STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155349	A. BUILDING 00 B. WING	12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SAINT ANNE HOME	1900 RANDALLIA DR FORT WAYNE, IN 46805

(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 Complaints IN00396574 and IN00396697. Complaint IN00396574 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00396697 - Substantiated. Federal/state deficiencies related to the allegations are cited at F600, F607, and F610. Survey dates: December 19 and 20, 2022 Facility number: 000240 Provider number: 155349 AIM number: 100274960 Census Bed Type: SNF/NF: 84 SNF: 4 Total: 88 Census Payor Type: Medicare: 5 Medicaid: 53 Other: 30 Total: 88 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed December 22, 2022	F 0000		
F 0600 SS=D 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			

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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	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; Based on interview and record review, the facility failed to ensure residents were free from staff abuse 1 of 5 residents reviewed (Resident J). Findings include: An Indiana report form, dated 12/8/22 at 4:30 p.m., indicated Resident J had reported to a nurse a male staff member (Employee 3) gave her a hug and kissed her on the lips. The male staff member had resigned earlier in the day. The male staff member was notified he was not allowed on the property, have contact with residents or families. Social services staff were to interview other residents for abuse or inappropriate contact. On 12/19/22 at 3:15 P.M., Resident J was observed seated in her wheelchair in her room. She was alert and oriented. She indicated she'd lived at the facility for 6 years and loved her room. Currently, she had no roommate. She was not observed in any distress and had a welcoming, genuine smile on her face. On 12/20/22 at 9:25 A.M., Resident J was observed in the living room area working on a puzzle. In an interview, Resident J indicated	F 0600	**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 respectfully requests a paper review of the plan of correction.** **F 600** - what corrective action(s) will 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 understood it was for the best. A licensed Social Worker, talk therapist met with the resident. The LSW documented Resident J hadn't indicated any emotional trauma nor had she perceived anything inappropriate**. - how other residents having the potential to be affected by the	01/20/2023

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	Employee 3 had been her special friend. She had spent much time with him talking about life, their children, books, and dying. She indicated he was her soulmate but not in a sexual way. They could talk about everything important to them and she came to love him like a son. On 12/8/22, in the afternoon, Emploee 3 came to her room. She was surprised because she hadn't usually seen him in the afternoon, just in the mornings. He came in the room, knelt down in front of her wheelchair, indicated he had been let go by the facility and was leaving his employment. He couldn't tell her why he had been let go. She indicated she had cried but had also been very angry with him. She indicated he was very intelligent but was a man, but didn't think with his head, rather another part of his anatomy. She indicated Employee 3 had been tempted by Resident N who lived on the 2nd floor of the facility. The resident indicated she'd known Resident N for years and had gone to school with her. She indicated Resident N was flirtatious with men and then would rebuff them when they became interested. When questioned why she thought this, she indicated that Employee 3 would always bring Resident N to mass and she observed him, several times, "tenderly" and "lovingly" caress the resident's shoulders. Resident J indicated it was a caress that would occur between a man and woman. Before Employee 3 had left her room, on 12/8/22, he had asked for her phone number so he could contact her after he left. She indicated she'd felt bad, but she had lied to him and told him she couldn't remember the number because she hadn't thought it was proper to give it to him. She told him she would pray for him and hoped he could get his life straightened out. She indicated he asked if he could kiss and hug her goodbye. She replied "yes", he could and would've been upset had he not asked. 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 to be affected. Inservice training on abuse prevention with examples of 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 not recur; Staff will be in-serviced on abuse prevention by January 20th and routine education will be provided with examples of what is considered appropriate/inappropriate. - how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Resident concerns will be audited weekly to ensure abuse prevention guidelines are followed. Once 100% compliant for two months, audits will be done monthly. Results will be reviewed in the QA meeting. Social Services/Administrator to monitor. - by what date the systemic changes for each deficiency will be completed. January 20th IDR	

