STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155735	A. BUILDING 00 B. WING	01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASHFORD PLACE HEALTH CAMPUS	2200 N RILEY HWY SHELBYVILLE, IN 46176

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00385727. This visit resulted in an Extended Survey- Substandard Quality of Care- Immediate Jeopardy. Complaint IN00385727 - Substantiated. Federal/State deficiencies related to the allegations are cited at F880. Survey dates: January 4, 5, 6, 7, 8, 9, 10, and 11, 2022 Facility number: 004268 Provider number: 155735 AIM number: 200504460 Census Bed Type: SNF/NF: 30 SNF: 19 Residential: 22 Total: 71 Census Payor Type: Medicare: 20 Medicaid: 22 Other: 7 Total: 49 This deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on January 18, 2023	F 0000	The submission of this plan of correction does not indicate an admission by Ashford place health campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Ashford place health campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on interview and record review, the facility failed to have the interdisciplinary team (IDT) determine and document that self administration of medications and treatments were clinically appropriate for 1 of 5 residents observed during medication administration. (Resident 40) Findings include: The clinical record for Resident 40 was reviewed on 1/10/23 at 2:23 p.m. The diagnoses for Resident 40 included, but was not limited to, chronic obstructive pulmonary disease. A Quarterly MDS assessment dated 10/28/22, indicated Resident 40 was cognitive intact. A physician order dated 1/27/22 indicated Resident 40 was to receive 50 micrograms (mcg) of flonase nasal spray. A physician order dated 8/25/22 indicated Resident 40 was to receive 100-25 mcg breo inhaler. An observation was made of a medication administration with License Practical Nurse LPN 15 on 1/10/23 at 9:40 a.m. During the preparing of a medication administration to Resident 40; LPN 15 indicated she had previously provided Resident 40 with his breo inhaler and flonase nasal spray. She had dropped them off to him earlier in the morning to administer himself. The resident was alert and oriented and able to administer the breo inhaler and flonase himself. Resident 40's clinical record did not include	F 0554	1. Resident 40 was affected by alleged deficient practice. A self-administration assessment was completed on resident. Resident able to successfully self-administer preferred medications per assessment findings. 2. All like residents have the potential to be affected by alleged deficient practice. Health Care Center audit of like residents were completed to ensure proper self-administration assessment completed for residents who preferred to self-administer. No new residents identified during audit. Interdisciplinary team in-serviced on self-administration assessment. 3. As a measure of ongoing compliance, the Director of Health Services and/or Designee will complete an audit of all new residents who request to self-administer medications weekly x 4 weeks, every other week x 8 weeks, and then monthly x 3 months. 4. As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as	02/01/2023

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	documentation the resident was able to self administer his medications. An interview was conducted with the Director of Nursing Services (DNS) on 1/10/23 at 3:17 p.m. She indicated Resident 40 had not had a documented self medication assessment. A "Self-Administration of Medications" policy was provided by the DNS on 1/10/23 at 3:17 p.m. It indicated "...Purpose. To ensure the safe administration of medication for residents who request to self-medicate or when self-medication is a part of their plan of care. Procedures. 1. Residents requesting to self-medicate or has self-medication as part of their plan of care shall be assessed using the observation Trilogy-Self Administration of Medication within the electronic health record. Results of the assessment will be presented to the physician for evaluation and an order for self medication. a. The order should include the type of medication(s) the resident is able to self-medicate. i.e: [that is] all oral meds, oral meds with the exception of..., nebulizer treatment only, all medications including injection, oral, inhalers, drops, etc. 2. The resident and/or family/responsible party will be informed of the results of the assessment and whether the resident has been determined to safely self-administer medications...6. A Self-Medication plan of care will be initiated and updated as indicated..." 3.1-11		warranted and will continue until 100% compliance is maintained.	
F 0600 SS=J Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from			

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	abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on interview and record review, the facility failed to protect the residents' right to be free from sexual abuse by not appropriately determining their capacity to consent to sexual interactions and implementing an effective plan to address the sexual activity between 2 residents for 2 of 2 resident's reviewed for abuse. (Resident 14 and Resident 28). The Immediate Jeopardy started on 5/5/22 when two cognitively impaired residents engaged in a sexual activity. Resident 14 and 28 continued to have sexual encounters after the 5/5/22 incident; resulting in increased falls, initiation of a prophylactic antibiotic, increase in antidepressant medication, initiation of a medication used to suppress sexual desire and emotional distress. The facility was unable to provide evidence an effective plan was in place to address the residents' sexual interactions and determining if Residents 28 and 14 had the mental capacity to consent to sexual activities. The Executive Director (ED), Director of Nursing Services (DNS), Nursing Clinical Support (NC) 3, Nursing Clinical Support 4, Registered Nurse 6, and Registered Nurse 7 were notified of the immediate jeopardy	F 0600	1. Residents 28 and 14 were affected by the alleged deficient practice. Both residents were assessed with no psychosocial distress noted. Skin assessments completed with no findings. Both residents were assessed for sexual activity and consent. Both residents have verbalized no interest in sexual activity upon assessment. 2. All cognitively impaired residents have the potential to be affected. All residents with BIMS = 10 interviewed for psychosocial distress and none noted. All residents with BIMS < 10 had a skin assessment completed and no findings. All staff educated on abuse policies. Interdisciplinary team and licensed staff educated on assessment and policy for sexual activity and consent. 3. As a measure of ongoing compliance, the ED (executive director) or designee will monitor for sexual behaviors daily in	02/01/2023

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	on 1/6/23 at 3:20 p.m. The Immediate Jeopardy was removed, and the deficient practice was corrected by 1/9/23 after the facility implemented a systemic plan that included the following actions: develop and implement a plan to address the residents' sexual interactions, their capacity to consent to such interactions, and ensure all staff are educated on sexual abuse. Findings include: 1a. The clinical record for Resident 14 was reviewed on 1/5/23 at 9:32 a.m. The Resident's diagnosis included, but were not limited to, Parkinson's disease, dementia, cognitive impairment, and depression. A Psychiatric Evaluation/ Follow-up note, dated 1/6/22, indicated Resident 14 was being seen for depression, dementia, and Parkinson's disease. He is alert and oriented to person only. His cognition is fairly declined, with long term memory fair to poor, short term memory and concentration poor. His executive functioning and abstract thinking are very impaired. His MOCA (Montreal Cognitive Assessment Test for Dementia) was 13/30 (10 to 17 points indicate moderate cognitive impairment). A care plan, initiated 1/7/22, indicated Resident 14 had impaired cognition with associated short term memory impairment and risk for confusion, disorientation, altered mood, and impaired or reduced safety awareness related to his dementia. The goal was for him to remain safe and not injure himself secondary to his impaired decision making. The interventions included, but were not limited to, assess his degree of hearing ability, impulsive behavior, and decrease in visual perception, initiated 1/7/22, observe for exit		clinical care meeting to ensure compliance with the sexual activity and consent policy and procedures and to identify any new sexual behaviors requiring an assessment as well as completion as warranted. Audit will be completed daily x 4 weeks. 3 times a week x 8 weeks, every other week 3 months. 4. As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained. IDR: I would like to dispute the alleged deficiency that no residents were in immediate jeopardy from this scenario. We were able to show consent through their BIMS scores and their actions towards one another. This shows that neither resident was at risk for sexual abuse. MD, ED, DHS, DSS, IDT team, and NP all followed closely and there was never any signs of psychosocial distress. Residents were only upset when staff would try and separate them. That is the reason the IDT team reexamined the situation and allowed it to continue safely, because it is a basic human right.	

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	seeking behaviors, wandering into unsafe areas, and entering other resident rooms un-invited, initiated 1/7/22, redirect him when agitated behavior occurs or potential for injury is evident, initiated 1/7/22, determine if his decisions endanger himself or others. Intervene as necessary, initiated 1/7/22, give him feedback when inappropriate decisions are made, initiated 1/7/22, and pay attention to basic needs and provide ADL (Acts of Daily Living) care as required. Provide cues and supervision for decision making, initiated 1/7/22. A Quarterly MDS (Minimum Data Set) Assessment, completed 4/11/22, indicated Resident 14 had moderately impaired cognition. 1b. The clinical record for Resident 28 was reviewed on 1/5/23 at 2:30 p.m. The diagnoses for Resident 28 included, but were not limited to, stroke, major depressive disorder, mild cognitive impairment, and dementia with behavioral disturbance. The resident had previously been living in an assisted living and was transferred to long term care on 11/22/21 in the same facility. A care plan dated 4/3/20 indicated "Resident [28] has impaired cognition with associated short term memory impairment and risk for confusion, disorientation, altered mood, impaired or reduce safety awareness...long term goal...Resident will remain safe and not injure self-secondary to impaired decision making.... Approach...Calm resident if signs or distress develop during the decision making process...Determine if decisions made by the resident endanger the resident or others. Intervene if necessary...Re-direct resident when agitated behaviors are present or potential for injury is evident..."			

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	A physician order dated 11/22/21 indicated Resident 28 was to receive 30 milligrams of Paxil daily for depression. A Quarterly Minimum Data Set (MDS) assessment dated 2/8/22 indicated Resident 28 was moderately cognitively impaired. A Quarterly MDS assessment dated 5/31/22 indicated Resident 28 was cognitively intact. An Annual MDS assessment dated 8/30/22 indicated Resident 28 was moderately cognitively impaired. A care plan dated 12/1/21 indicated "Resident demonstrates physically abusive and resistive behaviors toward staff during hands on care/combative with care...Approach...Approach resident in a calm and unhurried manor to deliver care and provide services...Explain care process prior to delivery of care as needed...Observe for signs and sensory overstimulation and encourage resident to move into less stimulating environment as needed. Offer choices in all hands-on care and contacts. Psych to continue to follow..." A physician order dated 5/3/22 indicated Resident 28 was to receive 125 milligrams and 250 milligrams of Depakote to total of 375 milligrams at bedtime for aggression and mood stabilization. A physician order dated 5/3/22 indicated Resident 28 was to receive 250 milligrams of Depakote twice a day for aggression and mood stabilization. A nursing progress note dated 5/4/22 indicated "Res [Resident] [28] was in hall with another resident [Resident 14]and put her hand in his lap.			

