

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155377	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/14/2013
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NAME OF PROVIDER OR SUPPLIER SEYMOUR CROSSING	STREET ADDRESS, CITY, STATE, ZIP CODE 707 S JACKSON PARK DR SEYMOUR, IN 47274
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F000000	<p>This visit was for the Investigation of Complaints IN00133821 and IN00134053.</p> <p>Complaint IN00133821 - Substantiated. Federal/state deficiencies related to the allegations are cited at F224, F225, and F226.</p> <p>Complaint IN00134053 - Substantiated. Federal/state deficiencies related to the allegations are cited at F224, F225, and F226.</p> <p>This visit was in conjunction with the Recertification and State Licensure Survey. This visit was also in conjunction with the investigation of complaints IN00128887 and IN00130258.</p> <p>Survey dates: August 5, 6, 7, 8, 9, 12, 13, and 14, 2013.</p> <p>Facility number: 000272 Provider number: 155377 AIM number: 100274710</p> <p>Survey team: Diana Sidell RN, TC Sunny Jungclaus RN Jennifer Carr RN</p>	F000000	The facility respectfully requests paper review IDR for tag F 224, F 225, and F 226. The facility has evidence for the following tags to support the deficiencies should not have been sited.	
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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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	<p>Angel Tomlinson RN (August 5, 6, 7, and 8, 2013)</p> <p>Census bed type: SNF/NF: 80 Total: 80</p> <p>Census payor type: Medicare: 5 Medicaid: 69 Other: 6 Total: 80</p> <p>Sample: 3</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on 8/22/2013 by Cheryl Fielden, RN.</p>			

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F000224 SS=D	<p>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATE</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review, observation, and interview, the facility failed to ensure a resident remained free from abuse in that one resident had narcotic pain patches removed. This affected 1 of 9 residents who met the criteria for abuse. (Resident #C)</p> <p>Findings include:</p> <p>Resident #C's record was reviewed on 8/8/13 at 3:12 p.m. The record indicated Resident #C was admitted with diagnoses that included, but were not limited to, diabetes, high blood pressure, backache, cerebral vascular disease, cognitive impairment, chronic back pain, insulin dependent diabetes mellitus, Alzheimer's disease, lumbar spinal stenosis, peripheral edema, hearing loss, insomnia, depression, dementia with mood disturbance, and chronic pain syndrome.</p> <p>A Quarterly Minimum Data Set Assessment (MDS), dated 6/1/13,</p>	F000224	<p>F 224 PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATION The facility respectfully requests paper review IDR for tag F 224. The facility has evidence for the following tags to support the deficiencies should not have been sited. The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? * Resident #C was not harmed by alleged deficient practice. * All staff inserviced on misappropriation of resident property and abuse directly after incident occurred on July 19, 2013. *Resident #C Fentanyl patches are checked for placement every shift How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. * Residents who reside in this facility have the potential to be affected by the alleged</p>	09/06/2013			

