STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155780	A. BUILDING 00 B. WING	02/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HOMESTEAD HEALTHCARE CENTER	7465 MADISON AVE INDIANAPOLIS, IN 46227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00372277, IN00372387, IN00373289, and IN00372425. This visit resulted in a Partially Extended Survey- Substandard Quality of Care-Immediate Jeopardy. Complaint IN00373289- Substantiated. Federal/State deficiencies related to the allegations are cited at F684 and F558. Complaint IN00372277. - Substantiated. Federal/State deficiencies related to the allegations are cited at F600, F609, F610, F580, F656, F657, F689, F726, F742, F745, and F835. Complaint IN00372387. Substantiated. Federal/State deficiencies related to the allegations are cited at F690, F641, F558, and F684. Complaint IN00372425 - Substantiated. Federal/State deficiencies related to the allegations are cited at F684, F656, F558, F600, F609, and F610. Survey dates: February 2, 7, 8, 9, 10, 11, 14, 15, and 16, 2022 Facility number: 012225 Provider number: 155780 AIM number: 200983560 Census Bed Type: SNF/NF: 103 Total: 103 Census Payor Type: Medicare: 6	F 0000	***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.***	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Medicaid: 73 Other: 24 Total: 103 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 24, 2022.			
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Based on interview and record review, the facility failed to ensure a resident had a means of mobility in relationship to their diagnoses of morbid obesity and fracture of the left lower leg for 1 of 2 residents reviewed for accommodation of needs. (Resident H) Finding includes: The clinical record for Resident H was reviewed on 2/7/22 at 2:40 p.m. An Admission MDS (Minimum Data Set) assessment, dated 12/18/21, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, morbid obesity, fracture of left lower leg, and chronic lymphedema with healing. A review of Resident H's MDS assessment, dated 12/24/21, indicated the resident required a wheelchair. There was no mention of the residents need for a bariatric wheelchair due to	F 0558	**1) Immediate actions taken for those residents identified:** Resident H was not harmed by the alleged deficient practice. Resident H was interviewed by the surveyor and it was determined that she had a proper and accessible wheelchair for transportation and mobility. Resident H also acknowledged that she was able to attend her appointments in her wheelchair via the facility van without difficulties. The ED/DON have interviewed resident H who confirmed to them that her current wheelchair meets her needs and she has not missed any appointments since she received this wheelchair. The MDS assessment does not require assessment of need for a bariatric wheelchair versus a	03/25/2022

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	size and comfort. A review of Resident H's care plan, dated 12/18/22, indicated Resident H's weight was document to be 445 pounds and would require a bariatric wheelchair and/ or a bariatric stretcher for mobilization and the ability to get to appointments. During an interview with the DON, on 2/14/22 at 1:15 p.m., she indicated she had made several attempts to get a bariatric stretcher for Resident H. The DON indicated Resident H was only able to use one type of transportation company. As of January 12, Resident H had been able to attend scheduled appointments with a "larger" wheelchair and transportation via the facility van. During an interview with Resident H, on 2/15/22 at 2:50 p.m., Resident H indicated her new wheelchair was comfortable and she had been able to make it to her appointments. This Federal tag relates to Complaints IN00372425, IN00373289, and IN00372387. 3.1-3(v)(1)		standard wheelchair; the MDS requires documentation of what assistive device is utilized for mobility such as a wheelchair or a walker. **2) How the facility identified other residents:** All residents who require wheelchairs have the potential to be affected by the alleged deficient practice. All residents requiring a wheelchair will have an audit conducted to ensure that each resident has a means of mobility and that they are able to attend appointments without difficulty related to their transportation method. **3) Measures put into place/System changes:** The Director of Nursing/Designee will in-service nursing staff on continuing to ensure that appointments are made and proper equipment is provided prior to resident's appointments so that the residents can safely attend appointments. **4) How the corrective actions will be monitored:** The DON/Designee will audit all admissions to ensure that each resident has the appropriate means for mobility based upon their assessed condition. This is an ongoing facility practice. The DON/designee will audit 3	

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			residents' transportation arrangements 3 times a week x 4 weeks and 3 residents' records 1 time weekly thereafter for 5 months to ensure that transportation is arranged with proper equipment on hand before appointments. Audits/observation will be conducted randomly, across all 3 shifts, and will include weekends. DON/Designee is responsible for the compliance. The results of these audits will be reviewed in Quality Assurance Committee monthly meetings for 6 months or until 100% compliance is achieved x 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);			

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	(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on interview and record review, the facility failed to notify the physician for a male resident that had been drinking alcohol in the facility which resulted in behavioral symptoms of	F 0580	**1) Immediate actions taken for those residents identified:** Resident B no longer resides in the facility. The physician was	03/25/2022

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	physical, sexual, and verbal abuse toward female residents for 1 of 3 residents reviewed for notification. (Resident B, Resident D, Resident E) Finding includes: During an interview on 2/7/22 at 9:00 a.m., QMA 3 indicated on 1/28/22 Resident B had been drinking out of a cup that smelled like alcohol. The resident could be verbally aggressive when he had been drinking alcohol. Resident B threatened to rape Resident D several times on 2/1/22. The QMA had overheard other staff discussing this at the nurse's station. The QMA was not sure if this had been reported but indicated the threats should have been reported to the supervisor. The QMA was unable to remember which staff members she heard discussing this at the nurse's station. During an interview on 2/7/22 at 9:50 a.m., Resident E indicated when Resident B got drunk, he would get violent. There was a day, the week before last, Resident B got out of his wheelchair and in her face and said, "you f**king b*tch, I'll knock you out of that wheelchair." Resident E told a member of the resident council and he said he would take care of it. The clinical record for Resident B was reviewed on 2/2/22 at 12:30 p.m. The diagnoses included, but were not limited to, major depressive disorder and alcohol abuse. The Quarterly Minimum Data Set (MDS) assessment, dated 1/12/22, indicated Resident B was cognitively intact, required extensive assistance of one staff member for bed mobility and transfers, and had moderate depression. The clinical record lacked physician notification of		notified of resident B's alcohol consumption upon the facility becoming aware of the information through investigation. **2) How the facility identified other residents:** Any resident residing in the facility who consumes alcohol without a physician's order has the potential to be affected by the alleged deficient practice. An audit was conducted on all residents who have a history of alcohol use and the physician and family were notified of any findings. If justified, the resident's plan of care was updated accordingly, a behavior contract was initiated, and alcohol counseling was offered. If a resident consumes alcohol without a physician's order, the physician and family will be or were notified and behavior modifications implemented, if warranted. **3) Measures put into place/System changes:** The DON/Designee in-serviced all nursing staff on the facility's existing policy identified as "Change in Condition" with emphasis on notification made to immediate Supervisor/MD/POA with any change of condition/behavior/alcohol consumption, including the expectation that staff would adhere to the exiting policy and that failure to do so will result in	

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	Resident B's alcohol use in the facility. During an interview on 2/9/22 at 2:35 p.m., the Director of Nursing indicated the physician should have been notified of Resident B's alcohol consumption and behaviors. On 2/7/22 at 11:00 a.m., the Director of Nursing provided a copy of a facility policy, titled "Physician Notification for Change in Condition Reporting," dated 8/1/16, and indicated this was the current policy used by the facility. A review of the policy indicated "Unless there are documented extenuating circumstances, the nurse will report immediately...new or worsening behavioral symptoms." This Federal tag relates to Complaint IN00372277. 3.1-5(a)(2)		consequences in accordance with the facility's progressive discipline policy. **4) How the corrective actions will be monitored:** Behaviors and/or change of condition will be reviewed by the Interdisciplinary Team and/or designee in the clinical morning meeting to ensure each resident's change of condition is reported to physician /psych services /family member/DON. This is an ongoing facility practice that will continue. DON/designee will audit 3 residents' records 3 times a week x 4 weeks, then 3 residents' records 1 time weekly thereafter for 5 months to ensure behavior monitoring orders are in place and care plans are updated. DON/Designee will interview 5 random staff members 5 times a week for 4 weeks and then 3 staff members for 4 weeks and then 1 staff member a week to ensure compliance and accurate reporting. Audits/observation will be conducted randomly, across all 3 shifts, and will include weekends. The DON/Designee is responsible for compliance. The results of these audits will be reviewed in the Quality Assurance Committee monthly meetings for 6 months or until 100% compliance is achieved x 3 consecutive months. The QA Committee will identify any trends or patterns and	

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			make recommendations to revise the plan(s) of correction as indicated.	
F 0600 SS=K Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §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 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; A. Based on observation, interview and record review, the facility failed to prevent sexual and physical (death) abuse resulting in a female resident being physically and sexually abused by a male resident for 2 of 4 residents reviewed for abuse. (Residents C, Resident B) B. Based on interview and record review, the facility failed to prevent verbal abuse resulting in 2 female residents being threatened with physical and sexual abuse by a male resident that was not Immediate Jeopardy for 3 of 4 residents reviewed for abuse. (Residents D, Resident B, Resident E) This deficient practice resulted in an Immediate Jeopardy. The Immediate Jeopardy began on, 2/2/22 at approximately 5:00 a.m., when the facility failed to prevent physical (death) and sexual	F 0600	1. The facility failed to prevent sexual, physical (death) and verbal abuse for 3 of 4 residents reviewed for abuse. A female resident was found with a male a resident on top of her with his pants off and her legs spread and brief pulled to the side. The male resident was holding a pillow over her head. The female resident was deceased. A complete head to toe assessment was completed for any other affected residents. Any findings were reported to the physician and family. · Immediately separated the residents and the licensed nurse evaluated the residents.	03/25/2022

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	abuse. The Administrator, Administrator in Training, Director of Nursing, and the Regional Director of Nursing were notified of the Immediate Jeopardy on 2/7/22 at 5:00 p.m. The Immediate Jeopardy was removed on 2/10/22 at 2:40 p.m., but noncompliance remained at the lower scope and severity level of pattern, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. Findings include: A. During the initial tour of the facility, on 2/2/22 from 11:40 a.m. to 12:15 p.m., Resident C was in her room with Police Officers standing guard at the door. Resident C could not be observed from the hallway. Resident B was in his room, located on a different unit in the facility, with a Police Officer standing guard at the door to the room. Resident B was observed sitting up in his electric wheelchair staring at the hallway with a flat affect (showing no emotion on his face). The clinical record for Resident B was reviewed on 2/2/22 at 12:30 p.m.. The diagnoses included, but were not limited to, major depressive disorder and alcohol abuse. The Quarterly Minimum Data Set (MDS) assessment, dated 1/12/22, indicated Resident B was cognitively intact, required extensive assistance of one staff member for bed mobility and transfers, and had moderate depression. The current physician's order, indicated Resident B could have alcoholic beverages, with a start date of 10/8/21. The clinical record for Resident C was reviewed on 2/2/22 at 12:15 p.m. The diagnoses included, but were not limited to, acute and chronic		· The male resident was immediately placed on 1:1 supervision in his room. · The female resident was noted to be without pulse or respirations and DNR advanced directives were validated. · The DON was notified of incident and IMPD notified. · Staff in the building validated that all other residents were secure and accounted for-noted no other concerns, residents safe and secure. · IMPD assumed responsibility for the male resident and continued 1:1 throughout day until departure with detectives. · Medical Director was notified of the event. · Marion County Coroner and Detectives are at the facility directing the investigation. · Self-report Incident submitted to ISDH gateway. · Call placed to Area Supervisor and discussed event. · The female resident's body was released to the Coroner. · In-service initiated on existing facility policy for Abuse prevention, investigation, and reporting, behavior monitoring, sexual behavior monitoring including reinforcing the expectation that facility policy would be followed and reminding staff of the consequences of failing to follow this policy. · Residents educated again	

