| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 000 | INITIAL COMMENTS<br><br>An unannounced Medicare/Medicaid complaint survey was conducted 1/3/17 through 1/5/17. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements and Virginia rules for regulation for the licensure of nursing facilities.<br><br>The census in the 140 bed facility was 128 at the time of survey. The survey sample consisted of 6 current resident reviews (Residents #1 through #6) and 1 closed record reviews (Resident #7). | F 000 | | |
| F 280 SS=D | RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br>CFR(s): 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2)<br><br>483.10<br>(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:<br><br>(i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.<br><br>(ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.<br><br>(iv) The right to receive the services and/or items included in the plan of care.<br><br>(v) The right to see the care plan, including the right to sign after significant changes to the plan | F 280 | | 2/17/17 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 01/24/2017

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of care.

(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--

(i) Facilitate the inclusion of the resident and/or resident representative.

(ii) Include an assessment of the resident's strengths and needs.

(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.

483.21
(b) Comprehensive Care Plans

(2) A comprehensive care plan must be-

(i) Developed within 7 days after completion of the comprehensive assessment.

(ii) Prepared by an interdisciplinary team, that includes but is not limited to--

(A) The attending physician.

(B) A registered nurse with responsibility for the resident.

(C) A nurse aide with responsibility for the resident.

(D) A member of food and nutrition services staff.

(E) To the extent practicable, the participation of

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| F 280 | Continued From page 2<br>the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br><br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br><br>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, facility document review, clinical record review and in the course of complaint investigation, it was determined that the facility staff failed to review and revise the care plan for two of seven residents in the survey sample, Residents #1 and #2.<br><br>1. The facility staff failed to update Resident #1's care plan after the resident was observed with her pants down in Resident #2's bathroom and verbalized desire for sexual contact on 12/16/16 and after the resident reportedly kissed Resident #2 on 12/29/16.<br><br>2. The facility staff failed to update Resident #2's care plan after Resident #1 was observed with her pants down in Resident #2's bathroom and Resident #2 verbalized desire for sexual contact on 12/16/16 and after the resident reportedly kissed Resident #1 on 12/29/16.<br><br>The findings include: | F 280 | The Laurels of University Park wishes to have this submitted plan of correction stand as its allegation of compliance. Our date of alleged compliance is February 17, 2017<br><br>Preparation and/or execution of this plan of correction does not constitute admission to, nor agreement with, either the existence of or the scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements.<br><br>Resident #1□s care plan has been updated.<br><br>Resident #2 no longer resides at the facility. | |

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| F 280 | Continued From page 3<br><br>1. Resident #1 was admitted to the facility on 4/27/16. Resident #1's diagnoses included but were not limited to: high blood pressure, diabetes and Alzheimer's disease. Resident #1's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 12/15/16, coded the resident's cognition as being moderately impaired. Section G coded Resident #1 as requiring supervision with setup help for transfers and as requiring supervision with one person physical assistance with walking in the room and corridor.<br><br>During the survey, an investigation was conducted due to a complaint that Resident #2 had attempted to rape Resident #1 (note- the complaint was unsubstantiated).<br><br>Review of Resident #1's clinical record and comprehensive care plan with a reference date of 11/29/16 failed to reveal documentation regarding any encounters between Resident #1 and Resident #2.<br><br>On 1/4/17 at 10:15 a.m., an interview was conducted with OSM (other staff member) #1 (social worker) and OSM #2 (social services director). OSM #1 and OSM #2 were asked if any incidents had occurred between Resident #1 and Resident #2. OSM #2 stated one weekend Resident #1 was in Resident #2's room so Resident #2 was moved to a different room. OSM #2 stated she was unaware of any further details regarding the incident. Further into the interview, OSM #2 stated she guessed Resident #2 had kissed Resident #1 because during a meeting, the interdisciplinary team talked about | F 280 | Current residents have the potential to be affected.<br><br>The MDS coordinator will complete an audit of care plans for the last 30 days for those who trigger for behaviors on the MDS. MDS will report any variances to NHA and DON. NHA will report variances to the quality assurance committee.<br><br>The Regional Clinical Resource specialist will educate social services and nursing administrative team on care planning behaviors and episodic care planning.<br><br>DON/ADON will educate license nursing staff on episodic care planning and care planning for behaviors.<br><br>MDS coordinator will audit comprehensive MDS assessments and their care plans for accurate care planning, including review and revision of and for behaviors weekly x 4 weeks. MDS coordinator will report any variances to NHA and DON. NHA will report results to the quality assurance committee.<br><br>Continued compliance will be monitored through the facility□s QA program. Additional monitoring will be initiated for any identified concerns. | |

