

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/13/2024	
NAME OF PROVIDER OR SUPPLIER WEST LAFAYETTE ALF OPERATIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 3575 SENIOR PLACE, WEST LAFAYETTE, , 47906					
(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 IN00435019, IN00434693 and IN00434524. Complaint IN00435019 - No deficiencies related to the allegations are cited. Complaint IN00434524 - No deficiencies related to the allegations are cited. Complaint IN00434693 - State deficiencies related to the allegations are cited at R0052 Survey dates: June 11, 12 and 13, 2024 Facility number: 014094 Residential Census: 48 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on June 24, 2024.	R 0000	N/A				

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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 record review and interview, the facility failed to ensure a resident with dementia was free from sexual abuse when another resident actively pursuing her touched her inappropriately for 2 of 2 residents reviewed for sexual abuse. (Residents C and D) Using the reasonable person concept, it is likely that this would lead to feelings of embarrassment, fear and anxiety, emotional constriction, feelings of betrayal, and a sense of shame for Resident C. Finding includes: An Indiana Department of Health report indicated, on 5/15/24, Resident C was found in Resident D's room without clothing on. Resident D had sexual contact with Resident C's	R 0052	Staff will monitor daily for the following behaviors such as: resident to resident relationship, interactions with each other, the sexual desires, holding hands, hugging, kissing, physical touch, and inappropriate comments made towards one another. Staff will be educated monthly through all staff meetings and in-services regarding inappropriate sexual behaviors, and sexual abuse. They report to their direct supervisor or to DON/ED immediately via phone call, text message, or in person. During daily meetings all resident to be discussed and assessed for sexual advancement towards each other along with continuing to monitor all resident's Change of condition, BIM/Mini-mentals, and screening for infection control for UTI/Behaviors with management team. Plan to initiate an Interdisciplinary Team Meeting weekly with management/clinical team to go over Changes of condition, assessment, care plans, risk factors, and LOC. This will be an ongoing change in facility protocol.	08/15/2024
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breasts. Resident D had his clothes on and was fondling resident C on her breast area. Since Resident C had moved in, Resident D had pursued her for a relationship. Resident C's family was aware of his persistence and did not approve of the relationship.

The clinical record for Resident C was reviewed on 6/13/24 at 12:50 p.m. The diagnoses included, but were not limited to, altered mental status, unspecified dementia with other behavioral disturbances, and bipolar disorder.

Her cognition score was a 5 which indicated a severe cognitive impairment.

The clinical record for Resident D was reviewed on 6/12/24 at 4:20 p.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus, bipolar disorder, and essential tremor.

His cognition score was a 26 which indicated no cognitive impairment.

A nursing note dated 4/24/24 indicated Resident C was found in Resident D's room. No sexual activity had occurred.

A nursing note dated 5/15/24 indicated Resident C and D were separated and interviewed by the staff. Resident C and D admitted Resident D had

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OMB NO. 0938-0391

touched Resident C's breasts. Both residents denied any other sexual contact. The residents refused a police report, and the families and physicians were notified. The residents were assessed, and no injuries were noted. No distress was noted with the residents. The residents were separated without complaint or resistance. The facility filed a police report.

A nursing note, dated 5/16/24, indicated Resident D told a resident in the dining room he had sexual relations with Resident C.

During an interview, on 6/11/24 at 2:07 p.m., Resident D indicated he had touched the breasts of Resident C. He indicated she had undressed in his room, he was fully clothed, and he touched her breast. Resident C did not resist. The staff had entered his room and separated them. He did not have a relationship with the resident prior to the incident. He liked the resident.

During an interview, on 6/11/24 at 12:35 p.m., the Executive Director (ED) indicated the residents were found by staff in Resident D's room. Resident D was fully clothed and Resident C was naked. Resident D was fondling Resident C's breasts. The residents were separated without difficulty. Both residents

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admitted to sexual contact. The residents did not want a police report filed.

During an interview, on 6/11/24 at 2:17 p.m., Resident C indicated she did not remember any incident involving her at the facility and she did not know Resident D.

During an interview, on 6/11/24 at 2:06 p.m., Staff Member 8 indicated she was made aware by housekeeping Resident C was not present in her room, on 5/15/24 at 1:40 p.m. She indicated she knew exactly where to look for the resident, in Resident D's room. She found Resident C in Resident D's room naked and Resident D was fondling Resident C's breasts. She was able to separate the two residents without difficulty. Resident C was taken to the ED's office after dressing. Resident C indicated Resident D had touched her breasts, but they had not had any sex.

During an interview, on 6/12/24 at 4:55 p.m., the ED indicated Resident D had been pursuing Resident C for a relationship during the months of April and May. She had spoken to Resident D and told him he could not have relations with Resident C. Resident C was severely cognitively impaired. Resident D did have sexual

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contact with Resident C on 5/15/24. She indicated Resident D had sexual relationships throughout his stay at the facility and he did not understand why he could not have a relationship with Resident C. Resident C did have a video monitor in her room which was set up by her family and was monitored by them.

A current facility policy, titled "Reporting Abuse, Neglect, or Financial Exploitation," dated 11/1/19 and received from the ED on 6/13/24 at 1:15 p.m., indicated "...A resident currently living in the community must be free from mental, verbal, sexual, and physical abuse, neglect, involuntary seclusion and financial exploitation...."

This citation relates to Complaint IN00434693.

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Based on record review and interview, the facility failed to ensure a resident with dementia was free from sexual abuse when another resident actively pursuing her touched her inappropriately for 2 of 2 residents reviewed for sexual abuse. (Residents C and D) Using the reasonable person concept, it is likely that this would lead to feelings of embarrassment, fear and anxiety, emotional constriction, feelings of betrayal, and a sense of shame for Resident C.

Finding includes:

An Indiana Department of Health report indicated, on 5/15/24, Resident C was found in Resident D's room without clothing on. Resident D had sexual contact with Resident C's breasts. Resident D had his clothes on and was fondling resident C on her breast area. Since Resident C had moved in, Resident D had pursued her for a relationship. Resident C's family was aware of his persistence and did not approve of the relationship.

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A nursing note dated 5/15/24 indicated Resident C and D were separated and interviewed by the staff. Resident C and D admitted Resident D had touched Resident C's breasts. Both residents denied any other sexual contact. The residents refused a police report, and the families and physicians were notified. The residents were assessed, and no injuries were noted. No distress was noted with the residents. The residents were separated without

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

LABORATORY DIRECTOR'S OR
PROVIDER/SUPPLIER REPRESENTATIVE'S

TITLE

(X6) DATE

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SIGNATURE		
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