| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | |
|--|--|---|----------------------------|---|---|------------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | 00 | COMPL | ETED |
| | | 155349 | B. W | NG | | 12/20/2022 | |
| | PROVIDER OR SUPPLIER | | <u> </u> | STREET ADDRESS, CITY, STATE, ZIP COD 1900 RANDALLIA DR FORT WAYNE, IN 46805 | | | |
| (X4) ID | SUMMARY S | STATEMENT OF DEFICIENCIE | | ID | | | (X5) |
| PREFIX | | CY MUST BE PRECEDED BY FULL | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | TE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION | | TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | 16 | DATE |
| F 0000 | | | | | | | |
| Bldg. 00 | IN00396574 and IN | e Investigation of Complaints 100396697. | F 00 | 000 | | | |
| | - | to the allegations are cited. | | | | | |
| | Complaint IN00396 Federal/state deficie allegations are cited | 2697 - Substantiated. Encies related to the at F600, F607, and F610. The right of the state of | | | | | |
| | accordance with 410 | reflect State Findings cited in 0 IAC 16.2-3.1. | | | | | |
| F 0600 SS=D Bldg. 00 | 483.12(a)(1) Free from Abuse a §483.12 Freedom Exploitation | | | | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiency statement 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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| STATEMENT OF DEFICIENCIES | | X1) PROVIDER/SUPPLIER/CLIA | ì í | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY | |
|---------------------------|--|--|-------|---|---|---------------------------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | | JILDING | 00 | COMPLI | |
| | | 155349 | B. WI | ING | | 12/20/ | 2022 |
| NAME OF I | PROVIDER OR SUPPLIE | R | | | ADDRESS, CITY, STATE, ZIP COD | | |
| SAINT A | NNE HOME | | | 1900 RANDALLIA DR FORT WAYNE, IN 46805 | | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | NCY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | ATE | COMPLETION |
| TAG | | | + | TAG | DEFICIENCY) | | DATE |
| TAG | abuse, neglect, m property, and exp subpart. This inclifreedom from corrinvoluntary seclus chemical restraint resident's medical §483.12(a) The fast §483.12(a) The fa | acility must- t use verbal, mental, sexual, c, corporal punishment, or | F 00 | 500 | This plan of correction is prepared and executed as required by the provisions of State and Federal law. As a consideration of the survey results the facility respectfur requests a paper review of the plan of correction. F 600 - what corrective action(s) be accomplished for those residents found to have been affected by the deficient practice. Resident J indicated that she was upset that former Employee 3 left but understeit was for the best. A license Social Worker, talk therapist met with the resident. The L documented Resident J had | lly he will tice? e ood ed t sw | 01/20/2023 |
| | observed in the livi | 5 A.M., Resident J was ing room area working on a riew, Resident J indicated | | | indicated any emotional trauma nor had she perceive anything inappropriate. how other residents having the potential to be affected by | ng | |

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| AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155349 | | A. BUILDING 00 B. WING | | 00 | COMPLETED 12/20/2022 | | | |
|---|--------------------|--|---|---|----------------------|--|--|----------------------------|
| | | ROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP COD 1900 RANDALLIA DR FORT WAYNE, IN 46805 | | | | |
| PRI |) ID EFIX AG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL 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 |
| | | spent much time wirchildren, books, and her soulmate but no talk about everythin came to love him lil afternoon, Emploee surprised because sl the afternoon, just in room, knelt down in indicated he had been was leaving his emp why he had been let cried but had also be indicated he was verbut didn't think with of his anatomy. She been tempted by Refloor of the facility, known Resident N f school with her. She flirtatious with men when they became in why she thought this Employee 3 would a mass and she observe "tenderly" and "lovis shoulders. Resident that would occur be Before Employee 3 he had asked for her contact her after he bad, but she had lied couldn't remember to thought it was proposed in the could him she would pray get his life straighter asked if he could king replied "yes", he couldned to the could him she would pray get his life straighter asked if he could king replied "yes", he couldn't remember to the could him she would pray get his life straighter asked if he could king replied "yes", he couldn't remember to the could him she would pray get his life straighter asked if he could king replied "yes", he couldn't remember to the could him she would pray get his life straighter asked if he could king replied "yes", he couldn't remember to the couldn't remember to | en her special friend. She had th him talking about life, their I dying. She indicated he was t in a sexual way. They could g important to them and she ke a son. On 12/8/22, in the 3 came to her room. She was he hadn't usually seen him in he the mornings. He came in the front of her wheelchair, he let go by the facility and holoyment. He couldn't tell her he go. She indicated she had he en very angry with him. She ry intelligent but was a man, his head, rather another part hindicated Employee 3 had he sident N who lived on the 2nd he resident indicated she'd hor years and had gone to he indicated Resident N was had then would rebuff them herested. When questioned he, she indicated that halways bring Resident N to he dhim, several times, had left her room, on 12/8/22, he phone number so he could heft. She indicated she'd felt he to him and told him she he number because she hadn't her to give it to him. She told hor out. She indicated he he sa and hug her goodbye. She had and would've been upset he hugged her and then kissed | | | same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential be affected. Inservice training abuse prevention with example what is considered appropriate/inappropriate. - what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does recur; Staff will be in-serviced on abuprevention by January 20th an routine education will be provide with examples of what is considered appropriate/inappropriate. - how the corrective action(will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; Resident concerns will be audit weekly to ensure abuse preventive guidelines are followed. Once 100% compliant for two month audits will be done monthly. Results will be reviewed in the meeting. Social Services/Administrator to month by what date the systemic changes for each deficiency where the completed. January 20th | on es of es of es of es of es not es es ded es | |

