STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADITIONS AT NORTH WILLOW	1703 W 86TH STREET, INDIANAPOLIS, , 46260

(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 IN00371908. Complaint IN00371908 - Substantiated. State deficiencies related to the allegations are cited at R52 and R90. Survey date: January 31, and February 1, 2022 Facility number: 013880 Residential Census: 95 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on February 10, 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:	R 0052	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the	03/23/2022

	(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 ensure a wandering resident with sexual ideation was supervised (Resident C) resulting in sexual behavior toward 2 cognitively impaired residents (Resident B and D), and failed to implement their written policy for reporting, investigating, and ensuring the protection of residents for allegations of sexual abuse for 3 of 3 residents reviewed for abuse (Resident B, C, and D). Findings include: On 1/31/22 at 9:36 a.m., Licensed Practical Nurse (LPN) 16 indicated, on 1/25/22 at approximately 8:10 a.m., she received a picture on her cellphone from Patient Care Assistant (PCA) 15, but was unable to understand the content. Upon arrival to the facility, LPN 16 found PCA 15 who explained to her that during morning rounds at 7:00 a.m., PCA 14 found Residents B and		statement of deficiencies, or any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests Desk Review in lieu a Post Survey Review. IDR requested: Community does not believe that abuse occurred. <u>RO52 Resident Rights</u> ***What corrective actions will be accomplished for those residents found to have been affected by the finding:*** For Residents B, C and D representatives and physicians all notified of incidents. Resident B, C and D services plans updated accordingly. Residents B and C were seen by NP on 1/26 and by Psych NP 1/28. Service plans	

	C in bed together naked and performing "oral sex." The picture was proof of the incident. At approximately 8:30 a.m., LPN 16 called the Wellness Director and informed her of the of incident. The Executive Director (ED) was informed of the incident after the 9:30 a.m. morning meeting. LPN 16 indicated she was instructed not to document the incident in the resident's medical records at that time and to wait for guidance on how to proceed. LPN 16 indicated to her knowledge the residents were not assessed for injury, there was never any documentation of the incident or follow up in the resident's medical records, the family representatives were not notified, and the incident had not been reported to the Indiana State Department of Health. On 1/25/22 LPN 16 indicated she and the aides were instructed by the ED to delete the photos off their phones as it was a HIPPA violation. The ED told them this incident was a dementia behavior, the men were not homosexuals before they had dementia, and in her mind, this was not a situation of sexual abuse. LPN 16 indicated she asked several times that day about documentation and was put off. On 1/26/22 LPN 16 notified Nurse Practitioner (NP)12 who said she'd reach out to psych services, but there was nothing that could be done		reflect conversation and agreement by POA for both resident B and C to engage in intimate interactions. ***How will you identify other residents having the potential to be affected by the same finding and what corrective action will be taken:*** Memory Care Residents observations reviewed for past 60 days and no additional possible intimate interactions noted. ***What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur:*** Following survey completion Executive Director, Wellness	

	if there was no documentation to get the "ball rolling." LPN 16 indicated she was not asked to write out any type of witness statement regarding the incident.		Director and Regional Vice President of Operations completed review of ISDH reportable guidelines and Traditions Management Reporting Policy. Staff will be in serviced on the Abuse prevention, Reporting, Investigating by March 23th, 2022 by the Executive Director and Wellness Director. The facility also conducts these in-services for new employees on hire, annually, and as needed for ongoing training. The Administrator or Designee will randomly select 5 staff members each week to take a test regarding abuse and reporting for 8 weeks, then 1 X a month times 4 months, then 1 X a quarter ongoing. The results will be reviewed at the monthly At Risk meeting. Memory Care residents will be checked on a minimum of q2hrs for safety to ensure they are in designated apartment or common area. ***How the corrective action(s)***	

	During an interview on 1/31/22 at 1:31 p.m., NP 12 indicated, on 1/25/22, LPN 16 reported she had been informed by the night shift aides that 2 male residents were observed performing "oral sex" on each other. LPN 16 told NP 12 the Wellness Director told her not to document the incident in the medical record, but the Wellness Director indicated to NP 12 that she would never say that. On 1/26/22 NP 12 reported this allegation to the Psychiatric (Psych) NP who then saw the residents on 1/28/22. NP 12 could not find documentation of the incident in either Resident B or C's medical records. On 1/28/22 the Psych NP contacted NP 12 and indicated she had ordered Fluoxetine (Prozac) for Resident C as she saw some documentation in his chart. A nurse's note, dated 9/16/21, where the resident was found in Resident D's room unclothed attempting to get into her bed, and a nurse's note, dated 9/19/21, where the resident was found in Resident D's room only wearing only a t-shirt then became aggressive when asked to go to his room. These notes indicated prior sexual behavior. During an interview on 1/31/22 at 3:09 p.m., the Wellness Director indicated, on 1/25/22 she had received a call on the way to work from LPN 16. It had been reported to LPN 16 from a		***will be monitored to ensure the finding will not recur:*** Administrator or designee will review nursing notes daily to ensure reportables are identified and reported in a timely manner per ISDH guidelines. Results of the reviews will be discussed at monthly At Risk meeting. Resident safety log will be signed Q shift by LPN/QMA to reflect completed safety monitoring of Memory Care residents. Wellness Director or Designee will audit safety log qd x 30 days, 1x weekly for 3 months, and 1x monthly thereafter. ***By what date the systemic changes will be completed:*** March 23th, 2022	

