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| F 490 | Continued From page 43<br>C. E2 examined R2 and no visible signs of sexual contact or trauma were discovered at 6:15 pm on 07-22-10.<br>D. R2's physician was contacted and notified of the alleged incident. Z2 was requested to examine the resident and he declined indicating that this was not necessary at 6 pm on 07-22-10.<br>E. The local emergency room was contacted on 07-22-10 at 10 pm and indicated because the alleged incident occurred early in the week it was not necessary to send resident.<br>F. List of all staff was obtained and in-service initiated on the Abuse Prevention policy and Procedure by E1 and E2. Education was initiated at 6:15 pm on 07-22-10 and on-going until all staff re-education was completed.<br>G. Facility Ombudsman notified of allegations by E1 at 12:20 am on 07-23-10.<br>H. The local Police Department was contacted per policy at 7 pm on 07-22-10.<br>I. Interviews initiated with staff working on the shift of the alleged incidents at 6:15 pm on 07-22-10. Interviews will be conducted per policy by the facility management team.<br>J. Directed In-service will be conducted by E13 on facility Abuse Prevention Policy. Also utilized will be the training program: Keeping nursing Facility Residents Safe (AHCA).<br>K. Z1, Medical Director, was contacted by E1 and notified of the situation. Z1 approved the facility's Quality Assurance Plan of Action on 07-23-10 at 11:09 am.<br>L. Quality Assurance tool has been created to assist with monitoring for staff compliance with the Abuse Policy and will be done at least 5 times a week by the facility managers. This is on-going.<br>M. Any concerns noted will be addressed immediately, re-education done as indicated and | F 490 | | |

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| F 490 | Continued From page 44<br>any patterns and trends will be discussed weekly in the Compliance Quality Assurance Sub-Committee for further recommendations. | F 490 | | |
| F9999 | FINAL OBSERVATIONS<br><br>LICENSURE VIOLATIONS<br><br>300.690a)<br>300.690b)<br>300.690c)<br>300.695a)3)<br>300.695b)3)<br>300.695c)<br>300.695d)<br>300.1210a)<br>300.3240a)<br>300.3240b)<br>300.3240d)<br><br>Section 300.690 Incidents and Accidents<br><br>a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident.<br><br>b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident.<br><br>c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If the facility is unable to contact the Regional Office, it shall | F9999 | | |

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| F9999 | Continued From page 45<br>notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.<br><br>Section 300.695 Contacting Local Law Enforcement<br><br>a) For the purpose of this Section, the following definitions shall apply:<br>3) Sexual abuse - sexual penetration, intentional sexual touching or fondling, or sexual exploitation (i.e., use of an individual for another person's sexual gratification, arousal, advantage, or profit).<br><br>b) The facility shall immediately contact local law enforcement authorities (e.g., telephoning 911 where available) in the following situations:<br>3) Sexual abuse of a resident by a staff member, another resident, or a visitor;<br><br>c) The facility shall develop and implement a policy concerning local law enforcement notification, including:<br>1) Ensuring the safety of residents in situations requiring local law enforcement notification;<br>2) Contacting local law enforcement in situations involving physical abuse of a resident by another resident;<br>3) Contacting police, fire, ambulance and rescue services in accordance with recommended procedure;<br>4) Seeking advice concerning preservation of a potential crime scene;<br>5) Facility investigation of the situation.<br><br>d) Facility staff shall be trained in implementing the policy developed pursuant to subsection | F9999 | | |

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| F9999 | Continued From page 46<br>(c).<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>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.<br><br>Section 300.3240 Abuse and Neglect<br><br>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)<br><br>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)<br><br>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)<br><br>These requirements were not met as evidenced by the following:<br><br>Based on record review and interviews, the facility failed to ensure that one of two residents, R2, who is in a persistent vegetative state, was kept free from sexual assault and mental abuse by Z3, spouse of R2. The facility staff had | F9999 | | |

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knowledge of Z3 turning off R2's oxygen and humidifier used with a tracheostomy and R2's tube feeding on 06-06-10. The facility staff also had knowledge of two additional incidents, 07-16-10 and 07-19-10, of sexual assault by Z3 to R2. The facility did not conduct investigations or implement preventive measures to protect R2 from harm and from actual and potential abuse. In addition, they failed to notify the Department and law enforcement of these incidents.

The findings include:

1. R2 is a 25 year old female resident who resides in the facility since 06-03-10 according to her admission record. The discharge summary dated 06-03-10 from a rehabilitation hospital documents discharge diagnoses as follows: Respiratory Failure: status-post liberation from ventilator; continues on tracheostomy collar and Persistent vegetative state.