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	her on the lips. She indicated she hadn't expected to be kissed on the lips and had been surprised when he did. Employee 3 then left her room and she hadn't heard from him since. She indicated she had cried for 2 days after he left and missed him. On 12/19/22 at 12:40 P.M., Resident J's record was reviewed. Diagnoses included hemiplegia (paralysis) of the right dominant side following a stroke and dependence on a wheelchair. A quarterly MDS (Minimum Data Set) assessment, dated 9/28/22, indicated she had no cognitive impairment, mood indicators, or behaviors. Care plans, revised on 9/14/20, indicated Resident J demonstrated independence in her decision making. She needed religious/spiritual support with a goal of having her spiritual needs met by pastoral care. Her care plans had not indicated any behaviors towards other residents/staff, behaviors of making false accusations or fabrication/embellishment of events. Progress notes indicated the following: -12/9/22 at 6:00 a.m., the resident reported to the nurse a male staff member (Employee 3) had given her a hug, kissed her on the lips as he was leaving and had asked for her phone number so he could keep in touch after he was no longer employed at the facility. The Administrator and Director of Nursing (DON) were notified. -At 9:48 a.m., the resident spoke with the day shift nurse (Employee 6) about the incident. The resident denied distress over the situation but reported her concern for "anyone else he may have done this to". The resident was told a member of management would speak with her.		Resident is competent to visit. Per ISDH Surveyor interview, SSD interview, all statements to her nurse, resident said she expected former employee to tell her goodbye, give her a hug and a kiss. Resident in all interviews stated she was upset that he was leaving because he was like a son to her. On 12/12, nurse documented resident asked for the former employee's ph #. When told the nurse didn't have it, the resident persisted by asking for the ph # the former employee attends.	

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	Record reviews hadn't indicated a member of management had spoken with her on that day. -12/10/22 at 11:14 a.m., Resident J stopped the day shift nurse (Employee 6) and reported she knew why Employee 3 was no longer at the facility. She believed Resident N, who lived upstairs, reported him. She indicated Resident N was always flirting and batting her eyes at Employee 3 and was a big "flirt" who was probably jealous. -12/12/22 at 10:45 a.m., a Social Services note indicated a follow up interview had been completed with Resident J. During the interview, Resident J had indicated she was upset at her friend choosing to leave the facility but she supported his decision because it was best for him. She became tearful as she described her relationship with Employee 3 whom she indicated was like a son to her. When asked about the kiss he had given her, she indicated it was what she had expected and he was like a son to her. She hadn't expressed any further concerns. She was offered the opportunity to speak with a talk therapist and she accepted. -At 6:16 p.m., a Licensed Social Worker (LSW)/talk therapist indicated she met with the resident in the dining room. Resident J was inviting, pleasant, spoke about the holiday and being with family. She was asked if she was doing alright since her friend (Employee 3) had been dismissed. She indicated they had been good friends. Employee 3 had told her the facility had let him go but he hadn't been able to tell her why. She went on to say he kissed her but it had been a peck on her mouth. He had asked her for her phone number but she told him she hadn't thought it was a good idea. She saw him as a friend to have good conversations with. When asked, she indicated she was no longer having			

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	any difficulties coping with the "actions and end of relationship". She had cried for 2 nights but indicated she was fine with it now. The LSW indicated Resident J hadn't indicated any emotional trauma nor had she perceived anything inappropriate when Employee 3 touched her. On 12/19/22 at 11:16 A.M., The Administrator indicated the residents family had been notified of the incident and had reported their belief Resident J embellished or fabricated stories to get attention. He indicated the resident hadn't understood Employee 3 could get into trouble for her report of him kissing her on the lips. He indicated he'd had a meeting with Employee 3 and had encouraged him to resign due to other concerns about Employee 3's behavior. Employee 3 agreed and resigned at that time. The Administrator indicated there had been no concerns expressed by residents or staff regarding the employee's behaviors towards residents, only those in his department. During a confidential interview, Employee 5 indicated Employee 3 could be manipulating. He would have angry outbursts at staff members, then would want to be helpful and pray with the staff member he had just had the verbal outburst at. Employee 3 worked often on the 2nd floor secured memory care unit and preferred to pray with residents in their rooms rather than complete other assigned duties. Employee 5 indicated Employee 3 had a close friendship with Resident J and had spent much time with her. On 12/20/22 at 10:20 A.M., Employee 6 was interviewed. She indicated Resident J reported to her Employee 3 had kissed her on the lips and was concerned there may have been other residents he had kissed as well. She indicated the resident			

