STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155338	A. BUILDING 00 B. WING	02/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF AVON	445 S COUNTY ROAD 525 E AVON, IN 46123

(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 IN00427703 and IN00427705. Complaint IN00427703 - Federal/state deficiencies related to the allegations are cited at F600 and F609. Complaint IN00427705 - Federal/state deficiencies related to the allegations are cited at F600 and F609. Survey dates: February 5 and 6, 2024 Facility number: 000231 Provider number: 155338 AIM number: 100267900 Census Bed Type: SNF/NF: 81 Total: 81 Census Payor Type: Medicare: 1 Medicaid: 73 Other: 7 Total: 81 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 21, 2024.	F 0000	Majestic Care of Avon will request a Desk review. Date of Compliance 3-1-24	
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
Nikki Osborne	Regional Nurse Consultant	03/13/2024

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 observation, interview, and record review, the facility failed to ensure a non-verbal, cognitively impaired resident was free from abuse for 1 of 3 residents reviewed for abuse (Resident B). Findings include: During the survey, the family provided the video from Resident B's web camera showing the abuse on 2/4/24. In the video Qualified Medication Aide (QMA) 11 was standing on the left side of the bed next to Resident B. The blankets were off of Resident B and QMA 11 was preparing to change the resident's incontinence brief. Certified Nurse Aide (CNA) 12 came to the right side of the bed from the bathroom. CNA 12 was smiling and talking with QMA 11. Resident B was calm and watching QMA 11 and CNA 12. Once CNA 12 was next to Resident B, CNA 12 reached over and grabbed Resident B's left arm and left hip to pull her toward her while QMA 11 pushed the resident's back and left shoulder to turn her onto her right side toward CNA 12. Resident B slid her legs down off the edge of the bed like she was getting out of bed. Resident B moved her hands toward CNA 12's lower arm and elbow and then	F 0600	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. We respectfully request a paper review and will provide any additional information requested. F 600 (D) **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Resident B was the only resident found to be affected by this deficient practice. Staff members involved have been terminated from facility. All staff educated on abuse and timeline reporting as of 2-5-24. **How other residents having the**	03/01/2024

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	behind CNA 12's back. The residents hands were no longer visible in the video. Suddenly, CNA 12 pushed Resident B's arms away from her body and hit Resident B on the left arm and upper abdomen with both open hands and yelled at the resident about grabbing and tearing her clothes. QMA 11 let go of Resident B to allow the resident to be on her back. QMA 11 shook her left hand side to side over the resident while CNA 12 was yelling at her but was not observed to verbally stop or physically intervene during the incident. CNA 12 and QMA 11 did not reposition Resident B's legs or reassure the resident that she was not falling. Resident B was turned onto her right side by CNA 12 again grabbing her left hip and pulling the resident towards her. She did not reposition the residents' legs. QMA 11 took off the soiled brief and started to clean Resident B. A male's voice was heard in the room and indicated "there is no reason for smacking her!" Another female's voice was heard indicating the resident had just woken up and staff did not need to be "so rough." CNA 12 indicated they were not being rough and Resident B was trying to fall by putting her foot down on the ground. The female voice indicated Resident B did not understand what the staff were doing. Then the video ended. An interview during the survey from Family Member 1 indicated voices heard in the video telling CNA 12 her behavior was inappropriate were from the camera where Resident B's family members were watching the incontinence care. The family members were not in the room but were able to see the care "live" from the camera and speak directly to staff during care. On 2/5/24 at 4:04 p.m., the Administrator provided the Grievance log for January and February 2024. On 2/4/24 a grievance was filed by a family		**potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** No other residents were identified by this deficient practice. Skin examinations were done completed for all residents residing on unit as of 2-5-24 with no additional findings. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** The Administrator will be immediately notified of any allegations of abuse. An investigation will be initiated immediately, and the alleged abuser will be suspended from the facility pending the outcome of the investigation. All staff will be in-serviced on types of abuse, prevention/intervention, burnout and stress management monthly times 3 in order to provide additional education then continue upon hire, annually and as needed. **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.** Abuse/Reporting Abuse Audits will be conducted weekly x4, bi-weekly x4 and Monthly x4 or until a 100% threshold is obtained.	