The progress note dated 06-05-10 from Z2, R2's physician, documents resident's history as "Patient became unresponsive at home, had respiratory failure and cardiac arrest. Patient was resuscitated at hospital...." These notes also indicate that during the exam R2 was unresponsive to verbal or painful stimuli, no reaction to light, and chest expansion poor.

The most recent assessment dated 06-16-10 indicates that R2, is in a persistent vegetative state and cannot make decisions nor communicate and is totally dependent on two or more staff physical assist for bed mobility, transfer, dressing, eating, toilet use, personal hygiene and bathing. The care plan for R2 dated 06-16-10 includes a concern that R2 is in a

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persistent vegetative state related to hypoxic/anoxia brain injury and is unable to make decisions related to care.

On 07-22-10 at 1:25 pm, E4, Licensed Practical Nurse, was interviewed. During this interview, E4 stated there was a problem concerning R2 and Z3 on 06-06-10 during the midnight shift. E4 also stated that she called E2, Director of Nursing, and E2 told her to write a note and put it under E2's office door. E4 stated she had a copy of this note and gave the note to the surveyor. The note documents that Z3 had been visiting R2 for several hours and at one point Z3 closed the door. E4 opened the door to check on the resident in bed one. E4 observed Z3 leaning over R2 and when the door opened he stood very fast with an odd look on his face. When Z3 left, E4 went into the room to check on R2's tracheostomy and feeding tube and found all machines had been turned off. E4 turned all equipment back on and performed suctioning on R2. E4 verified the information in the note and also stated that R2 had facial grimacing when E4 saw her after the incident when the machines were turned off.

E4 stated that after Z3 would visit R2, R2 would appear to be agitated and would move her head from side to side. E7, Registered Nurse/Nurse Manager verified during an interview on 07-23-10 at 2:45 pm, that R2 can give expressions of stress or agitation if staff are doing something to her she does not like.

E6, Certified Nurses Aide, stated during an interview on 07-22-10 at 3:00 pm that R2 "can't say yes or no but when husband is here, she has an expression like 'help me.' It is always the

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| F9999 | Continued From page 49<br>same expression."<br><br>E11, Social Service Designee, stated during an interview on 07-27-10 at 2:00 pm that the first time she heard anything pertaining to a problem with R2 and Z3 was in morning meeting soon after R2's admission on 06-03-10. E11 stated during this interview that staff were talking about maybe the husband turned off equipment in R2's room, hid in the curtain, and was looking suspicious if someone walked by R2's room.<br><br>On 07-22-10 at 4:45 pm during the daily status meeting, E2 stated that she did not know that all of R2's equipment had been turned off the evening of 06-06-10 and did not remember reading a note that had been pushed under her office door.<br><br>A consultant report completed by Z4, Social Service Consultant, on 06-17-10 with copies to E11 and E12, Interim Administrator, during this time period, documents that "it appears husband visits need to be monitored closely for any issues. Staff are concerned he may have unplugged some of her equipment. Per nsg. (nursing) notes there is more movement/reaction after husband visit (appears negative reaction - biting lip, etc)." E1, Administrator, and E2 verified that they did not know of Z4's recommendations.<br><br>During an interview on 07-22-10 at 11:00 am, E2 verified that staff did not follow the abuse policies and procedures, did not start an investigation as to how the equipment got turned off, did not implement Z4's recommendation of increased monitoring with husband, and did not make any changes to R2's plan of care to keep R2 safe. | F9999 | | |

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| F9999 | Continued From page 50<br>2. On 07-22-10 at 3:45 pm, E5, Certified Nurses Aide, was interviewed and stated that on 07-16-10 in the early hours of the morning, she was taking a break outside and observed that R2's window blind was not covering the window completely because of care items in the window. E5 observed Z3 pull R2 to the edge of the bed. Z3 unzipped his pants and put her hand in his pants. Z3 looked around and then went to the window and got a container of skin barrier cream. Z3 then stood next to the bed with his left foot on the floor and his right foot over R2 in the bed. E5 ran to tell E8, Licensed Practical Nurse, what was going on in R2's room. E8 had E5 call the on-call nurse, E10. E10 was not sure what to do so she told E5 that she would call E2 and E3, Assistant Director of Nurses. E10 could not get E2 and E3 to answer so she called E9, Licensed Practical Nurse and E9 told her to have Z3 leave. E10 called the facility with the information but Z3 had left the building by that time.<br><br>E10 stated in an interview on 07-27-10 at 10:40 am that E2 called her back at 7:00 am that morning and E10 told her what had happened earlier that morning. E10 also stated that in morning meeting on 07-16-10, E2 told E1, Administrator that they needed to talk about the "R2 situation."<br><br>During an interview on 07-23-10 at 2:20 pm, E9 verified that E10 had called her during the early hours of 07-16-10 for advice on what to do about the situation with R2 and Z3. E9 also verified that E2 told E1 that they needed to talk about the "R2 situation."<br><br>During an interview on 07-22-10 at 11:00 am, E1 and E2 verified that staff did not follow the abuse | F9999 | | |

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policies and procedures, did not start an investigation as to what had occurred on the morning of 07-16-10, did not implement increased monitoring and supervision when Z2 visited, and did not make any changes to R2's plan of care to keep R2, who could not speak for herself, safe.

