

COMMONWEALTH OF KENTUCKY  
CABINET FOR HEALTH AND FAMILY SERVICES  
OFFICE OF INSPECTOR GENERAL  
DIVISION OF HEALTH CARE  
TYPE "A" CITATION

Date: June 1, 2010

Facility Name: Hazard Nursing Home  
Facility Address: 390 Park Avenue, Hazard, Kentucky 41702

Facility Administrator: Sheila Noe

**This citation is issued pursuant to KRS 216.555 and KRS 216.557 and 900 KAR 2:040, Section 2 for violations of 902 KAR 20:300, Section 5.(3) and 42 CFR 483.13. This citation may be appealed according to the provisions of 900 KAR 2:020, which states that a written request for a hearing must be made to the Secretary of the Cabinet for Health and Family Services within twenty (20) days of the receipt of the written notice of the action. Any penalty assessed for this citation may be appealed under the same provisions.**

Based on the findings of an abbreviated survey initiated on May 21, 2010, it was determined the facility failed to protect residents from unwanted sexual contact, failed to report the allegations to appropriate state agencies, and failed to thoroughly investigate the allegations of sexual abuse. Based on staff interviews, the facility had knowledge that residents #1 and #2, male residents with cognitive impairment, had a history of exhibiting sexual behaviors. However, the facility failed to implement interventions to address residents #1 and #2's behaviors to protect resident #3 and other facility residents from unwanted sexual contact.

According to resident #3's medical record, the facility assessed resident #3 as cognitively impaired and displaying "unrealistic fears." There was no evidence the facility conducted physical/psychological assessments of resident #3 after any reported incidents of unwanted sexual activity.

Staff interviews revealed resident #2 had a history of masturbating and exposing his penis to residents #3, #11, and #12, female residents of the facility. In addition, staff interview revealed resident #12 had been observed performing oral sex on resident #2. Staff stated they observed resident #2 with his penis exposed in resident #3's presence on two occasions, January 25, 2009 and January 31, 2009. Interviews with staff and review of resident #2's medical record revealed on March 5, 2009, resident #2 exposed the resident's penis in the hallway of the facility and was placed on Depo-Provera injections. The facility failed to monitor resident #2 and implement interventions related to the resident's continued sexual behavior. According to interviews and a review of the facility's investigative summary, resident #2 was observed with the resident's penis exposed, standing in front of resident #3, with semen observed on resident #3's face on May 18, 2009.

According to interviews with facility staff and a review of resident #1's medical record, the facility was aware resident #1 had a history of sexual behaviors and the resident had been receiving Depo-Provera since October 2008, when the resident was observed in bed with a cognitively impaired female resident. However, the facility failed to assess resident #1's continued sexual

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behaviors, and failed to implement interventions to address the behavior. Interviews with staff and a review of the facility's Investigative summary revealed on August 8, 2009, staff observed the door to resident #1's room closed, and blocked, and staff had to enter resident #1's room through an adjacent bathroom. Facility staff stated on entrance to resident #3's room, resident #1's penis was exposed, and resident #3 was observed to have semen on the face and around the mouth.

Both residents #1 and #2 continue to reside at the facility, and review of the medical records revealed no interventions were implemented to ensure residents were protected from continued sexual behaviors. Although incidents of unwanted sexual contact were reported to facility administration the facility failed to report the allegations to appropriate state agencies, and failed to thoroughly investigate the allegations of sexual abuse.

The facility's failure to have an effective system in place to protect residents from unwanted sexual contact placed residents in imminent danger and at substantial risk of serious physical/psychological harm. The facility was notified of the imminent danger on May 25, 2010.

ISSUED BY: Donetta Ball RECEIVED BY: Shila R. Noe  
TITLE: NCI TITLE: Administrator  
DATE: 6/1/10 DATE: 6/1/10  
WITNESS: [Signature]  
DATE TO BE CORRECTED: **IMMEDIATELY - June 1, 2010**  
CORRECTED DATE: 5/29/10  
VERIFIED CORRECTED DATE: 6/1/10 Donetta Ball