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S 000	Initial Comments Annual Health Statement of Licensure violations	S 000		
S9999	Final Observations 300.610a) 300.1210b) 300.1210c) 300.3240a) 300.3240b) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures	S9999	**Attachment A** **Statement of Licensure Violations**	

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shall include, at a minimum, the following procedures
c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act)
b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act)

These requirements were not met as evidenced by:

Based on interview and record review the facility failed to protect seven of seven residents (R36, R60 and R97) reviewed for abuse in the sample of 69. R219 sexually abused these seven female residents on multiple occasions. This deficient practice has the potential to affect all 48 female residents in the facility.

Findings include:

1. R219's Hospital Records, dated 04/19/2017, documents in part, "History of Presenting Complaint: This is a 53 year old male, nursing home resident who was brought to the emergency room after he was found sexually in a compromising social position with a demented fellow resident. At present, he denies these complaints. He does have a diagnosis of sexual dysfunction. Medication: Progesterone." The Physical Examination documents in part, "General: middle-aged male, robust, awake, alert,

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orientated x 3." The Assessment/Plan documents in part, "admitted with inappropriate sexual behavior. Will refer to Psychiatry."

R219's Progress Notes, dated 05/25/2017 at 2:07 PM, documents, in part, "Report called in from (hospital) diagnosis of mild developmental delay and reports of inappropriate behavior from previous long term care facility on 04/19/2017. (R219) reportedly admitted extended amount of time due to placement issues."

R219's Care Plan, dated 05/25/2017, documents R219 was admitted to this facility on 05/25/2017. R219's Care Plan documents in part, "expressing inappropriate behaviors." The intervention listed is documented as "continue to monitor medication, activities of daily living and behaviors." Under the psychotropic medication section, "(R219) has a history of expressing inappropriate behaviors towards others." The intervention documents, "monitor for changes with behaviors, when expressing inappropriate behaviors redirect and explain appropriate actions. When needed provide 1:1 monitoring. Resident has a history of aggressive, inappropriate, attention-seeking and/or maladaptive behavior, but has demonstrated stability during the admission screening process and is therefore considered appropriate for admission." The Goal is listed as "the resident will not touch or rub any of his fellow peers while he is a resident in the program (5/25/2017)." The intervention is documented as "Intervene when any inappropriate behavior is observed. Communicate assertively that the resident must exercise control over impulses and behavior." The Care Plan, dated 05/25/2017, further documents in part, "Focus- maladaptive behavior, Goal- The residents will not touch or rub any of

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his fellow peers while he is a resident in the program."

On 4/04/2018 at 3:17 PM, V3, Care Plan Nurse, reported when she initiated R219's Care Plan she probably looked at the History and Physical (H&P) that came from the hospital prior to R219's admittance on 5/25/2017, but could not remember. V3 stated, "Inappropriate or maladaptive behavior could be verbal, harm to self or others, sexual. It doesn't necessarily mean sexual." V3 reported she heard nothing said about R219 being sexually inappropriate when he was admitted. V3 stated one-to-one observation is when a person is with the resident observing them. V3 reported it could be initiated by the physician or nurse. V3 reported R219 was on a 15 minute observation status for his entire stay at the facility as are all of the residents who are on Daisy Drive, which is the independent behavioral hall. V3 reported it is the responsibility of the Psycho-social Technicians on that hall to document on each resident on that hall every 15 minutes. When V3 was asked what "close monitoring" means, V3 stated, "15 minutes checks are close monitoring."

R219's Quarterly Minimum Data Set (MDS), dated 11/28/2017, documents a Brief Interview of Mental Status (BIMS)score of 15 out of 15, indicating he was cognitively intact. The MDS documents R219 can walk in his room with staff supervision, oversight, and encouragement of cueing. R219 is documented as having physical behavioral symptoms directed towards others such as hitting, kicking, pushing, scratching, grabbing, and abusing others sexually and this is documented as occurring 1 to 3 days per week.

