Iowa Department of Inspections and Appeals
Health Facilities Division
Citation

FC#6346				**Date: November 18, 2016**
Northgate Care Center		**Survey Dates: November 3 and 8–9, 2016**		
960 4th St. NW				
Waukon, IA 52172	**JKM**			
		Class	**Fine Amount**	**Correction date**
58.28(3)e	**481—58.28(135C) Safety.** The licensee of a nursing facility shall be responsible for the provision and maintenance of a safe environment for residents and personnel. (III) **58.28(3)** *Resident safety.* *e.* Each resident shall receive adequate supervision to protect against hazards from self, others, or elements in the environment. (I, II, III)	**I**	**$8000** **Held in Suspension**	**Upon Receipt**
58.43 (135C)	**481—58.43(135C) Resident abuse prohibited.** Each resident shall receive kind and considerate care at all times and shall be free from mental, physical, sexual, and verbal abuse, exploitation, neglect, and physical injury. Each resident shall be free from chemical and physical restraints except as follows: when authorized in writing by a physician for a specified period of time; when necessary in an emergency to protect the resident from injury to the resident or to others, in which case restraints may be authorized by designated professional personnel who promptly report the action taken to the physician; and in the case of an intellectually disabled individual when ordered in writing by a physician and authorized by a designated qualified intellectual disabilities professional for use during behavior modification sessions. Mechanical supports used in normative situations to achieve proper body position and balance shall not be considered to be a restraint. (II) **DESCRIPTION:**			

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	Based on record review, staff and resident interviews, the facility failed to ensure each resident was free from sexual abuse by failing to provide adequate nursing supervision for one of four residents reviewed. (Resident #2). The facility reported a census of 48 residents. Findings include: 1) According to the Minimum Data Set (MDS) assessment tool dated 10/26/16, Resident #2 displayed intact cognition and was independent with transfers, ambulation, dressing, personal hygiene and toilet use. The MDS documented Resident #2 required staff supervision with bathing. The plan of care with a target date of 1/24/17 revealed Resident #2 admitted to the facility on 5/21/14 and had diagnoses that included unspecified intellectual disabilities and adult failure to thrive. The plan of care identified the resident tended to be a loner and needed reminders from staff to participate in activities he/she enjoyed. The plan of care documented the Resident #2 liked to be naked in his/her room at times and directed staff to provide privacy and pull the privacy curtain. Interventions related to Resident #2's behaviors included providing Resident #2 a private place if staff found Resident #2 disrobing or stimulating him/herself in a public area. The nurse's notes revealed a follow-up assessment dated 11/2/16 at 10:56 a.m. The nurse documented Resident #2 had been (previously) sexually assaulted by another resident. That shift, Resident #2 had been walking around the facility with his/her nephew. The resident showed little or no emotion related to assault, but stated it was an awful thing that happened.			

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	In an order note dated 11/2/16, The Nurse Practitioner wrote: (Resident #2) may return to facility and resume previous orders. Place Resident #2 away from (Resident #1) to prevent further complaints since Resident #1 has been known for the behavior displayed tonight. In the nurse's notes dated 11/3/16, a third shift nurse documented Resident #2 slept well this shift with no complaints. It was reported when I got here last night Resident #2 kept turning his/her call light on and shutting it off him/herself as if he/she was testing it. During an interview on 11/8/16 at 12:48 p.m., Resident #2 was asked how things were going. Resident #2 reported there had been an incident in the past when he/she was in bed and Resident #1 came to his/her side of the room and grabbed Resident #2. The Resident stated his/her pants had been partially undone. When asked where Resident #1 had grabbed him/her, Resident #2 demonstrated around his/her neck and groin. When asked if Resident #1 had grabbed his/her private/genital area, Resident #2 responded in the affirmative. Resident #2 stated he/she pulled his/her call light. Resident #1 had not done this before. During an interview on 11/8/16 at 12:24 p.m., Staff B stated when Resident #2 activated his/her call light the night of 11/1/6, she immediately went to his/her room. Staff B stated both privacy curtains were pulled and she went toward the top of the curtain on Resident #2's side of the room. Staff B stated she observed Resident #2 in bed with his/her pants partially down with crease of buttocks visible, and Resident #1 with his/her underwear pulled down, standing beside Resident #2 making thrusting motions to Resident #2's buttocks. Staff B reported she couldn't see Resident #1's genitalia from			