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	Resident were separated at that time. No further action required." A nursing progress note, dated 5/05/22 at 9:00 p.m., indicated Resident 14 was in another resident's (Resident 28) room and the other resident was touching him inappropriately. The families of both residents were notified. A Behavior Event dated 5/5/22 for Resident 28 indicated "...Describe behavior exhibited...sexual behavior towards other residents... Does resident's mental function vary over the course of the day? For example: Sometimes better, sometimes worse; behaviors sometimes present, sometimes not. [marked as] Yes...Indicate Non-Pharmacological measures taken - check all that apply... [marked as] redirection and relocated to quite (sic) location..." A reportable incident to the Indiana Department of Health was provided by the ED on 1/5/23 at 2:23 p.m. It indicated a sexual interaction had occurred between Resident 28 and 14 on 5/5/22. The "...brief description of incident...Both residents were in female resident's room. when staff entered room the observed resident with her hand under his shorts...Preventative Measures Taken...Psych to continue to follow for behaviors and make recommendations as needed...Follow us: No further resident to resident contact made. Psych to continue to follow for behaviors and make recommendations as needed..." A Psych visit note for Resident 28 dated 5/5/22 completed by Psych Nurse Practitioner (NP) 1 indicated "...Treatment Plan...5/5/22...Staff reports she had an episode of putting her hand in the pants of a male peer. Writer notes the patient has a male peer in her room with the door shut. Nursing did remove the male from the room. The			

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	patient's Depakote was reduced last visit for a GDR. this has failed. The patient has been having behavior issues with being sexually aggressive and preoccupied. Her dose was increased back up to 250 [milligrams] mg bid [twice a day] and 375 mg hs [nightly] 2 days ago. If the patient's symptoms do not improve in 1 week we are going to look at increasing her Paxil from 30 mg to 40 mg daily. The patient was noted today to have a male in her room with the door shut. She is saying that she feels sex is normal and she is going to do what she wants...Her cognition continues to be very declined...The Psychiatric Examination:Appearance and Behavior:...Cooperative: no,...Memory: poor, Attention: fair, Thought Content:...Insight: poor, judgment: poor,...thought process: more confused, Orientation: Person: yes, Place: no, Time: no..." An Interdisciplinary Team (IDT) note dated 5/6/22 indicated "Last evening [5/5/22] resident [28] was in her room and another male resident [14] came to visit her. When staff entered room the observed resident with her hand under his shorts. Resident separated and skin assessments completed, no findings. Psych informed and had been in to visit resident earlier in day and medication adjustments made. Psych to continue to follow and make recommendations made as needed." A nursing progress note dated 5/6/22 at 8:35 p.m. indicated "resident [28] has had sexual comments and behavior towards male resident [14] and staff members this shift..." A Quarterly MDS Assessment, completed 5/10/22, indicated Resident 14 had moderately impaired cognition			

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	Resident 28's and Resident 14's clinical records did not include a plan of care and/or interventions in place for sexual behaviors at that time. A nursing progress note, dated 5/13/22 at 1:16 a.m., indicated Resident 14 was found in another resident's (Resident 28) room sitting on his knees beside her bed. The wheelchair was positioned in front of the door. He was returned to his own room and instructed to not enter other resident's rooms. A Behavior Event for Resident 28 dated 5/24/22 indicated "...Description: inappropriately touching a male resident [Resident 14] ... Event details:resident had her hand on male resident leg near privates...where did the behavior occur? resident [28]'s room...who was involved in the behavior? ...2. possible triggers (contributing factors) ...[marked as] other - expressed feelings toward male resident...3. intervention: [marked as] quieted environment...other resident removed from situation and taken back to room.... Evaluation notes: resident's monitored for inappropriate behavior and staff intervene as needed..." A reportable incident to the Indiana Department of Health was provided by the ED on 1/5/23 at 2:23 p.m. It indicated a sexual interaction had occurred between Resident 28 and 14 on 5/24/22. The "...brief description of incident...Resident [14] was found in resident [28]'s room and she was inappropriately touching him...Immediate Action Taken: ...Residents were immediately separated. Head to toe assessments completed without injuries noted... Preventative Measures Taken...No further resident to resident contact made. Psych to continue to follow for behaviors and make recommendations as needed...Follow			

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	up: Resident's monitored for inappropriate behavior and staff continue to intervene as needed. Family aware and informed of resident's desire to be spend time together and socialize. Care plan updated. Residents continue to be followed by psych services and medications adjusted as needed." A physician order dated 5/25/22 indicated Resident 28 was to receive 2.5 milligrams of Zyprexa at night for sexual aggression. A progress note, dated 5/26/22 at 4:14 p.m., indicated Resident 14 was being monitored for inappropriate behavior and staff continued to intervene as needed. His family was aware and informed of residents' desire to be spend time together and socialize. The family was agreeable to allowing residents to spend time together and aware of their desire to be intimate. Residents continue to be followed by psych services. A progress note for Resident 28, dated 5/26/22, by Executive Director indicated, "Resident's monitored for inappropriate behavior and staff continue to intervene as needed. Family aware and informed of resident's desire to spend time together and socialize. Family agreeable to allow resident to spend time together and aware of resident's desire to be intimate. Residents continue to be followed by psych services." A progress note dated 5/29/22 at 9:04 p.m. indicated Resident 14 was agitated when the CRCA (Certified Resident Care Assistant) and QMA (Qualified Medication Assistant) separated him from a female resident (Resident 28). He was sitting in the doorway of the female resident's room. Resident 14 stated that the workers were crows and always watching over him and the			

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	female resident. He was educated on why they needed to be separated and did not agree. He expressed that it was like a prison. Resident 14 was easily calmed down and did not attempt to go back into the female's room. A care plan for Resident 28, initiated 5/31/22, indicated "Resident demonstrates inappropriate behaviors including: touching another male resident in a sexual manner...long term goal...Residents behaviors will not result in disruption of others environment and resident will remain safe...Approach...Assess for unmet needs such as need for toileting, rest, food, companionship, etc...Assist resident to away from other residents as needed...Determine cause for inappropriate behavior and refer to physician as needed for intervention...Encourage participation in structured activities as appropriate...Observe for triggers of inappropriate behaviors and alter environment as needed..." A care plan for Resident 28, initiated 5/31/22, indicated "Resident enjoys to[sic] company of another male resident/enjoys visiting with male resident in her room. Family aware of relationship although not 100% supportive...Long term goal...Resident will be safe...Approach...Family aware and consents of resident spending time with and socializing with male resident in her room...Intervene as needed...Psych to continue to follow..." A care plan, initiated 5/31/22, indicated Resident 14 enjoyed the company of a female resident and visits with her in her room. The family was aware of the relationship although not 100% supportive. The goal was to keep Resident 14 safe. The approaches, initiated 5/31/22, were to intervene as needed, the family was aware and consented to			

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	resident's desire to spend time and socialize with the other resident, and for psychiatric services to continue to follow Resident 14. A care plan, initiated 5/31/22, indicated Resident 14 demonstrated inappropriate behaviors including touching another resident in a sexual manner. The goal was for the behavior not to result in disruption of others environment. The approaches were to determine the cause for the inappropriate behavior and refer to physician as needed for intervention, initiated 5/31/22, psychiatric services would continue to follow, initiated 5/31/22, encourage Resident 14 to participate in structured activities as appropriate, initiated 5/31/22, observe for triggers of inappropriate behaviors and alter the environment as needed, initiated 5/31/22, assess for unmet needs such as need for toileting, rest, food, companionship, etc., initiated 5/31/22, assist resident away from other residents as needed, initiated 5/31/22, and to administer anti-depressant medication as ordered, initiated 6/12/22. The clinical records for Resident 14 and Resident 28 did not contain information of informed consent to sexual activity such as, understanding of risks or benefits of sexual activity and knowledge of when sexual advances are appropriate such as time and place. A Psychiatric Evaluation/ Follow-up note, dated 6/2/22, indicated Resident 14 continued to receive Zoloft (anti-depressant) for depression and had no difficulty with side effects. His cognition remains somewhat confused but stable. He had been visiting a particular female (Resident 28) on his hall and was found allowing her to touch him privately He was provided with information about this being inappropriate and needing to avoid that			

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	female which he agreed to. A Psych Visit Note for Resident 28 dated 6/2/22 by Psych NP 1 indicated "Interval History...6/2/22 Staff report the patient is continuing to have ongoing difficulty with sexual aggression. She was found fondling a male peer while lying in her bed. She makes frequent sexual comments about him. She was started on Zyprexa 2.5 mg hs to address her difficulty with delusions and sexual aggression...Presenting Problem & Patient Interview...She is fairly loud during our visit. She states nursing staff have been treating her poorly due to her affair. She describes this as something she enjoys, and she feels it is appropriate. She also states there should be no rule against people having sex in the facility. she also tells writer a story where she says that staff had blood on their shirts when they came in her room and they told her that a male peer had been in a motorcycle accident. She found out later this was not true and that he was fine. she says she is angry with staff for making up the story. The patient is illogical with this information. The patient was provided reality feedback. He (sic) also was provided with direction regarding inappropriateness of sexual relations in the facility with male peers. The patient disagrees with this somewhat loudly but is not derogatory during the discussion. Writer is unable to assist the patient to recent due to her level of cognitive decline...Treatment Plan...6/2/22 The patient is continuing significant difficulty with behavior issues and psychosis. Paxil is ordered for sexual aggression. we are going to increase from 30 mg to 40 mg daily due to her ongoing sexual aggression. The patient has fondled a male peer in her room. She continues to seek him out and talk about her relationship with him sexually. We are going to increase Zyprexa for psychosis. she was started on 2.5 [mg] last week			

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	and has not had improvement. She is delusional today talking about staff telling her male peer had a motorcycle accident. her cognition continues to be declining slowly..." A physician order dated 6/3/22 indicated Resident 28 was to receive 40 mg of Paxil daily for sexual aggression. A physician order dated 6/3/22 indicated Resident 28 was to receive 5 mg of Zyprexa for psychosis with delusions, which was discontinued on 7/5/22. A Behavior Event for Resident 28 date 6/3/22 indicated "...Description. med changes: Zyprexa and paxil - monitor behaviors of sexual nature. What behavioral expression was exhibited? behaviors of sexual nature.... Where did the behavior occur? room..2. Evaluation Possible Triggers (contributing factors): Recent change in Medications - Zyprexa and paxil...3. Interventions: Engaged in a different activity...conversation...called family to talk...psych notified...Evaluation notes: Resident [28] has dx [diagnosis] of dementia with behaviors. Psych services aware and managing medications..." A nursing progress note dated 6/4/22 for Resident 28 indicated "resident lifting front of dress to male resident [14] x 2 [twice]. staff monitored closely and resident redirected when seen. resident spoke to male resident that she is not supposed to do that. resident monitored closely by staff this shift." A nursing progress note dated 6/7/22 for Resident 28 indicated "...One episode of inappropriate talk with a male resident [Resident 14]. staff intervened and separated them. resident did not have any			

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	more behaviors after that." A nursing progress note dated 6/8/22 for Resident 28 indicated "Resident up in wheelchair, able to move self around hallways. Resident was saying that she wanted a male resident friend [Resident 14] to eat dinner with or to eat in the riley dining hall with her. Resident was easily redirected. Later resident was taking clothes off in hallway. She was wheeled back into her room and dressed 3 different times, each time wheeling back into the hallways and stripping again." A care plan dated 6/9/22 indicated "Resident demonstrates inappropriate behaviors AEB [as evidenced by] taking clothes off in hallway/stripping...Approach...Assess for unmet needs such as toileting, rest, food, companionship, etc...Assist resident to away from other residents as needed...Determine cause for inappropriate behavior and refer to physician as needed for intervention...Encourage participation in structured activities as appropriate...Observe for triggers of inappropriate behaviors and alter environment as needed..." A nursing progress note dated 6/9/22 for Resident 28 indicated "...She was at the HUB [common area] after dinner and was tearful and sad. She was looking for her male companion she stated. She was tearful until she was ready for bed." A nursing progress note dated 6/10/22 for Resident 28 indicated "...She was yelling in the hallway outside of her room at staff. She was trying to go into another male resident [14]'s room. When she was redirected away from male resident's room, she started yelling and crying and said she was going to throw a fit like a 2 year old. She wheeled herself out of her room and was			

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	talking inappropriately with another resident. Resident then wheeled into her room when asked to not talk like that..." An Event Report, dated 6/11/22 at 10:25 p.m., indicated Resident 14 had a fall in another resident's (Resident 28) room. He was sexually active with another patient (Resident 28) at the time of the fall. There were no injuries noted. He was alert and oriented to person and place. He refused to stay out of the other resident's room. The notes include that he was found on his knees next to a recliner. He had his right hand on the other patient's body and his left hand on his penis. He had been incontinent of bladder. We was assisted to the wheelchair and assessed to have no injuries. He was agitated with staff for interrupting with multiple attempts to make care as difficult as possible. He threatened to have his family come to the facility to physically assault the staff. His family and the physician were called and notified. The Director of Health Services was notified. A nursing progress note, dated 6/12/22 at 10:05 a.m., indicated a message was left for the psychiatric nurse practitioner notifying her of Resident 14's behaviors on 6/11/22 with another resident (Resident 28). A nursing progress note, dated 6/12/22 at 11:33 a.m. indicated NP (Nurse Practitioner) 1 had returned call and given a new order for Resident 14 to receive Paxil (anti-depressant) 10 mg(milligram) daily. A care plan for Resident 28, initiated 6/13/22, indicated "Resident demonstrates inappropriate behaviors AEB [as evidence by] inappropriate sexual comments in conversing with			