The facility's Occurrence Investigation and

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S9999	Continued From page 4 Resolution Report, dated 02/12/2018 documents, in part, "Our investigation has included interview of all known potential witnesses, Housekeeping staff (V10) was in the dining room and observed (R219) to be looking about himself in a suspicious manner and felt that he had reached out toward a female resident. Several other residents were also present in the dining room at this time. This housekeeper asked a male CNA who was present to observe (R219) and ensure safety while she went to report to Social Services. (R219) was then invited to the East Hall Dining Room as a precaution pending initial investigation. None of the other persons present observed inappropriate contact between (R97) and (R219). However, when asked, (R97) indicated that (R219) had touched her upper body. We were unable to question her further due to her significant cognitive impairment. We conclude from available evidence that this event did occur. (R219) has been under constant observation since the initial report. He has not been deprived of adequate socialization and freedom of movement; he has cooperated voluntarily with remaining on his hall, dining space which includes recreation/dining spaces. His guardian has agreed to support transfer to other living arrangements." The report also documented "(R97) - Adult failure to thrive, Alzheimer disease, alert and oriented x 1, severely impaired (R219)- Unspecified psychosis, diffuse traumatic brain injury, alert and orientated x 3, BIMS (Brief Interview Mental Status) 15, indicating cognitively intact." The Facility's 15 minute observation checks, from 2/12/18 at 6:00 PM through 2/16/18 at 10:45 AM, documented R219 was checked every 15 minutes for inappropriate behaviors and wandering.	S9999		

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The local police's Offense/Incident Report, dated 02/12/2018, document in part, "(R219) was arrested on 02/16/2018 at 11:00 AM. (R219) was booked on 02/16/2018 at 11:00 AM." The Arrest Classification is document as "FELONY." The Report also documents the date of the incident as 02/12/2018 at 4:31 PM at the facility. The Report documents a video surveillance of the incident was reviewed by V13, Police Officer, and documents the following: "(R219) grabbing (R97's) left breast several times with his right hand, and (R97) attempting to slap (R219's) hand. (R97) attempting to move away from (R219) and (R219) pushes (R97's) wheelchair back to the area she just left. (R219) was grabbing and touching the breast area of (R97). I observed (R219) grabbing and touching the breast area of (R97) from the outside of her sweatshirt several times throughout the incident using my department issued camera. I later logged the video into the evidence as exhibit #1. (V2), police officer and I attempted to speak with (R97). I asked (R97) about the incident and she did not respond. (R97) mumbled something that I could not understand. I called (V15, Sergeant Police Officer) who stated he would not be making the scene and not to make an arrest at this time due to the mental health issues surrounding (R219). "

The Offense/Incident Police Report, dated 02/12/2018, documents the following: "At approximately 4:31 PM, (R219) is seen standing next to (R97) who is sitting in a wheelchair. (R219) reaches down with his right hand and touches (R97's) left breast on the outside of her clothing. (R97) appears to try and block (R219) hands from touching her breast. (R219) appears to be continually looking around and scan the

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area. (R97) is seen trying to protect herself and cover herself up and pushes (R219's) hand away. (R219) swats at (R97's) hand and is also seen slapping (R97) on her left cheek area with the back if his right hand. (R219) is seen touching (R97's) left breast again and reaches inside the top of her shirt and fondles her left breast. (R97) appears to try and push (R219's) hand away. (R97) starts using her feet to pull her wheelchair away from (R219). (R219) is seen pulling (R97) back towards him, looking at the door and is seen reaching inside the top of (R97's) shirt touching her left breast. When a worker comes into the area, (R219) steps away from (R97) but moves back by her when the worker leaves the room. R219 sits down in front of (R97) partially blocking her from the view of the surveillance camera. (R219) is seen leaning forward towards (R97), the bottom of (R97's) shirt appears to keep being raised up. R97 looks like she pushed (R219's) hand away. At approximately 4:45 PM, (R219) is seen reaching for (R97's) crotch area. She pushes his hand away. (R97) is seen with her right leg crosses over her left. (R219) uncrosses (R97's) legs and appears to be touching (R97's) vaginal area through her clothing. At approximately 4:49 PM, a worker is seen entering the room and (R219) leaves the room at approximately 4:50 PM."

