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FORM APPROVE
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING _____ B. WING _____	C 09/27/2001

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH OGDEN REHAB CENTER	5865 S WASATCH DR OGDEN, UT 84403

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F 224 SS=K	483.13(c)(1)(i) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. (Use F224 for deficiencies concerning mistreatment, neglect or misappropriation of resident property.) This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility neglected to provide necessary services and supervision to resident 1 to prevent him from exhibiting "sexually inappropriate behaviors" towards other facility residents. The facility had documented in resident 1's medical record that starting 10/00, resident 1 had been continuously monitored by facility staff for "sexually inappropriate behaviors". On 7/23/01 the facility identified sexually inappropriate behavior involving resident 1 and resident 2. From that date, facility staff were put on notice of resident 1's potentially sexually abusive behaviors towards cognitively impaired residents. Three further instances occurred after 7/23/01. On 9/5/01, there was 1 incident of sexually inappropriate behavior involving resident 1 and resident 3. On 9/20/01, there were 2 incidents of sexually inappropriate behavior involving resident 1 and resident 4. (In all incidents, there were no direct observations of the interactions between the residents.) These incidents indicate the facility's failure to put in place necessary services and supervision to adequately intervene in resident 1's facility identified sexually inappropriate behavior. The facility's failure to provide necessary services and	F 224 JCB 10/23/01	F224 As of 09/26/01 resident 1 is no longer in the building and can no longer be considered a danger to any other residents. It should also be reminded that no direct observations of any interactions between the residents were made. The report on 07/23/01 that is referred to was not made in the form of an incident report. It was word of mouth from one person to another and no actual report was ever made in written form except for written nurses's notes that was a late entry and was not made by the actual nurse that was on shift that day that it occurred. Until the report on 09/05/01, there was no indication that a plan of reduction in sexual aggression was needed as there weren't any reports of sexually aggressive reports made. No physical harm, mental anguish or mental illness reports were made. Resident 1 has been noted in the nurses' notes to have made inappropriate sexual remarks daily. These have also been noted on the behavior sheets for this resident. MDS's are being checked for those who may be sexually inappropriate.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 10-18-01

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days aft such information is 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 224	Continued From Page 1 supervision of resident 1 led to a determination of Immediate Jeopardy to residents for neglect. Neglect is defined in Appendix PP of the State Operations Manual as: "Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness". The facility removed the Immediate Jeopardy by discharging resident 1 to an acute psychiatric setting on 9/26/01. (During the survey investigation, no other residents were found who posed a physical or emotional threat to residents.) Findings include: 1. Resident 1 was admitted to the facility on 8/31/87, with diagnoses which included chronic schizophrenia. On 9/27/01, a review of resident 1's medical record revealed the following: a. A MDS was completed for resident 1 on 7/12/01. Facility staff assessed resident 1 as having short and long term memory problems with moderately impaired cognitive skills for daily decision making. Resident 1 was assessed as having the behaviors of wandering, being verbally abusive, and resisting cares. He was not assessed as being socially inappropriate. b. A review of resident 1's comprehensive care plan was done. The care plan was dated May 2001. The care plan included a problem of, "Altered mental status" which was manifest by, "Displays sexual inappropriateness, delusions, [and] hallucinations." The goals for this identified problem did not address the reduction or elimination of sexually inappropriate behaviors. The plan of care interventions did not include strategies for reducing sexually inappropriate behaviors. There was also a psychotropic medication care plan with target behaviors of sexually	F 224	The care plans of all the residents are being reviewed and are being checked for inclusion of strategies for reducing inappropriate behaviors. Behavior sheets have been re-emphasized at inservices to their importance of tracking behaviors in residents and the results of the drugs or strategies used to change these behaviors. Because the county human services caseworker never made his notes on any patients he works with available to the facility for review we were unaware of his feelings that the facility would not be able to prevent resident 1's sexually inappropriate behavior with other residents. The term "opportunistic predator" came to our attention only after the most recent reports were made. No suggestions or questions were posed by him about the manner in which resident 1 was monitored, considering his findings of "opportunistic predator" were known to him long before the facility considered resident 1 so. The TRT has been inserviced with the other employees of the facility to the importance of monitoring and recording all inappropriate behaviors of any	

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F 224	Continued From Page 2 inappropriateness. This care plan was dated May 2001, and was updated on 9/21/01 to include sexual aggression. Prior to 9/21/01, the goals for the identified problem of "Altered mental status" did not address the reduction or elimination of sexually inappropriateness. On 9/21/01, a goal was added to this identified problem that the resident would have a reduction in sexual aggression. Interventions for this identified problem included the administration of medication (Celexa, Seroquel), monitoring of target behaviors every shift, redirection or reality orientation if target behaviors were exhibited, documentation of target behaviors and side effects to medications. On 9/21/01, the approaches were updated to include the use of Ativan and Depo Provera. 2. Facility staff were documenting sexual inappropriate behaviors of resident 1 on his Celexa medication flow sheet. Totaled monthly, as documented on the flow sheets, resident 1 exhibited sexually inappropriate behaviors as follows: January 2001 - 15 February 2001 - 15 March 2001 - 1 April 2001 - 25 May 2001 - 68 June 2001 - 58 July 2001 - 61 August 2001 - 93 9/1 - 9/25 - 14 (For the month of September 2001 there were 14 shifts that were left blank.) 3. An interview was held with resident 1's county human services social worker/case worker on 9/26/01 at 12:30 PM. He stated he had been working with resident 1 for 13 months. He stated that he believed	F 224	resident no matter how long they have been at the facility or what their "usual" behaviors are. The SSW was a new hire in July and would not be aware of any questionable behaviors prior to that point. The DON and SSW meet on a weekly basis to discuss any reports of behaviors that have been made that may have the potential of becoming abusive in nature. The IDT will be informed of these reports and make assessments if they appear to becoming abusive and will determine what strategies will be developed to decrease or stop the behavior. If this included hiring additional help to monitor a resident one on one, then that would be presented to the Administrator for approval. At the time Depo Provera was administered, resident 1 was in a private room on the SNU. With 2 CNA's to manage 14 residents the ratio appeared appropriate for resident 1's closer observations.	