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	others...Approach...Assess for unmet needs such as need for toileting, rest, food, companionship, etc...Determine cause for inappropriate behavior and refer to physician as needed for intervention...Encourage participation in structured activities as appropriate...Observe for triggers of inappropriate behaviors and alter environment as needed...Psych to continue to follow..." A care plan for Resident 28, initiated 6/13/22, indicated "Resident demonstrates verbally abusive behaviors/yelling at staff...Approach...Encourage resident to express wants and needs during hands on care and contacts. Encourage resident to voice feelings constructively to staff as appropriate. Observe for patterns of behaviors that may trigger verbally abusive language. Alter as appropriate. Observe mood, affect, and behaviors with all hands on care and contacts. Psych to continue to follow. Re-direct resident during periods of frustration and anger..." An IDT note for Resident 28 dated 6/15/22 indicated "Patient continues to be monitored for behaviors. Was noted to yell out at times, have statements and behaviors of a sexual nature toward a male resident [Resident 14] and making inappropriate comments. Patient has a diagnosis of cerebral infarction, Major depressive disorder, Mild cognitive impairment and Unspecified dementia with behavioral disturbance. Is followed by psych with recommendations made as indicated. Patient started on Depakote 5/3 and takes it BID and was started on Paxil and zyprexa 6/3. Will continue to monitor for changes and further behaviors and consult psych as indicated."			

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	A nursing progress note for dated 6/16/22 for Resident 28 indicated "this resident and a male resident in hallway sitting together. this resident unbutton top and let male resident rub all over her breast. Staff separated residents and took to room. resident sat in room quietly until put to bed." A nursing progress note for Resident 14, dated 6/16/22 at 8:41 p.m., indicated that he was with another resident in the hallway and found rubbing all over her breasts. He was redirected to his room and informed to stay away from the other resident. An Event Report, dated 6/18/22 at 7:30 p.m., indicated Resident 14 had a fall while he was transferring himself. There were no injuries noted from the fall. He was alert and oriented to person, place, time, and situation. He required assistants to transfer and ambulate and refused to comply with safety measures such as call light use, alarms, and appliances. He was taken to his room and assisted to bed after the fall. The notes for the event included, but were not limited to, the following: 6/18/22 at 8:20 p.m., Resident 14 was in Resident 28's room sitting in high fowlers (upright with legs extended in front of him). His wheelchair was on his right side and his back was against the door. It took a lot of encouragement by numerous staff to get him to move far enough away from the door to allow staff to enter the room. Staff entered the room after approximately 15 minutes and assisted him back to his wheelchair. He was fully dressed, and no inappropriate behaviors were noted. 6/23/22 at 1:35 p.m., Resident 14 had a fall while visiting Resident 28 in her room. The door was shut, and he was sitting with his back against the door. An intervention of leaving the door open when visiting was initiated. 6/25/22 at 1:46 p.m., Resident 14 was found in Resident 28's room. He often seeks companionship from this female			

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	resident. He was removed from room and returned to his own room. 6/27/22 at 3:06 a.m., Resident 14 was found to be returning to his room at 1:05 a.m. He was noted to have BM (Bowel Movement) on bilateral upper extremities from his fingertips to his elbows. He became agitated when being cleaned up and struck out at staff. A nursing progress note dated 7/1/22 for Resident 28 indicated she was admitted to hospital with urinary tract infection and pneumonia. Resident 28 returned from the acute care hospital on 7/5/22, with a physician's order to receive 300 mg cefdinir twice a day with a discontinuation date of 7/7/22. A Pharmacy Recommendations Event Report for Resident 14, dated 7/5/22 at 9:03 a.m., indicated he had Paxil added on 6/12/22 due to some inappropriate sexual behaviors. He was also receiving sertraline (anti-depressant) 50 mg, which is another SSRI (Selective Serotonin Reuptake Inhibitor). It is not recommended to use both, please review. A physician's order for Resident 14, dated 7/7/22, indicated to discontinue the Zoloft (Sertraline). A Psych Visit note dated 7/7/22 by Psych NP 1 indicated "...Interval history...7/7/22 The patient had an episode of inappropriate talk with a male peer and also lifted the front of her dress for him. She also was noted to be undressing in the hall several times. She told staff she has performed sexual acts with the male peer. She has observed allowing him to touch her breast. She was sent to ER [emergency room] 7/1/22. she has been back for 2 days with no sexual behaviors since her return. Her cognition is significantly declined. it is			

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	unchanged from last visit." An Event Report, dated 7/17/22 at 3:11 p.m., indicated Resident 14 was displaying sexual gestures to another female resident by attempting to stick his foot into Resident 28's private area while sitting in the open hub area. The possible changes included recent discontinuation of Zoloft and sexual desires. The interventions were that he was assisted to his room and his family was called. The notes for the event included, but were not limited to, the following: 7/17/22 at 3:08 p.m., Resident 14 was sitting in the hub area when noted to have his foot between another female resident's legs. He was educated that this was not appropriate, and he laughed and said "heck, let's just screw right here". 7/18/22 at 8:38 p.m., Resident 14 and Resident 28 were in the hallway outside of Resident 28's room. She was manipulating his penis. A family member came to the nursing station to report the incident. The residents were immediately separated, and the Executive Director was informed. 7/21/22 at 8:27 p.m., Resident 14 was visiting Resident 28 with the door shut for a consensual visit. 7/26/22 at 1:30 a.m., Resident 14 was found on his knees in another resident's room without pants or a brief on. He had placed his wheelchair in front of the door to prevent staff from entering. He was assessed and found to have abrasions on both knees and complained of knee pain. The female resident in the room reported that they had engaged in sexual relations. He refused to leave room or let staff assist him off of the floor. The female resident asked him to kiss her and that she was going to bite his lip. Family notified of the incident an appears increasingly frustrated with the situation. A Behavior Event Note for Resident 28 dated			

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	7/17/22 indicated "...Description: sexual gestures to another male resident. What behavioral expression was exhibited? exposing herself to male resident who was trying to stick his foot in her private areas...Where did the behavior occur? in hub area. 2. Evaluation possible triggers (contributing factors) ... under-stimulation (boredom) - sexual desires. 3.) Intervention: address unmet needs - she just wants [Resident 14]'s penis, assist to different area - away from [Resident 14], call family to talk - no answer.... Evaluation: IDT note: resident sexual gestures are consensual. staff encouraged to redirect and educate on safe/healthy habits. Encouraged to room for sexual desires for privacy..." Resident 14's and 28's medical records did not include an assessment at that time for capacity to consent to sexual activity, nor plan of care plan with interventions in place to ensure safety regarding sexual encounters. A nursing progress note for Resident 28 dated 7/18/22 at 1:38 p.m. indicated "resident told male staff member to stick his finger in her belly button after pulling her gown up. She then expressed the desire to stick her finger into a specific male resident [Resident 14]'s belly button. Then stated she was only joking to get a reaction out of writer." A nursing progress note for Resident 28 dated 7/18/22 at 1:42 p.m. indicated "resident has been in hallway yelling twice for a specific male resident [Resident 14]. resident was asked to please not yell in the hallway as it disrupts other residents resting. resident got louder and yelled at writer and other staff around to push her up the hallway to this male resident's room. staff encouraged resident to propel her own chair which she did			

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	and that the other resident she was seeking was resting in his room. this resident then asked to go sit in the common area, which staff assisted with mobility." A nursing progress note for Resident 28 dated 7/20/22 indicated "up in w/c sitting in doorway yelling down hall for male resident [Resident 14] ...to get down to her room. No close contact with this resident as of yet today." An IDT note for Resident 28 dated 7/22/22 indicated "Resident continues to have intimate relationship with another resident. Both residents enjoy the company of each other. They hand [sic] out in common area and in resident room. Residents are encouraged to go to room when having sexual desires for privacy. Resident educated and agreeable. Resident 28's POA made aware and understands situation, no concerns voi ced. Discussed safety concerns with both resident and resident [28's POA]."A nursing progress note dated 7/26/22 for Resident 28 indicated "Male resident [Resident 14] found on knees next to female resident's bed after reportedly falling off. Female resident stated, 'we were screwing' and had brief down around her knees. Male resident was naked from the waist down. Denies any pain or discomfort. States behavior was consensual. States she was going to bite male resident's lip and asked him to stand up so she could look at him naked."An IDT note for Resident 28 dated 7/26/22 indicated "male friend found on knees next to female resident's during night. states they were			

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	having sexual relations and fell. IDT team reviewed incident and agreed to rearrange resident room to maximize space and promote safety. resident in bari low bed, height can be adjusted for comfort and positions. NP [Nurse Practitioner] ed [Executive Director] and ss [Social Services] and family aware of incident and interventions to promote safety during intimate relations." A Nursing Home Visit note, by medical NP 2 on 7/29/22, indicated Resident 14 was seen for decision making evaluation. His last BIMS (Brief Interview for Mental Status) score was 12 which indicates moderately impaired. His SLUMS (Saint Louis University Mental Status Examination) was 19 (0-20 indicates dementia). The facility has asked for him to be seen due to having a sexual relationship with another patient who also has some memory impairment. The facility wanted to ensure the patients are of similar cognitive abilities. A SLUMS was completed with a score of 20 (indicative of dementia). He was able to discuss his relationship with his girlfriend and appears to understand the reasoning of the assessment of his decision-making abilities. He had a history of frequent falls and there are safety concerns, but this has been discussed with therapy and they are working with both patients. He has the right to have a sexual			

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	relationship and appeared appropriate with his decision making about the subject. A medical NP 2 note for Resident 28 dated 7/29/22 indicated "...Details...seen today for decision making evaluation. facility asked for assessment d/t [due to] patient having a sexual relationship with another patient. She does have a dx of dementia and her BIMS [Brief Interview for Mental Status] fluctuates. Her most recent ECF [extended care facility] BIMS assessment on 5/31/22 was a 13 indicating intact cognition. No SLUMS assessment in chart...Plan: Patient SLUMS assessment scored a 14 today (1-20 indicative of dementia). She was able to discuss her relationship with her boyfriend and appears to understand the reasoning of assessing her decision making abilities. There are some physical safety concerns but this has been discussed with therapy and they are working on a plan for this with both patients. Patient has the right to a consensual sexual relationship and appears appropriate with her decision making regarding the subject. Facility notes indicate family is aware of the relationship. she is at risk for UTI, spoke with DON [Director of Nursing] about possibly starting a ppx [prophylaxis] atb [antibiotic] and she was in agreement with this plan...1. 100 mg of macrobid daily 2. Floraster 250 mg BID..." A physician order dated 8/1/22 indicated Resident 28			