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Resident #2 kissing Resident #1 and the team thought it would be best to move Resident #2. At this time, OSM #2 was asked who was responsible for documenting sexual encounters between residents in the clinical record. OSM #2 stated, "Normally we document as a team." OSM #2 confirmed the incident should have been documented in both residents' clinical record. OSM #2 also confirmed both residents' care plans should have been updated. At this time, OSM #2 and OSM #1 were asked to review Resident #1's and Resident #2's care plans. OSM #1 and OSM #2 confirmed neither resident's care plan was updated.

On 1/4/17 at 11:45 a.m., an interview was conducted with ASM (administrative staff member) #1 (the administrator). ASM #1 stated she had been managing "the situation" between Resident #1 and Resident #2 but had not found a way to document the information in the clinical record. At this time, ASM #1 presented a typed document signed by ASM #1 (no date) that documented, "NHA (Nursing home administrator) received a phone call from staff on 12/16/16 stating that (Resident #1) was in (Resident #2's) bathroom with her pants pulled down. He remained in his room, no physical interaction occurred. (Resident #1) was unable to state initially why she was in his bathroom, after questioning by the staff she expressed an intention to have a sexual relationship with him. (Resident #1) was relocated to another room and q (every) 15 checks were in place for both her and (Resident #2). Her family decided to take her home on LOA (leave of absence) for the weekend. On 12/20/16 NHA and the social workers spoke with (Resident #1's) daughter, she has returned to her room from LOA, no further

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incident at this time. She voiced a concern with her mom not returning to original room due to cognition and potential for increased confusion. NHA stated that she needed to investigate further and would provide a follow up phone call to her. On 12/20/16 NHA and the social workers met with (Resident #2) regarding his relationship with (Resident #1). (Resident #2) states that he is fond of her and that 'I am 92, do you know what a 92 year's body can do?, nothing, I can't have sex.' He reports that he feels that (Resident #1) can make her own decisions. NHA explained to the resident that she cannot disclose (Resident #1's) status that (sic) but that (Resident #1) may not be able to fully understand. NHA explained to him that he can spend time with her, but not in her room and if she comes to his room he needs to call for assistance. He was also informed that he may need to be moved if this continues. He verbalized an understanding. NHA informed him that she would be discussing this with his responsible party. He voiced he did not want his wife to be made aware. NHA informed him that his daughter is his first contact and he gave permission to contact her. On 12/20/16 NHA met with (Resident #1), she voiced that (Resident #2) is her friend and that she likes him, denies any negative interaction, does not recall the situation on 12/16/16. She was unable to provide any other interaction and no psychosocial distress observed or reported. On 12/20/16 NHA spoke with (name), daughter of (Resident #2). Made her aware of the situation and the discussion had with (Resident #2). Although (Resident #2) has a BIMS (brief interview for mental status) 15/15, he does have stm (short term memory loss), and the daughter referenced his neurology consultation stating her father has 'poor executive function' and cannot comprehend consequences for his

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actions. She was made aware of more frequent checks in place and an evaluation by the psychologist at the facility will take place. She was made aware that that (sic) he may be relocated within the facility or possibly placed elsewhere but the goal was to make this a successful placement for both residents. On 12/20/16 a referral was made to (name), psychologist for evaluation. On 12/20/16 NHA called (Resident #1's) daughter back and informed her that NHA cannot disclose the status of (Resident #2) but that a plan was in place to evaluate his status. Assured her that her mom will be staying in her permanent room and that frequent checks are in place. She expressed appreciation for this decision and said that she has been very appreciative of the facility's willingness and flexibility to work with her mom. On 12/29/16 staff called NHA to inform her that (Resident #2) was kissing (Resident #1). Nursing informed (Resident #2) and his daughter that he would need to relocate to another unit immediately. (Resident #2) moved to the Jefferson Unit and q 15 checks for him remained in place."

