STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	11/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER CROSSING ASSISTED LIVING COMMUNITY	2400 MARKET ST, CHARLESTOWN, , 47111

(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 Complaint IN00366838 and Complaint IN00366557. Complaint IN00366838 - Substantiated. State Residential Findings are cited at R0041, R0052, R0053, and R0060. Complaint IN00366557 - Unsubstantiated due to lack of sufficient evidence. Survey dates: November 17 and 18, 2021 Facility number: 012007 Residential Census: 83 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on November 23, 2021.	R 0000	To Whom it May Concern: Preparation and submission of this statement of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or of the correctness of the conclusion stated on the statement of deficiencies. This statement of correction is prepared and submitted solely because of requirements under state and federal laws. We cordially request a desk review regarding the alleged deficiencies in lieu of any revisit.	
R 0041	Residents' Rights - Deficiency	R 0041	Preparation and submission of	12/10/2021

	410 IAC 16.2-5-1.2(o)(4) (4) The facility shall develop and implement policies for investigating and responding to complaints when made known and grievances made by: (A) an individual resident; (B) a resident council or family council, or both; (C) a family member; (D) family groups; or (E) other individuals. Based on record review and interview, the facility failed to ensure allegations of abuse were thoroughly investigated for 4 of 6 residents reviewed for investigation of abuse. (Residents E, F, G, and H.) Findings include: 1. The State reportable incident, dated 11/9/21 at 6:23 p.m., indicated HHA (Home Health Aide) 4 was yelling at several residents and took an aggressive stance, holding up her fists on one of the residents. When her charge nurse asked her to leave, she declined. When the charge nurse was instructed to call 911, the employee left. The residents affected included Residents E, F, G.		this statement of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or of the correctness of the conclusion stated on the statement of deficiencies. This statement of correction is prepared and submitted solely because of requirements under state and federal laws. We cordially request a desk review regarding the alleged deficiencies in lieu of any revisit. **Immediate Intervention:** . Residents E, F, G and H were assessed with no signs of injury or mental anguish by a licensed nurse Nursing to follow up with each of these residents weekly and as needed for the next 30 days related to the incident. . An abuse investigation was completed and sent to IDOH for residents E, F, G, and H per policy. The investigation	

	The clinical record for Resident E was reviewed on 11/17/21 at 10:00 a.m. The resident's clinical record lacked documentation of any physical assessment after the incident, or any documentation of the incident. 2. The clinical record for Resident G was reviewed, on 11/17/21 at 1:07 p.m. The resident's clinical record lacked documentation of any physical assessment after the incident, or any documentation of the incident. 3. The clinical record for Resident F was reviewed, on 11/17/21 at 10:00 a.m. The resident's clinical record lacked documentation of any physical assessment after the incident, or any documentation of the incident. 4. The clinical record for Resident H was reviewed, on 11/17/21 at 10:00 a.m. The resident's clinical record lacked documentation of any physical assessment after the incident, or any documentation of the incident. On 11/17/21 at 10:20 a.m., the ED (Executive Director) provided the incident file. The file did not contain any Resident Abuse investigation forms, any assessments for signs of injury, or interviews of other residents		included use of the resident abuse investigation forms, assessments for signs of injury, interviews of other residents and staff. Documentation was noted in each of their clinical record of the above. : The Director of Nursing and the Executive Director were educated on the “abuse, prevention and prohibition” policy by the Regional Director to include the following: o Resident abuse must be reported immediately to the Executive Director. o The facility and Executive Director will ensure a thorough investigation of alleged violations of individual rights and document appropriate action. o Utilize Resident Abuse Investigation Forms for completing investigation.	

	or staff who may have been involved, aside from handwritten statements from Resident E, LPN 6, and CNA 5. There were no abuse questionnaires. During an interview, on 11/17/21 at 11:47 a.m., the DON (Director of Nursing) indicated she did not believe anyone had gotten a statement from Resident H. She did ask the residents if they were ok, or if they had any physical altercations or bruising, but she would be honest, she probably had not documented it.		o A licensed professional nurse will assess the resident for signs of injury and notify the resident's physician and responsible party of any injuries noted. o Complete a thorough investigation. o Two management level staff will conduct interviews with witnesses or other staff, residents or visitors who could have knowledge of the allegation. Witnesses will be asked to assist with completing a questionnaire and statements if indicated that will be attached to the Abuse Investigation Format. o Every employee will be interviewed who was working on the specific hall/wing that the affected resident resides on. If the allegation occurred on a specific shift, all staff for the identified shift will complete a question	

	During an interview, on 11/18/21 at 10:00 a.m., the ED indicated he was contacted around 12:00 am about the abuse allegation. The residents and staff were interviewed by the DON, ADON (Assistant Director of Nursing) and himself about the incident that took place. They took statements from everyone involved. He was not aware at the time, cooperate had a Resident Abuse Investigation Form for completing an investigation. He did not know if an assessment on the residents were completed, the physician was notified, or if family was called. He was aware that it was part of the protocol. He indicated he did not identify in the statements whether management conducted the interviews. He did not know what had set off HHA 4. They weren't able to find that out. The Abuse, Prevention and Prohibition Policy, last revised 4/2020, provided on 11/17/21 at 10:00 a.m. by the ED, included, but was not limited to, "... Investigation: Resident abuse must be reported immediately to the Executive Director. The facility and Executive Director will ensure a thorough investigation of alleged violations of individual rights and document appropriate action...Utilize Resident Abuse Investigation Forms for completing investigation... A		**Identify Others Affected** . All residents were potentially at risk of same alleged deficient practice. All IDOH reportable events that have been submitted through IDOH Gateway within past 60 days have been reviewed to ensure that the investigation included use of the resident abuse investigation forms, assessments for signs of injury, interviews of other residents and staff. Documentation was noted in each of their clinical record of the above. . All residents were interviewed to determine if they had experienced any form of abuse, including mental or verbal, while in the facility. If they reported they had it was further investigated to ensure the appropriate abuse investigation was completed and any noted issues addressed. **The measures the facility will take or systems the facility will alter to ensure**	

	licensed professional nurse will assess the resident for signs of injury and notify the resident's physician and responsible party of any injuries noted... Complete a thorough investigation. Two management level staff will conduct interviews with witnesses or other staff, residents or visitors who could have knowledge of the allegation. Witnesses will be asked to assist with completing a questionnaire and statements if indicated that will be attached to the Abuse Investigation Format... Every employee will be interviewed who was working on the specific hall/wing that the affected resident resides on. If the allegation occurred on a specific shift, all staff for the identified shift will complete a questionnaire and complete a statement if indicated..." This State Residential Finding relates to Complaint IN00366838. Based on record review and interview, the facility failed to ensure allegations of abuse were thoroughly investigated for 4 of 6 residents reviewed for investigation of abuse. (Residents E, F, G, and H.) Findings include: 1. The State reportable incident, dated 11/9/21 at 6:23 p.m., indicated HHA (Home Health		**that the problem will be corrected and will not reoccur:** • All staff were educated on the “abuse, prevention and prohibition” policy by the Director of Nursing and the Executive Director to include the following: • Resident abuse must be reported immediately to the Executive Director. • The facility and Executive Director will ensure a thorough investigation of alleged violations of individual rights and document appropriate action. • Utilize Resident Abuse Investigation Forms for completing investigation. • A licensed professional nurse will assess the resident for signs of injury and notify the resident's physician and	

	Aide) 4 was yelling at several residents and took an aggressive stance, holding up her fists on one of the residents. When her charge nurse asked her to leave, she declined. When the charge nurse was instructed to call 911, the employee left. The residents affected included Residents E, F, G. The clinical record for Resident E was reviewed on 11/17/21 at 10:00 a.m. The resident's clinical record lacked documentation of any physical assessment after the incident, or any documentation of the incident. 2. The clinical record for Resident G was reviewed, on 11/17/21 at 1:07 p.m. The resident's clinical record lacked documentation of any physical assessment after the incident, or any documentation of the incident. 3. The clinical record for Resident F was reviewed, on 11/17/21 at 10:00 a.m. The resident's clinical record lacked documentation of any physical assessment after the incident, or any documentation of the incident. 4. The clinical record for Resident H was reviewed, on 11/17/21 at 10:00 a.m. The resident's clinical record lacked		responsible party of any injuries noted. • Complete a thorough investigation. • Two management level staff will conduct interviews with witnesses or other staff, residents or visitors who could have knowledge of the allegation. Witnesses will be asked to assist with completing a questionnaire and statements if indicated that will be attached to the Abuse Investigation Format. • Every employee will be interviewed who was working on the specific hall/wing that the affected resident resides on. If the allegation occurred on a specific shift, all staff for the identified shift will complete a question Education includes all agency staff and new staff prior to working.	

	documentation of any physical assessment after the incident, or any documentation of the incident. On 11/17/21 at 10:20 a.m., the ED (Executive Director) provided the incident file. The file did not contain any Resident Abuse investigation forms, any assessments for signs of injury, or interviews of other residents or staff who may have been involved, aside from handwritten statements from Resident E, LPN 6, and CNA 5. There were no abuse questionnaires. During an interview, on 11/17/21 at 11:47 a.m., the DON (Director of Nursing) indicated she did not believe anyone had gotten a statement from Resident H. She did ask the residents if they were ok, or if they had any physical altercations or bruising, but she would be honest, she probably had not documented it. During an interview, on 11/18/21 at 10:00 a.m., the ED indicated he was contacted around 12:00 am about the abuse allegation. The residents and staff were interviewed by the DON, ADON (Assistant Director of Nursing) and himself about the incident that took place. They took statements from everyone involved. He was not aware at the time, cooperate had a Resident Abuse Investigation Form for completing an		**Quality Assurance Plans to monitor facility performance to ensure that corrections are achieved and permanent:** : Regional Director/Designee, in collaboration with ED/Designee and DON/Designee, will audit the completeness of every abuse allegation for 6 months, to include use of the resident abuse investigation forms, assessments for signs of injury, interviews of other residents and staff. Documentation was noted in each of their clinical record of the above. . Audit will be performed by the ED or designee on 3 random residents weekly for 60 days about whether they had any issues with abuse. . Audit by the ED or designee that 3 staff will be questioned weekly for the next 60 days to ensure they understand the “abuse, prevention and prohibition”	

	investigation. He did not know if an assessment on the residents were completed, the physician was notified, or if family was called. He was aware that it was part of the protocol. He indicated he did not identify in the statements whether management conducted the interviews. He did not know what had set off HHA 4. They weren't able to find that out. The Abuse, Prevention and Prohibition Policy, last revised 4/2020, provided on 11/17/21 at 10:00 a.m. by the ED, included, but was not limited to, "... Investigation: Resident abuse must be reported immediately to the Executive Director. The facility and Executive Director will ensure a thorough investigation of alleged violations of individual rights and document appropriate action...Utilize Resident Abuse Investigation Forms for completing investigation... A licensed professional nurse will assess the resident for signs of injury and notify the resident's physician and responsible party of any injuries noted... Complete a thorough investigation. Two management level staff will conduct interviews with witnesses or other staff, residents or visitors who could have knowledge of the allegation. Witnesses will be asked to assist with completing a questionnaire and statements		policy to include the reporting and investigation requirements Regional Director/Designee, in collaboration with ED/Designee and DON/Designee, will review audits with QA Committee monthly x3 months for identified issues. QA Committee will determine if audits necessitate extension past 3 months and will continue to review audit results monthly for duration of the extended timeframe as applicable. Criteria for determining if further monitoring is necessary or if monitoring can be stopped: If investigation is discovered to be incomplete or not in line with established policy and procedure, then audits will be extended for a length of time agreed upon by QA Committee. Date of Completion: December 10, 2021	

if indicated that will be attached to the Abuse Investigation Format... Every employee will be interviewed who was working on the specific hall/wing that the affected resident resides on. If the allegation occurred on a specific shift, all staff for the identified shift will complete a questionnaire and complete a statement if indicated..."

This State Residential Finding relates to Complaint IN00366838.

Based on record review and interview, the facility failed to ensure allegations of abuse were thoroughly investigated for 4 of 6 residents reviewed for investigation of abuse. (Residents E, F, G, and H.)

Findings include:

1. The State reportable incident, dated 11/9/21 at 6:23 p.m., indicated HHA (Home Health Aide) 4 was yelling at several residents and took an aggressive stance, holding up her fists on one of the residents. When her charge nurse asked her to leave, she declined. When the charge nurse was instructed to call 911, the employee left. The residents affected included Residents E, F, G.