	night shift PCA that at approximately 7:15 a.m., Residents B and C were found naked in bed together potentially having sex and had told the aides to get out of the room. PCA's 14 and 15 did not notify the charge nurse LPN 17, the Wellness Nurse, or the ED. Wellness Director indicated, she thought LPN 16 might have assessed the residents, but there was no documentation of the incident or follow up in the resident's charts. Family members were not notified of a potential incident to her knowledge. New staff hires met with the Memory Care Coordinator and were trained on abuse, and a behavioral based program used by the facility. Staff were trained/educated to tell the charge nurse of potential abusive situations, and the charge nurse was to call the Wellness Director and the ED. The situation would be investigated to determine if there were abuse. If there was abuse, they would report to family, Medical Doctor (MD), and ISDH. The Wellness Directors indicated it was her responsibility to assure resident wellbeing and documentation as needed On 2/1/22 at 9:29 a.m., NP 12 indicated even though Resident C was profoundly demented she felt he could make the decision to have sex or not. He would tell			

	persons to stop if they were doing something he did not like. She was not sure if Resident C's Legal Representative would agree or not, or if she had been notified. Also felt Resident B was very vocal and although demented he could make the decision to have sexual relations if he wanted. Resident B was married, and not sure if she as his Legal Representative had been approached or if she would agree with her husband having sexual relations with another male resident. During an interview on 2/1/22 at 9:36 a.m., the Psych NP indicated she had saw both Residents B and C last on 1/28/22, and both were profoundly confused. While speaking to Resident C, he kept pointing to Resident D who he thought was his wife. Resident C had ongoing behaviors where he kept saying he wanted to go to Resident D's room and touch her inappropriately. Based on his assessment, the psych NP thought Resident C's thought processes were more obsession and ruminations from the past versus behaviors. She had spoken to Resident C's daughter, and they agreed to start Prozac for the obsessive behaviors. Due to being severely demented Resident C could not even do a slums test (tests for orientation, memory, attention, and executive			

	function), could not say the day of the week, where he was, etc. In her professional opinion, Resident C absolutely did not have the mental capacities to make decisions about having sexual relations with another resident, and absolutely did not have the capacity to decide about having sex with a male peer. When she asked Resident C questions about the situation, he was very upset and said it was absurd he would not have been in a sexual situation with a male or female. Resident B was also interviewed, and he absolutely did not have the mental capacity to make decisions about having sex with another person. Resident B had dementia from a younger age, could not remember anything such as meals, care, etc. When asked if he had ever looked at another resident or thought about sex, Resident B was emphatic that he had not. The psych NP indicated, she had not found any documentation in Resident B's medical records about a being found in a sexually inappropriate situation last week and had only found 1 reference in Resident C's. Both gentlemen were sweet, but both profoundly demented, she was unable to question them as they were unable to answer one question from the next. The psych NP indicated, "the ED was wrong, absolutely not! These residents were			

	profoundly confused and not capable of making decisions regarding sexual relations." During an interview on 2/1/22 at 1:25 p.m., PCA 15 indicated on 1/25/22 she came in to work at 6:00 a.m. During her morning rounds she went into Resident C's room to help with am care and observed him and Resident B in the bed, both naked, and Resident C was sucking on Resident B's penis. When she attempted to redirect Resident B out of the room, both residents started yelling at her to get out. She did not attempt to separate the residents or look to see if they were both willing participants as she felt the residents had the right to do what they wanted to do. PCA 15 went to get PCA 14 to observed what was happening. Later in the morning PCA 15 called LPN 16 the unit manager and reported the incident, she did not fill out any type of statement as it was not her job to do the follow up, it was the unit manager's responsibility. Later in the day the ED asked her what she had seen, and she told her the same story of seeing the men in bed together naked engaged in oral sex, she was not asked to writer out a statement. To her knowledge there had been no staff education provided regarding abuse since the incident. PCA 15 indicated she did not have			

any pictures of the incident on her phone. She did not respond when asked if there had originally been a picture sent to LPN 16 and later deleted per request of management.

1. On 1/31/22 11:00 a.m., Resident C was on the secured memory care unit sitting on a couch among female peers participating in an activity. He was alert and attempting to participate and answer trivia. No behaviors were observed.

On 1/31/22 at 11:56 a.m., Resident C was sitting at the head of a table with 5 female peers in the front memory care dining room eating lunch. He was quiet and had no behaviors.

On 2/1/22 at 1:19 p.m., Resident C was sitting in the activity room by himself, looking around quietly.

Resident C's record was reviewed on 1/31/22 at 9:45 a.m. Diagnoses on Resident C's profile included but were not limited to, dementia without behavioral disturbance.

An Individual Service Plan for Resident C, dated 7/12/21, indicated the resident had a primary diagnoses of dementia without behavioral disturbance. The resident required assistance with orientation several times a day to include

simple information about the day, time and location. The resident was independent with mobility and with toileting and fed himself after set up. He required assistance with medications, am and pm care, and stand by assist with bathing. Resident C displayed behaviors of frustration at times and may yell/raise his voice due to his frustration and physical/mental condition and required assistance with his behaviors as needed. The resident required safety checks every 2 hours. There was no documentation to indicate the resident had potential sexual behaviors.

A FAST (Functional Assessment Staging Test used to quantitatively assess the degree or disability and to document changes that occur over time) scale, dated 7/12/21, indicated the resident exhibited decreased job function, required assistance in choosing properly without assistance, and based on the FAST scale was in Stage 6: moderately severe dementia. Based on this assessment the resident required memory care.

A Progress Note for Resident C, dated 9/16/21 at 9:49 p.m., indicated the resident was found in female Resident D's room unclothed attempting to get in bed with the resident. Staff redirected Resident C twice.