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Event ID:

Facility ID: 000240

27LN11

If continuation sheet Page 3 of 17

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURV | | | SURVEY | | |
|--|---|---|-----------|-------|---|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDI | ING | 00 | COMPL | ETED |
| | | 155349 | B. WING | | | 12/20/ | 2022 |
| | | | СТ | DEETA | DDDESS CITY STATE ZID COD | | |
| NAME OF P | ROVIDER OR SUPPLIER | 8 | | | DDRESS, CITY, STATE, ZIP COD | | |
| CAINTAI | NINE LIONE | | | | ANDALLIA DR | | |
| SAINTAI | NNE HOME | | | JRIW | VAYNE, IN 46805 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | II |) | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | PRE | FIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' | TE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION | TA | \G | DEFICIENCY) | | DATE |
| | her on the lips. She | indicated she hadn't expected | | | Resident is competent to visit. | Per | |
| | to be kissed on the lips and had been surprised | | | | ISDH Surveyor interview, SSD | | |
| | | byee 3 then left her room and | | | interview, all statements to her | | |
| | _ | m him since. She indicated she | | | nurse, resident said she exped | | |
| | had cried for 2 days | after he left and missed him. | | | former employee to tell her | | |
| | · | | | | goodbye, give her a hug and a | ì | |
| | On 12/19/22 at 12:4 | 40 P.M., Resident J's record was | | | kiss. Resident in all interviews | | |
| | | es included hemiplegia | | | stated she was upset that he v | | |
| | _ | ght dominant side following a | | | leaving because he was like a | | |
| | | nce on a wheelchair. | | | to her. On 12/12, nurse | | |
| | • | | | | documented resident asked fo | r the | |
| | A quarterly MDS (N | Minimum Data Set) | | | former employee's ph #. When | | |
| | | /28/22, indicated she had no | | | told the nurse didn't have it, th | | |
| | | nt, mood indicators, or | | | resident persisted by asking for | | |
| | behaviors. | | | | the ph # the former employee | | |
| | | | | | attends. | | |
| | Care plans, revised | on 9/14/20, indicated Resident | | | | | |
| | - | ependence in her decision | | | | | |
| | | l religious/spiritual support | | | | | |
| | - | ng her spiritual needs met by | | | | | |
| | - | are plans had not indicated | | | | | |
| | _ | rds other residents/staff, | | | | | |
| | - | g false accusations or | | | | | |
| | fabrication/embellis | | | | | | |
| | | | | | | | |
| | Progress notes indic | cated the following: | | | | | |
| | | 1., the resident reported to the | | | | | |
| | | nember (Employee 3) had given | | | | | |
| | · · | er on the lips as he was leaving | | | | | |
| | and had asked for h | er phone number so he could | | | | | |
| | keep in touch after | he was no longer employed at | | | | | |
| | the facility. The Ad | ministrator and Director of | | | | | |
| | Nursing (DON) wer | | | | | | |
| | -At 9:48 a.m., the re | esident spoke with the day shift | | | | | |
| | nurse (Employee 6) | about the incident. The | 1 | | | | |
| | resident denied dist | ress over the situation but | | | | | |
| | reported her concern for "anyone else he may | | | | | | |
| | have done this to". | The resident was told a | | | | | |
| | member of manager | ment would speak with her. | | | | | |
| | | | | | | | 1 |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE | | | (X3) DATE | SURVEY | |
|--|----------------------|--|-------|----------|---|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | 00 | COMPL | ETED |
| | | 155349 | B. W | ING | | 12/20/ | /2022 |
| | | | | CTDEET A | DDDECC CITY CTATE ZID COD | | |
| NAME OF F | PROVIDER OR SUPPLIEF | ₹ | | | ADDRESS, CITY, STATE, ZIP COD ANDALLIA DR | | |
| CAINT A | NINE LIONE | | | 1 | | | |
| SAINTAI | NNE HOME | | | FURIV | VAYNE, IN 46805 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | ICY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | ΓE | COMPLETION |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | - | DATE |
| | Record reviews had | ln't indicated a member of | | | | | |
| | management had sp | ooken with her on that day. | | | | | |
| | | | | | | | |
| | | a.m., Resident J stopped the day | | | | | |
| | | vee 6) and reported she knew | | | | | |
| | | as no longer at the facility. She | | | | | |
| | | N, who lived upstairs, reported | | | | | |
| | | Resident N was always flirting | | | | | |
| | | s at Employee 3 and was a big | | | | | |
| | "flirt" who was pro | bably jealous. | | | | | |
| | | | | | | | |
| | | a.m., a Social Services note | | | | | |
| | | ip interview had been | | | | | |
| | | sident J. During the interview, | | | | | |
| | | cated she was upset at her | | | | | |
| | _ | eave the facility but she | | | | | |
| | | ion because it was best for | | | | | |
| | | earful as she described her | | | | | |
| | _ | mployee 3 whom she indicated | | | | | |
| | | er. When asked about the kiss | | | | | |
| | _ | ne indicated it was what she | | | | | |
| | _ | e was like a son to her. She | | | | | |
| | _ | y further concerns. She was | | | | | |
| | | nity to speak with a talk | | | | | |
| | therapist and she ac | - | | | | | |
| | | eensed Social Worker | | | | | |
| | | st indicated she met with the | | | | | |
| | | ng room. Resident J was | | | | | |
| | | poke about the holiday and | | | | | |
| | 1 - | She was asked if she was doing | | | | | |
| | _ | end (Employee 3) had been | | | | | |
| | | cated they had been good | | | | | |
| | | 3 had told her the facility had | | | | | |
| | | ndn't been able to tell her why. he kissed her but it had been a | | | | | |
| | | He had asked her for her | | | | | |
| | 1 ~ | she told him she hadn't | | | | | |
| | _ | | | | | | |
| | | od idea. She saw him as a conversations with. When | | | | | |
| | _ | | | | | | |
| | askeu, sne maicated | d she was no longer having | | | | | |