The clinical record for Resident E was reviewed on 11/17/21 at 10:00 a.m. The resident's

	clinical record lacked documentation of any physical assessment after the incident, or any documentation of the incident. 2. The clinical record for Resident G was reviewed, on 11/17/21 at 1:07 p.m. The resident's clinical record lacked documentation of any physical assessment after the incident, or any documentation of the incident. 3. The clinical record for Resident F was reviewed, on 11/17/21 at 10:00 a.m. The resident's clinical record lacked documentation of any physical assessment after the incident, or any documentation of the incident. 4. The clinical record for Resident H was reviewed, on 11/17/21 at 10:00 a.m. The resident's clinical record lacked documentation of any physical assessment after the incident, or any documentation of the incident. On 11/17/21 at 10:20 a.m., the ED (Executive Director) provided the incident file. The file did not contain any Resident Abuse investigation forms, any assessments for signs of injury, or interviews of other residents or staff who may have been involved, aside from handwritten statements from Resident E,			

	LPN 6, and CNA 5. There were no abuse questionnaires. During an interview, on 11/17/21 at 11:47 a.m., the DON (Director of Nursing) indicated she did not believe anyone had gotten a statement from Resident H. She did ask the residents if they were ok, or if they had any physical altercations or bruising, but she would be honest, she probably had not documented it. During an interview, on 11/18/21 at 10:00 a.m., the ED indicated he was contacted around 12:00 am about the abuse allegation. The residents and staff were interviewed by the DON, ADON (Assistant Director of Nursing) and himself about the incident that took place. They took statements from everyone involved. He was not aware at the time, cooperate had a Resident Abuse Investigation Form for completing an investigation. He did not know if an assessment on the residents were completed, the physician was notified, or if family was called. He was aware that it was part of the protocol. He indicated he did not identify in the statements whether management conducted the interviews. He did not know what had set off HHA 4. They weren't able to find that out. The Abuse, Prevention and Prohibition Policy, last revised			

	4/2020, provided on 11/17/21 at 10:00 a.m. by the ED, included, but was not limited to, "... Investigation: Resident abuse must be reported immediately to the Executive Director. The facility and Executive Director will ensure a thorough investigation of alleged violations of individual rights and document appropriate action...Utilize Resident Abuse Investigation Forms for completing investigation... A licensed professional nurse will assess the resident for signs of injury and notify the resident's physician and responsible party of any injuries noted... Complete a thorough investigation. Two management level staff will conduct interviews with witnesses or other staff, residents or visitors who could have knowledge of the allegation. Witnesses will be asked to assist with completing a questionnaire and statements if indicated that will be attached to the Abuse Investigation Format... Every employee will be interviewed who was working on the specific hall/wing that the affected resident resides on. If the allegation occurred on a specific shift, all staff for the identified shift will complete a questionnaire and complete a statement if indicated..."			

This State Residential Finding relates to Complaint IN00366838.

Based on record review and interview, the facility failed to ensure allegations of abuse were thoroughly investigated for 4 of 6 residents reviewed for investigation of abuse. (Residents E, F, G, and H.)

Findings include:

1. The State reportable incident, dated 11/9/21 at 6:23 p.m., indicated HHA (Home Health Aide) 4 was yelling at several residents and took an aggressive stance, holding up her fists on one of the residents. When her charge nurse asked her to leave, she declined. When the charge nurse was instructed to call 911, the employee left. The residents affected included Residents E, F, G.

The clinical record for Resident E was reviewed on 11/17/21 at 10:00 a.m. The resident's clinical record lacked documentation of any physical assessment after the incident, or any documentation of the incident.

2. The clinical record for Resident G was reviewed, on 11/17/21 at 1:07 p.m. The resident's clinical record lacked documentation of any physical assessment after the incident,

	or any documentation of the incident. 3. The clinical record for Resident F was reviewed, on 11/17/21 at 10:00 a.m. The resident's clinical record lacked documentation of any physical assessment after the incident, or any documentation of the incident. 4. The clinical record for Resident H was reviewed, on 11/17/21 at 10:00 a.m. The resident's clinical record lacked documentation of any physical assessment after the incident, or any documentation of the incident. On 11/17/21 at 10:20 a.m., the ED (Executive Director) provided the incident file. The file did not contain any Resident Abuse investigation forms, any assessments for signs of injury, or interviews of other residents or staff who may have been involved, aside from handwritten statements from Resident E, LPN 6, and CNA 5. There were no abuse questionnaires. During an interview, on 11/17/21 at 11:47 a.m., the DON (Director of Nursing) indicated she did not believe anyone had gotten a statement from Resident H. She did ask the residents if they were ok, or if they had any physical altercations or bruising, but she would be honest, she			

	probably had not documented it. During an interview, on 11/18/21 at 10:00 a.m., the ED indicated he was contacted around 12:00 am about the abuse allegation. The residents and staff were interviewed by the DON, ADON (Assistant Director of Nursing) and himself about the incident that took place. They took statements from everyone involved. He was not aware at the time, cooperate had a Resident Abuse Investigation Form for completing an investigation. He did not know if an assessment on the residents were completed, the physician was notified, or if family was called. He was aware that it was part of the protocol. He indicated he did not identify in the statements whether management conducted the interviews. He did not know what had set off HHA 4. They weren't able to find that out. The Abuse, Prevention and Prohibition Policy, last revised 4/2020, provided on 11/17/21 at 10:00 a.m. by the ED, included, but was not limited to, "... Investigation: Resident abuse must be reported immediately to the Executive Director. The facility and Executive Director will ensure a thorough investigation of alleged violations of individual rights and document appropriate action...Utilize Resident Abuse			

	Investigation Forms for completing investigation... A licensed professional nurse will assess the resident for signs of injury and notify the resident's physician and responsible party of any injuries noted... Complete a thorough investigation. Two management level staff will conduct interviews with witnesses or other staff, residents or visitors who could have knowledge of the allegation. Witnesses will be asked to assist with completing a questionnaire and statements if indicated that will be attached to the Abuse Investigation Format... Every employee will be interviewed who was working on the specific hall/wing that the affected resident resides on. If the allegation occurred on a specific shift, all staff for the identified shift will complete a questionnaire and complete a statement if indicated..." This State Residential Finding relates to Complaint IN00366838.			
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; (2) physical abuse;	R 0052	Preparation and submission of this statement of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or of the correctness of the conclusion stated on the statement of deficiencies. This statement of	01/28/2022

	(3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. 2. The clinical record for Resident G was reviewed, on 11/17/21 at 1:07 p.m. The resident's diagnoses included, but were not limited to, schizophrenia, depression, anxiety, insomnia, GERD (Gastroesophageal Reflux Disease), bipolar, glaucoma, and dementia. The BIMS assessment, dated 5/27/21, indicated the resident was cognitively intact. During an interview, on 11/17/21 at 9:30 a.m., the resident indicated she heard yelling outside her door on the 300 Hall. She came out and there were residents and staff down by the puzzle table. She witnessed HHA 4 screaming she would not deal with Resident H. She would not change his diaper because she didn't get paid enough to care for him. Another resident came out of his room and asked "... Are you talking about me?" She started cussing and threatening the resident. She said she was going to kick his a** and beat the living s**t out of him. She put up her fists up like she was going to hit him. Three people		correction is prepared and submitted solely because of requirements under state and federal laws. We cordially request a desk review regarding the alleged deficiencies in lieu of any revisit. **Immediate Intervention:** • HHA 4 was suspended immediately and later terminated related to the finding of mental abuse against them. • Residents E, F, G and H were assessed with no signs of injury or mental anguish by a licensed nurse. Nursing staff to follow up with each of these residents weekly and as needed for the next 30 days related to the incident. • An abuse investigation was completed and sent to IDOH for residents E, F, G, and H per policy. The investigation included use of the resident abuse investigation forms, assessments for signs of injury, interviews of other residents and staff. Documentation was noted in each of their	

	had to stop her. She threatened to kill the residents and the nurses. The resident indicated she thought if HHA 4 had a gun on her, she would have shot the place up. She believed the HHA would really have hurt the residents. HHA 4 was always going around saying she was going to kick someone's a**. She would refuse to help the residents. The nurses escorted her out of the building, and she was cussing and yelling all the way out. The resident was so terrified, and her anxiety was so high, she had to sit at the nurse's station for a couple of hours to feel safe enough to go back to her room. 3. The clinical record for Resident F was reviewed, on 11/17/21 at 10:00 a.m. The resident's diagnoses included, but were not limited to, diabetes, hypertension, kidney stones, cardiac stents, osteoarthritis, left hip replacement, amputation Left middle toe, hernia repair, and appendectomy. The BIMS assessment, dated 10/19/21, indicated the resident was cognitively intact. During an interview, on 11/17/21 at 10:00 a.m., Resident F indicated he was sitting at the puzzle table working a puzzle. HHA 4 was observed cursing Resident E. She was cursing loud and making threats. She		clinical record of the above. • Nursing staff were provided education by the Executive Director or designee that they should assess residents to evaluate if they experienced any negative psychosocial effects when they experienced mental abuse or potential abuse. They should also provide ongoing support to meet their needs throughout and after the investigation occurs. • The Director of Nursing and the Executive Director were educated on the “abuse, prevention and prohibition” policy by the Regional Director to include the following: • Each resident has the right to be free from abuse... and involuntary seclusion. • Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff •	

	lifted her fists and acted like she was going to hit him. She threatened other residents. He did not know what set her off. She was going to beat up the residents, and the nurses had to restrain her. They escorted her out of the building. He couldn't do anything, so he kept quiet and was an innocent bystander. 4. The clinical record for Resident H was reviewed, on 11/17/21 at 10:00 a.m. The resident's diagnoses included, but were not limited to, Traumatic incomplete cord injury, alcohol abuse, dementia secondary to ETOH abuse, GERD, anxiety, neuropathy, impulse control, bipolar, and arterial vascular disease. The BIMS assessment, dated 5/17/21, indicated the resident was cognitively intact. During an interview, on 11/17/21 at 10:45 a.m., Resident H indicated HHA 4 refused to provide care and help him get into bed. She was cursing at him. She left his room and never did come back. He had to wait until someone else could assist him to bed. A review of the police report, dated 11/9/21 at 1:44 p.m., indicated upon arrival to the facility the police spoke with the DON. The DON advised that an employee was fired and		All instances of abuse... can cause physical harm, pain or mental anguish. • The resident has the right to be free from verbal, mental, sexual, exploitation, or physical abuse... and involuntary seclusion. • Abuse- means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish... Instance of abuse of all residents, irrespective of any mental or physical condition, cause harm, pain, or mental anguish. It includes verbal abuse... and mental abuse... Mental abuse includes, but is not limited to, humiliation, harassment, and threats of punishment or deprivation. • Mistreatment Means inappropriate treatment or exploitation of a resident... Involuntary	

	escorted off the premises in the overnight hours. The employee was identified as HHA 4, and she had threatened a patient as well as staff members. HHA 4 indicated to him that a patient threatened her and she did tell the patient if he put hands on her that she was going to hit him back. The Abuse, Prevention and Prohibition Policy, last revised 4/2020, provided on 11/17/21 at 10:00 a.m. by the ED, included, but was not limited to, "... Each resident has the right to be free from abuse... and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff... all instances of abuse... can cause physical harm, pain or mental anguish... The resident has the right to be free from verbal, mental, sexual, exploitation, or physical abuse... and involuntary seclusion... Definitions... Abuse- means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish... Instance of abuse of all residents, irrespective of any mental or physical condition, cause harm, pain, or mental anguish. It includes verbal abuse... and mental abuse... Mental abuse includes, but is not limited to, humiliation, harassment, and		seclusion is defined as separation of a resident from other residents or confinement in his/her room... against the resident's will..." **Identify Others Affected** . All residents were potentially at risk of same alleged deficient practice. All residents were interviewed to determine if they had experienced any form of abuse, including mental or verbal, while in the facility. If they reported they had it was further investigated to ensure the appropriate abuse investigation was completed and any noted issues addressed. **The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not reoccur:** • All staff were educated on the “abuse, prevention and prohibition” (including what is mental abuse) and how	

	threats of punishment or deprivation... Mistreatment Means inappropriate treatment or exploitation of a resident... Involuntary seclusion is defined as separation of a resident from other residents or confinement in his/her room... against the resident's will..." This State Residential Finding relates to Complaint IN00366838. Based on record review and interview, the facility failed to ensure residents are free of mental abuse for 4 of 6 residents reviewed for abuse. (Residents E, F, G, and H.) Findings include: 1. The State reportable incident, dated 11/9/21 at 6:23 p.m., indicated HHA (Home Health Aide) 4 was yelling at several residents and took an aggressive stance, holding up her fists on one of the residents. When her charge nurse asked her to leave, she declined. When the charge nurse was instructed to call 911, the employee left. The residents affected included Residents E, F, and G.		to monitor residents for potential occurrence of mental abuse) . policy by the Director of Nursing and the Executive Director to include the following: • Each resident has the right to be free from abuse... and involuntary seclusion. • Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff • All instances of abuse... can cause physical harm, pain or mental anguish. • The resident has the right to be free from verbal, mental, sexual, exploitation, or physical abuse... and involuntary seclusion. • Abuse- means the willful infliction of injury, unreasonable confinement,	

	The clinical record for Resident E was reviewed on 11/17/21 at 10:00 a.m. Diagnoses included, but were not limited to, metastatic cancer and depression. The BIMS (Brief Interview of Mental Status) assessment, dated 8/13/21, indicated Resident E was cognitively intact. The handwritten, undated statement of Resident E indicated on November 8th, he woke up about 9:00 p.m., because it was fairly loud in the hallway. It went on for about an hour and twenty minutes before he came out and informed staff he had a headache, and they were being disrespectful as people were trying to sleep. HHA 4 argued with him, and he went back to his room. She carried on making comments in the hall for ten minutes, and then it died down. A little after midnight he heard HHA 4 outside his door saying no one was going to talk to her like that, and running her mouth. He walked out and asked the aide if she was talking about him. She told him to get his a** in his room and started walking toward him. He told her she couldn't talk to him like that, or any other resident that way. She said "F*** you and every resident in here...", and then pumped her fists at him and		intimidation, or punishment with resulting physical harm, pain, or mental anguish... Instance of abuse of all residents, irrespective of any mental or physical condition, cause harm, pain, or mental anguish. It includes verbal abuse... and mental abuse... Mental abuse includes, but is not limited to, humiliation, harassment, and threats of punishment or deprivation. • Mistreatment Means inappropriate treatment or exploitation of a resident... Involuntary seclusion is defined as separation of a resident from other residents or confinement in his/her room... against the resident's will..." Education includes all agency staff and new staff prior to working. **Quality Assurance Plans to monitor facility performance to ensure that corrections are**	

	squared off. After the fourth time he told her if she hit him, he would beat her teeth out. She started calling him stupid and a crybaby. She was a bully and was going to hurt someone if she continued working in the environment. She did not care about the residents and shouldn't be allowed to work around the sick or elderly. He had never witnessed something so horrible in his life.		**achieved and permanent:** : Staff will be quizzed weekly at random for each shift x 6 months regarding Abuse, Prevention and Prohibition Policyincluding what topics are reportable events, What is mental abuse, and what actions or resident responses might indicate mental abuse may be potentially occurring. Staff will be in-serviced ongoing upon hire regarding Abuse, Prevention and Prohibition Policy including what topics are reportable events, What is mental abuse, and what actions might indicate mental abuse . All residents will be educated regarding Abuse Prevention and Prohibition Policy, what is a reportable event, and how to report to IDOH by 1/14/22. Residents will be informed monthly at Resident Council of resident rights, abuse prevention, and how to report an event to IDOH, including what is a reportable event. . Regional Director/Designee, in collaboration with ED/Designee and DON/Designee will audit	