The local police's Supplemental Report, dated 02/12/2018 at 5:13 PM, documents in part, "I contacted (V9), family of (R97), and I informed her that I was assigned to investigate this case. She confirmed that she was the (R97's) surrogate for decision making. She said she was aware of what had transpired between the suspect, (R219) and her aunt (R97). She said (R219) has had problems in the past similar to what had taken place with (R97). She further advised me she was

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an employee of the facility and was in route to the location to have a meeting with (V1) regarding the incident. She told me she would contact me when she had further information. At approximately 10:20 AM, (V9) contacted me, and stated she had met with (V1) and the (V2), Director of Nursing of the facility. She said she wanted to pursue charges against (R219) on (R97)'s behalf."

Police Report, dated 02/14/2018 at 5:13 PM, documents: "On 02/14/2018, (V9) arrived at the police department and signed a Police Department Victim Protocol Form on (R97's) behalf indicating she wanted to pursue criminal charges against (R219). Additional Information: On 02/13/2018, police officer, (V13), responded to the facility to meet with (R219) and conduct an audio/video recorded interview with him regarding this investigation. Upon arrival, we spoke with (V1) and (V2). We advised them we were investigating a complaint involving (R97) and (R219) and requested to conduct an interview with (R219) regarding his involvement. The interview began at approximately 1:58 PM. (R219) was advised that everything in the room was being audio and video recorded. (R219) was advised he was not under arrest but I told him I would be reading him his Rights per Miranda. While going through the check list, (R219) said he had lived in the facility for about 6 months and shared a room with 3 other residents. The following are statements from (R219):
(R219) stated he did not know (R97's) name but acknowledged her as being a woman in a wheelchair. (R219) stated he was aware that everything in the dining room was recorded. (R219) acknowledged he had reached down and touched (R97's) breast, (R219) stated he had touched (R97's) on the breast twice. (R219) acknowledged (R97) wanted him to stop when

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she pushed his hands away.
(R219) stated he was caught touching (R97's) breast through her clothing on two occasions. (R219) stated if he was caught touching (R97's) breast that he would be talked to. (R219) stated he was touching (R97's) breast because he was trying to get with her. (R219) stated he was caught touching another woman's breast in the facility prior to the incident involving (R97). (R219) stated he likes touching peoples' breasts and it felt good to him. (R219) stated he got a little aroused when he touched (R97). (R219) stated he touched another woman's breast (unknown identify), she left the facility and he does not see her anymore. (R219) stated he believed it was wrong to touch someone if they did not want to be touched. (R219) stated he was moved from the previous facility that he lived in because of the same thing... (R219) stated he believed it was wrong to do what he did to (R97). The interview was concluded at approximately 2:21 PM. "

On 03/21/2018 at 1:30 PM, V1, Administrator, stated, "(R219) is no longer in the building. The police came and got him, arrested him and put him in handcuffs." When asked why R219 was arrested, V1 responded "I don't know."

On 03/23/2018 at 9:10 AM, V1 stated, "No, I am not really aware of (R219's) behavior history. I started working here on 12/01/2017 so I can only speak from 12/2017 and forward. I had some generalization that he had some behaviors that were inappropriate. The Director of Nursing (V2, DON) and I were not personally aware of (R219's) history. One instance, a single incident soon after he got here, there was an incident with an alert and oriented resident who he attempted to touch (R106). This was investigated." V1, Administrator, stated "The only residents I am

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aware of sexually inappropriate behavior by (R219) are (R97) and (R60). There was an incident in February with (R97) and (R219). I called the police, I wasn't aware of what they did. I have reason to believe the incident at my sister facility also was taken into investigation with the police."

On 03/29/2018 at 5:01 PM, V1 stated, "I was the one who had called the police regarding (R97). (R219) admitted to doing it. The police officer and I reviewed the video surveillance and saw that he had touched (R97) inappropriately in the dining room and a few days later (R219) was arrested."