On 1/4/17 at 12:15 p.m., an interview was conducted with LPN (licensed practical nurse) #1 (unit manager). LPN #1 stated she did not witness any sexual interactions between Resident #1 and Resident #2. In regards to the event on 12/16/16, LPN #1 stated staff called her to tell her Resident #1 was in Resident #2's bathroom with her pants down and wanted to have sex with Resident #2. LPN #1 stated it was reported to her that Resident #2 was by his bed (approximately 15 feet from the bathroom). LPN #1 stated staff reported they had separated the residents and staff was "watching" Resident #2.

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LPN #1 stated she then called ASM #1. LPN #1 stated later that evening, she spoke to Resident #1's daughter, made the daughter aware of the incident and told the daughter that ASM #1 suggested moving Resident #1 to a different room on another hall. LPN #1 stated Resident #1's daughter took the resident out of the facility for a couple of days. LPN #1 stated a couple of days later, Resident #1 returned to her room (next door to Resident #2) and Resident #2 remained on 15 minute checks. LPN #1 stated about a week later, Resident #1 and Resident #2 was noted kissing and Resident #2 was moved to another unit. When asked what should be documented in the clinical record regarding the above incidents, LPN #1 stated she knew ASM #1 was keeping a file. When asked if the residents' care plans should be updated after the above incidents, LPN #1 stated, "Yes." LPN #1 stated either a nurse or the social workers should have updated the care plans.

On 1/4/17 at 6:00 p.m., ASM #1, ASM #2 (the director of nursing) and ASM #3 (the regional manager of operations) were made aware of the above concern.

The facility policy titled, "Interdisciplinary care plans" documented, "Care plans are revised as dictated by change(s) in the guest's condition. Reviews are done at least quarterly..."

No further information was presented prior to exit.

2. Resident #2 was admitted to the facility on 3/22/16. Resident #2's diagnoses included but were not limited to: high cholesterol, muscle weakness and dementia. Resident #2's most recent MDS, a quarterly assessment with an ARD

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of 12/7/16, coded the resident's cognition as being moderately impaired. Section G coded Resident #2 as requiring supervision with setup help for transfers/walking in room/locomotion on and off the unit, and as requiring limited one person assistance with walking in the corridor.

During the survey, an investigation was conducted due to a complaint that Resident #2 had attempted to rape Resident #1 (note- the complaint was unsubstantiated).

Review of Resident #2's clinical record and comprehensive care plan with a reference date of 4/4/16 failed to reveal documentation regarding any encounters between Resident #1 and Resident #2.

On 1/4/17 at 10:15 a.m., an interview was conducted with OSM (other staff member) #1 (social worker) and OSM #2 (social services director). OSM #1 and OSM #2 were asked if any incidents had occurred between Resident #1 and Resident #2. OSM #2 stated one weekend Resident #1 was in Resident #2's room so Resident #2 was moved to a different room. OSM #2 stated she was unaware of any further details regarding the incident. Further into the interview, OSM #2 stated she guessed Resident #2 had kissed Resident #1 because during a meeting, the interdisciplinary team talked about Resident #2 kissing Resident #1 and the team thought it would be best to move Resident #2. At this time, OSM #2 was asked who was responsible for documenting sexual encounters between residents in the clinical record. OSM #2 stated, "Normally we document as a team." OSM #2 confirmed the incident should have been documented in both residents' clinical record.

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OSM #2 also confirmed both residents' care plans should have been updated. At this time, OSM #2 and OSM #1 were asked to review Resident #1's and Resident #2's care plans. OSM #1 and OSM #2 confirmed neither resident's care plan was updated.