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	respiratory failure, morbid obesity, congestive heart failure, and obstructive sleep apnea. An Admission Initial Evaluation, dated 1/28/22 at 3:15 p.m., indicated Resident C was nonverbal, bedfast (confined to bed), and mobility was very limited (she made occasional slight changes in body or extremity position but unable to make frequent or significant changes independently). During an interview on 2/3/22 at 5:10 p.m., QMA (Qualified Medication Aide) 1 indicated she entered Resident C's room and Resident B was lying on top of Resident C, in bed, with his pants down. Resident C's face was covered with Resident B's hand. Resident B jumped off of Resident C and left the room. QMA 1 removed a pillow from Resident C's face. Resident C was without clothing, had a small scratch to her left leg, and her incontinence brief was pulled to the side. During an interview on 2/7/22 at 10:20 a.m., LPN (Licensed Practical Nurse) 2 indicated on 2/2/22 at approximately 5:00 a.m., he was at the nurse's station for the 100 and 200 Hall. QMA 1 had come to the nurse's station and was unable to verbalize what she saw. QMA 1 grabbed his hand and said, "come on, come on." When he entered Resident C's room, he saw Resident B standing approximately a foot away from Resident C's bed with his pants down to his ankles. The resident's electric wheelchair was inside the room, approximately a foot behind him. Resident B was trying to sit in the wheelchair but was unsteady and confused when trying to speak to the nurse. The nurse smelled alcohol when Resident B was trying to speak. There was a large bottle of dry gin on the floor. Resident B was escorted out of Resident C's room and immediately placed on		on reporting abuse to facility staff and staff's commitment to act upon any such report. SSD is following up with any affected resident and notifying psychologist, physician, and family for additional support. Care plans updated as needed. 2. All other residents had the potential to be affected. Abuse interviews were completed with all alert and oriented residents to identify any concerns. Residents who could not be interviewed underwent a head to toe skin assessment with no findings. All staff were interviewed to determine if they were aware of any allegations that may constitute abuse. Any findings were reported to ISDH and other reporting agencies. Families and physicians have been notified. SSD is following up with any affected resident and notifying psychologist, physician, and family for additional support. Care plans updated as needed. Behavior monitoring of all residents was reviewed to identify any increased behaviors or behaviors requiring physician notification or nursing intervention. Through resident and staff interviews behaviors were reviewed to identify any behavior that constitutes abuse or requires follow-up. Any concerns were immediately addressed to the	

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	one-on-one supervision with another staff member. Resident C was lying in bed, on her back, with legs spread apart and her face looking at the ceiling. Resident C did not have a pulse, but her body was warm to touch. During an interview on 2/3/22 at 5:24 p.m., CNA (Certified Nursing Assistant) 1 indicated, on 2/2/22, when she entered Resident C's room the resident's brief was pulled to the side. During an interview on 2/7/22 at 8:53 a.m., QMA 2 indicated Resident B seemed depressed over the past few weeks because his roommate moved out. On 2/2/22 at 2:06 p.m., Resident B was observed to be handcuffed and assisted into the back of the police van. He required minimal assistance from the police officer. Resident B stepped up into the back of the van. B.1. During an interview on 2/7/22 at 9:00 a.m., QMA 3 indicated on 1/28/22 Resident B had been drinking out of a cup that smelled like alcohol. The resident could be verbally aggressive when he had been drinking alcohol. Resident B threatened to rape Resident D several times on 2/1/22. The QMA had overheard other staff discussing this at the nurse's station. The QMA was not sure if this had been reported but indicated the threats should have been reported to the supervisor. The QMA was unable to remember which staff members she heard discussing this at the nurse's station. During an interview on 2/7/22 at 9:20 a.m., Resident D indicated on 2/1/22 at approximately 2:00 p.m., Resident B began making inappropriate sexual comments toward her. Resident B indicated to Resident D that he was going to "eat between		residents' satisfaction. 3. The facility needs to ensure abuse does not occur and that any abuse allegation is reported and investigated in accordance with existing facility policy. All allegations of abuse or a concern that may constitute abuse will be reported to the Executive Director immediately. DON/Designee educated all staff on the existing facility policy identified as, “Indiana Abuse, Neglect, and Misappropriation”, with emphasis on reporting and investigating and reinforcing the expectation this policy will be followed including discussion of the consequences of not following facility policy for both the residents and staff. In-services on the facility’s abuse prevention, investigation, and reporting policy will be conducted once a quarter. Alert and oriented residents were educated and encouraged to report any acts of abuse or reports of abuse to facility staff. All new hires will continue to receive education during their orientation on the facility’s Abuse policy, the expectation that this policy will be followed, and the consequences of not following this policy. All residents are screened prior to admission to validate appropriateness of placement, including but not limited to checking the sex offender registry. Any resident who is not	

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	my legs" and made comments about Resident D's breasts. Resident B laughed and said, "just wait until tonight, just wait until tonight." Resident B continued to make these comments several times throughout that day. Resident D reported this to QMA 4 around 11:00 p.m. on 2/1/22. At that time, QMA 4 indicated to her (Resident D) not to worry because she would watch the hall. The clinical record for Resident D was reviewed on 2/7/22 at 11:00 a.m. The diagnoses included, but were not limited to, debility, morbid obesity, and acquired absence of right and left legs above the knee. The Quarterly MDS assessment, dated 12/11/21, indicated Resident D was cognitively intact. B.2. During an interview on 2/7/22 at 9:50 a.m., Resident E indicated Resident B told her she was beautiful and offered to buy her jewelry. She said no. When he (Resident B) got drunk, he would get violent. There was a day, the week before last, Resident B got out of his wheelchair and in her face and said, "you f**king b*tch, I'll knock you out of that wheelchair." Resident E told a member of the resident council and he said he would take care of it. During an interview on 2/7/22 at 10:00 a.m., the resident council member indicated Resident B had been vulgar to female residents that didn't like him. About a week and a half ago, Resident E was afraid of Resident B because of vulgar comments he had made to her. The resident council member had reported this to staff. He was unable to remember which staff member he reported this to. The clinical record for Resident E was reviewed on 2/7/22 at 11:40 a.m. The diagnoses included, but were not limited to, morbid obesity, reduced		appropriate will be denied admission. Care plans will be implemented for any assessed behavior that has the potential to impact other residents negatively. An Ad Hoc Resident Council meeting was held and the system for reporting abuse was reviewed including but not limited to the facility's grievance process including the ability to report concerns anonymously, reporting abuse to the Executive Director or any facility staff member, and education was also provided on the reporting guidelines, investigation, and follow-up. Monthly Resident Council meetings will review any concerns related to abuse and/or behaviors. Those concerns will be reported to the Executive Director immediately and reported per facility policy. The Resident Council President was educated on the facility's abuse policy/process in the event abuse is reported directly to Resident Council President. All staff have been educated on the facility's existing policy and the expectation that when behaviors occur they are to be reported immediately to the charge nurse/DON/ED/SSD. All staff have been educated on the facility's policy on assessing challenging behaviors, resident substance abuse, and residents who are unaware of personal	

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	mobility, and debility. The Quarterly MDS assessment, dated 11/11/21, indicated Resident E was cognitively intact. On 2/7/22 at 11:00 a.m., the Director of Nursing provided a copy of a facility policy, dated 9/1/17, titled "Indiana Abuse and Neglect and Misappropriation of Property," and indicated this was the current policy used by the facility. A review of the policy indicated, "It is the intent of this facility to prevent the abuse, mistreatment or neglect of residents." The Immediate Jeopardy, that began on 2/2/22, was removed on 2/10/22 when the facility inserviced the facility staff on abuse policies and behaviors, but the noncompliance remained at the lower scope and severity of no actual harm with potential for more than minimal harm that is not Immediate Jeopardy because a systemic plan of correction had not been developed and implemented to prevent recurrence. This Federal tag relates to Complaints IN00372277 and IN00372425. 3.1-27(a)(1)		boundaries; this education included but was not limited to documentation of behaviors in the clinical record, documentation from CNA/QMA in POC on daily assigned task identified as “Any changes in my resident today”, Residents identified with behaviors, substance abuse, or personal boundary concerns will be referred to SSD, MD, and IDT to determine if there is a need for additional psychotherapy, outpatient services, temporary 1:1, substance abuse counseling, or if relocation is required. All staff and alert and oriented residents have been educated on the facility’s existing policy and process on reporting abuse, including but not limited to what constitutes abuse, when to report abuse, to whom to report abuse to, the Executive Director's phone number, and the grievance process including where to locate grievance forms. 4. The DON/SSD/Designee will interview 5 random staff members and 5 random residents weekly x 4 weeks, then 10 random staff members and 10 random residents monthly x 2 months, then 5 random staff members and 5 random residents monthly x 3 months to ensure no incidents have occurred and to ensure staff and residents are aware of reporting responsibilities. Interviews will be conducted on	

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			random days, including weekends, and all shifts. Any findings will be investigated and reported per facility policy. Monitoring residents' behaviors and potential substance abuse will be conducted by the DON/Designee Monday-Friday and the designated clinical manager Saturday and Sunday by a review of the 24-hour report, high priority progress notes, and Einteract alerts for change in condition. This is an on-going facility practice. Non-verbal residents will have a skin assessment completed no less than weekly and any changes in skin conditions including but not limited to bruising and discoloration will be reported immediately to the DON. This is an on-going facility practice. The DON/ Designee will report the findings of the interviews to the QA Committee monthly and the QA Committee will determine how best to conduct ongoing monitoring so that facility policy is implemented and followed and to reinforce the facility's commitment to abuse prevention investigation, and reporting and to ensure the staff is aware of the potential consequences for both residents and staff for failing to follow the facility's policies.	