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F 224	Continued From Page 3 resident 1 was an "opportunistic predator". He stated that resident 1 has known the consequences of his actions. The case worker stated he knew resident 1 was aware of the consequences of his behavior because of the great lengths the resident would take to avoid being caught. The case worker stated that he did not feel the facility's staff would be able to prevent resident 1's sexually inappropriate behavior with other residents because resident 1 would watch for any possible opportunity and exploit it. 4. An interview was held with the facility's interdisciplinary team (IDT) on 9/27/01 at 2:30 PM. The IDT consisted of the DON, SSW, therapeutic recreation therapist (TRT), and the food service supervisor (FSS). a. The SSW stated that she had been unaware that resident 1 had sexually inappropriate behaviors toward other residents prior to the 7/23/01 incident involving residents 1 and 2. The other members of the IDT stated that resident 1's sexually inappropriate behaviors were generally verbal, sexually explicit comments to staff members. b. The TRT made the comment that the incidents involving resident 1 and the other residents were probably not considered abuse because, "It was just [resident 1]". She stated that he had been in the facility so long and had sexually inappropriate behaviors toward staff for so long that it did not seem unusual. c. The DON and SSW stated the IDT did not meet to discuss resident 1's behaviors to other residents until after the incident with resident 3 on 9/5/01. The SSW stated that following the 9/5/01 incident, the IDT met	F 224	The nurses have been instructed in inservices that they need to document all assessments of questionable situations in the future. Administrator will monitor all the above to ensure Plan of Corrections are being followed at the monthly QA meeting. Completion Date: October 10, 2001	

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F 224	Continued From Page 4 to discuss possible solutions to resident 1's behaviors. d. The SSW stated she contacted resident 1's county human services social worker/case worker. She stated that the case worker told her that he felt resident 1 was an opportunistic predator. e. The DON stated that an order was obtained to administer Depo Provera to resident 1 to decrease his sexual behaviors. The DON stated that she knew it would take days, and up to a week or so before the Depo Provera would have any effect on resident 1. f. The DON was asked what interventions were put in place to prevent further incidents with resident 1 and other residents until the medication began to work. The DON stated she directed the nurse aide staff to monitor him closely. g. The SSW also stated that she directed the nurse aide staff to watch resident 1 very closely, to not let him out of their sight. h. The DON and SSW were asked how the nursing staff were enabled to increase their monitoring of resident 1 and continue to provide the necessary cares to other residents. Both the DON and SSW stated that no increase in staffing or other changes were made to allow the nurse aide staff to monitor resident 1 more closely. i. The SSW and DON were asked if any assessments of residents 1, 2, 3, 4, or 5 were done when staff found the residents in a potentially abusive situation. The DON and SSW stated they were unaware of any assessments that the nursing staff may have done, and that the IDT did not conduct any assessments of the residents.	F 224		

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F 224	Continued From Page 5 INCIDENTS OF SEXUALLY INAPPROPRIATE BEHAVIOR: Resident 1 was identified through nursing notes, incident reports and staff interviews as being involved in four incidents of sexually inappropriate behavior with three other residents during the period of 7/23/01 to 9/21/01. INCIDENT 1 1. An interview with the facility's Director of Nursing (DON) was held on 9/26/01 at 9:00 AM. The DON stated that resident 1 had an incident with resident 2 sometime during the month of July 2001. The DON stated that resident 1 and resident 2 were roommates on the Special Needs Unit (SNU) at the time of the incident. She stated that during this July incident, a staff member entered residents' 1 and 2 room and found semen on the face of one of the residents' face. 2. A review of resident 1's medical record was done on 9/27/01. The following entry was documented in the resident's nursing notes: "Late Entry 7-23-01 CNA [certified nurse aide] reported finding resident [1] kneeling over another male resident's [2] naked private area, wiping his mouth after an apparent inappropriate sexual encounter. Unable to determine extent of incident because of non-responsiveness from victim, and garbled, evasive replies from resident [1]. Reported probable incident to D.O.N. and SSW, who authorized transfer of [resident 1] to a different room Transferred from room --- with all belongings and cautioned about engaging in inappropriate behaviors and possible consequences."	F 224		

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F 224	Continued From Page 6 This nursing note entry was preceded by another "Late Entry" dated 7/1/01. The nursing note entry prior to these late entries was 8/30/01. This would indicate the 7/23/01 "late entry" was written at least 37 days after the incident between residents 1 and 2 occurred. 3. A telephone interview was held with employee 1 on 10/01/01 at 2:45 PM. She stated she was a CNA and the CNA referenced in resident 1's 7/23/01 nursing note. Employee 1 explained the incident between residents 1 and 2 differently than was described in the nursing note entry. Employee 1 stated on that night, during a graveyard shift, resident 2 walked toward the double doors leading from the SNU. She stated the double doors were open and that she was at the nurse's station. She stated the nurse responsible for the SNU and the other nurse aide assigned to the SNU were also at the nurse's station. Employee 1 stated she went to resident 2 and found he had "semen" on his face. She described it as a white substance. She stated she was certain it was semen. She stated she escorted resident 2 to his room where resident 1 had remained. She stated resident 1 was nude and out of his bed. She stated the door to resident 1 and 2's room was open. Employee 1 stated she requested the nurse to assess resident 2 to verify what she knew was semen on resident 2's face. She stated the nurse, as well as the other nurse aide, refused to assess resident 2. Nurse aide 1 stated she then went to clean resident 2's face. 4. An interview was held with employee 2 on 10/1/01 at 4:50 PM. Employee 2 was the charge nurse the night of 7/23/01. She stated she was the nurse who documented the "Late Entry" nursing note, dated	F 224		

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F 224	Continued From Page 7 7/23/01. She stated that employee 1 informed her that resident 2 had a substance on his face that she characterized as "ejaculate". She stated that she believed that employee 1 also told her that resident 1 was nude at the time. She said that she did not go down to resident 1 and 2's room because "it was supposition; no definite proof". She indicated that she felt that the it was "preposterous" that resident 2 might have had ejaculate on his face. She indicated that resident 2 frequently had food spills on his face that he refused to allow staff to clean. When asked if an incident report had been filled out, she stated she did not recall filling one out. 5. An interview was held with the facility's SSW on 9/26/01 at 9:55 AM. The SSW stated resident 1 was moved to another room following this incident with resident 2 on 7/23/01. The SSW stated that resident 1 was moved into a room with resident 3 as a roommate. She stated that resident 1 was moved in with resident 3 because resident 3 had aggressive behaviors and would not tolerate unwanted sexual advances. The facility's Administrator was present when the SSW made these comments and confirmed that resident 1 was placed with resident 3 for the reasons identified by the SSW. 6. On 10/01/01, the DON faxed a copy of an investigation of resident 1 to the State Survey Agency. The following information was documented in investigation report:	F 224		

