

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 08/15/2024	
NAME OF PROVIDER OR SUPPLIER WOODLAND TERRACE OF DANVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 200 S ARBOR LANE, DANVILLE, , 46122					
(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 IN00439605. Complaint IN00439605 - State deficiencies related to the allegations are cited at R0090 and R0217. Survey dates: August 15, 2024 Facility number: 014518 Residential Census: 51 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on August 26, 2024.	R 0000	This plan of correction is submitted as required under State law. The submission of this Plan of Correction does not constitute any admission of civil or criminal liability on the part of the named Community as to contents stated in this Statement of Deficiencies. Any changes to the Community's policies and procedures made because of its receipt of this Statement of Deficiencies are subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer,				

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			director, attorney, or shareholder of theCommunity or affiliated companies.	
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 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	R 0090	This plan of correction is submitted as required under State law. The submission of this Plan of Correctiondoes not constitute any admission of civil or criminal liability on the part of the named Community as tocontents stated in this Statement of Deficiencies. Any changes to the Community's policies and proceduresmade because of its receipt of this Statement of Deficiencies are subsequent remedial measures as thatconcept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civilprocedure and should be inadmissible in any proceeding on that basis. The Community submits this planof correction with the intention that it be inadmissible by any third party in any civil or criminal actionagainst the Community or any employee, agent, officer, director, attorney, or shareholder of theCommunity or affiliated companies.	02/28/2025

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	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 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 interview and record review, the facility failed to ensure the Executive Director (ED) or Health Wellness Director (HWN D) reported bruising of unknown origin and an incident with law enforcement to the Indiana		What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The resident was found to be safe and unharmed. An incident report had been created within 24 hours within our EHR system and followed up on to ensure resident safety. Per the state surveyor on 8/15/24, not all bruises of unknown origin should be reported to the state, only ones with injury and/or pain associated and that have a resolution after an investigation that indicates abuse. It is our request that the wording in this citation be reviewed, as much of what was documented as interviewed by the state surveyor with the Executive Director and the Health & Wellness Director is incorrect. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Community will retrain care staff on reporting changes in condition which include changes to skin, such as bruising.	
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Department of Health (IDOH). This deficient practice had the potential to affect 2 of 11 resident residing on the memory care unit (Resident C and D). Findings include: 1. On 8/15/24 at 10:56 a.m., a record review was completed for Resident C. She had the following diagnoses which included but were not limited to essential hypertension (HTN), major depressive disorder, Alzheimer's disease with late onset, and osteoarthritis. A progress note, dated 7/17/24 at 10:02 a.m., indicated Certified Nursing Aide (CNA) informed nurse that the resident had a bruise to the right arm. Upon assessment the resident had two bruises to upper right arm. One quarter sized bruise on the underarm and one nickel size bruise on the inside of the arm. The bruises were purple in color and did not appear to be painful. A head to toe assessment indicated no other bruises to body. The HWD was notified Health Wellness Director (HWD). A progress note, dated 7/24/24 at 6:54 p.m., indicated during Resident C's shower the CNA identified a large bruise to the resident's left bicep. The bruise measured 6.0 centimeter (cm) by (x) 4.0 cm and the color	What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? The Health & Wellness Director or designee will train care staff on skin checks, incident reporting and timely reporting bruises of unknown origin to the Health & Wellness Director and/or Executive Director. The director notified will report to the other to discuss follow-up in determining if the bruise is reportable to the state. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Training was provided to direct care staff on reporting any changes in skin integrity identified with bathing, dressing changes, etc., for needed follow-up by nursing, including documentation on Change Alerts and incident reports. Change Alert forms submitted will be reviewed daily with verification that an Incident Report is documented and applicable follow-up, including state reporting, has been completed. With compliance
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ranged from yellow around the edge to deep purple in the center. The bruise was obtained by unknown origin since the resident unable to identify cause of bruise.

A progress note, dated 7/25/24 at 10:46 a.m., indicated the HWD was not notified of bruising by staff. The bruising was reported to HWD by Resident C's spouse. Upon inspection bruises were noted to be on bilateral (both) arms. The areas appeared to be old and had turned yellow. Resident C was not cognitively able to state how she received the bruises. The resident denied pain to bilateral arms. Resident C's skin was checked in the presence of spouse. There were no other bruising or skin concerns noted.

