2, R8, R9, R18, R21, R25, R27, R28, R29, and R34) by another resident (R19). R19 sexually abused these 10 residents from 1-17-2009 through 5-26-2009. Findings Include: The 4-23-2009 Physician Progress Notes document R19 as having diagnoses of chronic obstructive pulmonary disease, hypertension, chronic kidney disease, and sexual behaviors. Additionally this same Physician Progress Note documents, "ambulates independently, has been propositioning and touching female residents. He is being closely monitored." On 6-2-2009 at 10:20am. and 6-3-2009 at 2:30pm, R19 was ambulating independently within the facility. R19 was at times out of staff's sight. On 6-9-2009 at 11:05am, E11 (RN/Registered Nurse) stated, "I started working here around February 11, 2009. I wasn't given specific information on (R19's) behaviors. I witnessed situations with (R19) on weekends, he favored the ladies. I kept a watchful eye on him. The majority of incidents I witnessed were where (R19) would approach non-verbal females and I would intervene. (R19) would get angry with me. I would put the female by me at the medication cart and (R19) didn't like it. He would say 'who do you think you are' or 'I'm going to get you fired.' He didn't like for me to intervene. I don't	F9999		

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F9999	Continued From page 64 think it was consensual. I didn't like it. I was uncomfortable. I wouldn't want it to happen to my parents. The residents were non-verbal. (R28) always looked frightened and I saw fear in her eyes. There were no specifics on how to provide interventions to the victims. I observed that (R19) targeted the non-verbal residents. I made sure (R19) saw me, because he would look around to see who was watching." E10 (Social Service Director) completed Risk Assessments for Abuse and Neglect in January 2009 and February 2009 on R2, R8, R9, R18, R21, R25, R27, and R29. E10 documented, on these same Risk Assessments for Abuse and Neglect, all the above identified residents, "High susceptible risk for abuse and neglect." R28's 1-21-2009 Risk Assessment for Abuse and Neglect completed by E10 (Social Service Director) is, "Victim of spousal neglect/abuse. High risk factor as susceptible for emotional/mental or other types of neglect/abuse." R33 on 6-5-2009 at 10:15am stated, "I have seen (R19) two times touching the breasts of unresponsive residents. (R28's) sister visits, is concerned, and asked me if I would watch (R28) from (R19) and said (R28) is scared to death of (R19). I can't remember the name of the second resident. (R19's) son told me he was going to get some medication to quench his (R19's) sex urges. (R19) has kissed other residents. (R19's) son came over a couple of weeks ago and he's hosted some dinners for us and told a couple of us about his dad. Staff have asked me several times to keep an eye on (R19) to watch him and tell them. His (R19) language is bad. He talks in	F9999		

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F9999	Continued From page 65 common areas loudly about his wet dreams and needs sexually. He has a loud voice. I go to my room a lot to not hear that. I hate the F word. This has been going on for some time. It was not consensual between the residents and (R19)." R26 on 6-5-2009 at 10:50am. stated, "(R19's) son asked me to kind of watch over his dad. I've heard him tell (R19) not to do stuff. (R19) knows I'll lay into him if he tries stuff. I'm not afraid of him." (R26 raised her fist and shook it). "So he don't try it on me. I'm safe, I don't know about anyone else." On 6-5-2009 at 10:20am. R25 nodded her head yes to I've been touched inappropriately and stated, "a man did it. I don't know too much, but I hope he's dead. He could be - yes dead." The 1-19-2009 and 4-17-2009 MDS (Minimum Data Set) documents R19 with socially inappropriate/disruptive behavioral symptoms occurring 4 to 6 times a week, behaviors not easily altered. R19's 1-27-2009 Care Plan Progress Review Verification Notes state, "is exhibiting mood and behaviors that tend to have increased. He has had some socially inappropriate behavior in regards to sexual inhibitions which staff are monitoring. Also is seeing (Z1, Psychiatrist) for this." The 2-12-2009 Care Plan for R19 documents approaches for his Problem of sexual behaviors as "Resident needs to be kept upbeat due to his behaviors. Resident has problems with all females and no males in activities so encourage him to attend in the last five minutes. Allow	F9999		