On 03/23/2018 at 3:18 PM, V1 stated, "(V10), Housekeeper, is the one who made the initial complaint and got a hold of (V11), Psych-Social Services Coordinator. (V10) could not remember the name of the resident she was concerned about. (V10) did not talk to me." I believe she (V10) originally thought the resident was (R93) because she was not sure of the name. We (myself and police) went to the cameras. This happened in the dining room, and after viewing the camera we were able to identify (R97) and (R219's) behavior. I looked at the camera, immediately and that is when we discovered (R219) had touched (R97's) breast. I was not able to make contact with (V10) until 3 days later, and I went back to the camera to confirm that (R219) did not touch (R93), but (R219) touched (R97's) breast instead. No, (V10) did not contact me, she contacted (V11)."

On 4/04/2018 at 3:45 PM, V1 reported R219 was on one-to-one observation status from 2/12/2018 at 6:00 PM until he left the facility with the local police on 2/16/2018 at 10:45 AM. V1 reported this

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is documented on the forms entitled, "15 Minute Observation" and documents the behavior for "inappropriate behavior, wandering". V1 reported the one to one observation form needs to be redone to be more specific to one-to-one observation. V1 reported the facility has no policies or procedures for observation status of any resident at this time. V1 reported, "Constant monitoring would essentially mean one-to-one observation monitoring. That would mean to keep them in sight. When in bed they can monitor him (R219) from the hallway."

R97's Annual Minimum Data Set (MDS), dated 2/19/2018, documents R97 was unable to complete the BIMS test and was scored as severe cognitive impairment. The MDS also documents (R97) is in a wheelchair, not steady, and only able to stabilize with staff assistance from a seated to standing position, walking and surface to surface transfers. R97's MDS does not document any behaviors.

R97's Care Plan with a start date of 02/19/2018 documents R97 is at risk for abuse and neglect related to weakness, adult failure to thrive, and dementia with behaviors. The Care Plan documents she requires assistance with her care. Under communication the Care Plan documents "(R97) has a communication deficit related to her minimal hearing deficit, dementia and unclear speech. She does not always understand what is being said unless speaker adjusts tone, she has to repeat statements at times." For goals under abuse it documents "staff will monitor well-being of others. Resident will have zero episodes of abuse and neglect."

R97's Physician Order Sheets (POS) dated February, 2018 documents in part, (R97) has

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diagnoses of adult failure to thrive, weakness, muscle weakness, other Alzheimer disease, dementia.

R97's Progress Report, dated 02/12/2018 at 6:50 PM, documents in part, "Resident noted being touched inappropriately by another resident. Residents were separated. Full body assessment performed by this nurse (V44, LPN). Family notified, DON and Administrator." The Progress Note does not document the name of the other resident.

On 03/23/2018 at 9:40 AM, V9, Family Member of R97, stated, "The facility called me and told me that they had caught (R219) on camera touching my aunt. I filed a police report and got a restraining order against (R219). I had a meeting with the Administrator (V1) about it. I just wanted to keep her safe. "

2. R219's Progress Notes, dated 11/13/2017 at 12:55 PM, "It was reported to Psychosocial Rehabilitation Services that (R219) was attempting to go on Lavender Lane (female hall) on several occasions after hours, the staff redirected him each time he attempted to walk down the hall. I asked staff to monitor him throughout the night and report any issues to the nurses and appropriate staff members."

R219's Progress Notes, dated 11/15/2017 6:38 PM, "Staff had to redirect resident several times this shift not to walk on Lavender Hall. Resident calm and cooperative. Spoke with resident case manager."

R219's Progress Notes, dated 11/28/2017 at 3:30 PM, "(R219) is a 54 year old male with a primary diagnosis of unspecified psychosis. He is alert

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and oriented x 3 with a BIMS score of 15 out 15 (cognitively intact). (R219) has been known to wander the halls and has to be redirected."

R60's Facility Incident Report Form, dated 12/20/17, documents on 12/20/17 at 5:15 PM a reportable event was reported: "date unknown and time unknown (evening or nights)." The Type of Event was documented as allegation of sexual abuse (inappropriate touching) from one resident to another resident. The Facility Incident Report Form also documented "while speaking to (V7), Social Service Designee (SSD), resident (R60) alleges that the above resident (R219) touched her inappropriately while in her room. The date and time is not known. Our investigation has begun. Residents are separated and will remain so: the male resident is on 1 to 1 pending transfer for a psychiatric evaluation. Notifications made to administrator, resident representatives, physicians and local police. Final report to follow within 5 days."

