STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385171	A. BUILDING _____ B. WING _____	**09/28/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LIFE CARE CENTER OF MCMINNVILLE	**1309 NE 27TH STREET MCMINNVILLE, OR 97128**

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 -** 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 interview and record review it was determined the facility failed to protect a resident from sexual abuse for 1 of 2 sampled residents (#s 1 and 2) reviewed for abuse. As a result, Resident 1 experienced sexual abuse and displayed symptoms of negative psychosocial impact as evidenced by fearful statements and refusals of care. Findings include: Resident 1 was admitted to the facility in 2018 with [DIAGNOSES REDACTED]. The facility Protection of Residents policy dated 11/2016 stated: it is the policy of the facility that all residents will be protected from abuse and/or neglect. The document defined sexual abuse as: Non-consensual sexual contact of any type with a resident. The facility's Abuse/Adverse Event Investigation Packet dated 8/5/20 indicated Staff 10 (CNA) reported to Staff 4 (Staffing Coordinator/LPN) and Staff 5 (Activities Director) following his shift on 8/5/20 he had touched someone like you weren't supposed to. Staff 10 stated he was changing Resident 1's brief and started wiping the resident repetitively and then digitally penetrated the resident's genital area. Per the report, Staff 10 was immediately terminated and the police and other appropriate entities were notified. On 8/6/20 at 3:59 PM a Health Status Progress Note indicated Resident 1 was making a lot of inappropriate comments during a shower such as; asking the CNA if she was going to drown her/him or if the CNA was going to hurt her/him while giving the shower. On 8/10/20 at 2:23 PM Staff 5 stated she had stopped to give Staff 10 a ride home from the facility on 8/5/20. Staff 5 indicated Staff 10 was upset and started to cry and stated he wanted to confess something. Staff 5 stated Staff 10 revealed he had sexually abused a resident at the facility. On 8/10/20 at 2:41 PM Staff 4 indicated she had received a phone call from Staff 5 who was in her car with Staff 10 regarding an incident which occurred with Staff 10 and a resident in the facility. Staff 4 met with Staff 10 in Staff 5's car and Staff 10 revealed to her that he had sexually abused Resident 1. Staff 10 indicated he had thought about doing the abuse previously and he was aware it was wrong. Staff 4 indicated they immediately reported the incident to the facility. On 8/11/2020 at 10:30 AM Witness 2 (Detective Sergeant McMinnville PD) indicated they received a call from the facility on 8/5/20. The alleged perpetrator (Staff 10/CNA) confessed what he had done to Resident 1. Witness 2 stated he did not feel there were other residents involved. Witness 2 indicated there was a high level of excitement indicated by Staff 10 and his mindset was he knew he was doing wrong. Staff 10 revealed he preset the room up so he could have the contact with the resident. Staff 10 knew the resident sometimes made sexual remarks, but did not give consent and Staff 10 appeared remorseful. The Police Department would not be able to provide a police report at this time because it was still an open and on-going case and they would need to get approval from the District Attorney. On 8/11/20 at 4:10 PM Resident 1 stated she/he had a girlfriend/boyfriend who worked at the facility. Resident 1 stated she/he was not supposed to talk about it because the girlfriend/boyfriend was too young for her/him. Resident 1 indicated she/he was lonely and so was the staff member and it was nice to have a girlfriend/boyfriend at the facility. The resident did not want to discuss any physical interactions that may have occurred. Numerous attempts were made to contact Staff 10 by telephone for an interview, but they were unsuccessful, and the voice mailbox was full. On 8/12/20 at 9:02 AM Witness 3 (Oregon State Board of Nursing Investigator) indicated Staff 10 revealed he had sexual contact with Resident 1 and it was not just a chance happening. Staff 10 revealed he had thought about doing it before he did it and he had set up the room in advance by lowering the blinds and turning the slats so no one could see into the room. Staff 10 was aware Resident 1 had cognitive issues and even if Resident 1 made sexual comments to him it was not appropriate for him to act on them, but he did anyway. Staff 10 reported to Witness 3 he had spent 20 minutes changing the resident and while doing so had digitally penetrated the resident's genitals for approximately 3 to 5 minutes. Staff 10 then indicated he lowered his pants and underpants and crawled into bed with the resident. Staff 10 stated he became overwhelmed by guilt and hopped down off the resident. Staff 10 indicated a staff member may have seen him in the room with the resident, but he did not indicate who that was by name. Witness 3 felt Staff 10 was not as forthcoming with details when he spoke to the police. The following are two progress notes and an interview which evidence psychosocial harm to Resident 1: -On 8/14/20 at 2:53 PM a Progress Note indicated Resident 1 refused to allow staff to put a shirt on her/him. Refusal of care is associated with psychosocial harm. -An interview on 8/17/20 at 12:45 PM Staff 7 (CNA) indicated Resident 1 wasn't allowing her or her female CNA partner to do brief changes. The resident didn't want anyone to see her/his body. Staff 7 indicated that a few weeks prior to the event the resident had been making sexual remarks about Staff 10. Refusals of care are associated with psychosocial harm. Inappropriate or increased sexual comments are indicators of sexual abuse. -On 8/19/20 at 10:44 AM a Progress Note indicated Resident 1 was on alert charting for the incident of sexual abuse with possible psychosocial harm. On 8/19/20 while two CNAs and a nurse were assisting the resident with a brief change, the resident asked what male was in the room. The staff informed the resident no males were in the room. The resident asked what male was in her/his room last night and the resident said she/he did not like what he did and that it hurt. The current care plan has only female caregivers for the resident so the statement most likely refers to the previous episode of abuse. On 8/19/20 at 3:30 PM Staff 1 (Interim Administrator), Staff 2 (New Administrator) and Staff 3 (DON) acknowledged Resident 1 had been sexually abused by Staff 10. The resident was placed on alert charting for sexual abuse and possible psychosocial harm associated with that event. In an email received on 9/25/20 at 10:03 PM Witness 4 (Police Officer) indicated he believed the abuse was limited to the one resident. The exact date of the incident was 8/3/20. Witness 4 was told another employee may have entered or was waiting to enter the room as Staff 10 left the room, however Staff 10 did not identify the staff member. It was unclear as to the full extent of the sexual contact by Staff 10 but Witness 4 felt in part Staff 10 was lying related to the question of penile penetration. Witness 4 indicated the resident being unable to fully cooperate with the investigation did not help to clarify what occurred. Witness 4 was hoping to receive further findings from the Oregon State Police crime lab in the near future.

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.