STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTER PLACE	741 PARK EAST BLVD, LAFAYETTE, , 47905

(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 Complaints IN00373571 and IN00383708. Complaint IN00373571-Substantiated. No deficiencies related to the allegations. Complaint IN00383708-Substantiated. State deficiencies related to the allegations were cited at R52. Survey dates: July 6 and 7, 2022 Facility number: 013045 Residential: 101 This State Residential Findings is cited in accordance with 410 IAC 16.2-5. Quality review was completed on July 15, 2022.	R 0000		

R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on interview and record review, the facility failed to implement their abuse policy and procedure by failing to report an allegation of abuse immediately to the Executive Director (ED) and the State Agency, investigate an allegation of abuse by a staff member (CNA 7) and protect a resident with had a diagnosis of Alzheimer's disease and an anxiety disorder by taking steps to prevent further potential abuse. The facility failed to ensure a resident was not neglected when a staff member (RN 6) failed to follow the facility abuse policy and procedure by ensuring a resident's safety from the perpetrator and assessing a resident for physical and emotional trauma after an abuse allegation and immediately reporting the abuse allegation for 1 of 4 residents	R 0052	Deficiency ID:R052 Completion Date:8/14/2022 Plan of Correction Text: WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DIFICIENT PRACTICE: Termination of employment for the employees that took place during the investigation period and prior to complaint investigation. Education provided to all staff members on Abuse and Resident Rights. Education provided to all Residents-on-Residents Rights. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTICE ACTION WILL BE TAKEN: All residents have the potential to be affected. Sample of residents were interviewed during investigation on 7/7/22 for any signs and symptoms for loss of rights and or abuse. No	08/01/2022

	who were reviewed for mistreatment of a resident (Resident C). Findings include: A confidential interview was conducted during the course of the survey. The Confidential Interviewee indicated CNA 5 reported to her on 6/20/22, during her visit to provide care for Resident C on 6/20/22 at approximately 1:15 p.m., an unidentified staff member working in the Dementia Care unit abused the resident. CNA 5 reported to her the unidentified CNA (CNA 7) grabbed the resident by the wrist and squeezed it to get the resident to comply with what the CNA wanted her to do. The resident was agitated and aggressive, which escalated to the resident calling the CNA 7 a name, then she smacked Resident C on the hand several times. CNA 5 was orienting a new employee (CNA 8) that day, so CNA 8 also witnessed the abuse. CNA 5 reported the abuse allegation to RN 6 and to the Director of the Hospice company. The Director of the Hospice company called RN 6 (who was Resident C's primary nurse and the Unit Manager on the Dementia unit) informing her the resident's bathing plan of care was changed to a bed bath only now, instead of the resident being showered due to the		residents reported any additional allegations during investigation. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES THE FACILITY WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT REUR: Abuse and Resident Rights training occurred on 7/7/22 training to maintain the knowledge of Resident Rights as well as the understanding what the rights entail and the importance of reporting when the rights are in question. HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DIFICIENT PRACTIVE WILL NOT RECUR: Documentation of education received on Resident Rights that were provided to Staff as well as residents. We will retrain staff 3 times a week for 2 weeks, 2 time per week for 2 weeks, then monthly for 6 months, also both Resident rights and Abuse will be educated to all new employees.	

resident often became agitated and aggressive towards CNA 5 when she went to visit to provide her with a shower, as she had on 6/20/22. She informed RN 6 because of the abuse allegation with the facility staff member (CNA 7), which CNAs 5 and 8 had witnessed prior to completing her shower, the bathing plan of care had been changed.

During an interview, on 7/6/22 at 1:13 p.m., the Executive Director (ED) indicated she had not been informed about any abuse allegation involving Resident C.