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Event ID:

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| | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155349 | | (X2) MULTIPLE CO A. BUILDING B. WING | onstruction 00 | (X3) DATE SURVEY COMPLETED 12/20/2022 | |
|-------------------|--|---|--|---|---------------------------------------|--|
| | PROVIDER OR SUPPLIE | R | 1900 R | ADDRESS, CITY, STATE, ZIP CO RANDALLIA DR WAYNE, IN 46805 | | |
| (X4) ID PREFIX | (EACH DEFICIE | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL | ID PREFIX | PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP | OULD BE COMPLETION PROPRIATE | |
| TAG | any difficulties cop of relationship". Si indicated she was indicated Resident emotional traumar inappropriate when on 12/19/22 at 11 indicated the resident emotional traumar inappropriate when on 12/19/22 at 11 indicated the resident and had J embellished or far He indicated the remployee 3 could him kissing her on a meeting with Emhim to resign due to Employee 3's beharesigned at that tin there had been no residents or staff rebehaviors towards department. During a confident indicated Employee would have angry then would want to staff member he had. Employee 3 wo secured memory cowith residents in the other assigned duttemployee 3 had a and had spent much on 12/20/22 at 10 interviewed. She in her Employee 3 had concerned there memorial indicated in the concerned there memory concerned there memory concerned there memory and the staff member had a concerned there memory and the staff member had a concerned there memory and the staff member had a concerned there memory and the staff memory of the staff member had a concerned there memory and the staff memory of the sta | concerns about evior. Employee 3 and had encouraged to other concerns about evior. Employee 3 agreed and he. The Administrator indicated he'd had uployee 3 and had encouraged to other concerns about evior. Employee 3 agreed and he. The Administrator indicated he'd had uployee 3 and had encouraged to other concerns about evior. Employee 3 agreed and he. The Administrator indicated concerns expressed by egarding the employee's residents, only those in his he helpful and pray with the helpful and preferred to pray heir rooms rather than complete hes. Employee 5 indicated close friendship with Resident J h time with her. 20 A.M., Employee 6 was andicated Resident J reported to dikissed her on the lips and was any have been other residents he She indicated the resident | TAG | DEFICIENCY | DATE | |

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Event ID:

27LN11

Facility ID: 000240

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| | NT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | , , | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 | | | (X3) DATE SURVEY COMPLETED | |
|---------|---|---|--------|---|---|----------|-------------------------------|--|
| | | 155349 | B. WIN | IG | | 12/20/ | /2022 | |
| | PROVIDER OR SUPPLIE | R | | 1900 R | ADDRESS, CITY, STATE, ZIP COD ANDALLIA DR VAYNE, IN 46805 | <u> </u> | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) | |
| PREFIX | (EACH DEFICIE) | NCY MUST BE PRECEDED BY FULL | I | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI | ATE | COMPLETION | |
| TAG | | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE | |
| | | ressed by what had occurred | | | | | | |
| | but had reported it. She indicated she knew the | | | | | | | |
| | | floor, Resident N, but couldn't | | | | | | |
| | | ported it to anyone. She hadn't | | | | | | |
| | | formation from Resident J | | | | | | |
| | | . Employee 6 indicated she had | | | | | | |
| | | nad she ever been told by | | | | | | |
| | | e 3 had been inappropriate with | | | | | | |
| | them. | | | | | | | |
| | On 12/20/22 at 11: | 25 A.M., the Administrator was | | | | | | |
| | interviewed. He in | dicated it was not appropriate | | | | | | |
| | for a staff member | to kiss a resident on the lips. | | | | | | |
| | | | | | | | | |
| | On 12/20/22 at 12: | 02 P.M., the Social Services | | | | | | |
| | Director (SSD) wa | s interviewed. He indicated he | | | | | | |
| | _ | esident J after the allegation | | | | | | |
| | | at J indicated Employee 3 had | | | | | | |
| | | ner and she was tearful while | | | | | | |
| | | tionship. She appreciated | | | | | | |
| | | g with her and treating her | | | | | | |
| | | tioned, he indicated he hadn't | | | | | | |
| | · · | ident reported the incident if | | | | | | |
| | | thered by it. He had not been | | | | | | |
| | | nt's concern about Resident N | | | | | | |
| | and the alleged rela | ntionship with Employee 3. | | | | | | |
| | On 12/20/22 at 12: | 36 P.M., the HR director was | | | | | | |
| | interviewed regard | ing a written statement dated | | | | | | |
| | 12/12/22 at 9:19 a. | m. She indicated she had been | | | | | | |
| | approached by the | Administrator to accompany | | | | | | |
| | the SSD during his | interview with Resident J. She | | | | | | |
| | | iewing the hall cameras, she | | | | | | |
| | | on 12/8/22 at 2:42 p.m., | | | | | | |
| | | d Resident J's room and exited | | | | | | |
| | the room at 2:48 p. | m. She indicated earlier on the | | | | | | |
| | | on, Employee 3 had given his | | | | | | |
| | resignation on the | recommendation of the | | | | | | |
| | Administrator. Em | ployee 3 had not been asked to | | | | | | |
| | leave the building | immediately upon tendering his | | | | | | |

