STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYNDMOOR OF CASTLETON, LLC	8480 CRAIG ST, INDIANAPOLIS, , 46250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Intake IN00464003. Intake IN00464003-State deficiencies related to the allegations are cited at R0052, R0091 and R0117. Survey dates: August 19 and 20, 2025 Facility number: 009894 Residential: 113 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-5. Quality review was completed on August 29, 2025.	R 0000		
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from: (1) sexual abuse;	R 0052	**R 052** What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient	09/12/2025

	(2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on interview and record review, the facility failed to ensure a bedbound dependent resident was free from abuse during incontinence care for 1 of 1 resident reviewed for abuse. (Resident B) Findings include: During an interview, on 8/19/25 at 11:46 a.m., Resident B indicated, approximately around 7/12/25 or 7/13/25, she had been constipated and in pain. She had turned her call light on, and CNA 3 came into her room. CNA 3 rolled her on her left side so she could try to have a bowel movement. She had to lay on her left side to have a bowel movement. As she was attempting to push the stool out, CNA 3 stuck one of his fingers in her rectum without her permission. She yelled "No". He withdrew his finger from her rectum. Then he stuck his finger into her rectum a second time. She yelled "No!!!" He repeated back to her "No" and she told him "No" again. He removed his finger for the second time.		practice? Upon being made aware of allegation resident was interviewed, associate was suspended, and additional resident and staff interviews were conducted. No additional concerns were noted by any other residents. Associate interviewed who was providing care and reported the 2 incidents stating they were attempting to remove pebble like stool from rectum. Associate involved was immediately suspended and removed from resident’s care.	

	Resident B indicated she told him she had not given him permission to stick his finger in her rectum. He finished her incontinence care and left the room. Then when she needed to have a bowel movement later in the evening, she turned on her light and CNA 3 came into the room and turned her onto her left side, so she was able to have a bowel movement. He stuck his finger in her rectum for the third time. She told him "NO." He backed out his finger. She felt sexually violated and unsafe staying in her apartment while CNA 3 was working in the facility. She was traumatized by him violating her and it affected her emotionally. She had been molested when she was 4 years old and then brutally raped in her early 20's. When he stuck his finger in her rectum those three times, he brought back all those feelings she had from being molested and raped and now she could not get those memories out of her head. She did not feel like the Administrator or the Director of Nursing (DON) would believe her when she told them she was sexually assaulted by a staff member. So, she waited for CNA 4 to get back from vacation (7/15/25) and told her about the incident. After CNA 4 reported the incident to the Administrator and the DON, they both came to her room, and she told them. The Administrator and DON		Police final report read “The incident does not meet criteria for a sexual assault”. The suspect was assisting with a present/ongoing condition that he believed precipitated his help”. How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken? The community completed resident interviews to ensure they were not affected by the same alleged deficient practice with no additional concerns noted. What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur? DON will have care staff sign off on in-service training on appropriate incontinence care.	

	asked her if she felt like she had been sexually abused and she had told them yes. The clinical record for Resident B was reviewed on 8/19/25 at 3:17 p.m. The diagnoses included, but were not limited to, depression, cerebral infarction, chronic pain, seizures, diabetes mellitus with diabetic polyneuropathy, heart failure, and hypertension. A document, titled "Psychiatry Follow Up," dated 6/2/25, indicated Resident Bs past psychiatric history was significant for depression and insomnia. She was content with her current medications. Her mood had been good with no signs of depression. A current service plan, last updated 8/19/25, indicated Resident B required daily cues, reminders, and reassurance from staff. She required routine nightly checks for incontinence care, wore incontinent products, and required physical assistance with wiping and pulling up and down her pants. She did not get up out of bed. She was diagnosed with depression and was followed by her primary care provider and psychiatrist. A review of the clinical record did not indicate emotional support follow-up was provided		Care staff will notify the nurse on duty of incontinence issues to determine if clinical support is required. All staff will be educated on Facility policy on Resident Rights” and Abuse. All statements taken from a resident or associate regarding allegations will be required to be signed and dated from that resident or associate to ensure that statements are accurate and cannot be changed later. How will the corrective actions be monitored to ensure the alleged deficient practice will not recure, ie. What quality assurance programs will be put into place? All statements taken from a resident or associate regarding allegations will be required to be signed and dated from that resident or associate to ensure that statements are	