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	hadn't seemed distressed by what had occurred but had reported it. She indicated she knew the resident on the 2nd floor, Resident N, but couldn't recall if she had reported it to anyone. She hadn't asked for further information from Resident J about her concerns. Employee 6 indicated she had not witnessed nor had she ever been told by residents Employee 3 had been inappropriate with them. On 12/20/22 at 11:25 A.M., the Administrator was interviewed. He indicated 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) was interviewed. He indicated he had spoken with Resident J after the allegation was made. Resident J indicated Employee 3 had been like a son to her and she was tearful while describing the relationship. She appreciated Employee 3 praying with her and treating her kindly. When questioned, he indicated he hadn't known why the resident reported the incident if she hadn't been bothered by it. He had not been aware of the resident's concern about Resident N and the alleged relationship with Employee 3. On 12/20/22 at 12:36 P.M., the HR director was interviewed regarding 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 indicated, after reviewing the hall cameras, she could confirm that on 12/8/22 at 2:42 p.m., Employee 3 entered Resident J's room and exited the room at 2:48 p.m. She indicated earlier on the day of the allegation, Employee 3 had given his resignation on the recommendation of the Administrator. Employee 3 had not been asked to leave the building immediately upon tendering his			

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	resignation and had gone to some of the resident's room to say goodbye. She indicated he had clocked out of the facility sometime between 3:15 and 3:30 p.m. During the interview with Resident J and SSD, the resident indicated Employee 3 had come to her room and explained he needed to leave the facility. He hadn't disclosed the reason but indicated it was time to leave. She was visibly emotional about this and indicated a number of times she was sad he was gone and was going to miss him "very much". Resident J indicated she thought of Employee 3 as the son she'd never had. They had sat and talked about their kids, family, life, and death. She indicated before he left her room, he had asked for her phone number but she had declined and told him she would keep him in her prayers. He then asked if he could kiss her and she gave permission. He kissed her on the lips and left the room. A current facility policy, titled "Abuse Prevention" and provided by the Administrator on 12/19/22 at 12:15 P.M., stated the following: "It is the policy of [facility] to adhere to CMS guidelines and Indiana Administrative Code (IAC) regarding resident's right to be free from abuse, neglect and exploitation...3. [Facility] will establish policies and procedures to prohibit and prevent abuse, neglect, exploitation and misappropriation property, watch for changes that may cause abusive behavior and review interventions on a regular basis, such as: A. Screen and train employees to protect residents and prohibit and prevent abuse, neglect and exploitation. B. Identify, investigate and report any incidents of abuse, neglect or exploitation...Abuse is defined as: Sexual, physical and mental abuse...." This Federal tag relates to Complaint IN00396697.			

