STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195446	A. BUILDING _____ B. WING _____	**06/23/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAKEVIEW MANOR NURSING HOME	**400 HOSPITAL ROAD NEW ROADS, LA 70760**

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

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F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 observation, record reviews and interviews, the facility failed to ensure residents were free from sexual abuse for 2 (#2, #4) of 8 (#1, #2, #3, #4, #5, #6, #7, #8) sampled residents. The deficient practice had the potential for more than minimal harm for the other 50 residents deemed unable to consent to sexual activity. Findings: Review of the facility's policy titled Abuse Prevention and Investigation revealed, in part, the following: Residents have the right to be free from verbal, sexual, physical, and mental abuse, neglect, corporal punishment, involuntary seclusion, and misappropriation of property, exploitation, and any physical or chemical restraint not required to treat the resident's medical symptoms. Resident will not be subjected to abuse by anyone. Policy Interpretation and Implementation The facility defines resident abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. Willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Sexual abuse is defined as non-consensual sexual contact of any type with a resident. Sexual contact is non-consensual if the resident either appears to want the contact to occur, but lacks the cognitive ability to consent or does not want the contact to occur. The facility will train employees through orientation and annual (at minimum) continuing-education in-services on issues related to resident abuse and facility resident abuse prohibition practices. Training of employees will include: -understanding behavioral symptoms of residents that may increase risk of abuse and neglect and how to respond -facility staff will identify and intervene for resident's whose behavior or medical condition puts them at increased risk for abuse. If a resident's behavior history or medical condition puts him or her at increased risk for abuse, interventions will be developed through the care planning process. -evaluate residents to ensure they have the capacity to consent to sexual activity as needed and appropriate The facility will monitor for and identify the incidents and/or patterns (trends) of incidents, as well as specific resident signs, symptoms, and outcomes that may indicate the need for further investigation. -Any report, grievance, or complaint that indicates resident abuse or the potential for resident abuse will be reported to the Administrator and investigated as needed in order to protect all residents. -Resident-to resident abuse allegations will be reviewed and the safety of residents will be ensured. -Any area of the building that is secluded, or has a particular resident population, or has characteristics that might increase the possibility of resident abuse occurring will be identified and staff will intervene appropriately in order to help ensure residents are protected. If an alleged violation or crime is verified, the facility will implement a corrective action plan and will evaluate its effectiveness. The QAA committee will monitor the reporting and investigation of all allegations and ensure that corrective action is implemented as necessary. Resident #2 and Resident #3 Review of the clinical record revealed Resident #2 was admitted to the facility on [DATE]. Resident #2's [DIAGNOSES REDACTED]. Review of the Quarterly MDS with an ARD of 02/03/2020 revealed a BIMS of 99, which indicated Resident #2 was unable to complete interview. Review of the Yearly MDS with an ARD of 05/04/2020 revealed a BIMS of Blank which indicates an interview was not attempted. Review of Resident #2's Care Plan revealed the following, in part: Problem: Impaired communication related to severe dementia. Resident is rarely understood/ resident rarely understands. 