STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155758	A. BUILDING 00 B. WING	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASBURY TOWERS HEALTH CARE CENTER	102 W POPLAR ST GREENCASTLE, IN 46135

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R 0000 Bldg. 00	This visit was for the Investigation of Residential Complaint IN00426715. Complaint IN00426715 - State deficiencies related to the allegation are cited at R091. Survey dates: January 25 and 26, 2024 Facility number: 001120 Residential Census: 54 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on February 8, 2024.	R 0000		
R 0091 Bldg. 00	410 IAC 16.2-5-1.3(h)(1-4) Administration and Management - Noncompliance (h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request. Based on interview and record review, the facility failed to ensure residents had increased supervision after an abuse allegation and failed to implement their written policy for timely reporting, investigating, and ensuring the protection of residents for 2 of 2 residents reviewed for abuse	R 0091	1. The order for in-house psych services was written on 1/19/24. The delay was related to difficulties obtaining consent from POA. SSD was able to contact and obtain consent for services	02/22/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Audra Rose	RN, DON	02/21/2024

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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	(Resident B and C). Findings include: On 1/25/24 at 11:05 a.m., interview with the Director of Nursing (DON). She indicated, on 1/19/24, Resident C was sitting in the main dining room at lunch time. There were no assigned seats. The residents were allowed to sit wherever they wanted. A dietary aide overheard Resident C making sexual comments to Resident B. The residents were separated, and Resident C was moved to the skilled side of the facility to be observed. She indicated Resident C had no issues with any residents prior to this incident. Resident B had been combative with staff since admission, which was her normal behavior. Resident C was returned to his room on the memory care unit on 1/23/24 and indicated he was to be referred for in house psychiatric services due to the nature of the comments he made to the resident. The DON indicated staff supervised the dining areas during meal service and activities. They ensured the other residents were safe from Resident C through staff supervision. Each resident had their own apartment, and he usually stayed in his room for the evening. The investigation included an examination of Resident B by the Medical Director and the DON interviewed both residents. On 1/25/24 at 11:27 a.m., observed the noon meal in the main dining room on the oasis memory care unit. Resident C was sitting at a table facing Resident B. She was unable to identify herself. Her memory recall was very poor. Verbal response was limited to yes and nodding of her head. There were 4 male residents in the dining area and 6 female residents sitting together at two long tables. The ability to separate residents was limited due to the small dining area.		from POA on 1/26/24. Resident C was seen and evaluated by in house psych services on 2/1/24. Actions to prevent reoccurrence will be to have resident/POA sign consent for services prior to admission for any prospective residents with known mood/behavioral histories. Consent forms for in-house psych services will be included in the admission packet as of 2/22/24. See exhibit A for forms. 2. Resident C has a diagnosis for major depression not Bi-Polar disorder. Resident has history of being admitted for an acute in-patient psych stay for suicidal ideation related to fall out with son and being homeless. To prevent reoccurrence the mental health screening form was updated to request the type of mood disorder be circled. The mental health screening form was also updated to request current service plan/care plans with intervention along with any mood/behavioral notes and progress notes from psychologist and/or psychiatrist for any prospective residents with known mood/behavioral histories. This form will be included in the admissions packet as of 2/22/24. See exhibit B for updated form. 3. Comfort kits (person centered activities) are created for interventions for residents who reside on the assisted living memory care Oasis. One was	

