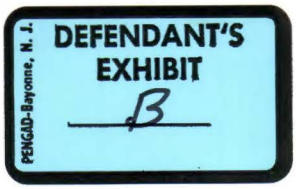
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/28/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105772	A. BUILDING _____ B. WING _____	R 03/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REHABILITATION CENTER OF ST PETE	435 42ND AVE S SAINT PETERSBURG, FL 33705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS SKILLED NURSING FACILITY REVISIT TO ANNUAL QIS AND LIFE SAFETY SURVEY CONDUCTED IN CONJUNCTION WITH COMPLAINT INVESTIGATION # 20140002548 (UQ2111) March 17 - March 20, 2014 Findings of on-going Immediate Jeopardy were identified at F 490 S/S: J AND F520 S/S: J. The following tags, identified at the Annual QIS survey, were not in substantial compliance: F431, F441, F490. A partial extended survey was completed on 3/20/14. The Administrator was informed of the on-going Immediate Jeopardy on 3/20/14 at 6: 55 p.m. The Rehabilitation Center of St. Petersburg is not in compliance with 42 CFR Part 483 Requirements for Long Term Care Facilities. The facility has not been in substantial compliance since 2/10/2014.	{F 000}		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.	F 278		4/19/14

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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A registered nurse must sign and certify that the assessment is completed.

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:
Based on observation, record review and interview, the facility failed to ensure that current assessment information regarding smoking habits were accurate for 1 (#20) of 9 sampled resident's to reflect a decline in health as evidenced by 3 transfers to a higher level of care during 01/14 and 02/14 regarding concerns of shortness of breath and COPD.

Findings include:

A review of Resident #20's clinical record documented an original date of admission of 10/10, a 56 year old female with diagnoses that

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included: difficulty in walking, pain in joint, ankle and foot, personal history of pneumonia/recurrent, anemia, congestive heart failure, depressive disorder, dementia with behavioral disturbances, polyneuropathy in diabetes, insomnia, chronic airway obstruction, hypertension, unspecified psychosis and esophageal reflux.

A review of Resident #20 ' s clinical chart revealed a transfer form, dated 02/23/14. (Date was confirmed with Director of Nursing (DON) at 9:26 a.m., 03/20/14). The form was signed by the 11 p.m. to 7 a.m. nurse, the current Medical Problem (reason for transfer): SOB (Shortness of breath), O2 at 83%.

A review of a physician telephone order, dated 02/07/14 at 12:00 p.m.: Per Patient transfer to a local hospital.

A review of a physician telephone order, dated 01/13/14: Sent to (a local hospital) to evaluate and treat, DX SOB (diagnosis shortness of breath).
A review of a local hospital history and physical, print date of 01/16/14 for a hospital admission of 01/13/14: This is a pleasant 56 year old ...who did come to (hospital) from her skilled nursing facility secondary to worsening shortness of breath. The patient does have a longstanding history of severe COPD with ongoing tobacco abuse ...

Further review of Resident #20's record revealed that she resided on the 3rd floor of the facility. During the survey conducted on 03/19/14, the 3rd floor of the facility was observed to have unattended elevator access to the 1st floor and

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unimpeded access to the outside smoking patio.

A review of the 01/22/14 Minimum Data Set (MDS) Quarterly Review for Resident #20, section J300 that asked the question of the status of "Current Tobacco Use" found this area was blank.

A review of the 02/10/14 MDS Discharge Data set for Resident #20, section J300 that asked the question of the status of "Current Tobacco Use" found this area was blank.

An observation was conducted on 03/17/14 at 3:30 p.m. conducted on the smoking patio of the facility. The smoking patio was located on the southwest side of the building. During the observation, no staff were present on the patio. Resident #20 was observed to be present on the patio in possession of a pack of cigarettes and a lighter. The resident was observed to light a cigarette and proceed to smoke.

A Review of a facility "Smoker Safety Awareness" form, dated 10/07/13, signed by the Activity Director, revealed that the level of observation determined by the assessor was that Resident #20 was to be "Observation" by a patio attendant for safety. Further review of the form revealed no documentation or evaluation of the resident's current diagnosis or medical conditions that could have a bearing on the resident's safety during the smoking activity. The form was further reviewed and found to have higher levels of services provided by staff, such as "Supervised by nursing staff in supervised group and 1:1 supervision by nursing staff."

Review of Resident #20 ' s progress notes

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revealed the following entries:

"03/09/14 at 3:56 a.m.: down to patio several times to smoke ...
03/08/14 at 22:41 p.m.: ...Patient alert and oriented. Remained ambulatory. Goes to smoke from time to time. Pain pill administered earlier.
03/07/14 at 14:17 p.m.: Vision Care: Resident has been referred for vision services.
03/04/14 at 14:09: Wheezing noted throughout. B/L lungs receives neb treatments prn every 4 hours ...PRN oxycodone for pain control..
03/04/14 at 2:47 a.m.: ...Patient ambulates throughout facility and smoke area at will.
03/03/14 at 2:16 a.m.: down to patio to smoke, abt in progress for pneumonia ...
02/16/14 at 2:31 a.m.: up ambulating about unit, downstairs to patio to smoke, back on unit."

During an interview conducted on 03/20/14 at 10:58 a.m. with Staff member E, the 11 p.m. to 3 p.m. shift nurse, she stated that she works at the facility 3-4 days a week. She stated that Resident #20 is a heavy smoker who can ambulate thru the facility independently. She stated that she or the CNA's will go down with the resident on occasion; but, that the resident has gone down to the smoking patio on her own.

An interview conducted on 03/20/14 at 9:46 a.m. with the DON, she stated that she came to the facility in 6/13 and has been in the DON position since that time. In regards to the smoking assessment for the residents, the Activity Director completes the "Smoker Safety Awareness."

She further stated that Nursing has an evaluation that they do upon admission that answers the

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F 278	Continued From page 5 question if the resident is a smoker. They are identified as a smoker. She also indicated that the nurses do complete a smoking assessment. (She stated that the prior electronic system had an assessment that would be completed by the nursing staff, and then the facility changed to a Point click care electronic system the smoking assessment was recently added.) The DON was asked to provide the Nursing Smoking assessment completed for Resident #20; she reviewed the electronic record for the resident at 9:51 a.m. on 03/20/14 and stated that there was not a nursing assessment for the resident in the system; she stated that since it was not in the electronic system, it should be in the chart. The smoking assessment that was provided was the 10/07/13 assessment, the "Smoker Safety Awareness" form that had been completed by the Activities Director. No additional assessment was provided. The DON agreed that the form did not capture the current medical conditions of the resident regarding the COPD and the shortness of breath that she had been experiencing.	F 278		
{F 431} SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be	{F 431}		

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{F 431}	Continued From page 6 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the facility failed to maintain the pharmaceutical integrity of time sensitive biological's and medications in two of three Medication Storage Rooms (First and Third Floor) and 3 of 6 Medication Carts (First Floor 1, Second Floor South, Third Floor North). Finding Include: 1. On 3/17/2014 at 12:20 p.m. observation of medication storage room First floor unit 1 revealed 1 bottle of #60 tablet of Advance Stress Zinc expiration date 1/20/2014. Interview with the Director of Nursing (DON) on	{F 431}		

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{F 431}	Continued From page 7 3/17/14 at 12:30 p.m. confirmed the expired medication. 2. On 3/17/2014 at 12:40 p.m. observation of the medication storage room of the Third floor revealed Novolog 100 unit vial opened 1/19/2014 per pharmacy label to discard 28 days after opening. Two Insulin Flex-pens open date not indicated on label of pen. Staff Interview with the Unit manager on 3/17/14 at 12:40 p.m. confirmed expired medication and syringe and stated she checks the storage room once week on every Monday. 3. On 3/18/14 at 10:40 a.m. observation of medication cart on the 3rd Floor North Team with Staff member C and Unit Manager revealed undated medications for the following medications and residents. Resident # 72 1) Levemir Insulin 100 unit vial, open date not indicated. 2) Novolog Insulin 100 unit open date not indicated and label from pharmacy reads " Discard 28 days after opening". Resident # 2 1) Humulin R 100 units vial, open date not indicated and label from pharmacy reads " Discard after 28 days of opening". Resident # 20 1) Novolog Mix 70/30 vial, open date not indicated and label from pharmacy reads " Discard after 28 days of opening". 2) Humulin R 100 unit vial open date not indicated and label from pharmacy reads " Discard after 28 days of opening". Resident # 13 1) Novolin R 100 unit vial, open date not indicated and label from pharmacy reads " Discard after 28 days of opening". Resident # 127 1) Novolin R 100 unit vial, open date not indicated and label from pharmacy reads " Discard after 28 days of opening". Resident # 47 1) Novolin R 100 unit vial, open	{F 431}		

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{F 431}	Continued From page 8 date not indicated and label from pharmacy reads " Discard after 28 days of opening". Staff member C and 3rd Floor Unit Manager confirmed the vials of insulin had multiple puncture marks in the top rubber stopper with various amounts of liquid remaining in vials. Staff member C stated " I didn ' t open those because I write the date on them. But your right they have been used and should have been dated. " 4. 3/18/14 at 1:05 p.m. observation of Medication cart Second Floor North cart with Staff member H revealed the following: One ipratropium bromide and albuterol sulfate inhaler solution 0.5 mg/ 3 mg per 3 ml. Open date not indicated and label from pharmacy reads " Discard after 7 days of opening". Confirmed by Staff member I. 5. 3/18/14 observation at 12:42 p.m. of Medication cart First Floor cart I at 12:42 p.m. with Staff member J revealed the following: One Bottle of Lorazepam 0.5 ml. 30 ml dispense Label from Pharmacy reads " Refrigerate after opening". "Discard after 90 days." First date of use 3/13/2014 at 6:00 a.m. 29 ml remaining. Medication left in the medication cart confirmed by nurse and stated " I didn't even know it said to refrigerate it". At 1:45 p.m.the nurse stated per the pharmacy the medication was still viable. 3/18/14 Interview with DON at 5:02 p.m. confirmed medication was not dated and the expired. She stated the Unit Manager is ultimately responsible to monitor the medication cart and storage rooms. The nurses are required to monitor the carts, write the date opened and dispose of expired medications. They have all been in-serviced.	{F 431}		
{F 441}	483.65 INFECTION CONTROL, PREVENT	{F 441}		

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{F 441} SS=D	Continued From page 9 SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	{F 441}		

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{F 441}	Continued From page 10	{F 441}		

This REQUIREMENT is not met as evidenced by:
Based on observations, record review, interview and review of the facility ' s policy on Hand Washing, facility staff failed to wash their hands after each direct care resident contact for which hand washing is indicated by accepted professional practice. Employees A and B failed to wash their hands after direct care for two of five resident observations (Resident 's #104 and # 14), The facility's current census was 151 residents.

The findings included:

1. The facility admitted Resident # 104 on 4/30/09 with diagnoses including Hypertension, Enteritis, Rheumatoid Arthritis, Contractures, Anemia and Cachexia, according to facesheet/demographic information.

Review of the Quarterly Minimum Data Set dated 2/6/14 revealed the resident scored a 15/15 on her Brief Interview for Mental Status indicating no cognitive impairment. No behaviors were coded during the assessment window. The resident was coded as requiring total staff dependence for ADLs. The resident was coded as always incontinent.

During an observation of personal incontinent care for Resident #104 on 3/18/14 at 9:25 AM, Employee A (CNA) knocked on the door and entered the room. She gathered her supplies and washed her hands. She provided incontinent care to the resident. While turning the resident and provided incontinent care, the aid's lanyard with her name badge and keys was observed to

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touch the resident's bare skin. Upon completion the aide removed her gloves, gathered her soiled linen and trash and tied the bags. She then emptied the water basins and stated that there were no paper towels and exited the room. She walked to the soiled utility room and used a key that was on a lanyard around her neck to open the door. She then exited that room and walked down the hallway to the soiled linen room and deposited the linen in a barrel. She then washed her hands.

During an observation of wound care for Resident #104 on 3/18/14 at 9:55 AM the treatment nurse, Employee C (LPN) washed her hands and donned gloves. She cleansed the wound and patted it dry. The wound was noted to be an irregularly shaped open wound. There was no evidence of a current fungal infection; however the surrounding skin was de-pigmented. Minor sero-sanguinous drainage was noted with no odor. The nurse washed her hands and donned clean gloves. She applied the alginate treatment and an island dressing. She then removed her gloves and gathered the trash. She exited the room and walking down the hallway, put her right hand in her right pocket and pulled out keys. She then opened the linen room door and put the keys back in her pocket. She exited the room and walked back to her cart, opened her cart and sanitized her hands.