05/05/2020 Resident was touched inappropriately by a male resident. Review of the Capacity to Consent to Sexual Activity assessment for Resident #2, dated 06/19/2020, revealed the resident did not have the capacity to consent to sexual activity. The facility did not identify residents who did not have the capacity to consent to sexual activity in order to increase monitoring on those residents until assessments were conducted on the residents on 06/19/2020. Upon completion of the assessments on 06/19/2020, the facility compiled a list of residents who did not have the capacity to consent to sexual activity. Review of the list of residents deemed incapable of being able to consent to sexual activity, provided by the facility on 06/19/2020, revealed Resident #2 was included on the list. Review of the clinical record revealed Resident #3 was admitted to the facility on [DATE]. Resident #3's [DIAGNOSES REDACTED]. Review of the MDS with an ARD of 04/09/2020 revealed a BIMS of 10, which indicated Resident #3 had moderate cognitive impairment. Review of Nurse's Notes written by S2DON dated 05/05/2020 for Resident #3 revealed the following: 05/05/2020 4:34 p.m. Resident assisted to the DON office per staff at the direction of facility administrator. Administrator reviewed video from hall 3 dining room of the reported incident. Met with Resident #3 to discuss his reported inappropriate behavior with Resident #2. He initially became agitated and defensive and saying he was going to his room and pack his things and leave. He slams the office door shut, and says I took one little peek to see what color her boobs were. I don't know what made me do it. Review of Nurse's Notes written by S8LPN dated 05/05/2020 for Resident #2 revealed the following: 05/05/2020 4:35 p.m. S17LA reported that while walking by hall 3 dining room Resident #3 was touching on Resident #2's breast. Resident #3 stated that Resident #2 said she had bugs on her and he was trying to help get them off her. Resident #2 and #3 were sitting at the table in hall 3 dining room. Review of the statement written by S17LA dated 05/05/2020 revealed the following: 05/05/2020 When I was coming back from putting linen in the closet on hall 3, I saw Resident #3 raising Resident #2's top and touching her breast, I told him that he could not do that, he said OK. I proceeded to call the nurse on hall 3, she was not available. So I came to the nurse on hall 2. An interview was conducted on 06/16/2020 at 10:50 a.m. with S17LA. She said on 05/05/2020 at 4:30 p.m., she was walking pass hall 3 dining room. She observed Resident #2 and Resident #3 sitting at the dining room table. She said Resident #3 lifted Resident #2's shirt and was touching her breast. She said she yelled out No, you cannot do that. She said Resident #3 immediately replied She said she had bugs under her shirt and I was checking it out. She said she told Resident #3 that he had to leave the dining room. She said Resident #3 started to propel himself from the dining room as she made her way to the nurse's station. She said S8LPN was not at hall 3 nurse's station so she ran to hall 2 nurse's station and informed S9LPN. She said S9LPN immediately proceeded to hall 3 dining room. An interview was conducted on 06/16/2020 at 10:56 a.m. with S9LPN. She said on 05/05/2020 at 4:30 p.m. S17LA ran down the hall and reported Resident #3 was in the dining room with Resident #2's shirt up and was touching her breast. When she proceeded down hall 3 to the dining room, Resident #3 was out of the dining room sitting in his wheelchair in the hallway. She said she asked Resident #3 what happened in the dining room. She said he reported She said she had bugs on her breast and I was checking her breast to make sure she was ok. She said she went into the dining room to check on Resident #2. She said Resident #2 was sitting at the table looking at a coloring book. She said she asked Resident #2 if she was ok. She said Resident #2 did not answer her and continued looking at a coloring book. She said she immediately reported the incident to S8LPN. On 06/16/2020 at 11:05 a.m. an attempt was made to speak with Resident #2. She did not answer questions. She immediately started talking about playing outside as a young child. No further attempt was made to interview Resident #2. An interview was conducted on 06/16/2020 at 11:10 a.m. with S8LPN. She said she worked hall 3 and was assigned to care

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.