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"As reported on July 23, 2001 between 11-11:30 p.m. by [employee 1]. She was sitting in the hall, [resident 2] came to the door of their room (he and [resident 1] were sharing the room) and he had what appeared to her to be semen on his face. She took him back into his room. At that time she found [resident 1] wandering around the room naked (as is usual for [resident 1]). She left (resident 2) there and reported her findings to [employee 2]. The nurse felt it was not necessary to investigate and [employee 1] cleaned him up. When [employee 1] asked [resident 2] what happened, he replied, 'are you going to kill me?' (a usual response from [resident 2]). When [resident 1] was questioned, he said nothing at all. [Resident 2] did have his pants and brief on and [resident 1] was naked as stated previously.

[Resident 1] was moved into [resident 3]'s room because it was closer to the middle of the unit and the CNAs could keep a better watch on him there. As well as [resident 3] was known to be combative when anyone approached him in any way."

7. On 9/27/01, the SSW and DON stated they were unable to locate an incident report for the incident which occurred on 7/23/01, between residents 1 and 2. Each of these staff members stated they believed an incident report was not completed.

8. Resident 2, the resident involved in the 7/23/01 incident, was admitted to the facility on 6/1/96 with diagnoses that included schizophrenia, organic brain syndrome, and seizure disorder.

On 9/27/01, a review of resident 2's medical record revealed the following:

a. An MDS (minimum data set) comprehensive

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F 224	Continued From Page 9 resident assessment, dated 6/21/01, documented that resident 2 had short and long term memory problems and that his cognitive skills for daily decision making were severely impaired. Resident 2 was assessed as having unclear speech which was slurred with mumbled words and that he was not always able to be understood. This assessment further documented that resident 2's cognitive status had deteriorated since the last assessment dated 3/29/01. b. A review of the nurse's note section revealed that there was no documentation of the 7/23/01 incident between resident 1 and resident 2. There was no documentation that resident 2 had been assessed for any injuries or problems following the incident. c. A review of the physician's progress note section revealed that resident 2 had been seen by his attending physician on 7/11/01, prior to the 7/23/01 incident. The next physician's progress note found in resident 2's medical record was dated 9/13/01. There was no physician's progress note regarding an assessment after the 7/23/01 incident found in resident 2's medical record. d. A review of the social progress notes section revealed that there was no documentation of the 7/23/01 incident between resident 1 and resident 2. INCIDENT 2 1. An interview with the facility's Director of Nursing (DON) was held on 9/26/01 at 9:00 AM. The DON stated that resident 1 had an incident with resident 3 sometime at the end of August or first part of September, 2001. The DON stated that resident 1 and resident 3 were roommates on the Special Needs Unit (SNU) at the time of the incident.	F 224		

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The DON stated that at the time of this incident, employee 3 had entered residents' 1 and 3 room and found both residents with their pants off. She stated employee 3 observed fecal material on one of the residents' bedding and that resident 3 was observed by staff to have blood in his underpants.

2. A review of resident 1's medical record was done on 9/27/01. The following entry was documented in the resident's nursing notes:

a. "9/7/01 @ 0840 A [8:40 AM] out of order charting for 9/5/01 @ 1540 p [3:40 PM]. A staff member [employee 3] came to report incident of this resident [and] other peer resident [resident 3]. Housekeeper [employee 3] came to nursing staff member because this resident [1] was in peer's [resident 3] side of room [and] was wiping B.M. (fecal matter) from the end of penis - Peer roommate [resident 3] was lying on his own bed with back to door and facing outside wall of room - Resident [1] who was standing was redirected [and] incident was reported to another staff employee [employee 4]- Employees [3 and 4] went to social service employee [and] DON - resident [1] was moved to a private room @ end of hall - with close monitoring."

b. The following nursing note entry, dated 9/7/01, documented, "1400 [2:00 PM] out of order charting for 9/5/01. Cont'd [continued] - Concern [with] resident's [1] [increased] sexual outbursts brought to the attention of [county human services social worker] will continue to monitor behaviors."

c. A nursing note entry date 9/6/01 documented, "Dr [resident 1 and 3's attending physician] called with concern over [increased] sexual outburst - new order for depro provera [Depo Provera] 150 mg [milligrams]

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F 224	Continued From Page 11 IM [intramuscular] ASAP [as soon as possible]...Depro provera IM given as ordered....will continue to monitor behavior." 3. Employee 3 completed an incident report regarding the incident between residents 1 and 3. The incident report was dated 9/5/01 and documented: "I [employee 3] was going into their [residents 1 and 3] room to deliver the clean laundry. I saw [resident 3] walking away from [resident 1's] bed pulling up his pants [and] [resident 1] was standing up on the side of his bed cleaning his bedspread [and] a pair of pants that were laid out on his bed. Then he [resident 1] hung the pants in his closet. As I was walking out [resident 1] told [resident 3] 'Hey how about we ask her to come [and] sit with us.' I then told [employee 4] what I saw [and] she asked [resident 1] what happened [and] he [resident 1] said 'It's none' of her business, he can do what he wants to [resident 3]. On the floor on the side of [resident 1]'s bed was a piece of toilet paper that had bowel movement on it. That's when [employee 4] and I told the social worker." Employee 3 documented the incident occurred on 9/5/01 at 1:20 PM. 4. An interview with employee 3 was held on 9/27/01 at 2:13 PM. Employee 3 stated she was currently working as a nurse aide but that she used to work in the laundry department. She stated she worked in the laundry department on 9/5/01, when she observed the documented incident between residents 1 and 3. At the time of the incident, she stated she entered resident 1 and 3's room. The two nurse aides working on the SNU, employee 4 and employee 5, were assisting other residents in resident rooms. She stated they were not in the hallway of the SNU. She stated she observed resident 3 walking away from resident 1's	F 224		