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	that angle because she was behind and to the left of Resident #1. Staff B reported she immediately asked Resident #1 what he/she was doing. Resident #2 did not respond, so Staff B asked again. Resident #1 jumped and quickly replaced his/her clothing, put his/her "privates" back into their underwear, and then attempted to exit Resident #2's side of the room. Staff B asked the resident if he/she was ok and Resident #2 replied "yes" and handed her the call light which he/she had pulled completely out of the wall outlet. During an interview on 11-08-16 at 11:12 a.m., Staff A reported during the overnight shift, staff had always kept an eye on Resident #1 due to his/her heterosexual tendencies. Resident #1 would visit the "snack bar" usually several times a night, but at least once at midnight. Staff A stated Resident #1 at times would expose him/herself, but on the night of the incident there had been not been behaviors reported to her. Staff A stated about 11:45 p.m. on 11-01-16, the call light in Resident #2's room was activated. Staff A stated she had not known Resident #2 to ever activate his/her call light, so she and Staff B hurried to Resident #2's room. Staff A stated Staff B came out of Resident #2's room very upset and reported to her what she had observed. Staff A stated she immediately responded to Resident #2 to ensure his/her safety. Staff A stated she asked Resident #2 if he/she was okay. Resident #2 responded affirmatively. Staff A stated she asked Resident #2 if he/she liked what Resident #1 was doing, Resident #2 responded negatively. Staff A asked Resident #2 if he/she wanted Resident #1 to do what he/she was doing and Resident #2 responded negatively. Finally, Staff A stated she asked Resident #2 if Resident #1 had forced him/her to do what Resident #1 wanted and Resident #2 responded affirmatively.			

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	During an interview with the Administrator on 11/8/16 at 10:00 a.m., she reported Resident #1 remained at the facility with 1:1 supervision after the incident and continues to deny anything happened with his/her roommate. The Administrator indicated Resident #1 denied everything, even actions he/she was almost caught in the act of doing. When asked, the Administrator stated staff had not seen a change in Resident #2 after the incident with Resident #1. Resident #2 has always been a very private person. During an interview on 11/3/16 at 12:52 p.m., the Director of Nursing (DON) reported Resident #2 was a very private person. She also reported when Resident #2 activated his/her call light that night, he/she had actually pulled the cord completely out of the outlet in the wall. The DON stated the facility is providing 1:1 supervision for Resident #1 after the assault, and the plan is to continue this level of supervision until they can find alternate placement for him/her. 2) The Medication Review Report dated 11/3/16 revealed Resident #1 was admitted to the facility on 11/20/12, and had diagnoses that included diabetes, hallucinations, high risk heterosexual behaviors, Parkinson's disease, and dementia with behavior disorder. According to the Minimum Data Set (MDS) assessment form dated 8/10/16, Resident #1 experienced moderate cognitive decline and was independent with transfers, ambulation (walking), dressing, personal hygiene and toilet use. The MDS documented Resident #1 required staff assistance with bathing.			

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	The facility's individual plan of care addressed Resident #1 and his/her history of exhibiting inappropriate sexual behavior toward staff and other residents. The plan of care documented the resident had been placed on medication for inappropriate sexual behavior and for delusions and hallucinations. Staff were directed to implement the following interventions: * If staff suspect Resident #1 is exhibiting sexual preoccupations or if Resident #1 misconstrues the treatment plan, it is important that staff protect themselves from Resident #1. * Staff will be honest in setting limits and boundaries by clarifying their roles. When dealing with Resident #1's behaviors, honesty is the best policy. Inform resident a relationship with him/her would be illegal, unethical, and unprofessional and would never be considered. * Staff will set limits by telling Resident #1 the consequences of his/her behavior. Staff will carry out what they say the consequences will be. * Staff will use a flat affect and firm matter-or-fact tone of voice, labeling sexually inappropriate behavior and directing Resident #1 to cease. * Staff will immediately report Resident #1's behavior and have it logged in Resident #1's behavioral record/general medical notes if Resident #1 continues to respond inappropriately. * Staff will ensure that Resident #1 is at a safe distance away from female residents. Staff should intervene and redirect Resident #1 to another area of the building if Resident #1 is bothering female residents.			

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	*The facility plan of care also addressed Resident #1, at times, liked to be naked in his/her room. The plan of care directed staff to provide privacy and pull the privacy curtain. Additional interventions related to Resident #1's behaviors directed staff to provide Resident #1 a private place if staff found Resident #1 disrobing or stimulating him/herself in a public area, and staff will counsel the resident if he/she engages in inappropriate behavior. A Psychology Note dated 6/30/16 documented staff reported Resident #1 had an increase in impulsive behaviors including some of a sexual nature. The nurse's notes dated 7/1/16 documented Resident #1 found roaming after dinner in the dining room with his/her pants around their ankles, exposing genitalia. Another resident told Resident #1 to put their pants on. When asked, the other resident denied it bothered him/her. Staff pulled the resident's pants up and took the resident to his/her room. The nurse's notes dated 7/2/16 documented Resident #1 asked a CNA, "What (do I) need to do to get a boner around here?" CNA told the resident the question was inappropriate and told him/her not to ask those types of questions. The nurse's notes dated 7/3/16 documented the resident was in his/her room naked and exposing themselves to the female residents across the hall. Staff assisted the resident with dressing and escorted the resident up the hall. The female resident was very upset. The Psychotropic Medication Assessment Progress Note dated 7/7/16 indicated Resident #1 had many sexual			