	by the facility after the resident indicated she was abused. During an interview, on 8/20/25 at 12:45 p.m., the DON indicated Resident B refused to participate in her psychiatry appointment on 7/19/25. The most current psychiatry notes were from 6/2/25. During a confidential phone interview, the confidential interviewee indicated Resident B reported she turned on her call light because she had constipation issues and needed to be changed. CNA 3 went into her room, rolled her onto her left side, then he put his finger in her rectum. She told him to stop. Then he stuck his finger in her rectum again and she told him not to. She needed to have a bowel movement later in the evening, so CNA 3 came back, put her on her left side again, and stuck his finger in her rectum the third time. She told him to stop for the third time. Resident B slept with a box cutter under her pillow until CNA 3 was fired because she was afraid of him. During an interview, on 8/20/25 at 3:20 p.m., with Resident B and an Indianapolis Metro Police Officer, Resident B indicated she slept with a box cutter under her pillow from the night CNA 3 sexually assaulted her (approximately around		accurate and cannot be changed later. All care associates will have in-service training on appropriate incontinence care and the scope of which care associates can render care. All staff will be educated on facility policy on Resident Rights and Abuse. Resident interviews will be conducted weekly X 1-month, Monthly X 6 months and ongoing with investigations or concerns related to resident rights, abuse, neglect, or exploitation. A Resident Abuse, Neglect and Exploitation Interview Completion Audit Tool will be completed monthly to ensure community remains in compliance. The Executive Director will receive reports monthly regarding results of such audits and will direct further action	

	7/12/25 or 7/13/25), until she knew he had been fired from the facility (7/16/25). She pointed to her dresser and indicated the box cutter she slept with was on top of the dresser. A black box cutter was observed laying on the dresser in front of the foot of her bed. During an interview, on 8/20/25 at 4:32 p.m., Resident B's family member indicated the resident told her CNA 3 stuck his finger in her rectum three times. She received a call from the Administrator, on 7/17/25 at 12:00 p.m., to inform her a male staff member had stuck his finger into her mother's rectum. The daughter told the Administrator the staff member had committed a sexual assault. She received another call today (8/20/25) to inform her the police had been called due to a state surveyor being in the building and her mother had told the state surveyor she had been sexually abused. The Administrator told her CNA 3 had admitted he stuck the tip of his finger into her mother's rectum during their call on 7/17/25. She became upset with the Administrator when she called today because the police should have been called when this was first reported to the management staff on 7/15/25. During an interview, on 8/20/25 at 10:40 a.m., the DON		if required. When will the systemic changes be implemented? 9/12/2025	

	indicated she called and left a voice mail message for CNA 3, on 7/15/25. She told him before he came to work to give her a call. CNA 3 came to work for his scheduled shift, on 7/15/25, so the DON and the Administrator interviewed him regarding the sexual abuse allegation made by Resident B. Since he had already reported to work and she had interviewed the resident, other residents, and other staff members and had not substantiated sexual abuse, she let him work his 6:00 p.m. to 10:00 p.m. shift. She ensured he was not placed on Resident B's assignment load. She then called the Regional Director of Operations and was told to terminate him because he worked outside his scope of practice. The DON indicated Resident B had never told them she felt she had been sexually abused, or she would not have let CNA 3 come back to work on 7/15/25. A facility as worked schedule indicated CNA 3 was scheduled to work orienting a new CNA on 7/15/25 from 2:00 p.m. to 10 p.m. A facility document, titled "Timecard," dated 7/1/25 to 7/15/25, indicated CNA 3 worked on 7/15/25 from 1:50 p.m. to 6:21 p.m., for a total of 4.52 hours.			