	The handwritten statement of CNA (Certified Nurse Aide) 5, dated 11/8/21 and 11/9/21, indicated HHA 4 had come down the hall and was mad at Resident H. They had gotten into an argument while she was going to put the resident to sleep. HHA 4 said she was not going to put up with the resident's mouths. At that time, for the third time, Resident E came out of his room and started yelling. CNA 5 was doing a puzzle with Resident F. HHA 4 and Resident E got into an argument. HHA 4 said she was sick of the resident's talking to her like that, she stated, "You might put up with their mouth, but I'm not." Resident E told her she needed to shut up and HHA 4 told him she would kick his a**, then put her fists up and told the resident to come on. CNA 5 then dragged the aide away and told her to calm down. She then went back to her 1 on 1 care. The handwritten statement of LPN (Licensed Practical Nurse) 6, dated 11/8/21, indicated at 11:00 p.m., she had witnessed HHA 4 approaching the 100 Hall nurses' station and was yelling "You all may put up with these resident but I'm not. I'm about to beat someone's ass." She approached HHA 4 and explained that she needed to tell her what the issue was. The staff member continued to		the completeness of every abuse allegation for 6 months, including thorough, proper documentation for all affected residents in both the investigation packet and affected resident clinical records andpsychosocial needs involvement. Regional Director/Designee, in collaboration with ED/Designee and DON/Designee will audit staff abuse prohibition policy quizzes x 6 months. Executive Director/Designee will interview 5 residents at random weekly x 6 months regarding Abuse, Prevention and Prohibition Policy including what topics are reportable events, and how to report an event to IDOH. Regional Director/Designee, in collaboration with ED/Designee and DON/Designee will review audits with QA Committee monthly x3 months for identified issues. QA Committee will determine if audits necessitate extension past 3 months and will continue to review audit results monthly for duration of the extended timeframe as applicable. Criteria for determining if further monitoring is necessary or if monitoring can be stopped: If investigation is discovered to be incomplete or not in line with established policy and procedure, then audits will be extended for a	

	scream at the nurse's station. She encouraged her to calm down and explained residents were present. HHA 4 then told her she was going to F*** up residents that talked to her that way. She then told HHA 4 to leave the building. HHA 4 told her to call the DON (Director of Nursing) and screamed at her telling her she was going to F*** the nurse and the building up, then exited the building. Multiple residents approached her, voicing concern for their safety. One of the residents was Resident G. The DON's typed statement, dated 11/9/21, indicated she had received a call from the facility. The nurse on duty called at 12:02 a.m. and stated HHA 4 was yelling at several residents in the hallway and had been in a yelling match with a resident, then took an aggressive stance with her fists up wanting to fight the resident. The DON instructed her to call 911. The nurse indicated HHA 4 had left but turned around and screamed that she was going to F*** the nurse and the building up. During an interview, on 11/17/21 at 9:35 a.m., Resident E indicated there had been an incident a week or two ago where an aide had threatened him. He recalled he'd had radiation for his cancer that day		length of time agreed upon by QA Committee. If staff quizzes or resident interviews indicate that further education is required, then additional training will be scheduled, and quizzes will be extended for a length of time agreed upon by the QA Committee.	

	and about 9:00 p.m., he woke up because it was loud in the hallway. It kept getting louder and louder, and he had a massive headache from his treatment. He stepped out and told the staff they were being disrespectful; the noise level was ridiculous and he had a headache. He went to go back in his room and the aide came after him and began to argue with him. He closed his door and for a while it died down. Later in the night, he believed after 12:00 a.m., he heard her outside his door again, making statements that nobody was going to talk to her that way. He walked out and asked if she was talking about him, she told him, "I ain't talking about your a**, get your a** back in there." He told her she was not going to talk to him or any other residents that way. She then looked at him and asked him what he was going to do. The resident then demonstrated the stance she took, by putting his fists up in the air. He indicated she acted like she was going to hit him four times. The nurse had to come and drag her down the hallway. As she was being dragged away, she looked at him and said, "You're stupid, you're not nothing but a f***ing crybaby." The resident indicated he would have beat the "hell" out of her if she'd touched him or any other resident, and he would have lost his home over			

	it. At this point, the resident was visibly upset, his voice was shaking, he was crying, and shaking as he recalled the incident. He stated "...she threatened to hit me! She was pumping her fist at me like me and her were in the ghetto and she wanted to fight man ... I'm a 53-year-old man who has brain cancer and lung cancer, I should not have to tolerate that... This is my home ... If I'd have been 80 or 90, she'd have bullied me right back into my bedroom. She's a bully and does not deserve to have a license. This isn't jail. It really disturbs me." During an interview, on 11/17/21 at 11:47 a.m., the DON indicated she got a call at about midnight and could hear yelling in the background. LPN 6 indicated HHA 4 had gotten into it with Resident E and had taken up a fighting stance against him. She instructed her to call 911, but LPN 6 informed her the aide was leaving. As she walked her toward the front door, she turned around and said "I'm gonna f*** you and this building up!", and then turned and left and walked out the door. Upon investigation, she had been told HHA had gone to Resident H's room. He said something to her, and then she came down the hall yelling. Resident E came out of his room and asked her to be quiet and that was when			

everything happened. HHA 4 told him, "take you'er a** back to your room!", and threatened him. She was told Resident G and Resident F observed it. Staff told her she left at 11:54 p.m. She didn't even know until then what was going on. Staff should try to divert and deescalate the situation and call her. She indicated she would not expect it to take several hours for that to happen.

During an interview, on 11/17/21 at 6:43 p.m., LPN 6 indicated she had worked the night of 11/8/21, and had come in around 10:00 p.m. Around 11:00 p.m., she heard screaming and took off towards it. HHA 4 came around the corner screaming, "I'm gonna beat his f***ing a**!" She asked her what had happened, and indicated she guessed they had gotten loud while working on a puzzle, and Resident E and HHA 4 had gotten into it. When he came out again and asked her to quiet down, HHA 4 had said some words and taken a stance like she was going to box. LPN 6 felt threatened when that happened, and she was scared for the residents around. HHA 4 was pretty irate. Several residents had been present and were shaken up. One resident was visibly shaking, and Resident G said she did not feel safe at the facility. She asked the aide to leave and walked

her up to the front of the building. Resident F was also a witness to the incident, and Resident E is the resident she had done this to.

During an interview, on 11/17/21 at 7:33 p.m., CNA 5 indicated HHA 4 had gone to do the laundry and when she came back, she was in a bad mood. CNA 5 was working a puzzle with Resident F and HHA came around the corner saying Resident H had cussed her out and she was done. She indicated "you might put up with what residents say and how they treat you, but that don't mean I have to." She asked HHA 4 to calm down and she said she wasn't going to do it. Then Resident E came out and asked them to be quiet. HHA 4 and Resident E went back and forth and then she stated to Resident E, "I'll just kick your ass!" Resident F then told them to calm down and they kept going. She also asked the aide to leave, and took her to the nurses station, and told the nurse she needed to leave. The incident upset the 1 on 1 patient she was taking care of. Resident G was out there, she was in the hallway. Resident H was out there. Resident F was in the middle of it. They felt threatened and they were scared.

2. The clinical record for

	Resident G was reviewed, on 11/17/21 at 1:07 p.m. The resident's diagnoses included, but were not limited to, schizophrenia, depression, anxiety, insomnia, GERD (Gastroesophageal Reflux Disease), bipolar, glaucoma, and dementia. The BIMS assessment, dated 5/27/21, indicated the resident was cognitively intact. During an interview, on 11/17/21 at 9:30 a.m., the resident indicated she heard yelling outside her door on the 300 Hall. She came out and there were residents and staff down by the puzzle table. She witnessed HHA 4 screaming she would not deal with Resident H. She would not change his diaper because she didn't get paid enough to care for him. Another resident came out of his room and asked "... Are you talking about me?" She started cussing and threatening the resident. She said she was going to kick his a** and beat the living s**t out of him. She put up her fists up like she was going to hit him. Three people had to stop her. She threatened to kill the residents and the nurses. The resident indicated she thought if HHA 4 had a gun on her, she would have shot the place up. She believed the HHA would really have hurt the residents. HHA 4 was always			

	going around saying she was going to kick someone's a**. She would refuse to help the residents. The nurses escorted her out of the building, and she was cussing and yelling all the way out. The resident was so terrified, and her anxiety was so high, she had to sit at the nurse's station for a couple of hours to feel safe enough to go back to her room. 3. The clinical record for Resident F was reviewed, on 11/17/21 at 10:00 a.m. The resident's diagnoses included, but were not limited to, diabetes, hypertension, kidney stones, cardiac stents, osteoarthritis, left hip replacement, amputation Left middle toe, hernia repair, and appendectomy. The BIMS assessment, dated 10/19/21, indicated the resident was cognitively intact. During an interview, on 11/17/21 at 10:00 a.m., Resident F indicated he was sitting at the puzzle table working a puzzle. HHA 4 was observed cursing Resident E. She was cursing loud and making threats. She lifted her fists and acted like she was going to hit him. She threatened other residents. He did not know what set her off. She was going to beat up the residents, and the nurses had to restrain her. They escorted her out of the building. He couldn't			

	do anything, so he kept quiet and was an innocent bystander. 4. The clinical record for Resident H was reviewed, on 11/17/21 at 10:00 a.m. The resident's diagnoses included, but were not limited to, Traumatic incomplete cord injury, alcohol abuse, dementia secondary to ETOH abuse, GERD, anxiety, neuropathy, impulse control, bipolar, and arterial vascular disease. The BIMS assessment, dated 5/17/21, indicated the resident was cognitively intact. During an interview, on 11/17/21 at 10:45 a.m., Resident H indicated HHA 4 refused to provide care and help him get into bed. She was cursing at him. She left his room and never did come back. He had to wait until someone else could assist him to bed. A review of the police report, dated 11/9/21 at 1:44 p.m., indicated upon arrival to the facility the police spoke with the DON. The DON advised that an employee was fired and escorted off the premises in the overnight hours. The employee was identified as HHA 4, and she had threatened a patient as well as staff members. HHA 4 indicated to him that a patient threatened her and she did tell the patient if he put hands on			

her that she was going to hit him back.

The Abuse, Prevention and Prohibition Policy, last revised 4/2020, provided on 11/17/21 at 10:00 a.m. by the ED, included, but was not limited to, "... Each resident has the right to be free from abuse... and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff... all instances of abuse... can cause physical harm, pain or mental anguish... The resident has the right to be free from verbal, mental, sexual, exploitation, or physical abuse... and involuntary seclusion... Definitions... Abuse- means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish... Instance of abuse of all residents, irrespective of any mental or physical condition, cause harm, pain, or mental anguish. It includes verbal abuse... and mental abuse... Mental abuse includes, but is not limited to, humiliation, harassment, and threats of punishment or deprivation... Mistreatment Means inappropriate treatment or exploitation of a resident... Involuntary seclusion is defined as separation of a resident from other residents or confinement in his/her room... against the

resident's will..."

This State Residential Finding relates to Complaint IN00366838.

Based on record review and interview, the facility failed to ensure residents are free of mental abuse for 4 of 6 residents reviewed for abuse. (Residents E, F, G, and H.)

Findings include:

1. The State reportable incident, dated 11/9/21 at 6:23 p.m., indicated HHA (Home Health Aide) 4 was yelling at several residents and took an aggressive stance, holding up her fists on one of the residents. When her charge nurse asked her to leave, she declined. When the charge nurse was instructed to call 911, the employee left. The residents affected included Residents E, F, and G.

The clinical record for Resident E was reviewed on 11/17/21 at 10:00 a.m. Diagnoses included, but were not limited to, metastatic cancer and depression.

The BIMS (Brief Interview of Mental Status) assessment, dated 8/13/21, indicated Resident E was cognitively intact.

The handwritten, undated

	statement of Resident E indicated on November 8th, he woke up about 9:00 p.m., because it was fairly loud in the hallway. It went on for about an hour and twenty minutes before he came out and informed staff he had a headache, and they were being disrespectful as people were trying to sleep. HHA 4 argued with him, and he went back to his room. She carried on making comments in the hall for ten minutes, and then it died down. A little after midnight he heard HHA 4 outside his door saying no one was going to talk to her like that, and running her mouth. He walked out and asked the aide if she was talking about him. She told him to get his a** in his room and started walking toward him. He told her she couldn't talk to him like that, or any other resident that way. She said "F*** you and every resident in here...", and then pumped her fists at him and squared off. After the fourth time he told her if she hit him, he would beat her teeth out. She started calling him stupid and a crybaby. She was a bully and was going to hurt someone if she continued working in the environment. She did not care about the residents and shouldn't be allowed to work around the sick or elderly. He had never witnessed something so horrible in his life.			