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F 0609 SS=K Bldg. 00	483.12(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on observation, interview, and record review, the facility failed to report allegations of sexual abuse for 3 of 4 residents reviewed for abuse (Residents B, Resident D, Resident E) this resulted in a female resident being physically (death) and sexually abused by a male resident. (Resident C, Resident B)	F 0609	**1.** The facility failed to report allegations of sexual abuse (vocalized sexual actions) by a male resident to female residents residing in the facility. Due to lack of reporting of prior sexual actions, the a female resident was found	03/25/2022

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	This deficient practice resulted in an Immediate Jeopardy. The Immediate Jeopardy began on, 2/1/22 at approximately 2:00 p.m., when the facility failed to report prior sexual actions of a resident which resulted in a female resident being sexually and physically (death) assaulted. The Administrator, Administrator in Training, Director of Nursing, and the Regional Director of Nursing were notified of the Immediate Jeopardy on 2/7/22 at 5:00 p.m. The Immediate Jeopardy was removed on 2/10/22 at 2:40 p.m., but noncompliance remained at a lower scope and severity level of pattern, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. Findings include: 1. During an interview on 2/7/22 at 9:00 a.m., QMA 3 indicated Resident B threatened to rape Resident D several times on 2/1/22. The QMA had overheard other staff discussing this at the nurse's station on 2/1/22. The QMA was not sure if this had been reported but indicated the threats should have been reported to the supervisor. The QMA was unable to remember which staff members she heard discussing this at the nurse's station. During an interview on 2/7/22 at 9:20 a.m., Resident D indicated on 2/1/22 at approximately 2:00 p.m., Resident B began making inappropriate sexual comments toward her. Resident B indicated to Resident D that he was going to "eat between my legs" and made comments about Resident D's breasts. Resident B laughed and said, "just wait until tonight, just wait until tonight." Resident B continued to make these comments several times throughout that day. Resident D reported this to QMA 4 around 11:00 p.m. on 2/1/22. At that time,		with the male resident on top of her with his pants off and the female resident had her legs spread with brief pushed to the side The male resident was holding a pillow over the female residents face and she was deceased. The Q.M.A. that failed to report an allegation of abuse is no longer employed with the company. The facility staff took the following actions: · Immediately separated the residents and the licensed nurse evaluated the residents. · The male resident was immediately placed on 1:1 supervision in his room. · The female residents was noted to be without pulse or respirations and DNR advanced directives were validated. · The DON was notified of incident and IMPD notified. · Staff in the building validated that all other residents were secure and accounted for-noted no other concerns, residents safe and secure. · IMPD assumed responsibility for the male resident and continued 1:1 throughout day until departure with detectives. · Medical Director was notified of the event. · Marion County Coroner and Detectives are at the facility directing the investigation. · Self-report Incident	

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	QMA 4 had indicated to her (Resident D) not to worry because she would watch the hall. The clinical record for Resident D was reviewed on 2/7/22 at 11:00 a.m. The diagnoses included, but were not limited to, debility, morbid obesity, and acquired absence of right and left legs above the knee. The Quarterly MDS (Minimum Data Set) assessment, dated 12/11/21, indicated Resident D was cognitively intact. 2. During an interview on 2/7/22 at 9:50 a.m., Resident E indicated there was a day, the week before last, Resident B got out of his wheelchair and in her face and said, "you f**king b*tch, I'll knock you out of that wheelchair." She didn't think staff saw this happen and had not reported this to staff. Resident E told a member of the resident council about the incident with Resident B, and he said he would take care of it. During an interview on 2/7/22 at 10:00 a.m., the resident council member indicated Resident B had been vulgar to female residents that didn't like him. About a week and a half ago, Resident E was afraid of Resident B because of vulgar comments he had made to her. The resident council member had reported this to staff. He was unable to remember which staff member he reported this to. The clinical record for Resident E was reviewed on 2/7/22 at 11:40 a.m. The diagnoses included, but were not limited to, morbid obesity, reduced mobility, and debility. The Quarterly MDS assessment, dated 11/11/21, indicated Resident E was cognitively intact. 3. During the initial tour of the facility, on 2/2/22 from 11:40 a.m. to 12:15 p.m., Resident C was in her room with Police Officers standing guard at the		submitted to ISDH gateway. · Call placed to Area Supervisor and discussed event. · The female resident's body was released to the Coroner. · In-service initiated on existing facility policy for Abuse prevention, investigation, and reporting, behavior monitoring, sexual behavior monitoring including reinforcing the expectation that facility policy would be followed and reminding staff of the consequences to both residents and staff of failing to follow this policy. · Residents educated again on reporting abuse to facility staff and staff's commitment to act upon any such report. **2.** All other residents had the potential to be affected. Abuse interviews were initiated with all alert and oriented residents to identify any concerns. Residents who could not be interviewed had a head to toe skin assessment completed and there were no findings. SSD is following up with any affected resident by notifying psychologist, physician, and family for additional support. Care plans have been revised where appropriate. All staff have been interviewed to identify any potential events or incidents that may constitute abuse and any events have been reported to the ISDH and all other reporting entities.	

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	door. Resident C could not be observed from the hallway. Resident B was in his room, located on a different unit in the facility, with a Police Officer standing guard at the door to the room. During an interview on 2/3/22 at 5:10 p.m., QMA (Qualified Medication Aide) 1 indicated, on 2/2/22 at approximately 5:00 a.m., she entered Resident C's room and Resident B was on top of Resident C, in bed, with his pants down. Resident C's face was covered with Resident B's hand. Resident B jumped off of Resident C and left the room. Resident C was naked, had a small scratch to her left leg, and her incontinence brief was pulled to the side. Resident C's pupils were dilated and she was found to be deceased. On 2/7/22 at 11:00 a.m., the Director of Nursing provided a copy of a facility policy, dated 9/1/17, titled "Indiana Abuse and Neglect and Misappropriation of Property," and indicated this was the current policy used by the facility. A review of the policy indicated, "Each occurrence ... of alleged abuse ... will be identified and reported to the supervisor and investigated timely. The supervisor or designee will notify the Director of Nursing and Executive Director of the incident or allegation immediately" The Immediate Jeopardy, that began on 2/1/22, was removed on 2/10/22 when the facility inserviced the staff on reporting abuse, but the noncompliance remained at the lower scope and severity of no actual harm with potential for more than minimal harm that is not Immediate Jeopardy because a systemic plan of correction had not been developed and implemented to prevent recurrence.		**3**. The facility must ensure all allegations of abuse are reported and investigated per the facility's policy to protect the residents. DON/Designee educated all staff on the facility's existing policy identified as, "Indiana Abuse, Neglect, and Misappropriation", with emphasis on reporting to the Executive Director and Director of Nursing and reinforcing the expectation this policy will be followed including a discussion of the consequences of not following facility policy for both the residents and staff. In-services on the facility's abuse prevention, investigation, and reporting policy will be conducted once a quarter. Alert and oriented residents were educated and encouraged to report any acts of abuse or reports of abuse to facility staff. All new hires will continue to receive education on the facility's Abuse policy in orientation, the expectation that this policy will be followed, and the consequences to both residents and staff of not following this policy during their orientation. An Ad Hoc Resident Council meeting was held and the system for reporting abuse was reviewed including but was not limited to the facility's grievance process including the ability to report concerns anonymously, reporting abuse to the Executive Director or	

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	This Federal tag relates to Complaints IN00372277 and IN00372425. 3.1-28(c)		any facility staff member. In addition, education was provided on the reporting guidelines, investigation, and follow-up. Any concerns related to abuse or behaviors which made at the monthly Resident Council meetings will be reported to the Executive Director immediately and investigated per facility policy. The Resident Council President has been educated on the facility's abuse policy/process in the event abuse is reported directly to the President. **4.** The DON/SSD/Designee will interview 5 random staff members and 5 random residents weekly x 4 weeks, then 10 random staff members and 10 random residents monthly x 2 months, then 5 random staff members and 5 random residents monthly x 3 months to ensure no incidents have occurred and to ensure staff and residents are aware of reporting responsibilities. Interviews will be conducted on random days, including weekends, and all shifts. Any findings will be investigated and reported per facility policy. The DON/ Designee will report the findings of the interviews to the QA Committee monthly and the QA Committee will determine how best to conduct ongoing monitoring so that facility policy is implemented and followed and to	

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			reinforce the facility's commitment to abuse prevention, investigation, and reporting and to ensure the staff is aware of the potential consequences for both residents and staff for failing to follow the facility's policies.	
F 0610 SS=K Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to investigate allegations of verbal abuse for 2 of 4 residents reviewed for abuse. (Residents D and E). This resulted in a female resident being physically (death) and sexually assaulted. (Resident C, Resident B) This deficient practice resulted in an Immediate Jeopardy. The Immediate Jeopardy began on, 2/1/22 at approximately 2:00 p.m., when the facility	F 0610	1. The facility failed to investigate an allegation of sexual abuse. The male resident had threatened at least two female residents with sexual violence. The allegations of sexual abuse were reported to facility staff and were not investigated. This same resident was found to be on top of a female resident with his pants	03/25/2022

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	failed to investigate reported allegations of sexual and verbal abuse. The Administrator, Administrator in Training, Director of Nursing, and the Regional Director of Nursing were notified of the Immediate Jeopardy on 2/7/22 at 5:00 p.m. The Immediate Jeopardy was removed on 2/10/22 at 2:40 p.m., but noncompliance remained at a lower scope and severity level of pattern, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. Findings include: 1. During an interview on 2/7/22 at 9:20 a.m., Resident D indicated on 2/1/22 at approximately 2:00 p.m., Resident B began making inappropriate sexual comments toward her. She had reported to QMA 4 around 11:00 p.m. on 2/1/22 that Resident B had made inappropriate sexual comments towards her. The QMA had indicated to her not to worry because she would watch the hall. The clinical record for Resident D was reviewed on 2/7/22 at 11:00 a.m. The Quarterly MDS (Minimum Data Set) assessment, dated 12/11/21, indicated Resident D was cognitively intact. During an interview on 2/7/22 at 9:00 a.m., QMA 3 indicated she had overheard other staff discussing that Resident B threatened to rape Resident D several times on 2/1/22. The QMA was not sure if this had been reported but indicated the threats should have been reported to the supervisor. QMA 3 was unable to remember which staff members she heard discussing this at the nurse's station. 2. During an interview on 2/7/22 at 10:00 a.m., the resident council member indicated Resident E came to him and was afraid of Resident B.		down and her brief pulled to the side with legs spread. The male resident was holding a pillow over the resident's face. The female resident was deceased. The female residents who were allegedly threatened have had their family, physician, SSD, and psychologist notified. Psychosocial well-being is being monitored by SSD and psychologist. Care plans will be updated accordingly as needed. 2. All other residents had the potential to be affected. Abuse interviews were conducted with all alert and oriented residents to identify any concerns. Residents who could not be interviewed had a head to toe skin assessment completed and there were no findings. SSD is following up with any affected resident by notifying psychologist, physician, and family for additional support. Care plans have been revised where appropriate to do so. All staff were interviewed to determine if they were aware of or to identify any potential allegations of abuse or events that require investigation. Any identified events or allegations were reported to ISDH and all other reporting entities. 3. The facility must ensure all allegations of abuse are investigated per the existing facility policy to protect the residents. The Regional Director of Clinical Operations (RDCO) will	