	In an email to the facility, dated 8/20/25 at 5:00 p.m., the Regional Director of Operations indicated, on 7/16/25, the Regional Director of Operations was notified by the DON and Administrator an investigation for Resident B was completed the prior day. The DON indicated CNA 3 was released from suspension based on statements. The Regional Director of Operations advised the DON that CNA 3 should have remained on suspension until disciplinary measures could have been determined. Upon full review of all the findings and based on the situation, she advised the DON and Administrator, CNA 3's employment should have been terminated.			

	A facility document, titled "Corrective Action Behavior," dated 7/15/25, indicated CNA 3 was suspended pending an investigation related to incontinence care provided to a resident. Resident B reported on the morning of 7/15/25, one day last week on two separate occasions CNA 3 attempted to remove stool with his finger while providing incontinence care. The resident had stated "NO." Resident B did not want someone to clear away stool in the manner CNA 3 was trying to remove it. He was to be suspended pending further investigation. A facility document, titled "Corrective Action Behavior," dated 7/16/25, indicated CNA 3 was terminated from his employment, on 7/16/25, related to Resident B reported one day last week CNA 3 attempted to remove stool with his finger while providing incontinence care. She told him "NO." She did not want someone clearing stool away from her rectum in that manner. As a result, the facility terminated CNA 3. A current facility policy, titled "Abuse, Neglect & Exploitation Policy," dated 1/1/23 and provided by the Administrator on 8/20/25 at 10:30 a.m., indicated "...Abuse: is defined in Indiana as a willful infliction of injury, unreasonable confinement,			

	intimidation or punishment with resulting physical harm or pain, anguish, or deprivation by and individual of goods or services that are necessary to attain or maintain physical, mental or psychosocial well-being. Abuse may also include sexual abuse and verbal abuse...." This citation relates to Intake IN00464003. Based on interview and record review, the facility failed to ensure a bedbound dependent resident was free from abuse during incontinence care for 1 of 1 resident reviewed for abuse. (Resident B) Findings include: During an interview, on 8/19/25 at 11:46 a.m., Resident B indicated, approximately around 7/12/25 or 7/13/25, she had been constipated and in pain. She had turned her call light on, and CNA 3 came into her room. CNA 3 rolled her on her left side so she could try to have a bowel movement. She had to lay on her left side to have a bowel movement. As she was attempting to push the stool out, CNA 3 stuck one of his fingers in her rectum without her permission. She yelled "No". He withdrew his finger from her rectum. Then he stuck his finger into her rectum a second time. She yelled "No!!!" He repeated			

	back to her "No" and she told him "No" again. He removed his finger for the second time. Resident B indicated she told him she had not given him permission to stick his finger in her rectum. He finished her incontinence care and left the room. Then when she needed to have a bowel movement later in the evening, she turned on her light and CNA 3 came into the room and turned her onto her left side, so she was able to have a bowel movement. He stuck his finger in her rectum for the third time. She told him "NO." He backed out his finger. She felt sexually violated and unsafe staying in her apartment while CNA 3 was working in the facility. She was traumatized by him violating her and it affected her emotionally. She had been molested when she was 4 years old and then brutally raped in her early 20's. When he stuck his finger in her rectum those three times, he brought back all those feelings she had from being molested and raped and now she could not get those memories out of her head. She did not feel like the Administrator or the Director of Nursing (DON) would believe her when she told them she was sexually assaulted by a staff member. So, she waited for CNA 4 to get back from vacation (7/15/25) and told her about the incident. After CNA 4 reported the incident to the Administrator			

	and the DON, they both came to her room, and she told them. The Administrator and DON asked her if she felt like she had been sexually abused and she had told them yes. The clinical record for Resident B was reviewed on 8/19/25 at 3:17 p.m. The diagnoses included, but were not limited to, depression, cerebral infarction, chronic pain, seizures, diabetes mellitus with diabetic polyneuropathy, heart failure, and hypertension. A document, titled "Psychiatry Follow Up," dated 6/2/25, indicated Resident Bs past psychiatric history was significant for depression and insomnia. She was content with her current medications. Her mood had been good with no signs of depression. A current service plan, last updated 8/19/25, indicated Resident B required daily cues, reminders, and reassurance from staff. She required routine nightly checks for incontinence care, wore incontinent products, and required physical assistance with wiping and pulling up and down her pants. She did not get up out of bed. She was diagnosed with depression and was followed by her primary care provider and psychiatrist.			