	The handwritten statement of CNA (Certified Nurse Aide) 5, dated 11/8/21 and 11/9/21, indicated HHA 4 had come down the hall and was mad at Resident H. They had gotten into an argument while she was going to put the resident to sleep. HHA 4 said she was not going to put up with the resident's mouths. At that time, for the third time, Resident E came out of his room and started yelling. CNA 5 was doing a puzzle with Resident F. HHA 4 and Resident E got into an argument. HHA 4 said she was sick of the resident's talking to her like that, she stated, "You might put up with their mouth, but I'm not." Resident E told her she needed to shut up and HHA 4 told him she would kick his a**, then put her fists up and told the resident to come on. CNA 5 then dragged the aide away and told her to calm down. She then went back to her 1 on 1 care. The handwritten statement of LPN (Licensed Practical Nurse) 6, dated 11/8/21, indicated at 11:00 p.m., she had witnessed HHA 4 approaching the 100 Hall nurses' station and was yelling "You all may put up with these resident but I'm not. I'm about to beat someone's ass." She approached HHA 4 and explained that she needed to tell her what the issue was. The staff member continued to			

	scream at the nurse's station. She encouraged her to calm down and explained residents were present. HHA 4 then told her she was going to F*** up residents that talked to her that way. She then told HHA 4 to leave the building. HHA 4 told her to call the DON (Director of Nursing) and screamed at her telling her she was going to F*** the nurse and the building up, then exited the building. Multiple residents approached her, voicing concern for their safety. One of the residents was Resident G. The DON's typed statement, dated 11/9/21, indicated she had received a call from the facility. The nurse on duty called at 12:02 a.m. and stated HHA 4 was yelling at several residents in the hallway and had been in a yelling match with a resident, then took an aggressive stance with her fists up wanting to fight the resident. The DON instructed her to call 911. The nurse indicated HHA 4 had left but turned around and screamed that she was going to F*** the nurse and the building up. During an interview, on 11/17/21 at 9:35 a.m., Resident E indicated there had been an incident a week or two ago where an aide had threatened him. He recalled he'd had radiation for his cancer that day			

	and about 9:00 p.m., he woke up because it was loud in the hallway. It kept getting louder and louder, and he had a massive headache from his treatment. He stepped out and told the staff they were being disrespectful; the noise level was ridiculous and he had a headache. He went to go back in his room and the aide came after him and began to argue with him. He closed his door and for a while it died down. Later in the night, he believed after 12:00 a.m., he heard her outside his door again, making statements that nobody was going to talk to her that way. He walked out and asked if she was talking about him, she told him, "I ain't talking about your a**, get your a** back in there." He told her she was not going to talk to him or any other residents that way. She then looked at him and asked him what he was going to do. The resident then demonstrated the stance she took, by putting his fists up in the air. He indicated she acted like she was going to hit him four times. The nurse had to come and drag her down the hallway. As she was being dragged away, she looked at him and said, "You're stupid, you're not nothing but a f***ing crybaby." The resident indicated he would have beat the "hell" out of her if she'd touched him or any other resident, and he would have lost his home over			

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everything happened. HHA 4 told him, "take you'er a** back to your room!", and threatened him. She was told Resident G and Resident F observed it. Staff told her she left at 11:54 p.m. She didn't even know until then what was going on. Staff should try to divert and deescalate the situation and call her. She indicated she would not expect it to take several hours for that to happen.

During an interview, on 11/17/21 at 6:43 p.m., LPN 6 indicated she had worked the night of 11/8/21, and had come in around 10:00 p.m. Around 11:00 p.m., she heard screaming and took off towards it. HHA 4 came around the corner screaming, "I'm gonna beat his f***ing a**!" She asked her what had happened, and indicated she guessed they had gotten loud while working on a puzzle, and Resident E and HHA 4 had gotten into it. When he came out again and asked her to quiet down, HHA 4 had said some words and taken a stance like she was going to box. LPN 6 felt threatened when that happened, and she was scared for the residents around. HHA 4 was pretty irate. Several residents had been present and were shaken up. One resident was visibly shaking, and Resident G said she did not feel safe at the facility. She asked the aide to leave and walked

her up to the front of the building. Resident F was also a witness to the incident, and Resident E is the resident she had done this to.

During an interview, on 11/17/21 at 7:33 p.m., CNA 5 indicated HHA 4 had gone to do the laundry and when she came back, she was in a bad mood. CNA 5 was working a puzzle with Resident F and HHA came around the corner saying Resident H had cussed her out and she was done. She indicated "you might put up with what residents say and how they treat you, but that don't mean I have to." She asked HHA 4 to calm down and she said she wasn't going to do it. Then Resident E came out and asked them to be quiet. HHA 4 and Resident E went back and forth and then she stated to Resident E, "I'll just kick your ass!" Resident F then told them to calm down and they kept going. She also asked the aide to leave, and took her to the nurses station, and told the nurse she needed to leave. The incident upset the 1 on 1 patient she was taking care of. Resident G was out there, she was in the hallway. Resident H was out there. Resident F was in the middle of it. They felt threatened and they were scared.

2. The clinical record for

	Resident G was reviewed, on 11/17/21 at 1:07 p.m. The resident's diagnoses included, but were not limited to, schizophrenia, depression, anxiety, insomnia, GERD (Gastroesophageal Reflux Disease), bipolar, glaucoma, and dementia. The BIMS assessment, dated 5/27/21, indicated the resident was cognitively intact. During an interview, on 11/17/21 at 9:30 a.m., the resident indicated she heard yelling outside her door on the 300 Hall. She came out and there were residents and staff down by the puzzle table. She witnessed HHA 4 screaming she would not deal with Resident H. She would not change his diaper because she didn't get paid enough to care for him. Another resident came out of his room and asked "... Are you talking about me?" She started cussing and threatening the resident. She said she was going to kick his a** and beat the living s**t out of him. She put up her fists up like she was going to hit him. Three people had to stop her. She threatened to kill the residents and the nurses. The resident indicated she thought if HHA 4 had a gun on her, she would have shot the place up. She believed the HHA would really have hurt the residents. HHA 4 was always			

	going around saying she was going to kick someone's a**. She would refuse to help the residents. The nurses escorted her out of the building, and she was cussing and yelling all the way out. The resident was so terrified, and her anxiety was so high, she had to sit at the nurse's station for a couple of hours to feel safe enough to go back to her room. 3. The clinical record for Resident F was reviewed, on 11/17/21 at 10:00 a.m. The resident's diagnoses included, but were not limited to, diabetes, hypertension, kidney stones, cardiac stents, osteoarthritis, left hip replacement, amputation Left middle toe, hernia repair, and appendectomy. The BIMS assessment, dated 10/19/21, indicated the resident was cognitively intact. During an interview, on 11/17/21 at 10:00 a.m., Resident F indicated he was sitting at the puzzle table working a puzzle. HHA 4 was observed cursing Resident E. She was cursing loud and making threats. She lifted her fists and acted like she was going to hit him. She threatened other residents. He did not know what set her off. She was going to beat up the residents, and the nurses had to restrain her. They escorted her out of the building. He couldn't			

	do anything, so he kept quiet and was an innocent bystander. 4. The clinical record for Resident H was reviewed, on 11/17/21 at 10:00 a.m. The resident's diagnoses included, but were not limited to, Traumatic incomplete cord injury, alcohol abuse, dementia secondary to ETOH abuse, GERD, anxiety, neuropathy, impulse control, bipolar, and arterial vascular disease. The BIMS assessment, dated 5/17/21, indicated the resident was cognitively intact. During an interview, on 11/17/21 at 10:45 a.m., Resident H indicated HHA 4 refused to provide care and help him get into bed. She was cursing at him. She left his room and never did come back. He had to wait until someone else could assist him to bed. A review of the police report, dated 11/9/21 at 1:44 p.m., indicated upon arrival to the facility the police spoke with the DON. The DON advised that an employee was fired and escorted off the premises in the overnight hours. The employee was identified as HHA 4, and she had threatened a patient as well as staff members. HHA 4 indicated to him that a patient threatened her and she did tell the patient if he put hands on			

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The Abuse, Prevention and Prohibition Policy, last revised 4/2020, provided on 11/17/21 at 10:00 a.m. by the ED, included, but was not limited to, "... Each resident has the right to be free from abuse... and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff... all instances of abuse... can cause physical harm, pain or mental anguish... The resident has the right to be free from verbal, mental, sexual, exploitation, or physical abuse... and involuntary seclusion... Definitions... Abuse- means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish... Instance of abuse of all residents, irrespective of any mental or physical condition, cause harm, pain, or mental anguish. It includes verbal abuse... and mental abuse... Mental abuse includes, but is not limited to, humiliation, harassment, and threats of punishment or deprivation... Mistreatment Means inappropriate treatment or exploitation of a resident... Involuntary seclusion is defined as separation of a resident from other residents or confinement in his/her room... against the

resident's will..."

This State Residential Finding relates to Complaint IN00366838.

Based on record review and interview, the facility failed to ensure residents are free of mental abuse for 4 of 6 residents reviewed for abuse. (Residents E, F, G, and H.)

Findings include:

1. The State reportable incident, dated 11/9/21 at 6:23 p.m., indicated HHA (Home Health Aide) 4 was yelling at several residents and took an aggressive stance, holding up her fists on one of the residents. When her charge nurse asked her to leave, she declined. When the charge nurse was instructed to call 911, the employee left. The residents affected included Residents E, F, and G.

The clinical record for Resident E was reviewed on 11/17/21 at 10:00 a.m. Diagnoses included, but were not limited to, metastatic cancer and depression.

The BIMS (Brief Interview of Mental Status) assessment, dated 8/13/21, indicated Resident E was cognitively intact.

The handwritten, undated

	statement of Resident E indicated on November 8th, he woke up about 9:00 p.m., because it was fairly loud in the hallway. It went on for about an hour and twenty minutes before he came out and informed staff he had a headache, and they were being disrespectful as people were trying to sleep. HHA 4 argued with him, and he went back to his room. She carried on making comments in the hall for ten minutes, and then it died down. A little after midnight he heard HHA 4 outside his door saying no one was going to talk to her like that, and running her mouth. He walked out and asked the aide if she was talking about him. She told him to get his a** in his room and started walking toward him. He told her she couldn't talk to him like that, or any other resident that way. She said "F*** you and every resident in here...", and then pumped her fists at him and squared off. After the fourth time he told her if she hit him, he would beat her teeth out. She started calling him stupid and a crybaby. She was a bully and was going to hurt someone if she continued working in the environment. She did not care about the residents and shouldn't be allowed to work around the sick or elderly. He had never witnessed something so horrible in his life.			

	The handwritten statement of CNA (Certified Nurse Aide) 5, dated 11/8/21 and 11/9/21, indicated HHA 4 had come down the hall and was mad at Resident H. They had gotten into an argument while she was going to put the resident to sleep. HHA 4 said she was not going to put up with the resident's mouths. At that time, for the third time, Resident E came out of his room and started yelling. CNA 5 was doing a puzzle with Resident F. HHA 4 and Resident E got into an argument. HHA 4 said she was sick of the resident's talking to her like that, she stated, "You might put up with their mouth, but I'm not." Resident E told her she needed to shut up and HHA 4 told him she would kick his a**, then put her fists up and told the resident to come on. CNA 5 then dragged the aide away and told her to calm down. She then went back to her 1 on 1 care. The handwritten statement of LPN (Licensed Practical Nurse) 6, dated 11/8/21, indicated at 11:00 p.m., she had witnessed HHA 4 approaching the 100 Hall nurses' station and was yelling "You all may put up with these resident but I'm not. I'm about to beat someone's ass." She approached HHA 4 and explained that she needed to tell her what the issue was. The staff member continued to			

	scream at the nurse's station. She encouraged her to calm down and explained residents were present. HHA 4 then told her she was going to F*** up residents that talked to her that way. She then told HHA 4 to leave the building. HHA 4 told her to call the DON (Director of Nursing) and screamed at her telling her she was going to F*** the nurse and the building up, then exited the building. Multiple residents approached her, voicing concern for their safety. One of the residents was Resident G. The DON's typed statement, dated 11/9/21, indicated she had received a call from the facility. The nurse on duty called at 12:02 a.m. and stated HHA 4 was yelling at several residents in the hallway and had been in a yelling match with a resident, then took an aggressive stance with her fists up wanting to fight the resident. The DON instructed her to call 911. The nurse indicated HHA 4 had left but turned around and screamed that she was going to F*** the nurse and the building up. During an interview, on 11/17/21 at 9:35 a.m., Resident E indicated there had been an incident a week or two ago where an aide had threatened him. He recalled he'd had radiation for his cancer that day			

	and about 9:00 p.m., he woke up because it was loud in the hallway. It kept getting louder and louder, and he had a massive headache from his treatment. He stepped out and told the staff they were being disrespectful; the noise level was ridiculous and he had a headache. He went to go back in his room and the aide came after him and began to argue with him. He closed his door and for a while it died down. Later in the night, he believed after 12:00 a.m., he heard her outside his door again, making statements that nobody was going to talk to her that way. He walked out and asked if she was talking about him, she told him, "I ain't talking about your a**, get your a** back in there." He told her she was not going to talk to him or any other residents that way. She then looked at him and asked him what he was going to do. The resident then demonstrated the stance she took, by putting his fists up in the air. He indicated she acted like she was going to hit him four times. The nurse had to come and drag her down the hallway. As she was being dragged away, she looked at him and said, "You're stupid, you're not nothing but a f***ing crybaby." The resident indicated he would have beat the "hell" out of her if she'd touched him or any other resident, and he would have lost his home over			

	it. At this point, the resident was visibly upset, his voice was shaking, he was crying, and shaking as he recalled the incident. He stated "...she threatened to hit me! She was pumping her fist at me like me and her were in the ghetto and she wanted to fight man ... I'm a 53-year-old man who has brain cancer and lung cancer, I should not have to tolerate that... This is my home ... If I'd have been 80 or 90, she'd have bullied me right back into my bedroom. She's a bully and does not deserve to have a license. This isn't jail. It really disturbs me." During an interview, on 11/17/21 at 11:47 a.m., the DON indicated she got a call at about midnight and could hear yelling in the background. LPN 6 indicated HHA 4 had gotten into it with Resident E and had taken up a fighting stance against him. She instructed her to call 911, but LPN 6 informed her the aide was leaving. As she walked her toward the front door, she turned around and said "I'm gonna f*** you and this building up!", and then turned and left and walked out the door. Upon investigation, she had been told HHA had gone to Resident H's room. He said something to her, and then she came down the hall yelling. Resident E came out of his room and asked her to be quiet and that was when			

everything happened. HHA 4 told him, "take you'er a** back to your room!", and threatened him. She was told Resident G and Resident F observed it. Staff told her she left at 11:54 p.m. She didn't even know until then what was going on. Staff should try to divert and deescalate the situation and call her. She indicated she would not expect it to take several hours for that to happen.

