MDH Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:	Report Number:	Date of Visit:
Truman Senior Living Inc.	HL22125001	January 17, 2017
Facility Address:	**Time of Visit:**	**Date Concluded:**
400 North 4th Avenue East	10:30 a.m. to 4:30 p.m.	September 1, 2017
Facility City:	**Investigator's Name and Title:**	
Truman	Kathleen Smith, DNP, RN, PHN, Special Investigator	

State:	ZIP:	County:
Minnesota	56088	Martin

☒ **Home Care Provider/Assisted Living**

Allegation(s):
It is alleged that neglect of supervision occurred when Client #2 inappropriately rubbed his penis on Client #1's neck and face.

☒ State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483)

☒ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)

☒ State Statutes Chapters 144 and 144A

Conclusion:
Based on a preponderance of evidence, neglect is substantiated. The home care provider failed to provide adequate supervision of a client and failed to reassess the vulnerability of clients, after a client required repeated redirection for sexually inappropriate behaviors, resulting in the client rubbing his penis on the face of another client.

Client #1 received services from the home care provider with a diagnoses including altered mental status and Alzheimer's dementia. The client's care plan indicated the client was at risk of being abused, and the interventions implemented by the facility to safeguard the client was to observe client interactions. Over the course of about five months, the facility documented incidents where Client #1 entered another client's room, laid in bed with another client, and had to be directed out of the client's room. The facility did not reassess this client's risk for abuse, and additional supervision or other interventions were not implemented.

Client #2 received services from the home care provider with a diagnoses that included neurocognitive disorder and PTSD. The client's care plan indicated the client had the potential to abuse others, and the facility implemented the intervention of observing the client's interactions with others. Prior to the incident and over the course of about five months, the facility documented the client attempted to kiss staff and another client, entered other client rooms, and exposed his genitalia to staff. Despite these repeated incidents, the client was not reassessed, and additional supervision or other interventions were not implemented.

Per interview, on the day of the incident a direct care staff stated a voice was heard in the hallway while s/he was assisting another client in that client's room. When the staff looked out into the hall, Client #2 was observed unzipping his pants and rubbing his penis on the face of Client #1. The staff separated the clients, directing Client #2 to his room and returning Client #1, who was in a wheelchair, to her/his room.

When interviewed, neither client recalled the incident. During interviews, family members stated there were no observable changes in behaviors of either resident after this incident.

The facility added a device that sounds when the door is opened alerting staff the door has been opened.

Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557):

☐ Abuse ☒ Neglect ☐ Financial Exploitation

☒ Substantiated ☐ Not Substantiated ☐ Inconclusive based on the following information:

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☐ Individual(s) and/or ☒ Facility is responsible for the

☐ Abuse ☒ Neglect ☐ Financial Exploitation. This determination was based on the following:

The facility is responsible for the maltreatment because the facility failed to implement supervision or other interventions to prevent the incident, despite repeated indicators such an incident was likely to occur. In addition, although the care plan for both clients stated the facility would monitor client interactions, the facility only staffed one home health aide on the shift when this incident occurred.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

Compliance:

State Statutes for Home Care Providers (MN Statutes section 144A.43 - 144A.483) - Compliance Not Met
The requirements under State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483) were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) - Compliance Not Met
The requirements under State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes Chapters 144 & 144A – Compliance Not Met - Compliance Not Met
The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

Compliance Notes:

Facility Corrective Action:

The facility took the following corrective action(s):

Definitions:

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect

"Neglect" means:

(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

(2) which is not the result of an accident or therapeutic conduct.

(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of

maltreatment occurred.

