Residents Affected - Few

Immediate Jeopardy began on 01/06/16 when Nurse #1 saw a nurse aide place his penis in Resident #1's mouth. Immediate Jeopardy was removed on 01/15/16 at 11:06 AM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm, that is not immediate jeopardy) to complete education and ensure monitoring system put into place are effective related to resident rights to be free from abuse.

The findings included:
Resident #1 was originally admitted to the facility on [DATE] and most recently on 08/07/14. Her [DIAGNOSES REDACTED]. The findings included:

Resident #1 was ultimately placed in the Skilled Nursing Facility (SNF) wing on [DATE]. On 1/6/16 the facility admitted a new resident (Resident #1). On 1/10/16 the facility admitted a new resident (Resident #2). On 1/13/16 the facility admitted a new resident (Resident #3). On 1/15/16 the facility admitted a new resident (Resident #4).

Residents Affected - Few

Immediate Jeopardy was removed on 01/15/16 at 11:06 AM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm, that is not immediate jeopardy) to complete education and ensure monitoring system put into place are effective related to resident rights to be free from abuse.

The findings included:
Resident #1 was originally admitted to the facility on [DATE] and most recently on 08/07/14. Her [DIAGNOSES REDACTED]. The findings included:

Resident #1 was ultimately placed in the Skilled Nursing Facility (SNF) wing on [DATE]. On 1/6/16 the facility admitted a new resident (Resident #1). On 1/10/16 the facility admitted a new resident (Resident #2). On 1/13/16 the facility admitted a new resident (Resident #3). On 1/15/16 the facility admitted a new resident (Resident #4).

Residents Affected - Few

Immediate Jeopardy was removed on 01/15/16 at 11:06 AM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm, that is not immediate jeopardy) to complete education and ensure monitoring system put into place are effective related to resident rights to be free from abuse.

The findings included:
Resident #1 was originally admitted to the facility on [DATE] and most recently on 08/07/14. Her [DIAGNOSES REDACTED]. The findings included:

Resident #1 was ultimately placed in the Skilled Nursing Facility (SNF) wing on [DATE]. On 1/6/16 the facility admitted a new resident (Resident #1). On 1/10/16 the facility admitted a new resident (Resident #2). On 1/13/16 the facility admitted a new resident (Resident #3). On 1/15/16 the facility admitted a new resident (Resident #4).

Residents Affected - Few

Immediate Jeopardy was removed on 01/15/16 at 11:06 AM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm, that is not immediate jeopardy) to complete education and ensure monitoring system put into place are effective related to resident rights to be free from abuse.

The findings included:
Resident #1 was originally admitted to the facility on [DATE] and most recently on 08/07/14. Her [DIAGNOSES REDACTED]. The findings included:

Resident #1 was ultimately placed in the Skilled Nursing Facility (SNF) wing on [DATE]. On 1/6/16 the facility admitted a new resident (Resident #1). On 1/10/16 the facility admitted a new resident (Resident #2). On 1/13/16 the facility admitted a new resident (Resident #3). On 1/15/16 the facility admitted a new resident (Resident #4).

Residents Affected - Few

Immediate Jeopardy was removed on 01/15/16 at 11:06 AM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm, that is not immediate jeopardy) to complete education and ensure monitoring system put into place are effective related to resident rights to be free from abuse.

The findings included:
Resident #1 was originally admitted to the facility on [DATE] and most recently on 08/07/14. Her [DIAGNOSES REDACTED]. The findings included:

Resident #1 was ultimately placed in the Skilled Nursing Facility (SNF) wing on [DATE]. On 1/6/16 the facility admitted a new resident (Resident #1). On 1/10/16 the facility admitted a new resident (Resident #2). On 1/13/16 the facility admitted a new resident (Resident #3). On 1/15/16 the facility admitted a new resident (Resident #4).

Residents Affected - Few

Immediate Jeopardy was removed on 01/15/16 at 11:06 AM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm, that is not immediate jeopardy) to complete education and ensure monitoring system put into place are effective related to resident rights to be free from abuse.

The findings included:
Resident #1 was originally admitted to the facility on [DATE] and most recently on 08/07/14. Her [DIAGNOSES REDACTED]. The findings included:

Resident #1 was ultimately placed in the Skilled Nursing Facility (SNF) wing on [DATE]. On 1/6/16 the facility admitted a new resident (Resident #1). On 1/10/16 the facility admitted a new resident (Resident #2). On 1/13/16 the facility admitted a new resident (Resident #3). On 1/15/16 the facility admitted a new resident (Resident #4).