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	behaviors this past month. Behaviors included exposing his/her genitalia on 6/13, 6/24, 6/26, & 7/1. On 7/2, Resident #1 made verbalizations which were sexual in nature. The nurse's notes dated 7/30/16 documented resident walking in hallway wearing t-shirt, underwear and socks and found by staff in another resident's room. Staff redirected the resident back into his/her own room and the resident got dressed and came to the dining room. Staff told resident this behavior was inappropriate. An entry in the nurse's notes dated 8/4/16 documented the resident was found in another resident's room with his/her pants down. The female resident was in the room also. The resident stated, "I'm on the wrong hall." Staff redirected the resident back to his/her room and informed him/her the behavior was inappropriate. The Psychotropic Medication Assessment Progress Note dated 8/10/16 indicated Resident #1 showed an improvement in behaviors with one incident of exposing him/herself and would continue with the present medication regimen. The medication was clinically appropriate to decrease libido which could cause mental distress to others and also used to decrease hallucinations. A Social Service Note dated 8/19/16 documented staff gave Social Worker a note that reported the resident continued to expose him/herself in common areas. Resident denied he/she did this. Social Worker told the resident he/she must be fully dressed in common areas and if he/she is not fully dressed, he/she must be in their room or bathroom with the privacy curtain pulled. The resident continued to deny inappropriate behavior.			

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	A Psychology Note dated 8/24/16 documented clinician discussed an incident with Resident #1 that occurred in the facility last week. The resident denied remembering it. The clinician documented she discussed Resident #1's cognitive testing results with him/her, and the likelihood that he/she couldn't remember; the tests measured Resident #1's memory as cognitively intact. The resident continued to deny any event. The clinician stated if it happened again, she would ask staff to take the resident aside and ask him/her why he/she felt like exposing him/herself. Resident #1 again denied and stated that "would have been a horrible thing but I do not remember doing it." Active listening and rapport building provided. The clinician documented the resident would be seen 1-2 times per week. A Psychiatric Progress note completed by an MD documented the resident still dropping their pants in public. The resident is very sexually inappropriate still and will try him/her on Trileptal 300 mg twice daily and recheck in two weeks. Documentation in the nurse's notes dated 8/25/16 revealed Resident #1 met with the psychiatrist who recommended adding Trileptal 300 mg (milligrams) twice daily due to sexually inappropriate behaviors. Documentation in the nurse's notes also revealed the facility received a fax back from the physician regarding resident's sexually inappropriate behaviors. The faxed contained an order that directed staff to administer Trileptal 300 mg twice daily. The nurse's notes dated 8/29/16 documented the resident remained on Trileptal as ordered, and revealed he/she was found spying on his/her roommate through the curtains. Staff redirected the resident.			

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	A Psychology Noted dated 9/21/16 documented Resident #1 had issues taking medication as staff found pills that he/she did not take and are taking steps to monitor mediation more effectively. The Psychotropic Medication Assessment Progress Note dated 10/12/16 indicated Resident #1 had no changes in medications or functional changes in the past month. He/she remains on Trileptal for high risk sexual behaviors. The resident was overheard on 9/19/16 asking a female resident if she "could take it all in?" Documentation in the nurse's notes dated 11/1/16 at 11:45 p.m. staff observed Resident #1 sexually assaulting his/her roommate. Staff intervened and implemented one on one supervision. Documentation in a follow up Psychiatric Progress note dated 11/3/16 at 8:19 p.m. revealed Resident #1 sexually assaulted another resident. Resident #1 denied all the assault and allegations. During an interview attempted on 11/8/16 at 3:10 p.m. Resident #1 responded that he/she would visit (talk), but Resident # 1 did not open his/her eyes. In addition Resident #1's speech was extremely slurred and difficult to understand. Although Resident #2 did not express his/her fear and trauma as a result of the sexual assault, interviews and review of the care plan reveal he/she had always been a very private person and a loner. When Resident #1 assaulted him/her, Resident #2 pulled the call light completely out of the wall outlet to get the staff to come to his/her aid. Although the resident expressed little to no emotion related to the assault, he/she stated it was an awful thing that happened. He/she was also observed by			

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	staff turning his/her call light on and then off as if testing it to see if it worked. **FACILITY RESPONSE:**			

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