During an interview, on 11/17/21 at 6:43 p.m., LPN 6 indicated she had worked the night of 11/8/21, and had come in around 10:00 p.m. Around 11:00 p.m., she heard screaming and took off towards it. HHA 4 came around the corner screaming, "I'm gonna beat his f***ing a**!" She asked her what had happened, and indicated she guessed they had gotten loud while working on a puzzle, and Resident E and HHA 4 had gotten into it. When he came out again and asked her to quiet down, HHA 4 had said some words and taken a stance like she was going to box. LPN 6 felt threatened when that happened, and she was scared for the residents around. HHA 4 was pretty irate. Several residents had been present and were shaken up. One resident was visibly shaking, and Resident G said she did not feel safe at the facility. She asked the aide to leave and walked

her up to the front of the building. Resident F was also a witness to the incident, and Resident E is the resident she had done this to.

During an interview, on 11/17/21 at 7:33 p.m., CNA 5 indicated HHA 4 had gone to do the laundry and when she came back, she was in a bad mood. CNA 5 was working a puzzle with Resident F and HHA came around the corner saying Resident H had cussed her out and she was done. She indicated "you might put up with what residents say and how they treat you, but that don't mean I have to." She asked HHA 4 to calm down and she said she wasn't going to do it. Then Resident E came out and asked them to be quiet. HHA 4 and Resident E went back and forth and then she stated to Resident E, "I'll just kick your ass!" Resident F then told them to calm down and they kept going. She also asked the aide to leave, and took her to the nurses station, and told the nurse she needed to leave. The incident upset the 1 on 1 patient she was taking care of. Resident G was out there, she was in the hallway. Resident H was out there. Resident F was in the middle of it. They felt threatened and they were scared.

2. The clinical record for

	Resident G was reviewed, on 11/17/21 at 1:07 p.m. The resident's diagnoses included, but were not limited to, schizophrenia, depression, anxiety, insomnia, GERD (Gastroesophageal Reflux Disease), bipolar, glaucoma, and dementia. The BIMS assessment, dated 5/27/21, indicated the resident was cognitively intact. During an interview, on 11/17/21 at 9:30 a.m., the resident indicated she heard yelling outside her door on the 300 Hall. She came out and there were residents and staff down by the puzzle table. She witnessed HHA 4 screaming she would not deal with Resident H. She would not change his diaper because she didn't get paid enough to care for him. Another resident came out of his room and asked "... Are you talking about me?" She started cussing and threatening the resident. She said she was going to kick his a** and beat the living s**t out of him. She put up her fists up like she was going to hit him. Three people had to stop her. She threatened to kill the residents and the nurses. The resident indicated she thought if HHA 4 had a gun on her, she would have shot the place up. She believed the HHA would really have hurt the residents. HHA 4 was always			

	going around saying she was going to kick someone's a**. She would refuse to help the residents. The nurses escorted her out of the building, and she was cussing and yelling all the way out. The resident was so terrified, and her anxiety was so high, she had to sit at the nurse's station for a couple of hours to feel safe enough to go back to her room. 3. The clinical record for Resident F was reviewed, on 11/17/21 at 10:00 a.m. The resident's diagnoses included, but were not limited to, diabetes, hypertension, kidney stones, cardiac stents, osteoarthritis, left hip replacement, amputation Left middle toe, hernia repair, and appendectomy. The BIMS assessment, dated 10/19/21, indicated the resident was cognitively intact. During an interview, on 11/17/21 at 10:00 a.m., Resident F indicated he was sitting at the puzzle table working a puzzle. HHA 4 was observed cursing Resident E. She was cursing loud and making threats. She lifted her fists and acted like she was going to hit him. She threatened other residents. He did not know what set her off. She was going to beat up the residents, and the nurses had to restrain her. They escorted her out of the building. He couldn't			

	do anything, so he kept quiet and was an innocent bystander. 4. The clinical record for Resident H was reviewed, on 11/17/21 at 10:00 a.m. The resident's diagnoses included, but were not limited to, Traumatic incomplete cord injury, alcohol abuse, dementia secondary to ETOH abuse, GERD, anxiety, neuropathy, impulse control, bipolar, and arterial vascular disease. The BIMS assessment, dated 5/17/21, indicated the resident was cognitively intact. During an interview, on 11/17/21 at 10:45 a.m., Resident H indicated HHA 4 refused to provide care and help him get into bed. She was cursing at him. She left his room and never did come back. He had to wait until someone else could assist him to bed. A review of the police report, dated 11/9/21 at 1:44 p.m., indicated upon arrival to the facility the police spoke with the DON. The DON advised that an employee was fired and escorted off the premises in the overnight hours. The employee was identified as HHA 4, and she had threatened a patient as well as staff members. HHA 4 indicated to him that a patient threatened her and she did tell the patient if he put hands on			

her that she was going to hit him back.

The Abuse, Prevention and Prohibition Policy, last revised 4/2020, provided on 11/17/21 at 10:00 a.m. by the ED, included, but was not limited to, "... Each resident has the right to be free from abuse... and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff... all instances of abuse... can cause physical harm, pain or mental anguish... The resident has the right to be free from verbal, mental, sexual, exploitation, or physical abuse... and involuntary seclusion... Definitions... Abuse- means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish... Instance of abuse of all residents, irrespective of any mental or physical condition, cause harm, pain, or mental anguish. It includes verbal abuse... and mental abuse... Mental abuse includes, but is not limited to, humiliation, harassment, and threats of punishment or deprivation... Mistreatment Means inappropriate treatment or exploitation of a resident... Involuntary seclusion is defined as separation of a resident from other residents or confinement in his/her room... against the

resident's will..."

This State Residential Finding relates to Complaint IN00366838.

Based on record review and interview, the facility failed to ensure residents are free of mental abuse for 4 of 6 residents reviewed for abuse. (Residents E, F, G, and H.)

Findings include:

1. The State reportable incident, dated 11/9/21 at 6:23 p.m., indicated HHA (Home Health Aide) 4 was yelling at several residents and took an aggressive stance, holding up her fists on one of the residents. When her charge nurse asked her to leave, she declined. When the charge nurse was instructed to call 911, the employee left. The residents affected included Residents E, F, and G.

The clinical record for Resident E was reviewed on 11/17/21 at 10:00 a.m. Diagnoses included, but were not limited to, metastatic cancer and depression.

The BIMS (Brief Interview of Mental Status) assessment, dated 8/13/21, indicated Resident E was cognitively intact.

The handwritten, undated

	statement of Resident E indicated on November 8th, he woke up about 9:00 p.m., because it was fairly loud in the hallway. It went on for about an hour and twenty minutes before he came out and informed staff he had a headache, and they were being disrespectful as people were trying to sleep. HHA 4 argued with him, and he went back to his room. She carried on making comments in the hall for ten minutes, and then it died down. A little after midnight he heard HHA 4 outside his door saying no one was going to talk to her like that, and running her mouth. He walked out and asked the aide if she was talking about him. She told him to get his a** in his room and started walking toward him. He told her she couldn't talk to him like that, or any other resident that way. She said "F*** you and every resident in here...", and then pumped her fists at him and squared off. After the fourth time he told her if she hit him, he would beat her teeth out. She started calling him stupid and a crybaby. She was a bully and was going to hurt someone if she continued working in the environment. She did not care about the residents and shouldn't be allowed to work around the sick or elderly. He had never witnessed something so horrible in his life.			

	The handwritten statement of CNA (Certified Nurse Aide) 5, dated 11/8/21 and 11/9/21, indicated HHA 4 had come down the hall and was mad at Resident H. They had gotten into an argument while she was going to put the resident to sleep. HHA 4 said she was not going to put up with the resident's mouths. At that time, for the third time, Resident E came out of his room and started yelling. CNA 5 was doing a puzzle with Resident F. HHA 4 and Resident E got into an argument. HHA 4 said she was sick of the resident's talking to her like that, she stated, "You might put up with their mouth, but I'm not." Resident E told her she needed to shut up and HHA 4 told him she would kick his a**, then put her fists up and told the resident to come on. CNA 5 then dragged the aide away and told her to calm down. She then went back to her 1 on 1 care. The handwritten statement of LPN (Licensed Practical Nurse) 6, dated 11/8/21, indicated at 11:00 p.m., she had witnessed HHA 4 approaching the 100 Hall nurses' station and was yelling "You all may put up with these resident but I'm not. I'm about to beat someone's ass." She approached HHA 4 and explained that she needed to tell her what the issue was. The staff member continued to			

	scream at the nurse's station. She encouraged her to calm down and explained residents were present. HHA 4 then told her she was going to F*** up residents that talked to her that way. She then told HHA 4 to leave the building. HHA 4 told her to call the DON (Director of Nursing) and screamed at her telling her she was going to F*** the nurse and the building up, then exited the building. Multiple residents approached her, voicing concern for their safety. One of the residents was Resident G. The DON's typed statement, dated 11/9/21, indicated she had received a call from the facility. The nurse on duty called at 12:02 a.m. and stated HHA 4 was yelling at several residents in the hallway and had been in a yelling match with a resident, then took an aggressive stance with her fists up wanting to fight the resident. The DON instructed her to call 911. The nurse indicated HHA 4 had left but turned around and screamed that she was going to F*** the nurse and the building up. During an interview, on 11/17/21 at 9:35 a.m., Resident E indicated there had been an incident a week or two ago where an aide had threatened him. He recalled he'd had radiation for his cancer that day			

	and about 9:00 p.m., he woke up because it was loud in the hallway. It kept getting louder and louder, and he had a massive headache from his treatment. He stepped out and told the staff they were being disrespectful; the noise level was ridiculous and he had a headache. He went to go back in his room and the aide came after him and began to argue with him. He closed his door and for a while it died down. Later in the night, he believed after 12:00 a.m., he heard her outside his door again, making statements that nobody was going to talk to her that way. He walked out and asked if she was talking about him, she told him, "I ain't talking about your a**, get your a** back in there." He told her she was not going to talk to him or any other residents that way. She then looked at him and asked him what he was going to do. The resident then demonstrated the stance she took, by putting his fists up in the air. He indicated she acted like she was going to hit him four times. The nurse had to come and drag her down the hallway. As she was being dragged away, she looked at him and said, "You're stupid, you're not nothing but a f***ing crybaby." The resident indicated he would have beat the "hell" out of her if she'd touched him or any other resident, and he would have lost his home over			

	it. At this point, the resident was visibly upset, his voice was shaking, he was crying, and shaking as he recalled the incident. He stated "...she threatened to hit me! She was pumping her fist at me like me and her were in the ghetto and she wanted to fight man ... I'm a 53-year-old man who has brain cancer and lung cancer, I should not have to tolerate that... This is my home ... If I'd have been 80 or 90, she'd have bullied me right back into my bedroom. She's a bully and does not deserve to have a license. This isn't jail. It really disturbs me." During an interview, on 11/17/21 at 11:47 a.m., the DON indicated she got a call at about midnight and could hear yelling in the background. LPN 6 indicated HHA 4 had gotten into it with Resident E and had taken up a fighting stance against him. She instructed her to call 911, but LPN 6 informed her the aide was leaving. As she walked her toward the front door, she turned around and said "I'm gonna f*** you and this building up!", and then turned and left and walked out the door. Upon investigation, she had been told HHA had gone to Resident H's room. He said something to her, and then she came down the hall yelling. Resident E came out of his room and asked her to be quiet and that was when			

everything happened. HHA 4 told him, "take you'er a** back to your room!", and threatened him. She was told Resident G and Resident F observed it. Staff told her she left at 11:54 p.m. She didn't even know until then what was going on. Staff should try to divert and deescalate the situation and call her. She indicated she would not expect it to take several hours for that to happen.

During an interview, on 11/17/21 at 6:43 p.m., LPN 6 indicated she had worked the night of 11/8/21, and had come in around 10:00 p.m. Around 11:00 p.m., she heard screaming and took off towards it. HHA 4 came around the corner screaming, "I'm gonna beat his f***ing a**!" She asked her what had happened, and indicated she guessed they had gotten loud while working on a puzzle, and Resident E and HHA 4 had gotten into it. When he came out again and asked her to quiet down, HHA 4 had said some words and taken a stance like she was going to box. LPN 6 felt threatened when that happened, and she was scared for the residents around. HHA 4 was pretty irate. Several residents had been present and were shaken up. One resident was visibly shaking, and Resident G said she did not feel safe at the facility. She asked the aide to leave and walked

her up to the front of the building. Resident F was also a witness to the incident, and Resident E is the resident she had done this to.