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	member related to Resident B as a "care concern." The Administrator indicated the grievance had not been completed as they were still completing the abuse investigation, but he had an appointment scheduled to meet with the family. A handwritten Witness Statement, dated 2/5/24, indicated it was written and signed by QMA 11. The statement indicated, QMA 11 had worked on the memory care on February 4, 2024, night shift. At about 5:40 a.m., QMA 11 and CNA 12 entered Resident B's room to provide care. QMA 11 turned Resident B towards CNA 12 to be able to clean her up. Resident B rolled towards CNA 12 and CNA 12 hit Resident B. QMA 11 told CNA 12 not to hit the resident. A typed document without a title, indicated QMA 11 was interviewed by the Administrator and the Director of Nursing (DON). QMA 11 indicated she had not abused a resident but had witnessed CNA 12 hit Resident B on her arm. During a telephone interview on 2/6/24 at 2:52 p.m., Resident B's Family Member 2 indicated the family had had problems with Resident B's care previously, so the family had decided to get a web camera. Multiple family members had access to the camera and the videos were also uploaded to a shared cloud drive (remote storage). On Sunday 2/4/24, Family Member 3 got notified on her phone of movement in Resident B's room and pulled up the video to check on the resident. Family Member 3 observed CNA 12 hit Resident B while providing care. Family Member 2 was able to pull the video from the cloud. The family contacted the facility and filed a grievance with the Administrator. The family provided the video to the facility. The family was told CNA12 would be fired, her license would be reported, and the police		This information will be presented at the QAPI committee during monthly meetings. b="">
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	were called. The family had an appointment with the facility scheduled for 2/7/24 at 10 a.m. He was told CNA 12 was going to be charged with a felony. During an interview on 2/6/24 at 12:05 p.m., QMA 11 indicated she went to Resident B' room with CNA 12 to assist with cleaning the resident. QMA 11 was helping CNA 12 with her work since Resident B needed 2 people for care. QMA 11 turned the resident toward CNA 12 and the resident moved her arms and was sliding out of bed. CNA 12 hit the resident. QMA 11 told the CNA 12 "no don't do that." Then QMA 11 heard "a voice from somewhere" asking why they were treating Resident B rough. QMA 11 told them she was not being rough, and they would finish care. CNA 12 stayed quiet and would not answer. Once care was done they left the room. QMA 11 tried to call the Administrator but there was no answer. It was the end of the shift and shift change. It had been a chaotic night, and she did not try to call again. She did tell the oncoming nurse what happened. She did not believe Resident B was trying to hit CNA 12. The resident did not know what she was doing she was just moving her arms. Resident B was not a violent person. QMA 11 believed CNA 12 was having a rough night and hit Resident B due to frustration. During an interview on 2/6/24 at 5:33 a.m., Licensed Practical Nurse (LPN) 13 indicated she was the nurse working on the locked unit. She had worked with CNA 12 numerous times in the past and had no concerns about her treatment of residents. She was surprised to hear of the incident.. Resident B was not combative and allowed care to be done to her. She was not able to help with care much anymore and she got scared or confused easily. Resident B may tug on			

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	clothing or hold on to staff, but she was not combative. Resident B tried to communicate that she could not help, or she was scared by moving her hands. Resident B did not verbally speak anymore due to her disease progress. She communicated nonverbally with facial expressions, tapping on things, and hitting the table if she wanted to go to sleep when sitting in activities or at dining. She was a 2 person assist for care due to her not being able to help much with her own care. It was safer for her to have 2 people assisting her. She was the only resident on the unit with a web camera. LPN 13 believed it was the family's request and the facility allowed it. It was a good thing since it showed abuse when no one was aware that was happening. All of the staff were shocked and surprised. During an interview on 2/6/24 at 5:33 a.m., CNA 14 indicated she had worked with CNA 12 previously and never had any concerns about her treatment of residents. Resident B was not combative and did not resist care. During an observation on 2/6/24 at 5:52 a.m., morning care was observed for Resident B with LPN 13 and CNA14. A sign was posted on the outside of the door and in the room on the wall indicating that the room was being recorded by video. As the staff entered the resident's room and turned on the lights a family member came on over the web camera and said, "good morning." The family member asked staff to unclip the call light from Resident B's blanket since the resident was unable to use it and the family member was afraid she would get tangled up in cord. During the observation of incontinence care and dressing of the resident LPN 13 and CNA 14 informed Resident B of what they were doing before they did it. When LPN 13 turned Resident B onto her			