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F9999	Continued From page 66 resident to express himself, never not talk to him. Tell him to come to you at any time." R19's 1-20-2009 Quarterly Social Service Progress Note includes, "Inappropriate sexual 'overture' to female residents. Care Plan addition for sexual behaviors and will schedule with (Z1/Psychiatrist) to assess possibilities, medication, increased risk for female residents, if to dementia wing versus closer supervision." On 6-3-2009 Z1 (Psychiatrist) stated, "I've been seeing (R19) since 11-10-2009. My first notes of sexual behaviors was on 3-26-2009. No history of sexually acting out behaviors were reported to me until 3-26-2009." R19's 3-26-2009 Psychiatric Progress Note documents the following: Behaviors Manifested: "Overly amorous with ladies." The 3-26-2009 Informed Consent To Use Psychotropic Medication documents R19's Reason for Medication: "Verbal outburst at almost every meal, depressed, sexual advances toward female residents." Nursing Note of 12-24-2008 at 11:30am states, "Overheard (R19) talking inappropriately to other female residents, attempting to lure these female residents to his room. Social Service notified." R19's 1-18-2009 at 10:00am Nursing Note states, "observed kissing another resident, attempted to handle her, and go to her room." The 1-25-2009 at 2:00pm Nursing Note states, "(R19) propositioned another resident to have relations with him."	F9999		

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F9999	Continued From page 67 Nursing Notes of 2-15-2009 at 10:00am and 2:00pm state, "(R19) talking inappropriately to a female." On 3-18-2009 at 2:00pm documented nursing note states, "(R19) acting out several times today, yelling, verbally aggressive. 3-18-2009 at 2:30pm (R19) propositioned another resident for relations. This nurse overheard and intercepted." In addition to the above Nursing Note incidents, four Concern Identification Forms/Witness Interview Forms dated 1-17-2009 through 3-10-2009 document R19 as victimizing R2, R25, R21, and R27 as follows: On 1-17-2009 E7 (Activities) reported, "I heard (R19) prodding (R25) along saying things such as, come on I (R19) just want to hold your hand. I (E7) tried to discretely remove (R25) from the situation, but it wasn't working as she was too confused. (R19) tried to get (R25) into his room, stating it's ok, he, referring to (R20, roommate) won't watch." E7 (Activities) reported that on 1-24-2009 at 10:30am, R2 and R19 were kissing. "I, (E7) spoke with (R2) about it and (R2) stated she's never done anything to get with (R19), but that (R19) is making her do it." E8 (CNA/Certified Nursing Assistant) reported on 3-4-2009 at 3:30pm, "I saw (R19) with his hand on (R21's) breast. (R21) screamed and it seemed like she was going to smack (R19). (R19) got very offensive with (Nurse) and started screaming at her, told her she was (fecal material) and was going to speak to the	F9999		

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F9999	Continued From page 68 (Administrator)." On 3-10-2009 E10 (Social Service Director) documented, "Nurse saw (R19) grab (R27's) breast. (Nurse) verbally cued (R19) and he responded it's all (fecal material) and mind your own business." E12 (Activities Aide) on 6-9-2009 at 9:35am. stated, "I've been the Activity Aide for about five years. I noticed a change in (R19) in January. I would report what I saw to the nurses. Some nurses told me to write a Concern Form, some said they would document it. The people I wrote Concern Forms on were defenseless. I know these people didn't like it. I feel (R19) knew what he was doing. (R19) went after dementia patients. The nurses asked me to watch (R19). They'd say he's already been on the women this morning, so watch him. They'd tell me this when I came in the morning. When I would leave for a short time he (R19) would wait until I was gone for moments and put his hands on, or target the dementia women. Sometimes he would pull back when I'd return or tell me to get out. (R19) would target (R8, R9, R27, and R28). Staff line them up in the lobby for meal times, three times a day and additional two to six times a day for cares or to be put to bed. (R19) would wait or sit in the lobby and at night there are less staff. Sometimes he would go from the first in line to the next while I was taking care of that person, he'd be at the next. (R19) wouldn't leave the lobby. It made me sick to watch this. I was sad. Who knows what else went on. I was told by nursing redirect (R19) or remove residents. The Social Service Director would only say we have to be more diligent. I am not aware of any meetings with Administration to discuss the incidents. I have a sense of relief	F9999		