During an interview, on 7/6/22 at 2:15 p.m., RN 6 and the Executive Director (ED) were present during the interview. RN 6 indicated CNA 7 was the CNA assisting CNA 5 and another hospice aide (CNA 8), while they provided care for Resident C. She indicated she did not report an allegation of abuse regarding Resident C or assess her for injuries following an abuse allegation because she was not informed about an abuse allegation, which involved Resident C or CNA 7. She indicated she did not have a phone conversation on 6/20/22, with anyone from Resident C's hospice company regarding changing her plan of care.

During an interview, on 7/6/22 at

2:26 p.m., CNA 7 and the ED were present during the interview. CNA 7 indicated on 6/20/22 in the afternoon sometime, two hospice aides, one was CNA 5 and the other one was a new hospice aide (CNA 8), came into the facility to give Resident C her shower. After both hospice CNAs, entered Resident C's room, CNA 5 came into the hallway and asked CNA 7 to assist her with getting the resident calmed down, so the hospice CNAs could provide her a shower. Resident C had laid down for an afternoon nap minutes prior to the hospice CNAs coming to provide her with a shower.

CNA 7 indicated during the entire time the hospice aides were providing care for Resident C, she had not provided any hands on care for the resident, until after the hospice aides left the room. At that time, she went back into the resident's room to check on her and discovered her pajama bottoms were wet from the knees down. She asked one of the hospice aides to come back into the resident's room to help her change them. The new hospice aide (CNA 8) came back into the resident's room and they changed them. CNA 7 indicated the only physical contact she had with Resident C, during the entire time the hospice aides were at the facility providing care for

her, was when she assisted CNA 8 to change her pajama bottoms. CNA 7 talked with Resident C to try to keep her calm while CNAs 5 and 8 transferred her from her bed to the wheelchair, then into the shower chair. She left the resident's room while she was being given a shower and went back into her room to check on her after she was transferred into bed by CNAs 5 and 8. The resident was calm during the time her pants were being changed. CNA 7 denied observing any abuse towards Resident C while care was being provided for her. She indicated Resident C was mad at her that particular day and was still mad at her almost two weeks now because she was in her room with the hospice aides when they got her out of bed and placed her on the shower chair. The resident usually was good with CNA 7, but when she got mad at a staff member, she held "grudges" against the staff member for weeks.

During a phone interview, on 7/6/22 at 2:44 p.m., CNA 5 indicated she was training a new hospice CNA (CNA 8) on 6/20/22, when they both went to the facility to provide care for Resident C. She asked RN 6 how Resident C had been doing that day and if she should have a shower. RN 6 asked CNA 5 why she would question

whether she needed to provide a shower for Resident C or not. CNA 5 explained dependent on the resident's mood she did not always shower her. She would provide a bed bath at different times if she was agitated and aggressive. RN 6 indicated Resident C's bathing plan of care indicated she was to be given a shower, so she was to be showered. Then, CNA 5 explained to RN 6 the resident had been laid down moments prior to her arriving at the facility for an afternoon nap, but if she wanted her gotten up to be showered, then that was what she would do. RN 6 told CNA 5 she wanted Resident C gotten up to be given a shower.

CNAs 5 and 8 attempted to arouse Resident C out of her sleep and get her up out of the bed by talking with her, but she would not get up, so CNA 5 stepped out into the hallway and asked one of the two CNAs to come help them and CNA 7 came to assist. CNA 7 attempted to get her out of the bed by talking calmly to her at first, then she began physically trying to arouse her out of her sleep by shaking her. Resident C started swinging both her arms at CNA 7 trying to hit her, while screaming and yelling "No, No, No" and telling CNA 7 to "Stop it." At that time, CNA 7 "grabbed" Resident C's bilateral wrists firmly with both her hands

and held them, to keep the resident from hitting her. CNA 5 indicated while CNA 7 gripped the resident's arms, she asked her if there was something she could do to assist her with the resident.