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	3.1-27(a)(b)			
F 0607 SS=D Bldg. 00	483.12(b)(1)-(5)(ii)(iii) Develop/Implement Abuse/Neglect Policies §483.12(b) The facility must develop and implement written policies and procedures that: §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) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. Based on interview and record review, the facility failed to implement policies and procedures to prevent abuse of 1 of 5 residents reviewed	F 0607	**F 607** - what corrective action(s) will	01/20/2023

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	(Resident J). Findings include: An Indiana report form, dated 12/8/22 at 4:30 p.m., indicated Resident J had reported to a nurse a male staff member (Employee 3) gave her a hug and kissed her on the lips. The male staff member had resigned earlier on 12/8/22. The male staff member was notified he was not allowed on the property or have contact with residents or families. Social services staff were to interview other residents for abuse or inappropriate contact. On 12/19/22 at 11:16 A.M., the Administrator was interviewed about the reported incident between Resident J and Employee 3. He indicated on 12/8/22 he'd had a meeting with Employee 3 and had encouraged him to resign due to other reported concerns about Employee 3's behaviors. Employee 3 agreed and resigned at that time. The Administrator indicated there had been no concerns expressed by residents regarding Employee 3's behaviors. During a confidential interview, Employee 5 indicated Employee 3 could be manipulating. He would have angry outbursts at staff members, then would want to be helpful and pray with the staff member. Employee 3 worked often on the 2nd floor secured memory care unit and preferred to pray with residents in their rooms rather than complete his assigned duties. Employee 5 indicated Employee 3 had a close friendship with Resident J and had spent much time with her. On 12/19/22 at 2:00 P.M., Employee 3's personnel file was reviewed. There were no disciplinary actions or concerns regarding performance of his duties or interactions with others. A criminal		be accomplished for those residents found to have been affected by the deficient practice; Criminal background check was done the day the original wasn't found. Employee had resigned. - how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected. Inservice training on abuse prevention regarding background checks, including criminal background checks. - what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Employee files will be audited for completeness. Any files missing will be flagged and corrected. New employee files will be audited weekly. - how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Audits to be completed weekly until 100% compliance for 2 months. At which time audits will be completed monthly. Data	

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	background check indicated it had been completed on 12/19/22. The Administrator indicated Human Resources (HR) staff had been unable to find the criminal background check done at the time Employee 3 was hired. On 12/20/22 at 12:36 P.M., the HR director was interviewed. She indicated, on 12/8/22, Employee 3 submitted his resignation on the recommendation of the Administrator. The HR Director indicated when Employee 3 had been hired, she had been leaving for an extended leave of absence and had been trying to orient her replacement. The position had been vacated abruptly and the position needed filled immediately. Employee 3 had credible references and was hired. She indicated she had not been able to find the employee's criminal background check. The check was required to be done for employment at the facility. She indicated it may have been missed due to the confusion with the leave of absence and the need to fill the open position immediately. A current facility policy, titled "Abuse Prevention" and provided by the Administrator on 12/19/22 at 12:15 P.M., stated the following: "It is the policy of [facility] to adhere to CMS guidelines and Indiana Administrative Code (IAC) regarding resident's right to be free from abuse, neglect and exploitation...3. [Facility] will establish policies and procedures to prohibit and prevent abuse, neglect, exploitation and misappropriation property, watch for changes that may cause abusive behavior and review interventions on a regular basis, such as: A. Screen and train employees to protect residents and prohibit and prevent abuse, neglect and exploitation. B. Identify, investigate and report any incidents of abuse, neglect or exploitation...Abuse is defined as: Sexual, physical and mental abuse...Screening		results shared at QA meeting. HR/Administrator/Designee - - by what date the systemic changes for each deficiency will be completed. Jan. 20, 2023	

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	Procedure: D. Obtain criminal history report on all employees...." This Federal tag relates to Complaint IN00396697. 3.1-28(b)(1)(A)			
F 0610 SS=D 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 conduct a thorough investigation of an allegation of abuse for 1 of 5 residents reviewed (Resident J). Findings include: An Indiana report form, dated 12/8/22 at 4:30 p.m., indicated Resident J had reported to a nurse that a male staff member (Employee 3) gave her a hug and kissed her on the lips. The male staff member had resigned earlier that day. The male staff	F 0610	- what corrective action(s) will 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 understood it was for the best. A licensed Social Worker, talk therapist met with the resident. The LSW documented Resident J hadn't indicated any emotional	01/20/2023