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	was to receive 100 mg of macrobid for UTI prevention. An IDT note for Resident 28 dated 7/30/22 indicated "Resident seen by NP [2] for increased in sexual desires with male resident. NP stated resident on prophylactic ATB to prevent UTI due to personal hygiene concerns. resident and family aware. resident incontinent of bowel and bladder. staff assist with pericare."A Psych visit note for Resident 28 dated 8/4/22 by Psych NP 1 indicated "...Presenting Problem & Patient Interview: ...She says 'the man I fell for has now fallen for me.' she also reports some 'normal fear that I will lose that.'...Treatment Plan:..Paxil 40 mg daily is ordered for sexual aggression and depression both...She is continuing to have some preoccupation with sexual interactions with a select male peer. Hopefully this will be deterred by medication he [Resident 14] will be ordered today. Her cognition remains declined and the patient has fairly significant dementia..." A Psychiatric Evaluation/ Follow-up note, dated 8/4/22, indicated Resident 14 had an episode of sexual behavior with female peer on 6/11/22. He was started on Paxil 10mg daily for sexual preoccupation. On 6/16/22 he had another episode in the hall of sexually touching the same female. He had another on 7/10/22 with no injury obtained. On 7/18/22, he was found in the hall being			

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	sexual with the same female. On 7/26/22, he was found attempting intercourse with the female peer. Today during the visit, he reports interest in sex, but denies inappropriate behavior with it. His Zoloft was discontinued, and Paxil was started, with the hope that the Paxil would address both his depression and his sexual preoccupation. Unfortunately, he has continued to have significant and increasing sexual encounters with female peer. He has also had several falls since starting the Paxil and are concerned this may have been a side effect of the medication. The Paxil was discontinued due to patient safety. Depo-Provera (sexual deterrent) 150 mg IM (Intermuscular Injection) weekly was started to address his sexual preoccupation and aggression. His cognition continues to have a slow decline.Resident 14 received his first dose of Depo-Provera on 8/5/22.A Quarterly MDS Assessment, completed 8/10/22, indicated Resident 14 had moderate cognitive impairment. A nursing progress note for Resident 28 dated 8/18/22 indicated "...earlier after dinner, she kept making attempts to enter room [Resident 14's room]. residents [Resident 14 and 40] in this room did not want her coming in, resident in [Resident 14] actually blocked the door with his w/c and himself trying to keep her out of their room. resident also			

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	cursing in hallway at staff." A nursing progress note for Resident 28 dated 8/20/22 at 11:58 p.m. indicated, "resident flashed another resident [Resident 14] and made comments about making a baby. male resident went to his room and female resident was assisted into bed per request." A nursing progress note for Resident 28 dated 8/20/22 at 12:39 p.m., indicated "res continues to have behaviors toward other male res. [Resident 14] tried to enter room and staff removed. male res was sleeping at the time and other male res still in his bed. this res stated male residents were smoking in their room and she wanted to check on them. this res taken to hub and reoriented. continue to monitor for res to not enter [Resident 14 and 40's room]. A nursing progress note for Resident 28 dated 8/20/22 at 3:35 p.m. indicated "resident sitting in hall on (sic) room down from another male res [Resident 14] and yelling for him to come out and see her. Took res down by her room and she wheeled herself right back." A nursing progress note for Resident 28 dated 8/21/22 indicated "Res sitting outside another male residents [Resident 14]'s room and yelling for him to come out. Male resident backed self out to door and they are by door visiting. Will continue to monitor."A nursing progress note for Resident 28 dated 8/24/22 indicated			

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	"resident was in hall multiple times yelling for [Resident 14], she had slapped an aides butt after being told not to touch the aid, at dinner resident refused to stay in the little dining room because she wanted [Resident 14] ..." A Psychiatric Evaluation/ Follow-up note, dated 8/25/22, indicated Resident 14 was doing well with present psychiatric issues. He had had no signs or symptoms of depression or anxiety. He has continued to be confused and asking staff to have his family pick him up at the hotel. He has had no sexual behaviors since the last visit. A Psych Visit note for Resident 28 dated 8/25/22 by Psych NP 1 indicated "...Presenting Problem & Patient Interview: "... 8/25/22 The patient report she is feeling somewhat sad because her male peer is no longer interested in her. She perceives this as having a relationship which has ended. The patient provided with assistance for grief therapy. She is responsive to this but still confused about the circumstances ...she does report some depression associated with this relationship. it does not appear problematic at this time. Her cognition is still significantly decline...Treatment Plan:..8/25/22 the patient is no longer being sexual with a male peer, mostly because he is no longer interested. She perceives as a loss of a relationship and is somewhat sad with mood. Her Paxil was increased last visit			

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	[6/2/22] to address her sexual aggression. Hopefully this will also help with her feelings of depression/sadness...Psychiatric Examination: Appearance and Behavior:...memory: poor, attention: fair, Thought Content:...insight: poor, judgment: poor,...affect: constricted, mood: sad, thought process: more confused, orientation: person - yes, place - no, time - no..."A nursing progress note for Resident 28 dated 8/29/22 indicated "writer informed resident that if she wanted to be with [Resident 14] they had to go to her room. informed her that [Resident 14] has a room mate and doesn't want to see them together. Resident yelled at a male resident and told him to come to her room and when the male resident went into his room and shut the door this resident was very angry about it and said this is why we do not go to my room because he wont come to my room. Informed resident that he has choices just like she does and resident went to her room to get ready for bed."A nursing note for Resident 28 dated 9/4/22 indicated "resident in hallway with male resident [Resident 14] being sexually explicit when talking to him, putting his foot between her legs and unzipped her top to expose her breasts visiting family members present. resident told several times she couldn't behave that way several times and they needed to go to her			

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	room if they wanted to act that way male resident went into his room and she was taken to her room." A nursing note for Resident 28 dated 9/16/22 indicated "...writer also spoke to np regarding marcobid which was started with no stop date related to patient and other resident's relationship. relationship seems to have subsided at this time. orders received to dc [discontinue] macrobid..." During an interview on 1/5/23 at 3:26 p.m., the ADON (Assistant Director of Nursing) indicated when the incidents of sexual behaviors started between Resident 14 and Resident 28 the facility actively attempting to decide what the correct course of action should have been. The behaviors were discussed frequently to reach a determination if Resident 14 and Resident 28 were able to consent to sexual contact and honor their rights to participate in sexual contact. The BIMS and SLUMS assessments were reviewed when we were determining their ability to consent. When the sexual contact started both Resident 14 and Resident 28 were "pretty with it". Resident 14 would seek her out and Resident 28 loved the attention. Resident 14's cognition would come and go when he was admitted and has declined since he has been here. Resident 28's cognition has declined since she has been here. The facility			

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	had never had a situation like this before. The staff were divided on how to handle the situation. The corporate office was consulted to assist the staff with guidance on the situation. Their intimate interactions were not planned occurrences. Resident 14 would go to her room in the evening or during the night. The staff would discover them and redirect them. Resident 14 began leaving his wheelchair in front of the door to keep staff from being able to come into the room. There were concerns about their safety due to Resident 14 falling often while attempting to be intimate and a concern for Resident 28 developing urinary tract infections due to intimate contact. Therapy became involved for safety management and Resident 28 was started on a prophylactic antibiotic to decrease the risk for urinary tract infections. During an interview on 1/6/23 at 10:59 a.m., Psych NP 1 indicated she had been made aware of the sexual encounters between Resident 14 and Resident 28 and had consulted about their ability to consent to sexual activity. She felt neither Resident 14 nor Resident 28 were able to consent sexual activity. She had used the MOCA Assessment scores, which assesses decision making abilities, to determine their inability to consent. She did not believe that either Resident 14 or Resident 28 had possessed the ability to consent at any time during the			

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	encounters. She thought the facility staff were intervening during the encounters and not allowing the residents to be alone. Resident 14 and Resident 28 were made aware that the activities were inappropriate but continued to seek each other out. Resident 28 had initiated the activity, and eventually Resident 14 became more interested and started to initiate the sexual contact. Resident 28 has a lot of mental health concerns such as psychosis, combativeness, and sexual behaviors. She had adjusted Resident 28's anti-depressant medication when the encounters started since Resident 28 was the initiator of the activities. When Resident 14 became more interested and started being the initiator, Psych NP 1 added an anti-depressant to deter the sexual activity. As the encounters continued and Resident 14 became more interested in initiating sexual encounters, his anti-depressant was discontinued, and Depo-Provera was started. There had been a concern that Resident 14's anti-depressant may have been contributing to his fall risk. The Depo-Provera had been effective in deterring Resident 14's sexual interest. Resident 28 was sad and frustrated the relationship had ended. That has resolved as well. Psych NP 1 was attempting to reduce the depo Provera since the sexual activity had not happened since September 2022.			

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	The facility had kept her aware of the behaviors and communicated well with her. On 1/6/23 at 11:50 a.m., the ED, DHS, NC 3 and NC 4, and the SSD (Social Services Director) were interviewed. The ED indicated that the first know sexual contact between Resident 14 and Resident 28 had occurred 5/5/22 and a reportable incident was filed the IDOH (Indiana Department of Health) at that time. The facility conducted interviews with both residents and consulted their BIMS scores, at the time his BIMS was lower and then it increased. When Resident 14's BIMS score increased, we re-examined the situation and consulted NP 2 and the Medical Director, I do not remember having conversations with Psych NP 1 about the situation. At the time, the facilities policy was that there was informed consent as long as there was verbalized consent to engage in the sexual activity. After the increase in Resident 14's BIMS score, we dug deeper and thought it was something we should let happen, because it was their right. I had conversations with each of the residents and both Resident 14 and Resident 28 expressed the desire to have sexual activity with each other. I then talked with families of each of them, that's when we changed our thought process to allow it. There were some staff members who thought it was inappropriate but spoke			

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	with them about allowing it due to Resident 14 and Resident 28 being two consenting adults. There were times when Resident 14 and Resident 28 had sexual expressions at the nurse's station, that may have been when their medications were adjusted. It appears that the facility was not on the same page as the psychiatric provider. If the relationship were to start again today, we would re-evaluate and do an assessment, as our current policy indicates. During the interview with the ED, DHS, NC 3 and NC 4, and the SSD on 1/6/23 at 11:50 a.m., the DHS indicated the sexual interactions were not random for either Resident 14 or Resident 28. They would only seek out each other. NP 1 routinely reads all progress notes. Resident 14's family members were in limbo about the relationship, they were okay with it, but didn't want it to get too extreme. The medications were used to keep the relationship at a minimum due Resident 14's multiple falls and safety issues. There was a lot of education provided to the staff during the twice daily "huddles" at the nurse's station in order to keep staff informed. During the interview with the ED, DHS, NC 3 and NC 4, and the SSD on 1/6/23 at 11:50 a.m., NC 3 indicated when Resident 14 and Resident 28 engaged in sexual expressions at the nurse's station, Resident			

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	28 was redirected to her room. An interview was conducted with Resident 28's representative on 1/6/23 at 5:23 p.m. He indicated Resident 28 does have dementia and "is not in her right frame of mind." She would not do anything like that prior to dementia regarding her sexual interactions. Resident 28 would be "mortified" if she knew prior to the dementia what she has said and done. During an interview on 1/9/23 at 11:10 a.m., FM (Family Member) 5 indicated that he was aware of the sexual relationship between Resident 14 and Resident 28. FM 5 was not really comfortable with the relationship because it seemed that Resident 14 was "sneaking around" in order to see Resident 28, which was not normal behavior. Resident 28 would often yell down the hallway that she wanted Resident 14's di** (penis). There was an incident when FM 5 had brought Resident 14 back from an appointment and Resident 28 told Resident 14 that she wanted his di** in front of FM 5 and another family member. FM 5 believed that prior to him having dementia, Resident 14 would have been embarrassed if someone would have said this to him. FM 5 believed he was embarrassed at the time it happened because it was said to him in front of his family. FM 5 had not been educated on what the Depo-Provera was for at the time it			