Then, she tried to get the resident to sit up by telling her to get up while trying to hold onto her wrists and using her wrists to lead her out of bed. At that time, the resident called CNA 7 a racial slur name. CNA 7 turned towards CNA 8 and asked her if she heard what Resident C just said to her. CNA 8 indicated back to CNA 7 she heard what the resident said to her. CNA 5 indicated the next thing she knew. CNA 7 let loose of the resident's left hand (CNA 5 believed this was the correct hand) and she slapped the top of the resident's right hand (CNA 5 believed this to be the correct hand) three times "like you would a small child while telling that child no, no, no and while slapping them." CNA 7 indicated to Resident C "Grandma, the nurse will not be happy, that you said that to me." Resident C had a noticeable reddened mark on her right wrist.

CNA 7 transferred the resident into the wheelchair and shower and she left the room. Resident C's shower was completed by CNAs 5 and 8, then she was

	transferred back into the bed. CNA 5 indicated following the shower, Resident C continued to have a noticeable reddened mark on her right (she believed this was the correct side) wrist, which was lighter than it was prior to her shower. As soon as she finished in the resident's room, she went immediately to RN 6 (the unit manager of the Dementia unit) and reported the alleged abuse involving Resident C and CNA 7. CNA 5 indicated she felt as if RN 6 was "blowing off the abuse allegation," due to the fact that, RN 6 indicated "OK, she will be fine" when she reported the abuse allegation to her. CNA 5 reported the alleged abuse to the Director of the Hospice company after she reported it to RN 6. During an interview, on 7/7/22 at 12:00 p.m., the ED indicated she had suspended CNA 7 and RN 6 while the abuse investigation was being completed. She suspended RN 6 for not reporting a potential abuse allegation immediately to the ED.			

A record review was completed for Resident C on 7/7/22 at 1:15 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, rheumatoid arthritis, fibromyalgia, anxiety disorder and cognitive communication deficit.

The "Resident Progress Notes" were reviewed for the date of 6/20/22, and there was no documentation found indicating an abuse allegation was reported to anyone.

There was no documentation of a new or worsening behavioral expression documented for 6/20/22 for the agitation and aggression the resident was displaying prior to being showered.

The Care plans were reviewed and there was no documentation for the resident refused showers or the interventions the staff should do instead of showering her.

During a phone interview on speaker phone on 7/7/22 at 3:53 p.m., with CNA 8 and the ED of the facility in attendance with permission from CNA 8. CNA 8 indicated she was a new employee with the hospice company who shadowed CNA 5 on 6/20/22, in the early afternoon at the facility. CNA 5 had asked the nurse (RN 6) how Resident C's day had been in

order to determine if she needed a shower or a bed bath. RN 6 indicated Resident C was to have a shower that particular day. CNA 5 requested assistance from two of the facilities CNAs to give the resident her shower due to CNA 8 being a new employee in orientation and the shower process might go easier if the resident had a staff member, who she recognized. An unidentified CNA (CNA 7) agreed to assist CNAs 5 and 8 with getting Resident C out of bed, since she was not wanting to get back up to take her shower.

Resident C had just been laid down in bed moments prior to the CNAs arriving at the facility and she did not want to get up to get her shower. CNA 8 indicated while CNA 7 was attempting to transfer the resident out of her bed into her wheelchair, she was yelling and screaming "No, No, No" and "Stop it", swinging her arms and kicking at CNA 7.

At that time, CNA 7 indicated to both the hospice CNAs, she would assist the resident out of bed. While the resident was swinging at CNA 7 attempting to hit her, CNA 7 grabbed both her wrists with each of her hands and gripped them, so she could not hit her. At that time, CNA 5 indicated to CNA 7 she would

give Resident C a shower on her next visit. CNA 7 indicated back to CNA 5, that she needed a shower "now."

At that time, Resident C called CNA 7 a name, which included a racial slur. CNA 7 asked the resident if she had

"really" just called her a racial slur name. The resident indicated something, which was non-sensical back to the CNA, while repeating "No, No, No" trying to get her hands free from the CNA. CNA 5 asked CNA 7 if there was something they could do to assist her with the resident. CNA 7 indicated there was not. At that time, the resident got a hand loose (she believed it was her left hand, but was not for sure) from CNA 7's grip, then she smacked the CNA. CNA 7 grabbed the hand, which the resident had gotten free from her grip and smacked the top of it once "like you would a small child," while indicating to her "No we're not going to do this." CNA 7 transferred the resident into her wheelchair, then into the shower chair. CNAs 5 and 8 completed Resident C's shower, then assisted her back to bed. The resident's bilateral wrists were red before and after the shower.