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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
	member was notified that he was not allowed on the property or have contact with residents or families. Social services staff were to interview other residents for abuse or inappropriate contact. On 12/20/22 at 9:25 A.M., during an interview, Resident J indicated Employee 3 had been her special friend. On 12/8/22, in the afternoon, he came to her room, knelt down in front of her wheelchair, indicated he had been let go by the facility and was leaving his employment. He couldn't tell her why he had been let go. She indicated she had cried but had also been very angry with him. She indicated he was very intelligent but was a man and didn't think with his head, rather another part of his anatomy. She indicated Employee 3 had been tempted by Resident N who lived on the 2nd floor of the facility. The resident indicated she'd known Resident N for years and had gone to school with her. She indicated Resident N was flirtatious with men and then would rebuff them when they became interested. When questioned why she thought this, she indicated that Employee 3 would always bring Resident N to mass. She had observed him several times "tenderly" and "lovingly" caress the resident's shoulders. Resident J indicated it was a caress that would occur between a man and woman. Before Employee 3 had left her room, on 12/8/22, he had asked for her phone number so he could contact her after he left. She indicated she'd felt bad, but she had lied to him and told him she couldn't remember the number because she hadn't thought it was proper to give it to him. She told him she would pray for him and hoped he could get his life straightened out. She indicated he asked if he could kiss and hug her goodbye. She replied "yes" he could and would've been upset had he not asked. He hugged her and then kissed her on		trauma nor had she perceived anything inappropriate. - how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected. Staff will be in-serviced on abuse prevention by January 20th and routine education will be provided with examples of 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 not recur; Staff will be in-serviced on abuse prevention by January 20th and routine education will be provided with examples of what is considered appropriate/inappropriate - how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Resident concerns will be audited weekly to ensure abuse prevention guidelines are followed. Once 100% compliant for two months, audits will be done monthly. Results will be reviewed in the QA meeting. Social	

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	155349	A. BUILDING 00 B. WING	12/20/2022

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	the lips. She indicated she hadn't expected to be kissed on the lips and had been surprised when he did. Employee 3 then left her room and she hadn't heard from him since. She indicated she had cried for 2 days after he left and missed him. On 12/19/22 at 12:40 P.M., Resident J's record was reviewed. Diagnoses included hemiplegia (paralysis) of the right dominant side following a stroke and dependence on a wheelchair. A quarterly MDS (Minimum Data Set) assessment, dated 9/28/22, indicated she had no cognitive impairment, mood indicators, or behaviors. Care plans, revised on 9/14/20, indicated Resident J demonstrated independence in her decision making. She needed religious/spiritual support with a goal of having her spiritual needs met by pastoral care. Her care plans had not indicated any behaviors towards other residents/staff or behaviors of making false accusations or fabrication/embellishment of events. Progress notes indicated the following: -12/9/22 at 6:00 a.m., the resident reported to the nurse a male staff member (Employee 3) had given her a hug kissed her on the lips as he was leaving and had asked for her phone number so he could keep in touch after he was no longer employed at the facility. The Administrator and Director of Nursing (DON) were notified. -At 9:48 a.m., the resident spoke with the day shift nurse (Employee 6) about the incident. The resident denied distress over the situation but reported her concern for "anyone else he may have done this to". The resident was told a member of management would speak with her.		Services/Administrator to monitor. - by what date the systemic changes for each deficiency will be completed. January 20, 2023 IDR Documents Uploaded to Support IDR 610 Request this tag be removed. 1) P. 17 2nd paragraph "The investigation of the alleged abuse had not included interviews with staff who may have witnessed the incident" – the resident was in the room by her self & former employee 3, HR was directed by the Administrator to check the hallway camera to see if and when the former employee entered and left the room and to see if anyone else entered the room – no one else was in the room. 2) P. 17 2nd paragraphed continues "had not included any cognitive intact residents who may have been affected by Employee 3, nor was there any investigation completed with residents and staff on the 2nd floor secured memory care unit where Employee 3 was observed to work often". On page 16 of this 2567, 3rd paragraph Surveyor documented "On 12/20/22 at 12:02 P.M., the Social Service Director (SSD) was interviewed about the investigation into the allegation. He indicated he interviewed some residents who may have received care from Employee 3 (a total of 7	