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	Resident B had made vulgar comments to her about a week and a half ago. The resident council member indicated he had told Resident B that he could not behave in that manner. He had reported this information to a staff member after Resident E spoke to him. During an interview on 2/7/22 at 9:50 a.m., Resident E indicated Resident B was making inappropriate comments and was verbally aggressive towards her. The resident reported Resident B's behaviors to a resident council member and he indicated he would take care of it. The clinical record for Resident E was reviewed on 2/7/22 at 11:40 a.m. The Quarterly MDS assessment, dated 11/11/21, indicated Resident E was cognitively intact. On 2/3/22 at 1:30 p.m., the police officer indicated that at approximately 5:00 a.m. on 2/2/22, police were dispatched to the facility following a sexual assault resulting in Resident C being found deceased. On 2/7/22 at 2:00 p.m., the Administrator in Training, DON, and Regional Nurse Consultant indicated they were unaware of Residents D's or E's allegations of verbal abuse. On 2/8/22 at 9:15 a.m., the DON indicated that the allegations should have been reported and investigated. On 2/7/22 at 11:00 a.m., The Director of Nursing provided a copy of a facility policy, dated 9/1/17, titled "Indiana Abuse and Neglect and Misappropriation of Property," and indicated this was the current policy used by the facility. A review of the policy indicated, "Each occurrence ... of alleged abuse ... will be identified and reported to the supervisor and investigated		ensure all investigations are conducted timely and thoroughly. In the event the RDCO is unavailable the Regional Director of Operations (RDO) will be responsible to ensure all investigations are conducted timely and thoroughly in accordance with facility policy. All allegations of abuse or a concern that may constitute abuse will be reported to the Executive Director immediately. DON/Designee educated all staff on the facility's existing policy identified as, "Indiana Abuse, Neglect, and Misappropriation", with emphasis on reporting and investigating and reinforcing the expectation this policy will be followed including a discussion of the consequences of not following facility policy for both the residents and staff. In-services on the facility's existing abuse prevention, investigating and reporting policy will be conducted once a quarter. Alert and oriented residents were educated and encouraged to report any acts of abuse or reports of abuse to facility staff. All new hires will continue to receive education on the facility's Abuse policy during their orientation including the expectation that this policy will be followed, and the consequences of not following this policy. All staff have been educated on the facility's policy and expectation that when behaviors	

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HOMESTEAD HEALTHCARE CENTER	7465 MADISON AVE INDIANAPOLIS, IN 46227

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	timely. The supervisor or designee will notify the Director of Nursing and Executive Director of the incident or allegation immediately". The Immediate Jeopardy, that began on 2/1/22, was removed on 2/10/22 when the facility inserviced staff on abuse policies and procedures, but the noncompliance remained at the lower scope and severity of no actual harm with potential for more than minimal harm that is not Immediate Jeopardy because a systemic plan of correction had not been developed and implemented to prevent recurrence. This Federal tag relates to Complaints IN00372277 and IN00372425. 3.1-28(d)		occur they are to be reported immediately to the charge nurse /DON/ED/SSD. All staff have been educated on the facility's policy on assessing challenging behaviors, resident substance abuse, and residents who are unaware of personal boundaries; this education included but was not limited to Identify, Preventing, and Managing Aggressive Behaviors, documentation of behaviors in clinical record, and documentation from CNA/QMA in POC on daily assigned task identified as "Any changes in my resident today", Residents with behaviors, substance abuse, or personal boundary concerns will be referred to SSD, MD, and IDT to determine if there is a need for additional psychotherapy, outpatient services, temporary 1:1, substance abuse counseling, or if relocation is required. 4. The RDCO will validate all abuse allegations are reported and investigated per the facility policy x 6 months. The DON/SSD/Designee will interview 5 random staff members and 5 random residents weekly x 4 weeks, then 10 random staff members and 10 random residents monthly x 2 months, then 5 random staff members and 5 random residents monthly x 3 months to ensure no incidents	

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			have occurred that were not reported or investigated, and to ensure staff and residents are aware of reporting responsibilities. Interviews will be conducted on random days, including weekends, and all shifts. Any findings will be investigated and reported per facility policy. Monitoring of residents' behaviors and potential substance abuse will be conducted by the DON/Designee Monday-Friday and the designated clinical manager Saturday and Sunday by a review of the 24-hour report, high priority progress notes, and Einteract alerts for change in condition. This is an on-going facility practice. Non-verbal residents will have a skin assessment completed no less than weekly and any changes in skin condition including but not limited to bruising and discoloration will be reported immediately to the DON. This is an on-going facility practice. The grievances will be reviewed Monday-Friday in the clinical morning meeting to ensure appropriate actions and resolution are provided. This is an ongoing facility practice. The DON/ Designee will report the findings of the interviews to the monthly QA Committee meeting and the QA Committee will determine how best to conduct on going monitoring so that facility	

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			policy is implemented and followed and to reinforce the facility's commitment to abuse prevention, investigation, and reporting and to ensure the staff is aware of the potential consequences for failing to follow the facility's policies.	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on interview and record review, the facility failed to provide an accurate MDS (Minimum Data Set) assessment by staff qualified to assess relevant care areas for 1 of 3 residents reviewed for accurate assessment. (Resident G) Findings include: The clinical record for Resident G was reviewed on 2/8/22 at 9:45 a.m. A Quarterly MDS assessment, dated 1/2/22, indicated the resident did not have an indwelling urinary catheter. The diagnoses included, but were not limited to, epilepsy, abnormal posturing, encephalitis, polymer. The resident had an indwelling urinary catheter. The MDS assessment, dated 1/4/22, did not indicate resident G had a Foley catheter. The TAR (Treatment Administration Record), was provided by the DON (Director of Nursing) on 2/8/22 at 12:23 p.m. The TAR dated 12/1/21 thru 12/31/21, did not indicate the resident had a Foley catheter. The resident's catheter was inserted on	F 0641	**1) Immediate actions taken for those residents identified:** Resident G was not harmed by the alleged deficient practice. Resident G's assessments on 01/02/2022 and 01/04/2022 were modified by MDS to reflect accurate status. Resident G was reassessed by nursing staff and the catheter was removed as per MD order on 02/09/2021. **2) How the facility identified other residents:** Any resident who has an indwelling catheter has the potential to be affected by the alleged deficient practice. An audit was conducted on all residents with indwelling catheters to confirm their most recent MDS reflects accurate coding of an indwelling catheter, that catheter care orders are in place, and that	03/25/2022

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	12/22/21. The clinical record lacked catheter care from 12/22/21-12/31/21. During an interview on 2/15/22 at 10:15 a.m., LPN 3 indicated she did not do an assessment after she inserted the residents Foley catheter in December 2021. A policy received on 2/9/22, revised 7/26/18, indicated this policy was the one the facility was using, indicated: " the facility will: i ... provide an assessment of the resident as an on going-periodic review that provides the foundation for a resident focused care and the care planning process..." This Federal tag relates to Complaint IN00372387. 3.1-31(d)		the plan of care is updated accordingly. Any findings were immediately corrected and the family and physician were notified. **3) Measures put into place/System changes:** The Regional Resident Care Coordinator has educated the MDS coordinator reinforcing the need for accurately completing an MDS per the guidelines of the RAI manual. **4) How the corrective actions will be monitored:** The Regional Resident Care Coordinator will audit 3 resident MDS's weekly x 4 weeks, then 5 resident MDS's monthly x 5 months to ensure the accuracy of the resident MDS assessment. MDS coordinator is responsible for the compliance. The results of these audits will be reviewed in the Quality Assurance Committee monthly meetings for 6 months or until 100% compliance is achieved x 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered			

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	care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.			

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	Based on interview and record review, the facility failed to ensure a person-centered care plan was developed for a resident that had physical, sexual, and verbally aggressive behaviors and diagnosed with alcohol abuse and major depressive disorder for 1 of 3 resident reviewed for behaviors. (Resident B) Findings include: The clinical record for Resident B was reviewed on 2/2/22 at 12:30 p.m., the diagnoses included, but were not limited to, major depressive disorder and alcohol abuse. The Quarterly Minimum Data Set (MDS) assessment, dated 1/12/22, indicated Resident B was cognitively intact and had moderate depression. The hospital discharge summary, dated 9/16/21 at 2:19 a.m., indicated Resident B had been consuming alcohol 3 to 5 times per week, consumed more alcohol than intended, and was homeless because his family member had made him leave home due to alcohol consumption. During an interview on 2/7/22 at 8:53 a.m., QMA 2 indicated Resident B seemed depressed over the past few weeks because his roommate moved out. During an interview on 2/7/22 at 9:00 a.m., QMA 3 indicated on 1/28/22 Resident B had been drinking out of a cup that smelled like alcohol. The resident could be verbally aggressive when he had been drinking alcohol. Resident B threatened to rape Resident D several times on 2/1/22. During an interview on 2/7/22 at 9:50 a.m., Resident E indicated Resident B told her she was	F 0656	**1) Immediate actions taken for those residents identified:** Resident B no longer resides in the facility.**2) How the facility identified other residents:**All residents have the potential to be affected by the alleged deficient practice. An audit was conducted on all residents to ensure that those residents with behaviors, major depressive disorders, and alcohol abuse have a care plan that accurately reflects their physical and mental health needs and assures their needs are addressed and met. Care plans were immediately updated to reflect an accurate, person-centered plan of care for the resident based upon the resident's assessed condition and needs, if required. **3) Measures put into place/ System changes:**The DON/MDS Coordinator educated the nursing staff and IDT on the facility's existing policy identified as, "Plan of Care Overview" with emphasis on development of a person-centered care plan for those residents exhibiting behaviors and a diagnosis including alcohol abuse and major depressive disorder. Staff was reminded of the potential consequences to both the residents and staff if the policy is not followed. **4) How the corrective actions will be monitored:**The Social Service	03/25/2022