On 1/4/17 at 11:45 a.m., an interview was conducted with ASM (administrative staff member) #1 (the administrator). ASM #1 stated she had been managing "the situation" between Resident #1 and Resident #2 but had not found a way to document the information in the clinical record. At this time, ASM #1 presented a typed document signed by ASM #1 (no date) that documented, "NHA (Nursing home administrator) received a phone call from staff on 12/16/16 stating that (Resident #1) was in (Resident #2's) bathroom with her pants pulled down. He remained in his room, no physical interaction occurred. (Resident #1) was unable to state initially why she was in his bathroom, after questioning by the staff she expressed an intention to have a sexual relationship with him. (Resident #1) was relocated to another room and q (every) 15 checks were in place for both her and (Resident #2). Her family decided to take her home on LOA (leave of absence) for the weekend. On 12/20/16 NHA and the social workers spoke with (Resident #1's) daughter, she has returned to her room from LOA, no further incident at this time. She voiced a concern with her mom not returning to original room due to cognition and potential for increased confusion. NHA stated that she needed to investigate further and would provide a follow up phone call to her. On 12/20/16 NHA and the social workers met with (Resident #2) regarding his relationship with (Resident #1). (Resident #2) states that he is

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fond of her and that 'I am 92, do you know what a 92 year's body can do?, nothing, I can't have sex.' He reports that he feels that (Resident #1) can make her own decisions. NHA explained to the resident that she cannot disclose (Resident #1's) status that (sic) but that (Resident #1) may not be able to fully understand. NHA explained to him that he can spend time with her, but not in her room and if she comes to his room he needs to call for assistance. He was also informed that he may need to be moved if this continues. He verbalized an understanding. NHA informed him that she would be discussing this with his responsible party. He voiced he did not want his wife to be made aware. NHA informed him that his daughter is his first contact and he gave permission to contact her. On 12/20/16 NHA met with (Resident #1), she voiced that (Resident #2) is her friend and that she likes him, denies any negative interaction, does not recall the situation on 12/16/16. She was unable to provide any other interaction and no psychosocial distress observed or reported. On 12/20/16 NHA spoke with (name), daughter of (Resident #2). Made her aware of the situation and the discussion had with (Resident #2). Although (Resident #2) has a BIMS (brief interview for mental status) 15/15, he does have stm (short term memory loss), and the daughter referenced his neurology consultation stating her father has 'poor executive function' and cannot comprehend consequences for his actions. She was made aware of more frequent checks in place and an evaluation by the psychologist at the facility will take place. She was made aware that that (sic) he may be relocated within the facility or possibly placed elsewhere but the goal was to make this a successful placement for both residents. On 12/20/16 a referral was made to (name),

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psychologist for evaluation. On 12/20/16 NHA called (Resident #1's) daughter back and informed her that NHA cannot disclose the status of (Resident #2) but that a plan was in place to evaluate his status. Assured her that her mom will be staying in her permanent room and that frequent checks are in place. She expressed appreciation for this decision and said that she has been very appreciative of the facility's willingness and flexibility to work with her mom. On 12/29/16 staff called NHA to inform her that (Resident #2) was kissing (Resident #1). Nursing informed (Resident #2) and his daughter that he would need to relocate to another unit immediately. (Resident #2) moved to the Jefferson Unit and q 15 checks for him remained in place."

On 1/4/17 at 12:15 p.m., an interview was conducted with LPN (licensed practical nurse) #1 (unit manager). LPN #1 stated she did not witness any sexual interactions between Resident #1 and Resident #2. In regards to the event on 12/16/16, LPN #1 stated staff called her to tell her Resident #1 was in Resident #2's bathroom with her pants down and wanted to have sex with Resident #2. LPN #1 stated it was reported to her that Resident #2 was by his bed (approximately 15 feet from the bathroom). LPN #1 stated staff reported they had separated the residents and staff was "watching" Resident #2. LPN #1 stated she then called ASM #1. LPN #1 stated later that evening, she spoke to Resident #1's daughter, made the daughter aware of the incident and told the daughter that ASM #1 suggested moving Resident #1 to a different room on another hall. LPN #1 stated Resident #1's daughter took the resident out of the facility for a couple of days. LPN #1 stated a couple of