After CNAs 5 and 8 completed Resident C's shower, CNAs 5 and 8 went to speak to RN 6

and CNA 5 reported the abuse allegation involving Resident C and CNA 7 to RN 6. RN 6 indicated back to both CNAs "Ok, she will be fine." At that time, CNA 7 requested one of the hospice CNAs to help her change Resident C's pajama bottoms, that had gotten wet at the bottom, in the shower. CNA 5 remained at the desk with RN 6 continuing to discuss the bathing issue and the abuse witnessed. After the two of the CNAs left the facility, CNA 5 notified the Director of the hospice company of the abuse allegation the two of them witnessed.

During an interview, on 7/7/22 at 4:15 p.m., the ED indicated she was substantiating the abuse allegation of Resident C because she was terminating CNA 7 for the actual abuse allegation and RN 6 for not following the abuse policy when an abuse allegation was reported to her.

A current policy, titled "Unusual Occurrences for Residents," dated with an approved and reviewed date of 12/2017, provided by the ED on 7/6/22 at 2:00 p.m., indicated "Purpose of Policy: This policy pertains to principles, rules, and guidelines formulated and adopted for this community's unusual occurrences for residents. Policy: All reportable incidents

which occur against a resident will be reported to ISDH [Indiana State Department of Health]. Reportable Incidents: A reportable incident is defined as any occurrence not consistent with the routine operation of the nursing facility, which may have caused or may have the potential for causing injury to residents, visitors, or loss or damage of resided property. Verbal dissatisfaction voiced b residents or visitors may considered reportable events. All reportable incidents are to be viewed as serious for purposes of investigation and follow-up...State Rules Related to Incident Reporting: State Rules: 410IAC 16.23-1-28(c)--The facility must ensure that all alleged violations involving mistreatment, reported immediately to the administrator of the facility and other officials in accordance with state law through established procedures including to the state survey and certification agency. 410IAC 16.2-3.1-13(g)(1)--Immediately informing the division by telephone, followed by written notice within twenty -four (24) hours, of unusual occurrences that directly threaten the welfare, safety, or health of the resident or residents, including, but not limited to, any...Types of incidents to be reported under residential rules (to be reported within 24 hours): Definitions: Abuse: The willful infliction of

injury, unreasonable confinement, intimidation or punishment with resulting physical harm pain, or mental anguish This includes deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental or psychosocial wellbeing. This presumes that instances of abuse of all residents, even those in a coma, cause physical harm, or pain, or mental anguish...Physical Abuse--willful act against a resident by another resident, staff or other individuals. Examples: hitting, beating, slapping, punching, shoving, spitting, striking with an object, pulling/twisting, squeezing, pinching, scratching, tripping, biting, burning, using overly hot/cold water, and/or improper use of restraints...Verbal Abuse--oral, written, or gestured language that includes disparaging and derogatory terms to residents or their families, or within their hearing, regardless of their age, ability to comprehend, or disability. Examples would include, but are not limited to...scolding or speaking to them in harsh voice tones...2. Staff to resident--any episode. Mental Abuse--Verbal or nonverbal infliction or anguish, pain or distress that results in psychological or emotional suffering. 1. Staff to resident--any episode..

Examples: humiliation...threats of punishment or deprivation, bullying...Neglect--failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness... Examples: An action or lack of action that places one or more residents in a like-threatening situation, such as...c. Staff failing to identify, assess, monitor, and respond to a resident suffering an acute condition...Injuries sustained while a resident is physically restrained..."

This State finding relates to Complaint IN00383708.