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| | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155349 | | (X2) MULTIPLE CO A. BUILDING B. WING | onstruction 00 | X3) DATE SURVEY COMPLETED 12/20/2022 | |
|-------------------|---|---|--|---|--------------------------------------|--|
| | PROVIDER OR SUPPLIE | R | STREET 1900 R FORT | D | | |
| (X4) ID PREFIX | (EACH DEFICIE | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL | ID PREFIX | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY) | PROPRIATE COMPLETION | |
| TAG | resignation and had resident's room to had clocked out of 3:15 and 3:30 p.m. Resident J and SSI Employee 3 had combe needed to leave disclosed the reason leave. She was visional indicated a number gone and was goin Resident J indicated the son she'd never about their kids, far indicated before he her phone number him she would kee asked if he could kee permission. He kis room. A current facility provention and pron 12/19/22 at 12: is the policy of [far guidelines and Indicated regarding resident' neglect and exploit policies and proceed abuse, neglect, exproperty, watch for abusive behavior a regular basis, such employees to protee prevent abuse, neglect or eas: Sexual, physical actions in the policies and proceed as: Sexual, physical actions are such as the proteed as: Sexual, physical actions are such as the proteed | d gone to some of the say goodbye. She indicated he the facility sometime between During the interview with D, the resident indicated ome to her room and explained the facility. He hadn't in but indicated it was time to fibly emotional about this and or of times she was sad he was go to miss him "very much". It is she thought of Employee 3 as a had. They had sat and talked mily, life, and death. She is left her room, he had asked for but she had declined and told up him in her prayers. He then iss her and she gave sed her on the lips and left the solicy, titled "Abuse ovided by the Administrator 15 P.M., stated the following: "It cility] to adhere to CMS in an Administrative Code (IAC) is right to be free from abuse, station3. [Facility] will establish dures to prohibit and prevent soloitation and misappropriation or changes that may cause and review interventions on a as: A. Screen and train the residents and prohibit and lect and exploitation. B. the and report any incidents of exploitationAbuse is defined all and mental abuse" | TAG | DEPOLENCE | DATE | |

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| | | X1) PROVIDER/SUPPLIER/CLIA | î í | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | |
|------------------|---|--|-------|----------------------------|--|--------|--------------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | | JILDING | 00 | COMPL | | |
| | | 155349 | B. WI | NG | | 12/20/ | 2022 | |
| NAME OF P | PROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP COD ANDALLIA DR | | | |
| SAINT AN | NNE HOME | | ļ | FORT V | VAYNE, IN 46805 | | | |
| (X4) ID | | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) | |
| PREFIX TAG | ` | ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | ΓE | COMPLETION DATE | |
| F 0607 | 3.1-27(a)(b) 483.12(b)(1)-(5)(ii) |)(iii) | | | | | BINE. | |
| SS=D Bldg. 00 | §483.12(b) The fa | nt Abuse/Neglect Policies acility must develop and policies and procedures | | | | | | |
| | §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and | | | | | | | |
| | | | | | | | | |
| | §483.12(b)(3) Incl paragraph §483.9 | lude training as required at 5, | | | | | | |
| | . , , , , | ablish coordination with the quired under §483.75. | | | | | | |
| | occurring in federa facilities in accorda the Act. The polic | sure reporting of crimes ally-funded long-term care lance with section 1150B of cies and procedures must of limited to the following | | | | | | |
| | | Posting a conspicuous e rights, as defined at (3) of the Act. | | | | | | |
| | retaliation, as defined and (2) of the Act. Based on interview failed to implement | and record review, the facility t policies and procedures to | F 06 | 507 | F 607 | | 01/20/2023 | |
| ļ | prevent abuse of 1 c | of 5 residents reviewed | | , | what corrective action(s) v | Nill | | |