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	right side, Resident B moved her legs off the bed and attempted to try to slide her legs down to the floor like she was getting out of bed. CNA 14 moved her legs back onto the bed and explained again they were going to lay her on her right side. The resident remained calm and did not resist care. Resident B would clap her hands together when she was unsure of what was happening and when she had been on her side for several minutes. LPN 13 and CNA 14 reassured Resident B and explained what they were doing. LPN 13 and CNA 14 were able to provide incontinence care, cleaned her face and armpits, dressed the resident for the day, and provided a clean top sheet and blanket without concerns. The skin on Resident B's arms and stomach were free from skin impairments and there were no signs of bruising or redness. During a telephone interview on 2/6/24 at 3:48 p.m. CNA 12 indicated she did not abuse Resident B. She had worked with the resident for a year. The early morning of 2/4/24 she was in the room with QMA 11, and they were changing Resident B. The QMA had turned the resident toward her to clean the resident. The resident's feet were falling down off the bed. The resident grabbed CNA 12's shirt and was holding onto it. When CNA 12 went to turn the resident back toward the QMA the resident was holding onto her and it was hard to turn her, so CNA 12 had to get the resident's hand off her shirt and push her hard to get her to turn. CNA 12 did not hit Resident B and would not hit her. CNA 12 was just trying to get Resident B off of her so she could turn her to finish cleaning her. On 2/6/24 at 10:22 a.m. Resident B's record was reviewed. Resident B's diagnoses included, but were not limited to, Pick's disease (frontotemporal or front lobe dementia), general anxiety disorder,			

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	depression, and psychotic disorder with delusions. A quarterly Minimum Data Set (MDS) assessment, dated 1/29/24, indicated Resident B had adequate hearing, was not comatose, did not speak, sometimes understood others, and sometimes made others understand her. Resident B had adequate vision, wore corrective lenses. A Brief Interview for Mental Status (BIMS) assessment was not completed by the resident nor staff. Resident B had no behaviors, no impairment of extremities, and used a wheelchair for mobility. A care plan, initiated on 8/3/21 and revised on 9/14/21, indicated Resident B needed assistance with activities of daily living. Interventions included, but were not limited to, assist with incontinent care, staff assistance with bed mobility, and staff assistance with personal hygiene and toileting. A care plan, initiated on 8/12/21 and revised on 6/21/22, indicated Resident B exhibited signs of cognitive impairment. Interventions included, but were not limited to, staff were to allow extra time for the resident to respond, always approach the resident in a friendly gentle manner, and be alert to nonverbal cues. A care plan, initiated on 4/25/23, indicated Resident B exhibited impulsivity of frequent jerking movements and rocking back and forth. Interventions included, but were not limited to, staff were to approach the resident in a calm and friendly manner, explain to the resident what they were going to do before starting the task, allow the resident to regain their composure if she became combative or resistive and postpone care			

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	or activity and re-approach as needed, maintain a safe environment, and listen to the resident's needs and adjust the plan of care as needed. A care plan, initiated on 4/25/23, indicated Resident B had difficulty with communication due to neurological symptoms and diagnoses of Pick's disease, dementia, anxiety, and psychotic disorder with delusions. Interventions included, but were not limited to, "do not rush" and observe for physical and nonverbal indicators of discomfort or distress. A care plan, initiated on 4/25/23, indicated Resident B's family requested a camera to be in the room and signs notifying the staff that recording was in progress would be posted in and outside the room. Interventions included, but were not limited to, staff were to allow the resident to vent feelings and needs, approach the resident in friendly calm manor, assess the resident's needs for toileting and body positioning, provide care in pairs, explain to the resident what they were going to do before initiating the task, maintain a safe environment, and if the resident became combative or resistive staff were to postpone care and allow the resident to regain composure. Focused charting, dated 2/4/24 at 12:33 a.m., indicated Resident B did not have signs or symptoms of emotional distress or tearfulness. There were no changes in the resident's facial expressions or resistance with care. A General Progress Note, dated 2/4/24 at 2:46 p.m., indicated Resident B did not have signs of distress or tearfulness. A skin assessment was completed with no new areas of concern. The resident's record lacked documentation of the			

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	incident. On 2/5/24 at 3:09 p.m., the Director of Nursing (DON) provided a current policy titled, "Abuse Prevention Program." The policy indicated, " ...Our residents have the right to be free from abuse, neglect ...Our facility is committed to protecting our residents from abuse by anyone including, but not necessarily limited to: facility staff ...Our abuse prevention/intervention education program includes ...Training staff to understand and manage a resident's verbal or physical aggression ...Monitoring staff on all shifts to identify inappropriate behavior toward residents (e.g., using derogatory language, rough handling of residents, ignoring residents while giving care ...." This citation relates to Complaints IN00427703 and IN00427705. 3.1-27(a)(1) 3.1-27(b)			
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(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			