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F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) for Resident #2 and Resident #3. She said she was in the restroom when she heard S17LA yelling down the hall for assistance in hall 3 dining room. She said it was reported to her that S17LA witnessed Resident #3 lifting Resident #2's shirt and touching her breast. She said Resident #3 was on hall 3 in his wheelchair when she arrived in hall 3 dining room. She said Resident #2 was sitting at the table looking at a coloring book. She said she did not appear to be disturbed or hurt. She said she called S2DON on the phone and reported the incident to her. She said S2DON came to hall 3 and escorted Resident #3 to the front office. She said she and the treatment nurse took Resident #2 to her room and did a complete skin assessment. She said she asked Resident #2 what happened in the dining room, but she did not answer the question. An interview was conducted on 06/16/2020 at 12:00 p.m. with S2DON. She said S8LPN reported S17LA witnessed Resident #3 touching Resident #2's breast in the hall 3 dining room. She said she immediately brought Resident #3 to the DON office and notified S1Adm. She said S1Adm watched video of the hall 3 dining room and confirmed Resident #3 displayed sexual acts that involved Resident #2. She said Resident #3 was extremely agitated in the office. She said at first Resident #3 denied touching Resident #2 but then admitted he was touching her breast to make sure she did not have bugs under her shirt. He then admitted he wanted to take a peek to see the color of her boobs. She said the local law enforcement was notified of the incident. She said the local law enforcement watched the video with S1Adm. On 06/16/2020 at 12:50 p.m., this surveyor along with another surveyor viewed the facility's video recording of the incident between Resident #2 and Resident #3 on 05/05/2020 at approximately 12:50 p.m. The video recording was viewed with S1Adm present. It was noted there was no sound on the video. 3:13 p.m. Resident #2 was seated alone in her wheelchair next to a table in the dining room. 3:20 p.m. Resident #3 entered the dining room in his wheelchair. 3:21 p.m. Resident #3 propelled to the table where Resident #2 was sitting. No physical contact. 3:22 p.m. Resident #3 propelled his wheelchair out of the dining room then propelled back into the dining room next to Resident #2. 3:24 p.m. The treatment nurse walked in and out room. 3:26 p.m. S13CNA walked in the room and Resident #3 propelled in his wheelchair out of the dining room. 3:37 p.m. Resident #3 propelled back in dining room and maneuvered next to Resident #2. S13CNA left the dining room. 3:28 p.m. Resident #3 looked around the room then touched Resident #2's left breast over her shirt. 3:29 p.m. S13CNA walked back in dining room, Resident #3 remained seated next to Resident #2. 3:31 p.m. S13CNA sat at table with both residents and Resident #3 propelled himself out of the dining room. 3:34 p.m. - 3:46 p.m. Resident #3 returned to dining room and maneuvered next to Resident #2. S13CNA was coloring with Resident #2. Resident #3 flipped through the coloring book. Resident #3 occasionally tapped his hand on the table and continued to look around the dining room. He moved closer to Resident #2. He reached for Resident #2's left arm, touched her left hand and continued to look around the room. 3:48 p.m. Resident #3 maneuvered his wheelchair closer to Resident #2. He looks around the room at the doors. S13CNA was coloring in her book and talking to Resident #2. Resident #2 was leaning toward the table. He reached slowly and touched Resident #2's left breast. Resident #2 did not react. 3:50 p.m. S13CNA turned her head to speak to another resident at the next table and Resident #3 grabbed Resident #2's left breast and immediately pulled back when S13CNA turned back to the table. 3:54 p.m. Resident #3 attempted reach to touch left breast but pulled away when S13CNA looked up from the coloring book. He rubbed Resident #2's left arm. 3:55 p.m. Resident #3 held Resident #2's left hand. 3:56 p.m. S13CNA assisted another resident at the next table. Resident #3 tapped Resident #2's left arm and grabbed her left breast. Resident #2 did not respond. 3:57 p.m. Resident #3 grabbed Resident #2's hand slowly and pulled her left hand to touch his penis area over his pants. 3:58 p.m. Resident #3 pulled Resident #2's left hand toward penis area but looked around and stopped. 3:59 p.m. S13CNA turned and assisted another resident. Resident #3 pulled down the front of his pants and exposed his penis, pulled Resident #2's left hand to touch penis then released her hand. 4:02 p.m. S13CNA got up and repositioned Resident #2 closer to the table. 