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	beautiful and offered to buy her jewelry. She said no. When he (Resident B) got drunk, he would get violent. There was a day, the week before last, Resident B got out of his wheelchair and in her face and said, "you f**king b*tch, I'll knock you out of that wheelchair." Resident E told a member of the resident council and he said he would take care of it. During an interview on 2/7/22 at 9:20 a.m., Resident D indicated on 2/1/22 at approximately 2:00 p.m., Resident B began making inappropriate sexual comments toward her. Resident B indicated to Resident D that he was going to "eat between my legs" and made comments about Resident D's breasts. Resident B laughed and said, "just wait until tonight, just wait until tonight." Resident B continued to make these comments several times throughout that day. Resident D reported this to QMA 4 around 11:00 p.m. on 2/1/22. At that time, the QMA 4 indicated to her (Resident D) not to worry because she would watch the hall. During an interview on 2/7/22 at 10:20 a.m., LPN (Licensed Practical Nurse) 2 indicated on 2/2/22 at approximately 5:00 a.m., he was at the nurse's station for the 100 and 200 Hall. QMA 1 had come to the nurse's station and was unable to verbalize what she saw. QMA 1 grabbed his hand and said, "come on, come on." When he entered Resident C's room, he saw Resident B standing approximately a foot away from Resident C's bed with his pants down to his ankles. The nurse smelled alcohol when Resident B was trying to speak. There was a large bottle of dry gin on the floor. Resident B was escorted out of Resident C's room and immediately placed on one-on-one supervision with another staff member. Resident C was lying in bed, on her back, with legs spread apart and her face looking at the ceiling. Resident		Director will audit 5 resident care plans x 4 weeks, then 3 resident care plans x 4 weeks, then 5 resident care plans monthly x 4 months to ensure development of a person-centered care plan for those residents exhibiting behaviors and a diagnosis including alcohol abuse and major depressive disorder are in place, accurate, and implemented. The Social Service Director is responsible for the compliance. Audit findings will be presented to the QA Committee monthly meetings x 6 months. The results of these audits will be reviewed in the monthly QA Committee monthly meetings for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	C did not have a pulse, but her body was warm to touch. The clinical record for Resident B lacked a care plan for behaviors, major depressive disorder, and alcohol abuse. During an interview on 2/11/22 at 8:30 a.m., the Director of Nursing indicated Resident B's alcohol consumption, major depressive disorder, and behaviors should have been care planned with appropriate interventions. On 2/14/22 at 1:00 p.m., the Director of Nursing provided a copy of a facility policy, titled "Plan of Care Overview," dated 7/26/18, and indicated this was the current policy used by the facility. A review of the facility policy indicated "it is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. Safety is the primary concern for our resident, staff and visitors." This Federal tag relates to Complaints IN00372425 and IN00372277. 3.1-35(a)			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for			

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	the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on interview and record review, the facility failed to update a care plan within 7 days of an assessment to reflect a resident's appropriate weight bearing status for 1 of 3 residents reviewed for activities of daily living. (Resident B). Finding includes: The clinical record for Resident B was reviewed on 2/2/22 at 12:30 p.m. The diagnoses included, but were not limited to, major depressive disorder and alcohol abuse. The Quarterly Minimum Data Set (MDS) assessment, dated 1/12/22, indicated Resident B was cognitively intact, required extensive assistance of one staff member for bed mobility and transfers, had moderate depression, and used a manual wheelchair.	F 0657	**1) Immediate actions taken for those residents identified:** Resident B no longer resides in the building. Resident B was not harmed by the alleged deficient practice. **2) How the facility identified other residents:** Any resident with a change in weight bearing status as identified by comprehensive assessment, therapy, physician orders, or observation has the potential to be affected by the alleged deficient practice. An audit was conducted on all residents who had a change in weight-bearing status to ensure	03/25/2022

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	A hospital discharge summary, dated 9/16/21 at 2:47 a.m., indicated the resident was non weight bearing. A care plan, dated 9/17/21 and current through 3/22/22, indicated Resident B required assistance with ADL (activities of daily living) related to non-weight bearing to RLE (right lower extremity), right ankle fixture, pain in right ankle. A therapy progress note, dated 11/29/21 at 3:45 p.m., indicated weight bearing as tolerated to the right lower extremity. During an interview on 2/15/22 at 3:11 p.m., the Director of Nursing indicated the care plan should have been updated to show Resident B's weight bearing status and improvement. On 2/14/22 at 1:00 p.m. The Administrator provided a copy of a facility policy, titled "Plan of Care Overview," dated 7/26/18, and indicated this was the current policy used by the facility. A review of the policy indicated "the facility will: review care plans quarterly and/or with significant changes in care." This Federal tag relates to Complaint IN00372277. 3.1-35(d)(2)(B)		their plan of care reflected accurately their weight bearing status and to meet their daily mobility needs. **3) Measures put into place/ System changes:** The DON/MDS coordinator educated the IDT and nursing staff on the existing facility policy identified as, “Plan of Care Overview” with emphasis on timely revision of resident care plans upon as assessed of observed condition change and the consequences for not following the existing policy for both the residents and staff. **4) How the corrective actions will be monitored:** The DON/Designee will audit 5 resident care plans x 4 weeks, then 3 resident care plans x 4 weeks, then 5 resident care plans monthly x 4 months to ensure timely revision of care plans. The Director of Nursing is responsible for the compliance. Audit findings will be presented to the QA Committee monthly meetings x 6 months. The results of these audits will be reviewed in the monthly QA Committee monthly meeting for 6 months or until 100% compliance is achieved x3 consecutive months. The QA	

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			Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to ensure a resident with diabetes mellitus type 2 had blood glucose monitoring completed and documented for 2 of 2 residents reviewed for blood glucose monitoring. (Resident B, Resident C) Findings include: 1. The clinical record for Resident B was reviewed on 2/2/22 at 12:30 p.m. The diagnoses included, but were not limited to, diabetes mellitus type 2, major depressive disorder, and alcohol abuse. A Nurse Practitioner progress note, dated 10/10/21 at 12:06 p.m., indicated the resident was to have his blood glucose levels checked twice a day. The clinical record lacked documentation the residents blood glucose levels were being	F 0684	**1) Immediate actions taken for those residents identified:** Resident B no longer resides in the facility and was not harmed by alleged deficient practice. Resident C no longer resides in the facility **2) How the facility identified other residents:** Any resident who requires blood sugar monitoring has the potential to be affected by the alleged deficient practice. All residents with blood sugar monitoring orders were reviewed to ensure blood sugar monitoring and documentation occurred over the last 14 days. Physician and family were notified immediately and new orders were obtained to meet the needs of the resident for	03/25/2022

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	monitoring. During an interview on 2/9/22 at 2:35 p.m., the Director of Nursing indicated Resident B's blood glucose levels should have been monitored and documented as indicated by the Nurse Practitioner's note. 2. The clinical record for Resident C was reviewed on 2/2/22 at 12:15 p.m. The diagnoses included, but were not limited to, diabetes mellitus type 2 and morbid obesity. The current Physician's orders, dated 1/30/22, indicated staff were to monitor the residents blood glucose levels four times a day. The clinical record lacked documentation of the residents blood glucose levels being monitored. During an interview on 2/9/22 at 2:35 p.m., the Director of Nursing indicated Resident C's blood glucose levels should have been documented. On 2/7/22 at 11:00 a.m. The Director of Nursing provided a copy of a facility policy, titled "Medication Administration," dated 12/14/17, and indicated this was the current policy used by the facility. A review of the policy indicated "record pertinent information ...blood sugars." This Federal tag relates to Complaints IN00372387, IN00372425, and IN00373289. 3.1-37(a)		any resident's whose blood sugar was not monitored in accordance with physician orders. **3) Measures put into place/ System changes:** The Director of Nursing/designee in-serviced nursing staff on the existing facility's policies identified as, "Medication Administration" and "Physician Orders" with emphasis on following physician orders, completion, documentation and the consequences for not following these existing policies and procedures for both residents and staff. **4) How the corrective actions will be monitored:** Director of Nursing/designee will audit 5 resident records with blood sugar monitoring weekly x4 weeks and then 3 resident records x 4 weeks then 1 resident record weekly for 4 months to ensure compliance with blood sugar monitoring orders and the blood sugar readings are documented. Care Plans will be updated to reflect the resident's current status and any changes in a resident's condition. Audits/observation will be conducted randomly, across all 3 shifts, and will include weekends. DON/Designee is responsible for the compliance. Audit findings will be presented to the QA Committee monthly meeting x 6 months. The results of these	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			audits will be reviewed in the monthly QA Committee monthly meetings for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to prevent a resident from driving an electric wheelchair while under the influence of alcohol for 1 of 3 resident reviewed for safety. (Resident B) Finding includes: The clinical record for Resident B was reviewed on 2/2/22 at 12:30 p.m. The diagnoses included, but were not limited to, major depressive disorder and alcohol abuse. The Quarterly Minimum Data Set (MDS) assessment, dated 1/12/22, indicated Resident B was cognitively intact and required extensive assistance of one staff member for bed mobility	F 0689	**1) Immediate corrective action(s) for those residents affected by the deficient practice:** Resident B no longer resides within facility. No residents were injured by this alleged deficient practice. **2) Plan/Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken:**Any resident who utilizes an electric wheelchair and has a history of alcohol use has the potential to be affected by the alleged deficient practice. An audit	03/25/2022

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	and transfers. During the initial tour of the facility, on 2/2/22 from 11:40 a.m. to 12:15 p.m., Resident B was in his room with a Police Officer standing guard at the door to the room. Resident B was observed sitting up in his electric wheelchair. During an interview on 2/7/22 at 9:00 a.m., QMA 3 indicated on 1/28/22 Resident B had been drinking out of a cup that smelled like alcohol. The resident could be verbally aggressive when he had been drinking alcohol. During an interview on 2/7/22 at 9:50 a.m., Resident E indicated when he (Resident B) got drunk, he would get violent. There was a day, the week before last, he got off of his wheelchair and in her face and said, "you f**king b*tch, I'll knock you out of that wheelchair." During an interview on 2/7/22 at 10:20 a.m., LPN (Licensed Practical Nurse) 2 indicated on 2/2/22 at approximately 5:00 a.m., Resident B's electric wheelchair was inside the room, approximately a foot behind him. Resident B was trying to sit in the wheelchair but was unsteady and confused when trying to speak to the nurse. The nurse smelled alcohol when the resident was trying to speak. There was a large bottle of dry gin on the floor. During an interview on 2/9/22 at 2:15 p.m., the Administrator indicated an evaluation was completed for residents who wish to drive an electric wheelchair for safety. The clinical record lacked an evaluation for Resident B to drive an electric wheelchair.		was conducted on all resident who utilize an electric wheelchair and have a history of alcohol use to ensure they were educated on proper use of the electric wheelchair and had a current assessment identified as "Powered Personal Mobility Device Skills Evaluation" completed and that facility policy prohibits the use of an electric wheelchair by any resident who has consumed alcohol. **3)Facility measures and systemic changes to ensure the deficient practice does not recur:**The DON/Designee completed in-servicing with all staff on the existing facility policy of continuously monitoring resident's ability to safely operate a motorized wheelchair and to notify MD/DON/ED/family immediately of any concerns or discrepancies with operation of the motorized wheelchair. **4)Facility plan to monitor corrective actions & sustain compliance; Integrate QA Process:**The DON/Designee will audit new admission /readmission and residents who express the desire to use a motorized wheelchair in the building for safety and ensure a "Powered Personal Mobility Device Skills Evaluation" is completed timely, this is ongoing facility practice. The DON/Designee will audit via observation 3 residents weekly x 4 weeks, then 1 resident	

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	During an interview on 2/9/22 at 2:35 p.m., the Director of Nursing indicated an evaluation should have been completed for Resident B to drive an electric wheelchair. The physician should have been notified when the staff realized Resident B had been drinking alcohol and let the physician make a recommendation regarding the electric wheelchair. She would have stopped Resident B from driving the electric wheelchair after drinking alcohol. On 2/16/22 at 2:00 p.m., the facility was unable to provide a policy regarding electric wheelchairs prior to exit. This Federal tag relates to Complaint IN00372277. 3.1-45(a)(2)		weekly x 4 weeks, then 3 residents monthly to ensure operation of the electric wheelchair is safe. The facility will continue its practice of assessing a resident's ability to safely operate a motorized wheelchair twice a year and more frequently if the resident demonstrates any unsafe operation of a motorized wheelchair. Audits/observation will be conducted randomly, across all 3 shifts, and will include weekends. DON/Designee is responsible for the compliance. Audit findings will be presented to the QA Committee monthly meetings x 6 months. The results of these audits will be reviewed in the monthly QA monthly meetings for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.			

