

## CORE ISSUES

Facility	License #	Physical Address	Phone Number
Spring Creek Inn Memory Care Community	12826	1641 Hunters Way	406-586-0074
Administrator	City	Zip Code	Survey Date
	Bozeman	59718	02/17/2017
Survey Team Leader	Survey Type		Response Due
Wooten, Tara	Complaint Inspection		02/27/2017

Item #	Rule ()	Description
1	37.106.2824-1 INVOLUNTARY DISCHARGE CRITERIA	<p>Review of Resident #1 file, interview with Staff #1, Administrator.</p> <p>Per review of record:</p> <ul style="list-style-type: none"> <li>On June 3, 2016, Resident #1 was found lying on his bed in his room with Resident #2. Incident Report (IR) indicates that Resident #1 had his hand down Resident #2's pants, but that Resident #2 was fully clothed. During this time period, Resident #1 was on an Estrogen supplement and an antidepressant medication.</li> <li>On August 1, 2016, Resident #1 was taken off of the estrogen supplement, along with a gradual dose reduction and then discontinuation of the antidepressant medication.</li> <li>On 8/10/2016, Resident #1 progress notes indicate he kissed another female resident. Documentation from 8/11/2016 – 1/3/2017 reviewed and no documentation of interactions with female residents was noted.</li> <li>On 1/4/2017, IR and progress notes revealed that Resident #1 and Resident #3 were found in Resident #1's room lying in bed together. IRs indicated that both residents were</li> </ul>

		<p>partially undressed, and Resident #1 had his hand on Resident #3's "private area." Late entry clarification progress note done 1/10/2017 for 1/4/2017 by licensed nurse states, "When attempting to separate the residents, (Resident #3) was saying with a raised voice to the caregiver, 'No you stop that' and was hitting at the caregiver resisting getting up from the bed pushing away from the caregiver - it appeared (Resident #3) was enjoying the interaction..."</p> <p>Review of the "Summary of Investigation":</p> <ul style="list-style-type: none"><li>• On 1/9/2017 Staff #2 and a day nurse met with Resident #3's family. Documentation states, "family concerned due to incident with male resident. Family's concerns focused on preventing a repeat incident and the desire for reassurance regarding mom's safety at Spring Creek Inn" This was signed as written by Staff #2</li><li>• On 1/10/2017 Staff #1, #2, and #3 met with Resident #3's family. Documentation states, "Family continues to want reassurance that incident will never occur again. Family has limited understanding of dementia and it's impact on sexual acting out." "(Staff #1) stated possible interventions may include: medications or discharge for the male resident." This was signed as written by Staff #2.<ul style="list-style-type: none"><li>o Additional entry on 1/10/2017, the documentation states, "(Staff #1) described entire incident/situation and the State feedback was that this situation occurred between two seemingly consenting adults therefore no further action is necessary." This was signed as written by Staff #2.</li></ul></li></ul> <p>Progress note dated 1/10/2017 at 1645 states, "While talking with (Resident #1's POA) I informed her the female resident's family was extremely distraught over the incident and asked her if she would consider putting (Resident #1) back on a trial</p>
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		<p>of estrogen. (Resident #1 POA) replied, ‘no since he has been off his estrogen therapy he has no longer had any anger issues and this was the first incident’”</p> <p>Resident #1 was given a 30-day discharge notice letter dated 1/13/2017. The letter stated, “Due to (Resident #1’s) recent incident in our community, this letter will serve as a 30-day notice with a discharge date of February 11, 2016.”</p> <p>In an interview, Staff #1 reported that the direction she received from the Department was to discharge Resident #1 if family did not agree to put him back on estrogen supplementation.</p> <p>This report was not found in any documentation received or reviewed at the time of survey.</p> <p>Review of facility records and documentation does not support the need for discharge for Resident #1. The resident had 2 sexual encounters in an approximately 6 month span. There is no indication that Resident #1 repeatedly and substantially interfered with the rights, health, safety or wellbeing of Resident #2, Resident #3, or any other residents at the facility.</p> <p>The letter given to Resident #1, and Resident #1’s POAs, did not include an adequate reason for discharge.</p>
2	37.106.2843-2 PERSONAL CARE SERVICES	<p>Review of resident files.</p> <p>On 1/4/2017, IR and progress notes revealed that Resident #1 and Resident #3 were found in Resident #1’s room lying in bed together. IRs indicated that both residents were partially undressed, and Resident #1 had his hand on Resident #3’s “private area.” Late entry clarification progress note done 1/10/2017 for 1/4/2017 by licensed nurse states, “When</p>

		<p>attempting to separate the residents, (Resident #3) was saying with a raised voice to the caregiver, 'No you stop that' and was hitting at the caregiver resisting getting up from the bed, pushing away from the caregiver - it appeared (Resident #3) was enjoying the interaction..."</p> <p>Review of Resident files:</p> <ul style="list-style-type: none"><li>• Resident #1 had a Power of Attorney (POA) for financial matter, and another POA for Health matters. The Health POA paperwork was reviewed, and it was determined upon review that the POA is not granted the right of involvement into personal relationships.</li><li>• Resident #3's POA covered both financial and health. The Health POA paperwork was reviewed, and it was determined upon review that the POA is not granted the right of involvement into personal relationships.</li></ul> <p>There is no indication that either Resident #1 or Resident #3 were injured, or had any health-related problems related to the occurrence of 1/4/2017. The facility failed to grant the rights of privacy and decision making to Resident #1 and Resident #3.</p>
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