Residents Affected - Few

Immediate Jeopardy was removed on 01/15/16 at 11:06 AM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm, that is not immediate jeopardy) to complete education and ensure monitoring system put into place are effective related to resident rights to be free from abuse.

The findings included:
Resident #1 was originally admitted to the facility on [DATE] and most recently on 08/07/14. Her [DIAGNOSES REDACTED]. The findings included:

Resident #1 was ultimately placed in the Skilled Nursing Facility (SNF) wing on [DATE]. On 1/6/16 the facility admitted a new resident (Resident #1). On 1/10/16 the facility admitted a new resident (Resident #2). On 1/13/16 the facility admitted a new resident (Resident #3). On 1/15/16 the facility admitted a new resident (Resident #4).
Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.

**NOTE: TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

Based on record review, staff interviews and police interview, the facility failed to immediately intervene and stop sexual abuse when observed. The ADON (Aide Director of Nursing) failed to immediately call law enforcement to report a crime and failed to immediately assess the resident for injuries. In addition the abuse policy did not include the resident involved in abuse would be assessed for injuries, when the assessment would occur, who would conduct the assessment, how long the assessment would be completed, and how the facility would remain in compliance.

Residents Affected - Few

Immediate Jeopardy began on 01/06/16 when Nurse #1 observed a nurse aide place his penis in Resident #1's mouth, shut the door without intervening while the abuse was occurring, and then Nurse #1 and Nurse #2 allowed the perpetrator to move about the facility unsupervised while they called administration for instructions. Immediate Jeopardy was removed on 01/15/16 when the facility provided and implemented an acceptable credible allegation of abuse protocol.

The facility remains out of compliance at a lower scope and severity of D (isolated, no actual harm with potential for more minimal harm, that is not immediate jeopardy) to complete education and to ensure monitoring systems put into place are effective related to protecting residents from being abused.

**Lessons Learned:**
- The facility failed to provide a safe environment for the residents.
- The facility failed to implement policies and procedures to prevent sexual abuse.

The findings included:

- The facility failed to ensure the privacy of the resident.
- The facility failed to ensure the safety of the resident.
- The facility failed to ensure the well-being of the resident.

The facility will be suspended immediately from employment pending the outcome of the investigation.

**Protection:** Employees accused of being directly involved in allegations of abuse, neglect, or misappropriation of property will be immediately removed from resident care pending investigation. Any employee who witnesses or suspects that abuse, neglect, or misappropriation of property has occurred, will immediately report the incident to his or her supervisor, who will immediately report the incident to the immediate supervisor, who will immediately report the incident to the Administrator, who will immediately report the incident to the Department of Health and Human Services, who will immediately report the incident to law enforcement.

**Measures** will be initiated to prevent any further potential abuse while the investigation is in progress.

**Protection:** Employees accused of being directly involved in allegations of abuse, neglect, or misappropriation of property will be suspended immediately from employment pending the outcome of the investigation.

The policy did not include that the resident affected by the abuse would be assessed for injuries, who would assess the resident and when, nor did it include when law enforcement would be notified of the incident.

Resident #1 was originally admitted to the facility on 01/30/15 and most recently on 08/07/14. Her [DIAGNOSIS REDACTED]...
Level of harm - Immediate jeopardy