	A review of the clinical record did not indicate emotional support follow-up was provided by the facility after the resident indicated she was abused. During an interview, on 8/20/25 at 12:45 p.m., the DON indicated Resident B refused to participate in her psychiatry appointment on 7/19/25. The most current psychiatry notes were from 6/2/25. During a confidential phone interview, the confidential interviewee indicated Resident B reported she turned on her call light because she had constipation issues and needed to be changed. CNA 3 went into her room, rolled her onto her left side, then he put his finger in her rectum. She told him to stop. Then he stuck his finger in her rectum again and she told him not to. She needed to have a bowel movement later in the evening, so CNA 3 came back, put her on her left side again, and stuck his finger in her rectum the third time. She told him to stop for the third time. Resident B slept with a box cutter under her pillow until CNA 3 was fired because she was afraid of him. During an interview, on 8/20/25 at 3:20 p.m., with Resident B and an Indianapolis Metro Police Officer, Resident B indicated she slept with a box			

	cutter under her pillow from the night CNA 3 sexually assaulted her (approximately around 7/12/25 or 7/13/25), until she knew he had been fired from the facility (7/16/25). She pointed to her dresser and indicated the box cutter she slept with was on top of the dresser. A black box cutter was observed laying on the dresser in front of the foot of her bed.			

	During an interview, on 8/20/25 at 4:32 p.m., Resident B's family member indicated the resident told her CNA 3 stuck his finger in her rectum three times. She received a call from the Administrator, on 7/17/25 at 12:00 p.m., to inform her a male staff member had stuck his finger into her mother's rectum. The daughter told the Administrator the staff member had committed a sexual assault. She received another call today (8/20/25) to inform her the police had been called due to a state surveyor being in the building and her mother had told the state surveyor she had been sexually abused. The Administrator told her CNA 3 had admitted he stuck the tip of his finger into her mother's rectum during their call on 7/17/25. She became upset with the Administrator when she called today because the police should have been called when this was first reported to the management staff on 7/15/25. During an interview, on 8/20/25 at 10:40 a.m., the DON indicated she called and left a voice mail message for CNA 3, on 7/15/25. She told him before he came to work to give her a call. CNA 3 came to work for his scheduled shift, on 7/15/25, so the DON and the Administrator interviewed him regarding the sexual abuse allegation made by Resident B. Since he had			

	already reported to work and she had interviewed the resident, other residents, and other staff members and had not substantiated sexual abuse, she let him work his 6:00 p.m. to 10:00 p.m. shift. She ensured he was not placed on Resident B's assignment load. She then called the Regional Director of Operations and was told to terminate him because he worked outside his scope of practice. The DON indicated Resident B had never told them she felt she had been sexually abused, or she would not have let CNA 3 come back to work on 7/15/25. A facility as worked schedule indicated CNA 3 was scheduled to work orienting a new CNA on 7/15/25 from 2:00 p.m. to 10 p.m. A facility document, titled "Timecard," dated 7/1/25 to 7/15/25, indicated CNA 3 worked on 7/15/25 from 1:50 p.m. to 6:21 p.m., for a total of 4.52 hours. In an email to the facility, dated 8/20/25 at 5:00 p.m., the Regional Director of Operations indicated, on 7/16/25, the Regional Director of Operations was notified by the DON and Administrator an investigation for Resident B was completed the prior day. The DON indicated CNA 3 was released			