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F9999	Continued From page 69 now that (R19) is gone. When you're eighty to have this happen to you. I believe this is on the verge of sex abuse. I'm not aware of any interventions with the women. They did put (R19) on medications. Staff, nurses, CNAs, and Social Service knew about these sexual incidents with (R19) in January. I didn't sleep for nights, two weeks worrying about this. Even with staff around this sex abuse went on. Leaving the women at the desk didn't help. Women are safe now. Before (R19) left no one was safe. It's a shame it went on this long." On 4-17-2009 the Social Service Progress Note states, "Increase in sexually inappropriate actions/words toward female residents, call into consultant for care plan suggestions. (R19) will see (Z1/Psychiatrist) 4-23-2009 with 8 documented incidents, so probably more. (R19) has problems with sexual behavior must monitor his actions toward our female residents. (R19) uses the walker, does move about on his own and where he wishes to go." The 4-20-2009 Sexuality Assessment for R19 identified the following: "Expresses an interest or intention in becoming sexually active with a peer." History of sexually inappropriate behavior documents, "excessive number of times at home with second wife." "(R19) has demonstrated sexually or inappropriate behavior in facility." Eight out of fifteen additional risk factors have been identified in this same assessment of R19. Summary: "(R19's) sexual advances to female residents is increasing in number and severity. Risks: Violation of private space -> sexual abuse." From 4-17-2009 through 4-25-2009 R19's	F9999		

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F9999	Continued From page 70 Nursing Notes document five incidents to female residents of "sexual innuendos, kissing and fondling breasts, kissing, grabbing, inappropriate talking, and exposing self, just squeeze it." Additionally from 4-16-2009 through 4-24-2009 four Concern Identification Forms/Witness Interview Forms document R19 victimizing R18, R28 and two unknown residents with similar behaviors as identified above. R19's 4-23-2009 Phychiatric Progress Note documents as follows: Behaviors Manifested: "Increased sexual action, shaking fist, aggressive, threatening, 4-25 kiss breast." Psychiatric Progress Note and Doctor Orders: "Met with patient and sons. Increased sexual behaviors, increased agitation, touching breasts, exposed self, impulsive behavior and comments. Discussed medications." From 4-25-2009 through 5-26-2009 R19's Nursing Notes document eight incidents to female residents of sexual innuendos, sexual inappropriate talk, kissing, fondling breasts, R19's hand between legs and fondling. These same Nursing Notes document R19's response to redirection from Nursing staff as verbally aggressive, angry, yelling, pointing and threatening to have staff fired. The eight Nursing Notes documenting R19's sexual abuse of unknown residents did not contain responses or interventions for the identified incidents other than inconsistent documentation of redirecting R19 or removing the female resident. On 5-20-2009 at 8:15pm, R19's Nursing Notes document, "Sitting in lobby in rocking chair watching television. This nurse walked another resident down to the shower room. When this	F9999		

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nurse returned in approximately two minutes later resident was standing over the top of another resident, who is in a wheelchair with his hands down the front of her pants moving his hand around. Resident was redirected away from the resident and (R19) began yelling, swearing, and name calling."

E10, Social Service Director on 5-23-2009 documents, "I tallied increased reports since (R19) saw (Z1/Psychiatrist) last (4)."

From 4-30-2009 through 5-22-2009 three Concern Identification Forms/Witness Interview Forms document R19 victimizing R8, R9, R29, and R34 with behaviors of kissing, touching/ fondling breasts, hands on lower half of resident's body, sexually inappropriate talking, and allegation of face slapping.

The 5-28-2009 Psychiatric Progress Note documents R19 as follows: Behaviors Manifested: "Targets other dementia females, kiss, hand under shirt, down pants, verbal outbursts." Psychiatric Progress Note and Doctor Orders: "Seen for follow-up sexual behaviors, some agitation, verbal outbursts."

On 6-5-2009 at 2:30pm, E22 (LPN/Licensed Practical Nurse) stated, "I think R19's behaviors were sexual in nature. Yes, it is sexual abuse when one resident touches another resident's breast without consent, regardless of their cognitive abilities. The incidents I witnessed were not consensual."

The 6-5-2009 at 2:23pm Nursing Note documents that R19 was transported for inpatient hospital evaluation.