4:04 p.m. S13CNA got up to assist another resident and Resident #3 grabbed Resident #2's left breast 4:05 p.m. S13CNA continued to assist another resident at another table and Resident #3 pulled the front of his pants down and exposed his penis. Resident #3 pulled Resident #2's left hand to touch his penis. Resident #3 continued to look around the room. 4:06 p.m. S13CNA walked out of the dining room. Resident #3 looked around, then rolled around the dining room. 4:08 p.m. S13CNA walked back in the dining room, readjusted Resident #2's wheelchair at the table. She walked out of the dining room and Resident #3 grabbed Resident #2's left breast. 4:10 p.m. Resident #3 moved around the dining room in his wheelchair and rolled back next to Resident #2. 4:11 p.m. Resident #3 grabbed Resident #2's left breast when S13CNA turned to assist another resident. 4:18 p.m. S13CNA walked away to assisted another resident in the room. Resident #3 grabbed Resident #2's left breast and attempted to pull up her shirt. S13CNA returned seconds later to table and sat next to Resident #2. 4:20 p.m. Resident #2 was leaning forward toward the table. Resident #3 moved his hand under the table and grabbed Resident #2's left breast. 4:26 p.m. S13CNA walked out of dining room. Resident #3 continued to look around and touch Resident #2's left breast repeatedly. 4:29 p.m. Resident #3 pulled the front of his pants forward and pulled Resident 2's left hand towards his penis area. He stops and looks around. 4:31 p.m. Resident #3 pulled the front of his pants down and grabbed Resident #2's left hand to his exposed penis and held her hand on his penis. He stopped and looked around. 4:32 p.m. Resident #3 pulled the front of his pants down and grabbed Resident #2's left hand to his exposed penis and held her hand on his penis. He held his penis and pulled back and forth on his penis. Resident #2 pulled away to grab a color. 4:34 p.m. Resident #3 attempted to pull up Resident #2's shirt but stopped when looking at the door. 4:34 p.m. Resident #3 pulled the front of his pants down and pulled her left hand to his exposed penis. He moved her hand side to side while he held her hand on his penis and grabbed her left breast. 4:36 p.m. Resident #3 puts his hand under Resident #2's shirt and moved his hand around touching left breast area. 4:37 p.m. Resident #3 pulled up Resident 2's shirt and rubbed both breast. 4:38 p.m. S17LA walked past the dining room. Resident #3 stopped touching Resident #2's breast when S17LA walked into the room. He immediately pulled away from the table and out of the dining room. Resident #4 and Resident #5 Review of facility census information revealed Resident #4 and Resident #5 both resided in rooms which were on the secured unit. Review of the clinical record for Resident #4 revealed the female resident was admitted on [DATE] and had [DIAGNOSES REDACTED]. Review of a quarterly MDS with an ARD of 03/19/2020 revealed Resident #4 had a BIMS score of 0 (severe cognitive impairment). The MDS also revealed the resident was unable to repeat three words given to her and was unable to accurately report the year, month, or day of the week. Review of a quarterly MDS with an ARD of 06/01/2020 revealed Resident #4's cognitive skills for daily decision making were severely impaired, and she had a BIMS score of 99 (unable to complete interview). The MDS also revealed the resident was unable to repeat three words given to her and was unable to accurately report the year, month, or day of the week. Review of the Care plan for Resident #4 revealed the following, in part: Impaired thought processes due to [DIAGNOSES REDACTED].#4 revealed the following: 05/05/2020 4:20 p.m. -Reported over the weekend Resident #5 was rubbing between the resident's (Resident #4) legs at the end of the secured unit hallway by the doors Review of the Capacity to Consent to Sexual Activity assessment for Resident #2, dated 06/19/2020, revealed the resident did not have the capacity to consent to sexual activity. The facility did not identify residents who did not have the capacity to consent to sexual activity in order to increase monitoring on those residents until assessments were conducted on the residents on 06/19/2020. Upon completion of the assessments on 06/19/2020, the facility compiled a list of residents who did not have the capacity to consent to sexual activity. Review of the list of residents deemed incapable of being able to consent to sexual activity, provided by the facility on 06/19/2020, revealed Resident #2 was included on the list. Review of the clinical record for Resident #5 revealed the male resident was