STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155636	A. BUILDING _____ B. WING _____	C 09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON TERRACE	**1924 WELLESLEY BLVD INDIANAPOLIS, IN 46219**

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F 000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00389336. This visit resulted in a Partially Extended Survey-Substandard Quality of Care - Immediate Jeopardy. Complaint IN00389336 - Substantiated. Federal/state deficiencies related to the allegations are cited at F600. Survey dates: September 7 and 8, 2022 Facility number: 000241 Provider number: 155636 AIM number: 100291310 Census Bed Type: SNF/NF: 64 Total: 64 Census Payor Type: Medicare: 2 Medicaid: 49 Other: 13 Total: 64 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 13, 2022	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This	F 600		

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

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F 600	Continued From page 1 includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure resident to resident sexual abuse did not occur with a resident who had a history of making inappropriate comments and gestures towards staff (Resident B). Interventions were not implemented per the plan of care and after a room move post an unusual occurrence involving Resident B and Resident C that later resulted in a resident, (Resident C), having his private parts touched by another resident, (Resident B). The Past Noncompliance Immediate Jeopardy began on 8/26/22. The Facility Administrator, Director of Nursing Service's and the Regional Director of Clinical Service's were notified of the Immediate Jeopardy on September 7, 2022 at 5:04 P.M. The Immediate Jeopardy was removed and corrected on 8/30/22, before entrance into the facility, when the facility completed staff training on abuse and resident identification labels for room changes, following resident-specific behavior care plans, keeping residents separated that are not to be near one another, and ensure staff are acclimated to the unit/assignment they are working if not familiar with the assignment. The correction date was prior to the start of the survey and was therefore	F 600	Past noncompliance: no plan of correction required.	

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Past Noncompliance.

Findings include:

1a. The clinical record for Resident B was reviewed on 9/7/22 at 1:30 p.m. The diagnoses included, but were not limited to, dementia with behavioral disturbance, diabetes mellitus, congestive heart failure, cognitive communication deficit, atrial fibrillation, anxiety disorder, major depressive disorder, and insomnia.

A Quarterly Minimum Data Set (MDS) assessment, dated 8/1/22, noted Resident B with moderate cognitive impairment.

A care plan, dated 5/28/21, was in place for Resident B's history of making sexual comments towards female staff at times. Resident B may also inappropriately touch staff members at times, especially during care interactions. This appeared to exceed during periods of isolation. An approach was to offer to assist resident with calling his wife during the times he was experiencing "sexual expressions".

A care plan, dated 7/13/21, was in place for Resident B's history of public masturbation at previous facility he resided at. He continued to prefer to masturbate while in his room.

A preference care plan, dated 8/30/21, was in place for Resident B's preference to sleep in the nude.

A care plan, dated 8/26/22, indicated the following, "...Resident may at times attempt to assist roommate when he perceives roommate needing help aeb [as evidenced by] roommate

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moaning or yelling out. Res [Resident] has contributing dx [diagnosis] of dementia and may forget at times to ask staff for assistance when needed for him or peer. This puts res at risk for peer to peer incidents...Approach...increased supervision as needed...room move occurred to allow res more privacy and less worry about roommate's condition...."

A psychiatric progress note, dated 8/31/22, noted a "Mental Status Examination" that indicated the following for Resident B, "...Alert and oriented x2...oriented to person and situation...THOUGHTS: Disorganized at times...MEMORY: Immediate memory is poor. Recent memory and remote memory, depending on what you talk about, are normal...IMMEDIATE: He is unable to perform digit recall...INSIGHT/JUDGEMENT: His insight & judgement is obviously poor because he just does not anticipate any consequences whatsoever...."

A progress note, dated 8/23/22 at 2:13 p.m., indicated Resident B was sitting in the doorway with no clothing on and asking staff for sexual favors.

A progress note, dated 8/25/22 at 1:38 p.m., indicated Resident B was attempting to touch female activity staff twice.

A progress note, dated 8/25/22 at 1:45 p.m., indicated Resident B grabbed a female staff member breast. Resident B apologized and stated he was just kidding.

1b. The clinical record for Resident C was reviewed on 9/7/22 at 1:45 p.m. The diagnoses

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included, but were not limited to, dementia with behavioral disturbance, cognitive communication deficit, anxiety disorder, cerebral infarction, repeated falls, lack of coordination, insomnia, mood disorder, history of traumatic brain injury, and hallucinations.

A Quarterly MDS assessment, dated 8/2/22, noted Resident C with severe cognitive impairment.

A physician note, dated 5/3/22, indicated the following, "...Physical Exam...Psychiatric...Insight: poor insight...Mental Status: confused, anxious, agitated, and abnormal affect. Orientation: not oriented to time, place, and person. Memory: recent memory abnormal and remote memory abnormal...."