	from suspension based on statements. The Regional Director of Operations advised the DON that CNA 3 should have remained on suspension until disciplinary measures could have been determined. Upon full review of all the findings and based on the situation, she advised the DON and Administrator, CNA 3's employment should have been terminated. A facility document, titled "Corrective Action Behavior," dated 7/15/25, indicated CNA 3 was suspended pending an investigation related to incontinence care provided to a resident. Resident B reported on the morning of 7/15/25, one day last week on two separate occasions CNA 3 attempted to remove stool with his finger while providing incontinence care. The resident had stated "NO." Resident B did not want someone to clear away stool in the manner CNA 3 was trying to remove it. He was to be suspended pending further investigation. A facility document, titled "Corrective Action Behavior," dated 7/16/25, indicated CNA 3 was terminated from his employment, on 7/16/25, related to Resident B reported one day last week CNA 3 attempted to remove stool with his finger while providing incontinence			

	care. She told him "NO." She did not want someone clearing stool away from her rectum in that manner. As a result, the facility terminated CNA 3. A current facility policy, titled "Abuse, Neglect & Exploitation Policy," dated 1/1/23 and provided by the Administrator on 8/20/25 at 10:30 a.m., indicated "...Abuse: is defined in Indiana as a willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain, anguish, or deprivation by and individual of goods or services that are necessary to attain or maintain physical, mental or psychosocial well-being. Abuse may also include sexual abuse and verbal abuse...." This citation relates to Intake IN00464003.			
R 0091	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(h)(1-4) (h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration.	R 0091	**R091** What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?	09/12/2025

	(4) Facility operations. The policies shall be made available to residents upon request. Based on interview and record review, the facility failed to ensure a staff member remained out of the facility during an abuse investigation for 1 of 1 staff member reviewed for an abuse allegation. (CNA 3) Findings include: During an interview, on 8/19/25 at 11:46 a.m., Resident B indicated, approximately around 7/12/25 or 7/13/25, she had been constipated and in pain. She had turned her call light on, and CNA 3 came into her room. CNA 3 rolled her on her left side so she could try to have a bowel movement. She had to lay on her left side to have a bowel movement. As she was attempting to push the stool out, CNA 3 stuck one of his fingers in her rectum without her permission. She yelled "No". He withdrew his finger from her rectum. Then he stuck his finger into her rectum a second time. She yelled "No!!!" He repeated back to her "No" and she told him "No" again. He removed his finger for the second time. Resident B indicated she told him she had not given him permission to stick his finger in		Associate in question was immediately suspended pending investigation and interviewed. Facility completed a full background screen on associate prior to hire and background was clear. Unusual Occurrence reporting was completed immediately following allegation. Including notification of IDOH. Investigation immediately initiated, including resident and staff interviews. Responsible party immediately notified. Resident interviews were conducted to ensure no trend existed. How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what	

	her rectum. He finished her incontinence care and left the room. Then when she needed to have a bowel movement later in the evening, she turned on her light and CNA 3 came into the room and turned her onto her left side, so she was able to have a bowel movement. He stuck his finger in her rectum for the third time. She told him "NO." He backed out his finger. She felt sexually violated and unsafe staying in her apartment while CNA 3 was working in the facility. She was traumatized by him violating her and it affected her emotionally. She had been molested when she was 4 years old and then brutally raped in her early 20's. When he stuck his finger in her rectum those three times, he brought back all those feelings she had from being molested and raped and now she could not get those memories out of her head. She did not feel like the Administrator or the Director of Nursing (DON) would believe her when she told them she was sexually assaulted by a staff member. So, she waited for CNA 4 to get back from vacation (7/15/25) and told her about the incident. After CNA 4 reported the incident to the Administrator and the DON, they both came to her room, and she told them. The Administrator and DON asked her if she felt like she had been sexually abused and she had told them yes.		corrective action will be taken? The community completed resident interviews to ensure they were not affected by the same alleged deficient practice. Resident interviews will be conducted weekly X 1-month, Monthly X 6 months and ongoing with investigations or concerns related to abuse, neglect, or exploitation including misappropriation of property. What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur? Although the resident did not allege sexual abuse when interviewed by the Executive Director and the Director of Nursing, the associate should have been removed from immediate care and re-trained on incontinence care for exceeding his scope of practice. Any associate who is being investigated on an allegation of abuse will remain	