The Facility's 2nd page of Occurrence Investigation and Resolution documented "Our investigation has included an interview, at the time of her allegation (R60) indicated that (R219), who she identified by photograph, had visited her that night had uncovered her, and had been touching her between the legs. (R60) has a diagnosis of dementia. The unidentified Certified Nursing Assistant (CNA) who originally reported that (R219) had entered the room had been monitoring (R60) hall. (R219) was visible beyond the hallway door as she stepped off the other end to bring a breakfast tray onto the hall. She (CNA) walked no more than 60 feet off the hall and 60 feet back. Returning to the hall where upon she immediately surprised (R219) in (R60's) room standing near her bed. (R60) was fully covered

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with the blanket in place. When she asked, why he (R219) was there. He responded that he was trying to visit a friend. The unidentified CNA stated (R60) did not seem disturbed, but she was staring at him. She asked (R60) with (R219) present did he touch you, to which she responded that he did not. The unidentified CNA then escorted (R219) off the hallway to his own room. The Video footage from the hall for the preceding 24 hours was reviewed by (V1) the administrator and the Director of Maintenance (V5). (R219) was not observed on the hall except at 8:29 AM on 12/20/17. (R219) walked onto Lavender Lane from the first nurse's station at 8:29 AM and limped slowly down the hall with a mass of folded papers in his left hand. He reached the threshold of (R60's) room at 8:29 AM and went in leaving the door open. The unidentified CNA is observed to come back onto the hall at the same time and goes directly to (R60's) room at 8:29:51 after noting (R219) on the hall. She exits the room with (R219). (R60) was sent immediately to the emergency department for medical evaluation based on her allegation. Their assessment found no signs of injury or other interference. (R219) denies touching (R60). (R219) received psychological evaluation immediately following this allegation and was returned to the facility with no findings. Interdisciplinary team has reviewed both residents plan of care and made changes as appropriate."

The facility form, dated 12/20/17 entitled interview with (R60) (conducted by V1, Administrator), documented "spoke with resident alone in her room, requested permission to speak with her, to which she nodded yes. (R60) has limited ability to communicate verbally, but she understands what is said to her. (R60) states that there was a man in her room last night she does not know his

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name, but states he is ugly. When asked if anything happened, she used the word touch, and made hand motions towards her lap and groin area. She expressed she was angry and upset." The form documented "(V1) collected verbal report from nursing staff as to whether any males had been observed on Lavender Lane, and one resident was identified. (V1) brought pictures of a few male residents to (R60) and (R60) identified the same resident that was on the hall."

R219's Progress Notes, dated 12/20/2017 at 6:22 PM, document in part, "This nurse was informed that the inappropriate sexual contact allegations have been reported to him and that (V21, Psychiatrist) needed to be contacted related to situation. Resident was on 1-1 monitoring. This nurse called (V21) at 6:00 PM and informed him of the allegations and new order was given to send resident to an out of state psychiatric hospital for psychological evaluation. Resident's guardian was called at 6:06 PM and voicemail left to give nurse a call at the facility. Report was given to emergency room. At 6:20 PM the emergency medical system transported resident to psychiatric hospital."

The local hospital Emergency Room Visit Report, dated 12/20/17, documents "(R60) was sent to emergency room due to reported sexual assault, which occurred prior to 9 AM. Patient was sent to emergency room at family request."

The local hospital Emergency Room Progress Note, dated 12/20/17 at 9:22 PM, documents "Registered Nurse (RN) spoke with (V7, SSD) concerning the fact that another resident in the care facility had put their hands down the patient's (R60's) pants." The Note documented it was reported that someone walked in on the

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incident occurring, which is how they determined what events happened. The report documented two RN's examined R60's genital area, and no evidence of trauma or injury were present.

R219's Care Plan was revised on 12/20/17 and documented "Allegations were made that (R219) acted inappropriately with peer. He was immediately placed on 1:1 care with staff and sent to ER for evaluation. 12/21/17 Returned from ER with no new orders, he remains on close monitoring by staff on and off the unit."