Based on interview and record review, the facility failed to implement their abuse policy and procedure by failing to report an allegation of abuse immediately to the Executive Director (ED) and the State Agency, investigate an allegation of abuse by a staff member (CNA 7) and protect a resident with had a diagnosis of Alzheimer's disease and an anxiety disorder by taking steps to prevent further potential abuse. The facility failed to ensure a resident was not neglected when a staff member (RN 6) failed to follow the facility abuse policy and procedure by ensuring a resident's safety from the perpetrator and assessing a resident for physical and emotional trauma

after an abuse allegation and immediately reporting the abuse allegation for 1 of 4 residents who were reviewed for mistreatment of a resident (Resident C).

Findings include:

A confidential interview was conducted during the course of the survey. The Confidential Interviewee indicated CNA 5 reported to her on 6/20/22, during her visit to provide care for Resident C on 6/20/22 at approximately 1:15 p.m., an unidentified staff member working in the Dementia Care unit abused the resident. CNA 5 reported to her the unidentified CNA (CNA 7) grabbed the resident by the wrist and squeezed it to get the resident to comply with what the CNA wanted her to do. The resident was agitated and aggressive, which escalated to the resident calling the CNA 7 a name, then she smacked Resident C on the hand several times. CNA 5 was orienting a new employee (CNA 8) that day, so CNA 8 also witnessed the abuse. CNA 5 reported the abuse allegation to RN 6 and to the Director of the Hospice company. The Director of the Hospice company called RN 6 (who was Resident C's primary nurse and the Unit Manager on the Dementia unit) informing her the resident's bathing plan of care was

changed to a bed bath only now, instead of the resident being showered due to the resident often became agitated and aggressive towards CNA 5 when she went to visit to provide her with a shower, as she had on 6/20/22. She informed RN 6 because of the abuse allegation with the facility staff member (CNA 7), which CNAs 5 and 8 had witnessed prior to completing her shower, the bathing plan of care had been changed.

During an interview, on 7/6/22 at 1:13 p.m., the Executive Director (ED) indicated she had not been informed about any abuse allegation involving Resident C.

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changing her plan of care.

During an interview, on 7/6/22 at 2:26 p.m., CNA 7 and the ED were present during the interview. CNA 7 indicated on 6/20/22 in the afternoon sometime, two hospice aides, one was CNA 5 and the other one was a new hospice aide (CNA 8), came into the facility to give Resident C her shower. After both hospice CNAs, entered Resident C's room, CNA 5 came into the hallway and asked CNA 7 to assist her with getting the resident calmed down, so the hospice CNAs could provide her a shower. Resident C had laid down for an afternoon nap minutes prior to the hospice CNAs coming to provide her with a shower.

CNA 7 indicated during the entire time the hospice aides were providing care for Resident C, she had not provided any hands on care for the resident, until after the hospice aides left the room. At that time, she went back into the resident's room to check on her and discovered her pajama bottoms were wet from the knees down. She asked one of the hospice aides to come back into the resident's room to help her change them. The new hospice aide (CNA 8) came back into the resident's room and they changed them. CNA 7 indicated the only physical contact she had with

Resident C, during the entire time the hospice aides were at the facility providing care for her, was when she assisted CNA 8 to change her pajama bottoms. CNA 7 talked with Resident C to try to keep her calm while CNAs 5 and 8 transferred her from her bed to the wheelchair, then into the shower chair. She left the resident's room while she was being given a shower and went back into her room to check on her after she was transferred into bed by CNAs 5 and 8. The resident was calm during the time her pants were being changed. CNA 7 denied observing any abuse towards Resident C while care was being provided for her. She indicated Resident C was mad at her that particular day and was still mad at her almost two weeks now because she was in her room with the hospice aides when they got her out of bed and placed her on the shower chair. The resident usually was good with CNA 7, but when she got mad at a staff member, she held "grudges" against the staff member for weeks.