	Charge nurse was aware, and staff would continue to monitor. A Progress Note for Resident C, dated 09/19/21 at 9:36 p.m., indicated during rounds and in preparation to help everyone ready for bed this resident was found in female Resident D's room. Resident C was wearing only a t-shirt. Resident C became aggressive when asked to go to his room. After some redirection and ensuring residents that they were not a marital couple he did to go to his room. A Progress Note for Resident C by NP 12, dated 1/26/22 at 12:02 p.m., indicated resident was seen in the memory care unit for concerns of interaction with another resident within the facility. Nursing staff reported concerns of resident with potentially inappropriate interaction with another resident in the unit. On exam, Resident C was profoundly confused and did not recall the incident. There were no signs of trauma. The incident was not witnessed by the reporting nurse and no negative responses noted by reporting staff. He was calm and cooperative without agitation. Although he was cognitively impaired from NP 12's professional judgment and interaction with him in the unit over the past 7 months, he had the ability to verbalize his wants			

	and desires and was capable to alert staff if he was in distress. A Progress Note for Resident C by the Psych NP, dated 1/28/22 at 2:58 p.m., indicated the resident was seen for a following up to his mood and behaviors. Resident C shared that his wife was not at the facility. But he had a very good friend, and she could trust him. They could do anything they wanted to do together. He was confused and shared that he did not remember much of things that went on. " ...Sexually inappropriate behavior: Based on my assessment, this behavior is more of obsession and or ruminations. Discussed plan of care with the patient's daughter and she agreed with a treatment plan to start him on Prozac 20 mg daily." A Physician's order for Resident C, dated 1/28/22, indicated Fluoxetine (Prozac used to treat depression, obsessive-compulsive disorder, bulimia nervosa, and panic disorder) take 20 milligram (mg) capsule by mouth daily. The was no documentation of the rational for the order. There was no documentation in Resident C's medical record to indicate the resident was having sexual behaviors on 1/25/22, nursing measures or behavioral intervention were attempted			

before prescribing Fluoxetine 20 mg on 1/28/22. There was no documentation of psychosocial wellbeing follow up.

2. On 1/31/22 at 11:17 a.m., Resident B was lying on his made up bed fully dressed, eyes closed and appeared to be sleeping. The door to the hallway was propped open with a small trash can.

On 1/31/22 at 11:58 a.m., Resident B was sitting at a table with a female peer in the back memory care dining room eating, quietly, and had no behaviors.

On 2/1/22 at 1:15 p.m., Resident B was lying on his bed with his eyes closed and the door to the hallway propped open.

On 2/1/22 at 1:54 p.m., Resident B indicated he did not remember being asked to participate in sexual activity with another resident. If a male resident asked him to participate in sex he would be upset as he didn't know why anyone would do that. He didn't remember any incident that would cause him to be upset but maybe his wife needed called in case there was something she should know about.

Resident B's record was reviewed on 1/31/22 at 10:30 a.m. Diagnoses on Resident B's

	profile included, but were not limited to, Alzheimer's disease, unspecified dementia without behavioral disturbance, and expressive language disorder. A FAST scale for Resident B, dated 11/17/21, indicated, the resident required assistance in choosing properly without assistance, was unable to bathe properly, urinary incontinence occasionally or more frequently, had difficulty putting clothes on properly, and based on the FAST scale was in Stage 6: moderately severe dementia. Based on this assessment the resident required memory care. An Individual Service Plan for Resident B, dated 11/17/21, indicated the resident required assistance with orientation several times a day. The resident was independent mobility and required assistance with am and pm care, using the bathroom, and with meals. The resident was administered medications per the staff. The resident displayed behaviors, required assistance with his behaviors, and required safety checks 12 times per day. A Progress Note for Resident B from the Psych NP, dated 1/28/22 at 4:00 p.m., indicated the resident was being seen today for follow up to mood and behaviors. She met with the resident, and he was profoundly			

	confused. He was well dressed, ambulatory, and occasionally had difficulty stating what he wanted to say because he forgot the previous sentence. When asked if he has engaged in any inappropriate relationship with a peers at the facility, he got upset while answering this question stating, "I will never do such thing." He agreed to Slum testing but got frustrated and refused to proceed with the test when he could not answer questions regarding the day of the week and the year. The resident was oriented to self only, had severe memory impairment, was exit seeking, had grossly impaired cognition, no insight, and profoundly impaired judgment. The resident's medical record lacked documentation to indicate the resident was having sexual behaviors on 1/25/22, nursing or behavioral interventions were attempted, or of psychosocial wellbeing follow up. A Progress Note for Resident B, dated 1/28/2022 at 9:30 p.m., indicated the resident was alert and able to make his needs known. Resident B provided urine for urinary analysis (UA). It has been collected and labeled. A Physician's order for Resident B, dated 1/28/22, indicated collect UA & culture for			

unsteady and worsening confusion. There was no documentation in the resident medical record to indicate lab results were completed or obtained.

3. Resident D's record was reviewed on 1/31/22 at 2:18 p.m. Diagnoses included, but were not limited to, Alzheimer's disease.

Progress Notes for Resident D, dated September 2021, lacked documentation of Resident C being undressed in Resident D's room or attempting to get into bed with the resident on 9/16/21 and 9/19/21.

An Individual Service Plan for Resident D, dated 12/7/21, indicated the resident required assistance with orientation up to 7 times per week. She used a wheelchair for ambulation and required assistance with transfers. Resident D displayed behaviors, required assistance with behaviors, am and pm routine, bathing, using the bathroom, with meals, and fall management. Staff provided medications. The resident required safety checks every 2 hours.

On 1/31/22 at 11:03 a.m., LPN 6 indicated he was the new Memory Care Coordinator of the secured memory unit as of that day, although he had worked in

	the facility for several years. He had not heard of any recent sexual abuse or sexual behaviors between men in the facility. If he was informed of potential abuse, he would inform his supervisor and start investigating to assure the residents were ok. The incident would then be documented to include follow up in the electronic medical record (EMR). On 1/31/22 at 11:43 a.m., QMA 10 indicated she worked on the memory care unit frequently. If she heard about sexual behaviors between residents, she would observe the residents and let her supervisor know. If she observed sexual behaviors, she would not want to interfere but would notify management and see what she was supposed to do and if she was supposed to document the incident. On 2/1/22 at 1:35 p.m., LPN 6 indicated, it was his 2nd day of being the Memory Care Coordinator. He had not yet received any type of education on the specific behaviors of the residents on the unit, he was unaware there had been an incident last week between 2 male residents, and to his knowledge no one had been instructed on new interventions to prevent a future occurrence. When there was any type of			

behaviors with residents, there was to be follow up to include documentation and new interventions documented on the service plan.