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	§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.			
	Based on observation, interview, and record review, the facility failed to provide appropriate treatment and services for care of a resident with a clinically-justified indwelling catheter for 1 of 5 residents reviewed for catheter care. (Resident G). Finding includes: The clinical record for Resident G was reviewed on 2/8/22 at 9:45 a.m. A Quarterly MDS (Minimum Data Set) assessment, dated 1/2/22, indicated the resident cognition was moderately impaired. The MDS assessment had no indication resident G	F 0690	**1.) Immediate actions taken for those residents identified:** Resident G was not harmed by the alleged deficient practice. Resident G was reassessed by nursing staff and the catheter was discontinued per MD order on 02/09/2021. . **2.) How the facility identified other residents:** Any resident who has an order for an indwelling Foley catheter has the potential to be affected by the alleged	03/25/2022

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	had a indwelling urinary catheter. The diagnoses included, but were not limited to: epilepsy, abnormal posturing, encephalitis, polyneuropathy. The resident had an indwelling catheter at that time. The physician's order, dated 12/22/21 at 2:34 p.m., indicated to insert a Foley catheter for a diagnosis of overactive bladder. There were no follow up progress notes indicating Resident G's toleration of the insertion of the Foley catheter or if any urine, including color was obtained. The TAR (Treatment Administration Record), was provided by the DON (Director of Nursing) on 2/8/22 at 12:23 p.m. The TAR for 12/22/21-12/31/21 lacked urinary catheter care. The TAR from 1/1/22-1/31/22 lacked urinary catheter care on 14 occurrences. On 2/15/22 at 11:00 a.m., Resident G was observed to not have a urinary catheter. A policy "Catheter Care" was provided by the Administrator and reviewed on 2/8/22 at 1:50 p.m., and read as follows:"catheter care at the beside is performed to promote cleanliness and dignity and by nursing staff....II: for a female resident...e. Obtain clean, wet washcloth with warm soap and water...Clean around catheter just above entrance downward approximately 6 inches, repeat until no visible soiling is observed on the catheter...h. Rinse with clean wet wash cloth...". This Federal tag relates to Complaint IN00372387. 3.1-41(a)(1)		deficient practice. An audit was conducted to identify those residents who currently utilize an indwelling Foley catheter to ensure catheter care orders and a plan of care were in place and implemented accurately and timely. **3.) Measures put into place/ System changes:**The DON/Designee educated the nursing staff and IDT on the existing facility policy identified as, “Catheter Care” with emphasis on ensuring orders were documented, followed, and that catheter care was provided in accordance with nursing practice and physician’s orders. The expectation this policy is followed was reinforced and staff was reminded of the consequences to the residents and staff if physician orders or facility policy are not followed. The Director of Nursing / Designee will ensure this plan of correction is implemented. Audits will be conducted 3 times weekly x 4 weeks, then 2 times weekly for 4 weeks and once a week thereafter to include all shifts for documentation of ordered catheter care, that bowel and bladder assessments completed, and the correct placement of catheter tubing. **4.) How the corrective actions will be monitored:**The DON/Designee will audit 5 residents weekly x 4 weeks, then 3 residents weekly x 4 weeks, then 3 residents monthly x 4	

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			months to ensure catheter care is being completed and documented appropriately in the clinical record. All admissions will be reviewed in the clinical morning meeting for the use of an indwelling Foley catheter and audited to ensure catheter care orders and a plan of care is in place, this is an ongoing facility practice. Audits/observation will be conducted randomly, across all 3 shifts, and will include weekends. DON/Designee is responsible for the compliance. Audit findings will be presented to the QA Committee monthly meeting x 6 months. The results of these audits will be reviewed in the monthly QA Committee monthly meetings for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
F 0726 SS=E Bldg. 00	483.35(a)(3)(4)(c) Competent Nursing Staff §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident			

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	assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.			
	Based on interview and record review, the facility failed to ensure staff had the skills and competencies to identify and address a male resident that had been drinking alcohol in the facility which resulted in behavioral symptoms of physical (death), sexual, and verbal abuse toward female residents for 4 of 4 residents reviewed for competent nursing staff. (Resident B, Resident C, Resident D, Resident E) Finding includes: The clinical record for Resident B was reviewed on 2/2/22 at 12:30 p.m., the diagnoses included, but were not limited to, major depressive disorder	F 0726	**1) Immediate actions taken for those residents identified:** Resident B no longer resides in the building. Residents affected were provided psychosocial support by social services and psychology services and all residents were satisfied with the services provided. **2) How the facility identified other residents:** All residents with exhibited behaviors and change of condition have the potential to be affected	03/25/2022

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	and alcohol abuse. The Quarterly Minimum Data Set (MDS) assessment, dated 1/12/22, indicated Resident B was cognitively intact, required extensive assistance of one staff member for bed mobility and transfers, and had moderate depression. The clinical record lacked documentation of a care plan for his behavior of drinking. During an interview on 2/7/22 at 9:00 a.m., QMA 3 indicated on 1/28/22 Resident B had been drinking out of a cup that smelled like alcohol. The resident could be verbally aggressive when he had been drinking alcohol. Resident B threatened to rape Resident D several times on 2/1/22. During an interview on 2/7/22 at 9:50 a.m., Resident E indicated Resident B got violent when he was drunk. There was a day, the week before last, Resident B got out of his wheelchair and in her face and said, "you f**king b*tch, I'll knock you out of that wheelchair." Resident E told a member of the resident council and he said he would take care of it. During an interview on 2/7/22 at 10:00 a.m., the resident council member indicated Resident B had been vulgar to female residents that didn't like him. About a week and a half ago Resident E was afraid of Resident B because of vulgar comments he had made to her. The resident council member had reported this to staff. He was unable to remember which staff member he reported this to. During an interview on 2/7/22 at 10:20 a.m., LPN (Licensed Practical Nurse) 2 indicated on 2/2/22 at approximately 5:00 a.m., QMA 1 had come to the nurse's station and was unable to verbalize what she saw. QMA 1 grabbed his hand and said,		by the alleged deficient practice. The clinical record of all residents with the potential for alcohol use or who have exhibited behaviors will be audited to ensure that any exhibited behavior has been reported to the physician and family, that behavior monitoring orders are documented and implemented and that appropriate interventions are in place. Interventions will be reviewed periodically for effectiveness and the physician notified if any intervention is ineffective. All care plans will be updated accordingly. **3) Measures put into place/System changes:** All staff have been educated on existing facility policy and nursing practice to report behaviors immediately to the charge nurse/DON/ED/SSD. All staff have been educated on assessing challenging behaviors, resident substance abuse and residents who are unaware of personal boundaries; this education included but was not limited identifying, preventing, best practices for managing aggressive behaviors, documentation of behaviors in the clinical record, documentation from CNA/QMA in POC on daily assigned task identified as “Any changes in my resident today”. Residents identified with behaviors, substance abuse, or personal boundary concerns will be referred	

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	"come on, come on." When he entered Resident C's room, he saw Resident B standing approximately a foot away from Resident C's bed with his pants down to his ankles. The resident's electric wheelchair was inside the room, approximately a foot behind him. Resident B was trying to sit in the wheelchair but was unsteady and confused when trying to speak to the nurse. The nurse smelled alcohol when Resident B was trying to speak. There was a large bottle of dry gin on the floor. During an interview on 2/9/22 at 2:35 p.m., the Director of Nursing indicated alcohol consumption would not be considered a change of condition, but the physician should have been notified Resident B was drinking alcohol. On 2/15/22 at 11:56 a.m., the Director of Nursing provided a copy of a facility policy, titled "Notification for Change in Condition," dated 11/30/18, and indicated this was the current policy used by the facility. A review of the policy indicated "unless there are documented extenuating circumstances, the nurse will report immediately changes in condition based on the following criteria for reporting to the Physician...New or worsening physical or verbal aggression or a danger to self or others." This Federal tag relates to Complaint IN00372277. 3.1-14(a)(1)		to SSD, MD, and IDT to determine if a need for additional psychotherapy, outpatient services, temporary 1:1, or substance abuse counseling, or if relocation is required **4) How the corrective actions will be monitored:** Monitoring of residents' behaviors and substance abuse will be conducted by the DON/Designee Monday-Friday and the designated clinical manager on Saturday and Sunday by reviewing the 24-hour report, high priority progress notes, and Einteract alerts for change in condition. This is an on-going facility practice. Residents will be monitored for behaviors 7 days weekly on all shifts via observation and verbal interactions with the residents, including but is not limited to administrative rounding, Angel care rounds, and nursing assessments and interactions. Non-verbal residents will have a skin assessment completed no less than weekly and any changes in skin conditions including but not limited to bruising and discoloration will be reported immediately to the DON. This is an on-going facility practice. Any grievances will be reviewed Monday-Friday in the clinical morning meeting to ensure appropriate action and resolution are provided. This is an ongoing facility practice. The DON/	

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			Designee will report the findings of the interviews to the QA Committee monthly meetings and the QA Committee will determine ongoing monitoring. DON/Designee is responsible for compliance. The results of these audits will be reviewed in the monthly QA Committee monthly meeting for 6 months or until 100% compliance is achieved x 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
F 0742 SS=K Bldg. 00	483.40(b)(1) Treatment/Srvcs Mental/Psychoscial Concerns §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; Based on observation, interview, and record review, the facility failed to monitor a male resident for verbal and physically aggressive behaviors, towards female residents, and alcohol consumption for 1 of 1 residents reviewed for behaviors. This resulted in resulted in 2 female residents being verbally abused and 1 female	F 0742	1. The facility failed to monitor a male resident for violent behaviors related to alcohol consumption which resulted in 2 female residents being verbally abused and 1 female resident being physically (death) and	03/25/2022