Review of the Non-Pressure Wound Assessment dated 3/14/14 revealed the resident had a right perianal area that measured 2 x 0.5 x 0.4 cm with light serous drainage noted. 20% fibrin tissue, 50% granulating tissue and 30% stable skin. The wound was stable. The wound was not present on admission.

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{F 441}	Continued From page 12	{F 441}		

The resident's current physician's order (March, 2014) to the Right Perineal Area was cleanse the wound and apply Silver Calcium Alginate to the wound daily.

2. The facility admitted Resident # 14 on 9/13/13 with diagnoses including Acute Respiratory Failure, Dementia, Alcohol Withdrawal, Hemiplegia, Hypertension and Dysphagia, according the facesheet/demographic information.

Review of the Wound Assessments revealed on 3/12/14 the right ankle measured 0.2 x 0.5 x 0.5 cm stage IV Pressure Ulcer with 10% slough. The current physician's order was to continue Santyl QD. She had bilateral boots.

During an observation of wound care for Resident # 14 on 3/18/14 at 10:15 AM, Employee B (LPN) washed her hands, donned gloves and removed the old dressing. The wound was noted to be yellow in color with macerated margins; sero-sanguinous drainage was noted but no odor. The Nurse stated the wound was a Stage IV. She washed her hands and donned clean gloves. She applied Santyl ointment and a clean dressing. She then re-applied boot. The nurse removed her gloves and gathered the trash. She exited the room and walked down the hallway. She pulled a key from her right pocket and opened soiled utility room. A hand washing sink was observed in the soiled utility room. She exited the soiled utility room and walked part way down the hallway to a hand sanitizing station and cleansed her hands in the hallway.

3. During an interview on 3/18/14 at 4:03 PM

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Employee B confirmed she did wash her hands after finishing the treatments for Resident #104 and Resident # 14. She stated that she sanitized her hands after she went to two soiled utility rooms to dispose of the trash bags. She confirmed that she reached in her pocket for the keys and did not wash her hands before exiting the resident's room. The nurse stated that she was aware she was supposed to wash her hands before exiting the room.

4. Review of the facility's policy entitled Hand Washing/Hand Hygiene revised 2006 revealed under Policy Interpretation and Implementation item 2. " Employees must wash their hands for 10 to fifteen seconds using antimicrobial or non-antimicrobial soap and under the following condition: a. when hands are visibly dirty or soiled with blood or other body fluids; b. after contact with blood, body fluids, secretions, mucous membranes or non-intact skin; c. after handling items potentially contaminated with blood, body fluids or secretions; and d. before eating and after using a restroom." Item 4. " The use of gloves does not replace hand washing/hand hygiene. " Under the section of General Guidelines, item 4. " If hands are not visibly soiled, use an alcohol based hand rub for all of the following situations: a. before direct contact with residents ...d. before preparing or handling medications. e. before handling clean or soiled dressings, gauze etc. f. before moving from a contaminated body site to a clean body site during resident care; g. after contact with a resident ' s intact skin; h. after handling used dressings, contaminated equipment .... after removing gloves. "

5. During an interview on 3/18/14 at 5:10 PM the Director of Nurses was informed of the treatment

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{F 441}	Continued From page 14 observations and breaks in infection control related to hand washing. She stated that she expected her nurses to wash her hands after removing their gloves and before exiting the resident rooms.	{F 441}		
{F 490} SS=J	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING 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 review of the Administrator's job description, resident and staff interviews, clinical record review, and three facility policies and procedures related to Abuse, the facility administration failed to operationalize facility policies related to abuse for three of nine sampled residents (#1, #11 and #225), one (#1) of whom was a known sexual offender; failed to investigate and report an allegation of sexual abuse to the abuse hotline and state agency and failed to provide emotional support and psychosocial services to Resident # 11. Despite the facility having knowledge of Resident # 1 being a known sexual offender, the administration failed to protect Resident # 11 from sexual advances. The administration failed to provide staff with the necessary information to protect Resident # 11 from the sexual approaches from Resident # 1. The administration failed to ensure that systems were in place and staff trained to prevent a	{F 490}		

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recurrence of the sexual assault by a known sexual offender.
Administration demonstrated a lack of action and commitment to protect Resident # 11 and all elderly and/or disabled residents of the facility which resulted in the determination of on- going Immediate Jeopardy on 3/20/14 at 6: 55 p.m.
Additionally, the facility administration failed to implement its policy and procedure for investigating and reporting all allegations of abuse immediately to the abuse hotline and the state agency related to an allegation of abuse made by resident # 225, one of nine sampled residents.

Findings include:

1. Review of the facility's "Administrator" job description revealed under "Purpose of your Job Position."

"The primary purpose of your job position is to direct the day-to-day functions of the facility in accordance with current federal, state and local standards, guideline, and regulations that govern nursing facilities to assure that the highest degree of quality care can be provided to our residents at all times."

2. Review of the Administrator's job description under the section entitled "Duties and Responsibilities - Administrative Functions" included:

"Plan, develop, organize, implement, evaluate, and direct the facility's programs and activities in accordance with guidelines issued by the governing board.
Develop and maintain written policies and

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procedures and profession as standards of practice that govern the operation of the facility Interpret the facility's policies and procedures to employees, residents, family members, visitors, government agencies, etc. as necessary. Assume the administrative authority, responsibility and accountability of directing the activities and programs of the facility."

3. Review of the Administrator's job description under the section entitled "Resident Rights" revealed:
"Ensure that the resident's rights to fair and equitable treatment, self-determination, individuality, privacy, property and civil rights, including the right to wage complaints are well established and maintained at all times. Review resident complaints and grievances and make written reports of action taken. Discuss such actions with resident and family as appropriate."

4. On 3/20/14 at 9: 34 a.m., a phone interview was conducted with Resident # 11. Resident # 11 related that on 2/13/14 at approximately 10: 00 p.m., his roommate, Resident # 1, "put his hand under the curtain and moved his hand on the sheet to about ¼ inch from my private parts." "I still have nightmares about it." Resident # 11 stated he was in bed with the curtain pulled when this occurred. He stated he yelled for Resident # 1 to stop or he would hit him with his cane and Resident # 1 then withdrew his hand. Resident # 11 stated he could not move away because he had recently had a stroke. He stated he was afraid he would come back at him, "he was a big guy, I got really scared and didn't sleep the whole night. He stated he did not tell anyone that night because he was embarrassed. He stated the

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next morning he was still in the room with Resident #1 when "some Doctor" came and he heard him ask Resident # 1 why he had molested two children. He stated that scared him more and he stated, "he could have hurt me; he could have been a murderer. They needed to check these things before they admit someone like that." He stated that he that he was not made aware of this when they moved his roommate into the room. He stated the Administrator and the Social Worker told him the next day, 2/14/14, that they wanted to talk to him about his roommate and he told him what had happened. He stated that the Administrator told him that he was sorry that had happened to him and they would move him to another room. He stated that after he told them about the incident with Resident # 1, they brought a "Big Nurse" into the room that stayed with him and protected him from Resident # 1. He stated the staff member said to him that he would protect him. He stated when Resident # 1 was moved out of his room "I was so relieved."

Review of the record for Resident # 11 revealed that he was admitted to the facility on 2/3/14 from the hospital with diagnosis of weakness due to right sided Cerebrovascular Accident Vascular Accident (CVA), according to an admission nursing note in the resident's record. Review of a Minimum Data Set (MDS) admission assessment, with an assessment reference date of 2/9/14, revealed that the resident scored 15 out of 15 on the Brief Interview for Mental Status (BIMS) assessment. The resident was coded as having no speech, vision or hearing problems, able to understand and be understood and no behaviors exhibited.

Functional Status on the admission MDS was

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coded as:
"Bed Mobility: Extensive assistance, two person physical assist
Transfer: Total dependence
Walk in room: Activity did not occur
Walk in Corridor: activity did not occur
Locomotion on unit and off unit: extensive assist of one person
Balance during transfer and walking: 2- Not steady, only able to stabilize with staff assistance.
Range Of Motion: Impairment on one side-upper and lower extremity."

Nursing Notes in the resident's record indicated that the resident was alert and able to make his needs known. During an interview with the Administrator, on 3/19/14 at 10:40 a.m., he was asked about the cognition of resident # 11, he stated "he was alert and oriented, just like you and me."

A review of Physical Therapy discharge notes and progress notes revealed that the resident was not able to transfer out of bed independently on 2/13/14. Review of the physical therapy discharge summary and notes indicated that, as of discharge from physical therapy on 2/20/14, the resident had met the goal on 2/7/14 of transferring from bed to wheelchair with caregiver assistance of one person. Review of a physical therapy progress note, dated 2/14/14, revealed "Patient has begun trials with (quad cane) for 4 hours 2/14/14 on even and uneven surfaces in facility."

Review of nursing progress notes for 2/7/14 at 10: 34 am revealed "Up in wheelchair daily and able to propel self slowly on unit, requires assist of one staff member for all transfers."

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Review of nursing progress notes for 2/20/14 at 11: 57 a.m. revealed, "Patient requires supervision with transfers, toileting, bed mobility and will ADLS."

5. Review of the record for Resident # 1 revealed that he was admitted to the facility on 2/13/14 from a local hospital. The facility provided a copy of the hospital records that came with Resident # 1 from the hospital. Included in these records was a History and Physical, dated 1/30/14, which indicated that the resident was a "prior sex offender." The resident was reported to have "generalized weakness with no focal neurological deficits, sensory and motor function intact, normal finger to nose test , gait not tested as patient did not want to get out of bed."

Review of a form from the hospital entitled "Physicians Certification statement for Ambulance Transportation," dated 2/13/14, for transport, the nursing facility stated, "Patient has periods of confusion and may try to get out of chair."

Review of pending admission paperwork, sent from the hospital to the facility, on 2/12/14, for pre admission screening, revealed "69 year old male, DX UTI, Weakness, HX of IDDM, HTN, A flutter, Depression" On antibiotic "rejected from ALF after being in jail."
Review of the HCA 03008 Medical Certification for nursing form sent from the hospital to the facility with the patient revealed that the resident was alert, and required assistance with ambulation and transfer.
Review of public records for Resident # 1 revealed:
Florida Department of Law Enforcement Sexual

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{F 490}	Continued From page 20 Offender Website: Sexual Offender Predator Flyer: (Resident # 1) - Designation: Sexual Offender Adjudication dated: 5/9/2008 Crime Description: Unlawful Sexual Activity with Certain Minors 16/17 yr. old; F.S. (794.05(1) Adjudication: Guilty /Convicted County Sheriff's Office Website: Subject Charge Report: Name: Resident # 1 Booking date: 8/21/13 Offense Description: "Lewd and Lascivious Battery of Elderly/Disabled Adult." Name: Resident # 1 Booking Date: 3/20/13 Offense Description: "Lewd and Lascivious Battery of Elderly/Disabled Adult" Disposition: "Released 4/20/13 No info/Dismissed" An interview was conducted with the Administrator and Director of Nursing on 3/19/14 at 10: 40 a.m. regarding the admission of Resident # 1, a known sexual offender, to the facility on 2/13/14. The Director of Nursing stated that the resident came by ambulance transport to the facility from the hospital on 2/13/14. She stated he arrived with a History and Physical from the hospital which stated that he was a prior sex offender. She stated she and the nurse were in the process of doing the admission when the ambulance transport company came back, handed them another packet and said this was another packet of information that the resident had with him. She stated the packet of papers were from the States Attorney's Office. The Director of Nursing stated the ambulance transport came back during the admission process. The DON stated the while nurse was	{F 490}		

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doing the admission, she, the DON, looked at the papers and told the nurse that "I need to make some phone calls" and to continue with the admission. She stated that she then alerted the Administrator that "we have papers that said he (#1) has done something and just recently." She stated the papers "pretty much said he was being charged with molestation or whatever it was, of a male at the facility he was at." She stated she thought the papers said it occurred in "September, October, November or something." The DON stated that she did not keep a copy of the papers as "those were his personal belongings."

The Administrator stated that he believed this occurred late in the day, stating "It was late, like 7: 00 p.m., I was in a meeting and (the DON) knocked and said we have an issue." He stated his response was "my goodness, did we not know?" The Administrator stated that he and the DON went up to talk with Resident # 1. He stated "there was not much communication, he just stared at us and mumbled." He stated they talked to both the nurse and the therapist and that the resident was "pretty much bed bound and wasn't going to be able to get up unless he was assisted up. He stated the therapist had already assessed him by the time he and the DON went up to see the resident. He stated the therapist stayed late to assess him because she knew there was a new admission and wanted to assess him before she went home. The Administrator said the therapist told him that the resident was lying in bed and couldn't move too much, that he just layed there, staring and mumbling. He indicated that the therapist who screened the resident on 2/13/14 was the Director of Therapy and provided her name. The Administrator stated

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they then went to the nurse and told her what was going on. He then called the Psychiatrist and was told that the Psychiatrist would assess resident # 1 in the morning. He stated the next morning, 2/14/14, they met with the psychiatrist and discussed the following concerns with him: "we admitted him, now we have to take care of him, what we do to keep him safe and do we need to do room moves." He stated that the Psychiatrist told him, that since the resident was not able to move around on his own and as long as he had someone alert and oriented in the room, we would take it from there.