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 12/20/2022 155349 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1900 RANDALLIA DR SAINT ANNE HOME FORT WAYNE. IN 46805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL. TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE (Resident J). be accomplished for those residents found to have been Findings include: affected by the deficient practice; Criminal background check was An Indiana report form, dated 12/8/22 at 4:30 p.m., done the day the original wasn't indicated Resident J had reported to a nurse a found. Employee had resigned. male staff member (Employee 3) gave her a hug and kissed her on the lips. The male staff member how other residents having had resigned earlier on 12/8/22. The male staff the potential to be affected by the member was notified he was not allowed on the same deficient practice will be property or have contact with residents or identified and what corrective families. Social services staff were to interview action(s) will be taken; other residents for abuse or inappropriate contact. All residents have the potential to be affected. Inservice On 12/19/22 at 11:16 A.M., the Administrator was training on abuse prevention interviewed about the reported incident between regarding background checks, Resident J and Employee 3. He indicated on including criminal background 12/8/22 he'd had a meeting with Employee 3 and checks. had encouraged him to resign due to other reported concerns about Employee 3's behaviors. Employee 3 agreed and resigned at that time. The what measures will be put Administrator indicated there had been no into place and what systemic concerns expressed by residents regarding changes will be made to ensure Employee 3's behaviors. that the deficient practice does not During a confidential interview, Employee 5 Employee files will be audited for indicated Employee 3 could be manipulating. He completeness. Any files missing would have angry outbursts at staff members, will be flagged and corrected. New then would want to be helpful and pray with the employee files will be audited staff member. Employee 3 worked often on the 2nd weekly. floor secured memory care unit and preferred to pray with residents in their rooms rather than how the corrective action(s) complete his assigned duties. Employee 5 will be monitored to ensure the indicated Employee 3 had a close friendship with deficient practice will not recur, Resident J and had spent much time with her. i.e., what quality assurance program will be put into place; and On 12/19/22 at 2:00 P.M., Employee 3's personnel Audits to be completed weekly

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file was reviewed. There were no disciplinary

duties or interactions with others. A criminal

actions or concerns regarding performance of his

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until 100% compliance for 2

be completed monthly. Data

months. At which time audits will

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SUR | | | (X3) DATE SURVEY | | |
|--|--|--|------|---------|---|--------------|---|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. B | UILDING | 00 | COMPLETED | |
| | | 155349 | B. W | ING | | 12/20/2022 | |
| | | | | CTREET | ADDRESS CITY STATE ZID COD | | _ |
| NAME OF P | PROVIDER OR SUPPLIER | 2 | | | ADDRESS, CITY, STATE, ZIP COD | | |
| CAINTAI | NINE LIONE | | | | ANDALLIA DR | | |
| SAINT AI | NNE HOME | | | FORT | VAYNE, IN 46805 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) | |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | COMPLETION | |
| TAG | REGULATORY OR | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | DATE | |
| | background check is | ndicated it had been | | | results shared at QA meeting. | | |
| | completed on 12/19 | /22. The Administrator | | | HR/Administrator/Designee | | |
| | indicated Human Ro | esources (HR) staff had been | | | _ | | |
| | unable to find the criminal background check | | | | - by what date the systemic | | |
| | done at the time Em | nployee 3 was hired. | | | changes for each deficiency w | <i>r</i> ill | |
| | | | | | be completed. | | |
| | On 12/20/22 at 12:3 | 36 P.M., the HR director was | | | Jan. 20, 2023 | | |
| | interviewed. She indicated, on 12/8/22, Employee 3 | | | | | | |
| | submitted his resign | nation on the recommendation | | | | | |
| | of the Administrator | r. The HR Director indicated | | | | | |
| | when Employee 3 h | ad been hired, she had been | | | | | |
| | leaving for an exten | ided leave of absence and had | | | | | |
| | been trying to orien | t her replacement. The | | | | | |
| | position had been va | acated abruptly and the | | | | | |
| | position needed fille | ed immediately. Employee 3 | | | | | |
| | had credible referen | nces and was hired. She | | | | | |
| | indicated she had no | ot been able to find the | | | | | |
| | employee's criminal | l background check. The check | | | | | |
| | was required to be d | done for employment at the | | | | | |
| | facility. She indicate | ed it may have been missed | | | | | |
| | due to the confusion | n with the leave of absence | | | | | |
| | and the need to fill t | the open position immediately. | | | | | |
| | | | | | | | |
| | A current facility po | - | | | | | |
| | _ | ovided by the Administrator | | | | | |
| | | 5 P.M., stated the following: "It | | | | | |
| | | ility] to adhere to CMS | | | | | |
| | l - | ana Administrative Code (IAC) | | | | | |
| | 1 | right to be free from abuse, | | | | | |
| | | ation3. [Facility] will establish | | | | | |
| | 1 | ures to prohibit and prevent | | | | | |
| | | oitation and misappropriation | | | | | |
| | | changes that may cause | | | | | |
| | | nd review interventions on a | | | | | |
| | " | as: A. Screen and train | | | | | |
| | | et residents and prohibit and | | | | | |
| | prevent abuse, neglect and exploitation. B. | | | | | | |
| | | e and report any incidents of | | | | | |
| | | ploitationAbuse is defined | | | | | |
| | as: Sexual, physical | and mental abuseScreening | | | | | |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE C | (X3) DATE SURVEY | | | |
|--|--|--|------------------|--|------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING | 00 | COMPLETED | |
| | | 155349 | B. WING | | 12/20/2022 | |
| | ROVIDER OR SUPPLIER | | 1900 R | ADDRESS, CITY, STATE, ZIP COD RANDALLIA DR WAYNE, IN 46805 | | |
| (X4) ID | SUMMARY S | STATEMENT OF DEFICIENCIE | ID | | (X5) | |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | COMPLETION | |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION | TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | DATE | |
| | Procedure: D. Obtai employees" | in criminal history report on all | | | | |
| | This Federal tag rela | ates to Complaint IN00396697. | | | | |
| | 3.1-28(b)(1)(A) | | | | | |
| F 0610 SS=D Bldg. 00 | §483.12(c) In resp abuse, neglect, ex the facility must: | nt/Correct Alleged Violation conse to allegations of oploitation, or mistreatment, | | | | |
| | - ',',' | e evidence that all alleged oughly investigated. | | | | |
| | - ',',' | vent further potential abuse, on, or mistreatment while s in progress. | | | | |
| | investigations to the designated reposition officials in accordational including to the St working days of | port the results of all the administrator or his or presentative and to other ance with State law, the survey Agency, within the incident, and if the severified appropriate | | | | |
| | Based on interview | and record review, the facility | F 0610 | | 01/20/2023 | |
| | | thorough investigation of an for 1 of 5 residents reviewed | | - what corrective action(s) be accomplished for those | WIII | |
| | (Resident J). | 101 1 01 3 lesidents feviewed | | residents found to have been | | |
| | (Resident 1). | | | affected by the deficient pract | ice. | |
| | Findings include: | | | Resident J indicated that she upset that former Employee 3 | was | |
| | An Indiana report fo | orm, dated 12/8/22 at 4:30 p.m., | | but understood it was for the | | |
| | _ | J had reported to a nurse that a | | A licensed Social Worker, talk | | |
| | | (Employee 3) gave her a hug | | therapist met with the residen | | |
| | | ne lips. The male staff member | | The LSW documented Reside | | |
| | | that day. The male staff | | hadn't indicated any emotiona | | |