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| F 280 | Continued From page 12<br>days later, Resident #1 returned to her room (next door to Resident #2) and Resident #2 remained on 15 minute checks. LPN #1 stated about a week later, Resident #1 and Resident #2 was noted kissing and Resident #2 was moved to another unit. When asked what should be documented in the clinical record regarding the above incidents, LPN #1 stated she knew ASM #1 was keeping a file. When asked if the residents' care plans should be updated after the above incidents, LPN #1 stated, "Yes." LPN #1 stated either a nurse or the social workers should have updated the care plans.<br><br>On 1/4/17 at 6:00 p.m., ASM #1, ASM #2 (the director of nursing) and ASM #3 (the regional manager of operations) were made aware of the above concern.<br><br>No further information was presented prior to exit. | F 280 | | |
| F 514 SS=D | RES<br>RECORDS-COMPLETE/ACCURATE/ACCESSIBLE<br>CFR(s): 483.70(i)(1)(5)<br><br>(i) Medical records.<br>(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-<br><br>(i) Complete;<br><br>(ii) Accurately documented;<br><br>(iii) Readily accessible; and<br><br>(iv) Systematically organized | F 514 | | 2/17/17 |

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| F 514 | Continued From page 13<br><br>(5) The medical record must contain-<br><br>(i) Sufficient information to identify the resident;<br><br>(ii) A record of the resident's assessments;<br><br>(iii) The comprehensive plan of care and services provided;<br><br>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;<br><br>(v) Physician's, nurse's, and other licensed professional's progress notes; and<br><br>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to maintain a complete and accurate clinical record for two of seven residents in the survey sample, Residents #1 and #2.<br><br>1. The facility staff failed to document in Resident #1's clinical record after the resident was observed with her pants down in Resident #2's bathroom and verbalized desire for sexual contact on 12/16/16 and after the resident reportedly kissed Resident #2 on 12/29/16.<br><br>2. The facility staff failed to document in Resident #2's clinical record after Resident #1 was observed with her pants down in Resident #2's bathroom and Resident #2 verbalized desire for | F 514 | Resident #1's documentation by both nursing and social services in the medical record has been included in the medical record.<br><br>Resident #2 no longer resides at the facility.<br><br>All residents currently in the facility have the potential to be affected by this practice.<br><br>NHA/designee will conduct an audit of all residents being monitored for behaviors for accurate and complete documentation. Any variances will be corrected and continued education will be reported to the facility□s quality assurance program. | |

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| F 514 | Continued From page 14<br>sexual contact on 12/16/16 and after the resident reportedly kissed Resident #1 on 12/29/16.<br><br>The findings include:<br><br>1. Resident #1 was admitted to the facility on 4/27/16. Resident #1's diagnoses included but were not limited to: high blood pressure, diabetes and Alzheimer's disease. Resident #1's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 12/15/16, coded the resident's cognition as being moderately impaired. Section G coded Resident #1 as requiring supervision with setup help for transfers and as requiring supervision with one person physical assistance with walking in the room and corridor.<br><br>During the survey, an investigation was conducted due to a complaint that Resident #2 had attempted to rape Resident #1 (note- the complaint was unsubstantiated).<br><br>Review of Resident #1's clinical record failed to reveal documentation regarding any encounters between Resident #1 and Resident #2.<br><br>On 1/4/17 at 10:15 a.m., an interview was conducted with OSM (other staff member) #1 (social worker) and OSM #2 (social services director). OSM #1 and OSM #2 were asked if any incidents had occurred between Resident #1 and Resident #2. OSM #2 stated one weekend Resident #1 was in Resident #2's room so Resident #2 was moved to a different room. OSM #2 stated she was unaware of any further details regarding the incident. Further into the interview, OSM #2 stated she guessed Resident | F 514 | DON/ADON will educate licensed staff and social services on maintaining clinical records of each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible, and systematically organized.<br><br>Unit managers will complete an audit weekly x 4 weeks on all new admissions and residents requiring a quarterly MDS assessment that trigger for behavior to assure that documentation is completed. Any variances identified will be corrected and continued education will be provided. The results of these audits will be reported to NHA and DON.<br><br>Continued compliance will be monitored through random chart audits by the DON and reported to the facility□s quality assurance program. Additional education and monitoring will be initiated for identified concerns. | |

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#2 had kissed Resident #1 because during a meeting, the interdisciplinary team talked about Resident #2 kissing Resident #1 and the team thought it would be best to move Resident #2. At this time, OSM #2 was asked who was responsible for documenting sexual encounters between residents in the clinical record. OSM #2 stated, "Normally we document as a team." OSM #2 confirmed the incident should have been documented in both residents' clinical record.