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	was started, however he was in agreement with it being used because Resident 14 was not fit for those type of activities at this time and it was putting him in a bad position. On 1/6/23 at 11:50 a.m., the ED provided the previous Guidelines for Resident Sexual Expression policy, approved 5/22/2018 and revised 10/24/22, which read "...To recognize and respect the rights and importance of emotional and physical intimacy in the lives of older adults including those with Alzheimer's disease and dementia. Sexual expression is a basic biological and physiological need as defined in Maslow's Hierarchy of Need- air, food, drink, shelter, warmth, sex, sleep. Maslow stated that one must satisfy lower-level basic needs before progressing on to meet higher level growth needs. It is the belief of ... that even though our residents are elderly, present with physical and cognitive concerns they still have the right to engagement and contributions in life...2. Residents have the right to sexual activity providing that the activity does not involve a. Non-consensual acts b. Acts with minors c. Acts between persons if there is known or suspected STD d. Acts of public display that would impact the resident community 3... guidelines recognizes and supports the right of residents to engage in sexual activity as long as there is demonstrated consent by words			

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	and/or affirmative actions. 4.The facility shall provide documentation to confirm that consent was and continues to be given to provide for the safety of those involved. 5. When evaluating the sexual activity of the residents the professional and care giving staff should set aside their personal biases and judgement to maintain objectivity...7. Notification...b. Involvement of a family member or legal representative may be indicated only in instances where the involved resident(s) is cognitively impaired. In these cases, it is the responsibility of the facility to uphold the choices and rights of cognitively impaired residents and to work with the families and/ or legal representatives if their suggested course of action is discrepant..."On 1/5/23 at 10:06 a.m., the ED provided the current Abuse and Neglect Procedural Guidelines policy, effective 8/29/19, which read "...had developed and implemented process, which strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect...Definitions...Sexual Abuse-is non-consensual sexual contact of any type with a resident..."On 1/9/23 at 3:29 p.m., the Assessment of Older Adults with Diminished Capacity: A Handbook for Psychologists ©American Bar Association Commission on Law and Aging - American Psychological Association from the			

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	American Psychological Association web site which read " ... ...There are no generally accepted approaches or criteria for the assessment of consent to sexual activity. Stavis et al., [1999] suggest that the following be considered by the examining clinician, with the understanding that some individuals with capacity to consent would not meet all of these criteria: Is an adult, as defined by state law; demonstrates an awareness of person, time, place, and event; possesses a basic knowledge of sexual activities; possesses the skills to participate safely in sexual activities; i.e., whether the person understands how and why to effectively use an appropriate method of birth control, and whether the person chooses to do so; understands the physical and legal responsibilities of pregnancy; is aware of sexually transmittable diseases and how to avoid them; demonstrates an awareness of legal implications concerning wrongful sexual behaviors [e.g., sexual assault, inappropriateness of sex with minors, exploitation, etc.]; can identify when others' rights are infringed; learns that 'no' from another person means to stop [i.e., understands that it is always inappropriate to have sex or engage in other activities with someone who says no or otherwise objects by words or action]s; knows when sexual advances are appropriate as to time and			

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	place [e.g., different places and times may apply to dancing, touching, sexual intercourse]; does not allow his or her own disability to be exploited by a partner; knows when both parties are agreeing to the same sexual activity; does not exploit another person with a lower functioning who might not be able to say no or defend oneself; expresses understandable responses to life experiences [i.e., can accurately report events]; can describe the decision-making process used to make the choice to engage in sexual activity; demonstrates the ability to differentiate truth from fantasy and lies; possesses a reasoning process that includes an expression of individual values; can reasonably execute choices associated with a judgmental process; is able to identify and recognize the feelings expressed by others, both verbally and nonverbally; expresses emotions consistent with the actual or proposed sexual situation; rejects unwanted advances or intrusions to protect oneself from sexual exploitation; identifies and uses private areas for intimate behavior; is able to call for help or report unwanted advances or abuse [Stavis et al., 1999, p. 63-64]. Peter Lichtenberg offers the following suggestions for assessing sexual consent capacity: 1. Patient's awareness of the relationship: a. Is the patient aware of who is initiating sexual			

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	contact? b. Does the patient believe that the other person is a spouse and, thus, acquiesces out of a delusional belief, or [is he/she] cognizant of the other's identity and intent? c. Can the patient state what level of sexual intimacy [he/she] would be comfortable with? 2. Patient's ability to avoid exploitation: a. Is the behavior consistent with formerly held beliefs/values? b. Does the patient have the capacity to say no to any uninvited sexual contact? 3. Patient's awareness of potential risks: a. Does the patient realize that this relationship may be time limited [placement on unit is temporary]? b. Can the patient describe how [he/she] will react when the relationship ends?' These authors note that while being able to state the level of sexual activity or intimacy is wanted is an important consideration, one must also assess the ability to refuse or resist sexual advances. Lichtenberg et al., also emphasized Assessment of Older Adults with Diminished Capacity: A Handbook for Psychologists ©American Bar Association Commission on Law and Aging - American Psychological Association 67 the importance of residents understanding that the ending of a relationship might be one of the potential risks of entering into a sexual relationship. Residents can leave facilities for a variety of reasons [e.g., transfer due to illness], thereby			

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	155735	A. BUILDING 00 B. WING	01/11/2023

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	terminating the relationship ..."3.1-27(a)(1)			
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to report to the Indiana Department of Health (IDOH) resident to resident sexual activity without the competency to consent for 2 of 2 residents reviewed for abuse. (Resident 14 and Resident 28)	F 0609	1. Resident 14 and 28 affected by the alleged deficient practice. Both residents assessed by a licensed nurse and found no adverse effects of alleged	02/01/2023

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	Findings include: 1a. The clinical record for Resident 14 was reviewed on 1/5/23 at 9:32 a.m. The Resident's diagnosis included, but were not limited to, Parkinson's disease, dementia, cognitive impairment, and depression. A Psychiatric Evaluation/ Follow-up note, dated 1/6/22, indicated Resident 14 was being seen for depression, dementia, and Parkinson's disease. He is alert and oriented to person only. His cognition is fairly declined, with long term memory fair to poor, short term memory and concentration poor. His executive functioning and abstract thinking are very impaired. His MOCA (Montreal Cognitive Assessment Test for Dementia) was 13/30 (10 to 17 points indicate moderate cognitive impairment). A care plan, initiated 1/7/22, indicated Resident 14 had impaired cognition with associated short term memory impairment and risk for confusion, disorientation, altered mood, and impaired or reduced safety awareness related to his dementia. The goal was for him to remain safe and not injure himself secondary to his impaired decision making. The interventions included, but were not limited to, assess his degree of hearing ability, impulsive behavior, and decrease in visual perception, initiated 1/7/22, observe for exit seeking behaviors, wandering into unsafe areas, and entering other resident rooms un-invited, initiated 1/7/22, redirect him when agitated behavior occurs or potential for injury is evident, initiated 1/7/22, determine if his decisions endanger himself or others. Intervene as necessary, initiated 1/7/22, give him feedback when inappropriate decisions are made, initiated		deficiency. Residents 14 and 28 had a Trilogy assessment for sexual activity/consent completed. Both have expressed no interest to have a relationship at this time. 2. All like residents assessed for competency to consent for sexual activity. No other residents have expressed the desire for a sexual relationship at this time. IDT (interdisciplinary team) was educated on the reportable guidelines and policy for abuse as well as educated on assessment for sexual activity/consent. All staff educated on reportable guidelines and policy for abuse and when the assessment for sexual activity consent is applicable. 3. As a measure of ongoing compliance, the Executive Director, Director of Health Services, or designee will audit sexual behaviors daily and any reports of alleged abuse in clinical care meeting to ensure compliance with the above policy and state guidelines. Audit will be completed daily x 4 weeks. 3 times a week x 8 weeks. And then weekly x 3 months. 4. As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality	

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	1/7/22, and pay attention to basic needs and provide ADL (Acts of Daily Living) care as required. Provide cues and supervision for decision making, initiated 1/7/22. A Quarterly MDS (Minimum Data Set) Assessment, completed 4/11/22, indicated Resident 14 had moderately impaired cognition. A care plan, initiated 5/31/22, indicated Resident 14 demonstrated inappropriate behaviors including touching another resident in a sexual manner. The goal was for the behavior not to result in disruption of others environment. The approaches were to determine the cause for the inappropriate behavior and refer to physician as needed for intervention, initiated 5/31/22, psychiatric services would continue to follow, initiated 5/31/22, encourage Resident 14 to participate in structured activities as appropriate, initiated 5/31/22, observe for triggers of inappropriate behaviors and alter the environment as needed, initiated 5/31/22, assess for unmet needs such as need for toileting, rest, food, companionship, etc., initiated 5/31/22, assist resident away from other residents as needed, initiated 5/31/22, and to administer anti-depressant medication as ordered, initiated 6/12/22. 1b. The clinical record for Resident 28 was reviewed on 1/5/23 at 2:30 p.m. The diagnoses for Resident 28 included, but were not limited to, stroke, major depressive disorder, mild cognitive impairment, and dementia with behavioral disturbance. The resident had previously been living in an assisted living and was transferred to long term care on 11/22/21 in the same facility. A care dated 4/3/20 indicated "Resident [28] has		Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained. IDR: I would like to dispute this alleged deficiency. By requesting the F600 tag be reduced due to the fact that the residents were able to consent and no sexual abuse occurred, there is no reason to report to the ISDH that they were engaging in sexual activity which is a basic human right.	

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	impaired cognition with associated short term memory impairment and risk for confusion, disorientation, altered mood, impaired or reduce safety awareness...long term goal...Resident will remain safe and not injure self-secondary to impaired decision making.... Approach...Calm resident if signs or distress develop during the decision making process...Determine if decisions made by the resident endanger the resident or others. Intervene if necessary...Re-direct resident when agitated behaviors are present or potential for injury is evident..." A care plan for Resident 28, initiated 5/31/22, indicated "Resident demonstrates inappropriate behaviors including: touching another male resident in a sexual manner...long term goal...Residents behaviors will not result in disruption of others environment and resident will remain safe...Approach...Assess for unmet needs such as need for toileting, rest, food, companionship, etc...Assist resident to away from other residents as needed...Determine cause for inappropriate behavior and refer to physician as needed for intervention...Encourage participation in structured activities as appropriate...Observe for triggers of inappropriate behaviors and alter environment as needed..." Resident 14 and Resident 28 had sexual interactions on the following dates: 6/2/22 - Resident 28 fondling a Resident 14 while lying in bed, 6/4/22 - Resident 28 lifting front of dress to Resident 14 twice, 6/11/22 - Resident 14 in Resident 28's room, touching Resident 28 and his penis while she is in bed, 6/16/22 - Resident 28 and Resident 14 sitting in			

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	hallway. Resident 28 unbutton top and let Resident 14 rub on her breast, 7/17/22- Resident 28 and Resident 14 sitting in common area. Resident 14's foot was positioned in between her legs while Resident 28's gown was pulled up revealing herself, 7/26/22 - Resident 14 and Resident 28 was in Resident 28's room. Resident 14 had fallen. He was on his knees with brief pulled down next to Resident 28's bed. Resident 28 was naked from waist down. Both residents verbalized sexual interaction took place at that time. 9/4/22 - Resident 28 and Resident 14 in hallway. Resident 28 placed Resident 14's foot in between her legs and unzipped her top exposing her breasts. The facility was unable to provide evidence those incidents were reported to the Indiana Department of Health. Cross Reference F600 During an interview that was conducted on 1/6/23 at 11:50 a.m., with the Executive Director (ED), Director of Health Services (DHS), Nurse Consultant (NC) 3 and NC 4, and the Social Services Director (SSD) were interviewed. The ED indicated that the first known sexual contact between Resident 14 and Resident 28 had occurred on 5/5/22 and a reportable incident was filed with the IDOH at that time. After investigating and looking into the interactions further it had been determined Resident 14 and 28's sexual interactions were consensual. He did not report sexual interactions between Resident 14 and Resident 28 to IDOH after 5/24/22. An abuse policy was provided by the ED on 1/5/23 at 10:56 a.m. It indicated, "...Purpose.			