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	resident being physically (death) and sexually abused. (Resident B, Resident C, Resident D, Resident E) This deficient practice resulted in an Immediate Jeopardy. The Immediate Jeopardy began on, 1/28/22 at approximately 12:00 p.m., when the facility failed to implement behavior monitoring and appropriate interventions to manage the behaviors for a male resident that became aggressive toward female residents and consuming alcohol. The Administrator and Director of Nursing were notified of the Immediate Jeopardy on 2/10/22 at 2:40 p.m. The Immediate Jeopardy was removed on 2/11/22 at 1:15 p.m., but noncompliance remained at a lower scope and severity level of pattern, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. Findings include: The clinical record of Resident B was reviewed on 2/2/22 at 12:30 p.m. The diagnoses included, but were not limited to, alcohol abuse and major depressive disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 1/12/22, indicated Resident B was cognitively intact. The clinical record for Resident B lacked a person-centered care plan with appropriate interventions to address major depressive disorder, alcohol abuse, and behaviors related to consuming alcohol. The hospital discharge summary, dated 9/16/21 at 2:19 a.m., indicated Resident B had been consuming alcohol 3 to 5 times per week,		sexually assaulted for 1 of 1 resident reviewed for behaviors. When a male resident was found on top of a female resident without his pants on and a pillow over her head, which resulted in death of the female resident. Staff observed an odor of alcohol on his breath and a bottle of liquor on the floor. Staff were aware of prior allegations of verbal threats and behaviors to female residents with the male residents alcohol use. 2. All residents and staff were interviewed to identify any residents with challenging behaviors, behaviors related to substance abuse, and residents who lack respect for personal boundaries. Any resident identified with a behavior had a behavior monitoring plan implemented. Residents identified with a substance abuse history or active use have agreed to participate in a behavior plan/contract outlining guidelines to comply with the facility's substance abuse policy. A resident's compliance with his/her plan of care to include the behavior plan/contract and cooperation with staff during their stay in the facility is encouraged. The intent of the ***Behavior Guidelines*** is to address the potential volitional behaviors of those individuals who have the capacity to understand the consequences of their behaviors. All residents with	

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	consumed more alcohol than intended, and was homeless because his family member had made him leave home due to alcohol consumption. During an interview on 2/7/22 at 8:53 a.m., QMA 2 indicated Resident B seemed depressed over the past few weeks because his roommate moved out. During the initial tour of the facility, on 2/2/22 from 11:40 a.m. to 12:15 p.m., Resident C was in her room with Police Officers standing guard at the door. Resident C could not be observed from the hallway. Resident B was in his room, located on a different unit in the facility, with a Police Officer standing guard at the door to the room. Resident B was observed sitting up in his electric wheelchair staring at the hallway with a flat affect (showing no emotion on face). During an interview on 2/3/22 at 5:10 p.m., QMA (Qualified Medication Aide) 1 indicated, she entered Resident C's room and Resident B was on top of Resident C, in bed, with his pants down. Resident C's face was covered with Resident B's hand. Resident B jumped off of Resident C and left the room. Resident C was naked, had a small scratch to her left leg, and her incontinence brief was pulled to the side. During an interview on 2/7/22 at 10:20 a.m., LPN (Licensed Practical Nurse) 2 indicated on 2/2/22 at approximately 5:00 a.m., he was at the nurse's station for the 100 and 200 Hall. QMA 1 had come to the nurse's station and was unable to verbalize what she saw. QMA 1 grabbed his hand and said, "come on, come on." When he entered Resident C's room, he saw Resident B standing approximately a foot away from Resident C's bed with his pants down to his ankles. Resident C's electric wheelchair was inside the room,		behaviors a have monitoring plan in place, appropriate interventions are implemented and current with the plan of care specific to any behaviors. 3. All staff have been educated on the existing facility policy requiring that behaviors are reported immediately to the charge nurse/DON/ED/SSD. All staff have been educated on the existing facility policy of assessing challenging behaviors, residents' potential substance abuse, and residents who are unaware of personal boundaries. This education included but was not limited to identifying, preventing, and managing aggressive behaviors, documentation of behaviors in the clinical record, documentation from CNA/QMA in POC on daily assigned task identified as "Any changes in my resident today". Residents identified with behaviors, potential substance abuse, or personal boundary concerns will be referred to SSD, MD, and IDT to determine if a need for additional psychotherapy, outpatient services, temporary 1:1, substance abuse counseling, or if relocation is required. 4. Monitoring of residents' behaviors and potential substance abuse will be conducted by the DON/Designee Monday-Friday and the designated clinical manager Saturday and Sunday by	

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	approximately a foot behind him. Resident B was trying to sit in the wheelchair but was unsteady and confused when trying to speak to the nurse. The nurse smelled alcohol when Resident B was trying to speak. There was a large bottle of dry gin on the floor. Resident B was escorted out of Resident C's room and immediately placed on one-on-one supervision with another staff member. Resident C was lying in bed, on her back, with legs spread apart and her face looking at the ceiling. Resident C did not have a pulse, but her body was warm to touch. During an interview on 2/7/22 at 9:00 a.m., QMA 3 indicated on 1/28/22 Resident B had been drinking out of a cup that smelled like alcohol. Resident B could be verbally aggressive when he had been drinking alcohol. Resident B threatened to rape Resident D several times on 2/1/22. QMA 3 overheard other staff discussing this at the nurse's station Resident D hadn't reported this to QMA 3. The QMA was not sure if this had been reported but indicated the threats should have been reported to the supervisor. The QMA was unable to remember which staff members she had heard discussing this at the nurse's station. During an interview on 2/7/22 at 9:20 a.m., Resident D indicated on 2/1/22 at approximately 2:00 p.m., Resident B began making inappropriate sexual comments toward her. Resident B indicated to Resident D that he was going to "eat between my legs" and made comments about Resident D's breasts. Resident B laughed and said, "just wait until tonight, just wait until tonight." Resident B continued to make these comments several times throughout that day. Resident D reported this to QMA 4 around 11:00 p.m. on 2/1/22. The QMA had indicated to Resident D not to worry because she would watch the hall.		a review of the 24-hour report, high priority progress notes, and Einteract alerts for change in condition. This is an on-going facility practice. Residents will be monitored for behaviors 7 days weekly on all shifts including weekends via observation and verbal interactions with the residents, this includes but is not limited to administrative rounding, Angel care rounds, and nursing assessments and interactions. Non-verbal residents will have a skin assessment completed no less than weekly and any changes in skin condition including but not limited to bruising and discoloration will be reported immediately to the DON. This is an on-going facility practice. Any grievances will be reviewed Monday-Friday in the clinical morning meeting to ensure appropriate actions and resolution are provided. This is an ongoing facility practice. The The DON/ Designee will report the findings of the interviews to the monthly QA Committee meeting and the QA Committee will determine ongoing monitoring so that facility policy is implemented and followed and to reinforce the facility's commitment to abuse prevention, investigation, and reporting and to ensure the staff is aware of the potential consequences to both staff and residents for failing to follow the	

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	During an interview on 2/7/22 at 9:50 a.m., Resident E indicated Resident B told her she was beautiful and offered to buy her jewelry. She said no. When he (Resident B) got drunk, he would get violent. There was a day, the week before last, Resident B got out of his wheelchair and in her face and said, "you f**king b*tch, I'll knock you out of that wheelchair." Resident E told a member of the resident council about the incident with Resident B, and he said he would take care of it. During an interview on 2/7/22 at 10:00 a.m., the resident council member indicated Resident B had been vulgar to female residents that he didn't think liked him. About a week and a half ago, Resident E was afraid of Resident B because of vulgar comments he had made to her. The resident council member had reported this to staff. He was unable to remember which staff member he reported this to. During an interview on 2/10/22 at 1:03 p.m., the Social Service Director indicated she was not aware of Resident B's alcohol use prior to admission but if a resident was admitted with a diagnosis of alcohol abuse and had been consuming alcohol, that would be considered a behavior. If the resident was currently consuming alcohol, first she would have attempted to send the resident to a recovery center. If a recovery center was not available or could not care for that resident, she would have had the resident sign a behavior contract. The contract should have included if the resident consumed alcohol, they would have received a 30-day notice for discharge. If psychiatric services would have recommended behavior monitoring, we would have had it in place.		facility's policies.	

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	During an interview on 2/10/22 at 1:12 p.m., the Admission Coordinator indicated she could not remember the admission for Resident B but if a resident was referred for admission with a diagnosis of alcohol abuse and had been consuming alcohol, that would have been a concern and should have been reported to the Director of Nursing. During an interview on 2/10/22 at 1:20 p.m., the Director of Nursing indicated she had a concern regarding Resident B's admission because he had left other facilities against medical advice and a criminal background check showed he had previous drug and alcohol problems. Resident B originally was admitted for rehabilitation to home, but when the discharge process was started Resident B indicated to social services he was homeless. During an interview on 2/11/22 at 8:30 a.m., the Director of Nursing indicated the alcohol consumption and behaviors caused by consuming alcohol should have been monitored. There should have been appropriate interventions in place to address Resident B's behaviors. On 2/11/22 at 8:30 a.m., the Director of Nursing provided a copy of a facility policy titled, "Behavior Management General," dated 4/8/16, and indicated this was the current policy used by the facility. A review of the policy indicated "It is the policy of this facility to identify and safely manage residents who are exhibiting behaviors related to psychotropic diagnoses or who may present a danger to themselves or others." The Immediate Jeopardy, that began on 1/28/22, was removed on 2/11/22 when the facility inserviced staff on reporting behaviors, but the			

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	noncompliance remained at the lower scope and severity of no actual harm with potential for more than minimal harm that is not Immediate Jeopardy because a systemic plan of correction had not been developed and implemented to prevent recurrence. This Federal tag relates to Complaint IN00372277. 3.1-43(a)(1)			
F 0745 SS=D Bldg. 00	483.40(d) Provision of Medically Related Social Service §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. Based on interview and record review, the facility failed to provide appropriate social service interventions for a male resident who was homeless and abused alcohol at the time of admission and was diagnosed with alcohol abuse for 1 of 1 residents reviewed for social services. (Resident B) Findings include: During an interview on 2/7/22 at 9:00 a.m., QMA 3 indicated on 1/28/22 Resident B had been drinking out of a cup that smelled like alcohol. The resident could be verbally aggressive when he had been drinking alcohol. During an interview on 2/7/22 at 9:50 a.m., Resident E indicated when he (Resident B) got drunk, he would get violent. There was a day, the week before last, Resident B got out of his wheelchair and in her face and said, "you f**king b*tch, I'll knock you out of that wheelchair."	F 0745	**1) Immediate actions taken for those residents identified:** Resident B no longer resides in the facility. **2) How the facility identified other residents:** All residents who have a history of alcohol abuse have the potential to be affected by the alleged deficient practice. All residents and staff were interviewed and asked to identify any residents with challenging behaviors, behaviors related to substance abuse, and lack of respect for personal boundaries. Any resident identified with a behavior had behavior monitoring plan implemented. Residents' identified with a substance abuse history and active use have agreed	03/25/2022