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

- [x] Medical Records
- [x] Nurses Notes
- [x] Assessments
- [x] Physician Orders
- [x] Physician Progress Notes
- [x] Care Plan Records
- [x] Facility Incident Reports
- [x] Service Plan

Other pertinent medical records:

Additional facility records:

- [x] Facility Internal Investigation Reports
- [x] Personnel Records/Background Check, etc.
- [x] Facility Policies and Procedures

Number of additional resident(s) reviewed: none

Were residents selected based on the allegation(s)? ○ Yes ○ No ◉ N/A

Specify: _____

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

◉ Yes ○ No ○ N/A

Specify: _____

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s) ◉ Yes ○ No ○ N/A

Specify: _____

If unable to contact complainant, attempts were made on:

Date:	Time:	Date:	Time:	Date:	Time:

Interview with family: ◉ Yes ○ No ○ N/A Specify: _____

Did you interview the resident(s) identified in allegation:

◉ Yes ○ No ○ N/A Specify: _____

Did you interview additional residents? ○ Yes ◉ No

Total number of resident interviews: _____

Interview with staff: ◉ Yes ○ No ○ N/A Specify: _____

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: _____

Physician Interviewed: ○ Yes ◉ No

Nurse Practitioner Interviewed: ○ Yes ◉ No

Physician Assistant Interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ○ Yes ○ No ◉ N/A Specify: _____

Attempts to contact:

Date:	Time:	Date:	Time:	Date:	Time:

If unable to contact was subpoena issued: ○ Yes, date subpoena was issued _____ ○ No

Were contacts made with any of the following:

☐ Emergency Personnel ☐ Police Officers ☐ Medical Examiner ☐ Other: Specify _____

Observations were conducted related to:

☒ Safety Issues

☒ Meals

☒ Facility Tour

Was any involved equipment inspected: ○ Yes ○ No ◉ N/A

Was equipment being operated in safe manner: ○ Yes ○ No ◉ N/A

Were photographs taken: ○ Yes ◉ No Specify: _____

cc:

Health Regulation Division - Home Care & Assisted Living Program

The Office of Ombudsman for Long-Term Care

Truman Police Department

Martin County Attorney

Truman City Attorney

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H22125	A. BUILDING: _____ B. WING _____	R-C 08/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRUMAN SENIOR LIVING INC	400 NORTH AVENUE EAST TRUMAN, MN 56088

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{0 000}	Initial Comments A licensing order follow-up was completed to follow up on correction orders issued related to complaint HL22125001. Truman Senior Living Inc was found in compliance with state regulations.	{0 000}		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

August 22, 2017

Ms. Lorna Craig-Paulson, Administrator
Truman Senior Living Inc.
400 North Avenue East
Truman, MN 56088

RE: Complaint Number HL22125001

Dear Ms. Craig-Paulson :

On August 1, 2017 an investigator of the Minnesota Department of Health, Office of Health Facility Complaints completed a re-inspection of your facility, to determine correction of orders found on the complaint investigation completed on January 31, 2017 with orders received by you on February 27, 2017. At this time these correction orders were found corrected and are listed on the attached State Form.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. Please feel free to call me with any questions.

Sincerely,

Matthew Heffron

Matthew Heffron, JD, NREMT
Health Regulations Division
Office of Health Facility Complaints
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: (651) 201-4221 Fax: (651) 281-9796

MH/ja
Enclosure

cc: Home Health Care Assisted Living File
Martin County Adult Protection
Office of Ombudsman
MN Department of Human Services

Minnesota Department of Health

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0 000	Initial Comments HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, these correction orders are issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: On January 17, 2017, a complaint investigation was initiated to investigate complaint #HL22125001. At the time of the survey, there were 26 clients receiving services under the comprehensive license. The following correction orders are issued.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings, which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
0 325 SS=F	144A.44, Subd. 1(14) Free From Maltreatment Subdivision 1. Statement of rights. A person who receives home care services has these rights: (14) the right to be free from physical and verbal abuse, neglect, financial exploitation, and all forms	0 325		

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0 325	Continued From page 1 of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act; This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure that a client was free from maltreatment (neglect of supervision) when the facility failed to reassess, implement interventions, and monitor the adequacy and effectiveness of the abuse prevention interventions, resulting in Client #1 (C1) rubbing his penis on the face of Client #2 (C2). This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the clients). The Findings Include: C1 began receiving services on August 4, 2016, with diagnoses that included neurocognitive disorder, PTSD, inappropriate sexual behaviors, and dementia. The Nursing Care Plan, dated August 4, 2016, noted C1 had the potential to abuse others, and the intervention documented was for staff to observe client interactions. A Progress Note, dated August 28, 2016, indicated C1 attempted to kiss ULP-W several times and was redirected. Progress Notes from September 4 and 6, 2016, indicated C1 required redirection from entering other clients' rooms, including on incident on September 4, 2016, where C1 was found in another client's room,	0 325		