A handwritten note, not dated or signed, indicated, "Each employee is in-serviced on the attached information every July and upon hire. An in-service is scheduled for Wednesday 2/2 and Thursday 2/3 ...."

No additional documentation of recent abuse or sexual behavior training was provided during the survey process.

On 2/1/22 at 9:30 a.m., the ED provided a policy titled, "Abusive Resident Behavior," dated 6/14, and indicated the policy was the one currently being used by the facility. The policy indicated, " ...No resident shall be permitted to endanger the safety or well-being of another resident or themselves by physical violence or verbal abuse. This includes all abusive behavior, such as but not limited to, the following: slapping, hitting, pinching, kicking and biting. Procedure: 1. Remove the resident from the actual or potential danger. 2. Protect the abusive resident from further harm to self or others. 3. Initiate 15 minute checks until a permanent intervention is determined ....6. The staff should then follow the Incident/Accident Report policy

	and procedure for reporting. 7. The Executive Director will discuss the incident with the Regional Director of Operations/VP Wellness as soon as possible ...8. The Executive Director and Wellness Director and staff will attempt to identify the cause[s] of the behavior and will implement alternative interventions to prevent a reoccurrence of the behavior. 9. The involved resident's physician and family will be notified regarding the incident ...."			

	On 2/1/22 at 9:30 a.m., the ED provided an undated form titled, "How is consent defined?" The form indicated, " ...Consent is not specifically defined under the current law. However, Indiana law provides that a person commits a sex crime if: [1] the victim is compelled by force or imminent threat of force; [2] the victim is unaware that the sexual intercourse or other sexual conduct is occurring; or [3] the victim is so mentally disabled or deficient that consent to sexual intercourse or other sexual conduct cannot be given ...Capacity to consent presupposes an intelligence capable of understanding the act, its nature, and possible consequences ...i.e.. Mentally disabled and unable to voice preferences or objections of any kind and in any situation ...." This State Residential Finding relates to Complaint IN00371908. Based on interview and record review, the facility failed to ensure a wandering resident with sexual ideation was supervised (Resident C) resulting in sexual behavior toward 2 cognitively impaired residents (Resident B and D), and failed to implement their written policy for reporting, investigating, and ensuring the protection of residents for			

	allegations of sexual abuse for 3 of 3 residents reviewed for abuse (Resident B, C, and D). Findings include: On 1/31/22 at 9:36 a.m., Licensed Practical Nurse (LPN) 16 indicated, on 1/25/22 at approximately 8:10 a.m., she received a picture on her cellphone from Patient Care Assistant (PCA) 15, but was unable to understand the content. Upon arrival to the facility, LPN 16 found PCA 15 who explained to her that during morning rounds at 7:00 a.m., PCA 14 found Residents B and C in bed together naked and performing "oral sex." The picture was proof of the incident. At approximately 8:30 a.m., LPN 16 called the Wellness Director and informed her of the of incident. The Executive Director (ED) was informed of the incident after the 9:30 a.m. morning meeting. LPN 16 indicated she was instructed not to document the incident in the resident's medical records at that time and to wait for guidance on how to proceed. LPN 16 indicated to her knowledge the residents were not assessed for injury, there was never any documentation of the incident or follow up in the resident's medical records, the family representatives were not notified, and the incident had not been reported to the Indiana			

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	absolutely did not have the mental capacity to make decisions about having sex with another person. Resident B had dementia from a younger age, could not remember anything such as meals, care, etc. When asked if he had ever looked at another resident or thought about sex, Resident B was emphatic that he had not. The psych NP indicated, she had not found any documentation in Resident B's medical records about a being found in a sexually inappropriate situation last week and had only found 1 reference in Resident C's. Both gentlemen were sweet, but both profoundly demented, she was unable to question them as they were unable to answer one question from the next. The psych NP indicated, "the ED was wrong, absolutely not! These residents were profoundly confused and not capable of making decisions regarding sexual relations." During an interview on 2/1/22 at 1:25 p.m., PCA 15 indicated on 1/25/22 she came in to work at 6:00 a.m. During her morning rounds she went into Resident C's room to help with am care and observed him and Resident B in the bed, both naked, and Resident C was sucking on Resident B's penis. When she attempted to redirect Resident B out of the room, both residents started yelling at her to get out.			

	She did not attempt to separate the residents or look to see if they were both willing participants as she felt the residents had the right to do what they wanted to do. PCA 15 went to get PCA 14 to observed what was happening. Later in the morning PCA 15 called LPN 16 the unit manager and reported the incident, she did not fill out any type of statement as it was not her job to do the follow up, it was the unit manager's responsibility. Later in the day the ED asked her what she had seen, and she told her the same story of seeing the men in bed together naked engaged in oral sex, she was not asked to writer out a statement. To her knowledge there had been no staff education provided regarding abuse since the incident. PCA 15 indicated she did not have any pictures of the incident on her phone. She did not respond when asked if there had originally been a picture sent to LPN 16 and later deleted per request of management. 1. On 1/31/22 11:00 a.m., Resident C was on the secured memory care unit sitting on a couch among female peers participating in an activity. He was alert and attempting to participate and answer trivia. No behaviors were observed. On 1/31/22 at 11:56 a.m.,			