During a phone interview, on 7/6/22 at 2:44 p.m., CNA 5 indicated she was training a new hospice CNA (CNA 8) on 6/20/22, when they both went to the facility to provide care for Resident C. She asked RN 6 how Resident C had been doing

that day and if she should have a shower. RN 6 asked CNA 5 why she would question whether she needed to provide a shower for Resident C or not. CNA 5 explained dependent on the resident's mood she did not always shower her. She would provide a bed bath at different times if she was agitated and aggressive. RN 6 indicated Resident C's bathing plan of care indicated she was to be given a shower, so she was to be showered. Then, CNA 5 explained to RN 6 the resident had been laid down moments prior to her arriving at the facility for an afternoon nap, but if she wanted her gotten up to be showered, then that was what she would do. RN 6 told CNA 5 she wanted Resident C gotten up to be given a shower.

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to "Stop it." At that time, CNA 7 "grabbed" Resident C's bilateral wrists firmly with both her hands and held them, to keep the resident from hitting her. CNA 5 indicated while CNA 7 gripped the resident's arms, she asked her if there was something she could do to assist her with the resident.

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CNA 7 transferred the resident into the wheelchair and shower

and she left the room. Resident C's shower was completed by CNAs 5 and 8, then she was transferred back into the bed. CNA 5 indicated following the shower, Resident C continued to have a noticeable reddened mark on her right (she believed this was the correct side) wrist, which was lighter than it was prior to her shower. As soon as she finished in the resident's room, she went immediately to RN 6 (the unit manager of the Dementia unit) and reported the alleged abuse involving Resident C and CNA 7. CNA 5 indicated she felt as if RN 6 was "blowing off the abuse allegation," due to the fact that, RN 6 indicated "OK, she will be fine" when she reported the abuse allegation to her. CNA 5 reported the alleged abuse to the Director of the Hospice company after she reported it to RN 6.

During an interview, on 7/7/22 at 12:00 p.m., the ED indicated she had suspended CNA 7 and RN 6 while the abuse investigation was being completed. She suspended RN 6 for not reporting a potential abuse allegation immediately to the ED.

A record review was completed for Resident C on 7/7/22 at 1:15 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, rheumatoid arthritis,

fibromyalgia, anxiety disorder and cognitive communication deficit.

The "Resident Progress Notes" were reviewed for the date of 6/20/22, and there was no documentation found indicating an abuse allegation was reported to anyone.

There was no documentation of a new or worsening behavioral expression documented for 6/20/22 for the agitation and aggression the resident was displaying prior to being showered.

The Care plans were reviewed and there was no documentation for the resident refused showers or the interventions the staff should do instead of showering her.

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assistance from two of the facilities CNAs to give the resident her shower due to CNA 8 being a new employee in orientation and the shower process might go easier if the resident had a staff member, who she recognized. An unidentified CNA (CNA 7) agreed to assist CNAs 5 and 8 with getting Resident C out of bed, since she was not wanting to get back up to take her shower.

Resident C had just been laid down in bed moments prior to the CNAs arriving at the facility and she did not want to get up to get her shower. CNA 8 indicated while CNA 7 was attempting to transfer the resident out of her bed into her wheelchair, she was yelling and screaming "No, No, No" and "Stop it", swinging her arms and kicking at CNA 7.

At that time, CNA 7 indicated to both the hospice CNAs, she would assist the resident out of bed. While the resident was swinging at CNA 7 attempting to hit her, CNA 7 grabbed both her wrists with each of her hands and gripped them, so she could not hit her. At that time, CNA 5 indicated to CNA 7 she would give Resident C a shower on her next visit. CNA 7 indicated back to CNA 5, that she needed a shower "now."