Residents Affected - Few

On 1/14/16 the nurse that witnessed the incident received disciplinary action, was drug tested, and the incident was not question any details of the story. The DON stated the police showed up around 7:00 AM. After the assessment the DON called the Lieutenant (LIE) for the physical medicine unit and nursing manager. The DON notified Resident #1’s responsible party of the abuse allegation. The DON stated that the ambulance driver was the first to feel for the resident around 7:30 AM to take Resident #1 to call the police. The DON stated she did not make a report and instructed them to do a rape kit. Police officers and a forensic investigator were in the facility when the ambulance took Resident #1 to the hospital. NA #1 was removed from the facility in handcuffs by the police. The DON interviewed NA #1 when she saw the abuse holding his penis in the resident's mouth. Nurse #1 was scared that something was going to happen to Resident #1 and that she went to get help. When the nurses arrived back to the resident’s room, NA #1 had already left the room. The DON stated she thought Nurse #1 reacted correctly by leaving Resident #1 in the room while she got help. The DON called the police when she spoke to her on the phone because she wanted to go to the facility and see what had transpired and be sure Nurse #1 saw what she reported she saw. The Administrator stated she had never called the police before unless she actually suspected a crime had been committed. She stated she did not want to be called in for no reason. The DON stated she talked with Nurse #1 who informed her that Nurse #1 saw an employee placing Resident #1's hand in their mouth. The DON stated she talked with Nurse #1 who informed her she (Nurse #1) saw an employee placing Resident #1's hand in their mouth. The DON stated she talked with Nurse #1 who informed her she (Nurse #1) saw an employee placing Resident #1's hand in their mouth. The DON stated she talked with Nurse #1 who informed her she (Nurse #1) saw an employee placing Resident #1's hand in their mouth. The DON stated she talked with Nurse #1 who informed her she (Nurse #1) saw an employee placing Resident #1’s hand in their mouth.

The DOH was interviewed on 01/12/16 at 5:31 PM. Detective #1 from the sheriff's office was interviewed a second time on 01/16/16 at 10:19 AM. An interview was conducted with two detectives from the sheriff's office. Lieutenant #1 stated the patrol officers were called to the facility and subsequently brought NA #1 to the sheriff's office. Lieutenant #1 stated NA #1 confessed to placing his penis in Resident #1's mouth. Review of a video tape of NA #1's interview by Lieutenant #1 revealed that NA #1 admitted he put his penis in Resident #1's mouth.

Credible allegation of Compliance: F 226

On 1/16 the accused NA employee was removed from resident care areas. On 1/16, the resident was assessed by the Director of Nursing (DON). On 1/16, the DON notified the resident's physician and an order was obtained to send the resident to the ED (hospital's Emergency Department) for further evaluation. On 1/16 the DON notified the resident’s responsible power of attorney (POA) of the abuse allegation. On 1/16, the Assistant Director of Nursing (ADON) called the police. On 1/16 the accused employee was suspended from employment. On 1/16 the accused employee left facility property with the police. On 1/16 the DON called report to the hospital. On 1/16 the accused employee was terminated from employment from facility Resident #1 was sent to the emergency room for an MRI an MRI was not returned to this facility. On 1/16 the alleged employee remains in jail. On 1/16 the administrator submitted the 24 hour report to DHSR (Division of Health Service Regulation) health care registry and followed up with the 5 day report submission on 1/16/16.

1/16, the Social Worker and Admissions Coordinator interviewed all and oriented residents related to abuse asking the following questions: Does anyone have any emotionally harmed you since you've been at Lake Park? If yes then who harmed you and who did you tell? Where did it occur? When did it occur? Why do you feel you were harmed? How were you harmed?" resulting in no negative findings. On 1/16, the RN supervisors, staff facilitator, and LPN’s (Licensed Practical Nurse) completed 100% of a critical safety checklist. On 1/16, the social worker, MDS nurses, RN nursing supervisor, and LPN staff nurses contacted, by phone or in person, 100% of all residents and all emergency staff, to notify that there had been an allegation of sexual abuse. On 1/16, the Social Worker interviewed the employee and the employee stated they had no more dealings with NA #1. The Administrator stated she spoke with Nurse #1 who stated she could not open the door all the way and once she saw the abuse, she shut the door and proceeded to find Nurse #2. During the interview, the Administrator was asked her expectations of what Nurse #1 should have done when she saw NA #1 put his penis in Resident #1’s mouth. The Administrator stated she was not present when Nurse #1 walked in on NA #1, nor was she aware of any complaints. She further stated she did not say what she expected Nurse #1 to do differently because she immediately got another nurse to help her.