admitted on [DATE] and had [DIAGNOSES REDACTED]. Review of a quarterly MDS with an ARD of 04/16/2020 revealed Resident #5 was able to make himself understood, was usually able to understand others, and comprehended most conversation. The MDS also revealed the resident was able to repeat three words given to him, and accurately report the year. Review of a discharge MDS with an ARD of 05/06/2020 revealed Resident #5's cognitive skills for daily decision making were coded as modified independence with some difficulty in new situations only. Further review of the MDS revealed the resident was coded as having physical behavioral symptoms toward others for 1 to 3 days. Review of a quarterly MDS with an ARD of 05/19/2020 revealed Resident #5 was able to make himself understood, was usually able to understand others, and comprehended most conversation. The MDS also revealed the resident was able to repeat three words given to him, accurately report the year, and report the correct month within five days. Review of the care plan for Resident #5 revealed the following, in part: Socially/Sexual inappropriate/disruptive behavior: 05/06/2020-Resident being transferred to behavioral center today related to inappropriate sexually physical touching of another resident without consent-resident has severe dementia-family notified-police report made. 05/14/2020-Returned to NH following in-patient stay at behavioral center; New order to discontinue [MEDICATION NAME] and start [MEDICATION NAME] and [MEDICATION NAME]; Start [MEDICATION NAME] Review of the Nurses' Notes for Resident #5 revealed the following entries: 04/25/2020 2:29 p.m.- Resident #5 was asking CNA how much

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F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) money will she take to have sex with him; when CNA put him to bed he tried to grab her breast; explained to him that is inappropriate to act that way and not to grab staff that they are there to assist him; they need to do their job without him grabbing on them; he told staff that he was sorry and stated I am just a man. I have needs. 05/05/2020 6:04 p.m. -S10CNA reported to S6LPN Resident #5 was touching Resident #4 inappropriately on the weekend 05/05/2020 6:24 p.m. -S6LPN reported she was notified on yesterday by S10CNA that resident was noted to be rubbing a resident between her legs while they were both sitting in their wheelchairs at the end of the hallway; facility administrator notified of the incident Administrator contacted S10CNA who stated she reported the incident to hall nurse S7LPN on Sunday. 05/06/2020 11:35 a.m. -Resident #5 transferred to behavioral hospital 05/13/2020 4:00 p.m.-Call received from behavioral hospital stating planning for discharge tomorrow; stated resident says he is aware he should not have made inappropriate behaviors Review of the information for Resident #5 from the behavioral hospital revealed the following: Psychiatric Evaluation dated 05/07/2020: referred for inappropriate sexual aggression in the context of dementia; on 05/03/2020 was observed rubbing another resident between her legs while they were in the hall way; resident does not understand why he is here; explained to him that he is here because of the reported sexually inappropriate behavior and the concern for the safety of the female resident; he states it's nothing but a lie. He acknowledges he is friendly with a female resident there though he denies anything sexual. He stated it is hurtful these things have been said about him and believes staff are lying about him in order to get rid of me. He states he did touch a very elderly woman at the nursing home who asked him how are you doing? to which he responded by touching her leg platonically and replying in kind. He does say he thinks it is okay to touch women in a sexual manner if they tell him he can do so and cannot express understanding that actions such as the ones he has committed would be inappropriate (although he denies the actions and seems to appreciate they were negative based on his defensive reaction.) Mental Status Examination: Orientation-person, place, day, date, month, and year Memory: Remote intact Thought Content: Normal Psychiatric Diagnosis: [REDACTED].