The investigative file was reviewed for an incident involving Resident B and Resident C on 8/26/22 at 12:20 p.m. It indicated Personal Care Assistant (PCA) 10 observed Resident B "standing up, naked from his wheelchair", next to Resident C's bed with his arm above Resident C's body, but not touching him. The Interdisciplinary Team (IDT) determined the root cause was Resident B was checking on roommate but was not dressed appropriately. Intervention put in place was for Resident C to move back into his original room since his isolation period was complete, place Resident B on 15-minute checks, signed Resident B for counseling services to create social boundaries, and STAT (right away) lab work to be completed.

An interview conducted with PCA 10, on 9/7/22 at 1:13 p.m., indicated she was working day shift on 8/26/22 with Resident B and Resident C. She

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walked into the room and observed Resident B over Resident C. Resident C's brief was "pulled over" and looked different from when she observed him previously. She wasn't sure what Resident B was doing and proceeded to call his name and Resident B pulled away from Resident C in his wheelchair. There was no physical contact. Resident B's hand was over Resident C's abdomen/hip area while Resident C was asleep. PCA 10 was told that Resident C was supposed to be put in another room but was still in their wheelchair in the dining room when she completed her shift at 2:00 p.m.

The clinical record noted Resident C was moved to another room on 8/26/22 at 5:28 p.m.

Another incident reported to the Indiana State Department of Health Survey Report System, dated 8/26/22 at 9:15 p.m., indicated staff entered Resident B's room and observed Resident B making inappropriate contact with Resident C.

A written statement, dated 8/26/22 at 9:25 p.m., was written by Certified Nursing Assistant (CNA) 12. The statement indicated the following, "...I came out of a patients room after providing care and saw [Resident B's room number] call light on. I went to go get the call light and I saw [name of Resident B] touching [name of Resident C's] penis. I asked [name of Resident B] what was he doing, he replied that he [Resident C] was gurgling and got up to help him."

An interview conducted with CNA 12, on 9/7/22 at 1:01 p.m., indicated she went to answer the call light that was on in Resident B's room and observed Resident B physically touching Resident C's private area. CNA 12 asked

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Resident B what he was doing, and he responded that Resident C was choking, and he wanted to check on him. Resident B then proceeded to masturbate there in the room naked. Resident C was still residing in the room with Resident B at the time of the incident. Resident C went into a room across the hallway after the incident but was in the room with Resident B while she was on shift from 6:00 p.m. until the incident occurred. CNA 12 commented on how she was not usually scheduled to work on the unit where Resident B and Resident C reside, and she wasn't sure what a normal behavior was over on that unit.

Resident C was located inside Resident B's room during the time CNA 12 was on shift from 6:00 p.m. until the incident occurred involving Resident B touching Resident C's private area at 9:15 p.m.

Resident B neither Resident C had an assessment completed for their capacity to consent to sexual interactions

An interview conducted with the Executive Director (ED), on 9/7/22 at 3:25 p.m., indicated there was education conducted on abuse and room moves. The staff moved Resident C back to his original room due to his isolation period being completed for COVID-19. The only item that wasn't done was the nametag off of Resident C's door from when he was in the room with Resident B.

The policy titled "Abuse Prohibition, Reporting, and Investigation", revised February 2020, was provided by the Executive Director (ED) on 9/7/22 at 12:08 p.m. The policy indicated the following, "...to provide each resident with an environment that is free from abuse, neglect, misappropriation

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of resident property, and exploitation. This includes but is not limited to verbal abuse, sexual abuse, physical abuse, mental abuse, corporal punishment, and involuntary seclusion...Sexual Abuse- Nonconsensual sexual contact of any type. Examples may include but not be limited to fondling, touching, rubbing, exposing, licking, kissing, gestures, sharing pornography, assault, rape, harassment, seduction, coercion, photographing a resident's rectal, genital, or breast areas, and/or exhibitionism...Investigation...Resident to Resident abuse...2. Staff member(s) will maintain the resident initiating the abuse under direct supervision until the initial investigation is complete and resident safety is maintained...c. Room changes may be necessary if residents are roommates...."

The Past Noncompliance Immediate Jeopardy began on 8/26/22. The Immediate Jeopardy was removed and corrected on 8/30/22, before entrance into the facility, when the facility completed staff training on abuse and resident identification labels for room changes, following resident-specific behavior care plans, keeping residents separated that are not to be near one another, and ensure staff are acclimated to the unit/assignment they are working if not familiar with the assignment. The correction date was prior to the start of the survey and was therefore Past Noncompliance.

This Federal Tag relates to Complaint IN00389336.

3.1-27(a)(1)