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	Trilogy Health Services (THS), LLC, has developed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect. Procedure. 1. This has implemented processes in an effort to provide a comfortable and safe environment....3. Definitions: Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology....d. sexual abuse - is non-consensual sexual contact of any type with a resident...g. Reporting/response i. Any staff member, resident, visitor or resident representative may report known or suspected abuse, exploitation, neglect, or misappropriation to local or state agencies. II. Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where the state law provides for jurisdiction in long-term care facilities) in accordance with State			

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	law through established procedures...Iv. A written report of the investigation outcome, including resident response and/or condition, final conclusion, and actions taken to prevent reoccurrence will be submitted to the applicable State Agencies within five days..." 3.1-28(e)			
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on observation, interview, and record review, the facility failed to accurately complete an Admission Minimum Data Set Assessment for 1 of 2 residents reviewed for dental services (Resident 21). Findings include: The clinical record for Resident 21 was reviewed on 1/4/22 at 2:24 p.m. The Resident's diagnosis included, but were not limited to, diabetes. An Admission MDS (Minimum Data Set) Assessment, completed 4/28/22, indicated Resident 21 was cognitively intact and had no dental concerns. On 1/04/23 at 2:21 p.m., Resident 21 was observed sitting in her wheelchair in her room. She had no natural teeth. She indicated she had recently seen a dentist who had referred her for new dentures. On 1/10/23 at 10:13 a.m., LPN (Licensed Practical Nurse) 20 provided the dental provider Patient Note History, dated 12/12/22, which indicated	F 0641	1.Resident MDS was inaccurately coded “none of the above” for dental status. Resident had upper and lower dentures present. Per RAI guidelines MDS modified, transmitted, and plan of care updated. 1.All residents have the potential to be affected. An oral exam was completed on all residents by the MDSC per RAI guidelines. All resident care plans and recent MDS’s were reviewed for accuracy and revised as appropriate on /li> 4. As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan	02/01/2023

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	Resident 21 was seen by the dentist due to being edentulous. The dentures she currently had were 25 years old. During an interview on 1/11/23 at 12:15 p.m., the MDSC (Minimum Data Set Coordinator) indicated that Resident 21 being edentulous should have been captured on the Admission MDS Assessment.		will be reviewed and updated as warranted and will continue until 100% compliance is maintained.	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and			

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	quarterly review assessments. Based on observation, interview, and record review, the facility failed to revise a resident's hearing loss care plan to include the use of an amplifier device for 1 of 16 residents whose care plans were reviewed. (Resident 16) Findings include: The clinical record for Resident 16 was reviewed on 1/4/23 at 2:00 p.m. Her diagnoses included, but were not limited to, dementia without behavioral disturbance. The 10/1/22 Quarterly MDS (Minimum Data Set Assessment) indicated she had a BIMS (brief interview for mental status) score of 14, indicating she was cognitively intact. It indicated she had minimal hearing difficulty with the use of a hearing aide or appliance. The 2/3/21 social services note, written by the SSD (Social Services Director) read, "Resident is having increased difficulty with hearing and SS provided resident with a "Superear-Personal Sound Amplifier" today. SS tested this with resident and resident was able to understand everything that SS said to her and SS was talking in a normal tone. SS showed resident how to use the device and also showed CNA (Certified Nursing Assistant) and told nurse about it. Resident is very happy with this device. The hearing loss care plan, last revised 10/11/22, indicated she demonstrated hearing loss and heard best in a quiet setting. The goal was for to be able to effectively communicate wants and needs and participate in her plan of care daily. There were no interventions regarding the use of a superear-personal sound amplifier referenced in	F 0657	1. Resident 16 was affected by the alleged deficient practice. Care plan was added to reflect the use of an amplifier device. 2. All like residents have the potential to be affected by alleged deficient practice. All like residents' care plans were audited to ensure care plan was in place for all hearing devices. MDS coordinator and Interdisciplinary team has been educated on care plan policy including addition of assistive devices and adaptive equipment. 3. As a measure of ongoing compliance, The Director of Health Services and/or Designee will complete an audit to ensure all care plans are in place for all residents that need an assistive hearing device. Audit will be conducted weekly x 4 weeks, every other week x 8 weeks, and monthly x 3 months. 4. As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained.	02/01/2023

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	the above social services note. An interview was conducted with Resident 16 on 1/4/23 at 2:05 p.m. She was not wearing any hearing aides or using any hearing appliance during the interview. She had difficulty hearing throughout the interview and requested one repeat themselves multiple times. She would put her hand up to her left ear requesting you speak directly into it. An interview and observation was conducted with Resident 16 on 1/5/23 at 11:15 a.m. She was not wearing any hearing aides or using any hearing appliance. During this interview, one had to speak loudly, directly into her left ear and repeat themselves multiple times. She indicated when she left her room, she couldn't hear what others were saying, so she often remained in her room. If she could hear better, she would go to exercise activities more often. She indicated had different sets of hearing aids, but couldn't get them to work and was uncertain exactly where they were. She couldn't recall the last time she'd worn them, because they didn't help anyway. If they helped her to hear, that would be great. She began rummaging through drawers in a side table, but was unable to locate them. An interview was conducted with CRCA (Certified Resident Care Assistant) 8 on 1/5/23 at 11:23 a.m. She indicated she'd worked at the facility for 5 years and noticed Resident 16's hearing difficulty. She had never known Resident 16 to wear hearing aides or seen any hearing aides in her room. CRCA 8 would speak loudly and clearly when she spoke to her. An interview was conducted with PTA (Physical Therapy Assistant) on 1/11/23 at 10:50 a.m. She			

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	indicated Resident 16 began therapy last week. She noticed she was hard of hearing and was unaware she had an amplifier device. She stated, "It would be great if she could hear me, so we could communicate better." An interview was conducted with the SSD on 1/5/23 at 12:04 p.m. She reviewed Resident 16's clinical record and indicated she had an amplifier device to assist with her hearing difficulty. It had headphones and was kind of like a "Walkman." Resident 16 would hold it, and there was a volume button to adjust the volume. The SSD hadn't used it with her "in a few months." It was kept in a little container in her room. She used it to do interviews with her. Resident 16 was receptive to using it, if the SSD initiated it, as Resident 16 wouldn't initiate using it herself. "She definitely needed prompts to use it." An interview and observation was conducted with Resident 16 in her room with the SSD on 1/5/23 at 2:25 p.m. Resident 16 indicated she found her hearing aids and pointed to some small boxes on her bed. The SSD opened the boxes. There was a hearing aid in one of the boxes. Another box had an amplifier inside. The SSD took the amplifier and placed the earphones onto Resident 16. The SSD explained how to use the amplifier to Resident 16. Resident 16 thanked the SSD and indicated she could hear well now. Resident 16 informed the SSD she'd been staying in her room, because when she left, and people spoke to her, she couldn't hear them. Resident 16 agreed to leave the amplifier out for staff to use with her. An interview was conducted with the SSD on 1/5/23 at 2:30 p.m. She indicated if the amplifier was left out for use on a routine basis, it could be used more regularly.			

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	An interview was conducted with the SSD on 1/10/23 at 10:17 a.m. She reviewed Resident 16's hearing loss care plan and indicated it did not reference her use of the amplifier device, but it should. 3.1-35(d)(2)(B)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on interview and record review, the facility failed to provide the necessary services to maintain good grooming and personal hygiene for a resident who was unable to carry out activities of daily living by not ensuring twice weekly showers/complete bed baths for 1 of 1 residents reviewed for activities of daily living (ADLs). Resident 20 Findings include: The clinical record for Resident 20 was reviewed on 1/10/23 at 9:32 a.m. Resident 20's diagnoses included, but not limited to, COVID-19 infection, atrial fibrillation, major depressive disorder, and acute embolism and thrombosis of unspecified deep veins. Resident 20 tested positive for COVID-19 on 12/26/22 and was subsequently placed into droplet isolation precautions. Resident 20's annual MDS (minimum data set) dated 12/30/22 indicated, Resident 20 was cognitively intact and required extensive assistance of one person for bed mobility,	F 0677	1. Resident #20 affected. Resident stated she did not get a shower at least 2 days a week. Resident was showered immediately. 2. All residents have the potential to be affected by alleged deficient practice. Director of Health Services completed a Health Care Center audit for all residents to identify preferred shower schedule and to ensure residents are offered a shower at least 2 days per week. Licensed staff were in-serviced on shower/bathing policy. 3. As a measure of quality assurance, The Director of Health Services and/or Designee will complete an audit to ensure residents are bathed at least 2 days a week. The audit will include 5 residents weekly x4 weeks, then 5 residents every	02/01/2023

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	toileting and personal hygiene; physical help in part of one person for bathing; and considered choosing between a tub bath, shower, bed bath or sponge bath "very important". An interview with Resident 20 was conducted on 1/04/23 at 3:37 p.m. Resident 20 indicated, she had not received a complete bed bath or shower since she was placed into droplet isolation precautions for COVID-19 infection. An interview with CRCA (certified resident care assistant) 21 was conducted on 1/10/23 at 10:00 a.m. CRCA 21 indicated showers/complete bed baths were to be recorded in Matrix care and residents' shower schedules were also in Matrix care. A review of Resident 20's point of care (POC) task tab was reviewed on 1/10/23 at 9:42 a.m. It indicated, Resident 20 received showers on the following dates: 1/10/23, 1/3/23, and 12/23/22. The POC record did not indicate Resident 20 had received any complete bed baths or refusals during the time she was in isolation. Resident 20's progress notes did not contain documentation regarding any refusals for complete bed baths/showers during that COVID-19 isolation timeframe. A Guidelines for Bathing Preference policy was received on 1/10/23 at 10:42 a.m. from NC (nurse consultant) 4. The policy indicated, "4. Bathing shall occur at least twice a week unless resident preference states otherwise." 3.1-38(a)(3) 3.1-38(b)(2) 3.1- 38(b)(4)		other week x 4 weeks, then 5 residents monthly x 4 months. 4. As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained.	