The DON stated that the Psychiatrist assessed Resident # 1 on 2/14/14 in the morning and was concerned because the resident told him he would try not to touch anyone. She stated the psychiatrist told her "I feel uncomfortable, he needs to go" referring to Resident # 1. Both the Administrator and the DON stated that the psychiatrist told them to alert the staff and the residents and alert the schools in the area.

The following written documentation, signed by the Administrator was found in the resident's record entitled
"Note to file:"
"February 13, 2014
Time: 7: 30 p.m.
Resident: (#1)
This Administrator was contacted by DON. DON stated that the new admission (Resident #1) was a registered sex offender and was admitted to this facility unknowing. He was accompanied by paperwork from the discharging hospital which confirmed his status and arrest record.

This administrator and DON went to resident's

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room and discussed his prior arrests. Resident presented as very confused and was not willing to speak at length. This administrator and DON left the resident alone to rest.

Administrator and DON next consulted with Rehab Director. She stated resident was already assessed by therapy and in their professional opinion resident was too weak to stand let alone pose a threat to other residents.

Next, Administrator put in a request for resident to be seen by staff psychiatrist."

"February 14, 2014
Time: 10: 30 a.m.
Resident: (#1)
This administrator met with (psychiatrist) and DON in the DON's office. He stated he had just see patient (Resident # 1). Resident #1 stated to him that he would "try" not to touch anyone during his stay at this facility. This was a concerning point for psychiatrist.

Psychiatrist next asked if administration had notified the roommate that he was living with a sexual predator.
Psychiatrist stated that all staff needed to be made aware, residents, and local schools within a certain minimum radius to this facility.
This administrator, accompanied by Social Worker, went to the resident's (Resident #1) room to speak with the roommate (Resident # 11). This admin found the roommate outside in the smoking section. Admin and social worker accompanied the roommate into the activities office where a private conversation could be held.

This admin started discussing (Resident # 1) to the roommate (Resident # 11) when the

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roommate interrupted this admin and stated "I know he is gay. You don't have to tell me. He tried to touch me while I was lying in bed through the covers. He didn't touch me but he tried. I yelled at him and told him never to try and touch me again." Resident # 11 went on to say "Now I really like my room and I like him as a roommate. I am fine rooming with him and I'll make sure I watch out for him."

This admin immediately went back to the DON's office. Psychiatrist had departed the building by this time. Admin and DON contacted (psychiatrist) on the phone and relayed the information regarding roommate. Psychiatrist stated he would come back to assess patient again given this new information. Admin told DON to immediately put patient (Resident 1) on a 1:1. DON complied and a male CNA was assigned to be with the patient at all times."

"February 14, 2014
Time: 5: 00 p.m.
Resident: (#1)
(Psychiatrist) re-assessed the patient and states his behaviors pose a danger to self and/or others.
(Psychiatrist) states resident should be Baker Acted.
This Administrator discussed Baker Act with both DON and the Social Services team. The resident is to remain on a constant 1:1 until transport arrives to pick him up and transport to (hospital)."

6. An interview was conducted with employee N, a Licensed Practical Nurse (LPN), by phone on 3/20/14 at 10:15 a.m. She confirmed that she was the 3 p.m. to 11 p.m. shift nurse who cared for Resident # 1 and Resident # 11 on 2/13/14. She stated that she remembered Resident # 1

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and "I did his admission." She stated "he was able to get up out of bed on his own but I encouraged him to call for help as we were not sure of his gait until he was assessed by therapy." She stated again, he was able to get out of bed on his own. She stated she does not recall seeing anyone from therapy assess the resident the evening on 2/13/14. She stated that during her shift, Resident # 1 never left his room. She stated "something came in with him that said he was previously a sex offender." She stated that she was not told by administration or anyone else to take any special precautions or keep an eye on him. She stated that she was not aware that anything had occurred with his roommate, that Resident # 11 never said anything to her.

7. An interview was conducted with the Director of Rehabilitation Services, on 3/19/14 at 3:38 p.m. She had previously been identified by the Administrator as the therapist who assessed Resident # 1 on the evening of 2/13/14. (The Administrator had stated that the Director of Rehabilitation Services had told him on 2/13/14 that Resident # 1 "pretty much bed bound and wasn't going to be able to get up unless he was assisted up." He stated the therapist had already assessed him by the time he and the DON went up to see the resident. He stated the therapist stayed late to assess him because she knew there was a new admission and wanted to assess him before she went home. The Administrator said the therapist told him that the resident was lying in bed and couldn't move too much, that he just layed there, staring and mumbling.

The Director of Rehabilitation Services stated that she did not evaluate or assess Resident # 1 until 2/14/14; she stated "I remember it was

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Valentine's Day." She stated she would check the date of her assessment and the time of admission for the resident and return with the information. She then provided documentation that she completed her assessment of Resident # 1 on 2/14/14 and documentation that Resident #1 was admitted late on 2/13/14. She stated, "he came in late the day before; I didn't assess him that day, I didn't stay to assess him. She was unaware of any other assessment of Resident # 1 by the therapy department on 2/13/14. She stated that when she assessed Resident #1, on 2/14/14, "he didn't want to do anything. He told me he had been in a wheelchair. He walked with me a few feet, he could ambulate, it was a waddle."
Review of Occupational Therapy Evaluation and Plan of Treatment, dated 2/14/14 revealed:
"Upper Extremity Range of Motion: WFL (Within Functional Limit)
Lower Extremity Range of Motion: WFL
Balance:
Sitting Balance: Sitting During ADL's = Good (maintains balance without support against moderate resistance)
Standing Balance: Standing During ADLS's = Fair (maintains standing balance 1-2 minutes without upper extremity support without loss of balance.
Clinical impressions: Patient presents with sob (shortness of breath) after 50 feet assisted gait with walker. Risk factors: history of Sexual Offender. Admitted here and made sexual advances to roommate today."

8. An interview was conducted with employee M, a CNA, on 3/20/14 at 11:00 a.m. He confirmed that he provided care to Resident # 1 and # 11 on 2/13/14 on the 3 p.m. to 11 p.m. shift. He stated that he remembered Resident # 1 that he had to

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assist him. He stated he was "a big heavy guy" and he did not leave the room during his shift. He stated that Resident # 1 was "just a normal admission and that he was not aware any history about Resident # 1." He stated he was not told to monitor or watch him any differently than any other resident which would be to check all residents every two hours. He stated he was not aware of anything occurring between Resident # 1 and Resident #11.

An interview was conducted with Employee K, an LPN, on 3/20/14 at 10: 30 a.m. She stated that she was the 7 a.m. to 3 p.m. nurse who cared for Residents # 1 and # 11 on 2/14/14. She stated she was not given any report from the 11 p.m. to 7 a.m. nurse about anything occurring with Resident 1 and Resident # 11. She stated "no, no report, nothing unusual." She stated that she was not made aware of any concerns related to Resident # 1 and any incident that occurred between Resident # 1 and # 11 until 2/15/14. She stated she was not made aware of Resident #1's history and was not told to monitor him on 2/14/14. She stated that other than going to therapy, he did not leave his room on 2/14/14.

9. An interview was conducted with the Unit Manager of the unit where Resident # 1 and Resident # 11 resided. She stated she was not aware of any concerns related to Resident #1 when he was admitted. She stated she did not know what happened until the next day and that she did not know when it occurred. She stated Resident # 11 was "a little irritated" regarding the incident with Resident # 1. She stated he told her that Resident # 1 either touched him or put his hand up to touch him but she could not remember.

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{F 490}	Continued From page 28 10. An interview was conducted with the Assistant Social Worker, on 3/19/14 at 2:46 p.m. She stated she went with the Administrator to talk to Resident # 11 on 2/14/14 and "to notify him (Resident # 11) of the situation." She stated the plan was to tell him that there was an offender and we were going to do precautions. She stated Resident # 11 told them "he tried to touch me." She stated that Resident # 11 told them that he was lying in bed and saw Resident #1's hand come under the curtain. She stated Resident #11, stated that he told Resident # 1 that he knew he was gay and to get his hand away from him or he would hit him with his cane. She stated Resident # 11 was angry. She stated Resident # 11 told them he had not told anyone about what happened because he was embarrassed. She stated he told her the only reason he was telling them was because they brought it up. She stated at the time of this interview, Resident # 11 was in a wheelchair, was still working with therapy on strengthing his legs that he was able to stand up and transfer but was very unsteady. She stated that the situation was unclear to her. She stated "it sounded like he was in bed (Resident # 11) and saw a hand coming from underneath the curtain." She stated she was not sure if he was lying in bed or sitting in a chair. She thinks resident # 11 told them it happened earlier in the day, on 2/14/14, right around breakfast or shortly after breakfast but she was not sure. She stated she was not involved in the investigation. "A few days later I passed him in the hall (Resident #11) and asked him how he was doing and he told me he was glad his roommate was gone." She stated that was the only other contact she had with Resident #11 about his roommate.	{F 490}		

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11. An interview was held, by phone on 3/20/14 at 11:41 a.m. with the Psychiatrist regarding Resident # 1. He stated he believed they called him about Resident # 1 the night he was admitted because "they had found out he was a sex offender." He stated that he and the facility administration talked about preventive measures such as putting him in a private room or putting him in with a resident who had both mental capacity and physical capacity. He stated, "We talked about supervised status. We never got to that point."

He stated he made a special effort to come in and see him the next morning after admission. He stated that as far as he knew at the time, Resident #1 had not done anything and denied intent. He stated that he could not just Baker Act someone because they are a sexual offender. He stated that after he saw Resident # 1 he told the administration to let the staff and resident's know that he was a sexual offender and to come up with a plan to keep the resident's safe. He stated "Then they found out after talking to his roommate that he had tried to do something to him, that is when I Baker acted him. Unfortunately they called me after the fact."

Review of a "Neuropsychiatric Consultation," dated 2/14/14, and by the Psychiatrist revealed "Reason for Consult: Patient with history sex offender." "Patient admit recent from (hospital). Has history sex offender." "Poor historian but oriented x 3." "He says he will try not to offend. No current desire." "Recommendations: Monitor his behavior."

Review of the "Certificate of Professional Initiating Involuntary Examination," signed by the

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Psychiatrist on 2/14/14, revealed "Patient is trying to fondle other residents. He has history of sexual battery."

12. Review of Resident #1's record revealed a nursing progress note, dated 2/14/14 at 16:48, which stated "Writer given in report from 7-3 nurse that this resident is being BA 52 for inappropriate sexually behavior with roommate."

Review of Resident # 1's record revealed a social service progress note, dated 2/24/14, and signed by the Social Services Assistant, ten days after Resident #11 reported an unwanted sexual advance from Resident # 1. The note stated "On 2/14/14 resident was discharged to (hospital) under a Baker Act based on an unwanted sexual advance toward his roommate. This writer and building administrator met with the resident's roommate to inform him of the resident's status as a sexual offender. Upon the beginning of the meeting, (Resident # 11) informed this writer and administrator that the resident put his hand under his curtain and was reaching toward his genitals. (Resident # 11) told the resident that he never wanted him to make such advancement again. This writer immediately notified (Psychiatrist) for a psych consultation regarding the unwanted sexual advancement. Resident was Baker Acted to hospital."

13. An interview was conducted with the Administrator on 3/19/14 at 10: 40 a.m. He stated that prior to the admission of Resident # 1, a sexual offender, to the facility on 2/13/14; the facility had no policy related to admission of sexual offenders. He stated "we take them on a case by case basis."

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He stated since the incident of 2/14/14 with Resident's # 1 and # 11, the facility now checks the Florida Department of Law Enforcement Sexual Offender website prior to accepting an admission to the facility. He stated this is done by admissions. He stated there was no facility policy related to this, stating that it was just a process we do.

14. An interview was conducted, on 3/20/14 at approximately 1:30 p.m., with a staff person who identified herself as a Medicaid Specialist for the management company who was working as the admissions person for the past two days. She stated the facility's admission person left the facility three days ago and she is doing admissions in his place. She stated she does check the Florida Department of Law Enforcement website on any potential admissions. She stated she had not seen a current policy on this from the facility.

On 3/20/14 at 7: 52 a.m., further interview with the Administrator revealed that the facility has not checked the status of current residents to see if any of the residents are sexual offenders or predators. He stated there was no need to do this as the police or the sheriff will come in to check on anyone who is a sexual offender and "we will find out that way."

