STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395552	A. BUILDING _____ B. WING _____	**07/07/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BETHLEN HM OF THE HUNGARIAN RF	**66 CAREY SCHOOL ROAD LIGONIER, PA 15658**

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** - 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 review of policies, clinical records, and investigation reports, as well as staff interviews, it was determined that the facility failed to ensure that two of nine residents reviewed (Residents 6, 7) were free from non-consensual sexual contact, by failing to assess if the residents had the capacity to consent to sexual activity. Findings include: The facility's policy regarding abuse and neglect, dated January 2, 2019, revealed that the facility's leadership prohibited abuse, and were to ensure that alleged violations involving abuse were reported immediately. All new and current employees, including volunteers, were to receive continuous education, training, and reinforcement that identified all aspects of abuse prohibition, including the prompt reporting of allegations without fear of reprisal. All alleged violations of abuse or criminal offense were to be reported immediately to the Administrator/Director of Nursing or Charge Nurse, and to other officals in accordance with state law, including the State Survey Agency (Department of Health). The facility's policy regarding resident sexual expression, dated October 17, 2019, indicated that the facility recognized and supported the older adult's right to engage in sexual activity, so long as there was consent among those involved. Consent may be demonstrated by the words and/or affirmative actions of an older adult with intact decision making ability, and with intact decision making ability who is nonverbal or with [MEDICAL CONDITION] or dementia. The former (intact decision making ability) may require, and the latter (intact decision making ability who is nonverbal or with [MEDICAL CONDITION] or dementia) requires an assessment conducted by the clinical staff, using the facility's Assessing Consent to Sexual Activity guidelines, to confirm that consent was and continues to be given, and to ensure the safety of those involved. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 6, dated April 16, 2020, indicated that the resident was usually understood, could usually understand others, had short and long-term memory problems, moderately impaired decision making ability, required limited assistance from staff for mobility throughout the facility, and had [DIAGNOSES REDACTED]. Resident 6's care plan, dated April 23, 2019, and updated December 10, 2019, indicated that she was at risk for harm due to inappropriate interactions with male residents, that staff needed to be aware that Resident 6 sometimes stated that Resident 7 was her husband, which put her at risk for harm, staff were to closely monitor her interactions with other residents to ensure that both residents were showing signs that they are both enjoying the interactions, and should one of them not appear to be enjoying the interaction staff should use distraction or redirection. An annual MDS assessment for Resident 7, dated May 7, 2020, revealed that the resident had severe cognitive impairment, required minimal assistance with care, and had [DIAGNOSES REDACTED]. Resident 7's care plan, dated November 8, 2019, indicated that he had behaviors, was seeking companionship and intimacy with a woman on the wing, and that staff would monitor for demonstration that the two were both in agreement with the expressions of intimacy. The resident's care plan dated, June 25, 2020, revealed that he had physical behavioral symptoms toward others, potential for seeking physical affection and sexually acting out, and staff would monitor interactions between him and other residents. A nursing note for Resident 6, dated October 17, 2019, at 2:00 p.m. revealed that the nurse witnessed the resident engaging in intimate contact (hugging, holding hands and sitting near each other) with Resident 7, that both parties appeared to be consenting, that no ill affects were noted due to the contact, and staff would continue to monitor and ensure that both residents remained consenting. A nursing note for Resident 7, dated October 17, 2019, at 2:05 p.m. revealed that the resident was observed on several occasions engaging in intimate contact (hugging, holding hands and sitting near each other) with Resident 6, that both parties appeared to be consenting, that no ill effects were noted due to the contact, and staff would continue to monitor and ensure that both residents remained consenting. A nursing note for Resident 7, dated October 17, 2019, at 4:40 p.m. revealed that the resident was observed seeking companionship and intimacy with another resident, and the nurse spoke with the resident's responsible party and told him that it was the resident's right to have a relationship, provided that they were both consenting, that staff would intervene should either resident, at any time, say or show that they no longer consented, and that it was in the resident's care plan. A nursing note for Resident 6, dated October 17, 2019, at 5:08 p.m. revealed that the resident was observed seeking companionship and intimacy with another resident, and the nurse spoke with the resident's responsible party and told him that it was the resident's right to have a relationship, provided that they were both consenting, that staff would intervene should either resident, at any time, say or show that they no longer consenting, and that it was in the resident's care plan. There was no documented evidence that assessments were conducted by the clinical staff, using the facility's Assessing Consent to Sexual Activity guidelines, to confirm that Residents 6 and 7, who were both cognitively impaired, had the capacity to consent to sexual activity. A nursing note for Resident 7 dated June 25, 2020, at 7:21 p.m. revealed that on June 24, 2020, at 2:30 p.m. the resident was observed rubbing Resident 6 on her buttocks, back, neck and lower stomach, that he directed her to sit into a chair and began undoing his pants, but was not successful exposing himself or removing his pants, that no further activity occurred, and that he returned to his room once he was discovered. A nursing note for Resident 6, entered as a late entry on