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Event ID:

27LN11

Facility ID: 000240

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE | | | SURVEY | | |
|--|---|--------------------------------------|-------|--------|--|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | ЛLDING | 00 | COMPL | ETED |
| | | 155349 | B. W | ING | | 12/20/ | 2022 |
| | | | | CTREET | ADDRESS CITY STATE ZID COD | | |
| NAME OF P | ROVIDER OR SUPPLIER | L | | | ADDRESS, CITY, STATE, ZIP COD | | |
| CAINTAI | NINE LIOME | | | | ANDALLIA DR | | |
| SAINT AI | NNE HOME | | | FORT | WAYNE, IN 46805 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | member was notifie | ed that he was not allowed on | | | trauma nor had she perceived | | |
| | the property or have | e contact with residents or | | | anything inappropriate. | | |
| | families. Social serv | vices staff were to interview | | | | | |
| | other residents for abuse or inappropriate contact. | | | | - how other residents havin | ıq | |
| | | | | | the potential to be affected by | - | |
| | On 12/20/22 at 9:25 | A.M., during an interview, | | | same deficient practice will be | | |
| | | Employee 3 had been her | | | identified and what corrective | | |
| | | 2/8/22, in the afternoon, he | | | action(s) will be taken; | | |
| | • | anelt down in front of her | | | All residents have the potentia | al to | |
| | | ed he had been let go by the | | | be affected. Staff will be | | |
| | · | ving his employment. He | | | in-serviced on abuse prevention | on by | |
| | - | y he had been let go. She | | | January 20th and routine | , | |
| | - | ried but had also been very | | | education will be provided with | ո | |
| | | e indicated he was very | | | examples of what is considere | | |
| | | a man and didn't think with his | | | appropriate/inappropriate. | | |
| | _ | part of his anatomy. She | | | | | |
| | | 3 had been tempted by | | | - what measures will be pu | t l | |
| | | ed on the 2nd floor of the | | | into place and what systemic | | |
| | | nt indicated she'd known | | | changes will be made to ensu | re | |
| | - | s and had gone to school with | | | that the deficient practice does | | |
| | | Resident N was flirtatious with | | | recur; | | |
| | men and then would | d rebuff them when they | | | Staff will be in-serviced on abu | use | |
| | | When questioned why she | | | prevention by January 20th ar | | |
| | | licated that Employee 3 would | | | routine education will be provi | | |
| | always bring Reside | ent N to mass. She had | | | with examples of what is | | |
| | | al times "tenderly" and | | | considered | | |
| | | e resident's shoulders. | | | appropriate/inappropriate | | |
| | | l it was a caress that would | | | | | |
| | occur between a ma | in and woman. Before | | | - how the corrective action(| (s) | |
| | Employee 3 had lef | ther room, on 12/8/22, he had | | | will be monitored to ensure the | ` ' | |
| | asked for her phone | number so he could contact | | | deficient practice will not recui | r, | |
| | her after he left. She | e indicated she'd felt bad, but | | | i.e., what quality assurance | | |
| | she had lied to him | and told him she couldn't | | | program will be put into place; | and | |
| | remember the numb | per because she hadn't thought | | | Resident concerns will be aud | | |
| | | e it to him. She told him she | | | weekly to ensure abuse preve | ntion | |
| | | and hoped he could get his life | | | guidelines are followed. Once | | |
| | | e indicated he asked if he | | | 100% compliant for two month | | |
| | _ | her goodbye. She replied | | | audits will be done monthly. | | |
| | _ | would've been upset had he | | | Results will be reviewed in the | QA | |
| | - | ed her and then kissed her on | | | meeting. Social | | |
| 1 | | | • | | • | | |