During an interview, on 11/17/21 at 7:33 p.m., CNA 5 indicated HHA 4 had gone to do the laundry and when she came back, she was in a bad mood. CNA 5 was working a puzzle with Resident F and HHA came around the corner saying Resident H had cussed her out and she was done. She indicated "you might put up with what residents say and how they treat you, but that don't mean I have to." She asked HHA 4 to calm down and she said she wasn't going to do it. Then Resident E came out and asked them to be quiet. HHA 4 and Resident E went back and forth and then she stated to Resident E, "I'll just kick your ass!" Resident F then told them to calm down and they kept going. She also asked the aide to leave, and took her to the nurses station, and told the nurse she needed to leave. The incident upset the 1 on 1 patient she was taking care of. Resident G was out there, she was in the hallway. Resident H was out there. Resident F was in the middle of it. They felt threatened and they were scared.

R 0053	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(w) (w) Residents have the right to be free from verbal abuse. 2. The clinical record for Resident G was reviewed, on 11/17/21 at 1:07 p.m. The resident's diagnoses included, but were not limited to, schizophrenia, depression, anxiety, insomnia, GERD (Gastroesophageal Reflux Disease), bipolar glaucoma, and dementia. The BIMS assessment, dated 5/27/21, indicated the resident was cognitively intact. During an interview, on 11/17/21 at 9:30 a.m., Resident G indicated she heard yelling outside her door on the 300 Hall. She came out and there were residents and staff down by the puzzle table. She witnessed HHA 4 screaming she would not deal with Resident H. She was also cussing and threaten another resident. She said she was going to kick his a-- and beat the living s--t out of him. She threatened to kill the residents and the nurses. The HHA 4 was always going around saying she was going to kick someone's a--. The nurses escorted her out of the building, and she was cussing and yelling all the way	R 0053	Preparation and submission of this statement of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or of the correctness of the conclusion stated on the statement of deficiencies. This statement of correction is prepared and submitted solely because of requirements under state and federal laws. We cordially request a desk review regarding the alleged deficiencies in lieu of any revisit. **Immediate Intervention:** • HHA 4 was suspended immediately and later terminated related to the finding of verbal abuse against them. • Residents E, F, G and H were assessed with no signs of injury and no noted mental anguish noted by a licensed nurse. Nursing Staff to follow up with each of these residents weekly and as needed for the next 30 days related to	01/28/2022

	out. She was so terrified, and her anxiety was so high she had to sit at the nurse's station for a couple of hours to feel safe enough to go back to her room. 3. The clinical record for Resident F was reviewed, on 11/17/21 at 10:00 a.m. The resident's diagnoses included, but were not limited to, diabetes, hypertension, kidney stones, cardiac stents, osteoarthritis, left hip replacement, amputation Left middle toe, hernia repair, and appendectomy. The BIMS assessment, dated 10/19/21, indicated the resident was cognitively intact. During an interview, on 11/17/21 at 10:00 a.m., Resident F indicated he was sitting at the puzzle table working a puzzle. HHA 4 was observed cursing Resident E. She was cursing loud and making threats. She threatened other residents. 4. The clinical record for Resident H was reviewed, on 11/17/21 at 10:00 a.m. The resident's diagnoses included, but were not limited to, Traumatic incomplete cord injury, alcohol abuse, dementia secondary to ETOH abuse, GERD, anxiety, neuropathy, impulse control, bipolar, and arterial vascular disease. The BIMS assessment, dated 5/17/21, indicated the resident		the incident. • An abuse investigation was completed and sent to IDOH for residents E, F, G, and H per policy. The investigation included use of the resident abuse investigation forms, assessments for signs of injury, interviews of other residents and staff. Documentation was noted in each of their clinical record of the above. • Nursing Staff were provided education by the Executive Director/ designee that they should assess residents to evaluate if the experienced any negative psychosocial effects when they experienced abuse or potential abuse. They should also provide ongoing support to meet their needs throughout and after the investigation occurs. • The Director of Nursing and the Executive Director	

	was cognitively intact. During an interview, on 11/17/21 at 10:45 a.m., Resident H indicated HHA 4 refused to provide care and help him get into bed. She was cursing at him. She left his room and never did come back. He had to wait until someone else could assist him to bed. A review of the police report, dated 11/9/21 at 1:44 p.m., indicated upon arrival to the facility the police spoke with the DON, who advised that an HHA 4 was fired and escorted off the premises in the overnight hours and she had threatened a patient as well as staff members. The DON provided two written statements that had been completed prior to his arrival. According to the statements HHA 4 had threatened violence against patients of the facility, the staff and against the facility itself. On 11/10/21, he spoke with HHA 4 via telephone, who advised a patient threatened her and she did tell the patient if he put hands on her that she was going to hit him back. The Abuse, Prevention and Prohibition Policy, last revised 4/2020, provided on 11/17/21 at 10:00 a.m. by the ED, included, but was not limited to, "... The resident has the right to be free from verbal... abuse... Verbal		were educated on the "abuse, prevention and prohibition" policy by the Regional Director to include the following: • Each resident has the right to be free from abuse... and involuntary seclusion. • Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff • All instances of abuse... can cause physical harm, pain or mental anguish. • The resident has the right to be free from verbal, mental, sexual, exploitation, or physical abuse... and involuntary seclusion. • Abuse- means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with	

	abuse is defined as the use of oral... or gestured language that willfully includes disparaging and derogatory terms to residents... or within the hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include but are not limited to threats of harm; saying things to frighten a resident..." This State Residential Finding relates to Complaint IN00366838. Based on record review and interview, the facility failed to residents were free from verbal abuse for 4 of 6 residents reviewed for abuse. (Residents E, F, G, and H.) Findings include: 1. The State reportable incident, dated 11/9/21 at 6:23 p.m., indicated HHA (Home Health Aide) 4 was yelling at several residents. The residents affected included Residents E, F, and G. The clinical record for Resident E was reviewed on 11/17/21 at 10:00 a.m. Diagnoses included, but were not limited to, metastatic cancer and depression. The BIMS (Brief Interview of Mental Status) assessment, dated 8/13/21, indicated Resident E was cognitively		resulting physical harm, pain, or mental anguish... Instance of abuse of all residents, irrespective of any mental or physical condition, cause harm, pain, or mental anguish. It includes verbal abuse... and mental abuse... Mental abuse includes, but is not limited to, humiliation, harassment, and threats of punishment or deprivation. • Mistreatment Means inappropriate treatment or exploitation of a resident... Involuntary seclusion is defined as separation of a resident from other residents or confinement in his/her room... against the resident's will..." **Identify Others Affected** • All residents were potentially at risk of same alleged deficient practice. All residents were	

	intact. The handwritten, undated statement of Resident E indicated on November 8th, HHA (Home Health Aide) 4 had argued with him, had cursed at him, telling him statements that he needed to get his a** back in his room, "F*** you and every resident in here." She called him stupid and a crybaby. He had never witnessed something so horrible in all his life. The handwritten statement of CNA (Certified Nurse Aide) 5, dated 11/8/21 and 11/9/21, indicated HHA 4 and Resident E got into an argument. HHA 4 told the resident she was going to beat his a**. The handwritten statement of LPN (Licensed Practical Nurse) 6, dated 11/8/21, indicated at 11 p.m. she had witnessed HHA 4 approaching the 100 Hall nurses station yelling that, and she told LPN 6 she was going to F*** up residents, the nurse, and the building. Multiple residents approached her, voicing concern for their safety. The residents included Residents G, J, and K. The DON's typed statement, dated 11/9/21, indicated she had received a call from the informing her HHA 4 was yelling at several residents in the hallway and had been in a		interviewed to determine if they had experienced any form of abuse, including mental or verbal, while in the facility. If they reported they had it was further investigated to ensure the appropriate abuse investigation was completed and any noted issues addressed. **The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not reoccur:** • All staff were educated on the “abuse, prevention and prohibition” ” (including what is verbal abuse) and how to monitor residents for potential occurrence of verbal abuse) policy by the Director of Nursing and the Executive Director to include the following: • Each	

	yelling match with a resident. HHA 4 had left but turned around and screamed that she was going to F*** the nurse and the building up. During an interview, on 11/17/21 at 9:35 a.m., Resident E indicated HHA 4 had argued with him, had cursed at him, and told him to get his "a**" back in his room. She stated to him, "You're stupid, you're not nothing but a f***ing crybaby." He stated "My lord, definitely it would be abuse... I should not have to tolerate that... This is my home ... It really disturbs me." During an interview, on 11/17/21 at 11:47 a.m., the DON indicated she got a call at about midnight and could hear yelling in the background. LPN 6 indicated HHA 4 had gotten into it with Resident E. She had been cursing and made verbal threats to the residents and the building. During an interview, on 11/17/21 at 6:43 p.m., LPN 6 indicated HHA 4 had been screaming and making verbal threats to beat a resident's "f***ing a**." Several residents had been present and were shaken up. One resident was visibly shaking, and Resident G said she did not feel safe at the facility. Resident F was also a witness to the incident, and Resident E is the		resident has the right to be free from abuse... and involuntary seclusion. • Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff • All instances of abuse... can cause physical harm, pain or mental anguish. • The resident has the right to be free from verbal, mental, sexual, exploitation, or physical abuse... and involuntary seclusion. • Abuse- means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish... Instance of abuse of all residents, irrespective of any mental or physical condition, cause harm, pain, or mental anguish. It includes verbal abuse... and	

	resident she had done this to. During an interview, on 11/17/21 at 7:33 p.m., CNA 5 indicated HHA 4 had made verbal threats to Resident E, stating, "I'll just kick your ass!" Resident F, G, and H had been present. They felt threatened and they were scared. 2. The clinical record for Resident G was reviewed, on 11/17/21 at 1:07 p.m. The resident's diagnoses included, but were not limited to, schizophrenia, depression, anxiety, insomnia, GERD (Gastroesophageal Reflux Disease), bipolar glaucoma, and dementia. The BIMS assessment, dated 5/27/21, indicated the resident was cognitively intact. During an interview, on 11/17/21 at 9:30 a.m., Resident G indicated she heard yelling outside her door on the 300 Hall. She came out and there were residents and staff down by the puzzle table. She witnessed HHA 4 screaming she would not deal with Resident H. She was also cussing and threaten another resident. She said she was going to kick his a-- and beat the living s--t out of him. She threatened to kill the residents and the nurses. The HHA 4 was always going around saying she		mental abuse... Mental abuse includes, but is not limited to, humiliation, harassment, and threats of punishment or deprivation. • Mistreatment Means inappropriate treatment or exploitation of a resident... Involuntary seclusion is defined as separation of a resident from other residents or confinement in his/her room... against the resident's will..." Education includes all agency staff and new staff prior to working. **Quality Assurance Plans to monitor facility performance to ensure that corrections are achieved and permanent:** . Staff will be quizzed weekly at random for each shift x 6 months regarding Abuse, Prevention and Prohibition Policy including what topics are reportable events, What	

	was going to kick someone's a--. The nurses escorted her out of the building, and she was cussing and yelling all the way out. She was so terrified, and her anxiety was so high she had to sit at the nurse's station for a couple of hours to feel safe enough to go back to her room. 3. The clinical record for Resident F was reviewed, on 11/17/21 at 10:00 a.m. The resident's diagnoses included, but were not limited to, diabetes, hypertension, kidney stones, cardiac stents, osteoarthritis, left hip replacement, amputation Left middle toe, hernia repair, and appendectomy. The BIMS assessment, dated 10/19/21, indicated the resident was cognitively intact. During an interview, on 11/17/21 at 10:00 a.m., Resident F indicated he was sitting at the puzzle table working a puzzle. HHA 4 was observed cursing Resident E. She was cursing loud and making threats. She threatened other residents. 4. The clinical record for Resident H was reviewed, on 11/17/21 at 10:00 a.m. The resident's diagnoses included, but were not limited to, Traumatic incomplete cord injury, alcohol abuse, dementia secondary to ETOH abuse, GERD, anxiety, neuropathy,		is verbal abuse, and what actions might indicate verbal abuse. Staff will be in-serviced ongoing upon hire regarding Abuse, Prevention and Prohibition Policy including what topics are reportable events, What is verbal abuse, and what actions/resident responses might indicate verbal abuse . All residents will be educated regarding Abuse Prevention and Prohibition Policy, what is a reportable event, and how to report to IDOH by 1/14/22. Residents will be informed monthly at Resident Council of resident rights, abuse prevention, and how to report an event to IDOH, including what is a reportable event. • Regional Director/Designee, in collaboration with ED/Designee and DON/Designee will audit the completeness of every abuse allegation for 6 months, including thorough, proper documentation for all affected residents in both the investigation packet and affected resident clinical records and Social	

	impulse control, bipolar, and arterial vascular disease. The BIMS assessment, dated 5/17/21, indicated the resident was cognitively intact. During an interview, on 11/17/21 at 10:45 a.m., Resident H indicated HHA 4 refused to provide care and help him get into bed. She was cursing at him. She left his room and never did come back. He had to wait until someone else could assist him to bed. A review of the police report, dated 11/9/21 at 1:44 p.m., indicated upon arrival to the facility the police spoke with the DON, who advised that an HHA 4 was fired and escorted off the premises in the overnight hours and she had threatened a patient as well as staff members. The DON provided two written statements that had been completed prior to his arrival. According to the statements HHA 4 had threatened violence against patients of the facility, the staff and against the facility itself. On 11/10/21, he spoke with HHA 4 via telephone, who advised a patient threatened her and she did tell the patient if he put hands on her that she was going to hit him back. The Abuse, Prevention and Prohibition Policy, last revised		Service involvement. Regional Director/Designee, in collaboration with ED/Designee and DON/Designee will audit staff abuse prohibition policy quizzes x 6 months. Executive Director/Designee will interview 5 residents at random weekly x 6 months regarding Abuse, Prevention and Prohibition Policy including what topics are reportable events, and how to report an event to IDOH. Regional Director/Designee, in collaboration with ED/Designee and DON/Designee will review audits with QA Committee monthly x3 months for identified issues. QA Committee will determine if audits necessitate extension past 3 months and will continue to review audit results monthly for duration of the extended timeframe as applicable. Criteria for determining if further monitoring is necessary or if monitoring can be stopped: If investigation is discovered to be incomplete or not in line with established policy and procedure, then audits	

	4/2020, provided on 11/17/21 at 10:00 a.m. by the ED, included, but was not limited to, "... The resident has the right to be free from verbal... abuse... Verbal abuse is defined as the use of oral... or gestured language that willfully includes disparaging and derogatory terms to residents... or within the hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include but are not limited to threats of harm; saying things to frighten a resident..." This State Residential Finding relates to Complaint IN00366838. Based on record review and interview, the facility failed to residents were free from verbal abuse for 4 of 6 residents reviewed for abuse. (Residents E, F, G, and H.) Findings include: 1. The State reportable incident, dated 11/9/21 at 6:23 p.m., indicated HHA (Home Health Aide) 4 was yelling at several residents. The residents affected included Residents E, F, and G.		will be extended for a length of time agreed upon by QA Committee. If staff quizzes or resident interviews indicate that further education is required, then additional training will be scheduled, and quizzes will be extended for a length of time agreed upon by the QA Committee.	

