STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265381	A. BUILDING _____ B. WING _____	**05/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NORTHWOOD HILLS CARE CENTER	**800 N ARTHUR ST, PO BOX 187 HUMANSVILLE, MO 65674**

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 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure one resident (Resident #1) was free from sexual abuse when an employee (Certified Medication Technician (CMT) B) kissed the resident in a romantic manner. The facility census was 96. The administrator and Director of Nursing (DON) were notified of the Past Non-Compliance which occurred between approximately 5/4/2020 and 5/11/2020. The facility staff suspended CMT B, began an investigation, and began immediate in-servicing of all staff were on-site and as they arrived for work prior to beginning their shift. The facility also notified the Department of Health and Senior Services (DHSS) and the local law enforcement agency of the event. The noncompliance was corrected on 5/11/2020. Record review of the facility's policy and procedure entitled, Protection of Residents: Reducing the Threat of Abuse and Neglect , revised 1/21/19, showed the following information: -To minimize the threat of abuse and/or neglect, nursing homes must incorporate clear-cut policies and practices that demonstrate a hardline, zero-tolerance approach to resident abuse; -Each resident has the right to be free from abuse of any type, by anyone. This includes, but is not limited to; staff, other residents, consultants, volunteers, staff from other agencies serving our residents, family members, the resident representative, friends, or any other individuals; -Sexual abuse is non-consensual sexual contact of any type with a resident. This includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault; -It is the policy of this facility that reports of abuse are promptly and thoroughly investigated; -If the accused individual is an employee, the alleged perpetrator will be removed from resident care areas immediately and placed on suspension pending results of the investigation; -Any investigation of alleged resident sexual abuse must start with a determination of whether the sexual activity was consensual on the part of the resident. A resident's apparent capacity to consent to engage in sexual activity is not valid if it is obtained through intimidation, coercion or extorted sexual activity with a resident. 1. Record review of Resident #1's annual Minimum Data Set (MDS), a federally mandated comprehensive assessment instrument completed by facility staff, dated 4/9/2020, showed the following information: -admitted to the facility on [DATE]; -[DIAGNOSES REDACTED]. Record review of the facility's investigation summary, signed by the DON, showed the following information: -On 5/11/2020, at 2:05 P.M., Certified Nursing Assistant (CNA) A reported to the DON that he/she had just witnessed (through the privacy curtain) CMT B leaning over Resident #1 and heard kissing noises. The DON and the administrator interviewed Resident #1. The resident confirmed the kissing and said he/she and CMT B had been talking and kissing for about a month; he/she denied any sexual contact. CMT B had already left the building for the day; -On 5/11/2020, at 3:00 P.M., the DON notified the physician, who said to monitor the resident. The DON notified the resident's guardian and the local police department; -The DON called CMT B and asked him/her if there was anything going on between him/her and any resident in the facility. CMT B initially said no. The DON asked specifically if anything was going on between him/her and Resident #1, and CMT B said they were just friends. The DON told him/her that a witness reported CMT B and Resident #1 kissed. CMT B said he/she and Resident #1 had been talking on Facebook. CMT B said Resident #1 tried kissing him/her once and he/she told the resident no; they could only hug. The DON notified CMT B that he/she was suspended pending investigation; -On 5/11/2020, at 5:00 P.M., CMT B called the DON and said he/she was caught off guard during the previous telephone conversation. The CMT said he/she and Resident #1 had been talking for the last month and started kissing about a week ago. The DON told CMT B the investigation was still ongoing, and CMT B was not allowed to come into the building. The internal investigation was substantiated; the facility terminated CMT B. During a telephone interview on 5/12/2020, at 12:32 P.M., CNA A said the following: -During the shift change on 5/11/2020, at approximately 2:00 P.M., he/she observed CMT B enter the room of Resident #1; -CNA A stepped just inside the room's doorway. The resident in the bed closest to the door was asleep, and the divider curtain was pulled between the residents' beds/sides of the room; -Through the curtain, CNA A could see the shadow/silhouette of CMT B, who stood on one foot to lean toward the resident, who sat in a recliner; -CNA A heard multiple kissing sounds from CMT B and Resident #1 and quickly withdrew from the room; -The CNA immediately went and reported the incident to the DON. During an interview on 5/12/2020, at 1:10 P.M., Resident #1 said the following: -He/she and CMT B did not know each other prior to his/her admission to the facility, but were friendly and through talking found they had many things in common. Their friendship started becoming more about one month prior; -He/she and CMT B did kiss on 5/11/2020; the kiss was romantic in nature. They had kissed one other time previously, but that was the extent of their physical relationship; -They were both consenting adults, but said he/she understood the nature of the relationship was inappropriate since he/she was a resident of the facility and CMT B was an employee. During a telephone interview on 5/12/2020, at 1:28 P.M., CMT B said the following: -He/she and Resident #1 started a friendship based on talking about common interests; -About a month ago, the relationship developed into more than a friendship; -He/she and Resident #1 did kiss on 5/11/2020, which he/she said the resident initiated. They had kissed one time prior to that; -Prior to the second time kissing, he/she and Resident #1 had briefly discussed waiting for the resident to discharge from the facility before progressing with the relationship; -CMT B said it was inappropriate for him/her to have the described interaction with a resident. During an interview on 5/12/2020, at 1:50 P.M., CNA C said he/she was aware of the the facility's policies and procedures regarding abuse and/or neglect of a resident by anyone. The CNA confirmed completion of the 5/11/2020 in-service pertaining to definitions of abuse and inappropriate interaction by staff to a resident, including kissing or touching in a romantic manner. During an interview on 5/12/2020, at 2:02 P.M., Licensed Practical Nurse (LPN) D said he/she was aware of the facility's policies pertaining to abuse and neglect. The LPN confirmed completion of the 5/11/2020 in-service on abuse, including definitions and specifics on inappropriate interaction with residents. LPN D had not witnessed or heard anything prior to the in-service about any inappropriate interaction between an employee and a resident, but would report such actions immediately. During an interview on 5/12/2020, at 2:35 P.M., CNA E said he/she was aware of the facility's policies regarding identifying and reporting abuse. The CNA said kissing and inappropriate touching of a resident by an employee was considered abuse and should be reported immediately. During an interview on 5/12/2020, at 3:20 P.M., the Social Services Director (SSD) and the Admissions Coordinator both said an employee kissing a resident in a romantic manner would be considered inappropriate interaction and reportable as abuse. Both staff denied knowledge of a romantic relationship between CMT B and Resident #1 prior to the reported incident on 5/11/2020. During an interview on 5/12/2020, at 3:50 P.M., the facility Administrator, Director of Nursing, and Assistant Director of Nursing, said it was inappropriate for any employee to kiss or touch a resident in a romantic manner. They said such actions would be considered abuse, even if the resident initiated the action or said he/she was not abused. #MO 026

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.