3. On 07-22-10 at 1:25 pm, E4, Licensed Practical Nurse, was interviewed. E4 stated that on 07-19-10, all staff made excuses to go into R2's room after Z3 came at approximately 12:30 am. E4 stated that she saw Z3 shave R2's legs, thighs, and maybe R2's pubic area.

E6, Certified Nurses Aide, was interviewed and stated that Z3 came in to see R2 at about midnight on 07-19-10. E6 stated that she and E5, Certified Nurses Aide, gave incontinent care to R2 and then both went outside for their breaks. Then, E6 stated she went to R2's window where the blinds were open at the bottom of the window to see what was going on in R2's room. She observed Z3 pull R2 to the edge of the bed with R2's back to him. Z3 kissed R2, went to the door and looked out, went back to the bed, undid his belt, and unzipped his pants. E6 said Z3 had one hand in his pants and the other in R2's vagina or rectum, moving his fingers at a fast pace. E6 stated she could see the left side of Z3's body. Z3 had raised the sheet up and she could see R2's naked buttock. E6 reported this incident to E4 immediately. After Z3 left, E6 and E4 did an assessment of R2's physical condition. E6 stated R2 was very red around the anus and vagina with fingerprint bruises on right buttock and a scratch on the left buttock and that her skin looked different than she looked just less than 30 minutes before when E6 had given incontinent

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| F9999 | Continued From page 52<br>care.<br><br>E4 stated during an interview on 07-22-10 at 1:25 pm that on 07-19-10, E5 came to get her to look through R2's window from the outside. Next, E4 saw Z3 with 3 or 4 fingers of his right hand in R3's vagina and his belt buckle undone hanging to the left side and his left arm moving. E4 stated after Z3 left, she did an assessment of R2's physical condition and observed the rectum was open, stretched to the size of a quarter, finger print red areas on the right buttock and scratches on the left buttock. E4 stated there were also loose hairs where the pubic hairs were partially shaved. E4 notified E9 a little after 3:00 am that Z3 had been in and had masturbated himself and R2. E4 tried to call E2 but there was no answer. E4 wrote a note about the incident and put it under E1's door and called him at 8:00 am. E1 told E4 to come to the facility at 10:00 am to tell staff what happened.<br><br>On 07-22-10 at 11:10 am, E2 was interviewed and stated, "I just did not know what to do and have never had anything like this happen."<br><br>4. On 07-23-10 at 10:11 am, Z3 was interviewed. During this interview, Z3 stated that he has taken care of R2 here like she was at home. He verified that he did shave her legs and upper thighs. Also, Z3 stated that she liked her pubic area shaved and he shaved it like she liked it on Monday morning, 07-19-10. When Z3 was asked if he has masturbated in R2's room, he stated no. When asked if he had his hands in his pants, he indicated that he was adjusting himself. When asked if he put R2's hand in his pants, he stated he put her hand on his upper leg. When asked if he ever put his fingers in R2's vagina, he replied | F9999 | | |

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that one time the facility was short handed and R2 had a bowel movement. Z3 told staff he would clean R2 up. There was bleeding when he wiped her and he wanted to know where the bleeding was from so he put his fingers in her vagina. He left the cloth on the table for staff to see.

A note dated 07-19-10 and signed by E1, E2, and E3 states in part that staff members E4, E5, and E6 reported to E1 and E2 that resident R2's husband Z3 had touched her in a sexual manner on 07-19-10 at approximately 0300 (3:00 am). Interviews were conducted with staff members involved. Regional Nurse, E13 was notified as well as E14, Regional Director of potential allegation of abuse. After speaking with E13 again, Z3 was contacted and asked to come to the facility to meet with administration and nursing management. Upon his arrival to facility, conference was held with Z3, E1, E2, and E3. Discussed with Z3 staff reports of sexual activity between him and his spouse and that due to the diagnosis of anoxic brain injury and persistent vegetative state rendering her incapable of expressing consent to such activity that state and federal regulations prohibited such contact. Advised Z3 that no form of sexual contact should occur while R2 was a resident of this nursing facility. Z3 was also encouraged to visit during daytime/early evening hours to allow R2 to rest and recuperate as quickly as possible as well as cut down on suspicions from staff members. Z3 verbalized understanding and agreement with proposed plan of care.

(A)