STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385222	A. BUILDING _____ B. WING _____	03/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEADOW PARK HEALTH & SPECIALTY CARE CENTER	75 SHORE DRIVE SAINT HELENS, OR 97051

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 observation, interview and record review, it was determined the facility failed to ensure residents were free from sexual, physical and verbal abuse for 1 of 3 sampled residents (#12) reviewed for abuse. This placed residents at risk for the potential to experience mental anguish, psychosocial decline and sexual abuse. Findings include: 1. Resident 12 admitted to the facility in 12/2017 with [DIAGNOSES REDACTED]. Resident 10 admitted to the facility in 9/2018 with [DIAGNOSES REDACTED]. Resident 10's Annual MDS dated [DATE] indicated the BIMS score was 13 out of 15, which indicated she/he was cognitively intact. On 2/15/20, an incident report in the incident investigation revealed Resident 10 and Resident 12 were in the dining room after an activity. Staff 4 (Activity Assistant) reported she left the room to return a puzzle to the family room which was about 29 feet way. Resident 10 and Resident 12 were sitting across the table from each other. When Staff 4 returned, she observed Resident 10 had moved her/him self around the table and had her/his hand up the front of Resident 12's shirt with her/his hand on Resident 12's breast. The residents were separated and authorities were notified. Review of the facility's 2/21/20 incident investigation note, revealed the facility determined the sexual abuse had occurred. Observations on 3/4/20 between 8:40 AM to 3:00 PM, Resident 10 was observed with one on one staff supervision. During an interview on 3/4/20 at 1:43 PM, Staff 5 (LPN) revealed on 2/15/20, Staff 4 reported the incident of Resident 10 to her. Staff 5 attempted to interview Resident 10 and she/he said nothing and hung her/his head. Staff 5 initiated one on one supervision for Resident 10. On 3/4/20 at 1:49 PM, Staff 4 reported on 2/15/20 she observed Resident 10 with her/his hand up the front of Resident 12's shirt and on her/his breast (she demonstrated on the right side of her body). She separated the residents and reported the incident immediately to Staff 5. During an interview on 3/4/20 at 2:58 PM, Resident 10 was asked to report what she/he recalled about an incident in February. Resident 10 stated well you know, many, almost none of the women here in the facility wear bras, (Resident 12) looked like (she/he) was wearing a bra, so I stuck my hand up on (her/his) breast to see if (she/he) was wearing a bra and (she/he) was not wearing a bra (showed by hand jester to her/his right side). Resident 10 started to wheel her/him self backwards away from surveyor. When asked if she/he thought Resident 12 would have wanted her/him to do that, she/he stated probably not and hung her/his head and moved farther away from surveyor. On 3/4/20 at 3:28 PM, Staff 2 (DNS) acknowledged the incident between Resident 10 and Resident 12. 2. Resident 12 admitted to the facility in 12/2017 with [DIAGNOSES REDACTED]. Resident 14 admitted to the facility in 2/2019 with [DIAGNOSES REDACTED]. Resident 14's Admission MDS dated [DATE] indicated the BIMS score was 15 out of 15, which indicated she/he was cognitively intact. An incident note in the incident investigation dated 6/4/19 revealed Resident 14 was walking down the hallway and asked Resident 12 to move. When Resident 12 did not respond to Resident 14's request, she/he became verbally and physically abusive and hit (Resident 12's wheel chair) with (her/his four wheel walker). Resident 14 continued to yell loudly. Staff intervened and stood between the residents. Resident 12 appeared unfazed by this altercation but later said that it scared her/him. The resident receiving this abuse, the resident giving the abuse were placed on alert and care plans were updated. Resident 12 was placed on alert and no further signs or symptoms were documented for changes in behavior or verbal statements related to the incident. On 3/4/20 at 2:20 PM, Staff 3 (Activity Director) reported she recalled Resident 14 yelling at Resident 12 but was unable to recall details. On 3/4/20 at 3:29 PM, Staff 2 (DNS) confirmed she completed the incident report. Staff 2 heard Resident 14 yelling at Resident 12 on 6/3/19. She stepped between Resident 12 and Resident 14. She acknowledged Resident 14 had other behavioral outbursts and was impulsive.

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.