R 0117	Personnel - Deficiency 410 IAC 16.2-5-1.4(b) (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on interview and record review, the facility failed to ensure a Certified Nursing Assistant (CNA) did not work outside of the scope of practice for 1 of 3 CNAs reviewed scope of practice. (CNA 3)	R 0117	**R 117** What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? Associate in question was immediately suspended pending investigation and interviewed. Associate involved signed job description but based on allegation and per associate's statement, the scope was exceeded. Unusual Occurrence reporting was completed immediately following allegation. Including notification of IDOH. Investigation immediately initiated, including resident and staff interviews. Responsible party immediately notified.	09/12/2025

Findings include:

During an interview, on 8/19/25 at 11:46 a.m., Resident B indicated, approximately around 7/12/25 or 7/13/25, she had been constipated and in pain. She had turned her call light on, and CNA 3 came into her room. CNA 3 rolled her on her left side so she could try to have a bowel movement. She had to lay on her left side to have a bowel movement. As she was attempting to push the stool out, CNA 3 stuck one of his fingers in her rectum without her permission. She yelled "No". He withdrew his finger from her rectum. Then he stuck his finger into her rectum a second time. She yelled "No!!!" He repeated back to her "No" and she told him "No" again. He removed his finger for the second time. Resident B indicated she told him she had not given him permission to stick his finger in her rectum. He finished her incontinence care and left the room. Then when she needed to have a bowel movement later in the evening, she turned on her light and CNA 3 came into the room and turned her onto her left side, so she was able to have a bowel movement. He stuck his finger in her rectum for the third time. She told him "NO." He backed out his finger.

The clinical record for Resident B was reviewed on 8/19/25 at

Resident interviews were conducted to ensure no trend existed.

How
will the facility identify other residents with the potential to be affected by
the same alleged deficient practice and what corrective action will be taken?

The community completed resident interviews to
ensure they were not affected by the same alleged deficient practice.

What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?

A
daily audit tool will be put in place to improve communication between care
associates and nursing staff that allows care associates to share care
concerns/issues with the

	3:17 p.m. The diagnoses included, but were not limited to, depression, cerebral infarction, chronic pain, seizures, diabetes mellitus with diabetic polyneuropathy, heart failure, and hypertension. A current service plan, last updated 8/19/25, indicated Resident B required daily cues, reminders, and reassurance from staff. She required routine nightly checks for incontinence care, wore incontinent products, and required physical assistance with wiping and pulling up and down her pants. During an interview, on 8/19/25 at 11:35 a.m., the Administrator indicated CNA 3 was terminated for working outside his scope of practice when he attempted to clear stool from Resident B's rectum while providing incontinence care and not reporting Resident B's constipation to the nurse. He should have stopped providing incontinence care and retrieved the nurse. A facility document, titled "Corrective Action Behavior," dated 7/15/25, indicated CNA 3 was suspended pending an investigation related to incontinence care provided to a resident. Resident B reported on the morning of 7/15/25, one day last week on two separate occasions CNA 3 attempted to		nurse/s on duty. The audit tool will be monitored daily X1 month, weekly x 1 month and then monthly there after by ED or designee to ensure proper communication is occurring. All care associates will be educated on Facility policy on “Incontinence Care”. All care associates will review job descriptions and expectations with the Director of Nursing in order to ensure they conform to the written job descriptions and do not work outside their scope of practice. How will the corrective actions be monitored to ensure the alleged deficient practice will not recur, ie, what quality assurance programs will be put into place? A daily audit tool will be put in place to improve communication between care associates and nursing staff that	