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F9999	Continued From page 72 On 6-5-2009 at 3:25pm, Z2 (Medical Director) stated, "about two or three weeks ago the Administrator called me about (R19's) sexual behaviors. I advised the Administrator to call the Psychiatrist and (R19's) primary care physician. Just yesterday I was told how many residents were involved. In my opinion the women were demented, do not know what was done. I have not been told about all the victims, reporting, and frequency. (R19) is in (acute care facility). The problem has been solved because (R19) is not present." E2 (DON/Director of Nursing) on 6-4-2009 at 2:40pm stated, "(R19's) sexual overtures with female residents began in January 2009. The CNA (Certified Nursing Assistants) staff kept coming to me about (R19's) behaviors and asking what to do. I'm wondering if we didn't do enough for the residents. In fact last night we (Administration) discussed did we act appropriately. Did we do enough, so we went and interviewed the residents. We discussed were they victimized and other ladies in the area. I thought damn I didn't do anything for them, (victims). I might have made wrong choices with (R19), but I don't think so. We have looked at this from (R19's) point of view." On 6-3-2009 Z1 (Psychiatrist) stated, "I agree there are two separate issues, (R19's) behaviors and how to manage these behaviors with other residents." During this same interview Z1 verbalized he saw R19 on 11-10-2009, 3-26-2009, 4-23-2009, and 5-28-2009. The facility's undated Abuse Policy lists the following Policy Statement and procedure:	F9999		

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F9999	Continued From page 73 "The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, neglect, or abuse of our residents. This will be done by: Identifying occurrences and patterns of potential mistreatment. C. Pattern Assessment At least quarterly, the Quality Assurance Committee will review Concern Identification Reports, Accident / Incident Reports.....to assess possible patterns or tends.....that may constitute abuse, neglect, or theft." The Abuse Prevention policy indicates that: "Sexual Abuse includes, but is not limited to, sexual harassment, sexual coercion, sexual assault." The facility did not follow their own policy and procedures when they did not track these incidents by R19, but rather reported the incidents with female resident victim known and unknown names, either on Concern Identification/Witness Interviews or in Nursing Notes. Three different Forms were used, some were one page, some double sided. Therefore a pattern was also not identified by Administrative personnel. The facility's undated Abuse Prevention Policy also indicates that: "All residents, visitors, volunteers, family members or others are encouraged to report their concerns or suspected incidents of potential mistreatment to supervisor or the administrator. Such reports will.....be thoroughly investigated. The nursing staff is additionally responsible for reporting on a facility incident report.....as they	F9999		

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(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
F9999	Continued From page 74	F9999		

occur. Upon report of such occurrences, the nursing supervisor is also responsible for assessing the resident, reviewing the documentation and reporting to the Administrator or designee."

This same policy outlines that: "If, during the course of an incident investigation, the Administrator/ DON/SSD has determined that there is reasonable cause to suspect mistreatment has occurred, the resident's representative and the Department of Public Health shall be informed immediately."

From 1-17-1009 through 5-26-2009 there are 11 Concern Identification / Witness Interviews documenting R19's sexual victimization of ten known residents, (R2, R8, R9, R21, R25, R27, R28, and R29). These reports are incomplete, lacking names of witnesses, victims, dates, times, locations. The reports also inconsistently document interventions, outcomes, who reporting to, if family or physician's were notified, resolutions, and interviews of involved residents were not completed.

On 6-3-2009 at 2:40pm. E2, (DON) stated, "Last night we (Administration) discussed did we act appropriately, did we do enough, so we went and interviewed the residents. We wanted to make sure we addressed the other ladies. We sent the one incident of 4-16-2009 involving (R19) and (R18) to Public Health. We did not report the other incidents to Public Health."

As a result of the facility failure to protect and provide interventions, 10 of 10 residents were sexually abused (R2, R8, R9, R18, R21, R25, R27, R28, R29, and R34) by another resident,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146116	A. BUILDING _____ B. WING _____	06/12/2009

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F9999	Continued From page 75 (R19). This incident began on 1-17-2009, with the first documented incident of abuse. Additional incidents of documented abuse occurred through 5-26-2009. On 6-2-2009 at 10:20am. and 6-3-2009 at 2:30pm. R19 was ambulating independently within the facility. R19 was at times, out of staff's sight. (A)	F9999		