At that time, Resident C called CNA 7 a name, which included a racial slur. CNA 7 asked the resident if she had

"really" just called her a racial slur name. The resident indicated something, which was non-sensical back to the CNA, while repeating "No, No, No" trying to get her hands free from the CNA. CNA 5 asked CNA 7 if there was something they could do to assist her with the resident. CNA 7 indicated there was not. At that time, the resident got a hand loose (she believed it was her left hand, but was not for sure) from CNA 7's grip, then she smacked the CNA. CNA 7 grabbed the hand, which the resident had gotten free from her grip and smacked the top of it once "like you would a small child," while indicating to her "No we're not going to do this." CNA 7 transferred the resident into her wheelchair, then into the shower chair. CNAs 5 and 8 completed Resident C's shower, then assisted her back to bed. The resident's bilateral wrists were red before and after the shower.

After CNAs 5 and 8 completed Resident C's shower, CNAs 5 and 8 went to speak to RN 6 and CNA 5 reported the abuse allegation involving Resident C and CNA 7 to RN 6. RN 6 indicated back to both CNAs "Ok, she will be fine." At that

time, CNA 7 requested one of the hospice CNAs to help her change Resident C's pajama bottoms, that had gotten wet at the bottom, in the shower. CNA 5 remained at the desk with RN 6 continuing to discuss the bathing issue and the abuse witnessed. After the two of the CNAs left the facility, CNA 5 notified the Director of the hospice company of the abuse allegation the two of them witnessed.

During an interview, on 7/7/22 at 4:15 p.m., the ED indicated she was substantiating the abuse allegation of Resident C because she was terminating CNA 7 for the actual abuse allegation and RN 6 for not following the abuse policy when an abuse allegation was reported to her.

A current policy, titled "Unusual Occurrences for Residents," dated with an approved and reviewed date of 12/2017, provided by the ED on 7/6/22 at 2:00 p.m., indicated "Purpose of Policy: This policy pertains to principles, rules, and guidelines formulated and adopted for this community's unusual occurrences for residents. Policy: All reportable incidents which occur against a resident will be reported to ISDH [Indiana State Department of Health]. Reportable Incidents: A reportable incident is defined as

any occurrence not consistent with the routine operation of the nursing facility, which may have caused or may have the potential for causing injury to residents, visitors, or loss or damage of resided property. Verbal dissatisfaction voiced b residents or visitors may considered reportable events. All reportable incidents are to be viewed as serious for purposes of investigation and follow-up...State Rules Related to Incident Reporting: State Rules: 410IAC 16.23-1-28(c)--The facility must ensure that all alleged violations involving mistreatment, reported immediately to the administrator of the facility and other officials in accordance with state law through established procedures including to the state survey and certification agency. 410IAC 16.2-3.1-13(g)(1)--Immediately informing the division by telephone, followed by written notice within twenty -four (24) hours, of unusual occurrences that directly threaten the welfare, safety, or health of the resident or residents, including, but not limited to, any...Types of incidents to be reported under residential rules (to be reported within 24 hours): Definitions: Abuse: The willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm pain, or mental anguish This includes

deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental or psychosocial wellbeing. This presumes that instances of abuse of all residents, even those in a coma, cause physical harm, or pain, or mental anguish...Physical Abuse--willful act against a resident by another resident, staff or other individuals. Examples: hitting, beating, slapping, punching, shoving, spitting, striking with an object, pulling/twisting, squeezing, pinching, scratching, tripping, biting, burning, using overly hot/cold water, and/or improper use of restraints...Verbal Abuse--oral, written, or gestured language that includes disparaging and derogatory terms to residents or their families, or within their hearing, regardless of their age, ability to comprehend, or disability. Examples would include, but are not limited to...scolding or speaking to them in harsh voice tones...2. Staff to resident--any episode. Mental Abuse--Verbal or nonverbal infliction or anguish, pain or distress that results in psychological or emotional suffering. 1. Staff to resident--any episode.. Examples: humiliation...threats of punishment or deprivation, bullying...Neglect--failure to provide goods and services necessary to avoid physical

	harm, mental anguish or mental illness... Examples: An action or lack of action that places one or more residents in a like-threatening situation, such as...c. Staff failing to identify, assess, monitor, and respond to a resident suffering an acute condition...Injuries sustained while a resident is physically restrained..." This State finding relates to Complaint IN00383708.			

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