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	During an interview on 2/7/22 at 10:20 a.m., LPN (Licensed Practical Nurse) 2 indicated on 2/2/22 at approximately 5:00 a.m., Resident B's electric wheelchair was inside the room, approximately a foot behind him. Resident B was trying to sit in the wheelchair but was unsteady and confused when trying to speak to the nurse. The nurse smelled alcohol when Resident B was trying to speak. There was a large bottle of dry gin on the floor. The clinical record for Resident B was reviewed on 2/2/22 at 12:30 p.m. The diagnoses included, but were not limited to, major depressive disorder and alcohol abuse. The Quarterly Minimum Data Set (MDS) assessment, dated 1/12/22, indicated Resident B was cognitively intact, required extensive assistance of one staff member for bed mobility and transfers, had moderate depression, and used a manual wheelchair. The hospital discharge summary, dated 9/16/21 at 2:19 a.m., indicated Resident B had been consuming alcohol 3 to 5 times per week, consumed more alcohol than intended, and was homeless because his family member had made him leave home due to alcohol consumption. During an interview on 2/10/22 at 1:03 p.m., the Social Service Director indicated she was not aware of Resident B's alcohol use prior to admission but if a resident was admitted with a diagnosis of alcohol abuse and had been consuming alcohol, that would be considered a behavior. If the resident was currently consuming alcohol, first she would have attempted to send the resident to a recovery center. If a recovery		to participate in a behavior contract outlining guidelines to comply with the facility's substance abuse policy. A resident's compliance with his/her plan of care including the behavior contract and cooperation with staff during the stay in the facility is encouraged. The intent of the ***Behavior Guidelines*** is to address the volitional behaviors of those individuals who have the capacity to understand the consequences of their behaviors. All residents with behaviors have behavior monitoring plans in place, a current plan of care, with appropriate interventions has been implemented and the implemented interventions are monitored for effectiveness. Ineffective interventions are removed from the care plan and the resident is reassessed for more appropriate and effective interventions. **3) Measures put into place/System changes:** The Regional Director of Clinical Operations has educated the Social Service Director, DON, ED, and IDT on the need to and proper implementation of appropriate interventions for residents identified with alcohol/substance abuse. The DON/SSD had educated the staff on the facility's expectation and policy on behavior monitoring with an emphasis on alcohol/substance abuse and	

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	center was not available or could not care for that resident, she would have had the resident sign a behavior contract. The contract should have included if the resident consumed alcohol, they would have received a 30-day notice for discharge. If psychiatric services would have recommended behavior monitoring, we would have had it in place. The clinical record lacked documentation of a referral to recovery center, behavior contract nor a 30-day notice for discharge. On 2/7/22 at 11:00 a.m., the Director of Nursing provided a copy of a facility policy, titled "Resident Substance Abuse in Facility," dated 8/20/18, and indicated this was the current policy used by the facility. A review of the policy indicated "Abused substances may also include alcohol. The facility will safeguard the resident under the influence...this may include up to discharge of the substance abusing resident." This Federal tag relates to Complaint IN00372277. 3.1-34(a)		appropriate and timely implementation of interventions designed to keep the resident and fellow residents safe. **4) How the corrective actions will be monitored:** DON/designee/Social Service will audit 3 resident records 3 times a week x 4 weeks, then 3 resident records 1 time weekly thereafter for 5 months to ensure appropriate interventions are implemented and in place for residents identified with alcohol/substance abuse. The DON will monitor the SSD to ensure compliance with audits and compliance. DON/Designee/Social service Director is responsible for compliance. The results of these audits will be reviewed in the QA Committee monthly meetings for 6 months or until 100% compliance is achieved x 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
F 0835 SS=E Bldg. 00	483.70 Administration §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on observation, interview, and record review, the facility administration failed to maintain the mental and physical wellbeing of	F 0835	**1)Immediate actions taken for those residents identified:** Resident B no longer resides in	03/25/2022

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	residents when a male resident (Resident B) verbally and physically abused 3 of 4 female residents. (Resident C, Resident D, Resident E) Findings include: The clinical record of Resident B was reviewed on 2/2/22 at 12:30 p.m. The diagnoses included, but were not limited to, alcohol abuse and major depressive disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 1/12/22, indicated Resident B was cognitively intact. The hospital discharge summary, dated 9/16/21 at 2:19 a.m., indicated Resident B had been consuming alcohol 3 to 5 times per week, consumed more alcohol than intended, and was homeless because his family member had made him leave home due to alcohol consumption. During an interview on 2/10/22 at 1:20 p.m., the Director of Nursing indicated she had a concern regarding Resident B's admission because he had left other facilities against medical advice and a criminal background check showed he had previous drug and alcohol problems. Resident B originally was admitted for rehabilitation to home, but when the discharge process was started Resident B indicated to social services he was homeless. 1. During the initial tour of the facility, on 2/2/22 from 11:40 a.m. to 12:15 p.m., Resident C was in her room with Police Officers standing guard at the door. Resident C was deceased. Resident B was in his room, located on a different unit in the facility, with a Police Officer standing guard at the door to the room. Resident B was observed sitting up in		the facility. Residents C no longer resides in the facility. Resident D and E were offered and if accepted were provided psychosocial therapy by psych services and additionally had follow-up for psychosocial well-being from SSD with continuing monitoring and inquiry. **2) How the facility identified other residents:** All residents had the potential to be affected by the alleged deficient practice. Abuse interviews were completed with all alert and oriented residents to identify any concerns. Residents who could not be interviewed had a head to toe skin assessment completed and any findings were reported to the physician. All staff were interviewed for any allegations of incidents that may constitute abuse that were potentially not reported or investigated in accordance with existing facility policy. Any findings have been reported to ISDH and other reporting agencies. Families and physicians have been notified. SSD is following up with any affected resident and notifying psychologist, physician, and family for additional support. Care plan have been updated as needed. All residents' behavior monitoring was reviewed to identify any	

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	his electric wheelchair staring at the hallway with a flat affect (showing no emotion on face). During an interview on 2/3/22 at 5:10 p.m., QMA (Qualified Medication Aide) 1 indicated, she entered Resident C's room and Resident B was on top of Resident C, in bed, with his pants down. Resident C's face was covered with Resident B's hand. Resident B jumped off of Resident C and left the room. Resident C was naked, had a small scratch to her left leg, and her incontinence brief was pulled to the side. During an interview on 2/7/22 at 10:20 a.m., LPN (Licensed Practical Nurse) 2 indicated on 2/2/22 at approximately 5:00 a.m., he was at the nurse's station for the 100 and 200 Hall. QMA 1 had come to the nurse's station and was unable to verbalize what she saw. QMA 1 grabbed his hand and said, "come on, come on." When he entered Resident C's room, he saw Resident B standing approximately a foot away from Resident C's bed with his pants down to his ankles. The resident's electric wheelchair was inside the room, approximately a foot behind him. Resident B was trying to sit in the wheelchair but was unsteady and confused when trying to speak to the nurse. The nurse smelled alcohol when Resident B was trying to speak. There was a large bottle of dry gin on the floor. Resident B was escorted out of Resident C's room and immediately placed on one-on-one supervision with another staff member. Resident C was lying in bed, on her back, with legs spread apart and her face looking at the ceiling. Resident C did not have a pulse, but her body was warm to touch. 2. During an interview on 2/7/22 at 9:00 a.m., QMA 3 indicated on 1/28/22 Resident B had been drinking out of a cup that smelled like alcohol.		increased behaviors. Through resident and staff interviews were conducted to identify any behavior that constitutes abuse and/or require follow-up. Any concerns were immediately addressed. **3)Measures put into place/System changes:** The Regional Director of Clinical Operations has educated the ED, DON, and IDT on existing facility policy and requirement for maintaining the mental and physical well-being of residents by ensuring behaviors are monitored and incidents are reported, investigated, and managed appropriately. The DON has in-serviced all staff and residents on the existing facility policy regarding reporting abuse directly to Administrator. Nursing staff was educated on existing facility policy and expectation that alleged abuse will be reported immediately to the ED for investigation and follow-up and the facility's existing policy and expectation that physician and family will be notified of any condition change, behavior, or injury. Behaviors and/or change of condition will be reviewed by the Interdisciplinary Team and/or designee to ensure resident's change of condition is reported to physician /psych services /family member/DON all	

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	Resident B could be verbally aggressive when he had been drinking alcohol. Resident B threatened to rape Resident D several times on 2/1/22. The QMA had overheard other staff discussing this at the nurse's station on 2/1/22. The QMA was not sure if this had been reported but indicated the threats should have been reported to the supervisor. The QMA was unable to remember which staff members she heard discussing this at the nurse's station. During an interview on 2/7/22 at 9:20 a.m., Resident D indicated on 2/1/22 at approximately 2:00 p.m., Resident B began making inappropriate sexual comments toward her. Resident B indicated to Resident D that he was going to "eat between my legs" and made comments about Resident D's breasts. Resident B laughed and said, "just wait until tonight, just wait until tonight." Resident B continued to make these comments several times throughout that day. Resident D reported this to QMA 4 around 11:00 p.m. on 2/1/22. At that time, QMA 4 had indicated to her (Resident D) not to worry because she would watch the hall. The clinical record for Resident D was reviewed on 2/7/22 at 11:00 a.m., the diagnoses included, but were not limited to, debility, morbid obesity, and acquired absence of right and left legs above the knee. The Quarterly MDS assessment, dated 12/11/21, indicated Resident D was cognitively intact. 3. During an interview on 2/7/22 at 9:50 a.m., Resident E indicated Resident B told her she was beautiful and offered to buy her jewelry. She said no. When he (Resident B) got drunk, he would get violent. There was a day, the week before last, Resident B got out of his wheelchair and in her face and said, "you f**king b*tch, I'll knock you		in accordance with existing facility policy and regulatory requirements. The Regional Director of Clinical Operations will be responsible for compliance of completing staff education. **4)How the corrective actions will be monitored:** SSD will interview 5 residents weekly x 4 weeks, then 3 residents weekly x 4 weeks, then 5 residents monthly to ensure their mental and physical well-being is being maintained by the facility and staff and that any behaviors or condition changes are reported and followed up upon in accordance with facility policy and regulatory requirements. Audits/observation will be conducted randomly, across all 3 shifts, and will include weekends. DON/Designee/Social Service Director is responsible for the compliance. The results of these audits will be reviewed in the monthly QA Committee monthly meetings for 6 months or until 100% compliance is achieved x 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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HOMESTEAD HEALTHCARE CENTER	7465 MADISON AVE INDIANAPOLIS, IN 46227

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	out of that wheelchair." She didn't think staff saw this happen and had not reported this to staff. Resident E told a member of the resident council about the incident with Resident B, and he said he would take care of it. During an interview on 2/7/22 at 10:00 a.m., the resident council member indicated Resident B had been vulgar to female residents that didn't like him. About a week and a half ago, Resident E was afraid of Resident B because of vulgar comments he had made to her. The resident council member had reported this to staff. He was unable to remember which staff member he reported this to. The clinical record for Resident E was reviewed on 2/7/22 at 11:40 a.m., the diagnoses included, but were not limited to, morbid obesity, reduced mobility, and debility. The Quarterly MDS assessment, dated 11/11/21, indicated Resident E was cognitively intact. On 2/7/22 at 11:00 a.m., The Director of Nursing provided a copy of a facility policy, dated 9/1/17, titled "Indiana Abuse and Neglect and Misappropriation of Property," and indicated this was the current policy used by the facility. A review of the policy indicated, "Each occurrence ... of alleged abuse ... will be identified and reported to the supervisor and investigated timely. The supervisor or designee will notify the Director of Nursing and Executive Director of the incident or allegation immediately" This Federal tag relates to Complaint IN00372277. 3.1-13(r)(2)			