On 8/15/24 at 11:19 a.m., Resident C's family member was interviewed. They indicated Resident C had been alone with Resident D. They family did not want Resident C to be alone with Resident D at any time unattended. They indicated the common area was fine. Staff thought it was cute when Resident C and D were together. Resident D was dominating over Resident C and the family felt he was the one causing her bruises to her arms as they appeared to be from grabbing.

verified with daily reviews, reviews will continue for four weeks, and with compliance verified with weekly reviews, then three times weekly for five months. With verification of compliance as provided, monitoring will be completed on 2/28/25

By what date the systemic changes will be completed?
2/28/25

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On 8/15/24 at 11:37 a.m., the HWD indicated she didn't know anything about Resident C's bruising until the resident's spouse notified her.

On 8/15/24 at 12:22 p.m., the ED indicated she did not report bruising of unknown origin to IDOH.

2. On 8/15/24 at 11:29 a.m., a record review was completed for Resident D. He had the following diagnoses which included but were not limited to vascular dementia moderate with agitation, insomnia, unspecified dementia with other behavioral disturbance, and essential HTN.

A progress note, dated 7/17/24 at 8:18 a.m., indicated, "
...Followed up with night nurse who reported that resident [Resident D] became aggressive after staff attempted to redirect him back to his room due to resident being unstable on his feet. Resident began banging on the door. Resident locked himself in room 22 and stated if anyone came in, he would shoot them. Staff entered and resident balled up his fist. Staff retreated from resident to give him space and resident continued to go to other rooms and staff was not able to redirect him. Staff became concerned and called police after first attempting to call

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Assistant Director of Nursing (ADON). Police arrived and resident attempted to get a fire extinguisher to hit officers. Officers used a taser to subdue resident, then handcuffed him and he was taken to a local hospital ...for evaluation"

On 8/15/24 at 1:04 p.m., Resident D's family member was interviewed. They indicated resident tried to hit police with a fire extinguisher and so the police tazed him. Resident D was at another nursing facility receiving therapy because he required extensive assistance with transfers and could only stand for 30 seconds.

On 8/15/24 at 1:35 p.m., the ED was interviewed along with the HWD. The ED indicated she was unaware if resident was really tazed or not. She did not get a police report after the incident. She did not realize she should have reported the incident to IDOH.

A policy titled, "Accidents, Incidents, and Unusual Occurrences," dated July 18, 2023, was provided by the HWD on 8/15/24 at 12:04 p.m. It indicated, "... Any unforeseen or unplanned event or any other irregular happening in the routine operations of the community. An incident includes any accident or unusual occurrence that takes place in

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the course of caring for a particular resident, or an unexpected event concerning a visitor of the community, whether or not injury to persons or property occurs ... The community will comply with statutory and regulatory requirements for reporting incidents and accidents to the appropriate governmental agencies"

This citation relates to Complaint IN00439605.

Based on interview and record review, the facility failed to ensure the Executive Director (ED) or Health Wellness Director (HWN D) reported bruising of unknown origin and an incident with law enforcement to the Indiana Department of Health (IDOH). This deficient practice had the potential to affect 2 of 11 resident residing on the memory care unit (Resident C and D).

Findings include:

1. On 8/15/24 at 10:56 a.m., a record review was completed for Resident C. She had the following diagnoses which included but were not limited to essential hypertension (HTN), major depressive disorder, Alzheimer's disease with late onset, and osteoarthritis.

A progress note, dated 7/17/24 at 10:02 a.m., indicated Certified

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Nursing Aide (CNA) informed nurse that the resident had a bruise to the right arm. Upon assessment the resident had two bruises to upper right arm. One quarter sized bruise on the underarm and one nickel size bruise on the inside of the arm. The bruises were purple in color and did not appear to be painful. A head to toe assessment indicated no other bruises to body. The HWD was notified Health Wellness Director (HWD).