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F 224	Continued From Page 12 bed, pulling up his pants and incontinence briefs. She stated resident 1 was standing by his bed, dressed and cleaning a pair of pants and his bedding with a tissue. She stated she hung up the clothes that she was delivering and that when she turned to leave the room, resident 1 stated, "How about we ask her to come sit with us too." She stated resident 1 was laughing when he made the comment. Employee 3 indicated she left resident 1 and 3's room to find employee 4, who was in the resident room next door, with the door closed. Employee 3 stated employee 4 followed her into resident 1 and 3's room at which point, there was a tissue on the floor, next to resident 1's bed with fecal material on it. Employee 3 indicated that employee 4 asked resident 1 what had happened. Resident 1 replied that it was none of her business, that he could do what he wanted with resident 3. Resident 1 then threatened to hit employee 4, stating he would knock her head off her shoulders. Employee 3 stated she and employee 4 left the room to inform the social worker, who was at the nursing station. Employee 3 stated that residents 1 and 3 remained in their room when they went to talk to the social worker. Employee 3 stated that she had entered resident 1's room on several occasions to find him masturbating, but that she had never observed him in a sexually inappropriate situation with another resident. She stated that a few days prior to 9/5/01, resident 1 asked her to come into his room for a "secret kiss". 5. An interview was held with employee 4 on 9/27/01 at 1:35 PM. Employee 4 stated she was a CNA. Employee 4 was asked if she was aware of an incident between resident 1 and 3 that occurred on 9/5/01.	F 224		

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F 224	Continued From Page 13	F 224		

Employee 4 stated she was and proceeded to discuss what occurred. Employee 4's description of what occurred was similar to the events described by employee 3. There were a few notable exceptions.

Employee 4 stated that when she and employee 3 left resident 1 and 3's room, resident 3 had left the room and was sitting on a chair in the hallway of the SNU. Employee 4 stated the incident occurred at the end of her shift and that she did not see resident 1 or 3 after she left to inform the social worker. She stated she had heard from another nursing staff member that resident 3 was noted to have blood in his stool, later in the day.

6. An interview with employee 5 was held on 9/26/01 at 10:46 AM. Employee 5 stated she was a CNA and that she worked only on the SNU in the facility. Employee 5 indicated that she was familiar with resident 1 and was aware that staff were to monitor him closely because he had sexually inappropriate behaviors.

Employee 5 stated the facility utilized two nurse aides for the SNU each shift. She stated whenever she worked, she and the other nurse aide would ensure that one of them remained in the hallway of the SNU to monitor resident 1's whereabouts.

Employee 5 stated there were times when both nurse aides, assigned to the SNU, were occupied in resident rooms providing activity of daily living (ADL) cares. At those times, employee 5 stated, staff would be unable to monitor resident 1's location.

7. An interview with employee 10, a facility charge nurse, was held on 9/27/01 at 2:00 PM. Employee 10 stated that she had never observed resident 1 being sexually inappropriate with another resident. She

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F 224	Continued From Page 14 stated she had received report about an incident between resident 1 and 3 and was asked to write a nursing note to describe the incident. She stated she did document the incident, but that it was not done on the day of the incident. 8. On 9/27/01, a review of resident 1's medical record revealed social service progress notes. A progress note, dated 9/7/01 documented the following: "SW [social worker] was notified on 9/5/01 of a suspected inappropriate sexual encounter between [resident 3 and resident 1]. [Resident 1]'s room has been changed and he no longer has a roommate. SW was unable to contact a family member for [resident 1], due to lack of a current phone number. However, SW did speak [with] --- [county human services social worker/case worker for resident 1]. Case worker has agreed to discuss [resident 1]'s behaviors with Pt [patient] and inform him that if the inappropriate behaviors continue [resident 1] may need to be considered for removal to the [state owned psychiatric facility]. Dr --- [resident 1's attending physician] was notified and has prescribed a chemical restraint for [resident 1] in an effort to curb further sexually inappropriate behaviors." A social work progress note, dated 9/13/01 documented, "[City police department] notified of the incident on 9/5/01. SW met [with] officers [names of officers] discussed incident between [resident 1] and [resident 3]....Suggested we watch [resident 1] closely and keep him seperate from other residents." 9. An interview was held with the facility's SSW on 9/26/01 at 9:55 AM. The SSW stated resident 1 was moved to a private room, on the SNU, on 9/5/01. She stated the new room had a private bathroom as well.	F 224		

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F 224	Continued From Page 15 10. On 10/01/01, the DON faxed a copy of an investigation of [resident 1] to the State Survey Agency. The following information was documented in investigation report: "On September 5, 2001 it was reported by [employee 3] that as she was delivering clean clothing to [resident 3]'s room she saw [resident 3] walking away from [resident 1]'s bed, pulling up his pants. His pants were just below his stomach. [Employee 3] stated in an interview on October 1, 2001 that he 'probably' had a brief on and was pulling at his pants. [Resident 1] was standing up at the side of his own bed. [Resident 1] was completely clothed. [Resident 1] was cleaning the bedspread and a pair of pants that were laid out on the bed with a piece of toilet paper. Then he took the pants and hung them in the closet. As she was walking out of the room [resident 1] said to [resident 3], 'Hey how about we ask her to come sit with us?' Then [employee 3] told [employee 4] what she saw and [employee 4] asked [resident 1] what had happened. He said it's none of her business, he can do what he wants to [resident 3]. On the floor on the side of [resident 1]'s bed was a piece of toilet paper that had bowel movement on it. [Employee 4] and [employee 3] reported this to the social worker. ... The social worker also called [county human services social worker/case worker]. She told him about the report that had been received about [resident 1]'s behavior. She told him that Dr [resident 1's attending physician] had prescribed DepoProvera and asked him to talk to his supervisors about any suggestions on what to do with [resident 1]. [County human services social worker/case worker]'s response was that [resident 1]'s next stop was the State Hospital. [County human services social worker/case worker] stated that [resident 1] was an opportunistic predator, however there is no written documentation in [resident	F 224		