June 29, 2020, and dated for June 25, 2020, at 10:00 a.m. revealed that on June 24, 2020, at 2:30 p.m. the resident was observed being rubbed on her buttocks, back, neck and lower stomach by Resident 7, that he directed her to sit into a chair and began undoing his pants, that no further activity occurred, and that he returned to his room once he was discovered. A nursing note for Resident 7 dated June 28, 2020, at 1:15 p.m. revealed that he walked past a female resident in the dining room, made a sexual advance toward her, the female resident said, no get away from me, and he said, ok I'll try later and walked away. Behavior logs for June 2020 revealed that there was one documented behavior for June 23, 2020, at 3:04 p.m. marked as other behaviors, and there was no documented evidence that behaviors occurred on June 24, 2020, at 2:30 p.m. The facility's investigative documents, dated June 25, 2020, included documentation of interviews by the Acting Nursing Home Administrator and the nursing staff on duty during the shift in question on June 24, 2020. The interviews of three staff revealed that they were told by the Director of Life Enrichment that Resident 7 was touching Resident 6, and that the residents were in the living room and were never alone or unsupervised. A written statement from the Director of Life Enrichment, dated June 24, 2020, at 2:30 p.m. indicated that as she entered the 200 unit she saw down the hall that Resident 7 was vigorously rubbing Resident 6 up and down her bum, back, and front area between her neck and lower part of her stomach. Resident 7 then motioned for Resident 6 to sit in the chair, and as she sat down, he approached her and started to undo his pants. She entered the nursing station and told two nurse aides and the licensed practical nurse what she witnessed. She was told by one nurse aide that it is their right. She and that nurse aide started to walk down the hall, the nurse aide went back to the nursing station, and she continued down the hall. When Resident 7 saw her, he took a couple steps back. The Director of Life Enrichment entered another resident's room and when she left that room, Resident 7 was back in Resident 6's face trying to pull down his pants. He saw her, took a step back, then Resident 7 stated that he did not know what the problem

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) was, there is sex everyday, then he stepped away. She also indicated that, under the former Nursing Home Administrator, staff were told several times in the morning meetings that it was both of the residents' right to have sex if they both agreed, and that they were not to intervene. A psychiatric evaluation completed on June 26, 2020, for Resident 6 contained no documented evidence that an assessment was done to determine if Resident 6 had the capacity to consent to sexual activity. A psychiatric evaluation completed on June 26, 2020, for Resident 7 contained no documented evidence that an assessment was done to determine if Resident 7 had the capacity to consent to sexual activity. There was still no documented evidence that assessments were conducted by the clinical staff, using the facility's Assessing Consent to Sexual Activity guidelines, to confirm that Residents 6 and 7, who were both cognitively impaired, had the capacity to consent to sexual activity. Interview with Registered Nurse 1 on July 6, 2020, at 2:50 p.m. revealed that she was aware that Residents 6 and 7 have been intimate together, that staff were always told by the former Nursing Home Administrator that the residents were allowed, and that several staff were not comfortable with that decision. She indicated that Resident 7 also acts sexually inappropriate toward staff by making sexual statements and grabbing them. Interview with the Dementia Education Partner on July 7, 2020, at 8:50 a.m. revealed that former administration felt that both Residents 6 and 7 were able to consent to sexual activity, and unless they looked as though they were not enjoying the intimacy, they would be permitted to continue. Interviews with the Acting Nursing Home Administrator and Interim Director of Nursing on July 7, 2020, at 11:40 a.m. revealed that they were not made aware of any incidents with Residents 6 and 7 on June 24, 2020, until June 25, 2020, when they started an investigation. The Acting Nursing Home Administrator confirmed that staff were told by former management that it was okay for Residents 6 and 7 to be intimate. She confirmed that both residents had psychiatric evaluations done on June 26, 2020, that revealed they both had severe cognitive impairment, but there was no documented evidence that Residents 6 and 7 were assessed to determine their capacity to consent to sexual activity as referenced in the facility's policy. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(e)(1) Management. 28 Pa. Code 211.10(c)(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(5) Nursing services.
F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, observations and staff interviews, it was determined that the facility failed to ensure that care-planned interventions to prevent falls and/or injury were followed for one of nine residents reviewed (Resident 7). Findings include: An annual Minimum Data Set (MDS) assessment (a mandated assessment to determine a resident's abilities and care needs) for Resident 7, dated May 7, 2020, revealed that the resident was cognitively impaired and required minimal assistance from staff for bed mobility, transfers, and ambulation in the hall and room. physician's orders [REDACTED]. all times (except for hygiene and laundry). Observations of Resident 7 on July 6, 2020, at 12:40 p.m. revealed that the resident was walking in the hallway and dining area using a wheeled walker, and there was no visible evidence that he was wearing hipsters or gerisleeves as ordered. Interview with Nurse Aide 2 on July 6, 2020, at 12:50 p.m. confirmed that Resident 7 was not wearing gerisleeves or hipsters. She indicated that the resident often refuses. Interview with the Director of Nursing on July 6, 2020, 3:10 p.m. confirmed that Resident 7 should have been wearing hipsters and gerisleeves and he was not. She indicated that if the resident was refusing to wear them, this should have been identified and care planned. 28 Pa. Code 211.11(d) Resident care plan. 28 Pa. Code 211.12(d)(5) Nursing services.