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	During observation Resident C did not interact with any of the other residents and was stoic during observation. He avoided making eye contact with anyone. During the initial interview Resident C indicated he had been at the facility since before Thanksgiving. He was alert and oriented to date, time, year, and location. On 1/25/24 at 11:43 a.m., Licensed Practical Nurse (LPN) 8 indicated she was aware of a resident-to-resident incident. It was reported to her that a Dietary Aide overheard Resident C say to Resident B, "I enjoyed what we did last night I enjoyed coming in you and I hope you give me a son." She reported the incident to the DON and was not aware of any issues with residents or staff. She indicated the staff was keeping an eye on him when he was in the dining room, and he stayed in his room most of the time, at night the staff checked on each resident every 2 hours. During an interview on 1/25/24 at 11:56 a.m., Registered Nurse (RN) 9 indicated Resident C did not have any behavior issues while he was on the skilled unit and did not have any interactions with female residents. He would go out to meals and then back to his room. During an interview on 1/25/24 at 1:11 p.m. the DON acknowledged Resident C had not been referred to psychiatric services. On the day the incident was reported she reviewed the allegation and interviewed the residents. She indicated the residents were checked every two hours and they keep the doors open for residents during the day. At night all the doors were closed. Resident B did wander at night. She indicated there were cameras in the facility and on the unit, but they did not work. She indicated the Medical Director talked		initiated for Resident C on 11/28/23. 4. Cognitive testing was completed by therapy services to determine if resident was appropriate for assisted living memory care placement due to residents' higher level of functioning compared to peers. The scores from several assessments such as Short Blessed Test, SLUMS, MOCA, and Mini Cog with family reports of Resident C's risk of elopement, and his diagnosis of dementia determined residents' eligibility to reside on the assisted living memory care unit. Resident C resided on memory care unit incident free and has not had any observable behaviors. IDT has meetings daily, excluding weekends and holidays, to discuss any change in conditions for all residents residing in the facility. IDT also has monthly behavioral meetings to discuss residents. Cognitive testing was completed again by therapy services on 2/5/24 and 2/9/24 to compare with initial scores. 5. Physical examination, resident interview, and room inspections were completed on 1/19/24. Both residents were assessed by the Medical Director on 1/19/24 and there was no evidence, such as bruising, on arms, legs, or face consistent with any recent sexual encounters. These assessments	

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	with the residents and she had conducted staff interviews. Through this investigation she determined the resident was not a threat and could return to the Assisted living unit on 1/23/24. During an observation and interview on 1/25/24 at 2:30 p.m., Resident C was in his room. He was polite and a little restless. He indicated he was nervous because he thought he was in trouble. He recalled talking to Resident B. He indicated he got too close to her and was talking into her ear, but he did not kiss her. Her lips touched his ear because he was deaf in one ear, could not hear well, and leaned into her. He had no difficulties hearing during the observation and interview. The resident indicated Resident B knocked on his door once, but he tried to keep the door locked. He talked to Resident B, but she did not know her name or his. He may have asked her how many children she had, but she did not recall. He indicated at lunch he thought he was going to jail but did not elaborate further. The resident indicated before he came into the facility he had an argument with his son and his family sent him to the homeless shelter. They thought he had a mental health issue, and he was sent to the neuro psych hospital. He was then discharged to another facility, then came to the current facility. His recall was very good both short term and long-term memory. He had three children and one of his sons died. He married for the second time when he was 31, his first wife was killed in a car accident. During a phone interview on 1/26/24 at 10:43 a.m., the Power of Attorney (POA) for Resident C indicated she had not been notified of the incident on 1/19/24. She verified the resident was at the facility because he was not able to protect himself and had had issues with foreign women. He		were documented in a Physicians Progress note on 1/19/24. An order to relocate Resident C to the locked skilled unit for observation was obtained on 1/19/24. During his stay on the locked skilled unit Resident C stayed in his room and only came out for meals and to go LOA with friend. This is his normal routine per the resident and staff interviews. Resident C did not interact with other residents during the observation period. Resident C's room was also located in view of the nurse's station and in a high observation area. When Resident C returned to his apartment in the assisted living memory care Oasis staff continued observations. Staff checked on Resident C every 2 hours but did not complete a log ensuring that the checks were completed. To prevent reoccurrence an order for frequency and duration of checks will be obtained from the Medical Director for any future incidents. An order to monitor behavior will also be obtained for any future incidents beginning 2/22/24. 6. DON interviewed multiple staff members who work directly with both residents across all shifts and all rotations. Those interviewed were 1 CNA, 2 QMA's, 2 LPNs, and the Assisted Living Coordinator (LPN). To prevent reoccurrence the DON will begin including more specific staff identifiers such as titles when	