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	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 interview and record review, the facility failed to ensure staff immediately reported to the Administrator witnessed abuse by another staff member to a resident for 1 of 3 residents reviewed for abuse (Resident B). Findings include: During the survey, the family provided the video from Resident B's web camera showing the abuse on 2/4/24. In the video Qualified Medication Aide (QMA) 11 was standing on the left side of the bed next to Resident B. The blankets were off of Resident B and QMA 11 was preparing to change the resident's incontinence brief. Certified Nurse Aide (CNA) 12 came to the right side of the bed from the bathroom. CNA 12 was smiling and talking with QMA 11. Resident B was calm and watching QMA 11 and CNA 12. Once CNA 12 was next to Resident B, CNA 12 reached over and grabbed Resident B's left arm and left hip to pull her toward her while QMA 11 pushed the resident's back and left shoulder to turn her onto	F 0609	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. We respectfully request a paper review and will provide any additional information requested.F 609 (D) **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Resident B was the only resident found to be affected by this deficient practice. Staff members involved have been terminated from facility. **How other residents having the**	03/01/2024

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	her right side toward CNA 12. Resident B slid her legs down off the edge of the bed like she was getting out of bed. Resident B moved her hands toward CNA 12's lower arm and elbow and then behind CNA 12's back. The residents hands were no longer visible in the video. Suddenly, CNA 12 pushed Resident B's arms away from her body and hit Resident B on the left arm and upper abdomen with both open hands and yelled at the resident about grabbing and tearing her clothes. QMA 11 let go of Resident B to allow the resident to be on her back. QMA 11 shook her left hand side to side over the resident while CNA 12 was yelling at her but was not observed to verbally stop or physically intervene during the incident. CNA 12 and QMA 11 did not reposition Resident B's legs or reassure the resident that she was not falling. Resident B was turned onto her right side by CNA 12 again grabbing her left hip and pulling the resident towards her. She did not reposition the residents' legs. QMA 11 took off the soiled brief and started to clean Resident B. A male's voice was heard in the room and indicated "there is no reason for smacking her!" Another female's voice was heard indicating the resident had just woken up and staff did not need to be "so rough." CNA 12 indicated they were not being rough and Resident B was trying to fall by putting her foot down on the ground. The female voice indicated Resident B did not understand what the staff were doing. Then the video ended. An interview during the survey from Family Member 1 indicated voices heard in the video telling CNA 12 her behavior was inappropriate were from the camera where Resident B's family members were watching the incontinence care. The family members were not in the room but were able to see the care "live" from the camera and speak directly to staff during care.		**potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** All residents had the ability to be affected by this deficient practice. All staff educated on abuse prevention/intervention and reporting guidelines on 2/5/24. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** CTMs have been educated on abuse prevention and timeline reporting to Administrator related to abuse allegations on 2-5-24. Education on types of abuse, prevention/intervention, reporting guidelines, burnout and stress management to continue monthly x3 months then to all staff upon hire, annually and as needed. **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.** Abuse/Reporting Abuse Audits will be done weekly x4, bi-weekly x4, and Monthly x4 or until a 100% threshold is obtained. Information will be presented to the QAPI committee during monthly meetings. b=""> ="" li=""> b="">	

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	155338	A. BUILDING 00 B. WING	02/06/2024

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	A handwritten Witness Statement, dated 2/5/24, indicated it was written and signed by QMA 11. The statement indicated, QMA 11 had worked on the memory care on February 4, 2024, night shift. At about 5:40 a.m., QMA 11 and CNA 12 entered Resident B's room to provide care. QMA 11 turned Resident B towards CNA 12 to be able to clean her up. Resident B rolled towards CNA 12 and CNA 12 hit Resident B. QMA 11 told CNA 12 not to hit the resident. They finished the resident's incontinence care together. When QMA 11 went to the nurses' station she got the Administrator's number and placed a call, but there was no response. During an interview with the Administrator and Director of Nursing (DON), on 2/6/24 at 9:01 a.m., the Administrator indicated he received 3 phone calls around 10:06 a.m. on 2/4/24 reporting the abuse allegation. One call was from Certified Nurse Aide (CNA) 8, one was from Licensed Practical Nurse (LPN) 10, and one was from Resident B's family. Qualified Medication Aide (QMA) 11 indicated in her written statement she had called the Administrator during her shift, but the Administrator did not call back. The Administrator indicated he had no record of QMA 11 calling him. QMA 11 said she called from the nurses' station, but there was no record of the call. The Administrator pulled out his cell phone's call log and showed there were no missed calls on 2/4/24. The first record of receiving a call on 2/4/24 on his phone's call log was at 10:06 a.m. Management was going to address with QMA 11 that there was no evidence of a missed call and re-educate QMA 11 on if she attempted to call the Administrator she was to continue her attempts to call until the Administrator answered and/or she was to call the DON to get an answer. The		=”” |i=””>	