R219's Psychiatric Follow-up visit, dated 12/28/17, documented, "No staff concerns." There was no documentation regarding his recent ER admit due to inappropriate behaviors.

On 3/23/2018 at 9:10 AM, V1, Administrator, stated, "There was an incident with (R219) and (R60). We sent (R219) out for a psychiatric evaluation on 12/20/2017. (R60) said he had touched her. (R60) was sent to the emergency room I believe to determine if it occurred. (R219) was sent out for a psychiatric evaluation to determine and get the Physician's opinion." V1 reported he was not sure if R219 was ever on any observation since admission to the facility on 05/25/2017. V1 stated, "Once I was aware of (R219's) inappropriate behavior to women residents - The investigation with (R60) showed that (R219) didn't attempt to do anything. (R219) was observed for a period of time - direct observation at minimum until the end of the investigation."

On 3/23/18 at 2:00 PM, V25, Certified Nurse's Aide (CNA), stated, "I was working on Humming Bird Lane. I took one tray down Lavender Lane going the back way, and as I was coming back, I

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saw (R219) in (R60's) room and I asked (R219) why he was in (R60's room). (R219) said I was speaking to her. (R60) said she didn't want him in her room."

R60's Electronic Medical Record, dated 03/01/18, documents R60's diagnoses (in part) of Abnormal Posture, Muscle Weakness (Generalized), Dysphagia, and Dementia.

R60's Care Plan, (revision date) dated 02/07/18, documents R60 is at risk for abuse and neglect related to cognitive deficit, amputations, and decreased mobility. R60's interventions are establishing a counseling schedule with resident, identify areas that put resident at risk, and observe the resident for signs of fear. R60's Care Plan further documents R60 is alert with a communication deficit.

3. R219's Psychiatric Evaluation form, dated 6/1/17, written by V21, Psychiatrist, documented "inappropriate behaviors."

R219's Progress Note, dated 06/07/2017 at 4:09 PM documents, in part, "Resident is a new admit to this program. Resident is alert and oriented throughout the facility with the ability to make needs and wants known peacefully. Resident scored a perfect score with his Brief Interview Mental Status (BIMS) (cognitively intact). Resident is calm and settled with fellow peers and staff. I talked with the resident about touching his fellow peer arms appropriately. Resident understood and said it would not happen again."

R36's Final Investigation Report documents "At 8:05 PM, 06/09/2017 resident was observed in wheelchair moving through day room. Co-resident sitting on couch reached out and

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brushed against her breast. Resident fully clothed. Staff witnessed event. Staff interviewed immediately, counseling/discussing with male resident (R219) to be aware of his arm movement and surrounding. No injuries or further issues."

On 03/29/2018 at 3:33 PM, V52, Licensed Practical Nurse (LPN), stated, "I remember (R219). I remember one day he was sitting in the day area with (R36) and he reached over and put his hand over her breast and tried to fondle her breast. (R36) was confused and incoherent. She randomly rolls around. I tried to stop it and told the administrator at that time. (R219) I think had a history of inappropriate sexual behavior. We always try to keep the men off of the (women's) hall."

R219's Care Plan was revised on 6/9/17 and documented, "Sat with psychsocial staff unit it was bedtime and continued monitoring on 15 minute checks."

R219's Progress Notes, dated 06/10/2017 at 1:53 PM, document, "Continues one on one with staff related to inappropriate physical contact with a female resident."

R219's Psychiatric Follow-up visit, dated 6/15/17, written by V21 documented "Inappropriate sexual behaviors. Patient admits of his inappropriate behavior."

R219's Progress Notes, dated 06/21/2017 at 1:01 PM, document in part, "Social Service Director talked with resident's guardian and sister, shared resident's behaviors and a potential all male group home."

R36's diagnoses from electronic medical

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documented Catatonic Schizophrenia, Receptive-Expressive Language Disorder, Cognitive communication Deficit, Myoclonus Unspecified Anxiety Disorder and Disorganized Schizophrenia.

R36's MDS, dated 2/27/2018, documents a BIMS score of 9 out of 15 (moderate cognitive impairment).