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	wanted to marry them and have more children with them. He was also sending money to them. He was admitted to a neuro psych facility and then discharged to another facility prior to entering the current facility. During an interview on 1/26/24 at 10:51 a.m., Dietary Aide 4 indicated she was serving lunch in the dining room on 1/19/24 around 12:00 p.m. Resident B walked into the room. Resident C pulled out her chair and asked her to sit with him. He leaned towards her and said, "I like what we did last night, and we need to do it again. I want to make you feel good, I want to protect you. I want to make you pregnant. Will you give me a son?" Most of the other residents were in the dining room another female resident looked up, but she did not seem to understand what he was talking about, but it was loud enough for them to hear what he was saying. There were no other staff members present. She acknowledged she reported the incident after she finished serving dinner in the health center. This was about 30 minutes after the event occurred. When she went back upstairs both residents were sitting together. He was taken to the health center around 1:15 p.m. Dietary Aide 4 indicated she received abuse training when she was hired. She could not recall what the timeline was for reporting suspected or witnessed resident to resident abuse. On 1/26/24 at 11:30 a.m., during a phone interview, Certified Nurse Aide (CNA) 6 indicated she had not observed any behaviors from Residents B or C. She acknowledged she checked on the residents every two hours and indicated Resident B often wandered the halls and followed staff and other residents. On 1/26/24 at 11:35 a.m., during a phone interview,		documenting any future investigative processes beginning 2/22/24.	

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	CNA 7 indicated Resident C stayed in his room at night and locked the door. The staff had a master key to open the door and check on the resident. She acknowledged she checked the residents every 2 hours. She had not observed Resident B or C going into each other's rooms and had not observed any behaviors of Resident C. 1. On 1/26/24 at 11:45 a.m., review of the medical record of Resident B was done. A Service Assessment, dated 1/2/24, the resident was disoriented, did not convey needs, and rarely understood information conveyed. She could not understand or remember or use information. She required continual verbal reminding, was dependent upon staff for bathing, and needed cues to dress. A psychiatric assessment, dated 12/7/23, indicated diagnosis of anxiety, dementia (the loss of cognitive functioning thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities), severe with psychotic disturbance, and psychophysiologic insomnia. Resident B's thought process was unable to assessed because the resident was nonverbal. The resident was to have a revisit in 2 weeks. The record lacked documentation of re-visit. The record lacked documentation of examination by nurse or physician for any signs of physical abuse. 2. On 1/26/24 at 12:00 p.m., review of the medical record of Resident C was done. The most recent admission assessment, dated 1/23/24 indicated the resident was cognitively intact with short term memory problems and was independent for all care. Diagnosis included but was not limited to, Diabetes type 2 (a disease that occurs when your blood glucose, also called blood sugar, is too			

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	high) and dementia (the loss of cognitive functioning thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities). The most recent psychiatric assessment, dated 9/25/23, indicated a diagnosis of bi-polar disorder with an acute psychiatric stay in the last two years. History considered to be dangerous to residents was indicated as not applicable. The medical records of Resident C lacked documentation of monitoring for behaviors between 1/19/24 to 1/26/24. The investigative process lacked documentation of all but one staff interview. On 1/25/24 at 11:00 a.m., the DON provided a document, titled, "Abuse Neglect and Exploitation," dated 3/15/23, and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy ...It is the policy of Asbury Towers, (hereafter known as the facility), to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse ...Verbal Abuse ...means the use of oral, written or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age , ability to comprehend, or disability ...I Screening ...B. Prospective residents will be screened to determine whether the facility has the capability and capacity to provide the necessary care and services for each resident admitted to the facility ...1. An assessment of the individual's functional and mood/behavioral status ...will be reviewed prior to admission ...II. Prevention of abuse ...D. The identification, ongoing assessment, care planning for			

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	appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect ...IV. Identifiers of Abuse, Neglect and Exploitation ...B. Possible indicators of abuse include but are not limited to ...5. Verbal abuse of a resident overheard ...7. Psychological abuse of a resident observed ...V. Investigation of alleged abuse, neglect, exploitation ...B. Written procedures for investigation include ...1. Identifying staff responsible for the investigation ...6. Providing complete and thorough documentation of the investigation ...VI. Protection of Resident ...C. Increased supervision of the alleged victim and residents ...VII. Reporting/Response ...4 ...b. Defining how care provisions will be changed and or improved to protect residents receiving services ...." This citation relates to Complaint IN00426715.			