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0 325	Continued From page 2 laying on the bed watching television. On September 6, 2016, a Progress Note documented C1 pushing ULP-K with both hands and placing his hands on another ULP, as well as going into multiple clients' rooms. A Progress Note from September 9, 2016, documented a note from the facility owner directing that C1 was not to be in the rooms of other clients. However, there was no vulnerability reassessment. A Progress Note, dated October 19, 2016, indicates C1 exposed his genitalia to ULP-H during medication administration. A Progress Note, dated October 10, 2016, noted C1 was redirected after being asked to remove his/her arm from around another client. A note dated November 1, 2016, indicates C1 attempted to move a wheelchair bound client to the couch where C1 was sitting, and then followed the client as staff moved the client. On November 2, 2016, a Progress Note reveals C1 attempted to kiss ULP-D. A Progress Note, dated November 21, 2016, reveals C1 kissed another client as ULP-D walked into the common area. Another note on November 23, 2016, reveals ULP-A observed C1 and another client kissing; both clients were redirected. A review of assessment documents for C1 did not reveal a nursing or vulnerability reassessment or an updated care plan. A review of the Behavior Flow Sheet, dated August 22, 2017, revealed C1 was upset because of restricted access to the long-term side of the facility. A Monthly Resident Charting document, dated August 2, 2016, noted C1 has the potential to hurt others. The same document for C1, dated September 2016, notes C1 had the potential to hurt others, but no changes in care plan or interventions were noted. A review of the Monthly Resident Charting document for C1 dated	0 325		

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0 325	Continued From page 3 November 2016 again indicates C1 had the potential to hurt others, and could be physically and verbally aggressive. The Behavior Flow Sheet for C1, dated November 2016, noted C1 kissed another client, and this same document for December 2016 reveals C1 was in another clients's room several times. C1's Vulnerability Assessment was not updated, nor was there an updated Abuse Prevention plan. A Progress Note dated January 6, 2017, documents ULP-N observed C1 placing his genitalia on the face of C2. Additionally, while ULP-N returned C2 to her room, C1 grabbed ULP-N's butt. An Incident Report dated January 6, 2017, indicates C1 exposed his genitalia and rubbed it on C2's face. An Internal Investigation document supported the Incident Report dated January 6, 2017, and provided a new intervention to reduce the risk of further sexual behavior incidents (a bell was placed on the door of C1's room). C2 began receiving services on August 30, 2016, for diagnoses that included altered mental status and Alzheimer's dementia. The Nursing Care Plan for C2 reveals C2 was at risk of being abused, and the intervention was for staff to observe client interactions. A Progress Note dated August 31, 2016, revealed staff observed C2 entering a private room with a male client; when ULP-D intervened, C2 hugged the male client and the male client walked away. On September 1, 2016, a Progress Note documents C2 returned to the male client's room; a ULP redirected C2. On September 4, 2016, a Progress Note documents C2 and C1 were in C2's room, laying in bed watching television. Staff directed C1 out of the room. A review of	0 325		

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0 325	Continued From page 4 assessment documents for C2 did not reveal a nursing or vulnerability reassessment or an updated care plan after these incidents. A Progress Note dated January 6, 2017, notes ULP-N observed C1 was in the lobby area and was rubbing his genitalia on C2's face and neck. C2 was immediately removed from the situation. ULP-N stated during an interview on January 25, 2017 at 11:09 a.m. that ULP-N was assisting another client, heard a male voice in the hall, and upon looking out, saw C1 unzip his clothing and rub his penis on the face of C2. ULP-N returned C2 to her room and stayed with her, and directed C1 to his room where he remained the rest of the night where he had been prior to the incident. ULP-W stated during an interview on January 17, 2017 at 1:15 p.m., that C1 did not show any change in behavior after the incident; C1 continued to stay in his room or sit in the common areas. ULP-W also stated C2 did not exhibit any change in behavior such as crying or acting fearful. C1 was interviewed on January 17, 2017 at 11:50 a.m., stated he had no recollection of the genital exposure incident. C1 also stated, earlier in the interview, that he could not remember what was served for breakfast because "my memory is a little fuzzy," and had also responded inaccurately to questions regarding his age and the number of children he had. C2 was interviewed on January 17, 2017 at 3:00 p.m., and denied that any incident occurred where someone's genitalia was rubbed on her face. C2 also denied the incident of laying in bed with C1.	0 325		