	The clinical record for Resident E was reviewed on 11/17/21 at 10:00 a.m. Diagnoses included, but were not limited to, metastatic cancer and depression. The BIMS (Brief Interview of Mental Status) assessment, dated 8/13/21, indicated Resident E was cognitively intact. The handwritten, undated statement of Resident E indicated on November 8th, HHA (Home Health Aide) 4 had argued with him, had cursed at him, telling him statements that he needed to get his a** back in his room, "F*** you and every resident in here." She called him stupid and a crybaby. He had never witnessed something so horrible in all his life. The handwritten statement of CNA (Certified Nurse Aide) 5, dated 11/8/21 and 11/9/21, indicated HHA 4 and Resident E got into an argument. HHA 4 told the resident she was going to beat his a**. The handwritten statement of LPN (Licensed Practical Nurse) 6, dated 11/8/21, indicated at 11 p.m. she had witnessed HHA 4 approaching the 100 Hall nurses station yelling that, and she told LPN 6 she was going to F*** up residents, the nurse, and the building. Multiple residents			

	approached her, voicing concern for their safety. The residents included Residents G, J, and K. The DON's typed statement, dated 11/9/21, indicated she had received a call from the informing her HHA 4 was yelling at several residents in the hallway and had been in a yelling match with a resident. HHA 4 had left but turned around and screamed that she was going to F*** the nurse and the building up. During an interview, on 11/17/21 at 9:35 a.m., Resident E indicated HHA 4 had argued with him, had cursed at him, and told him to get his "a**" back in his room. She stated to him, "You're stupid, you're not nothing but a f***ing crybaby." He stated "My lord, definitely it would be abuse... I should not have to tolerate that... This is my home ... It really disturbs me." During an interview, on 11/17/21 at 11:47 a.m., the DON indicated she got a call at about midnight and could hear yelling in the background. LPN 6 indicated HHA 4 had gotten into it with Resident E. She had been cursing and made verbal threats to the residents and the building. During an interview, on 11/17/21			

	at 6:43 p.m., LPN 6 indicated HHA 4 had been screaming and making verbal threats to beat a resident's "f***ing a**." Several residents had been present and were shaken up. One resident was visibly shaking, and Resident G said she did not feel safe at the facility. Resident F was also a witness to the incident, and Resident E is the resident she had done this to. During an interview, on 11/17/21 at 7:33 p.m., CNA 5 indicated HHA 4 had made verbal threats to Resident E, stating, "I'll just kick your ass!" Resident F, G, and H had been present. They felt threatened and they were scared. 2. The clinical record for Resident G was reviewed, on 11/17/21 at 1:07 p.m. The resident's diagnoses included, but were not limited to, schizophrenia, depression, anxiety, insomnia, GERD (Gastroesophageal Reflux Disease), bipolar glaucoma, and dementia. The BIMS assessment, dated 5/27/21, indicated the resident was cognitively intact. During an interview, on 11/17/21 at 9:30 a.m., Resident G indicated she heard yelling outside her door on the 300 Hall. She came out and there were residents and staff down			

	by the puzzle table. She witnessed HHA 4 screaming she would not deal with Resident H. She was also cussing and threaten another resident. She said she was going to kick his a-- and beat the living s--t out of him. She threatened to kill the residents and the nurses. The HHA 4 was always going around saying she was going to kick someone's a--. The nurses escorted her out of the building, and she was cussing and yelling all the way out. She was so terrified, and her anxiety was so high she had to sit at the nurse's station for a couple of hours to feel safe enough to go back to her room. 3. The clinical record for Resident F was reviewed, on 11/17/21 at 10:00 a.m. The resident's diagnoses included, but were not limited to, diabetes, hypertension, kidney stones, cardiac stents, osteoarthritis, left hip replacement, amputation Left middle toe, hernia repair, and appendectomy. The BIMS assessment, dated 10/19/21, indicated the resident was cognitively intact. During an interview, on 11/17/21 at 10:00 a.m., Resident F indicated he was sitting at the puzzle table working a puzzle. HHA 4 was observed cursing Resident E. She was cursing loud and making threats. She			

	threatened other residents. 4. The clinical record for Resident H was reviewed, on 11/17/21 at 10:00 a.m. The resident's diagnoses included, but were not limited to, Traumatic incomplete cord injury, alcohol abuse, dementia secondary to ETOH abuse, GERD, anxiety, neuropathy, impulse control, bipolar, and arterial vascular disease. The BIMS assessment, dated 5/17/21, indicated the resident was cognitively intact. During an interview, on 11/17/21 at 10:45 a.m., Resident H indicated HHA 4 refused to provide care and help him get into bed. She was cursing at him. She left his room and never did come back. He had to wait until someone else could assist him to bed. A review of the police report, dated 11/9/21 at 1:44 p.m., indicated upon arrival to the facility the police spoke with the DON, who advised that an HHA 4 was fired and escorted off the premises in the overnight hours and she had threatened a patient as well as staff members. The DON provided two written statements that had been completed prior to his arrival. According to the statements HHA 4 had threatened violence against			

patients of the facility, the staff and against the facility itself. On 11/10/21, he spoke with HHA 4 via telephone, who advised a patient threatened her and she did tell the patient if he put hands on her that she was going to hit him back.

The Abuse, Prevention and Prohibition Policy, last revised 4/2020, provided on 11/17/21 at 10:00 a.m. by the ED, included, but was not limited to, "... The resident has the right to be free from verbal... abuse... Verbal abuse is defined as the use of oral... or gestured language that willfully includes disparaging and derogatory terms to residents... or within the hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include but are not limited to threats of harm; saying things to frighten a resident..."

This State Residential Finding relates to Complaint IN00366838.

Based on record review and interview, the facility failed to residents were free from verbal abuse for 4 of 6 residents reviewed for abuse. (Residents E, F, G, and H.)

Findings include:

1. The State reportable incident, dated 11/9/21 at 6:23 p.m., indicated HHA (Home Health

Aide) 4 was yelling at several residents. The residents affected included Residents E, F, and G.

The clinical record for Resident E was reviewed on 11/17/21 at 10:00 a.m. Diagnoses included, but were not limited to, metastatic cancer and depression.

The BIMS (Brief Interview of Mental Status) assessment, dated 8/13/21, indicated Resident E was cognitively intact.

The handwritten, undated statement of Resident E indicated on November 8th, HHA (Home Health Aide) 4 had argued with him, had cursed at him, telling him statements that he needed to get his a** back in his room, "F*** you and every resident in here." She called him stupid and a crybaby. He had never witnessed something so horrible in all his life.

The handwritten statement of CNA (Certified Nurse Aide) 5, dated 11/8/21 and 11/9/21, indicated HHA 4 and Resident E got into an argument. HHA 4 told the resident she was going to beat his a**.

The handwritten statement of LPN (Licensed Practical Nurse) 6, dated 11/8/21, indicated at 11 p.m. she had witnessed HHA 4 approaching the 100 Hall nurses

	station yelling that, and she told LPN 6 she was going to F*** up residents, the nurse, and the building. Multiple residents approached her, voicing concern for their safety. The residents included Residents G, J, and K. The DON's typed statement, dated 11/9/21, indicated she had received a call from the informing her HHA 4 was yelling at several residents in the hallway and had been in a yelling match with a resident. HHA 4 had left but turned around and screamed that she was going to F*** the nurse and the building up. During an interview, on 11/17/21 at 9:35 a.m., Resident E indicated HHA 4 had argued with him, had cursed at him, and told him to get his "a**" back in his room. She stated to him, "You're stupid, you're not nothing but a f***ing crybaby." He stated "My lord, definitely it would be abuse... I should not have to tolerate that... This is my home ... It really disturbs me." During an interview, on 11/17/21 at 11:47 a.m., the DON indicated she got a call at about midnight and could hear yelling in the background. LPN 6 indicated HHA 4 had gotten into it with Resident E. She had been cursing and made verbal			

threats to the residents and the building.

During an interview, on 11/17/21 at 6:43 p.m., LPN 6 indicated HHA 4 had been screaming and making verbal threats to beat a resident's "f***ing a**." Several residents had been present and were shaken up. One resident was visibly shaking, and Resident G said she did not feel safe at the facility. Resident F was also a witness to the incident, and Resident E is the resident she had done this to.

During an interview, on 11/17/21 at 7:33 p.m., CNA 5 indicated HHA 4 had made verbal threats to Resident E, stating, "I'll just kick your ass!" Resident F, G, and H had been present. They felt threatened and they were scared.

2. The clinical record for Resident G was reviewed, on 11/17/21 at 1:07 p.m. The resident's diagnoses included, but were not limited to, schizophrenia, depression, anxiety, insomnia, GERD (Gastroesophageal Reflux Disease), bipolar glaucoma, and dementia.

The BIMS assessment, dated 5/27/21, indicated the resident was cognitively intact.

During an interview, on 11/17/21 at 9:30 a.m., Resident G indicated she heard yelling

	outside her door on the 300 Hall. She came out and there were residents and staff down by the puzzle table. She witnessed HHA 4 screaming she would not deal with Resident H. She was also cussing and threaten another resident. She said she was going to kick his a-- and beat the living s--t out of him. She threatened to kill the residents and the nurses. The HHA 4 was always going around saying she was going to kick someone's a--. The nurses escorted her out of the building, and she was cussing and yelling all the way out. She was so terrified, and her anxiety was so high she had to sit at the nurse's station for a couple of hours to feel safe enough to go back to her room. 3. The clinical record for Resident F was reviewed, on 11/17/21 at 10:00 a.m. The resident's diagnoses included, but were not limited to, diabetes, hypertension, kidney stones, cardiac stents, osteoarthritis, left hip replacement, amputation Left middle toe, hernia repair, and appendectomy. The BIMS assessment, dated 10/19/21, indicated the resident was cognitively intact. During an interview, on 11/17/21 at 10:00 a.m., Resident F indicated he was sitting at the puzzle table working a puzzle.			

	HHA 4 was observed cursing Resident E. She was cursing loud and making threats. She threatened other residents. 4. The clinical record for Resident H was reviewed, on 11/17/21 at 10:00 a.m. The resident's diagnoses included, but were not limited to, Traumatic incomplete cord injury, alcohol abuse, dementia secondary to ETOH abuse, GERD, anxiety, neuropathy, impulse control, bipolar, and arterial vascular disease. The BIMS assessment, dated 5/17/21, indicated the resident was cognitively intact. During an interview, on 11/17/21 at 10:45 a.m., Resident H indicated HHA 4 refused to provide care and help him get into bed. She was cursing at him. She left his room and never did come back. He had to wait until someone else could assist him to bed. A review of the police report, dated 11/9/21 at 1:44 p.m., indicated upon arrival to the facility the police spoke with the DON, who advised that an HHA 4 was fired and escorted off the premises in the overnight hours and she had threatened a patient as well as staff members. The DON provided two written statements that had been completed prior to his			

arrival. According to the statements HHA 4 had threatened violence against patients of the facility, the staff and against the facility itself. On 11/10/21, he spoke with HHA 4 via telephone, who advised a patient threatened her and she did tell the patient if he put hands on her that she was going to hit him back.

The Abuse, Prevention and Prohibition Policy, last revised 4/2020, provided on 11/17/21 at 10:00 a.m. by the ED, included, but was not limited to, "... The resident has the right to be free from verbal... abuse... Verbal abuse is defined as the use of oral... or gestured language that willfully includes disparaging and derogatory terms to residents... or within the hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include but are not limited to threats of harm; saying things to frighten a resident..."

This State Residential Finding relates to Complaint IN00366838.

Based on record review and interview, the facility failed to residents were free from verbal abuse for 4 of 6 residents reviewed for abuse. (Residents E, F, G, and H.)