	remove stool with his finger while providing incontinence care. The resident had stated "NO." Resident B did not want someone to clear away stool in the manner CNA 3 was trying to remove it. He was to be suspended pending further investigation. A facility document, titled "Corrective Action Behavior," dated 7/16/25, indicated CNA 3 was terminated from his employment, on 7/16/25, related to Resident B reported one day last week CNA 3 attempted to remove stool with his finger while providing incontinence care. She told him "NO." She did not want someone clearing stool away from her rectum in that manner. As a result, the facility terminated CNA 3. A current facility job description, titled "Certified Nursing Assistant (CNA)," dated 2019 and provided by the Administrator on 8/20/25 at 10:15 a.m., indicated "...Essential Functions...Receives and communicates report to management on resident status at the beginning and end of each shift and as needed. Notifies the management of any changes in resident medical condition/status...Performs clinical procedures according to community policy...Maintains a working knowledge of		allows care associates to share care concerns/issues with the nurse/s on duty. The audit tool will be monitored daily X1 month, weekly x 1 month and then monthly there after by ED or designee to ensure proper communication is occurring. DON will review Communication Audit tool to ensure that care needs are addressed. The Executive Director will receive reports regarding results of such audits and will direct further action if required. When will the systemic changes be implemented?	

Community policy & procedure pertinent to role...."

This citation relates to Intake IN00464003.

Based on interview and record review, the facility failed to ensure a Certified Nursing Assistant (CNA) did not work outside of the scope of practice for 1 of 3 CNAs reviewed scope of practice. (CNA 3)

Findings include:

During an interview, on 8/19/25 at 11:46 a.m., Resident B indicated, approximately around 7/12/25 or 7/13/25, she had been constipated and in pain. She had turned her call light on, and CNA 3 came into her room. CNA 3 rolled her on her left side so she could try to have a bowel movement. She had to lay on her left side to have a bowel movement. As she was attempting to push the stool out, CNA 3 stuck one of his fingers in her rectum without her permission. She yelled "No". He withdrew his finger from her rectum. Then he stuck his finger into her rectum a second time. She yelled "No!!!" He repeated back to her "No" and she told him "No" again. He removed his finger for the second time. Resident B indicated she told him she had not given him permission to stick his finger in her rectum. He finished her

incontinence care and left the room. Then when she needed to have a bowel movement later in the evening, she turned on her light and CNA 3 came into the room and turned her onto her left side, so she was able to have a bowel movement. He stuck his finger in her rectum for the third time. She told him "NO." He backed out his finger.

The clinical record for Resident B was reviewed on 8/19/25 at 3:17 p.m. The diagnoses included, but were not limited to, depression, cerebral infarction, chronic pain, seizures, diabetes mellitus with diabetic polyneuropathy, heart failure, and hypertension.

A current service plan, last updated 8/19/25, indicated Resident B required daily cues, reminders, and reassurance from staff. She required routine nightly checks for incontinence care, wore incontinent products, and required physical assistance with wiping and pulling up and down her pants.

During an interview, on 8/19/25 at 11:35 a.m., the Administrator indicated CNA 3 was terminated for working outside his scope of practice when he attempted to clear stool from Resident B's rectum while providing incontinence care and not reporting Resident B's constipation to the nurse. He

should have stopped providing incontinence care and retrieved the nurse.

A facility document, titled "Corrective Action Behavior," dated 7/15/25, indicated CNA 3 was suspended pending an investigation related to incontinence care provided to a resident. Resident B reported on the morning of 7/15/25, one day last week on two separate occasions CNA 3 attempted to remove stool with his finger while providing incontinence care. The resident had stated "NO." Resident B did not want someone to clear away stool in the manner CNA 3 was trying to remove it. He was to be suspended pending further investigation.

A facility document, titled "Corrective Action Behavior," dated 7/16/25, indicated CNA 3 was terminated from his employment, on 7/16/25, related to Resident B reported one day last week CNA 3 attempted to remove stool with his finger while providing incontinence care. She told him "NO." She did not want someone clearing stool away from her rectum in that manner. As a result, the facility terminated CNA 3.

A current facility job description, titled "Certified Nursing Assistant (CNA)," dated 2019 and provided by the

	Administrator on 8/20/25 at 10:15 a.m., indicated "...Essential Functions...Receives and communicates report to management on resident status at the beginning and end of each shift and as needed. Notifies the management of any changes in resident medical condition/status...Performs clinical procedures according to community policy...Maintains a working knowledge of Community policy & procedure pertinent to role...." This citation relates to Intake IN00464003.			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

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