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0 325	Continued From page 5 A review of the Behavior Documentation Policy, with no approval date, reveals a change in behaviors or escalation in behaviors should be documented so it can be addressed with interventions and documented on the care plan. Additionally, the Behavior Documentation Policy, documents behavior occurring on a regular basis should be reported to the registered nurse to do a new rate determination. During the investigation, the Nursing Assessment, Vulnerability Assessment, and Abuse Prevention Plan policies were requested, however, no other policies were received. A document titled Vulnerable Adult Policy (not dated), stated there is no tolerance of client neglect at any time. TIME PERIOD FOR CORRECTION: TWENTY-ONE (21) DAYS	0 325		
0 810 SS=F	144A.479, Subd. 6(b) Individual Abuse Prevention Plan (b) Each home care provider must develop and implement an individual abuse prevention plan for each vulnerable minor or adult for whom home care services are provided by a home care provider. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults or minors; the person's risk of abusing other vulnerable adults or minors; and statements of the specific measures to be taken to minimize the risk of	0 810		

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0 810	Continued From page 6 abuse to that person and other vulnerable adults or minors. For purposes of the abuse prevention plan, the term abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and document review, the agency failed to adequately assess, reassess, and implement an effective abuse prevention plan for two of two clients (Client #1 {C1} and Client #2 {C2}), including an assessment of risk for abusing other vulnerable adults, resulting in C1 rubbing his penis on the face of C2. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the clients). The findings include: C1 began receiving services on August 4, 2016, with diagnoses that included neurocognitive disorder, PTSD, inappropriate sexual behaviors, and dementia. The Nursing Care Plan, dated August 4, 2016, noted C1 had the potential to abuse others, and the intervention documented was for staff to observe client interactions. The Vulnerability assessment for C1, dated August 4, 2016, did not indicate C1 had aggressive behaviors towards others or wandering, and indicated C1 was able to report abuse, neglect, or concerns. A Progress Note dated August 7, 2016, notes C1	0 810		