	Resident C was sitting at the head of a table with 5 female peers in the front memory care dining room eating lunch. He was quiet and had no behaviors. On 2/1/22 at 1:19 p.m., Resident C was sitting in the activity room by himself, looking around quietly. Resident C's record was reviewed on 1/31/22 at 9:45 a.m. Diagnoses on Resident C's profile included but were not limited to, dementia without behavioral disturbance. An Individual Service Plan for Resident C, dated 7/12/21, indicated the resident had a primary diagnoses of dementia without behavioral disturbance. The resident required assistance with orientation several times a day to include simple information about the day, time and location. The resident was independent with mobility and with toileting and fed himself after set up. He required assistance with medications, am and pm care, and stand by assist with bathing. Resident C displayed behaviors of frustration at times and may yell/raise his voice due to his frustration and physical/mental condition and required assistance with his behaviors as needed. The resident required safety checks			

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A Progress Note for Resident C, dated 09/19/21 at 9:36 p.m., indicated during rounds and in preparation to help everyone ready for bed this resident was found in female Resident D's room. Resident C was wearing only a t-shirt. Resident C became aggressive when asked to go to his room. After some redirection and ensuring residents that they were not a marital couple he did to go to his

room.

A Progress Note for Resident C by NP 12, dated 1/26/22 at 12:02 p.m., indicated resident was seen in the memory care unit for concerns of interaction with another resident within the facility. Nursing staff reported concerns of resident with potentially inappropriate interaction with another resident in the unit. On exam, Resident C was profoundly confused and did not recall the incident. There were no signs of trauma. The incident was not witnessed by the reporting nurse and no negative responses noted by reporting staff. He was calm and cooperative without agitation. Although he was cognitively impaired from NP 12's professional judgment and interaction with him in the unit over the past 7 months, he had the ability to verbalize his wants and desires and was capable to alert staff if he was in distress.

A Progress Note for Resident C by the Psych NP, dated 1/28/22 at 2:58 p.m., indicated the resident was seen for a following up to his mood and behaviors. Resident C shared that his wife was not at the facility. But he had a very good friend, and she could trust him. They could do anything they wanted to do together. He was confused and shared that he did not remember much of things

	that went on. " ...Sexually inappropriate behavior: Based on my assessment, this behavior is more of obsession and or ruminations. Discussed plan of care with the patient's daughter and she agreed with a treatment plan to start him on Prozac 20 mg daily." A Physician's order for Resident C, dated 1/28/22, indicated Fluoxetine (Prozac used to treat depression, obsessive-compulsive disorder, bulimia nervosa, and panic disorder) take 20 milligram (mg) capsule by mouth daily. The was no documentation of the rational for the order. There was no documentation in Resident C's medical record to indicate the resident was having sexual behaviors on 1/25/22, nursing measures or behavioral intervention were attempted before prescribing Fluoxetine 20 mg on 1/28/22. There was no documentation of psychosocial wellbeing follow up. 2. On 1/31/22 at 11:17 a.m., Resident B was lying on his made up bed fully dressed, eyes closed and appeared to be sleeping. The door to the hallway was propped open with a small trash can. On 1/31/22 at 11:58 a.m., Resident B was sitting at a table with a female peer in the back			

	memory care dining room eating, quietly, and had no behaviors. On 2/1/22 at 1:15 p.m., Resident B was lying on his bed with his eyes closed and the door to the hallway propped open. On 2/1/22 at 1:54 p.m., Resident B indicated he did not remember being asked to participate in sexual activity with another resident. If a male resident asked him to participate in sex he would be upset as he didn't know why anyone would do that. He didn't remember any incident that would cause him to be upset but maybe his wife needed called in case there was something she should know about. Resident B's record was reviewed on 1/31/22 at 10:30 a.m. Diagnoses on Resident B's profile included, but were not limited to, Alzheimer's disease, unspecified dementia without behavioral disturbance, and expressive language disorder. A FAST scale for Resident B, dated 11/17/21, indicated, the resident required assistance in choosing properly without assistance, was unable to bathe properly, urinary incontinence occasionally or more frequently, had difficulty putting clothes on properly, and based on the			

	FAST scale was in Stage 6: moderately severe dementia. Based on this assessment the resident required memory care. An Individual Service Plan for Resident B, dated 11/17/21, indicated the resident required assistance with orientation several times a day. The resident was independent mobility and required assistance with am and pm care, using the bathroom, and with meals. The resident was administered medications per the staff. The resident displayed behaviors, required assistance with his behaviors, and required safety checks 12 times per day. A Progress Note for Resident B from the Psych NP, dated 1/28/22 at 4:00 p.m., indicated the resident was being seen today for follow up to mood and behaviors. She met with the resident, and he was profoundly confused. He was well dressed, ambulatory, and occasionally had difficulty stating what he wanted to say because he forgot the previous sentence. When asked if he has engaged in any inappropriate relationship with a peers at the facility, he got upset while answering this question stating, "I will never do such thing." He agreed to Slum testing but got frustrated and refused to proceed with the test when he could not answer questions regarding the day of			

the week and the year. The resident was oriented to self only, had severe memory impairment, was exit seeking, had grossly impaired cognition, no insight, and profoundly impaired judgment.

The resident's medical record lacked documentation to indicate the resident was having sexual behaviors on 1/25/22, nursing or behavioral interventions were attempted, or of psychosocial wellbeing follow up.

A Progress Note for Resident B, dated 1/28/2022 at 9:30 p.m., indicated the resident was alert and able to make his needs known. Resident B provided urine for urinary analysis (UA). It has been collected and labeled.

A Physician's order for Resident B, dated 1/28/22, indicated collect UA & culture for unsteady and worsening confusion. There was no documentation in the resident medical record to indicate lab results were completed or obtained.

3. Resident D's record was reviewed on 1/31/22 at 2:18 p.m. Diagnoses included, but were not limited to, Alzheimer's disease.