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F 224	Continued From Page 16 1]'s chart which indicates any such concern. [County human services social worker/case worker] was supposed to get back to the social worker, but never did...." 11. Resident 3, the resident involved in incident 2, was admitted to the facility on 5/18/01 with diagnoses that included Alzheimer's disease, hypertension, and diabetes mellitus. On 9/27/01, a review of resident 3's medical record revealed the following: a. A MDS comprehensive resident assessment, dated 8/23/01, documented that resident 3 had short and long term memory problems and that his cognitive skills for daily decision making were moderately impaired. b. A review of the nurse's notes section revealed that there was no documentation of the 9/5/01 incident between resident 1 and resident 3. There was no documentation that resident 3 was assessed for any bleeding problems or injuries following the incident. c. A review of the physician's progress note section revealed no documentation that resident 3 had been seen by his attending physician since 8/28/01. d. A review of the social progress notes revealed a note, dated 9/5/01, that documented, "SW spoke on telephone [with] ---[relative of resident 3], about a suspected incident of inappropriate sexual behavior between [resident 1 and resident 3]. SW answered [relative of resident 3] questions and notified him of removal of [resident 1] as [resident 3]'s roommate. SW was notified by CNA and Laundry aide of this incident. A report was completed and faxed to APS [Adult Protective Services]. SW also spoke [with]---[county human services social worker/case	F 224		

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F 224	Continued From Page 17 worker] for [resident 1] regarding this incident. DON and administration were notified." INCIDENTS 3 and 4 1. An interview with the facility's Director of Nursing (DON) was held on 9/26/01 at 9:00 AM. The DON stated that resident 1 had an incident with resident 4 in the past week or two. The DON stated that resident 1's room was located next to resident 4's room, on the SNU, at the time of the incident, and the residents have remained in the same rooms since the incident. She stated a staff member entered resident 4's room to find resident 1 standing, nude, next to resident 4's bed. Resident 4's pants and under pants were off as well. When the staff member entered the room, resident 1 ran out of the room and into his room. 2. A review of resident 1's medical record was done on 9/27/01. The following entry was documented in the resident's nursing notes, "9/21/01 7A - 7P - CNA [employee 6] reports that pt was found in a female resident's rm [room] [with] [no] pants on and the CNA found one of the female residents [with] her brief down around her ft [feet] - pt. states to [employee 6] that he was saying hello to his 'mother' - will cont [continue] to monitor." A nursing note entry documented, "9/21/01 2100 [9:00 PM] Dr [resident 1's attending physician] notified He ordered Depo-Provera 150 mg [times] 1 tomorrow. Ativan 1 mg po [by mouth] [every four hours] PRN [as needed]. 3. Employee 7, a nurse aide, completed an incident report for an incident involving residents 1, 4, and 5.	F 224		

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F 224	Continued From Page 18 The incident report was dated 9/21/01 at 9:50 PM and documented: "When I got in the room [resident 4 and 5's room] which is [resident 4 and 5]'s room, I saw [resident 1] naked standing behind the curtain next to [resident 5]'s bed. He said 'I just want to say hi to ---' I was not sure what name he mention - and he ran out of the room - I checked [resident 5], [resident 4], they just lay there with the cover on. [Resident 5] was awake, [resident 4] was sleeping. I didn't notice any strange so I got out and went through the hall to check all the residents, it took me about 10 min [minutes]. After finished the round I came out and told [employee 8]." 4. Employee 6, a nurse aide, completed an incident report for an incident involving residents 1 and 2. This incident report was signed by employee 9, a charge nurse. The incident report was dated 9/20/01 at 10:00 PM and documented, "CNA walked into [resident 4]'s room on last rounds to find [resident 1] completely naked and [resident 4] standing at the end of her bed [with] her brief around her ankles." 5. A telephone interview was held with employee 6, a nurse aide, on 10/3/01 at 8:30 AM. Employee 6 stated she was working with employee 7 when two incidents occurred between resident 1 and resident 4. She stated that it was at the end of their 2:00 PM to 10:00 PM shift. She stated that she had left the building to empty the garbage and while returning to the SNU, employee 7 was informing the charge nurse (employee 8) that resident 1 was in resident 4's room and naked. Employee 6 stated that she immediately went onto the SNU, as she thought the incident had just occurred. As she entered the doors to the SNU, she stated resident 1 ran out of resident 4's room and into his own	F 224		

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F 224	Continued From Page 19 room. Resident 1 was nude. Employee 6 stated she entered resident 4's room, the door to which was open, to find resident 4 standing at the foot of her bed with her briefs around her ankles. She stated resident 4 was holding onto the foot board of her bed. Employee 6 indicated that she assessed resident 4 for signs of bruising or redness and found none, then pulled the briefs up and assisted the resident into bed. Employee 6 stated she then entered resident 1's room and asked him what had happened, to which resident 1 replied, "I went to say hello to my mother." Employee 6 stated she then reported the incident to employee 8. 6. A telephone interview was held with employee 9 on 10/3/01 at 9:00 AM. Employee 9, a charge nurse, stated that she was not working the night of the two incidents between residents 1 and 4. Employee 9 stated that on 9/21/01, she received a report that resident 1 had been found, nude, in resident 4's room on two occasions the night before. She stated she was informed the incidents occurred about 10 minutes apart. She stated she looked for documentation of the incidents and could find no nursing notes or incident reports. Employee 9 stated she instructed employee 6 to complete an incident report about what employee 6 observed. She stated she signed the incident report that employee 6 completed. She stated the incident report was dated 9/20/01, because that was the date of the incident. Employee 9 stated she documented the incidents in resident 1's nursing notes since employee 8 had not done so. 7. On 10/01/01, the DON faxed a copy of an	F 224		