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0 810	Continued From page 7 stood up and confronted another resident after a verbal disagreement, C1 sat down after direction from Unlicensed Personnel (ULP) ULP-K. A Progress Note dated August 27, 2016, notes C1 shoved another resident while in the wheelchair. Another Progress Note, dated August 28, 2016, indicated C1 attempted to kiss ULP-W several times and was redirected. Progress Notes from September 4 and 6, 2016, indicated C1 required redirection from entering other clients' rooms, including an incident on September 4, 2016, where C1 was found in another client's room, laying on the bed watching television. On September 6, 2016, a Progress Note documented C1 pushing ULP-K with both hands and placing his hands on another ULP, as well as going into multiple clients' rooms. A Progress Note from September 9, 2016, documented a note from the facility owner directing that C1 was not to be in the rooms of other clients. However, there was no vulnerability reassessment. A Progress Note, dated October 19, 2016, indicates C1 exposed his genitalia to ULP-H during medication administration. A Progress Note, dated October 10, 2016, noted C1 was redirected after being asked to remove his/her arm from around another client. A note dated November 1, 2016, indicates C1 attempted to move a wheelchair bound client to the couch where C1 was sitting, and then followed the client as staff moved the client. On November 2, 2016, a Progress Note reveals C1 attempted to kiss ULP-D. A Progress Note, dated November 21, 2016, reveals C1 kissed another client as ULP-D walked into the common area. Another note on November 23, 2016, reveals ULP-A observed C1 and another client kissing; both clients were redirected. A Progress Note dated January 6, 2017, documents ULP-N observed C1 placing his	0 810		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 8 genitalia on the face of C2. Additionally, while ULP-N returned C2 to her room, C1 grabbed ULP-N's butt. A review of assessment documents for C1 did not reveal a nursing or vulnerability reassessment to determine if the current interventions were effective or adequate. A review of the Behavior Flow Sheet, dated August 22, 2017, revealed C1 was upset because of restricted access to the long-term side of the facility. A Monthly Resident Charting document, dated August 2, 2016, noted C1 has the potential to hurt others. The same document for C1, dated September 2016, notes C1 had the potential to hurt others, but no changes in care plan or interventions were noted. A review of the Monthly Resident Charting document for C1 dated November 2016 again indicates C1 had the potential to hurt others, and could be physically and verbally aggressive. The Behavior Flow Sheet for C1, dated November 2016, noted C1 kissed another client, and this same document for December 2016 reveals C1 was in another clients's room several times. C1's Vulnerability Assessment was not updated, nor was there an updated Abuse Prevention plan. An Incident Report dated January 6, 2017, indicates C1 exposed his genitalia and rubbed it on C2's face. An Internal Investigation document supported the Incident Report dated January 6, 2017, and provided a new intervention to reduce the risk of further sexual behavior incidents (a bell was placed on the door of C1's room). C2 began receiving services on August 30, 2016, for diagnoses that included altered mental status and Alzheimer's dementia. The Nursing Care Plan for C2 reveals C2 was at risk of being	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H22125	A. BUILDING: _____ B. WING _____	C 01/31/2017

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0 810	Continued From page 9 abused, and the intervention was for staff to observe client interactions. A Progress Note dated August 31, 2016, revealed staff observed C2 entering a private room with a male client; when ULP-D intervened, C2 hugged the male client and the male client walked away. On September 1, 2016, a Progress Note documents C2 returned to the male client's room; a ULP redirected C2. On September 4, 2016, a Progress Note documents C2 and C1 were in C2's room, laying in bed watching television. Staff directed C1 out of the room. A review of assessment documents for C2 did not reveal a nursing or vulnerability reassessment or an updated care plan after these incidents. A Progress Note dated January 6, 2017, notes ULP-N observed C1 was in the lobby area and was rubbing his genitalia on C2's face and neck. C2 was immediately removed from the situation. ULP-N stated during an interview on January 25, 2017 at 11:09 a.m. that ULP-N was assisting another client, heard a male voice in the hall, and upon looking out, saw C1 unzip his clothing and rub his penis on the face of C2. ULP-N returned C2 to her room and stayed with her, and directed C1 to his room where he remained the rest of the night where he had been prior to the incident. ULP-W stated during an interview on January 17, 2017 at 1:15 p.m., that C1 did not show any change in behavior after the incident; C1 continued to stay in his room or sit in the common areas. ULP-W also stated C2 did not exhibit any change in behavior such as crying or acting fearful. C1 was interviewed on January 17, 2017 at 11:50 a.m., stated he had no recollection of the genital	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 810	Continued From page 10 exposure incident. C1 also stated, earlier in the interview, that he could not remember what was served for breakfast because "my memory is a little fuzzy," and had also responded inaccurately to questions regarding his age and the number of children he had. C2 was interviewed on January 17, 2017 at 3:00 p.m., and denied that any incident occurred where someone's genitalia was rubbed on her face. C2 also denied the incident of laying in bed with C1. A review of the Behavior Documentation Policy, with no approval date, reveals a change in behaviors or escalation in behaviors should be documented so it can be addressed with interventions and documented on the care plan. Additionally, the Behavior Documentation Policy, documents behavior occurring on a regular basis should be reported to the registered nurse to do a new rate determination. During the investigation, the Nursing Assessment, Vulnerability Assessment, and Abuse Prevention Plan policies were requested, however, no other policies were received. TIME PERIOD FOR CORRECTION: TWENTY-ONE(21) DAYS	0 810		