On 1/4/17 at 11:45 a.m., an interview was conducted with ASM (administrative staff member) #1 (the administrator). ASM #1 stated she had been managing "the situation" between Resident #1 and Resident #2 but had not found a way to document the information in the clinical record. At this time, ASM #1 presented a typed document signed by ASM #1 (no date) that documented, "NHA (Nursing home administrator) received a phone call from staff on 12/16/16 stating that (Resident #1) was in (Resident #2's) bathroom with her pants pulled down. He remained in his room, no physical interaction occurred. (Resident #1) was unable to state initially why she was in his bathroom, after questioning by the staff she expressed an intention to have a sexual relationship with him. (Resident #1) was relocated to another room and q (every) 15 checks were in place for both her and (Resident #2). Her family decided to take her home on LOA (leave of absence) for the weekend. On 12/20/16 NHA and the social workers spoke with (Resident #1's) daughter, she has returned to her room from LOA, no further incident at this time. She voiced a concern with her mom not returning to original room due to cognition and potential for increased confusion. NHA stated that she needed to investigate further

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and would provide a follow up phone call to her. On 12/20/16 NHA and the social workers met with (Resident #2) regarding his relationship with (Resident #1). (Resident #2) states that he is fond of her and that 'I am 92, do you know what a 92 year's body can do?, nothing, I can't have sex.' He reports that he feels that (Resident #1) can make her own decisions. NHA explained to the resident that she cannot disclose (Resident #1's) status that (sic) but that (Resident #1) may not be able to fully understand. NHA explained to him that he can spend time with her, but not in her room and if she comes to his room he needs to call for assistance. He was also informed that he may need to be moved if this continues. He verbalized an understanding. NHA informed him that she would be discussing this with his responsible party. He voiced he did not want his wife to be made aware. NHA informed him that his daughter is his first contact and he gave permission to contact her. On 12/20/16 NHA met with (Resident #1), she voiced that (Resident #2) is her friend and that she likes him, denies any negative interaction, does not recall the situation on 12/16/16. She was unable to provide any other interaction and no psychosocial distress observed or reported. On 12/20/16 NHA spoke with (name), daughter of (Resident #2). Made her aware of the situation and the discussion had with (Resident #2). Although (Resident #2) has a BIMS (brief interview for mental status) 15/15, he does have stm (short term memory loss), and the daughter referenced his neurology consultation stating her father has 'poor executive function' and cannot comprehend consequences for his actions. She was made aware of more frequent checks in place and an evaluation by the psychologist at the facility will take place. She was made aware that that (sic) he may be

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relocated within the facility or possibly placed elsewhere but the goal was to make this a successful placement for both residents. On 12/20/16 a referral was made to (name), psychologist for evaluation. On 12/20/16 NHA called (Resident #1's) daughter back and informed her that NHA cannot disclose the status of (Resident #2) but that a plan was in place to evaluate his status. Assured her that her mom will be staying in her permanent room and that frequent checks are in place. She expressed appreciation for this decision and said that she has been very appreciative of the facility's willingness and flexibility to work with her mom. On 12/29/16 staff called NHA to inform her that (Resident #2) was kissing (Resident #1). Nursing informed (Resident #2) and his daughter that he would need to relocate to another unit immediately. (Resident #2) moved to the Jefferson Unit and q 15 checks for him remained in place."