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F 224	Continued From Page 20 investigation of [resident 1] to the State Survey Agency. The following information was documented in investigation report: "On September 20, 2001 a report was received that at approximately around 10 p.m. [employee 7] stated that she started rounds and when she walked into [resident 4] and [resident 5]'s room she saw [resident 1] in there naked. He was standing behind the curtain next to [resident 5]'s bed. He said to her, 'I just want to say hi to ____' and he ran out of the room. She checked [resident 5] and [resident 4] and they were both OK lying on their beds, covered with blankets. [Resident 5] was awake and [resident 4] was asleep. She finished her rounds and went out and told [employee 8] about the situation. [Employee 8] told [employee 6] to go check on them ([resident 5 and resident 4]) and when she went back to the room, she found [resident 1] completely naked and [resident 4] standing at the foot of her bed with her brief around her ankles. It is not uncommon for [resident 4]'s brief to slip off her when she stands." 8. Resident 4, the resident involved in incidents 3 and 4, was admitted to the facility on 8/5/95 with diagnoses that included dementia. On 9/27/01, a review of resident 2's medical record revealed the following: a. A MDS quarterly resident assessment, dated 7/12/01, documented that resident 4 had short and long term memory problems and that her cognitive skills for daily decision making were severely impaired. b. A review of the nurse's note section revealed that there was no documentation found of the 9/20/01 incident between residents 1 and 4. There was no documentation that resident 4 had been assessed for any injuries or problems following the incident.	F 224		

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F 224	Continued From Page 21 c. A review of the physician's progress note section revealed that resident 4 had not been seen by her attending physician since 8/8/01. d. A review of the social progress notes section revealed that there was no documentation of the 9/20/01 incident between residents 1 and 4.	F 224		
F 226 SS=K	483.13(C)(1)(i) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. (Use F226 for deficiencies concerning the facility's development and implementation of policies and procedures.) This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to operationalize and fully implement policies and procedures when allegations of sexual abuse involving residents 1, 2, 3, and 4 were made. The facility failure is as follows: 1. Facility staff failed to identify the incident between residents 1 and 2, which occurred on 7/23/01, and the incidents between residents 1 and 4, which occurred on 9/20/01, as potential sexual abuse; 2. Facility staff failed to fully investigate 4 instances of alleged resident to resident sexual abuse which occurred between 7/23/01 and 9/20/01;	F 226		

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F 226	Continued From Page 22 3. Facility staff failed to provide immediate protection to potential abuse victims while investigation into the allegations were underway in 3 instances of alleged resident to resident sexual abuse which occurred 7/23/01 and 9/20/01; 4. Facility staff failed to assess potential abuse victims for possible injury in 3 instances of alleged resident to resident sexual abuse which occurred 7/23/01 and 9/20/01; and, 5. The facility failed to notify the State Survey Agency, and Adult Protective Services or local law enforcement, immediately following the receipt of an allegations of resident to resident sexual abuse which occurred on 7/23/01 and 9/20/01. On 7/23/01, the facility identified sexually inappropriate behavior involving residents 1 and resident 2. From that date, facility staff were put on notice of resident 1's potentially sexually abusive behaviors towards cognitively impaired residents. Three further instances occurred after 7/23/01. On 9/5/01, there was 1 incident of sexually inappropriate behavior involving resident 1 and resident 3. On 9/20/01, there were 2 incidents of sexually inappropriate behavior involving resident 1 and resident 4. (In all incidents, there were no direct observations of the interactions between the residents.) The facility's failure to implement policies and procedures to identify potential resident to resident sexual abuse, to fully investigate these allegations of abuse, to provide protection to residents from further risk of abuse, and to report these allegations of abuse to appropriate authorities, led to a determination of Immediate Jeopardy to residents. The facility removed the Immediate Jeopardy by discharging	F 226 MB 10/23/01	F226 Inservices have been held the day after the surveyors' exit and on a weekly basis until all employees have attended exit concerning abuse: what it is; when to report it; who to report it to; what to do after reporting it; and then what happens after those reports are made. All employees of the facility have been in attendance to at least one of these inservices including employees 1 through 10. Each new employee, as they are oriented to the facility are inservices as well. The staff was also inservices on what to do immediately if a suspected abuse has been reported. Late entries were acceptable, but that entries made into the nurses' notes at the time the incident occurred are the best form of reporting. Those notes on the incident report and in the nurses' notes are to include only factual findings and no speculation or guesses. The charge nurse is required to go to the room of the resident and do a thorough exam of the situation including those involved so as to make an accurate report and be able to take appropriate corrections of the situation.	

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F 226	Continued From Page 23 resident 1 to an acute psychiatric setting on 9/26/01. (During the survey investigation, no other residents were found who posed a physical or emotional threat to residents.) Findings include: Between 7/23/01 and 9/20/01, facility staff observed resident 1 on four occasions with three different residents to be involved in circumstances that had a potential to be sexually abusive in nature. (Refer to Tag F-224.) 1. A telephone interview with employee 1 was held on 10/1/01 at 2:45 PM. Employee 1 stated that on 7/23/01, she observed resident 2 in the hallway of the Special Needs Unit (SNU) with semen on his face. She stated that when she assisted resident 2 to his room, his roommate, resident 1, was nude. Employee 1 stated she left resident 2 in the room with resident 1 and went to the nursing station to report the incident to the charge nurse (employee 2). Employee 1 stated she asked employee 2 to come to the residents' room to verify what she knew was semen on resident 2's face. She stated employee 2 refused to assess resident 2. Employee 1 stated the incident occurred during the graveyard shift and that there was herself, one other nurse aide, and employee 2 on duty. She stated the other nurse aide and employee 2 were at the nursing station when the incident occurred. 2. A telephone interview was held with employee 2 on 10/1/01 at 4:50 PM. Employee 2 stated that she was the charge nurse on 7/23/01, when an incident occurred between residents 1 and 2. Employee 2 stated that employee 1 informed her that resident 2 had a substance on his face that she	F 226	The monitoring that occurs on a regular basis has continued with the CNA's making observations every shift on each resident that is on any psychotropic medications and/or have behaviors that are abnormal and need to be monitored. If the situation merits, the charge nurse designates a CNA or other individuals to monitor specific residents on a one to one basis to ensure the safety of all the residents. All incident reports are being tracked for potential abuse and routed through the SSW. All incident reports are also being noted in the nurses' notes. These reports are being routed by the Safety Committee Chairman to the SSW. The facility has further implemented those parts of the policies and procedures that hadn't been followed closely concerning abuse. These would include reports made within one working day of the occurrence, and letting the appropriate agencies know of the reports. Also the assessments of the residents involved, both the alleged perpetrator and the victim are being made. The Administrator has been informed of the need to notify the appropriate state agencies in the absence of the DON and the SSW.	