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	<p>indicated Resident #C had severe impairment in cognitive skills for daily decision making and was on a scheduled pain medication regimen.</p> <p>Physician's recapitulation orders dated 7/01/13 through 7/31/13 indicated an order for Fentanyl 75 micrograms (mcg) per hour, apply 1 patch topically every 72 hours for pain, with a start date of 4/17/13.</p> <p>A Physician's telephone order dated 7/16/13 (no time written on the order) indicated "1X order Fentanyl Patch 75 mcg." This order indicated a care plan update of: "Patch mistakenly removed".</p> <p>A Physician's telephone order clarification dated 7/16/13 indicted: "Order clarification. (1) Fentanyl 75 mcg per hour. Apply q (every) 3 days. Apply Oppsite (clear adhesive cover) over Patch. DX (diagnosis): Chronic Back Pain. (2) [change] Seroquel DX: to Dementia [with] Psychosis. (3) [check] placement [of] patch q shift."</p> <p>A Physician's telephone order dated 7/18/13 at 8:00 p.m., indicated an order for "1X Fentanyl patch replacement." This order had a notation of "clarification" written below</p>		<p>deficient practice. * All staff inserviced by the Director of Nursing and/or designee on misappropriation of resident property and abuse directly after incident occurred on July 19, 2013 and again on August 27, 2013 *Director of Nursing and/or designee conducted an audit of all narcotic patches to ensure all were in place per physician's order What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? * All staff inserviced by the Director of Nursing and/or designee on misappropriation of resident property and abuse after incident occurred on July 19, 2013 and again on August 27, 2013 * Director of Nursing and/or designee will complete 100% audit on all narcotic patches and initiate checks every shift to ensure placement *Inservicing for all new staff over abuse/misappropriation of resident funds/property was conducted on August 27, 2013 and will be completed upon hire and on annual basis by Director of Nursing and/or designee How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? * An Abuse Prohibition and Investigation CQI tool will be utilized by Director of Nursing and/or designee weekly x 4 weeks, monthly x 2 months and</p>		

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	<p>the order.</p> <p>A Physician's telephone order, dated 7/19/13 at 10:30 a.m., indicated "Fentanyl patch 75 mcg, Apply X1 et (and) Keep schedule to every 72 hrs (hours) starting today." This order included a care plan update of: "Pain patch off, Replace patch/Reduce pain."</p> <p>A reportable incident of misappropriation of property was provided by the Director of Health Services on 8/9/13 at 12:23 p.m. The incident was dated 7/19/13 and indicated, but was not limited to: "Resident [#C] has order for Fentanyl Patch 75 mcg. Last changed on 7/17/13 at 8am, patch found missing on 7/18/13 at 2:20 p.m. Suspected to have fallen off. Order received to reapply patch x1. Patch was reapplied at 3:30pm with tegaderm (clear adhesive) covering to keep in place on mid back. Checked at 10pm and was reported still in place. Patch found missing on 7/19/13 at 6:20 am during check...." The DHS indicated the daily staffing was reviewed and all staff that were working during the time frame when the Fentanyl patches went missing were tested for drugs.</p>		<p>quarterly X1 for at least 6 months * Audit tools will be submitted to the CQI committee and action plans will be developed as needed if threshold of 100% is not met.</p>		

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	<p>Resident #C was observed on 8/7/13 at 2:45 p.m., walking around with her walker. The resident could speak to others, was very confused, and had no indications of being in pain. She was very calm, and had no facial grimaces nor guarding of any parts of her body.</p> <p>A policy, titled "Abuse Prohibition, Reporting, and Investigation" policy and procedure, was provided by the Executive Director on 8/12/13 at 11:04 a.m. The policy indicated, but was not limited to, "It is the policy of American Senior Communities to protect residents from abuse including physical abuse, sexual abuse, verbal abuse, mental abuse, neglect, involuntary seclusion, and misappropriation of resident property and/or funds...Misappropriation of Resident Funds or Property - the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent...1. American Senior Communities will not permit residents to be subjected to abuse by anyone, including employees, other residents...."</p> <p>This Federal tag relates to complaint IN00133821 and IN00134053.</p>				

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	3.1-27(a)(3) 3.1-28(b)			

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F000225 SS=E	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p>	F000225	F 225 INVESTIGATE/REPORT	09/06/2013			