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	Administrator indicated if staff witnessed any unsafe behavior from staff to residents, the staff were to remove the alleged staff person away from the residents immediately and then call the Administrator. He indicated he would have preferred for CNA 12 to have been moved to the front lobby instead of completing care and then he would have come to the facility to address the abuse allegation with CNA 12. During an interview with the Administrator and Director of Nursing (DON), on 2/6/24 at 9:01 a.m., The DON indicated she was called around 10 a.m. by the dayshift nurse LPN 10 and the dayshift CNA 8. During an interview on 2/6/24 at 5:33 a.m., Licensed Practical Nurse (LPN) 13 indicated if she had concerns with staff or witnessed abuse she would separate the staff from the residents and call the Administrator. Staff were to call the Administrator repeatedly until he answered. Since they worked night shift the Administrator may be sleeping and it could take a couple of times for him to wake up to the phone, but he would answer. LPN 13 had never had to call about abuse but had called the Administrator regarding other issues before. During an interview on 2/6/24 at 12:05 p.m., QMA 11 indicated she went to Resident B' room with CNA 12 to assist with cleaning the resident. QMA 11 was helping CNA 12 with her work since Resident B needed 2 people for care. QMA 11 turned the resident toward CNA 12 and the resident moved her arms and was sliding out of bed. CNA 12 hit the resident. QMA 11 told the CNA 12 "no don't do that." Then QMA 11 heard "a voice from somewhere" asking why they were treating Resident B rough. QMA 11 told them she			

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	was not being rough, and they would finish care. CNA 12 stayed quiet and would not answer. Once care was done they left the room. QMA 11 tried to call the Administrator but there was no answer. It was the end of the shift and shift change. It had been a chaotic night, and she did not try to call again. She did tell the oncoming nurse what happened. She did not believe Resident B was trying to hit CNA 12. The resident did not know what she was doing she was just moving her arms. Resident B was not a violent person. QMA 11 believed CNA 12 was having a rough night and hit Resident B due to frustration. On 2/6/24 at 10:22 a.m. Resident B's record was reviewed. Resident B's diagnoses included, but were not limited to, Pick's disease (frontotemporal or front lobe dementia), general anxiety disorder, depression, and psychotic disorder with delusions. A quarterly Minimum Data Set (MDS) assessment, dated 1/29/24, indicated Resident B had adequate hearing, was not comatose, did not speak, sometimes understood others, and sometimes made others understand her. Resident B had adequate vision, wore corrective lenses. A Brief Interview for Mental Status (BIMS) assessment was not completed by the resident nor staff. Resident B had no behaviors, no impairment of extremities, and used a wheelchair for mobility. On 2/5/24 at 3:09 p.m., the Director of Nursing (DON) provided a current policy titled, "Abuse Prevention Program." The policy indicated, " ...Our facility is committed to protecting our residents from abuse by anyone including, but not necessarily limited to: facility staff ...Our abuse prevention/intervention education program			

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	include ...Expect all personnel, residents, family members, visitors, etc., to report any signs or suspected incidents of abuse to facility management immediately ...Reporting and Response ...2. All personnel, residents, family members, resident representatives, visitors, etc., are encouraged to report incidents of resident abuse or suspected incidents of abuse. Such reports may be made without fear of retaliation from the facility or its staff. 3. Employees, facility consultants and/or attending Physicians must immediately report any suspected abuse or incidents of abuse to the Administrator. In the absence of the Administrator, such reports may be made to his/her designee. 4. The Administrator must be immediately notified of alleged abuse/neglect or incidents of abuse/neglect. If such incidents occur or are discovered after hours, the Administrator and Director of Nursing Services must be called at home or must be paged and informed of such incident ...25.Any staff member or person affiliated with this facility who has witnessed or who believes that a resident has been a victim of mistreatment, abuse, neglect, or any other criminal offenses shall immediately report or cause a report to be made of, the mistreatment or offense. Failure to report such an incident may result in legal/criminal action being filed against the individual(s) withholding such information ...." This citation relates to Complaints IN00427703 and IN00427705. 3.1-28(c)			