Progress Notes for Resident D, dated September 2021, lacked documentation of Resident C

	being undressed in Resident D's room or attempting to get into bed with the resident on 9/16/21 and 9/19/21. An Individual Service Plan for Resident D, dated 12/7/21, indicated the resident required assistance with orientation up to 7 times per week. She used a wheelchair for ambulation and required assistance with transfers. Resident D displayed behaviors, required assistance with behaviors, am and pm routine, bathing, using the bathroom, with meals, and fall management. Staff provided medications. The resident required safety checks every 2 hours. On 1/31/22 at 11:03 a.m., LPN 6 indicated he was the new Memory Care Coordinator of the secured memory unit as of that day, although he had worked in the facility for several years. He had not heard of any recent sexual abuse or sexual behaviors between men in the facility. If he was informed of potential abuse, he would inform his supervisor and start investigating to assure the residents were ok. The incident would then be documented to include follow up in the electronic medical record (EMR). On 1/31/22 at 11:43 a.m., QMA 10 indicated she worked on the			

	memory care unit frequently. If she heard about sexual behaviors between residents, she would observe the residents and let her supervisor know. If she observed sexual behaviors, she would not want to interfere but would notify management and see what she was supposed to do and if she was supposed to document the incident. On 2/1/22 at 1:35 p.m., LPN 6 indicated, it was his 2nd day of being the Memory Care Coordinator. He had not yet received any type of education on the specific behaviors of the residents on the unit, he was unaware there had been an incident last week between 2 male residents, and to his knowledge no one had been instructed on new interventions to prevent a future occurrence. When there was any type of behaviors with residents, there was to be follow up to include documentation and new interventions documented on the service plan. A handwritten note, not dated or signed, indicated, "Each employee is in-serviced on the attached information every July and upon hire. An in-service is scheduled for Wednesday 2/2 and Thursday 2/3 ...." No additional documentation of recent abuse or sexual behavior			

	training was provided during the survey process.			

	On 2/1/22 at 9:30 a.m., the ED provided a policy titled, "Abusive Resident Behavior," dated 6/14, and indicated the policy was the one currently being used by the facility. The policy indicated, " ...No resident shall be permitted to endanger the safety or well-being of another resident or themselves by physical violence or verbal abuse. This includes all abusive behavior, such as but not limited to, the following: slapping, hitting, pinching, kicking and biting. Procedure: 1. Remove the resident from the actual or potential danger. 2. Protect the abusive resident from further harm to self or others. 3. Initiate 15 minute checks until a permanent intervention is determined ....6. The staff should then follow the Incident/Accident Report policy and procedure for reporting. 7. The Executive Director will discuss the incident with the Regional Director of Operations/VP Wellness as soon as possible ...8. The Executive Director and Wellness Director and staff will attempt to identify the cause[s] of the behavior and will implement alternative interventions to prevent a reoccurrence of the behavior. 9. The involved resident's physician and family will be notified regarding the incident ...." On 2/1/22 at 9:30 a.m., the ED provided an undated form titled,			

	"How is consent defined?" The form indicated, " ...Consent is not specifically defined under the current law. However, Indiana law provides that a person commits a sex crime if: [1] the victim is compelled by force or imminent threat of force; [2] the victim is unaware that the sexual intercourse or other sexual conduct is occurring; or [3] the victim is so mentally disabled or deficient that consent to sexual intercourse or other sexual conduct cannot be given ...Capacity to consent presupposes an intelligence capable of understanding the act, its nature, and possible consequences ...i.e.. Mentally disabled and unable to voice preferences or objections of any kind and in any situation ...." This State Residential Finding relates to Complaint IN00371908.			
R 0090	Administration and Management - Deficiency 410 IAC 16.2-5-1.3(g)(1-6) (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence	R 0090	R090 Administration and Management	03/23/2022

	that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most		***What corrective actions will be accomplished for those residents found to have been affected by the finding:*** Immediately following survey completion Executive Director, Wellness Director, and Regional Vice President of Operations completed review of ISDH reportable guidelines and Traditions Management Reporting Policy. ***How will you identify other residents having the potential to be affected by the same finding and what corrective action will be taken:*** Memory Care Residents observations reviewed for past 60 days and no additional possible intimate interactions noted.	

	recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request Based on observation, interview, and record review, the facility failed to ensure the Executive Director reported abuse allegations to the Indiana State Department of Health for 3 of 3 allegations of abuse reviewed (Residents B, C, and D). Findings include: On 1/31/22 at 9:36 a.m., Licensed Practical Nurse (LPN) 16 indicated on 1/25/22 at approximately 8:10 a.m., she received a picture on her cellphone from Patient Care Assistant (PCA) 15, but was unable to understand the content. Upon arrival to the facility, LPN 16 found PCA 15 who explained to her that during morning rounds at 7:00 a.m., PCA 14 found Residents B and C in bed together, naked, and performing "oral sex." The		***What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur:*** Following survey completion Executive Director, Wellness Director and Regional Vice President of Operations completed review of ISDH reportable guidelines and Traditions Management Reporting Policy.	