On 1/4/17 at 12:15 p.m., an interview was conducted with LPN (licensed practical nurse) #1 (unit manager). LPN #1 stated she did not witness any sexual interactions between Resident #1 and Resident #2. In regards to the event on 12/16/16, LPN #1 stated staff called her to tell her Resident #1 was in Resident #2's bathroom with her pants down and wanted to have sex with Resident #2. LPN #1 stated it was reported to her that Resident #2 was by his bed (approximately 15 feet from the bathroom). LPN #1 stated staff reported they had separated the residents and staff was "watching" Resident #2. LPN #1 stated she then called ASM #1. LPN #1 stated later that evening, she spoke to Resident #1's daughter, made the daughter aware of the incident and told the daughter that ASM #1

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| F 514 | Continued From page 18 | F 514 | | |

suggested moving Resident #1 to a different room on another hall. LPN #1 stated Resident #1's daughter took the resident out of the facility for a couple of days. LPN #1 stated a couple of days later, Resident #1 returned to her room (next door to Resident #2) and Resident #2 remained on 15 minute checks. LPN #1 stated about a week later, Resident #1 and Resident #2 was noted kissing and Resident #2 was moved to another unit. When asked what should be documented in the clinical record regarding the above incidents, LPN #1 stated she knew ASM #1 was keeping a file.

On 1/4/17 at 6:00 p.m., ASM #1, ASM #2 (the director of nursing) and ASM #3 (the regional manager of operations) were made aware of the above concern. Policies were requested. On 1/5/17 at 10:00 a.m., ASM #1 stated the facility did not have a policy regarding documentation.

No further information was presented prior to exit.

2. Resident #2 was admitted to the facility on 3/22/16. Resident #2's diagnoses included but were not limited to: high cholesterol, muscle weakness and dementia. Resident #2's most recent MDS, a quarterly assessment with an ARD of 12/7/16, coded the resident's cognition as being moderately impaired. Section G coded Resident #2 as requiring supervision with setup help for transfers/walking in room/locomotion on and off the unit, and as requiring limited one person assistance with walking in the corridor.

During the survey, an investigation was conducted due to a complaint that Resident #2 had attempted to rape Resident #1 (note- the complaint was unsubstantiated).

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Review of Resident #2's clinical record failed to reveal documentation regarding any encounters between Resident #1 and Resident #2.

On 1/4/17 at 10:15 a.m., an interview was conducted with OSM (other staff member) #1 (social worker) and OSM #2 (social services director). OSM #1 and OSM #2 were asked if any incidents had occurred between Resident #1 and Resident #2. OSM #2 stated one weekend Resident #1 was in Resident #2's room so Resident #2 was moved to a different room. OSM #2 stated she was unaware of any further details regarding the incident. Further into the interview, OSM #2 stated she guessed Resident #2 had kissed Resident #1 because during a meeting, the interdisciplinary team talked about Resident #2 kissing Resident #1 and the team thought it would be best to move Resident #2. At this time, OSM #2 was asked who was responsible for documenting sexual encounters between residents in the clinical record. OSM #2 stated, "Normally we document as a team." OSM #2 confirmed the incident should have been documented in both residents' clinical record.

On 1/4/17 at 11:45 a.m., an interview was conducted with ASM (administrative staff member) #1 (the administrator). ASM #1 stated she had been managing "the situation" between Resident #1 and Resident #2 but had not found a way to document the information in the clinical record. At this time, ASM #1 presented a typed document signed by ASM #1 (no date) that documented, "NHA (Nursing home administrator) received a phone call from staff on 12/16/16 stating that (Resident #1) was in (Resident #2's) bathroom with her pants pulled down. He