15. On 3/17/14 at 9:00 a.m., the Administrator was asked to provide the facility ' s policies and procedures related to abuse, neglect, mistreatment and misappropriation of property. The Administrator provided a document entitled, "Reporting Abuse to State Agencies and Other Entities /Individuals." The Administrator was asked to provide all policies in effect related to

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Abuse, neglect, mistreatment and misappropriation of property and he then provided two additional documents for a total of three:

a. A Policy entitled, "Reporting Abuse to State Agencies and Other Entities/Individuals" with a revision date of November 2010.

b. A sheaf of paper clipped documents each entitled "Abuse Policy." Each document was signed by an employee and contained signature dates for 2014. The documents included a statement "Residents in this facility are to be treated with dignity and respect at all times and under any circumstances. Mistreatment in the form of verbal or physical abuse of any nature will not be tolerated." The document defined abuse and included information on reporting abuse.

c. A stapled sheaf of forms with a cover document entitled, "Abuse Reporting" Thursday April 25. Please plan on attending the following in- service." Under the cover document was a policy entitled, "Abuse, Neglect, Exploitation and Misappropriation of Property, Prevention, Protection and Response Policy and Procedures" with a revision date of 9/12. Sign in sheets for staff were attached with an in service date of 4/25/13.

On 3/ 20/14 at 7: 52 a.m., an interview was conducted with the Administrator regarding the documents (2 and 3 above) entitled "Abuse Reporting" and "Abuse Policy." He was asked to review the policies and advise as to which policy was in effect related to the definition of abuse as there were some differences in the wording in the policies regarding the definition of abuse. He indicated #2, the sheaf of paper clipped documents entitled, "Abuse Policy," stating "because we are training everyone on this one,

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I've got to go with this one, this is what we are training on so this is our definition of abuse." He indicated that all of the policies were part of the facility's abuse protocol.

Review of the document entitled "Abuse Policy" revealed the following information:
"Residents in this facility are to be treated with dignity and respect at all times and under any circumstances. Mistreatment in the form of verbal or physical abuse of any nature will not be tolerated.
Abuse is defined as the following:
1. Any act of absence of action inconsistent with human rights which results in or could result in physical injury to a resident.
2. Any act which constitutes sexual activity directed towards a resident.
3. Insulting or coarse language or gestures directed at a resident, which subjects the resident to humiliation or degradation.
4. Depriving a resident of real or personal property by fraudulent of (sic) illegal means.
All employees are obligated to report any acts of abuse to the abuse coordinator, who is (Director of Social Services).
All suspected, alleged, observed, or reported acts of abuse shall be thoroughly investigated by the Abuse Coordinator. All suspected acts of abuse will be reported immediately by the Abuse Coordinator to the H.R.S. Abuse Hotline 1- 800 -96ABUSE.
1. Any person, who knowingly and willfully fails to report a case of unknown or suspected abuse, neglect, or exploitation of an aged person or disabled adult or who knowingly and willfully prevents another person from doing so, is guilty of a misdemeanor of the second degree.
2. Any person who knowingly or willfully makes

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public or discloses any confidential information contained in the Central Abuse Registry, in the computer system, in the record of any case of abuse, neglects (sic), exploitation of an aged or disable adult id (sic) is guilty of a misdemeanor of the second degree.
3. Any person who knowingly or willfully abuses, neglects, or exploits an aged person, or disabled person, and in so doing causes great bodily harm, permanent disfigurement or permanent disability to such person is guilty of a felony of the second degree.
4. Any person who knowingly or willfully abuses, neglects, or exploits an aged person or a disabled person is guilty of a misdemeanor of the first degree."

Review of the policy referenced in # 1 above "Abuse, Neglect, Exploitation and Misappropriation of Property, Prevention, Protection and Response Policy and Procedures" with a revision date of 9/12 revealed:
"Policy: Abuse, Neglect, Exploitation and Misappropriation of Property, collectively known and referred to as ANE and as hereafter defined, will not be tolerated by anyone, including staff, patients, volunteers, family members or legal guardians, friends or any other individuals.
The health center Administrator is responsible for assuring that patient safety, including freedom from risk of ANE, holds the highest priority.
The Administrator has designated the following individual as the health center's ANE Prevention Coordinator: (Lists the name and phone number of the ANE Prevention Coordinator)
Definitions:
Abuse: the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or

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mental anguish.

Verbal Abuse: the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend or disability.

Sexual Abuse: includes but is not limited to, sexual harassment, sexual coercion, or sexual assault.

Physical Abuse: includes hitting, slapping, pinching or kicking. It also includes controlling behavior through corporal punishment.

Mental Abuse: includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation.

Involuntary Seclusion: the separation of a patient from other patients, or from her/his room or confinement to her/his room against the patient's will. "

Neglect: The failure to provide goods and services necessary to avoid physical harm, mental anguish, or illness. Neglect occurs when facility staff fails to monitor and/ or supervise the delivery of patient care and services to assure that care is provided as needed by the resident.

Misappropriation of Patient Property: the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a patient's belongings or money without the patient's consent.

Injuries of Unknown Source: An injury for which both of the following conditions exist:

1. The source of the injury was not observed by any person or the source of the injury could not be explained by the resident.

AND

2. The injury is suspicious because of; the extent of the injury or location of the injury, or the

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number of injuries observed at any particular point in time, or the incidence of injuries over time.

I. Screening Issues:

Policy: the center will not employ individuals who have been

a. Found guilty of abusing, neglecting, or mistreating patients/residents by a court of law; or

b. Have had a confirmed finding entered into the State nurse aide registry concerning abuse

Procedure: Check references for all applicants to obtain information from previous employers and current employers (with applicant permission)

Check the appropriate licensing board or registry

Criminal background checks as indicated.

II. Training Issues:

Policy: The center will train all staff, through orientation and ongoing in-services in ANE prevention and response.

Procedure: In Service training will include at a minimum:

What constitutes abuse, neglect, exploitation and misappropriation of patient property.

The reporting system established by the center.

Appropriate interventions to deal with aggressive behaviors.

(See Dementia training module for additional information)

How to recognize signs of burnout, frustration and stress in both patient and staff that might lead to ANE and how to effectively intervene.

(See Dementia training module for additional information)

III. Prevention Issues:

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Policy: The center will provide supervision and support services designed to reduce the likelihood of abusive behaviors.

Procedure: All supervisory staff will identify inappropriate behaviors, including but not limited to the use of derogatory language, rough handling, ignoring patients while giving care, directing patients who need toileting assistance to urinate or defecate in their beds, and will take immediate steps to correct such behaviors. Supervisors will be especially sensitive to signs and symptoms of acute frustration.

Policy: The center will seek and accept complaints from patients, patient families and staff without reprisal.

Procedure: The right to report a concern or incident is not limited to a formal, written grievance process but includes any verbalized complaint to any facility staff.

Prompt efforts will be made to resolve concerns.

The names, addresses, and telephone numbers of all pertinent State client advocate groups such as the State survey and certification agency, the State licensure office, the state ombudsman program and the protection and advocacy network will be provided to all patients and their families in the Admission Packet and this information is also posted prominently in the center.

Policy: Patients with needs and behaviors that might lead to conflict with staff or other patients will be identified by the Care Planning team, with interventions and follow through designed to minimize the risk of conflict.

Procedure: Any patient identified as having behaviors which might lead to conflict or neglect, such as:

a. patients with a history of aggressive

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REHABILITATION CENTER OF ST PETE	435 42ND AVE S SAINT PETERSBURG, FL 33705

(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
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behaviors,
b. patients who enter other resident's rooms while wandering,
c. patients with self- injurious behaviors, or history of self-inflicted injuries,
d. patients with communication disorders,
e. Patients who require heavy nursing care or are totally dependent on nursing care will be considered as potential victims of abuse.
The interventions designed to meet the needs of such patients will include but will not be limited to:
a. identification of patients whose personal histories render them at risk for abusing other patients or staff,
b. assessment of appropriate intervention strategies to prevent occurrences,
c. monitoring the patient for any changes that would trigger abusive behavior,
d. Reassessment of the protective strategies on a regular basis.
IV. Identification Issues:
Policy: Any patient event that is reported to any staff by patient, family , other staff, or any other person will be considered as possible ANE if it meets any of the following criteria:
a. Any indication of possible willful infliction of injury to include unexplained bruising.
b. Unreasonable confinement, to include unwanted restriction of access to all patient areas of the building.
c. Any patient or family complaint of physical harm, pain of mental anguish, resulting from willful infliction from others.
d. Any complaint of deprivation by an individual caregiver of goods and services necessary to attain or maintain physical, mental, and psychological well- being to include toileting issues.
e. Any complaint of the use of oral, written or

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gestured language that willfully includes disparaging and derogatory terms to patients or families or within their hearing distance.
f. Any complaint of sexual harassment, sexual coercion, or sexual assault.
g. Any instances of hitting, slapping, pinching or kicking or other potentially harmful action.
h. Any behavior control strategy involving corporal punishment.
i. Any complaint of humiliation, harassment, threats of punishment or deprivation.
j. Any allegation of misappropriation of patient property.
Procedure: Any and all staff observing or hearing about such events will report the event immediately to the ABUSE HOTLINE AT 1-800-962-2873. The event will also be reported immediately to the immediate supervisor, AND AT LEAST ONE OF THE FOLLOWING INDIVIDUALS, Social Worker (ANE Prevention Coordinator), Director of Nursing, or Administrator.

Any and all employees are empowered to initiate immediate action as appropriate.
V. Investigative Issues:
Policy : Any employee having either direct or indirect knowledge of any event that might constitute abuse must report the event promptly.
Procedure: Any and all staff observing or hearing about such events must report the event immediately to the ANE Prevention Coordinator or Administrator. The event should also be reported immediately to the employee's supervisor.
All employees are encouraged and empowered to contact the ABUSE HOTLINE AT 1-800-962-2873 if they witness such event or have reasonable cause to suspect such an event has occurred.

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Policy: All events reported as ANE will be investigated to determine whether ANE did or did not take place.
Procedure: The ANE PREVENTION COORDINATOR will initiate investigative action.

The Administrator of the center, the Director of Nurses and /or the Social Worker (ANE PREVENTION COORDINATOR) will be notified of the complaint and action being taken as soon as practicable.

VI. Protection Issues:

Policy: Patients will be protected from harm during an investigation.
Procedure: any individual found to be in danger or injury will be removed from the source of the suspected abusive behavior. Medical and emotional support will be made immediately available to any individual suffering suspected abuse.
Policy: Staff person or persons suspected of ANE will be suspended immediately pending result of investigation. Pay status during suspension is at the discretion of the administrator.

Residents who are suspected of initiating abusive behavior toward other residents will be immediately separated from any suspected victim or victims. The specific approach employed to separate victim and perpetrator and to ensure the protection of all potential victims will vary on a case specific basis.
In all cases, every appropriate effort will be made to ensure the protection of our residents. The resident's attending physician should be contacted promptly to determine the most appropriate interventions. These may include but are not limited to:
a. One on one assignment of staff to protect resident victims.

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b. Involvement of law enforcement.
c. Review of medication regimen.
d. Review of the residents care plan interventions.
e. Involuntary Discharge.

VII. Reporting and Response Issues:

Policy: All allegations of possible ANE will be immediately reported to the Abuse Hotline and will be assessed to determine the direction of the investigation.

Procedure: Any investigation of alleged abuse, neglect or exploitation will be reported immediately to the Administrator and the ANE Coordinator. It will also be reported to other officials, in accordance with State and Federal Law.

A. The Immediate Report

All allegations of abuse, neglect, exploitation, or misappropriation of property, including injuries of unknown source, must be reported immediately. This allegation must be reported to the Abuse Hotline (Adult Protective Services) within twenty four hours whenever an allegation is made.

The ANE Prevention Coordinator will also submit The Agency for Health Care Administration AHCA Federal Immediate/5 Day Report and send it to:

Complaint Administration Unit
Phone: 850-488-5514
Fax: 850-488- 6094
E-Mail: fedrep@ahca.myflorida.com

B. The Report of Investigation (Five Day Report):

The facility ANE Prevention Coordinator will send the result of facility investigations to the State Survey Agency within five working days of the incident. This will be completed using the same AHCA Federal/Five Day Report, and sending it to

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the Complaint Investigation Unit as noted above.
C. Designated Reporters:
Shall immediately make a report to the State Survey Agency, by fax, email, or telephone.
All necessary corrective actions depending on the result of the investigation will be taken
Report any knowledge of actions by a court of law against any employee, which would indicate an employee is unfit for service as a nurse aide or other facility staff to the State nurse aide registry or other appropriated licensing authorities.
Any report to Adult Protective Services will trigger an internal investigation following the protocol of Untoward Events Policy and Procedure.
Policy: Trends of investigative findings will be analyzed and addressed by the QA RM committee process.
Procedure: An accurate summary reporting of all investigations conducted by the center will be maintained as a working document of the Quality Assessment and Risk Management Committees.
QA and RM will review and analyze investigations to track and determine presence of any trends.
Any trends will be forwarded to all members of the QA TEAM and center management."