A progress note, dated 7/24/24 at 6:54 p.m., indicated during Resident C's shower the CNA identified a large bruise to the resident's left bicep. The bruise measured 6.0 centimeter (cm) by (x) 4.0 cm and the color ranged from yellow around the edge to deep purple in the center. The bruise was obtained by unknown origin since the resident unable to identify cause of bruise.

A progress note, dated 7/25/24 at 10:46 a.m., indicated the HWD was not notified of bruising by staff. The bruising was reported to HWD by Resident C's spouse. Upon inspection bruises were noted to be on bilateral (both) arms. The areas appeared to be old and had turned yellow. Resident C was not cognitively able to state how she received the bruises. The resident denied pain to

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bilateral arms. Resident C's skin was checked in the presence of spouse. There were no other bruising or skin concerns noted.

On 8/15/24 at 11:19 a.m., Resident C's family member was interviewed. They indicated Resident C had been alone with Resident D. They family did not want Resident C to be alone with Resident D at any time unattended. They indicated the common area was fine. Staff thought it was cute when Resident C and D were together. Resident D was dominating over Resident C and the family felt he was the one causing her bruises to her arms as they appeared to be from grabbing.

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essential HTN.

A progress note, dated 7/17/24 at 8:18 a.m., indicated, "...Followed up with night nurse who reported that resident [Resident D] became aggressive after staff attempted to redirect him back to his room due to resident being unstable on his feet. Resident began banging on the door. Resident locked himself in room 22 and stated if anyone came in, he would shoot them. Staff entered and resident balled up his fist. Staff retreated from resident to give him space and resident continued to go to other rooms and staff was not able to redirect him. Staff became concerned and called police after first attempting to call Assistant Director of Nursing (ADON). Police arrived and resident attempted to get a fire extinguisher to hit officers. Officers used a taser to subdue resident, then handcuffed him and he was taken to a local hospital ...for evaluation"

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On 8/15/24 at 1:04 p.m., Resident D's family member was interviewed. They indicated resident tried to hit police with a fire extinguisher and so the police tazed him. Resident D was at another nursing facility receiving therapy because he required extensive assistance with transfers and could only stand for 30 seconds.

On 8/15/24 at 1:35 p.m., the ED was interviewed along with the HWD. The ED indicated she was unaware if resident was really tazed or not. She did not get a police report after the incident. She did not realize she should have reported the incident to IDOH.

A policy titled, "Accidents, Incidents, and Unusual Occurrences," dated July 18, 2023, was provided by the HWD on 8/15/24 at 12:04 p.m. It indicated, "... Any unforeseen or unplanned event or any other irregular happening in the routine operations of the community. An incident includes any accident or unusual occurrence that takes place in the course of caring for a particular resident, or an unexpected event concerning a visitor of the community, whether or not injury to persons or property occurs ... The community will comply with statutory and regulatory requirements for reporting

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	incidents and accidents to the appropriate governmental agencies" This citation relates to Complaint IN00439605.			
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.	R 0217	I respectfully request a review of Survey Event ID TPZI11, R217. During the interview/survey process with the Executive Director and Health & Wellness Director, the state surveyor did not take notes and consequently several of the reported comments included in this deficiency are inaccurate. The residents were safe and unharmed, and were not having the sexual encounters the surveyor inferred in the SOD. We worked directly with the residents and their families regarding the residents' relationship. Attached is documentation of the communication, staff redirection of the residents and verbal consent from the family to "not press the issue of keeping the two residents apart". In summary, the Community supported the resident's safety and dignity in collaboration with the residents and their families, with resident rights the laser focus of all parties' efforts. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The services offered shall be reviewed and	09/30/2024

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(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.

(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.

Based on interview and record review, the facility failed to keep cognitively impaired residents separated from each other, as female family members desired. This had the potential to affect 2 of 11 resident residing on the memory care unit (Resident C and D).

Findings include:

On 8/15/24 at 10:56 a.m., a record review was completed for Resident C. She had the following diagnoses which included but were not limited to essential hypertension (HTN), major depressive disorder, Alzheimer's disease with late onset, and osteoarthritis.