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	<p>Based on record review and interview, the facility failed to immediately report allegations of abuse to the State Agency. This affected 6 of 9 residents reviewed who met the criteria for abuse. (Residents #C, L, M, J, K, and A)</p> <p>Findings include:</p> <p>1. A reportable incident of misappropriation of property was provided by the Director of Health Services on 8/9/13 at 12:23 p.m. The incident was dated 7/19/13 and indicated, but was not limited to: "Resident [#C] has order for Fentanyl Patch 75 mcg. Last changed on 7/17/13 at 8am, patch found missing on 7/18/13 at 2:20 p.m. Suspected to have fallen off. Order received to reapply patch x1. Patch was reapplied at 3:30pm with tegaderm (clear adhesive) covering to keep in place on mid back. Checked at 10pm and was reported still in place. Patch found missing on 7/19/13 at 6:20 am during check...." The DHS indicated the daily staffing was reviewed and all staff that were working during the time frame when the Fentanyl patches went missing were tested for drugs.</p> <p>On 8/13/13 at 10:46 a.m., the Director</p>		<p>ALLEGATIONS/INDIVIDUALS T he facility respectfully requests paper review IDR for tag F 225. The facility has evidence for the following tags to support the deficiencies should not have been sited. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? * Resident #C, L, M, J, K, and A were not harmed by alleged deficient practice. * All staff inserviced on abuse policy and procedure abuse on August 27, 2013. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. * Residents who reside in this facility have the potential to be affected by the alleged deficient practice. * All staff inserviced by the Director of Nursing and/or designee on abuse policy and procedure and reporting immediately on August 27, 2013 What measures will be put into place or what systemic changes you will make to ensure</p>				

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	<p>of Health Services (DHS) provided an e-mail confirmation that indicated the incident of the misappropriation of Resident #C's Fentanyl patches were reported to the ISDH on 7/19/13 at 2:33 p.m. which was over 24 hours from when the patch was found missing on 7/18/13.</p> <p>2. A reportable incident of an allegation of resident to resident abuse, was provided by the Director of Health Services on 8/13/13 at 10:46 a.m. The incident involved Resident #L and Resident #M, and had occurred on 8/10/13 at 3:30 p.m. The residents were separated, the DNS and Executive Director notified, and one on one supervision was initiated with Resident #L. The incident was investigated and the DHS provided a dated e-mail that indicated the incident was reported to the ISDH on 8/11/13 at 12:12 p.m. which was approximately 21 hours after the incident occurred.</p> <p>3. An allegation of staff to resident abuse involving QMA #24, had occurred on 7/27/13 at 9:00 a.m., and indicated: "Reported that staff #1 (QMA #24) pushed back Resident #K's head and stated rudely "It's time to eat" then went to Resident #J and stated, "I don't have time to feed you</p>		<p>that the deficient practice does not recur? * All staff inserviced by the Director of Nursing and/or designee on abuse policy and procedure and reporting immediately on August 27, 2013</p> <p>* Executive Director and/or designee will place guide at each nurses' station regarding abuse/neglect/misappropriation of resident property or funds/injuries of unknown origin with instructions to complete the guide. Information from the guide will then be relayed to Executive Director and/or designee which will allow Executive Director and/or designee to report immediately to ISDH *Inservicing for all new staff over abuse/misappropriation of resident funds/property was conducted on August 27, 2013 and will be completed upon hire and on annual basis by Director of Nursing and/or designee How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? * An Abuse Prohibition and Investigation CQI tool will be utilized by Director of Nursing and/or designee weekly x 4 weeks, monthly x 2 months and quarterly X1 for at least 6 months</p> <p>* Audit tools will be submitted to the CQI committee and action plans will be developed as needed if threshold of 100% is not met.</p>	

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	<p>so you need to feed yourself. Type of Injury/Injuries: Residents were assessed and no injuries noted...."</p> <p>An investigation was begun and this incident was reported to the ISDH on 7/27/13 at 2:55 p.m., which was almost 6 hours later.</p> <p>During an interview on 8/14/13 at 10:36 a.m., the DHS indicated she takes every allegation of abuse very seriously. The employee, QMA #24 had worked here and did not have any allegations against her. The DHS indicated she investigates by getting statements to rule out the allegation, and checks if their tone was rough or was it misconstrued as rough, or were the employees misunderstanding. She also indicated the two CNA's did not report it to the supervisor until 11:00 a.m. and she stressed the importance of reporting immediately when she did the abuse inservices.</p> <p>4. An investigation of a reportable allegation of staff to resident abuse was provided by the DHS on 8/8/13 at 3:20 p.m. The investigation indicated that a family member of a discharged resident (Resident #A) had reported two CNA's that were "rushing with care" and also were rough and rude to the resident to the facility on 11/29/12. Resident #A had been</p>				