#5 does say he touched a woman on her leg though remains adamant he didn't do anything sexual; he says he understands he should never touch another woman at the facility and says he never will; he verbalizes that they could send me to Angola should he repeat the behavior Review of a statement by S10CNA dated 05/06/2020 revealed the following information: Incident happened 05/02/2020; time (12:15-12:40 p.m.) Resident: Resident #5 Saturday, around 12:15/12:40, when I was walking down Hall 1, I noticed Resident #5 and Resident #4 both facing the double doors looking out the door. I noticed Resident #5's hands moving, as in touching Resident #4, but I wasn't sure so I snuck up behind them quietly and there he was constantly rubbing between Resident #4's legs and, she wasn't saying anything. That's when I approached him and asked him what he was doing and told him to move his hands off of her and that's when he told me he wasn't doing anything which he was. He then turned around and went back up the hall toward his room. I went and reported it to the nurse. This was my first time witnessing him doing this towards another resident. I walked the hall the next 2 days after that but them two days he was in his bed and did not want to get up. An interview was held with S6LPN on 06/16/2020 at 8:55 a.m. She voiced she was the assigned nurse for the dementia unit for the 6:00 a.m. - 6:00 p.m. shift on 06/16/2020, and said the dementia unit was her normal unit to work. She was asked about an incident reported concerning Resident #5 touching Resident #4 inappropriately. She stated the incident occurred on a weekend when she was not working. She stated Resident #5 was oriented to his daughter and recognized the voices and faces of staff but could not give their names. She said the resident was normally able to answer questions appropriately. An interview was held with S1Adm on 06/16/2020 at 2:20 p.m. S2DON was also present during the interview. The Administrator was questioned regarding the reported incident of Resident #5 inappropriately touching Resident #4. The Administrator voiced she was made aware of the incident by S19MDS. The Administrator stated when she called S10CNA, S10CNA said she had walked to the end of the hall on the dementia unit, and Resident #5 had his hand between Resident #4's legs on top of her clothes. The Administrator stated Resident #5 was sent to a behavioral hospital on [DATE]. An interview was held with S7LPN on 06/17/2020 at 9:57 a.m. She said on Saturday, 05/02/2020, S10CNA had commented Resident #4 was not mumbling like normal when Resident #5 was rubbing her hand while they were sitting at the end of the hallway on the secured unit. She voiced because S10CNA had said Resident #5 was rubbing Resident #4's hand she did not think anything inappropriate had occurred so she did not report anything or increase monitoring on Resident #5. She said she was working Wednesday, 05/06/2020, when Resident #5 was transferred to the behavioral hospital. She stated the resident was oriented X 3. An interview was held with S10CNA on 06/17/2020 at 10:47 a.m. She stated on Saturday, 05/02/2020, she was going down the hall on the secured unit to answer a light. She stated Resident #4 and Resident #5 were sitting at the end of the hall at the back door facing the door. She stated she walked up behind the residents, and Resident #5 had his hand between Resident #4's legs on her genital area rubbing up and down on top of Resident #4's clothes. She stated when she told Resident #5 to take his hands off Resident #4 he said he was not doing anything wrong and rolled off in his wheelchair. She voiced she went and reported to S7LPN that she saw Resident #5 rubbing in between Resident #4's legs. She stated the incident happened between 12:15 p.m. and 12:40 p.m., but she could not remember the exact time. An interview was held with S16CNA on 06/17/2020 at 11:15 a.m. She voiced she normally worked the secured unit on the 2:00 p.m. - 10:00 p.m. shift. She stated Resident #5 was confused at times, but it was infrequent. An interview was held with S1Adm and S2DON on 06/18/2020 at 12:20 p.m. The Administrator confirmed the facility had two sexual abuse allegations, one incident between Resident #2 and Resident #3 in May 2020 and one incident between Resident #4 and Resident #5 in May 2020. She stated rounds on the units were made every morning and every afternoon by the Administrator and DON and included looking for potential abuse. She stated the ADON also made rounds on the units. She stated the rounds had been in place and were not something new started after the two allegations of sexual abuse at the facility. She stated the rounds made by the Administrator, DON, and ADON were not documented. She stated administrative rounds were also made on all units every morning which were documented on a rounding sheet, but it did not include abuse. She stated those administrative rounds were already in the place prior to the sexual abuse reports at the facility. She stated she could not provide documentation there had been increased monitoring for sexual abuse implemented for residents other than the two accused.