The Director of Nursing (DON) was interviewed on 01/12/16 at 3:27 PM. She stated she was interviewed between 4:00 AM and 4:10 AM she missed a phone call from the Administrator. She stated she immediately called the Administrator back who informed her there was an allegation of abuse and she was instructed to go to the facility as soon as possible. The DON arrived at the facility around 5:40 AM and was told by the Administrator to treat everything like a crime scene. She stated she and the ADON completed a head to toe assessment and found old bruising on Resident #1’s right hand from previously hitting her hand on the wheelchair and found an abrasion on her coccyx area. The DON stated Resident #1’s face was clean and there was a little spot on a little knobby but she did not touch anything. She further stated she was not aware of any policy related to calling the police and it was 2014, the ADON notified the police around 6:45 AM. On 1/6/16, the Administrator stated she had no more dealings with NA #1. The Administrator stated she spoke with Nurse #1 who stated she could not open the door all the way and once she saw the abuse, she shut the door and proceeded to find Nurse #2. During the interview, the Administrator was asked her expectations of what Nurse #1 should have done when she saw NA #1 put his penis in Resident #1’s mouth. The Administrator stated she was not present when Nurse #1 walked in on NA #1, nor was she aware of any complaints. She further stated she did not say what she expected Nurse #1 to do differently because she immediately got another nurse to help her.

The Director of Nursing (DON) was interviewed on 01/12/16 at 3:27 PM. She stated she was interviewed between 4:00 AM and 4:10 AM she missed a phone call from the Administrator. She stated she immediately called the Administrator back who informed her there was an allegation of abuse and she was instructed to go to the facility as soon as possible. The DON arrived at the facility around 5:40 AM and was told by the Administrator to treat everything like a crime scene. She stated she and the ADON completed a head to toe assessment and found old bruising on Resident #1’s right hand from previously hitting her hand on the wheelchair and found an abrasion on her coccyx area. The DON stated Resident #1’s face was clean and there was a little spot on a little knobby but she did not touch anything. She further stated she was not aware of any policy related to calling the police and it was 2014, the ADON notified the police around 6:45 AM. On 1/6/16, the Administrator stated she had no more dealings with NA #1. The Administrator stated she spoke with Nurse #1 who stated she could not open the door all the way and once she saw the abuse, she shut the door and proceeded to find Nurse #2. During the interview, the Administrator was asked her expectations of what Nurse #1 should have done when she saw NA #1 put his penis in Resident #1’s mouth. The Administrator stated she was not present when Nurse #1 walked in on NA #1, nor was she aware of any complaints. She further stated she did not say what she expected Nurse #1 to do differently because she immediately got another nurse to help her.
NAME OF PROVIDER OF SUPPLIER

LAKE PARK NURSING AND REHABILITATION CENTER

For information on the nursing home’s plan to correct this deficiency, please contact the nursing home or the state survey agency.

F 0226

Level of harm - Immediate jeopardy

Residents Affected - Few

resident immediately after she entered the building.

On 1/14/16 at 11:30 AM an in-service was completed for all staff including contract staff working today by the director of nursing and assistant director of nursing:

The abuse policy (Verbal, sexual, mental, or physical abuse, neglect, or mistreatment of [REDACTED]) is it every employee’s responsibility to immediately report any incident of resident abuse or suspected abuse to his or her supervisor.

The supervisor and/or employee must report immediately to the administrator. If the immediate supervisor is the alleged perpetrator, the report is to be made to the administrator or director of nursing. Any employee who fails to immediately report suspected mistreatment, abuse including injuries.

On 1/14/16 all staff including contract staff working were in-services on the older abuse act policy and how to report to the local law enforcement related to the elder justice act including the following: If there reportable event results in serious bodily injury, the staff member shall report the suspicion immediately to law enforcement, but not later than 2 hours after forming the suspicion. If the reportable event does not result in serious bodily injury, the staff member shall report the suspicion not later than 24 hours after forming the suspicion. Staff must report the suspicion of an incident to their supervisor, who will report the incident to the administrator.

On 1/14/16 all staff including contract staff working were trained that any staff member can call local law enforcement with any type of observed abuse

1. Immediately intervene and stop abuse.
2. Immediate removal of the employee or perpetrator, immediate notification to the Administrator, DON, and law enforcement.
3. The employee or perpetrator remain supervised 1:1 until the Administrator, DON, or law enforcement arrives.
4. On 1/14/16 the ADON, DON, MD, and law enforcement were trained on the responsibilities of protection, identification and reporting abuse, the elder abuse act, and notification by the corporate vice president of operations related to the elder justice act including the following: If the reportable event results in serious bodily injury, the staff member shall report the suspicion immediately to law enforcement, but not later than 2 hours after forming the suspicion. If the reportable event does not result in serious bodily injury, the staff member shall report the suspicion not later than 24 hours after forming the suspicion. Staff must report the suspicion of an incident to their supervisor, who will report the incident to the administrator.