A review of the policy entitled, "Reporting Abuse to State Agencies and Other Entities/Individuals" (with a revision date of November 2010), revealed different information on reporting of Abuse, as to who to report to, what to report and when to report, than what was contained in section VII. Reporting and Response Issues of the policy entitled "Abuse, Neglect, Exploitation, and Misappropriation of Property. Prevention, Protection and Response Policy and Procedures (revision date 9/12)."
Review of the "Reporting Abuse to State Agencies and Other Entities/Individuals" Policy

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revealed:
"Policy Statement: All suspected violations and all substantiated incidents of abuse will be immediately reported to appropriate state agencies and other entities or individuals as may be required by law.

Policy Interpretation and Implementation:
1. Should a suspected violation or substantiated incident or mistreatment, neglect, injuries of unknown source, or abuse (including resident to resident abuse) be reported, the facility Administrator or his/her designee, will promptly notify the following persons or agencies (verbally and written of such incident:
a. The State licensing/certification agency responsible for surveying/licensing the facility;
b. The local/State Ombudsman;
c. The resident's Representative (Sponsor) of Record;
d. Adult Protective Services;
e. Law enforcement officials;
f. The resident's Attending Physician; and
g. The facility Medical Director
2. Verbal/written notices to agencies will be made within twenty-four (24) hours of the occurrence of such incident and such notice may be submitted via special carrier, fax, e-mail, or by telephone. Notices will include, as appropriate:
a. The name of the resident;
b. The number of the room in which the resident resides;
c. The type of abuse that was committed (i.e., verbal, physical, sexual, neglect, etc.)
d. The date and time the alleged incident occurred;
e. The names(s) of all persons involved in the alleged incident; and
f. What immediate action was taken by the

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facility.
3. The Administrator or his/her designee will provide the appropriate agencies or individuals listed above with a written report of the findings of the investigation within five (5) working says of the occurrence of the incident.
4. Should the investigation reveal findings of abuse, such findings will be reported to the State Abuse Registry. The individual (s) involved in the incident will be notified of such findings, and such individuals (s) will be suspended, without pay, until the State Abuse Registry has investigated the claim and found the allegations to be true or unfounded.
5. Should the allegations be true, the employee(s) will be terminated from employment. Should the allegations be unfounded, the employees(s) will be reinstated to his/her /their former position with back pay.
6. Records of all allegations will be filed in the accused employees' personnel record along with any statement by the employee disputing the allegation, if the employee chooses to make one. Records concerning unfounded allegations will be destroyed.
7. The State Abuse Registry will:
a. Notify the employee when he/she has been implicated in any investigation;
b. Inform the employee of the nature of the allegation;
c. Inform the employee of the time and date of occurrence;
d. Inform the employee of his/her right to a hearing;
e. Inform the employee of the state's intent to record findings of resident abuse into the abuse registry; and
f. Inform the employee of his /her right to file a statement disputing the allegation.

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{F 490}	Continued From page 45 8. Appropriate professional and licensing boards will be notified when an employee is found to have committed abuse. 9. Any violation of this policy may result in disciplinary action. 10. Inquiries concerning resident abuse should be referred to the Director of Nursing Services or to the Administrator. 11. Inquiries concerning the reporting of abuse to state agencies should be referred to the Administrator." 16. An interview was conducted with the Administrator, on 3/19/14 at 2:15 p.m. regarding Resident # 1 and the investigation conducted by the facility after the incident with Resident #11. The Administrator stated he did not know what time Resident #1 made an unwanted sexual advance to Resident # 11. He stated that it was "probably sometime in the night, he didn't get any specific time." He stated that Resident #11 told him that Resident #1 "put his hand through the cubicle curtain, he saw his hand getting in the area of the sheet and he yelled out to stop it." He stated that he understood from Resident #11 that Resident #1 was in his own bed at the time. He stated "I don't know how he could reach him without getting out of the bed; you can get your hand through the cubicle curtain but not physically be able to touch the other bed unless you have eight foot long arms." He stated since it was during the night, he talked to the day nurses to see if they had gotten any information on their 24 hour report about it and they said no. He stated he did not question the night nurse or the CNA about Resident #1's movements during the night. He stated he did not talk to any other residents or other staff to determine whether any other incidents had occurred with Resident # 1 or	{F 490}		

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if Resident # 1 was seen getting out of bed. He stated that the resident was unable to move and was in a room with an alert and oriented resident. He stated the psychiatrist had told him on 2/13/14 on the phone that "in his current state he is not going to harm anyone." He stated that "there was no harm as Resident # 1 did not touch or harm Resident # 11 in any way and that Resident # 11 stated he wanted to keep Resident #1 as his roommate." He stated that the facility would report inappropriate and/or unwanted sexual advances to the abuse hotline but since there was no allegation of inappropriate and/or unwanted sexual advances and "we confirmed no harm was done," it was not reported to the abuse hotline. He stated there was no investigation needed as "nothing happened."

An interview was conducted with the Social Service Director, on 3/20/14 at 8: 19 a.m. She stated that she is the Abuse Coordinator. She stated she was not part of the investigation regarding the incident with Resident # 1 and Resident # 11. She stated it was mainly the Administrator and she thinks she was off that day. She stated "They said he (resident # 11) had volunteered information but had not reported it to that point. She stated that she thought it was handled as a grievance but was not able to find it in the grievance log.

17. An observation was conducted on 03/18/14 at approximately 11:20 a.m. of Resident #225. She was sitting in a wheel chair near the nurses' station, she was observed to be heavy set, she was able to answer some questions that were asked of her.

An interview was conducted on 03/18/14 at

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approximately 11:30 a.m. with Resident #225. The resident voiced concerns about wanting to go home; her money and at the end of the interview, she stated that the staff "throw me on the toilet." "All the time" Lots of the staff. Resident was asked if she could identify the staff members that did this to her and she was not able to specify which staff were involved; Resident was asked if she told someone; she stated that she had, but, she was unsure who.

18. An interview was conducted on 03/18/14 at approximately 1:00 p.m. with the Social Service Director (SSD)/ Abuse Coordinator. She confirmed that she was unaware of the allegation that had been made by Resident #225.

During a subsequent interview conducted on 03/20/14 at 8:19 a.m. with the SSD, she confirmed that she had 1 Abuse allegation in 03/14, that it had been disclosed to her on 03/18/14 that Resident #225 had made a statement that the staff throw her onto the toilet all the time. The SSD stated that when she went to see the resident, she was on the toilet, the wheelchair was by the bed and she had walked to the toilet. The SSD stated that she had interviewed the staff, but she had not interviewed the roommate. The SSD further stated that Resident #225 makes confabulations and she is 500lbs, "I don't see that anyone could throw her on the toilet." It was observed that approximately 43 hours had elapsed from the time that the SSD became aware of the allegation of abuse until the interview.

During the interview, the SSD confirmed that she had called the Abuse hotline. She further confirmed that she had not submitted a 1 day

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{F 490}	Continued From page 48 federal report as it was not accepted by the hotline. She clarified that she would not submit a 1 day federal report if the allegation was not accepted by the Abuse hotline.	{F 490}		
F 520 SS=J	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on resident record review and staff and resident interviews, it was determined that the facility's Quality Assessment and Assurance	F 520		4/9/14

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F 520	Continued From page 49 Committee failed to identify errors and omissions in staffs interpretation and implementation of facility policies for abuse, and failed to ensure that an issue related to the admission of a known sexual offender was effectively addressed to ensure protection of residents. The facility administrations' lack of investigation and acknowledgement of an allegation of sexual abuse failed to ensure that all issues and concerns related to resident sexual abuse were identified and action plans developed to prevent further occurrences related to an allegation of sexual advances toward Resident # 11 from a known sexual offender (Resident #1) representing two (#1 and #11) of nine sampled residents. The facility administration failed to implement policies and procedures related to investigation of allegations of abuse, protection of residents and reporting of allegations to the abuse hotline and state agency. The facility failed to correct F 490, Effective Administration, from the Annual Survey of January 28, 2014 - February 3, 2014 and was determined to be out of compliance on the complaint survey of 3/17/14-3/20/14. These failures resulted in the determination of ongoing immediate jeopardy identified on 3/20/14 at 6: 55 p.m.. Additionally, the facility failed to ensure the quality assurance committee was actively involved in the effective creation, implementation and monitoring of the plan of correction for deficient practice related to medication storage and infection control practices identified during the January 28, 2014 - February 3, 2014 Annual QIS Survey. Failure to create an effective plan of correction resulted in continued noncompliance with federal standards which has the potential to affect 151 of 151 current residents.	F 520		

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Findings include:

1. On 3/20/14 at 9: 34 a.m., a phone interview was conducted with Resident # 11. Resident # 11 related that on 2/13/14 at approximately 10: 00 p.m., his roommate, Resident # 1, "put his hand under the curtain and moved his hand on the sheet to about ¼ inch from my private parts." "I still have nightmares about it." Resident # 11 stated he was in bed with the curtain pulled when this occurred. He stated he yelled for Resident # 1 to stop or he would hit him with his cane and Resident # 1 then withdrew his hand. Resident # 11 stated he could not move away because he had recently had a stroke. He stated he was afraid he would come back at him, "he was a big guy, I got really scared and didn't sleep the whole night." He stated he did not tell anyone that night because he was embarrassed. He stated the next morning he was still in the room with Resident #1 when "some Doctor" came and he heard him ask Resident # 1 why he had molested two children. He stated that scared him more and he stated, "he could have hurt me; he could have been a murderer. They needed to check these things before they admit someone like that." He stated that he that he was not made aware of this when they moved his roommate into the room. He stated the Administrator and the Social Worker told him the next day, 2/14/14, that they wanted to talk to him about his roommate and he told him what had happened. He stated that the Administrator told him that he was sorry that had happened to him and they would move him to another room. He stated that after he told them about the incident with Resident # 1, they brought a "Big Nurse" into the room that stayed with him. He stated the staff member said to him that he

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would protect him. He stated when Resident # 1 was moved out of his room "I was so relieved."
Review of the record for Resident # 11 revealed that he was, a 56 year old male, admitted to the facility on 2/3/14 from the hospital with diagnosis of weakness due to right sided Cerebrovascular Accident Vascular Accident (CVA), according to an admission nursing note in the resident ' s record. Review of a Minimum Data Set (MDS) admission assessment, with an assessment reference date of 2/9/14, revealed that the resident scored 15 out of 15 on the Brief Interview for Mental Status (BIMS) assessment. The resident was coded as having no speech, vision or hearing problems, able to understand and be understood and no behaviors exhibited.
Functional Status on the admission MDS was coded as:
"Bed Mobility: Extensive assistance, two person physical assist
Transfer: Total dependence
Walk in room: Activity did not occur
Walk in Corridor: activity did not occur
Locomotion on unit and off unit: extensive assist of one person
Balance during transfer and walking: 2- Not steady, only able to stabilize with staff assistance.
Range Of Motion: Impairment on one side- upper and lower extremity."
Nursing Notes in the resident's record indicated that the resident was alert and able to make his needs known. During an interview with the Administrator, on 3/19/14 at 10:40 a.m., he was asked about the cognition of Resident # 11, he stated "he was alert and oriented, just like you and me."

A review of Physical Therapy discharge notes and progress notes revealed that the resident was not

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able to transfer out of bed independently on 2/13/14. Review of the physical therapy discharge summary and notes indicated that, as of discharge from physicial therapy on 2/20/14, the resident had met the goal on 2/7/14 of transferring from bed to wheelchair with caregiver assistance of one person. Review of a physicial therapy progress note, dated 2/14/14, revealed "Patient has begun trials with (quad cane) for 4 hours 2/14/14 on even and uneven surfaces in facility."
Review of nursing progress notes for 2/7/14 at 10: 34 am revealed "Up in wheelchair daily and able to propel self slowly on unit, requires assist of one staff member for all transfers."
Review of nursing progress notes for 2/20/14 at 11: 57 a.m. revealed, "Patient requires supervision with transfers, toileting, bed mobility and will ADLS."