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	<p>discharged in 9/2013.</p> <p>During an interview on 8/8/13 at 3:20 p.m., the DHS indicated the facility got a letter from a resident's family member on 11/29/12, that contained a list of formal concerns. She indicated she went through the entire letter and investigated all the allegations, gave each allegation a number and put in what they did to correct it if it was substantiated. The DHS indicated she was a consultant at that time and assisted the Executive Director, (ED) who is no longer at the facility, along with the Director of Health Services at that time. She indicated she didn't know if the ED got back with the mother, but they let the other agency involved know about the results, because the other agency had sent a letter to find out what they were going to do about it. They handled it like a legal matter. One CNA is no longer employed, and the other is still here. The ED provided a copy of a letter, that had been sent by the former ED to the other agency, with an attachment with the information gathered from the investigation.</p> <p>During an interview on 8/14/13 at 5:14 p.m., the DHS indicated they could not find confirmation the</p>				

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	<p>allegations had been reported to the ISDH and other agencies, so they went ahead and reported this on 8/14/13 at 5:01 p.m.</p> <p>A policy, titled "Abuse Prohibition, Reporting, and Investigation" policy and procedure, was provided by the Executive Director on 8/12/13 at 11:04 a.m. The policy indicated, but was not limited to, "It is the policy of American Senior Communities to protect residents form abuse including physical abuse, sexual abuse, verbal abuse, mental abuse, neglect, involuntary seclusion, and misappropriation of resident property and/or funds...1. American Senior Communities will not permit residents to be subjected to abuse by anyone, including employees, other residents...5. All abuse allegations/abuse must be reported to the Executive Director immediately, and to the resident's representative (sponsor, responsible party) within 24 hours of the report...7. The Executive Director/designee will report all unusual occurrences, which include allegations of abuse, immediately, to the Long Term Care Division of the Indiana State Department of Health...Copies of the completed investigation must also be sent to Adult Protective Services,</p>				

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	<p>Ombudsman, and Director of Operations...."</p> <p>This Federal tag relates to Complaints IN00133821, and IN00134053.</p> <p>3.1-28(c)</p>			

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NAME OF PROVIDER OR SUPPLIER SEYMOUR CROSSING				STREET ADDRESS, CITY, STATE, ZIP CODE 707 S JACKSON PARK DR SEYMOUR, IN 47274			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F000226 SS=E	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to implement their policies and procedures regarding reporting, in that allegations of abuse were not reported immediately to the ISDH and other agencies. This affected 6 of 9 residents reviewed for abuse reporting. (Residents #C, L, M, J, K, and A)</p> <p>Findings include:</p> <p>1. A reportable incident of misappropriation of property was provided by the Director of Health Services on 8/9/13 at 12:23 p.m. The incident was dated 7/19/13 and indicated, but was not limited to: "Resident [#C] has order for Fentanyl Patch 75 mcg. Last changed on 7/17/13 at 8am, patch found missing on 7/18/13 at 2:20 p.m. Suspected to have fallen off. Order received to reapply patch x1. Patch was reapplied at 3:30pm with tegaderm</p>	F000226	F 226 DEVELOP/IMPLEMENT ABUSE/NEGLECT,ETC POLICIES The facility respectfully requests paper review IDR for tag F 226. The facility has evidence for the following tags to support the deficiencies should not have been sited. The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? * Resident #C, L, M, J, K, and A were not harmed by alleged deficient practice. * All staff inserviced by the Director of Nursing and/or designee on abuse policy and procedure and reporting immediately on August 27, 2013 How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. * Residents who reside in this facility have the potential to be affected by the alleged deficient practice. * All staff inserviced by the Director of	09/06/2013			