A progress note dated 5/30/24 at 5:15 p.m., indicated, "...Executive Director (ED) placed call to legal representative to discuss resident's platonic and sexual consensual relationship with a

revised as appropriate by the Resident and facility as needs or desires change, and an approach to oversight, including 1:1 supervision provided by a third party, will be documented in the progress notes and in the care plan. If heightened supervision, provided by a third-party is not feasible to meet the desired outcome, the Community will evaluate with the Resident and/or legal representative whether exploring alternative placement is warranted. How identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? For residents whose needs or desires change, and in collaboration with the residents and/or their legal representative and facility, an approach to oversight, as desired, including 1:1 supervision provided by a third party, will be documented in the progress notes and in the care plan. If heightened supervision, provided by a third-party is not feasible to meet the desired outcome, the Community will evaluate with the Resident and/or legal representative whether exploring alternative placement is warranted. What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur? For residents whose needs or desires change, and in collaboration with the residents and/or their legal representative and facility, an approach to oversight, as desired, including 1:1 supervision provided by a third party, will be documented in the progress notes and in the care

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OMB NO. 0938-0391

male resident [Resident D] in memory care of similar cognitive capacity. Writer advised of incidents of consensual physical contact ...in each observed incident resident verbalized consent and did not wish to leave the male resident. Provided education and reassurance regarding sexual expressions for residents [Resident C and D] with cognitive deficits in memory care. Discussion included dialogue on consent, dignity, and resident rights. Legal representative verbalized gratitude for the information and verbalized understanding of education provided. Legal representative wishes to add behavioral health services ...and report that he will pick up consent forms tomorrow.

Resident C's record lacked documentation that her service plan was updated regarding the sexual relationship with Resident D.

During an interview on 8/15/24 at 1:15 p.m. Resident C's family member indicated he was not okay with Resident C having a relationship with another male resident, Resident D. He received a phone call on 5/29/24 indicating Resident C was having sex with another male resident in the bathroom. After he received the phone call, he phoned the ED and left her a

plan. If heightened supervision, provided by a third-party is not feasible to meet the desired outcome, the Community will evaluate with the Resident and/or legal representative whether exploring alternative placement is warranted. How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? For residents whose needs or desires change, and in collaboration with the residents and/or their legal representative and facility, an approach to oversight, as desired, including 1:1 supervision provided by a third party, will be documented in the progress notes and in the care plan. If heightened supervision, provided by a third-party is not feasible to meet the desired outcome, the Community will evaluate with the Resident and/or legal representative whether exploring alternative placement is warranted. The Health and Wellness Director, or , will review care plans monthly, for six months, for adherence to the desired plan as determined by the Resident and/or Legal Representative and Facility. If there is a requested update to the desired plan, such as removing 1:1 supervision or exploring alternative placement, the nurse will update the care plan as warranted. By what date be completed? 9/30/2024

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voicemail message. The ED and three of Resident C's immediate family met. He was told that Resident C could consent for herself and there was nothing he can do because she was a consenting adult. He indicated the Health Wellness Director (HWD) indicated she could not keep them separated and that this relationship for good for Resident C because the resident was lonely. He told the ED that he wanted the two residents to be separated and not to be in each other's apartments. Resident D was interfering with Resident C's family visits. Resident D came over and took Resident C's hand and told her visiting was done during a recent visit with another family member.

On 8/15/24 at 11:29 a.m., a record review was completed for Resident D. He had the following diagnoses which included but were not limited to vascular dementia moderate with agitation, insomnia, unspecified dementia with other behavioral disturbance and essential HTN.

Resident D's record lacked documentation that his service plan was updated regarding the sexual relationship with Resident C.

During an interview on 8/15/24 at 1:04 p.m., Resident D's family

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member indicated she was only aware of the relationship with Resident D and Resident C because she saw Resident C undressing in his room. She indicated she went and got staff to report the incident and staff would pull her away from Resident D. She was never consulted regarding the relationship.

During an interview on 8/15/24 at 12:22 p.m., the ED indicated that Resident C and D could be together if they wanted to. They were consenting adults. The two residents had dementia with severe cognitive impairment and did not have the ability to consent.