2. Review of the record for Resident # 1 revealed that he was admitted to the facility on 2/13/14 from a local hospital. The facility provided a copy of the hospital records that came with Resident # 1 from the hospital. Included in these records was a History and Physical, dated 1/30/14, which indicated that the resident was a "prior sex offender." The resident was reported to have "generalized weakness with no focal neurological deficits, sensory and motor function intact, normal finger to nose test , gait not tested as patient did not want to get out of bed."

Review of a form from the hospital entitled "Physicians Certification statement for Ambulance Transportation," dated 2/13/14, for transport, the nursing facility stated, "Patient has periods of confusion and may try to get out of chair."

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Review of pending admission paperwork, sent from the hospital to the facility, on 2/12/14, for pre admission screening, revealed "69 year old male, DX UTI, Weakness, HX of IDDM, HTN, A flutter, Depression" On antibiotic "rejected from ALF after being in jail."

Review of the HCA 03008 Medical Certification for nursing form sent from the hospital to the facility with the patient revealed that the resident was alert, and required assistance with ambulation and transfer.

An interview was conducted with the Administrator and Director of Nursing on 3/19/14 at 10: 40 a.m. regarding the admission of Resident # 1, a known sexual offender, to the facility on 2/13/14. The Director of Nursing stated that the resident came by ambulance transport to the facility from the hospital on 2/13/14. She stated he arrived with a History and Physical from the hospital which stated that he was a prior sex offender. She stated she and the nurse were in the process of doing the admission when the ambulance transport company came back, handed them another packet and said this was another packet of information that the resident had with him. She stated the packet of papers were from the States Attorney's Office. The Director of Nursing stated the ambulance transport came back during the admission process. The DON stated the while nurse was doing the admission, she, the DON, looked at the papers and told the nurse that "I need to make some phone calls" and to continue with the admission. She stated that she then alerted the Administrator that "we have papers that said he (#1) has done something and just recently." She stated the papers "pretty much said he was being

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charged with molestation or whatever it was, of a male at the facility he was at." She stated she thought the papers said it occurred in "September, October, November or something." The DON stated that she did not keep a copy of the papers as "those were his personal belongings."

The Administrator stated that he believed this occurred late in the day, stating "It was late, like 7: 00 p.m., I was in a meeting and (the DON) knocked and said we have an issue." He stated his response was "my goodness, did we not know?" The Administrator stated that he and the DON went up to talk with Resident # 1. He stated "there was not much communication, he just stared at us and mumbled." He stated they talked to both the nurse and the therapist and that the resident was "pretty much bed bound and wasn't going to be able to get up unless he was assisted up. He stated the therapist had already assessed him by the time he and the DON went up to see the resident. He stated the therapist stayed late to assess him because she knew there was a new admission and wanted to assess him before she went home. The Administrator said the therapist told him that the resident was lying in bed and couldn't move too much, that he just layed there, staring and mumbling. He indicated that the therapist who screened the resident on 2/13/14 was the Director of Therapy and provided her name. The Administrator stated they then went to the nurse and told her what was going on. He then called the Psychiatrist and was told that the Psychiatrist would assess resident # 1 in the morning. He stated the next morning, 2/14/14, they met with the psychiatrist and discussed the following concerns with him: "we admitted him, now we have to take care of him,

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what we do to keep him safe and do we need to do room moves." He stated that the Psychiatrist told him that since the resident was not able to move around on his own and as long as he had someone alert and oriented in the room, we would take it from there.

The DON stated that the Psychiatrist assessed Resident # 1 on 2/14/14 in the morning and was concerned because the resident told him he would try not to touch anyone. She stated the psychiatrist told her "I feel uncomfortable, he needs to go" referring to Resident # 1. Both the Administrator and the DON stated that the psychiatrist told them to alert the staff and the residents and alert the schools in the area.

The following written documentation, signed by the Administrator was found in the resident's record entitled
"Note to file:"
"February 13, 2014
Time: 7: 30 p.m.
Resident: (#1)
This Administrator was contacted by DON. (DON) stated that the new admission (resident # 1) was a registered sex offender and was admitted to this facility unknowing. He was accompanied by paperwork from the discharging hospital which confirmed his status and arrest record.
This administrator and DON went to resident's room and discussed his prior arrests. Resident presented as very confused and was not willing to speak at length. This administrator and DON left the resident alone to rest.
Administrator and DON next consulted with Rehab Director. She stated resident was already assessed by therapy and in their professional

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opinion resident was too weak to stand let alone pose a threat to other residents.
Next, Administrator put in a request for resident to be seen by staff psychiatrist."

"February 14, 2014
Time: 10: 30 a.m.
Resident: (#1)
This administrator met with (psychiatrist) and DON in the DON's office. He stated he had just see patient (Resident # 1). Resident # 1 stated to him that he would "try" not to touch anyone during his stay at this facility. This was a concerning point for (psychiatrist).
(Psychiatrist) next asked if administration had notified the roommate that he was living with a sexual predator.
(Psychiatrist) stated that all staff needed to be made aware, residents, and local schools within a certain minimum radius to this facility.

This administrator, accompanied by Social Worker, went to the resident's (resident # 1) room to speak with the roommate (Resident # 11). This admin found the roommate outside in the smoking section. Admin and social worker accompanied the roommate into the activities office where a private conversation could be held.

This admin started discussing (Resident # 1) to the roommate (Resident # 11) when the roommate interrupted this admin and stated "I know I know he is gay. You don't have to tell me. He tried to touch me while I was lying in bed through the covers. He didn't touch me but he tried. I yelled at him and told him never to try and touch me again." (Resident # 11) went on to say "Now I really like my room and I like him as a roommate. I am fine rooming with him and I'll

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make sure I watch out for him."

This admin immediately went back to the DON's office. (Psychiatrist) had departed the building by this time. Admin and DON contacted (psychiatrist) on the phone and relayed the information regarding roommate. (Psychiatrist) stated "he would come back to assess patient again given this new information. Admin told DON to immediately put patient (Resident 1) on a 1:1. DON complied and a male CNA was assigned to be with the patient at all times."

"February 14, 2014
Time: 5: 00 p.m.
Resident: (# 1)
(Psychiatrist) re- assessed the patient and states his behaviors pose a danger to self and/or others. (Psychiatrist) states resident should be Baker Acted.
This Administrator discussed Baker Act with both DON and the Social Services team. The resident is to remain on a constant 1: 1 until transport arrives to pick him up and transport to (hospital)."

3. An interview was conducted with employee N, a Licensed Practical Nurse (LPN), by phone on 3/20/14 at 10: 15 a.m. She confirmed that she was the 3 p.m. to 11 p.m. shift nurse who cared for Resident # 1 and Resident # 11 on 2/13/14. She stated that she remembered Resident # 1 and "I did his admission." She stated "he was able to get up out of bed on his own but I encouraged him to call for help as we were not sure of his gait until he was assessed by therapy." She stated again, he was able to get out of bed on his own. She stated she does not recall seeing anyone from therapy assess the resident the evening on 2/13/14. She stated that during

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her shift, Resident # 1 never left his room. She stated "something came in with him that said he was previously a sex offender." She stated that she was not told by administration or anyone else to take any special precautions or keep an eye on him. She stated that she was not aware that anything had occurred with his roommate, that Resident # 11 never said anything to her.

4. An interview was conducted with the Director of Rehabilitation Services, on 3/19/14 at 3:38 p.m. She had previously been identified by the Administrator as the therapist who assessed Resident # 1 on the evening of 2/13/14. (The Administrator had stated that the Director of Rehabilitation Services had told him on 2/13/14 that Resident # 1 "pretty much bed bound and wasn't going to be able to get up unless he was assisted up." He stated the therapist had already assessed him by the time he and the DON went up to see the resident. He stated the therapist stayed late to assess him because she knew there was a new admission and wanted to assess him before she went home. The Administrator said the therapist told him that the resident was lying in bed and couldn't move too much, that he just layed there, staring and mumbling.

The Director of Rehabilitation Services stated that she did not evaluate or assess Resident # 1 until 2/14/14, she stated "I remember it was Valentine's Day." She stated she would check the date of her assessment and the time of admission for the resident and return with the information. She then provided documentation that she completed her assessment of Resident # 1 on 2/14/14 and documentation that Resident # 1 was admitted late on 2/13/14. She stated, "he came in late the day before; I didn't assess him

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that day, I didn't stay to assess him. She was unaware of any other assessment of Resident # 1 by the therapy department on 2/13/14. She stated that when she assessed Resident #1, on 2/14/14, "he didn't want to do anything. He told me he had been in a wheelchair. He walked with me a few feet, he could ambulate, it was a waddle."
Review of Occupational Therapy Evaluation and Plan of Treatment, dated 2/14/14 revealed:
"Upper Extremity Range of Motion: WFL (Within Functional Limit)
Lower Extremity Range of Motion: WFL
Balance:
Sitting Balance: Sitting During ADL's = Good (maintains balance without support against moderate resistance)
Standing Balance: Standing During ADLS's = Fair (maintains standing balance 1-2 minutes without upper extremity support without loss of balance.
Clinical impressions: Patient presents with sob (shortness of breath) after 50 feet assisted gait with walker. Risk factors: history of Sexual Offender. Admitted here and made sexual advances to roommate today."

5. An interview was conducted with employee M, a CNA, on 3/20/14 at 11:00 a.m. He confirmed that he provided care to Resident # 1 and # 11 on 2/13/14 on the 3 p.m. to 11 p.m. shift. He stated that he remembered Resident # 1 that he had to assist him. He stated he was "a big heavy guy" and he did not leave the room during his shift. He stated that Resident # 1 was " just a normal admission and that he was not aware any history about Resident # 1." He stated he was not told to monitor or watch him any differently than any other resident which would be to check all residents every two hours. He stated he was not

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aware of anything occurring between Resident # 1 and Resident #11.

An interview was conducted with Employee K, an LPN, on 3/20/14 at 10: 30 a.m. She stated that she was the 7 a.m. to 3 p.m. nurse who cared for Residents # 1 and # 11 on 2/14/14. She stated she was not given any report from the 11 p.m. to 7 a.m. nurse about anything occurring with Resident 1 and Resident # 11. She stated "no, no report, nothing unusual." She stated that she was not made aware of any concerns related to Resident # 1 and any incident that occurred between Resident # 1 and # 11 until 2/15/14. She stated she was not made aware of Resident # 1 ' s history and was not told to monitor him on 2/14/14. She stated that other than going to therapy, he did not leave his room on 2/14/14.

6. An interview was conducted with the Unit Manager of the unit where Resident # 1 and Resident # 11 resided. She stated she was not aware of any concerns related to Resident #1 when he was admitted. She stated she did not know what happened until the next day and that she did not know when it occurred. She stated Resident # 11 was "a little irritated" regarding the incident with Resident # 1. She stated he told her that Resident # 1 either touched him or put his hand up to touch him but she could not remember.

7. An interview was conducted with the Assistant Social Worker, on 3/19/14 at 2: 46 p.m. She stated she went with the Administrator to talk to Resident # 11 on 2/14/14 and "to notify him (resident # 11) of the situation." She stated the plan was to tell him that there was an offender and we were going to do precautions. She

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stated Resident # 11 told them "he tried to touch me." She stated that Resident # 11 told them that he was lying in bed and saw Resident # 1's hand come under the curtain. She stated Resident #11, stated that he told Resident # 1 that he knew he was gay and to get his hand away from him or he would hit him with his cane. She stated Resident # 11 was angry. She stated Resident # 11 told them he had not told anyone about what happened because he was embarrassed. She stated he told her the only reason he was telling them was because they brought it up. She stated at the time of this interview, Resident # 11 was in a wheelchair, was still working with therapy on strengthing his legs that he was able to stand up and transfer but was very unsteady. She stated that the situation was unclear to her; she stated "it sounded like he was in bed (Resident # 11) and saw a hand coming from underneath the curtain." She stated she was not sure if he was lying in bed or sitting in a chair. She thinks resident # 11 told them it happened earlier in the day, on 2/14/14, right around breakfast or shortly after breakfast but she was not sure. She stated she was not involved in the investigation. A few days later I passed him in the hall (Resident #11) and asked him how he was doing and he told me he was glad his roommate was gone. She stated that was the only other contact she had with Resident #11 about his roommate and the incident.