	picture was proof of the incident. At approximately 8:30 a.m., LPN 16 called the Wellness Director and informed her of the of incident. The Executive Director (ED) was informed of the incident after the 9:30 a.m. morning meeting. LPN 16 indicated she was instructed not to document the incident in the resident's medical records at that time and to wait for guidance on how to proceed. LPN 16 indicated there was never any documentation of the incident or follow up in the resident's medical records, the family representatives were not notified, and the incident had not been reported to the Indiana State Department of Health. Review of Indiana State Department of Health Survey Report System reports, dated 9/30/21 - 1/31/22, indicated no documentation of resident to resident abuse having been reported for Residents B, C, or D. 1. Resident C's record was reviewed on 1/31/22 at 9:45 a.m. Diagnoses on Resident C's profile included, but were not limited to, dementia without behavioral disturbance. A Progress Note for Resident C, dated 9/16/21 at 9:49 p.m., indicated the resident was found in female Resident D's room unclothed attempting to get in		Staff will be in serviced on the Abuse prevention, Reporting, and Investigating by March 23th, 2022 by the Executive Director and Wellness Director. The facility also conducts these in-services for new employees on hire, annually, and as needed for ongoing training. The Administrator or Designee will randomly select 5 staff members each week to take a test regarding abuse and reporting for 8 weeks, then 1 X a month times 4 months, then 1 X a quarter. The results will be reviewed at the monthly At Risk meeting. Memory Care residents will be checked on a minimum of q2hrs for safety to ensure they are in designated apartment or common area. ***How the corrective action(s) will be monitored to ensure the finding will not recur:*** The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the	

bed with the resident. Staff redirected Resident C twice.

A Progress Note for Resident C, dated 9/19/21 at 9:36 p.m., indicated during rounds the resident was found in female Resident D's room. Resident C was wearing only a t-shirt. Resident C became aggressive when asked to go to his room. After some redirection and ensuring residents that they were not a marital couple he did go to his room.

There was no documentation in Resident C's medical record to indicate the resident was having sexual behaviors on 1/25/22, nursing measures or behavioral intervention were attempted before prescribing Fluoxetine 20 mg on 1/28/21.

2. Resident B's record was reviewed on 1/31/22 at 10:30 a.m. Diagnoses on Resident B's profile included, but were not limited to, Alzheimer's disease, unspecified dementia without behavioral disturbance, and expressive language disorder.

There was no documentation in the resident's medical record to indicate the resident was having sexual behaviors on 1/25/22, or that nursing or behavioral interventions were attempted. There was no documentation of psychosocial wellbeing follow up.

statement of deficiencies, or any violation of regulation.

This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests Desk
Review in lieu a Post Survey Review.

IDR Requested: Community believes no abuse occurred.

Administrator or designee will review nursing notes daily to ensure
reportables are identified and reported in a timely manner per ISDH
guidelines. Results of the reviews will
be discussed at monthly At Risk meeting.

Resident safety
log will be signed Q shift by LPN/QMA to reflect completed safety monitoring of
Memory Care residents.
Wellness Director or Designee will audit safety log qd x
30 days, 1x weekly for 3 months, and 1x monthly therafter.

	3. Resident D's record was reviewed on 1/31/22 at 2:18 p.m. Diagnoses included, but were not limited to, Alzheimer's disease. Progress Notes for Resident D, dated September 2021, lacked documentation of Resident C being undressed in Resident D's room or attempting to get into bed with the resident on 9/16/21 and 9/19/21. On 1/31/22 at 3:29 p.m., the ED indicated, on 1/25/22 after the morning meeting, she was told by LPN 16 that aides had caught 2 male memory care residents in Resident C's bed. The ED understood at first staff thought the men were just fondling each other then they thought the men were engaged in oral sex. The ED indicated to her knowledge the 2 male residents were not physically assessed after the incident, but she thought there was no indication of psychosocial affects. To her knowledge LPN 16 had notified family members and the NP. There was no documentation in either resident's medical records of the incident or follow up having been completed by the nurse, Wellness Director or the ED. The ED indicated, she supposed she could have put a community note in the residents' charts, but even though both residents resided on the		***By what date the systemic changes will be completed:*** March 23th, 2022	

secured memory care unit, she felt they were both high functioning enough to make the decision of having sexual relations. The ED indicated NP 12 told her they could make those kinds of decisions. No one had told her they felt finding a male in the other male residents' bed was abuse or she would have reported it. Whole incident was investigated, although there was nothing documented as there was not a nurse that had seen the incident. As the facility had no Social Service Director, the Memory Care Coordinator would have been responsible for documenting follow up psychosocial.

On 2/1/22 at 2:01 p.m., the ED indicated PCA 15 had taken a picture of Residents B and C naked in bed together, but the ED had looked at the pictures and there was no nudity visible, and she had counseled both on the fact of never taking pictures of residents. To her knowledge the pictures had been deleted in front of her. The ED indicated she had asked staff for witness statements regarding the incident on 1/25/22 but had not received statements from anyone. During the investigation, Resident B and C's Healthcare Representatives had not been asked if they would approve sexual relationships among their

residents. Resident C and Resident D were drawn to one another after his admission, and his daughter was ok with them being friendly. After the incident in September between Residents C and D, she thought the residents had both been put on hourly checks. Resident C tended to sleep naked, thought the incident in September was due to his habits, not due to sexual activity. She had reviewed the situation between Residents B and C, and due to the gentlemen being of "like mind and friends," she did not see that this could be abuse, therefore did not file a State Reportable incident.

On 2/1/22 at 9:30 a.m., the ED provided a policy titled, "Resident Neglect, Abuse, and Misappropriation of Property," dated 11/18, and indicated the policy was the one currently being used by the facility. The policy indicated, " ...Sexual abuse includes, but not limited to, sexual harassment, sexual coercion, or sexual assault ...All reported incidents of alleged abuse, neglect, or misappropriation of resident property are immediately investigated and reported per state and federal law [typically within 24 hours of witness/identification]. The community has a designated Team Member/supervisor on each shift responsible for the

initial reporting and investigation of allegations of abuse ...This designated team member will communicate all investigation information to the Executive Director who will determine further action ...13. Written results of investigations [including criminal, abuse...] are reported by the Executive Director to other officials in accordance with local, state, and federal law...14. If the alleged violation is verified, appropriate corrective action is taken, including measures to prevent further abuse...."

This State Residential Finding relates to Complaint IN00371908.