On 8/15/24 at 1:35 p.m., the ED indicated the staff would re-direct the two residents whenever they were seen together. She indicated she did not receive consents for the two residents to be in a relationship together.

A policy titled, "Sexual Expression by Residents," dated 7/7/23, was provide by the HWD on 8/15/24 at 1:49 p.m. It indicated, "...The community will recognize and support residents' right to engage in sexual activity, so long as there is consent among those involved. Consent may be demonstrated by words and/or affirmative actions of residents

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...."

A policy titled, "Resident Service Plan," dated 1/16/24, was provided by the HWD on 8/15/24 at 1:49 p.m. It indicated, "...A service plan addressing the individualized needs of the residents will be developed during the initial assessment and completed for each resident before nursing services are initiated, per applicable law. Reassessments will allow the community to verify that it can continue to meet the needs of the resident or that a discussion with the resident and appropriate parties regarding any concerns is warranted"

This citation relates to Complaint IN00439605.

Based on interview and record review, the facility failed to keep cognitively impaired residents separated from each other, as female family members desired. This had the potential to affect 2 of 11 resident residing on the memory care unit (Resident C and D).

Findings include:

On 8/15/24 at 10:56 a.m., a record review was completed for Resident C. She had the following diagnoses which included but were not limited to essential hypertension (HTN), major depressive disorder, Alzheimer's disease with late

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onset, and osteoarthritis.

A progress note dated 5/30/24 at 5:15 p.m., indicated, "...Executive Director (ED) placed call to legal representative to discuss resident's platonic and sexual consensual relationship with a male resident [Resident D] in memory care of similar cognitive capacity. Writer advised of incidents of consensual physical contact ...in each observed incident resident verbalized consent and did not wish to leave the male resident. Provided education and reassurance regarding sexual expressions for residents [Resident C and D] with cognitive deficits in memory care. Discussion included dialogue on consent, dignity, and resident rights. Legal representative verbalized gratitude for the information and verbalized understanding of education provided. Legal representative wishes to add behavioral health services ...and report that he will pick up consent forms tomorrow.

Resident C's record lacked documentation that her service plan was updated regarding the sexual relationship with Resident D.

During an interview on 8/15/24 at 1:15 p.m. Resident C's family member indicated he was not

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okay with Resident C having a relationship with another male resident, Resident D. He received a phone call on 5/29/24 indicating Resident C was having sex with another male resident in the bathroom. After he received the phone call, he phoned the ED and left her a voicemail message. The ED and three of Resident C's immediate family met. He was told that Resident C could consent for herself and there was nothing he can do because she was a consenting adult. He indicated the Health Wellness Director (HWD) indicated she could not keep them separated and that this relationship for good for Resident C because the resident was lonely. He told the ED that he wanted the two residents to be separated and not to be in each other's apartments. Resident D was interfering with Resident C's family visits. Resident D came over and took Resident C's hand and told her visiting was done during a recent visit with another family member.			
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Resident D's record lacked documentation that his service plan was updated regarding the sexual relationship with Resident C.

During an interview on 8/15/24 at 1:04 p.m., Resident D's family member indicated she was only aware of the relationship with Resident D and Resident C because she saw Resident C undressing in his room. She indicated she went and got staff to report the incident and staff would pull her away from Resident D. She was never consulted regarding the relationship.

During an interview on 8/15/24 at 12:22 p.m., the ED indicated that Resident C and D could be together if they wanted to. They were consenting adults. The two residents had dementia with severe cognitive impairment and did not have the ability to consent.

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re-direct the two residents whenever they were seen together. She indicated she did not receive consents for the two residents to be in a relationship together.

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A policy titled, "Resident Service Plan," dated 1/16/24, was provided by the HWD on 8/15/24 at 1:49 p.m. It indicated, "...A service plan addressing the individualized needs of the residents will be developed during the initial assessment and completed for each resident before nursing services are initiated, per applicable law. Reassessments will allow the community to verify that it can continue to meet the needs of the resident or that a discussion with the resident and appropriate parties regarding any concerns is warranted"

This citation relates to Complaint IN00439605.

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

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