On 1/14/16 in-in-service was completed when that there is an allegation of abuse the resident involved and roommate are to be assessed immediately for injury and the resident involved in allegation is to be immediately sent to hospital emergency department for further evaluation and treatment.

On 1/14/16 in-service related to action check list for allegation of abuse neglect was completed for all licensed staff. The action check list includes the following:

1. Remove involved employee.
2. Notify Administrator and/or DON immediately. Document notification in chart.
5. Implement MD orders as indicated.
7. Obtain employee witness statement of incident.
8. Drug test employee per personnel policy as applicable or as instructed by administrator or DON.
10. Implement corrective measures to protect resident.
11. Completion of resident QUI reporting form.
12. Continue to monitor resident.

No employee will be allowed to work until all in-services is completed.

New hires will receive all training during orientation prior to taking an assignment.

Nurse #1 and Nurse #2 have completed all above in-services.

Immediate jeopardy was removed on 01/15/16 at 11:06 AM when interviews with nursing and administrative staff and non-nursing staff confirmed they had received inservice training on the facility’s policy to immediately intervene and stop abuse when witnessed, immediately remove the perpetrator from resident care areas and call the police.

F 0490

Level of harm - Immediate jeopardy

Residents Affected - Few

Based on record review, staff interviews and police interviews, the administration failed to impose expectations related to immediately intervening when sexual abuse is witnessed, failed to impose expectations related to immediately removing a perpetrator from resident care areas, failed to impose expectations related to conducting a crime investigation if a crime is witnessed, failed to empower staff to make the call to law enforcement when a crime is witnessed or when staff have knowledge of such crime, failed to recognize that a nurse that witnessed a crime to a resident reacted in a manner that was not in the best interest of all the residents.

Immediate Jeopardy began on 01/06/16 when Nurse #1 failed to intervene when she witnessed a sexual abuse incident. Failed to immediately call law enforcement, and when the called administrative staff, administrative staff failed to provide her the direction to call law enforcement immediately. Immediate Jeopardy was removed on 01/15/16 at 11:06 AM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower level.

Based on record review, staff interviews and police interviews, the administration failed to impose expectations related to immediately intervening when sexual abuse is witnessed, failed to impose expectations related to immediately removing a perpetrator from resident care areas, failed to impose expectations related to conducting a crime investigation if a crime is witnessed, failed to empower staff to make the call to law enforcement when a crime is witnessed or when staff have knowledge of such crime, failed to recognize that a nurse that witnessed a crime to a resident reacted in a manner that was not in the best interest of all the residents.

The abuse policy (Verbal, sexual, mental, or physical abuse, neglect, or mistreatment of [REDACTED]) is it every employee’s responsibility to immediately report a crime that does not result in serious bodily injury, the staff member shall report the suspicion immediately to law enforcement, but not later than 24 hours after forming the suspicion. Staff must report the suspicion of an incident to the administrator.

On 1/14/16 an in-service was completed when that there is an allegation of abuse the resident involved and roommate are to be assessed immediately for injury and the resident involved in allegation is to be immediately sent to hospital emergency department for further evaluation and treatment.

On 1/14/16 in-service related to action check list for allegation of abuse neglect was completed for all licensed staff. The action check list includes the following:

1. Remove involved employee.
2. Notify Administrator and/or DON immediately. Document notification in chart.
5. Implement MD orders as indicated.
7. Obtain employee witness statement of incident.
8. Drug test employee per personnel policy as applicable or as instructed by administrator or DON.
10. Implement corrective measures to protect resident.
11. Completion of resident QUI reporting form.
12. Continue to monitor resident.

No employee will be allowed to work until all in-services is completed.

New hires will receive all training during orientation prior to taking an assignment.

Nurse #1 and Nurse #2 have completed all above in-services.

Immediate jeopardy was removed on 01/15/16 at 11:06 AM when interviews with nursing and administrative staff and non-nursing staff confirmed they had received inservice training on the facility’s policy to immediately intervene and stop abuse when witnessed, immediately remove the perpetrator from resident care areas and call the police.

Be administered in an acceptable way that maintains the well-being of each resident.