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F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to inform the physician of blood sugar results below 150, as ordered by the physician, for 1 of 1 resident reviewed for insulin (Resident 21). Findings include: The clinical record for Resident 21 was reviewed on 1/4/22 at 2:24 p.m. The Resident's diagnosis included, but were not limited to, diabetes. A care plan, initiated 4/29/22, indicated Resident 21 was at risk for hypoglycemia (low blood sugar) and/or hyperglycemia (high blood sugar) related to having diabetes. The goal was for her to be free of symptoms of hypoglycemia and hyperglycemia. The interventions included, but were not limited to, administering medication as ordered, monitor blood sugars per physician's orders. The interventions were initiated on 4/29/22. A physician's order, dated 10/14/22, indicated to perform accuchecks (blood sugar checks) at bedtime and call if results were greater than 400 or less than 150.	F 0684	1. Resident #21 affected by alleged deficient practice due to failure to notify MD of blood glucose level per order of less than 150 mg/dl. Resident assessed, blood glucose levels reviewed for resident and MD notified. No adverse reactions noted. 2. All like residents potential to be affected by alleged deficient practice. Health Care Center audit completed to identify residents with blood glucose call orders and licensed nursing staff in-serviced on guidelines for following physician's orders to ensure MD notification per policy. 3. As a measure of quality assurance, The Director of Health Services and/or Designee will complete an audit to ensure MD is notified of blood sugars out of range. The audit will include 3 residents weekly x4 weeks, then 3 residents every other week x 4 weeks, then 3 residents monthly x 4 months. 4. As a quality measure, the	02/01/2023

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	A Quarterly MDS (Minimum Data Set) Assessment, completed 10/25/22, indicated she was cognitively intact and received insulin (medication for diabetes) daily. During an interview on 1/4/22 at 2:24 p.m., Resident 21 indicated that she sometimes got her insulin after she ate instead of before. The December 2022 and January 2023 MAR (Medication Administration Records) indicated Resident 21 bedtime blood sugar results were below 150 on the following days: 12/5, 12/6, 12/8, 12/9, 12/10, 12/11, 12/12, 12/13, 12/15, 12/18, 12/19, 12/20, 12/21, 12/22, 12/23, 12/24, 12/26, 12/28, 12/ 29, 12/30, 1/3, and 1/5. The clinical record did not indicate the physician had been notified of the blood sugar results being below 150 on the listed days. During an interview on 1/22/22 at 12:27 a.m., LPN (Licensed Practical Nurse) 10 indicated if a blood sugar was outside of the call parameters, it should be called to the physician. 3.1-37		Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained.	
F 0791 SS=D Bldg. 00	483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with			

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	§483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. Based on observation, interview, and record review, the facility failed to timely address a dental referral for 1 of 2 residents reviewed for dental services (Resident 21).	F 0791	1. Resident #21 affected by alleged deficient practice due to failure to schedule dental services timely. All residents assessed and reviewed for need for dental	02/01/2023

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	Findings include: The clinical record for Resident 21 was reviewed on 1/4/22 at 2:24 p.m. The Resident's diagnosis included, but were not limited to, diabetes. An Admission MDS (Minimum Data Set) Assessment, completed 4/28/22, indicated Resident 21 was cognitively intact and had no dental concerns. On 1/04/23 at 2:21 p.m., Resident 21 was observed sitting in her wheelchair in her room. She had no natural teeth. She indicated she had recently seen a dentist who had referred her for new dentures. She had been told by the facility that they could not transport her to the dental office she had been referred to because they did not go to that town. She was unsure how she was going to obtain her new dentures. On 1/10/23 at 10:13 a.m., LPN (Licensed Practical Nurse) 20 provided the dental provider Patient Note History, dated 12/12/22, which indicated Resident 21 was seen by the dentist due to being edentulous. The dentures she currently had were 25 years old and she was referred to a provider to obtain new dental appliances. A copy of the referral form was included with the note. During an interview on 11/11/21 at 10:02 a.m., the SSD (Social Services Director) indicated she had not been made aware of the referral. The outside dental providers would normally send back paperwork if there were referrals made, and she had not received any for Resident 21. The SSD did not normally call the outside providers to check with them about if referrals were needed. An appointment had not yet been set up for		services. Referrals made to dental services as appropriate. 2. All residents have the potential to be affected by alleged deficient practice. Interdisciplinary team has been educated on identifying residents with dental concerns in clinical care meeting to ensure any recommendations were addressed timely. Social Services Director has been educated on Dental Services Policy. 3. As a measure of quality assurance, The Director of Health Services and/or Designee will complete an audit on residents with dental recommendations to ensure dental service is followed per policy. The audit will be completed on 3 residents weekly x4 weeks, then 3 residents every other week x 4 weeks, then 3 residents monthly x4 months. 4. As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained.	

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	Resident 21 to receive new dentures. On 1/11/23 at 12:07 p.m., Nurse Consultant 3 provided the Dental Services Including Repair, Replacement Procedure, effective 11/8/2017, which read "...It is the practice of ... to assist residents in obtaining routine and emergency dental care, per the resident request. The facility will assist by making appointments and/or by arranging for transportation to and from the dental services location...7. Social Services or their designee will assist with making the dental appointments and arranging transportation, if needed..." 3.1-24(b)			
F 0867 SS=D Bldg. 00	483.75(c)(d)(e)(g)(2)(i)(ii) QAPI/QAA Improvement Activities §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments,			

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	including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and			

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	(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance.			

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	§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. Based on interview and record review, the facility failed to identify and implement an effective corrective plan of action to address two residents that were having sexual interactions. This affected 2 of 2 residents reviewed for abuse. (Resident 14 and Resident 28) Findings include: A quality deficiency was identified during a recertification, complaint and residential survey on 1/4/23 to 1/11/23. It was determined the deficiency was an Immediate Jeopardy at F600. Two residents that did not have capacity to consent were having sexual interactions in public and in private settings that occurred in May 2022 through September 2022. The facility did not provide evidence the facility's Quality Assurance & Performance Improvement (QAPI) committee had identified, developed or implemented an appropriate action plan with measures to address	F 0867	1. Residents 28 and 14 were affected by the alleged deficient practice. Corrective action plan implemented and placed in QAPI to ensure compliance with abuse policy. Medical director was notified. 2. All like residents have the potential to be affected by alleged deficient practice. All residents with BIMS = 10 interviewed for psychosocial distress and none noted. All residents with BIMS < 10 had a skin assessment completed and no findings. 3. As a measure of ongoing compliance, the Director of Health Services and/or Designee will complete an audit of all weekly QAPI meetings weekly x 8 weeks, every other week x 4 weeks, and then monthly x 3 months.	02/01/2023

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	the sexual interactions between Resident 14 and Resident 28. Cross reference F600 An interview was conducted with the Executive Director (ED) on 1/11/23 at 12:19 p.m. He indicated QAPI had not reviewed and/or had a plan in place for anything regarding abuse during that time. The Quality Assessment and Assurance Committee/Quality Assurance and Performance Improvement (QAPI) Program policy was provided by the ED on 1/5/23 at 10:06 a.m. It indicated "...Purpose. To develop, implement and maintain an effective, comprehensive, data driven QAPI program that focuses on indicators of the outcomes of care and quality of life. To maintain documentation and demonstrate evidence of its ongoing QAPI program, presenting evidence to state agencies, federal surveyor, CMS [Centers for Medicare & Medicaid Services] or other compliance department approved parties upon request. To establish and maintain the integrity of care and services provided at THS campuses and protecting the health and welfare of the residents and staff. It is the expectation of Trilogy Health Services, LLC (THS) to maintain compliance with Federal and State regulations. Procedures Meetings: 1. The Quality Assessment and Assurance Committee shall meet at least quarterly. This will ensure continuous evaluation of campus systems with the objectives: a. Develop and implement appropriate plans of action to assure all systems function satisfactorily. b. Review and analyze data related to the care and services to prevent deviation from acceptable care processes, including data collected under the QAPI program including data resulting from drug regimen		4. As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained. IDR: I would like to dispute the alleged deficiency that we did not have a QAPI plan in place for resident abuse. I disagree that at any time any resident was subject to abuse, hence requesting an IDR for the F600 tag. If there is no abuse then there is not a need for a QAPI plan in place.	

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	reviews; and c. Correct inappropriate care processes by acting on available data to make improvements. Ultimately, the QAA committee is responsible for the development and maintenance of its QAPI program to be on going, comprehensive, and to address the full range of care and services provided by the campus..." 3.1-52			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:			

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	(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASHFORD PLACE HEALTH CAMPUS	2200 N RILEY HWY SHELBYVILLE, IN 46176

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	its IPCP and update their program, as necessary. Based on interview and record review, the facility failed to maintain contact isolation precautions for 1 of 6 resident reviewed for infections (Resident 13). Findings include: The clinical record for Resident 13 was reviewed on 1/4/22 at 1:37 p.m. The Resident's diagnosis included, but were not limited to, enterocolitis (infection of colon) due to recurrent Clostridium difficile (C-diff). A Quarterly MDS (Minimum Data Set) Assessment, completed 12/2/22, indicated that Resident 13 was cognitively intact. She was frequently incontinent of bowel. An IDT progress note, dated 12/4/22 at 10:36 a.m., indicated that Resident 13 had been sent to the hospital due to abdominal pain and increased temperature. A nursing progress noted, dated 12/7/22 at 3:58 p.m., indicated Resident 13 had been readmitted from the acute care hospital with diagnosis of pancolitis (inflammation of the entire colon) due to persistent C-diff infection. An Infection Event Report, dated 12/7/22 indicated Resident 13 had returned from the acute care hospital with colitis verses C-diff. She was placed in contact isolation precautions. The signs and symptoms of the infection were loose stools and abdominal cramping and pain. A physician's order, dated 12/8/22, indicated she	F 0880	1. Resident #13 affected by alleged deficient practice due to failure to maintain isolation precautions. 2. All residents have the potential to be affected. All Licensed staff has been educated on the following CDC and facility policy, donning and doffing PPE with return demonstration prior to entering isolation room as well as implementation of isolation precautions for residents with Clostridium difficile (C-diff). The Executive Director (ED), Director of Health Services (DHS), Campus Infection Preventionist (IP), and consultant Infection Preventionists to complete a root cause analysis (RCA). Along with RCA, the same team will review the Long-Term Care Facility Self-Assessment for determination of accuracy with adjustments made as needed. Additional education to be scheduled based on review of the RCA and Facility Self-Assessment. 3. As a measure of ongoing compliance, the following audits and/or observations for 3 residents will be conducted by the ED, campus IP, or designee 2 times per week times 8 weeks then monthly x 4 months to ensure compliance. Monitoring / auditing of this plan of correction will occur on all shifts: Residents requiring	02/01/2023

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	was to receive Vancocin (vancomycin antibiotic) 125 mg (milligram) every 6 hours, which was discontinued on 12/15/22. A nursing progress note, dated 12/10/22, indicated Resident 12 was walking to the bathroom with the assistance of staff when she fell. A physician's order, dated 12/15/22, indicated she was to receive Firvanq (vancomycin antibiotic) 5 ml (milliliters) to equal 125 mg every 6 hours, which was discontinued on 12/24/22. A progress note, dated 12/16/22 at 10:18 a.m., indicated that Resident 13 had fallen on 12/10/22 on the night shift. She was walking to the bathroom with staff when the fall occurred. The intervention was to use a gait belt while assisting resident to walk to the bathroom. A progress note, dated 12/22/22, indicated the intervention of using a gait belt when assisting Resident 13 to ambulate to the bathroom had been effective. She was continuing to receive an antibiotic for C-diff. During an interview on 1/10/23 at 4:03 PM, the DNS (Director of Nursing Services) indicated that Resident 13 had a roommate, who also used the bathroom, during her treatment for C. Diff during December 2022. Resident 13 should have had a bedside commode to use since she was not in a private room while being treated for C-diff and should not have used the bathroom in the room. On 1/10/23 at 4:00 p.m., the DNS provided the Guidelines for Contact Precautions policy, approved 5/22/2018, which read "...		isolation precautions for C-diff. Additionally monitoring/Auditing staff PPE donning and doffing with return demonstration. All findings from the RCA, if different from current audit, will result in additional audits. The ED, campus IP, or designee will round the campus daily to ensure appropriate infection control practices are maintained and for any needs as determined from RCA findings for a minimum of 6 weeks and will continue thereafter until compliance is maintained. 4. As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained.	