R36's Care Plan, initiated 2/1/2017, documents, "ABUSE/NEGLECT: At risk for abuse and neglect related to Schizophrenia, Development disorder."

On 03/23/2018 at 10:09 AM, V16, Licensed Practical Nurse (LPN), stated, "I came in October 17 2017, and by November I told Psychosocial Rehabilitation Coordinator (V11, former employee) and (V18, Psychosocial Service) that I was having to redirect (R219) from going into the women's rooms. I never actually saw him groping anyone, but I was always redirecting him."

On 03/23/2018 at 1:30 PM, V18, Psychiatric Social Worker, stated, "For the most part, (R219) stayed in his room. We kept an eye on him 1 on 1 in January. The former administrator (V22) told us to keep an eye on (R219). When the new administrator (V1) came, we brought 2 (psychiatric) technicians. Back in October, they told me (R219) likes to try and touch women. (V11, Psychosocial staff), and the old administrator (V32) were aware that (R219) was sexually inappropriate to women."

On 03/23/2018 at 1:31 PM, V29, CNA, stated, "When I go into the room, (R219) would say 'Hey baby.' I knew he was sexually inappropriate, and he was put out in the psychiatric social room for awhile to keep people safe. Then all of a sudden

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(V11), Psych-Social Services Coordinator worker put him back in the main dining room, I am not sure why he came back."

On 03/23/2018 at 1:35 PM, V34, LPN, stated, "(R219) was here for awhile, 3- 6 months. He lived in the independent hall- Daisy Drive. I had no problems with him. I was aware he had sexually inappropriate behaviors when he first arrived. I know at one point he was on 1:1 observations - I was told it was for his behaviors- It was in a report. Psychiatric social technicians and I would be with him during the 1:1 time. I don't know them by name. (V18, Psychiatric Social Worker) usually sat with him during meals."

On 03/23/2018 at 1:50 PM, V18, Psychosocial Service, also stated "(R219) stayed in his room for the most part during the day. He would usually not come out of his room until the evening and midnight shifts. (R219) would wander around when he knew there was less staff. We discussed it with staff that he knows what he is doing, and when there is no staff around. We tried to keep any eye on him. He liked to wander into other resident's room. I run groups and deal with all behaviors in the building. I was not aware of (R219's) behavior when he was first admitted. I was not aware until after the incident with (R60)."

R219's Physician Progress Notes written by V14, R219's Physician, dated 6/1/17, 6/15/17, 8/10/17, 10/5/17 and 2/8/18, did not document any inappropriate sexual behaviors.

On 3/27/18 at 12:52 PM, V14, R219's Physician, stated "(Current facility) has younger residents and an increased percentage of residents in wheelchairs. I remember (R219) had some

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history of sexual inappropriateness. Whether it was verbal or physical, I can't recall. If (R219) had physical sexual inappropriate behaviors, I would not expect him to be placed in (Current facility)."

On 3/28/18, at 3:00 PM, V21, R219's psychiatrist, stated, "I don't remember any behaviors" with regards to R219.

The Facility's Abuse Prevention Facility Procedures, undated, document in part, "IV. Establishing a Resident Sensitive Environment
The facility desires to prevent abuse, neglect or misappropriation of property by establishing a resident sensitive and resident secure environment. This will be accomplished by a comprehensive quality management approach involving the following: Resident Assessment: As part of the resident social history evaluation and MDS (Minimum Data Set) assessment, staff will identify residents with increased vulnerability for abuse, neglect, mistreatment or who have needs and behaviors that might lead to conflict.
Through the care planning process, staff will identify problems, goals, and approaches, which would reduce the chance of abuse, neglect or mistreatment for these residents. Staff will continue to monitor the goals and approaches on a regular basis." The Procedures documented "V. Protection of Residents
Residents who allegedly mistreated other residents will be removed from contact with other residents during the course of the investigation. The accused resident's condition shall be immediately evaluated to determine the most suitable therapy, care, care approaches, and placement, considering his or her safety, as well as the safety of others residents and employees of the facility."

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S9999	Continued From page 21 4. On 3/20/18, the facility provided a Resident Roster. The Roster documented 48 female residents were residing in the facility. (B)	S9999		