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remained in his room, no physical interaction occurred. (Resident #1) was unable to state initially why she was in his bathroom, after questioning by the staff she expressed an intention to have a sexual relationship with him. (Resident #1) was relocated to another room and q (every) 15 checks were in place for both her and (Resident #2). Her family decided to take her home on LOA (leave of absence) for the weekend. On 12/20/16 NHA and the social workers spoke with (Resident #1's) daughter, she has returned to her room from LOA, no further incident at this time. She voiced a concern with her mom not returning to original room due to cognition and potential for increased confusion. NHA stated that she needed to investigate further and would provide a follow up phone call to her. On 12/20/16 NHA and the social workers met with (Resident #2) regarding his relationship with (Resident #1). (Resident #2) states that he is fond of her and that 'I am 92, do you know what a 92 year's body can do?, nothing, I can't have sex.' He reports that he feels that (Resident #1) can make her own decisions. NHA explained to the resident that she cannot disclose (Resident #1's) status that (sic) but that (Resident #1) may not be able to fully understand. NHA explained to him that he can spend time with her, but not in her room and if she comes to his room he needs to call for assistance. He was also informed that he may need to be moved if this continues. He verbalized an understanding. NHA informed him that she would be discussing this with his responsible party. He voiced he did not want his wife to be made aware. NHA informed him that his daughter is his first contact and he gave permission to contact her. On 12/20/16 NHA met with (Resident #1), she voiced that (Resident #2) is her friend and that she likes him, denies any

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negative interaction, does not recall the situation on 12/16/16. She was unable to provide any other interaction and no psychosocial distress observed or reported. On 12/20/16 NHA spoke with (name), daughter of (Resident #2). Made her aware of the situation and the discussion had with (Resident #2). Although (Resident #2) has a BIMS (brief interview for mental status) 15/15, he does have stm (short term memory loss), and the daughter referenced his neurology consultation stating her father has 'poor executive function' and cannot comprehend consequences for his actions. She was made aware of more frequent checks in place and an evaluation by the psychologist at the facility will take place. She was made aware that that (sic) he may be relocated within the facility or possibly placed elsewhere but the goal was to make this a successful placement for both residents. On 12/20/16 a referral was made to (name), psychologist for evaluation. On 12/20/16 NHA called (Resident #1's) daughter back and informed her that NHA cannot disclose the status of (Resident #2) but that a plan was in place to evaluate his status. Assured her that her mom will be staying in her permanent room and that frequent checks are in place. She expressed appreciation for this decision and said that she has been very appreciative of the facility's willingness and flexibility to work with her mom. On 12/29/16 staff called NHA to inform her that (Resident #2) was kissing (Resident #1). Nursing informed (Resident #2) and his daughter that he would need to relocate to another unit immediately. (Resident #2) moved to the Jefferson Unit and q 15 checks for him remained in place."

On 1/4/17 at 12:15 p.m., an interview was

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conducted with LPN (licensed practical nurse) #1 (unit manager). LPN #1 stated she did not witness any sexual interactions between Resident #1 and Resident #2. In regards to the event on 12/16/16, LPN #1 stated staff called her to tell her Resident #1 was in Resident #2's bathroom with her pants down and wanted to have sex with Resident #2. LPN #1 stated it was reported to her that Resident #2 was by his bed (approximately 15 feet from the bathroom). LPN #1 stated staff reported they had separated the residents and staff was "watching" Resident #2. LPN #1 stated she then called ASM #1. LPN #1 stated later that evening, she spoke to Resident #1's daughter, made the daughter aware of the incident and told the daughter that ASM #1 suggested moving Resident #1 to a different room on another hall. LPN #1 stated Resident #1's daughter took the resident out of the facility for a couple of days. LPN #1 stated a couple of days later, Resident #1 returned to her room (next door to Resident #2) and Resident #2 remained on 15 minute checks. LPN #1 stated about a week later, Resident #1 and Resident #2 was noted kissing and Resident #2 was moved to another unit. When asked what should be documented in the clinical record regarding the above incidents, LPN #1 stated she knew ASM #1 was keeping a file.

On 1/4/17 at 6:00 p.m., ASM #1, ASM #2 (the director of nursing) and ASM #3 (the regional manager of operations) were made aware of the above concern. Policies were requested.

On 1/5/17 at 10:00 a.m., ASM #1 stated the facility did not have a policy regarding documentation.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495109 | A. BUILDING _____ B. WING _____ | C 01/05/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE LAURELS OF UNIVERSITY PARK | 2420 PEMBERTON RD RICHMOND, VA 23233 |

| (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 514 | Continued From page 23<br>No further information was presented prior to exit. | F 514 | | |