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	<p>(clear adhesive) covering to keep in place on mid back. Checked at 10pm and was reported still in place. Patch found missing on 7/19/13 at 6:20 am during check...."</p> <p>On 8/13/13 at 10:46 a.m., the Director of Health Services (DHS) provided an e-mail confirmation that indicated the incident of the misappropriation of Resident #C's Fentanyl patches was reported to the ISDH on 7/19/13 at 2:33 p.m. which was over 24 hours from when the patch was found missing on 7/18/13.</p> <p>2. A reportable incident of an allegation of resident to resident abuse was provided by the Director of Health Services on 8/13/13 at 10:46 a.m. The incident involved Resident #L and Resident #M and had occurred on 8/10/13 at 3:30 p.m. The incident was investigated and the DHS provided a dated e-mail that indicated the incident was reported to the ISDH on 8/11/13 at 12:12 p.m. which was approximately 21 hours after the incident occurred.</p> <p>3. An allegation of staff to resident abuse, that involved QMA #24, had occurred on 7/27/13 at 9:00 a.m. The incident indicated an investigation was begun and reported to the ISDH</p>		<p>Nursing and/or designee on abuse policy and procedure and reporting immediately on August 27, 2013 What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? * All staff inserviced by the Director of Nursing and/or designee on abuse policy and procedure and reporting immediately on August 27, 2013 * Executive Director and/or designee will place guide at each nurses' station regarding abuse/neglect/misappropriation of resident property or funds/injuries of unknown origin with instructions to complete the guide. Information from the guide will then be relayed to Executive Director and/or designee which will allow Executive Director and/or designee to report immediately to ISDH *Inservicing for all new staff over abuse/misappropriation of resident funds/property was conducted on August 27, 2013 and will be completed upon hire and on annual basis by Director of Nursing and/or designee How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? * An Abuse Prohibition and Investigation CQI tool will be utilized by Director of Nursing and/or designee weekly x 4 weeks, monthly x 2 months and quarterly X1 for at least 6 months</p>		

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	<p>on 7/27/13 at 2:55 p.m., which was almost 6 hours later.</p> <p>During an interview on 8/14/13 at 10:36 a.m., the DHS indicated the two CNA's did not report it to the supervisor until 11:00 a.m.</p> <p>4. An investigation of a reportable allegation of staff to resident abuse was provided by the DHS on 8/8/13 at 3:20 p.m. The investigation indicated that a family member of a discharged resident (Resident #A) had reported two CNA's to the facility that were "rushing with care" and also were rough and rude to the resident to the facility on 11/29/12. Resident #A had been discharged in 9/2012.</p> <p>During an interview on 8/14/13 at 5:14 p.m., the DHS indicated they could not find confirmation the allegations had been reported to the ISDH and other agencies, so they went ahead and reported this on 8/14/13 at 5:01 p.m.</p> <p>A policy, titled "Abuse Prohibition, Reporting, and Investigation" policy and procedure, was provided by the Executive Director on 8/12/13 at 11:04 a.m. The policy indicated, but was not limited to, "It is the policy of American Senior Communities to</p>		* Audit tools will be submitted to the CQI committee and action plans will be developed as needed if threshold of 100% is not met.		

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	<p>protect residents form abuse including physical abuse, sexual abuse, verbal abuse, mental abuse, neglect, involuntary seclusion, and misappropriation of resident property and/or funds...1. American Senior Communities will not permit residents to be subjected to abuse by anyone, including employees, other residents...5. All abuse allegations/abuse must be reported to the Executive Director immediately...7. The Executive Director/designee will report all unusual occurrences, which include allegations of abuse, immediately, to the Long Term Care Division of the Indiana State Department of Health...Copies of the completed investigation must also be sent to Adult Protective Services, Ombudsman, and Director of Operations...."</p> <p>This Federal tag relates to Complaints IN00133821, and IN00134053.</p> <p>3.1-28(a)</p>			