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	Record reviews hadn't indicated a member of management had spoken with her. -12/10/22 at 11:14 a.m., Resident J stopped the day shift nurse (Employee 6) and reported she knew why Employee 3 was no longer at the facility. She believed Resident N, who lived upstairs, reported him. She indicated Resident N was always flirting, batting her eyes at Employee 3 and was a big "flirt" who was probably jealous. During a confidential interview, Employee 5 indicated Employee 3 worked often on the 2nd floor secured memory care unit and preferred to pray with residents in their rooms rather than complete other assigned duties. On 12/20/22 at 10:20 A.M., Employee 6 was interviewed. She indicated Resident J reported to her Employee 3 had kissed her on the lips and she was concerned there may have been other residents he had done this to. She indicated the resident hadn't seemed distressed by what had occurred but had reported it. She indicated she knew which resident on the 2nd floor Resident J had referred to, Resident N, but couldn't recall if she had reported it to anyone. She hadn't asked for further information from Resident J about her concerns. Employee 6 indicated she had not witnessed nor had she ever been told by residents Employee 3 had been inappropriate with them. On 12/20/22 at 12:02 P.M., the Social Services Director (SSD) was interviewed about the investigation into the allegation. He indicated he interviewed some residents who may have received care from Employee 3 (a total of 7 residents). The 7 residents were asked if it was okay for staff to hug, hold hands, or to kiss a resident. 4 residents reported it was ok. 1 resident		residents). As Administrator, I or my designee in my absence, am in charge of abuse investigations. When notified of the allegation, I reported to ISDH. Talked to HR to check the camera to identify if he went in, when he left and any other activity. Talked to our SSD, reviewed questions that residents should be asked specific to the allegation. Contacted the former employee 3 for a statement and notified him he is not allowed to come back on the property. Called the daughter regarding the allegation and our steps to make sure her mom was safe. Reviewed with the pastoral staff that he was not allowed back in the bldg. and if they knew of any inappropriate conduct with residents. I received a letter from the daughter stating that her family has experienced the resident saying things that were not true. I received the email from the former employee stating he did stop and tell her he wouldn’t be back. He denied kissing her on the lips.	

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	indicated staff should not hug, hold hands or kiss a resident. 1 resident indicated it would be okay if the resident hadn't minded and knew what the hug was about. 1 resident indicated hugs were okay but never was it okay to kiss a resident on the lips. The SSD indicated the facility had no specific questions to ask residents when conducting investigations regarding 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 hadn't been bothered by it and had not been aware of the resident's concern about Resident N and the alleged relationship with Employee 3. He had not conducted any interviews of residents or staff on the 2nd floor. The investigation of the alleged abuse had not included interviews with staff who may have witnessed the incident, any cognitively intact residents who may have been affected by Employee 3, nor was there any investigation completed with residents and staff on the 2nd floor secured memory care unit where Employee 3 was observed to work often. A current facility policy, titled "Abuse Prevention" and provided by the Administrator on 12/19/22 at 12:15 P.M., stated the following: "It is the policy of [facility] to adhere to CMS guidelines and Indiana Administrative Code (IAC) regarding resident's right to be free from abuse, neglect and exploitation...3. [Facility] will establish policies and procedures to prohibit and prevent abuse, neglect, exploitation and misappropriation property...B. Identify, investigate and report any incidents of abuse, neglect or exploitation...." The policy hadn't indicated what the expectations were for an investigation to be considered thorough and complete.			

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