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	On 1/11/22 at 1:30 p.m., LPN (Licensed Practical Nurse) 20 provided the Guidelines for Management of Residents with Clostridium Difficile policy, revised 5/11/2016, which read "...To prevent the transmission of Clostridium Difficile to other residents and HCW [Health Care Workers]...Contact Precautions should be initiated at the onset of diarrhea...and continue until disease is ruled out or resolved...Staff caring for patients on Contact Precautions should wear a gown and gloves for all interactions...especially those that have been implicated in transmission through environmental contaminations [e.g...C difficile...] This Federal Tag relates to complaint IN00385727. 3.1-18(a)			
F 0881 SS=D Bldg. 00	483.80(a)(3) Antibiotic Stewardship Program §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. Based on interview and record review, the facility failed to ensure a resident had a true infection with the usage of an antibiotic prophylactically for the prevention of Urinary Tract infections (UTI) for 1 of 5 residents reviewed for unnecessary medications. (Resident 28) Findings include:	F 0881	1. Resident #28 affected by alleged deficient practice receiving antibiotic that did not meet criteria for Antibiotic Stewardship. 2. All residents have the potential to be affected by alleged deficient practice. Residents currently receiving antibiotics have	02/01/2023

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	The clinical record for Resident 28 was reviewed on 1/5/23 at 2:30 p.m. The diagnoses for Resident 28 included, but were not limited to, stroke, major depressive disorder, mild cognitive impairment, and dementia with behavioral disturbance. The resident had previously been living in an assisted living and was transferred to long term care on 11/22/21 in the same facility. A medical NP 2 note for Resident 28 dated 7/29/22 indicated "...Details:..Patient has the right to a consensual sexual relationship and appears appropriate with her decision making regarding the subject. Facility notes indicate family is aware of the relationship. she is at risk for UTI, spoke with DON [Director of Nursing] about possibly starting a ppx [prophylaxis] atb [antibiotic] and she was in agreement with this plan...1. 100 mg of macrobid daily..." An IDT note for Resident 28 dated 7/30/22 indicated "Resident seen by NP [2] for increased in sexual desires with male resident. NP stated resident on prophylactic ATB to prevent UTI due to personal hygiene concerns. resident and family aware. resident incontinent of bowel and bladder. staff assist with pericare." A physician order dated 8/1/22 indicated Resident 28 was to receive 100 mg of Macrobid daily for UTI prevention. The August and September 2022 Medication Administration Record indicated Resident 28 had received Macrobid daily from 8/1/22 through 9/16/22. A nursing note for Resident 28 dated 9/16/22 indicated "...writer also spoke to np [NP]		been audited to ensure resident meets criteria. MD aware if applicable. Director of health services and assistance director of health services have been in-serviced per regional clinical support nurse on Antibiotic Stewardship Program and procedure. 3. As a measure of quality assurance, The Director of Health Services and/or Designee will complete an audit of residents prescribed new orders for antibiotics to ensure Antibiotic Stewardship policy is followed appropriately. The audit will be completed in clinical care meeting for 3 residents weekly x4 weeks, then 3 residents every other week x 4 weeks, then 3 residents monthly x 4 months. 4. As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained.	

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	regarding marcobid which was started with no stop date related to patient and other resident's relationship. relationship seems to have subsided at this time. orders received to dc [discontinue] macrobid..." An observation was made with the Assistant Director of Nursing Services (ADNS) of the antibiotic usage tracking binder on 1/10/23 at 2:32 p.m. The ADNS was unable to locate the mapping and tracking of Resident 28's prophylactic Macrobid antibiotic in the binder. She indicated Resident 28's Macrobid antibiotic usage should have been tracked, monitored and documented in the antibiotic usage binder; regardless if it met the Mcgreer's criteria or not. The resident was on the Macrobid antibiotic to prevent a UTI. An Antibiotic Stewardship Guideline policy was provided on 1/4/23 at 1:22 p.m. It indicated, "...Purpose. Optimize the treatment of infections by ensuring that residents who require an antibiotic, are prescribed the appropriate antibiotic. Reduce the risk of adverse events, including the development of antibiotic-resistant organisms, from unnecessary or inappropriate antibiotic use. Encompass a facility-wide system to monitor the use of antibiotics. Procedures. 1. Review infections and monitor antibiotic usage patterns. New orders for antibiotic usage will be reviewed during the campus Clinical Care Meeting on regular business days...5. Include a separate report for the number of residents on antibiotics that did not meet criteria (McGeer Criteria) for active infection..."			
F 0886 SS=D Bldg. 00	483.80 (h)(1)-(6) COVID-19 Testing-Residents & Staff §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff,			

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	including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as			

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	appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. Based on interview and record review, the facility failed to test a resident who had symptoms of Covid-19 for Covid-19 for 1 of 1 resident reviewed for respiratory care. (Resident 4) Findings include: The clinical record for Resident 4 was reviewed on 1/4/23 at 1:56 p.m. Her diagnoses included, but were not limited to, Alzheimer's disease. On 1/4/23 at 1:22 p.m., the ED (Executive Director) provided a list of residents who were considered Covid positive on 1/4/23. The list included 7 of the 49 residents in the facility.	F 0886	1.) No residents were affected by the deficient practice. Resident #4 was tested immediately upon discovery and was negative for Covid 19. 2.) All residents have the potential to be affected. Licensed nursing staff educated on the facility policy on proper testing procedures for residents who present with symptoms of Covid 19. All residents with respiratory symptoms have been tested and were negative for Covid 19. 3.) As a measure of quality	02/01/2023

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R 0000	The 12/31/22, 8:49 a.m. nurse's note, recorded as a late entry on 1/1/23 at 8:51 a.m., read, "Call to hospice re [regarding] yellow green thick nasal drainage throughout shift, decreased alertness and appearance of increased discomfort, vitals wnl [within normal limits,] awaiting call back." There was no information in the clinical record to indicate Resident 4 was tested for Covid-19 due to her symptoms. An interview was conducted with the IP (Infection Preventionist) on 1/4/23 at 3:20 p.m. She reviewed Resident 4's clinical record and indicated she had nasal drainage and green phlegm. She began having symptoms on 12/31/22. She was last tested for Covid-19 on 12/29/31, and it was negative. Typically they would test residents for Covid-19 once symptoms began, and Resident 4 should have been tested on 12/31/22, when her symptoms began. Per the Centers for Disease Control and Prevention, possible Covid-19 symptoms include: fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, and diarrhea. The Mandatory Staff & Resident Testing policy was provided by NC (Nurse Consultant) 4 on 1/10/23 at 10:01 a.m. It read, "Residents and staff, with even mild symptoms of Covid-19, should receive a viral test (POC-point of care) for Covid-19 as soon as possible."		assurance, the DHS or designee will review all residents with new respiratory symptoms, ensuring that they were tested for Covid 19 upon the onset of symptoms. Audits will be daily in clinical care meeting 5 days a week for 4 weeks, 3 days a week for 4 weeks, 1 day a week for 4 months. 4.) As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained.	

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Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00385727. Complaint IN00385727 - Substantiated. Federal/State deficiencies related to the allegations are cited at F880. Survey dates: January and 11, 2023 Facility number: 004268 Residential Census: 22 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on January 18, 2023	R 0000	The submission of this plan of correction does not indicate an admission by Ashford place health campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Ashford place health campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	
R 0033 Bldg. 00	410 IAC 16.2-5-1.2(h)(1-2) Residents' Rights - Noncompliance (h) The facility must furnish on admission the following: (1) A statement that the resident may file a complaint with the director concerning resident abuse, neglect, misappropriation of resident property, and other practices of the facility. (2) The most recently known addresses and telephone numbers of the following: (A) The department. (B) The office of the secretary of family and social services.			

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	(C) The ombudsman designated by the division of disability, aging, and rehabilitation services. (D) The area agency on aging. (E) The local mental health center. (F) Adult protective services. The addresses and telephone numbers in this subdivision shall be posted in an area accessible to residents and updated as appropriate. Based on observation, interview, and record review, the facility failed to ensure advocacy addresses and telephone numbers were posted in an area accessible to residents for 22 of 22 residents in the facility. Findings include: An environmental tour of the Assisted Living facility was conducted with the Plant Operations Assistant on 1/11/23 at 2:00 p.m. There was no posting of the addresses and telephone numbers to the IDOH (Indiana Department of Health,) the office of the secretary of family and social services, the ombudsman, the area agency on aging, a local mental health center, and adult protective services observed during the tour. The Plant Operations Assistant was unable to locate a posting during the tour and indicated he was unaware of a location for the posting. On 1/11/23 at 2:18 p.m., an observation of the staff break room was made with the LED (Life Enrichment Director.) An interview was conducted with the LED at this time. There was a posting on a bulletin board with the IDOH address, phone number, and how to file a complaint. The LED indicated this area was not accessible to residents. The LED was unable to	R 0033	**1.** No residents were affected by the alleged deficient practice. **2.** All residents have the potential to be affected. New signage placed in residential area. All staff educated on location of signage on AL and HC. **3.** An audit will be conducted by ED or designee once weekly for 1 month to ensure that the posting is in the correct place. Then once monthly for 5 months. 4. As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained.	02/01/2023

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	locate a posting of any additional advocacy addresses and phone numbers.			
R 0301 Bldg. 00	410 IAC 16.2-5-6(c)(5) Pharmaceutical Services - Deficiency (5) Labeling of prescription drugs shall include the following: (A) Resident ' s full name. (B) Physician ' s name. (C) Prescription number. (D) Name and strength of the drug. (E) Directions for use. (F) Date of issue and expiration date (when applicable). (G) Name and address of the pharmacy that filled the prescription. If medication is packaged in a unit dose, reasonable variations that comply with the acceptable pharmaceutical procedures are permitted.			
	Based on observation, interview, and record review, the facility failed to ensure medications that were stored in the medication cart were not expired and labeled with open dates for 1 of 2 medication carts observed. (Resident 10 and Resident 15) Findings include: 1. The clinical record for Resident 10 was reviewed on 1/11/23 at 11:23 a.m. The diagnoses for Resident 10 included, but was not limited to, type 2 diabetes mellitus. A physician order dated 6/21/22 indicated Resident 10 was to receive a sliding scale of humalog insulin. The sliding scale was the following: blood sugar reading was 151-200 = 2 units of insulin, blood sugar reading was 201-250= 4 units, blood sugar reading 251-300 = 6 units,	R 0301	1. Residents 10 and 15 were affected by the alleged deficient practice. 2. All residents have the potential to be affected by the alleged deficient practice. Medication was destroyed per policy. Med carts were audited to ensure no other medications were opened and undated. Licensed staff educated on medication storage policy. 3. DHS or designee will audit the med carts for any opened medications and ensure they are dated. This audit will occur twice weekly for 1 month, then once weekly for a month, then biweekly for a month, and then monthly for 3 months.	02/01/2023

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	blood sugar reading was 301-350 = 8 units, blood sugar reading was 351-400 = 10 units, blood sugar reading over 400 call medical provider. The January 2023 Medication Administration Record indicated on 1/8/23 at 7:30 a.m., 2 units of the humalog insulin was administered using the expired humalog insulin vial. 2. The clinical record for Resident 15 was reviewed on 1/11/23 at 11:30 a.m. The diagnoses for Resident 15 included, but was not limited to, type 2 diabetes mellitus. A physician order dated 1/1/23 indicated Resident 15 should receive 20 units of levemir insulin at night. A January 2023 Medication Administration Record indicated Resident 15 had received levemir insulin 1/1/23 through 1/9/23. An observation was made of a medication cart with License Practical Nurse (LPN) 16 on 1/11/23 at 10:11 a.m. The medication cart was observed with a humalog insulin vial with an open date of 9/18/22 for Resident 10 and a levemir insulin pen for Resident 15 with no open date. LPN 16 indicated at that time, the humalog insulin vial had expired 30 days after it was opening. The last given date was 1/7/23 and the levemir insulin pen should have an open date.		4. As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained.	