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 12/20/2022 155349 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1900 RANDALLIA DR SAINT ANNE HOME FORT WAYNE. IN 46805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE the lips. She indicated she hadn't expected to be Services/Administrator to monitor. kissed on the lips and had been surprised when by what date the systemic he did. Employee 3 then left her room and she changes for each deficiency will hadn't heard from him since. She indicated she be completed. had cried for 2 days after he left and missed him. January 20, 2023 **IDR** On 12/19/22 at 12:40 P.M., Resident J's record was Documents Uploaded to Support reviewed. Diagnoses included hemiplegia **IDR 610** (paralysis) of the right dominant side following a Request this tag be removed. stroke and dependence on a wheelchair. 1) P. 17 2nd paragraph "The investigation of the alleged abuse A quarterly MDS (Minimum Data Set) had not included interviews with staff who may have witnessed the assessment, dated 9/28/22, indicated she had no cognitive impairment, mood indicators, or incident" - the resident was in the behaviors. room by her self & former employee 3, HR was directed by Care plans, revised on 9/14/20, indicated Resident the Administrator to check the J demonstrated independence in her decision hallway camera to see if and when making. She needed religious/spiritual support the former employee entered and with a goal of having her spiritual needs met by left the room and to see if anyone pastoral care. Her care plans had not indicated else entered the room – no one any behaviors towards other residents/staff or else was in the room. behaviors of making false accusations or 2) P. 17 2nd paragraphed fabrication/embellishment of events. continues "had not included any cognitive intact residents who may Progress notes indicated the following: have been affected by Employee 3, nor was there any investigation -12/9/22 at 6:00 a.m., the resident reported to the completed with residents and staff nurse a male staff member (Employee 3) had given on the 2nd floor secured memory her a hug kissed her on the lips as he was leaving care unit where Employee 3 was and had asked for her phone number so he could observed to work often". On page keep in touch after he was no longer employed at 16 of this 2567, 3rd paragraph the facility. The Administrator and Director of Surveyor documented "On Nursing (DON) were notified. 12/20/22 at 12:02 P.M., the Social -At 9:48 a.m., the resident spoke with the day shift Service Director (SSD) was nurse (Employee 6) about the incident. The interviewed about the investigation resident denied distress over the situation but into the allegation. He indicated he reported her concern for "anyone else he may interviewed some residents who have done this to". The resident was told a may have received care from member of management would speak with her. Employee 3 (a total of 7

| STATEMENT OF DEFICIENCIES | | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY | | |
|------------------------------|---|---|----------------------------|--|-----------------------------------|-----------------|------|
| AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER | A. BU | A. BUILDING <u>00</u> | | COMPLETED | |
| | | 155349 | B. WI | B. WING | | 12/20/2022 | |
| <u> </u> | | | | STREET A | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF PROVIDER OR SUPPLIER | | | | | ANDALLIA DR | | |
| SAINT ANNE HOME | | | | | WAYNE, IN 46805 | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIE | | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | | PREFIX (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AL DEFICIENCY) | | D BE COMPLETION | |
| TAG | | REGULATORY OR LSC IDENTIFYING INFORMATION | | TAG | | DATE | |
| | | In't indicated a member of | | | residents). | | |
| | management had spoken with her. | | | | A - A dusinistant - 1 - 1 - 1 - 1 | | |
| | 12/10/22 at 11:14 a m. Pasident Laterned the day | | | As Administrator, I or my | | _ | |
| | -12/10/22 at 11:14 a.m., Resident J stopped the day shift nurse (Employee 6) and reported she knew | | | | designee in my absence, am in | | |
| | | | | charge of abuse investigations. | | | |
| | why Employee 3 was no longer at the facility. She believed Resident N, who lived upstairs, reported | | | When notified of the allegation, I | | 1, 1 | |
| | him. She indicated Resident N was always flirting, | | | reported to ISDH. | | nera | |
| | batting her eyes at Employee 3 and was a big | | | Talked to HR to check the camera to identify if he went in, when he | | | |
| | "flirt" who was probably jealous. | | | | left and any other activity. | | |
| | Thit who was probably jealous. | | | | Talked to our SSD, reviewed | | |
| | During a confidential interview, Employee 5 | | | | questions that residents should | d be | |
| | indicated Employee 3 worked often on the 2nd | | | | asked specific to the allegatio | | |
| | floor secured memory care unit and preferred to | | | | Contacted the former employe | | |
| | pray with residents in their rooms rather than | | | | for a statement and notified hi | | |
| | complete other assigned duties. | | | | is not allowed to come back o | | |
| | | | | | the property. | | |
| | On 12/20/22 at 10:20 A.M., Employee 6 was | | | | Called the daughter regarding | the | |
| | interviewed. She indicated Resident J reported to | | | | allegation and our steps to make | | |
| | her Employee 3 had kissed her on the lips and she | | | sure her mom was safe. | | | |
| | was concerned there may have been other | | | Reviewed with the pastoral staff | | | |
| | residents he had done this to. She indicated the | | | that he was not allowed back in | | | |
| | resident hadn't seemed distressed by what had | | | the bldg. and if they knew of any | | ny | |
| | occurred but had reported it. She indicated she | | | inappropriate conduct with | | | |
| | knew which resident on the 2nd floor Resident J | | | | residents. | | |
| | had referred to, Resident N, but couldn't recall if | | | I received a letter from the daughter stating that her family | | | |
| | she had reported it to anyone. She hadn't asked | | | | | у | |
| | for further information from Resident J about her | | | | has experienced the resident | | |
| | concerns. Employee 6 indicated she had not | | | saying things that were not tru | | ie. | |
| | witnessed nor had she ever been told by residents | | | I received the email from the | | | |
| | Employee 3 had been inappropriate with them. | | | former employee stating he di | | | |
| | 0 10/00/00 | 22.73.4 | | | stop and tell her he wouldn't b | | |
| | On 12/20/22 at 12:02 P.M., the Social Services | | | back. He denied kissing her on | | | |
| | Director (SSD) was interviewed about the | | | | the lips. | | |
| | | ne allegation. He indicated he | | | | | |
| | | esidents who may have | | | | | |
| | | Employee 3 (a total of 7 | | | | | |
| | | sidents were asked if it was | | | | | |
| | okay for staff to hug, hold hands, or to kiss a | | | | | | |
| | L resident, 4 residents | s reported it was ok. 1 resident | ı | | 1 | | |