8. An interview was held, by phone on 3/20/14 at 11: 41 a.m. with the Psychiatrist regarding Resident # 1. He stated he believed they called him about Resident # 1 the night he was admitted because "they had found out he was a sex offender." He stated that he and the facility administration talked about preventive measures

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F 520	Continued From page 62 such as putting him in a private room or putting him in with a resident who had both mental capacity and physicial capacity. He stated, "We talked about supervised status. We never got to that point. " He stated he made a special effort to come in and see him the next morning after admission. He stated that as far as he knew at the time, Resident #1 had not done anything and denied intent. He stated that he could not just Baker Act someone because they are a sexual offender. He stated that after he saw Resident # 1 he told the administration to let the staff and resident's know that he was a sexual offender and to come up with a plan to keep the resident's safe. He stated "Then they found out after talking to his roommate that he had tried to do something to him, that is when I Baker acted him. Unfortunately they called me after the fact." Review of a "Neuropsychiatric Consultation," dated 2/14/14, revealed "Reason for Consult: Patient with history sex offender." "Patient admit recent from (hospital).Has history sex offender." "Poor historian but oriented x 3." "He says he will try not to offend. No current desire." "Recommendations: Monitor his behavior." Review of the "Certificate of Professional Initiating Involuntary Examination," sgned by the Psychiatrist on 2/14/14, revealed "Patient is trying to fondle other residents. He has history of sexual battery. " 9. Review of Resident # 1's record revealed a nursing progress note, dated 2/14/14 at 16:48, which stated "Writer given in report from 7-3 nurse that this resident is being BA 52 for inappropriate sexually behavior with roommate."	F 520		

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Review of Resident # 1's record revealed a social service progress note, dated 2/24/14, and signed by the Social Services Assistant, ten days after Resident #11 reported an unwanted sexual advance from Resident # 1. The note stated "On 2/14/14 resident was discharged to (hospital) under a Baker Act based on an unwanted sexual advance toward his roommate. This writer and building administrator met with the resident's roommate to inform him of the resident's status as a sexual offender. Upon the beginning of the meeting, (Resident # 11) informed this writer and administrator that the resident put his hand under his curtain and was reaching toward his genitals. (Resident # 11) told the resident that he never wanted him to make such advancement again. This writer immediately notified (Psychiatrist) for a psych consultation regarding the unwanted sexual advancement. Resident was Baker Acted to hospital."

10. An interview was conducted with the Administrator on 3/19/14 at 10: 40 a.m. He stated that prior to the admission of resident # 1, a sexual offender, to the facility on 2/13/14; the facility had no policy related to admission of sexual offenders. He stated "we take them on a case by case basis."

He stated since the incident of 2/14/14 with resident # 1 and # 11, the facility now checks the Department of Law Enforcement Sexual Offender website prior to accepting an admission to the facility. He stated this is done by admissions. He stated there was no facility policy related to this, stating that it was just a process we do. He stated that there was no need for an action plan or policy.

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11. An interview was conducted, on 3/20/14 at approximately 1:30 p.m., with a staff person who identified herself as a Medicaid Specialist for the management company who was working as the admissions person for the past two days. She stated the facility's admission person left the facility three days ago and she is doing admissions in his place. She stated she does check the Florida Department of Law Enforcement website on any potential admissions. She stated she has not seen a current policy on this from the facility.

12. On 3/20/14 at 7: 52 a.m., further interview with the Administrator revealed that the facility has not checked the status of current residents to see if any of the residents are sexual offenders or predators. He stated there was no need to do this as the police or the sheriff will come in to check on anyone who is a sexual offender and "we will find out that way."

13. On 3/17/14 at 9: 00 a.m., the Administrator was asked to provide the facility ' s policies and procedures related to abuse, neglect, mistreatment and misappropriation of property. The Administrator provided a document entitled, "Reporting Abuse to State Agencies and Other Entities /Individuals." The Administrator was asked to provide all policies in effect related to Abuse, neglect, mistreatment and misappropriation of property and he then provided two additional documents for a total of three:
A Policy entitled, "Reporting Abuse to State Agencies and Other Entities/Individuals" with a revision date of November 2010.
A sheaf of paper clipped documents each entitled "Abuse Policy." Each document was signed by

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an employee and contained signature dates for 2014. The documents included a statement "Residents in this facility are to be treated with dignity and respect at all times and under any circumstances. Mistreatment in the form of verbal or physical abuse of any nature will not be tolerated." The document defined abuse and included information on reporting abuse.
A stapled sheaf of forms with a cover document entitled, "Abuse Reporting" "Thursday April 25. Please plan on attending the following in-service." Under the cover document was a policy entitled, "Abuse, Neglect, Exploitation and Misappropriation of Property, Prevention, Protection and Response Policy and Procedures" with a revision date of 9/12. Sign in sheets for staff were attached with an in service date of 4/25/13.
On 3/ 20/14 at 7: 52 a.m., an interview was conducted with the Administrator regarding the documents (2 and 3 above) entitled "Abuse Reporting" and "Abuse Policy." He was asked to review the policies and advise as to which policy was in effect related to the definition of abuse as there were some differences in the wording in the policies regarding the definition of abuse. He indicated #2, the sheaf of paper clipped documents entitled, "Abuse Policy," stating "because we are training everyone on this one, I've got to go with this one, this is what we are training on so this is our definition of abuse." He indicated that all of the policies were part of the facility's abuse protocol.
a. Review of the document entitled "Abuse Policy" revealed the following information: "Residents in this facility are to be treated with dignity and respect at all times and under any circumstances. Mistreatment in the form of verbal or physical abuse of any nature will not be

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tolerated.
Abuse is defined as the following:
1. Any act of absence of action inconsistent with human rights which results in or could result in physical injury to a resident.
2. Any act which constitutes sexual activity directed towards a resident.
3. Insulting or coarse language or gestures directed at a resident, which subjects the resident to humiliation or degradation.
4. Depriving a resident of real or personal property by fraudulent of (sic) illegal means.
All employees are obligated to report any acts of abuse to the abuse coordinator, who is (Director of Social Services).
All suspected, alleged, observed, or reported acts of abuse shall be thoroughly investigated by the Abuse Coordinator. All suspected acts of abuse will be reported immediately by the Abuse Coordinator to the H.R.S. Abuse Hotline 1- 800 -96ABUSE.
1. Any person, who knowingly and willfully fails to report a case of unknown or suspected abuse, neglect, or exploitation of an aged person or disabled adult or who knowingly and willfully prevents another person from doing so, is guilty of a misdemeanor of the second degree.
2. Any person who knowingly or willfully makes public or discloses any confidential information contained in the Central Abuse Registry, in the computer system, in the record of any case of abuse, neglects (sic), exploitation of an aged or disable adult id (sic) is guilty of a misdemeanor of the second degree.
3. Any person who knowingly or willfully abuses, neglects, or exploits an aged person, or disabled person, and in so doing causes great bodily harm, permanent disfigurement or permanent disability to such person is guilty of a felony of the

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second degree.
4. Any person who knowingly or willfully abuses, neglects, or exploits an aged person or a disabled person is guilty of a misdemeanor of the first degree."

b. Review of the policy referenced in # 1 above "Abuse, Neglect, Exploitation and Misappropriation of Property, Prevention, Protection and Response Policy and Procedures" with a revision date of 9/12 revealed:
"Policy: Abuse, Neglect, Exploitation and Misappropriation of Property, collectively known and referred to as ANE and as hereafter defined, will not be tolerated by anyone, including staff, patients, volunteers, family members or legal guardians, friends or any other individuals.
The health center Administrator is responsible for assuring that patient safety, including freedom from risk of ANE, holds the highest priority.
The Administrator has designated the following individual as the health center's ANE Prevention Coordinator: (Lists the name and phone number of the ANE Prevention Coordinator)
Definitions:
Abuse: the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish.
Verbal Abuse: the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend or disability.
Sexual Abuse: includes but is not limited to, sexual harassment, sexual coercion, or sexual assault.
Physical Abuse: includes hitting, slapping,

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pinching or kicking. It also includes controlling behavior through corporal punishment.

Mental Abuse: includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation.

Involuntary Seclusion: the separation of a patient from other patients, or from her/his room or confinement to her/his room against the patient's will."

Neglect: The failure to provide goods and services necessary to avoid physical harm, mental anguish, or illness. Neglect occurs when facility staff fails to monitor and/ or supervise the delivery of patient care and services to assure that care is provided as needed by the resident.

Misappropriation of Patient Property: the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a patient's belongings or money without the patient's consent.

Injuries of Unknown Source: An injury for which both of the following conditions exist:

1. The source of the injury was not observed by any person or the source of the injury could not be explained by the resident.

AND

2. The injury is suspicious because of; the extent of the injury or location of the injury, or the number of injuries observed at any particular point in time, or the incidence of injuries over time.

I. Screening Issues:

Policy: the center will not employ individuals who have been

a. Found guilty of abusing, neglecting , or mistreating patients/residents by a court of law; or

b. Have had a confirmed finding entered into the State nurse aide registry concerning abuse

Procedure: Check references for all applicants

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to obtain information from previous employers and current employers (with applicant permission)

Check the appropriate licensing board or registry

Criminal background checks as indicated.

II. Training Issues:

Policy: The center will train all staff, through orientation and ongoing in-services in ANE prevention and response.

Procedure: In Service training will include at a minimum:

What constitutes abuse, neglect, exploitation and misappropriation of patient property.

The reporting system established by the center.

Appropriate interventions to deal with aggressive behaviors.

(See Dementia training module for additional information)

How to recognize signs of burnout, frustration and stress in both patient and staff that might lead to ANE and how to effectively intervene.

(See Dementia training module for additional information)

III. Prevention Issues:

Policy: The center will provide supervision and support services designed to reduce the likelihood of abusive behaviors.

Procedure: All supervisory staff will identify inappropriate behaviors, including but not limited to the use of derogatory language , rough handling, ignoring patients while giving care, directing patients who need toileting assistance to urinate or defecate in their beds, and will take immediate steps to correct such behaviors. Supervisors will be especially sensitive to signs

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and symptoms of acute frustration.

Policy: The center will seek and accept complaints from patients, patient families and staff without reprisal.

Procedure: The right to report a concern or incident is not limited to a formal, written grievance process but includes any verbalized complaint to any facility staff.

Prompt efforts will be made to resolve concerns.

The names, addresses, and telephone numbers of all pertinent State client advocate groups such as the State survey and certification agency, the State licensure office, the state ombudsman program and the protection and advocacy network will be provided to all patients and their families in the Admission Packet and this information is also posted prominently in the center.

Policy: Patients with needs and behaviors that might lead to conflict with staff or other patients will be identified by the Care Planning team, with interventions and follow through designed to minimize the risk of conflict.

Procedure: Any patient identified as having behaviors which might lead to conflict or neglect, such as:

a. patients with a history of aggressive behaviors,

b. patients who enter other resident's rooms while wandering,

c. patients with self- injurious behaviors, or history of self - inflicted injuries,

d. patients with communication disorders,

e. Patients who require heavy nursing care or are totally dependent on nursing care will be considered as potential victims of abuse.

The interventions designed to meet the needs of such patients will include but will not be limited to:

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a. identification of patients whose personal histories render them at risk for abusing other patients or staff,
b. assessment of appropriate intervention strategies to prevent occurrences,
c. monitoring the patient for any changes that would trigger abusive behavior,
d. Reassessment of the protective strategies on a regular basis.

IV. Identification Issues:

Policy: Any patient event that is reported to any staff by patient, family , other staff, or any other person will be considered as possible ANE if it meets any of the following criteria:

a. Any indication of possible willful infliction of injury to include unexplained bruising.
b. Unreasonable confinement , to include unwanted restriction of access to all patient areas of the building.
c. Any patient or family complaint of physical harm, pain of mental anguish, resulting from willful infliction from others.
d. Any complaint of deprivation by an individual caregiver of goods and services necessary to attain or maintain physical, mental, and psychological well- being to include toileting issues.
e. Any complaint of the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to patients or families or within their hearing distance.
f. Any complaint of sexual harassment, sexual coercion, or sexual assault.
g. Any instances of hitting, slapping, pinching or kicking or other potentially harmful action.
h. Any behavior control strategy involving corporal punishment.
i. Any complaint of humiliation, harassment, threats of punishment or deprivation.

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j. Any allegation of misappropriation of patient property.
Procedure: Any and all staff observing or hearing about such events will report the event immediately to the ABUSE HOTLINE AT 1-800-962-2873. The event will also be reported immediately to the immediate supervisor, AND AT LEAST ONE OF THE FOLLOWING INDIVIDUALS, Social Worker (ANE Prevention Coordinator), Director of Nursing, or Administrator.

Any and all employees are empowered to initiate immediate action as appropriate.

V. Investigative Issues:

Policy: Any employee having either direct or indirect knowledge of any event that might constitute abuse must report the event promptly.

Procedure: Any and all staff observing or hearing about such events must report the event immediately to the ANE Prevention Coordinator or Administrator. The event should also be reported immediately to the employee's supervisor.

All employees are encouraged and empowered to contact the ABUSE HOTLINE AT 1-800-962-2873 if they witness such event or have reasonable cause to suspect such an event has occurred.

Policy: All events reported as ANE will be investigated to determine whether ANE did or did not take place.