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F 226	Continued From Page 24 characterized as "ejaculate". She stated she believed employee 1 also informed her that resident 1 was nude at the time. Employee 2 stated she did not go down to resident 1 and 2's room because "it was supposition; no definite proof". Employee 2 stated that it was "preposterous" that resident 2 might have had ejaculate on his face. Employee 2 stated that she did not complete an incident report for the incident. She also stated she did not document the incident in resident 1's medical record. She stated she made a late entry nursing note sometime after the occurrence. (Per record review, the late entry for the incident occurred sometime after 8/30/01.) 3. A telephone interview was held with employee 6, on 10/3/01 at 8:30 AM. Employee 6 stated she was working with employee 7 and employee 8 when two incidents occurred between resident 1 and resident 4. Employee 6 stated that the incident occurred at the end of their 2:00 PM to 10:00 PM shift. She stated that she had left the building to empty the garbage and while returning to the SNU, employee 7 was informing the charge nurse (employee 8) that resident 1 was in resident 4's room and naked. Employee 6 stated that she immediately went onto the SNU, as she thought the incident had just occurred. As she entered the doors to the SNU, she stated resident 1 ran out of resident 4's room and into his own room. Resident 1 was nude. Employee 6 stated she entered resident 4's room, the door to which was open, to find resident 4 standing at the foot of her bed with her briefs around her ankles. She stated resident 4 was holding onto the foot board	F 226	There is training on the care and treatment of those residents on the SNU. This training will include what to do in potentially abusive situations and how to manage those residents who may be sexually abusive. This would include one on one staffing for the resident who is suspected of being abusive in any form. There have been requests made to the county human services to have access to those notes made by the county human services social worker who works with any of our residents so that we can be as informed as they on the potentially abusive residents before situations occur. Any suspected abuse that has been reported to the facility will be followed by interviews of the employee making the report as well as potential witnesses. Also the resident will be interviewed if they are able. Actual quotes will be used in the reports and the facts will be entered, as assumptions will not be documented.	

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F 226	Continued From Page 25 of her bed. Employee 6 indicated that she assessed resident 4 for signs of bruising or redness and found none, then pulled the briefs up and assisted the resident into bed. Employee 6 stated she reported the incident to employee 8. Employee 6 stated that she had been employed at the facility since May 2001, and that she had received no specific training on how to monitor resident 1's behaviors. 4. A telephone interview was held with employee 9 on 10/3/01 at 9:00 AM. Employee 9, a charge nurse, stated that she was not working the night of the two incidents between residents 1 and 4. She stated that on 9/21/01, she received a report that resident 1 had been found, nude, in resident 4's room on two occasions the night before. She stated she was informed the incidents occurred about 10 minutes apart. Employee 9 stated she looked for documentation of the incidents and could find no nursing notes or incident reports. She stated she instructed employee 6 to complete an incident report about what employee 6 observed. Employee 9 stated she signed the incident report that employee 6 completed. She stated the incident report was dated 9/20/01, because that was the date of the incident. Employee 9 stated she documented the incidents in resident 1's nursing notes since employee 8 had not done so. 5. An interview with employee 10, a facility charge nurse, was held on 9/27/01 at 2:00 PM. Employee 10 stated that she had never observed resident 1 being sexually inappropriate with another resident. Employee 10 stated she had received report about an incident between resident 1 and 3 and was asked to write a nursing note to describe the incident. She	F 226	During the investigation the resident and their family will be free of fear of reprisal from the accused. It is important to note that an interview with employee 5 was held in which she informed the DON and the SSW that resident 1 has never been seen to have an erection. He may have been masturbating, but no erection was noted. Administrator will monitor at monthly QA meeting to ensure Plan of Correction are followed. Completion Date: October 10, 2001	

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F 226	Continued From Page 26 stated she did document the incident, but that it was not done on the day of the incident. 6. An interview was held with the facility's DON and SSW on 9/27/01 at 10:45 AM. When asked about late entry documentation that occurred following incidents involving resident 1, the DON stated the licensed nurses did not know they needed to also document the incidents in the nursing notes, believing that the incident reports were the only documentation needed. The DON stated that she became aware of the nurses' misperceptions because she frequently came across incident reports and found no corroborating nursing notes. The SSW stated that she had never seen an incident report for the incident between resident 1 and resident 2 that occurred on 7/23/01. She also stated that she was still trying to get the incident reports from the staff who observed the incidents that occurred 9/20/01 between residents 1 and 4. 7. An interview was held with the facility's interdisciplinary team (IDT) on 9/27/01 at 2:30 PM. The IDT consisted of the DON, SSW, therapeutic recreation therapist (TRT), and the food service supervisor (FSS). a. The SSW stated that she had been unaware that resident 1 had sexually inappropriate behaviors toward other residents prior to the 7/23/01, incident involving residents 1 and 2. The other members of the IDT stated that resident 1's sexually inappropriate behaviors were generally verbal, sexually explicit comments to staff members. b. The TRT made the comment that the incidents involving resident 1 and the other residents were	F 226		

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F 226	Continued From Page 27 probably not considered abuse because, "It was just [resident 1]". She stated that he had been in the facility so long and had sexually inappropriate behaviors toward staff for so long that it did not seem unusual. c. The DON and SSW stated the IDT did not meet to discuss resident 1's behaviors to other residents until after the incident with resident 3 on 9/5/01. d. The SSW stated that following the 9/5/01 incident, the IDT met to discuss possible solutions to resident 1's behaviors. She stated she contacted resident 1's county human services social worker/case worker. She stated that the case worker told her that he felt resident 1 was an opportunistic predator. e. The DON stated that an order was obtained to administer Depo Provera to resident 1 to decrease his sexual behaviors. The DON stated that she knew it would take day, and possibly up to a week or so before the Depo Provera would have any effect on resident 1. f. The DON was asked what interventions were put in place to prevent further incidents with resident 1 and other residents until the medication began to work. The DON stated she directed the nurse aide staff to monitor him closely. g. The SSW also stated that she directed the nurse aide staff to watch resident 1 very closely, to not let him out of their site. h. The DON and SSW were asked how the nursing staff were enabled to increase their monitoring of resident 1 and continue to provide the necessary cares to other residents. Both the DON and SSW stated that no increase in staffing or other changes were made to allow the nurse aide staff to monitor resident 1 more	F 226		