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| AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER 155349 | A. BUILDING B. WING | 00 | COMPLETED 12/20/2022 | | | | |
|------------------------|---|---|----------------------|--|----------------------|--|--|--|--|
| NAME OF F | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COD 1900 RANDALLIA DR | | | | | |
| SAINT ANNE HOME | | | FORT WAYNE, IN 46805 | | | | | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | (X5) | | | | |
| PREFIX TAG | (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | PREFIX TAG | CROSS-REFERENCED TO THE APPROPRI | ATE COMPLETION DATE | | | | |
| TAG | REGULATORY OR LSC IDENTIFYING INFORMATION indicated staff should not hug, hold hands or kiss | | IAG | | DATE | | | | |
| | a resident. 1 resident indicated it would be okay if | | | | | | | | |
| | | ninded and knew what the hug | | | | | | | |
| | was about. 1 resident indicated hugs were okay | | | | | | | | |
| | but never was it oka | ry to kiss a resident on the | | | | | | | |
| | lips. The SSD indicated the facility had no specific | | | | | | | | |
| | questions to ask residents when conducting | | | | | | | | |
| | | ding abuse nor was there any | | | | | | | |
| | procedure to identify residents to be interviewed. | | | | | | | | |
| | When questioned, he indicated he hadn't known why the resident reported the incident if she | | | | | | | | |
| | | d by it and had not been | | | | | | | |
| | | nt's concern about Resident N | | | | | | | |
| | | tionship with Employee 3. He | | | | | | | |
| | | any interviews of residents or | | | | | | | |
| | staff on the 2nd floo | - | | | | | | | |
| | The investigation of | f the alleged abuse had not | | | | | | | |
| | | with staff who may have | | | | | | | |
| | | ent, any cognitively intact | | | | | | | |
| | residents who may l | have been affected by | | | | | | | |
| | Employee 3, nor wa | as there any investigation | | | | | | | |
| | | dents and staff on the 2nd | | | | | | | |
| | | ory care unit where Employee 3 | | | | | | | |
| | was observed to wo | rk often. | | | | | | | |
| | A current facility po | olicy, titled "Abuse | | | | | | | |
| | | ovided by the Administrator | | | | | | | |
| | on 12/19/22 at 12:1: | 5 P.M., stated the following: "It | | | | | | | |
| | | ility] to adhere to CMS | | | | | | | |
| | | ana Administrative Code (IAC) | | | | | | | |
| | | right to be free from abuse, | | | | | | | |
| | | ation3. [Facility] will establish | | | | | | | |
| | | ures to prohibit and prevent | | | | | | | |
| | | oitation and misappropriation | | | | | | | |
| | | cy, investigate and report any neglect or exploitation" The | | | | | | | |
| | | | | | | | | | |
| | policy hadn't indicated what the expectations were for an investigation to be considered thorough | | | | | | | | |
| | and complete. | to of complacion morough | | | | | | | |
| | l | | | | | | | | |

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| STATEMEN | IENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|---|-------------------------------|--|---|-------------------------------|------------------|------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | a. building <u>00</u> | | | COMPLETED | | |
| | | 155349 | B. WING | | | 12/20/2022 | | |
| NAME OF PROVIDER OR SUPPLIER SAINT ANNE HOME | | | | STREET ADDRESS, CITY, STATE, ZIP COD 1900 RANDALLIA DR FORT WAYNE, IN 46805 | | | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) | |
| PREFIX | (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | PREFIX (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROPRIES. | | | COMPLETION | | |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE | |
| | This Federal tag rela | ates to Complaint IN00396697. | | | | | | |

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