The finding included:

Cross refer to F 223: Based on record review, staff interviews and police interviews, the facility failed to maintain 1 of 4 sampled residents right to be free of sexual abuse. (Resident #1). Cross refer to F 226: Based on record review, staff interviews and police review, the facility failed to immediately intervene one and stop sexual abuse when observed, failed to immediately remove the perpetrator from resident areas, failed to immediately call law enforcement to report a crime and failed to immediately assess the resident for injuries. In addition, the abuse policy did not include the resident involved in abuse would be assessed for injuries, when the assessment would occur, who would assess the resident, when the law enforcement would be notified of a crime and by whom. This affected 1 of 4 residents reviewed for abuse. (Resident #1).

On 01/13/16 at 7:04 PM the Administrator, DON, corporate nurse consultant and the corporate vice president was informed of immediate Jeopardy.

The Administrator provided an acceptable credible allegation of compliance on 01/15/16 9:14 AM.

Credible allegation of Compliance: F 490

On 1/6/16 the accused CNA employee was removed from resident care areas. On 1/6/16, the resident was assessed by the director of nursing (DON). On 1/6/16, the DON notified the resident’s physician and an order was obtained to send the resident to the ED for further evaluation. On 1/6/16 the DON notified the resident’s responsible party (RP). On 1/6/16, the assistant director of nursing (ADON) contacted the police department. On 1/6/16 the accused employee was suspended from employment.

Resident #1 was sent to the emergency room for a diagnosis ”after an allegation of sexual abuse on 01/16/16 per MD order and did not return.

On 1/6/16 the accused employee left facility property with the police. On 1/6/16 the DON called report to the hospital. On 1/6/16 the accused employee was terminated. On 1/6/16 the accused employee was terminated.

On 1/6/16, the social worker and admissions coordinator interviewed all alert and oriented residents related to abuse asking the following questions:

Do you feel anyone has intentionally harmed you since you’ve been Lake Park? If you why then who harmed you? When did they do it? Where did it occur?, When did it occur?, Why do you feel you were harmed?, How were you harmed? Resulting in no negative findings. On 1/6/16, the RN supervisors, staff facilitator, and LPNs staff nurses completed 100% of the audits of all residents for any evidence of abuse. Staff members completed 100% of the surveys and 100% of the audits of all Residents for any evidence of abuse. Staff members completed 100% of the surveys and 100% of the audits of all residents for any evidence of abuse. Staff members.

MDS nurses, RN nursing supervisor, and LPN staff nurses contacted, by phone or in person, 100% of the responsible parties of residents, to notify that there had been an allegation of sexual abuse from an employee to resident. On 1/6/16.

FORM CMS-2567(02-99) Event ID: YL1011 Facility ID: 345502 If continuation sheet Page 4 of 6
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

For the information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

**Event ID:** YL1O11

**Date:** 01/06/16

**Time:** 07:30 AM

**Location:** Lake Park Nursing and Rehabilitation Center, 3315 Faith Church Road, Indian Trail, NC 28079

**Deficiency:**

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**Level of harm - Immediate jeopardy**

**Residents Affected - Few**

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**Level of harm - Minimal harm or potential for actual harm**

**Residents Affected - Few**

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**Resident #1** was originally admitted to the facility on [DATE] and most recently on 08/07/14. Her [DIAGNOSES REDACTED]. The annual Minimum Data Set (MDS) dated [DATE] coded Resident #1 with severely impaired cognitive skills (unable to answer any of the questions on the Brief Interview for Mental Status), having no behaviors, and needing extensive assistance with all activities of daily living skills. She weighed 76 pounds. The Care Area Assessment (CAA) for cognition dated 11/19/15 stated she was unable to make her needs known verbally, had confusion, disorientation and forgetfulness. Staff needed to work with her to maintain her dignity and independence.

Nurse #1 was interviewed on 01/13/16 at 7:12 AM. Nurse #1 stated that on 01/06/16 at approximately 3:30 AM to 4:00 AM, she tried to enter Resident #1 room to check her Wanderguard. The door was completely closed and when she tried to open it, the door started to open and Resident #1's (footboard) when the resident's legs moved. Nurse #1 observed the opening of the door, which she stated was open approximately 6 inches open, enough where she could clearly see but not #1's face. She approached the door, Nurse #1 stated she saw Nurse Aide (NA) #1 standing next to Resident #1 and sexually assaulting the resident.