Based on observation, interview, and record review, the facility failed to ensure the Executive Director reported abuse allegations to the Indiana State Department of Health for 3 of 3 allegations of abuse reviewed (Residents B, C, and D).

Findings include:

On 1/31/22 at 9:36 a.m., Licensed Practical Nurse (LPN) 16 indicated on 1/25/22 at approximately 8:10 a.m., she received a picture on her cellphone from Patient Care Assistant (PCA) 15, but was unable to understand the content. Upon arrival to the

	facility, LPN 16 found PCA 15 who explained to her that during morning rounds at 7:00 a.m., PCA 14 found Residents B and C in bed together, naked, and performing "oral sex." The picture was proof of the incident. At approximately 8:30 a.m., LPN 16 called the Wellness Director and informed her of the of incident. The Executive Director (ED) was informed of the incident after the 9:30 a.m. morning meeting. LPN 16 indicated she was instructed not to document the incident in the resident's medical records at that time and to wait for guidance on how to proceed. LPN 16 indicated there was never any documentation of the incident or follow up in the resident's medical records, the family representatives were not notified, and the incident had not been reported to the Indiana State Department of Health. Review of Indiana State Department of Health Survey Report System reports, dated 9/30/21 - 1/31/22, indicated no documentation of resident to resident abuse having been reported for Residents B, C, or D.			

1. Resident C's record was reviewed on 1/31/22 at 9:45 a.m. Diagnoses on Resident C's profile included, but were not limited to, dementia without behavioral disturbance.

A Progress Note for Resident C, dated 9/16/21 at 9:49 p.m., indicated the resident was found in female Resident D's room unclothed attempting to get in bed with the resident. Staff redirected Resident C twice.

A Progress Note for Resident C, dated 9/19/21 at 9:36 p.m., indicated during rounds the resident was found in female Resident D's room. Resident C was wearing only a t-shirt. Resident C became aggressive when asked to go to his room. After some redirection and ensuring residents that they were not a marital couple he did go to his room.

There was no documentation in Resident C's medical record to indicate the resident was having sexual behaviors on 1/25/22, nursing measures or behavioral intervention were attempted before prescribing Fluoxetine 20 mg on 1/28/21.

2. Resident B's record was reviewed on 1/31/22 at 10:30 a.m. Diagnoses on Resident B's profile included, but were not limited to, Alzheimer's disease, unspecified dementia without

behavioral disturbance, and expressive language disorder.

There was no documentation in the resident's medical record to indicate the resident was having sexual behaviors on 1/25/22, or that nursing or behavioral interventions were attempted. There was no documentation of psychosocial wellbeing follow up.

3. Resident D's record was reviewed on 1/31/22 at 2:18 p.m. Diagnoses included, but were not limited to, Alzheimer's disease.

Progress Notes for Resident D, dated September 2021, lacked documentation of Resident C being undressed in Resident D's room or attempting to get into bed with the resident on 9/16/21 and 9/19/21.

On 1/31/22 at 3:29 p.m., the ED indicated, on 1/25/22 after the morning meeting, she was told by LPN 16 that aides had caught 2 male memory care residents in Resident C's bed. The ED understood at first staff thought the men were just fondling each other then they thought the men were engaged in oral sex. The ED indicated to her knowledge the 2 male residents were not physically assessed after the incident, but she thought there was no indication of psychosocial

affects. To her knowledge LPN 16 had notified family members and the NP. There was no documentation in either resident's medical records of the incident or follow up having been completed by the nurse, Wellness Director or the ED. The ED indicated, she supposed she could have put a community note in the residents' charts, but even though both residents resided on the secured memory care unit, she felt they were both high functioning enough to make the decision of having sexual relations. The ED indicated NP 12 told her they could make those kinds of decisions. No one had told her they felt finding a male in the other male residents' bed was abuse or she would have reported it. Whole incident was investigated, although there was nothing documented as there was not a nurse that had seen the incident. As the facility had no Social Service Director, the Memory Care Coordinator would have been responsible for documenting follow up psychosocial.

On 2/1/22 at 2:01 p.m., the ED indicated PCA 15 had taken a picture of Residents B and C naked in bed together, but the ED had looked at the pictures and there was no nudity visible, and she had counseled both on the fact of never taking pictures

of residents. To her knowledge the pictures had been deleted in front of her. The ED indicated she had asked staff for witness statements regarding the incident on 1/25/22 but had not received statements from anyone. During the investigation, Resident B and C's Healthcare Representatives had not been asked if they would approve sexual relationships among their residents. Resident C and Resident D were drawn to one another after his admission, and his daughter was ok with them being friendly. After the incident in September between Residents C and D, she thought the residents had both been put on hourly checks. Resident C tended to sleep naked, thought the incident in September was due to his habits, not due to sexual activity. She had reviewed the situation between Residents B and C, and due to the gentlemen being of "like mind and friends," she did not see that this could be abuse, therefore did not file a State Reportable incident.

On 2/1/22 at 9:30 a.m., the ED provided a policy titled, "Resident Neglect, Abuse, and Misappropriation of Property," dated 11/18, and indicated the policy was the one currently being used by the facility. The policy indicated, " ...Sexual abuse includes, but not limited

	to, sexual harassment, sexual coercion, or sexual assault ...All reported incidents of alleged abuse, neglect, or misappropriation of resident property are immediately investigated and reported per state and federal law [typically within 24 hours of witness/identification]. The community has a designated Team Member/supervisor on each shift responsible for the initial reporting and investigation of allegations of abuse ...This designated team member will communicate all investigation information to the Executive Director who will determine further action ...13. Written results of investigations [including criminal, abuse...] are reported by the Executive Director to other officials in accordance with local, state, and federal law...14. If the alleged violation is verified, appropriate corrective action is taken, including measures to prevent further abuse...." This State Residential Finding relates to Complaint IN00371908.			

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