Findings include:

	1. The State reportable incident, dated 11/9/21 at 6:23 p.m., indicated HHA (Home Health Aide) 4 was yelling at several residents. The residents affected included Residents E, F, and G. The clinical record for Resident E was reviewed on 11/17/21 at 10:00 a.m. Diagnoses included, but were not limited to, metastatic cancer and depression. The BIMS (Brief Interview of Mental Status) assessment, dated 8/13/21, indicated Resident E was cognitively intact. The handwritten, undated statement of Resident E indicated on November 8th, HHA (Home Health Aide) 4 had argued with him, had cursed at him, telling him statements that he needed to get his a** back in his room, "F*** you and every resident in here." She called him stupid and a crybaby. He had never witnessed something so horrible in all his life. The handwritten statement of CNA (Certified Nurse Aide) 5, dated 11/8/21 and 11/9/21, indicated HHA 4 and Resident E got into an argument. HHA 4 told the resident she was going to beat his a**. The handwritten statement of LPN (Licensed Practical Nurse)			

	6, dated 11/8/21, indicated at 11 p.m. she had witnessed HHA 4 approaching the 100 Hall nurses station yelling that, and she told LPN 6 she was going to F*** up residents, the nurse, and the building. Multiple residents approached her, voicing concern for their safety. The residents included Residents G, J, and K. The DON's typed statement, dated 11/9/21, indicated she had received a call from the informing her HHA 4 was yelling at several residents in the hallway and had been in a yelling match with a resident. HHA 4 had left but turned around and screamed that she was going to F*** the nurse and the building up. During an interview, on 11/17/21 at 9:35 a.m., Resident E indicated HHA 4 had argued with him, had cursed at him, and told him to get his "a**" back in his room. She stated to him, "You're stupid, you're not nothing but a f***ing crybaby." He stated "My lord, definitely it would be abuse... I should not have to tolerate that... This is my home ... It really disturbs me." During an interview, on 11/17/21 at 11:47 a.m., the DON indicated she got a call at about midnight and could hear yelling in the background. LPN 6			

	indicated HHA 4 had gotten into it with Resident E. She had been cursing and made verbal threats to the residents and the building. During an interview, on 11/17/21 at 6:43 p.m., LPN 6 indicated HHA 4 had been screaming and making verbal threats to beat a resident's "f***ing a**." Several residents had been present and were shaken up. One resident was visibly shaking, and Resident G said she did not feel safe at the facility. Resident F was also a witness to the incident, and Resident E is the resident she had done this to. During an interview, on 11/17/21 at 7:33 p.m., CNA 5 indicated HHA 4 had made verbal threats to Resident E, stating, "I'll just kick your ass!" Resident F, G, and H had been present. They felt threatened and they were scared.			
R 0060	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(dd) (dd) The facility shall provide reasonable access to any resident, consistent with facility policy, by any entity or individual that provides health, social, legal, and other services to any resident, subject to the resident ' s right to deny or withdraw consent at any time.	R 0060	Preparation and submission of this statement of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or of the correctness of the conclusion stated on the statement of deficiencies. This statement of correction is prepared and submitted solely because of requirements	01/28/2022

Based on record review and interview, the facility failed to ensure social services follow-up after allegations of mental and verbal abuse were completed for 4 of 6 resident's reviewed for social services. (Residents E, F, G, and H)

Findings include:

1. The State reportable incident, dated 11/9/21 at 6:23 p.m., indicated HHA (Home Health Aide) 4 was yelling at several residents and took an aggressive stance, holding up her fists on one of the residents. When her charge nurse asked her to leave, she declined. When the charge nurse was instructed to call 911, the employee left. The residents affected included Residents E, F, and G.

The clinical record for Resident E was reviewed on 11/17/21 at 10:00 a.m. Diagnoses included, but were not limited to, metastatic cancer and depression.

The BIMS (Brief Interview of Mental Status) assessment, dated 8/13/21, indicated Resident E was cognitively intact.

under state and federal laws. We cordially request a desk review regarding the alleged deficiencies in lieu of any revisit.

Immediate Intervention:

- Residents E, F, G and H were assessed with no signs of injury and no noted mental anguish was noted by a licensed nurse. Nursing Staff to follow up with each of these residents weekly and as needed for the next 30 days related to the incident.
- The Executive Director and the Director of Nursing educated by the Regional Director that Nursing Staff should assess residents to evaluate if the experienced any negative psychosocial effects when they experienced abuse or potential abuse. They should also provide ongoing support to meet their needs throughout and after the investigation occurs.

The resident's clinical record lacked documentation of any psychosocial monitoring or provision of Social Services follow-up after the incident.

2. The clinical record for Resident G was reviewed, on 11/17/21 at 1:07 p.m. The resident's diagnoses included, but were not limited to, schizophrenia, depression, anxiety, insomnia, GERD (Gastroesophageal Reflux Disease), bipolar glaucoma, and dementia.

The BIMS assessment, dated 5/27/21 indicated the resident was cognitively intact.

During an interview, on 11/17/21 at 9:30 a.m., Resident G indicated she had witnessed an altercation between HHA 4 and other residents, where the HHA was screaming, cursing, and threatening residents. She was so terrified, and her anxiety was so high she had to sit at the nurse's station for a couple of hours to feel safe enough to go back to her room.

The resident's clinical record lacked documentation of any psychosocial monitoring or provision of Social Services follow-up after the incident.

3. The clinical record for Resident F was reviewed, on 11/17/21 at 10:00 a.m. The resident's diagnoses included,

Identify Others Affected

- All residents were potentially at risk of same alleged deficient practice. All residents were interviewed to determine if they had experienced any form of abuse, including mental or verbal, while in the facility if they had Social Service support. Any identified issues were addressed.

The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not reoccur:

- Nursing Staff were provided education by the Executive Director/designee that they should assess residents to evaluate if the experienced any negative psychosocial effects

	but were not limited to, diabetes, hypertension, kidney stones, cardiac stents, osteoarthritis, left hip replacement, amputation Left middle toe, hernia repair, and appendectomy. The BIMS assessment, dated 10/19/21 indicated the resident was cognitively intact. During an interview, on 11/17/21 at 10:00 a.m., Resident F indicated he'd witnessed HHA 4 cursing at other residents and making threats. She'd lifted her fists and acted like she was going to hit another resident. She threatened other residents. She was going to beat up the residents, and the nurses had to restrain her. The resident's clinical record lacked documentation of any psychosocial monitoring or provision of Social Services follow-up after the incident. 4. The clinical record for Resident H was reviewed, on 11/17/21 at 10:00 a.m. The resident's diagnoses included, but were not limited to, traumatic incomplete cord injury, alcohol abuse, dementia secondary to ETOH abuse, GERD, anxiety, neuropathy, impulse control, bipolar, and arterial vascular disease.		when they experienced abuse or potential abuse. They should also provide ongoing support to meet their needs throughout and after the investigation occurs. **Quality Assurance Plans to monitor facility performance to ensure that corrections are achieved and permanent:** . The executive director or designee will review all abuse allegations for the next 60 days to ensure Nursing Staff involvement in support for the resident and assessment of resident psychosocial needs. • The Executive Director / designee will review nurses' notes for documentation of assessment related to any negative psychosocial effects when they experienced abuse or potential abuse. For 30 days following initial allegation of abuse.	

The BIMS assessment, dated 5/17/21 indicated the resident was cognitively intact.

During an interview, on 11/17/21 at 10:45 a.m., Resident H indicated HHA 4 refused to provide care and help him get into bed. She was cursing at him. She left his room and never did come back. He had to wait until someone else could assist him to bed.

The resident's clinical record lacked documentation of any psychosocial monitoring or provision of Social Services follow-up after the incident.

During an interview, on 11/17/21 at 11:47 a.m., the DON (Director of Nursing) indicated they did not have anyone doing any psychosocial follow up weekly with the residents after the incident. She was not aware of that policy.

The Abuse, Prevention and Prohibition Policy, last revised 4/2020, provided on 11/17/21 at 10:00 a.m. by the ED, included, but was not limited to, "... Investigation... Follow-up counseling should be made available by the Social Service Designess, weekly for at least two weeks or as needed, to victims of abuse and or neglect..."

This State Residential Finding relates to Complaint

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The
executive director or designee will audit 3 residents weekly for the next 60
days to ensure they feel supported by nursing staff to address their
psychosocial needs.

Regional
Director/Designee, in collaboration with ED/Designee and DON/Designee will
review audits with QA Committee monthly x3 months for identified issues. QA Committee will determine if audits
necessitate extension past 3 months and will continue to review audit results
monthly for duration of the extended timeframe as applicable. Criteria for determining if further monitoring is necessary or if monitoring can be stopped.

IDR request for R060

December 8, 2021

River Crossing, #012007

Re: Complaint IN00366838, 11/17/21

Good afternoon,

This letter is in reference to complaint #IN00366838

IN00366838.

Based on record review and interview, the facility failed to ensure social services follow-up after allegations of mental and verbal abuse were completed for 4 of 6 resident's reviewed for social services. (Residents E, F, G, and H)

Findings include:

1. The State reportable incident, dated 11/9/21 at 6:23 p.m., indicated HHA (Home Health Aide) 4 was yelling at several residents and took an aggressive stance, holding up her fists on one of the residents. When her charge nurse asked her to leave, she declined. When the charge nurse was instructed to call 911, the employee left. The residents affected included Residents E, F, and G.

The clinical record for Resident E was reviewed on 11/17/21 at 10:00 a.m. Diagnoses included, but were not limited to, metastatic cancer and depression.

The BIMS (Brief Interview of Mental Status) assessment, dated 8/13/21, indicated Resident E was cognitively intact.

The resident's clinical record lacked documentation of any psychosocial monitoring or

conducted at River Crossing, facility number 012007, on November 17 and 18, 2021. This letter is intended to serve as notice that a desk review IDR is requested for R060. The alleged deficient practice cited indicates that “The facility failed to ensure Social Services follow up after allegations of mental and verbal abuse were completed for 4 of 6 residents reviewed”. We respectfully disagree with this based upon the grounds that Social Services are not readily offered to any residents in assisted living, and physician orders were followed for residents E, F, G and H as ordered and notated in the clinical record for all allegedly affected residents. Social Services are not provided on-site in residential as they are in skilled nursing, and without a physician’s order River Crossing cannot effectuate any actions toward or for any resident residing at the community. We cordially request that R060 be retracted, and Statement of Deficiencies be amended to take requested changes into consideration.

Respectfully,

provision of Social Services follow-up after the incident.

2. The clinical record for Resident G was reviewed, on 11/17/21 at 1:07 p.m. The resident's diagnoses included, but were not limited to, schizophrenia, depression, anxiety, insomnia, GERD (Gastroesophageal Reflux Disease), bipolar glaucoma, and dementia.

The BIMS assessment, dated 5/27/21 indicated the resident was cognitively intact.

During an interview, on 11/17/21 at 9:30 a.m., Resident G indicated she had witnessed an altercation between HHA 4 and other residents, where the HHA was screaming, cursing, and threatening residents. She was so terrified, and her anxiety was so high she had to sit at the nurse's station for a couple of hours to feel safe enough to go back to her room.

The resident's clinical record lacked documentation of any psychosocial monitoring or provision of Social Services follow-up after the incident.

3. The clinical record for Resident F was reviewed, on 11/17/21 at 10:00 a.m. The resident's diagnoses included, but were not limited to, diabetes, hypertension, kidney stones, cardiac stents, osteoarthritis, left

Rich Pedersen

Executive Director

hip replacement, amputation Left middle toe, hernia repair, and appendectomy.

The BIMS assessment, dated 10/19/21 indicated the resident was cognitively intact.

During an interview, on 11/17/21 at 10:00 a.m., Resident F indicated he'd witnessed HHA 4 cursing at other residents and making threats. She'd lifted her fists and acted like she was going to hit another resident. She threatened other residents. She was going to beat up the residents, and the nurses had to restrain her.

The resident's clinical record lacked documentation of any psychosocial monitoring or provision of Social Services follow-up after the incident.

4. The clinical record for Resident H was reviewed, on 11/17/21 at 10:00 a.m. The resident's diagnoses included, but were not limited to, traumatic incomplete cord injury, alcohol abuse, dementia secondary to ETOH abuse, GERD, anxiety, neuropathy, impulse control, bipolar, and arterial vascular disease.

The BIMS assessment, dated 5/17/21 indicated the resident was cognitively intact.

During an interview, on 11/17/21 at 10:45 a.m., Resident H

indicated HHA 4 refused to provide care and help him get into bed. She was cursing at him. She left his room and never did come back. He had to wait until someone else could assist him to bed.

The resident's clinical record lacked documentation of any psychosocial monitoring or provision of Social Services follow-up after the incident.

During an interview, on 11/17/21 at 11:47 a.m., the DON (Director of Nursing) indicated they did not have anyone doing any psychosocial follow up weekly with the residents after the incident. She was not aware of that policy.

The Abuse, Prevention and Prohibition Policy, last revised 4/2020, provided on 11/17/21 at 10:00 a.m. by the ED, included, but was not limited to, "... Investigation... Follow-up counseling should be made available by the Social Service Designess, weekly for at least two weeks or as needed, to victims of abuse and or neglect..."

This State Residential Finding relates to Complaint IN00366838.

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The resident's clinical record lacked documentation of any psychosocial monitoring or provision of Social Services follow-up after the incident.

3. The clinical record for Resident F was reviewed, on 11/17/21 at 10:00 a.m. The resident's diagnoses included, but were not limited to, diabetes, hypertension, kidney stones, cardiac stents, osteoarthritis, left hip replacement, amputation Left middle toe, hernia repair, and appendectomy.

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was cognitively intact.

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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