Procedure: The ANE PREVENTION COORDINATOR will initiate investigative action.

The Administrator of the center, the Director of Nurses and /or the Social Worker (ANE PREVENTION COORDINATOR) will be notified of the complaint and action being taken as soon as practicable.

VI. Protection Issues:

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Policy: Patients will be protected from harm during an investigation.
Procedure: any individual found to be in danger or injury will be removed from the source of the suspected abusive behavior. Medical and emotional support will be made immediately available to any individual suffering suspected abuse.
Policy: Staff person or persons suspected of ANE will be suspended immediately pending result of investigation. Pay status during suspension is at the discretion of the administrator.
Residents who are suspected of initiating abusive behavior toward other residents will be immediately separated from any suspected victim or victims. The specific approach employed to separate victim and perpetrator and to ensure the protection of all potential victims will vary on a case specific basis.
In all cases, every appropriate effort will be made to ensure the protection of our residents. The resident's attending physician should be contacted promptly to determine the most appropriate interventions. These may include but are not limited to:
a. One on one assignment of staff to protect resident victims.
b. Involvement of law enforcement.
c. Review of medication regimen.
d. Review of the residents care plan interventions.
e. Involuntary Discharge.

VII. Reporting and Response Issues:
Policy: All allegations of possible ANE will be immediately reported to the Abuse Hotline and will be assessed to determine the direction of the investigation.

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Procedure: Any investigation of alleged abuse, neglect or exploitation will be reported immediately to the Administrator and the ANE Coordinator. It will also be reported to other officials, in accordance with State and Federal Law.

A. The Immediate Report

All allegations of abuse, neglect, exploitation, or misappropriation of property, including injuries of unknown source, must be reported immediately. This allegation must be reported to the Abuse Hotline (Adult Protective Services) within twenty four hours whenever an allegation is made.

The ANE Prevention Coordinator will also submit The Agency for Health Care Administration AHCA Federal Immediate/5 Day Report and send it to :

Complaint Administration Unit
Phone: 850-488-5514
Fax: 850-488- 6094

E-Mail: fedrep@ahca.myflorida.com

B. The Report of Investigation (Five Day Report):

The facility ANE Prevention Coordinator will send the result of facility investigations to the State Survey Agency within five working days of the incident. This will be completed using the same AHCA Federal/Five Day Report, and sending it to the Complaint Investigation Unit as noted above.

C. Designated Reporters:

Shall immediately make a report to the State Survey Agency, by fax, email, or telephone.

All necessary corrective actions depending on the result of the investigation will be taken

Report any knowledge of actions by a court of law against any employee, which would indicate an employee is unfit for service as a nurse aide or other facility staff to the State nurse aide registry or other appropriated licensing authorities.

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Any report to Adult Protective Services will trigger an internal investigation following the protocol of Untoward Events Policy and Procedure.
Policy: Trends of investigative findings will be analyzed and addressed by the QA RM committee process.
Procedure: An accurate summary reporting of all investigations conducted by the center will be maintained as a working document of the Quality Assessment and Risk Management Committees. QA and RM will review and analyze investigations to track and determine presence of any trends. Any trends will be forwarded to all members of the QA TEAM and center management."

c. A review of the policy entitled, "Reporting Abuse to State Agencies and Other Entities/Individuals" (with a revision date of November 2010), revealed different information on reporting of Abuse, as to who to report to, what to report and when to report, than what was contained in section VII. Reporting and Response Issues of the policy entitled "Abuse, Neglect, Exploitation, and Misappropriation of Property. Prevention, Protection and Response Policy and Procedures (revision date 9/12)."
Review of the "Reporting Abuse to State Agencies and Other Entities/Individuals" Policy revealed:
"Policy Statement: All suspected violations and all substantiated incidents of abuse will be immediately reported to appropriate state agencies and other entities or individuals as may be required by law.

Policy Interpretation and Implementation:
Should a suspected violation or substantiated incident or mistreatment, neglect, injuries of unknown source, or abuse (including resident to

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resident abuse) be reported, the facility Administrator or his/her designee, will promptly notify the following persons or agencies (verbally and written of such incident:
a. The State licensing/certification agency responsible for surveying/licensing the facility;
b. The local/State Ombudsman;
c. The resident's Representative (Sponsor) of Record;
d. Adult Protective Services;
e. Law enforcement officials;
f. The resident's Attending Physician; and
g. The facility Medical Director
Verbal/ written notices to agencies will be made within twenty- four (24) hours of the occurrence of such incident and such notice may be submitted via special carrier, fax, e-mail, or by telephone.
Notices will include, as appropriate:
a. The name of the resident;
b. The number of the room in which the resident resides;
c. The type of abuse that was committed (i.e., verbal, physical, sexual, neglect, etc.)
d. The date and time the alleged incident occurred;
e. The names(s) of all persons involved in the alleged incident; and
f. What immediate action was taken by the facility.
The Administrator or his/her designee will provide the appropriate agencies or individuals listed above with a written report of the findings of the investigation within five (5) working says of the occurrence of the incident.
Should the investigation reveal findings of abuse, such findings will be reported to the State Abuse Registry. The individual (s) involved in the incident will be notified of such findings, and such individuals (s) will be suspended, without pay,

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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
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until the State Abuse Registry has investigated the claim and found the allegations to be true or unfounded.
Should the allegations be true, the employee(s) will be terminated from employment. Should the allegations be unfounded, the employees(s) will be reinstated to his/her /their former position with back pay.
Records of all allegations will be filed in the accused employees' personnel record along with any statement by the employee disputing the allegation, if the employee chooses to make one.
Records concerning unfounded allegations will be destroyed.
The State Abuse Registry will:
a. Notify the employee when he/she has been implicated in any investigation;
b. Inform the employee of the nature of the allegation;
c. Inform the employee of the time and date of occurrence;
d. Inform the employee of his/her right to a hearing;
e. Inform the employee of the state ' s intent to record findings of resident abuse into the abuse registry; and
f. Inform the employee of his /her right to file a statement disputing the allegation.
Appropriate professional and licensing boards will be notified when an employee is found to have committed abuse.
Any violation of this policy may result in disciplinary action.
Inquiries concerning resident abuse should be referred to the Director of Nursing Services or to the Administrator.
Inquiries concerning the reporting of abuse to state agencies should be referred to the Administrator.

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	105772	A. BUILDING _____ B. WING _____	R 03/20/2014

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14. An interview was conducted with the Administrator, on 3/19/14 at 2:15 p.m. regarding resident # 1 and the investigation conducted by the facility after the incident with Resident #11. The Administrator stated he did not know what time Resident #1 made an unwanted sexual advance to Resident # 11. He stated that it was "probably sometime in the night, he didn't get any specific time." He stated that Resident #11 told him that Resident #1 "put his hand through the cubicle curtain, he saw his hand getting in the area of the sheet and he yelled out to stop it." He stated that he understood from Resident #11 that Resident #1 was in his own bed at the time. He stated "I don't know how he could reach him without getting out of the bed; you can get your hand through the cubicle curtain but not physically be able to touch the other bed unless you have eight foot long arms." He stated since it was during the night, he talked to the day nurses to see if they had gotten any information on their 24 hour report about it and they said no. He stated he did not question the night nurse or the CNA about Resident # 1's movements during the night. He stated he did not talk to any other residents or other staff to determine whether any other incidents had occurred with Resident # 1 or if Resident # 1 was seen getting out of bed. He stated that the resident was unable to move and was in a room with an alert and oriented resident. He stated the psychiatrist had told him on 2/13/14 on the phone that "in his current state he is not going to harm anyone." He stated that there was no harm as Resident # 1 did not touch or harm Resident # 11 in any way and that Resident # 11 stated he wanted to keep Resident #1 as his roommate." He stated that the facility would report inappropriate and/or unwanted sexual

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advances to the abuse hotline but since there was no allegation of inappropriate and/or unwanted sexual advances and "we confirmed no harm was done," it was not reported to the abuse hotline. He stated there was no investigation needed as "nothing happened."

15. An interview was conducted with the Social Service Director, on 3/20/14 at 8:19 a.m. She stated that she is the Abuse Coordinator. She stated she was not part of the investigation regarding the incident with Resident # 1 and Resident # 11. She stated it was mainly the Administrator and she thinks she was off that day. She stated " They said he (resident # 11) had volunteered information but had not reported it to that point. She stated that she thought it was handled as a grievance but was not able to find it in the grievance log.
She described her process for investigation of an allegation of abuse. She stated if a resident or staff report abuse "I do the investigation and call the hotline." If a resident says something happened, I do a thorough investigation, interview staff, roommates and other residents and call the hotline. She stated that she would not submit a 1 day Federal Immediate report if the abuse hotline did not accept the call. She stated the only time she would do a 1 Day Immediate Federal Report was if the abuse hotline accepted to report of abuse. Review of the State Agency's Nursing Home Federal reports site on 3/21/14 at 4:05 p.m. determined that no federal one and five day reports had been submitted.

16. Observation on 3/17/14 at 12:20 p.m. of the first floor medication storage room revealed expired medication was found to be present. Interview with the DON on 3/17/13 at 12:30 p.m.

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confirmed the presence of this expired medication.

Observation on 3/17/14 at 12:40 p.m. of the third floor medication storage room revealed expired medication and biologicals were present. Interview with the 3rd floor unit manager during the observation confirmed the presence of these expired items.

Observation on 3/18/14 at 10:40 a.m. of a medication cart on the third floor revealed 6 bottles of undated insulin for 6 facility residents. Interview during this observation with Staff Member C and the 3rd floor unit manager confirmed the presence of these undated items.

Observation on 3/18/14 at 12:42 p.m. of a medication cart on the first floor revealed a bottle of a benzodiazepine which was not properly stored in the refrigerator per pharmacy label instructions and did not contain an open date per facility policy. The presence of this undated and improperly stored medication was verified by Staff Member J at the time of the observation.

Observation on 3/18/14 at 1:05 p.m. of a medication cart on the 2nd floor revealed the presence of a prescription inhaler which did not contain an open date. The presence of this undated item was confirmed by Staff Member I at the time of the observation.

Interview with the Director of Nursing (DON) on 3/18/14 at 5:02 p.m. confirmed medication was not dated and had expired. The DON stated the Unit Manager is ultimately responsible to monitor the medication cart and storage rooms. The nurses are required to monitor the carts, write the

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date opened and dispose of expired medications. All staff has been in-serviced.
17. Review of the facility's written plan of correction from the Annual QIS Survey ending in February 2014 revealed the following relevant information related to medication storage (F431):
a. All nurses were re-educated to observe the medication carts and medication storage rooms for out dated medications and treatments and dispose of them properly

b. Unit Managers will monitor the medication and treatment carts at least weekly for 4 weeks and report to the ADON and DON.

c. DON will make any adjustments necessary to assure that medications and treatments that are out dated are not in the patient care areas.

d. This will be reported to QA committee monthly for 3 months.

e. Continued investigation revealed a total of 23 nurses out of a total of 38 facility nurses were in-serviced on expired medications according to the employee listing provided to the survey team on 3/17/14. Seven of the 23 nurses who had received the in-service training had received it after the 3/5/2014 correction date. It should also be noted that all of the nurses who were present during the 3/17/14 and 3/18/14 medication storage observations had signed as receiving the in-service training.

18. Interview with the nursing home administrator on 3/19/14 at 2:55 p.m. revealed the following relevant information:

When the facility first received their statement of

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deficiencies via fax on 2/17/2014 the quality assurance (QA) committee met and broke out into teams to create the plan of correction. No sign-in sheets were maintained for this meeting. In addition to this meeting, the facility has a daily QA meeting at 9:00 a.m. and a stand down meeting at the end of each day Monday - Friday. Sign-in sheets are not maintained for these meetings but notes are kept of the discussions. The facility held their "bigger" QA meeting on March 4, 2014. The March 4th, 2014 meeting did include a sign-in sheet and an agenda which indicated that F431's plan of correction was discussed.

Interview with the DON on 3/19/2014 at 3:19 p.m. in the presence of the NHA revealed the following relevant information in regards to medication storage (F431):

I do audits where I "check the checker, checker." The DON stated my audit consists of checking the med rooms, med carts, and treatment carts. Periodically, I go behind and I check through everything to include the refrigerators. When the surveyors came out on Monday, 3/17/2014, with the bag full of needles dated 2010; I told the surveyor that someone has to be sabotaging us. We are a needleless facility so someone had to have set us up and brought them in. I pulled everything that the surveyors had found in regards to insulin that didn't have open dates. When I do my random checks I never saw any of this and pharmacy was here last week and did their checks too. If I see something that is expired, I would pull it, and destroy it. When I came in this morning there were other items sitting on the counter which all expired in 2012. We don't even use these types of items.

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