Review of Resident's clinical record revealed no nursing notes after 01/02/16 at 1:14 PM until the following:

- On 1/14/16 the administration was trained on enforcing the policies of protection, identification and reporting abuse, the elder abuse act, and notification by the corporate vice president of operations related to the elder justice act including the reportable event results in serious bodily injury, the staff member shall report the suspicion immediately to law enforcement, but not later than 2 hours after forming the suspicion. If the reportable event does not result in serious bodily injury, the staff member shall report the suspicion not later than 24 hours after forming the suspicion. Staff must report the suspicion of an incident to their supervisor, who will report the incident to the administrator.

- On 1/14/16 the administrator was in-service by the corporate vice president of operations related to the administrator of the nursing home you are the leader and required to enforce the policy on abuse. You must establish a no tolerance for an abusive environment. You must also enforce the elder abuse act policy.

- On 1/14/16 the administration was trained on enlisting the policies of protection, identification and reporting abuse, the elder abuse act, and notification by the corporate vice president of operations related to the elder justice act including the reportable event results in serious bodily injury, the staff member shall report the suspicion immediately to law enforcement, but not later than 2 hours after forming the suspicion. If the reportable event does not result in serious bodily injury, the staff member shall report the suspicion not later than 24 hours after forming the suspicion. Staff must report the suspicion of an incident to their supervisor, who will report the incident to the administrator.

- On 1/14/16 the administration was trained on enforcing the policies of protection, identification and reporting abuse, the elder abuse act, and notification by the corporate vice president of operations related to the elder justice act including the reportable event results in serious bodily injury, the staff member shall report the suspicion immediately to law enforcement, but not later than 2 hours after forming the suspicion. If the reportable event does not result in serious bodily injury, the staff member shall report the suspicion not later than 24 hours after forming the suspicion. Staff must report the suspicion of an incident to their supervisor, who will report the incident to the administrator.

- On 01/14/16 the admission was trained on enforcing the policies of protection, identification and reporting abuse, the elder abuse act, and notification by the corporate vice president of operations related to the elder justice act including the reportable event results in serious bodily injury, the staff member shall report the suspicion immediately to law enforcement, but not later than 2 hours after forming the suspicion. If the reportable event does not result in serious bodily injury, the staff member shall report the suspicion not later than 24 hours after forming the suspicion. Staff must report the suspicion of an incident to their supervisor, who will report the incident to the administrator.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER
345502

(X2) MULTIPLE CONSTRUCTION
A. BUILDING ______
B. WING ______

(X3) DATE SURVEY COMPLETED
01/15/2016

NAME OF PROVIDER OF SUPPLIER
LAKE PARK NURSING AND REHABILITATION CENTER
STREET ADDRESS, CITY, STATE, ZIP
3315 FAITH CHURCH ROAD
INDIAN TRAIL, NC 28079

For information on the nursing home’s plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 0514
Level of harm - Minimal harm or potential for actual harm
Residents Affected - Few had contractures. The reason for transfer was Other--per MD order.

On 01/13/16 at 3:00 PM the Administrator stated they filled out an incident report concerning the allegation of abuse and nurse's account of the incident but the incident report was not part of the medical record. She stated she would have expected something in the nursing notes related to some type of skin assessment but that was all. She stated the details were in her red file, again not part of the medical record, and she did not want such an allegation to be in the medical record where uninvolved persons would have access to the information. She stated the information should be vague due to the nature of the incident. She further stated that any professional needing to know about the abuse, i.e. psychologist would be informed verbally. She further stated that staff may have been waiting on direction from the legal department to write a nursing note. She stated she did not like written addendums in the nursing notes and it was such a crazy day, the resident was out of the facility before a nursing note could be written. She ended by stating that Nurse #1 did not ask her about writing a nursing note. She stated she expected the physician to note something about Resident #1's transfer to the hospital in his discharge summary which was not yet available as they are dictated.

On 01/14/16 at 12:02 PM, the DON stated the assessment she completed on Resident #1 included looking in her mouth which she found clean and her face was clean except for the one spot on her collarbone. She did not say why she did not include the observations of Resident #1’s mouth and collarbone in her progress note.

On 01/13/16 at 4:07 PM, Administrator provided a fax copy of the physician's hand written Discharge Summation dated 01/06/16. This note indicated he was called around 7:10 AM on 01/06/16 by the DON to notify him that the resident been sexually assaulted as witnessed by a staff nurse. The abuser was an employee. The physician noted he informed the DON to urgently send the resident to the emergency department to allow proper legal documentation and clinical testing.