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F 226	Continued From Page 28 closely. i. The SSW and DON were asked if any assessments of residents 1, 2, 3, 4, or 5 were done when staff found the residents in a potentially abusive situation. The DON and SSW stated they were unaware of any assessments that the nursing staff may have done, and that the IDT did not conduct any assessments of the residents. j. The SSW stated that the State Survey Agency and Adult Protective Services were not contacted following the incident with residents 1 and 2 on 7/23/01, or either of the two incidents with residents 1 and 4 on 9/20/01. She stated the only incident that was called to the State Survey Agency and Adult Protective Services, was the incident between residents 1 and 3, which occurred on 9/5/01. 8. A review of resident 2's medical record was done on 9/27/01. (Resident 2 was the resident identified in the 7/23/01 sexually inappropriate behavior of resident 1.) Resident 2's medical record contained no documentation of the incident between him and resident 1 which occurred on 7/23/01. There were no assessments of resident 2 that would have indicated staff investigated a potentially sexually abusive incident. There was no documentation in resident 2's medical record that would indicate staff provided protection to the resident while conducting an investigation into the incident. (Facility staff did move resident 1 out of resident 2's room, however there was no other measures documented to indicate staff protected resident 2.)	F 226		

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F 226	Continued From Page 29 9. A review of resident 4's medical record was done on 9/27/01. (Resident 4 was the resident identified in the two 9/20/01 sexually inappropriate behaviors of resident 1.) Resident 4's medical record contained no documentation of the incidents between her and resident 1 which occurred on 9/20/01. There were no assessments of resident 4 that would have indicated staff investigated these potentially sexually abusive incidents. There was no documentation in resident 4's medical record that would indicate staff provided protection to the resident while conducting investigations into these incidents. 10. A review of resident 3's medical record was done on 9/27/01. (Resident 3 was the resident identified in the 9/5/01 sexually inappropriate behavior of resident 1.) Resident 3's medical record contained a social service progress note, dated 9/5/01, which documented that the resident's son, Adult Protective Services, and a county human services social worker/case worker were notified of the incident between resident 1 and 3 that occurred on 9/5/01. There were no assessments of resident 3 that would have indicated staff investigated a potentially sexually abusive incident. 11. A review of resident 1's medical record was done on 9/27/01. Facility nursing staff failed to immediately document potentially sexually abusive incidents in resident 1's medical record.	F 226		

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F 226	Continued From Page 30 a. The incident which occurred on 7/23/01, involving residents 1 and 2, was not documented until after 8/30/01. (The incident, as described in the nursing note, differed from the incident described in interviews of the staff who observed it.) b. The incident which occurred on 9/5/01, involving residents 1 and 3, was not documented until 9/7/01. The nursing note that was documented on 9/7/01, was written by a nurse that did not observed the incident. c. The two incidents which occurred on 9/20/01, involving residents 1 and 4, were not documented immediately. The incidents were documented on 9/21/01, by a nurse (employee 9), who was not working the time of the incidents. 12. The facility's Director of Nursing (DON) provided a copy of the facility's "Anti-Abuse Policy For Residents" on 9/27/01. The policy contained the following direction to facility staff: a. "...Training New Employees and Continuing Education For All Facility Employees As part of each employee's general orientation upon hire to this facility, training will be given by the Staff Developer regarding the types of abuse, how to recognize possible abuse, how to report suspected abuse by co-workers or patient-to-patient, or family-to-patient abuse, and how to protect the residents in this facility from possible abusive actions taken against them...." b. "...When Should Abuse Be Reported? All suspected abuse must be reported to the supervisor on shift at the time of the incident is noted. If a staff	F 226		

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member suspects some form of abuse toward a resident and they do not report it--they will also be held accountable for their actions. At the time of general orientation, all new employees will be instructed to report any type of abuse noted immediately to their supervisor."

c. "Who Should Suspected Abuse Be Reported To Within The Facility?

All employees within this facility have an immediate supervisor when they are on shift. Each department has a Dept. Head who is the general supervisor over that particular department. During the time when a Dept. Head is not on duty, a staff member is designated to be the responsible supervisor. This person is generally the charge nurse or the Nursing Supervisor. When a case of suspected abuse is noted by an employee, they must immediately report it to their Depart. Head or the nursing supervisor.

Once the employee has reported the suspected abuse to their supervisor, they will be requested to put on writing what they saw and/or heard as part of the facility investigation."

d. "What Outside Agencies Must Be Notified Of The Suspected Abuse?"

All allegations of suspected abuse must be investigated within the facility, but must also be called in to the State Health Department survey division. The investigation must begin immediately once the allegation has been made. The investigation may not be complete when the DOH [Department of Health] has been notified, however the immediate findings must be shared as soon as possible. The notification may be made by the facility Social Worker, or their in their absence, the Director of Nursing or facility

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F 226	Continued From Page 32 Administrator. This call needs to be made within one working day from receiving the allegation. Other agencies that must also be notified are the area Ombudsman, Adult Protective Services, and the local police if the suspected abuse results in actual physical harm...." e. "How Should The Suspected Abuse Be Investigated Within The Facility? Once the suspected abuse has been reported to the immediate supervisor, the facility Director of Nursing, facility Social Worker, and the facility Administrator must be notified. The employee placing the report must be interviewed and their response written down on the abuse form that the facility provides. The patient must also be interviewed and their response documented as well. Any bruising or unexplained injury must be noted and documented. If there were any witnesses to the suspected abuse incident, such as a roommate or another employee, they will be interviewed and responses documented. Document actual quotes from the patient and the witnesses regarding the incident. Do not document your own assumptions, only actual facts. Documentation in the patient record must be factual as to the incident and descriptive as to any injuries or bruising. Patient quotes may also be documented...." f. "...Protection Of The Alleged Abuse Patient During The Investigation During the investigation, the patient and their family must be free of fear of reprisal from the accused. The accused will not be allowed to visit or discuss the abuse charges with the resident unless the patient and family agree and the visit is supervised by the family	F 226		

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F 226	Continued From Page 33 and facility DON, SSW, or Administrator...."	F 226		