STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155716	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GOOD SAMARITAN HOME HEALTH CENTER AND RESIDENTIA	601 N BOEKE RD EVANSVILLE, IN 47711

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00391154. Complaint IN00391154 - Substantiated. Federal/State deficiencies related to the allegations are cited at F607. Survey dates: October 5 and 6, 2022 Facility number: 000439 Provider number: 155716 AIM number: 100275070 Census Bed Type: SNF/NF: 109 SNF: 7 Residential: 8 Total: 124 Census Payor Type: Medicare: 7 Medicaid: 90 Other: 19 Total: 116 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed October 11, 2022.	F 0000	This plan of correction Is submitted as required under Federal and State regulation and status applicable to long term care providers. This plan of correction does not constitute an admission of liability on the part of the facility and such liability is hereby specifically denied. The submission of the plan does not constitute an agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies are correctly applied.	
F 0607 SS=D Bldg. 00	483.12(b)(1)-(3) 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,			

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

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	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, Based on observation, interview, and record review, the facility failed to ensure staff implemented abuse policies for 1 of 5 residents reviewed for abuse. Staff did not report the full details of resident to resident abuse allegation to the administrator. (Resident C, Resident F) Finding includes: On 10/5/22 at 12:34 P.M., Resident C was observed in the bed as staff served a meal tray. Resident C was in the room alone. On 10/5/22 at 12:42 P.M., Resident C's clinical record was reviewed. The diagnosis included, but was not limited to, dementia with behavioral disturbance. The most recent quarterly MDS (Minimum Data Set) assessment, dated 8/10/22, indicated a severe cognitive impairment. The Progress Notes included, but were not limited to, the following: On 9/24/22 at 6:24 P.M., "Female resident had wandered into residents room et [and] gotten in residents roommates bed. Upon picking up dinner trays, CNA [Certified Nursing Aide] observed this resident sitting in roommates bed with female resident legs in his lap rubbing lower legs. Clothes	F 0607	F 607: Develop/Implement Abuse/Neglect Policies: Education: 1. All Abuse/Neglect policies have been updated. 2. All staff have been re-educated on Abuse/Neglect clinical protocol, reporting requirements for any suspicion of abuse or neglect, Abuse Investigation and Reporting and Abuse Prevention. Audits: 1 Administrator and/or Director of Nursing will audit documentation of clinical staff as needed for any documentation of abuse or suspicious abuse. Unit Managers and Social Services will audit staff documentation of abuse/neglect. 2. Audits will be performed by Social Services/Unit Manger/Director of Nursing and/or Administrator 5 x weekly x 4 weeks, then monthly x 3 months. PIP will be added to QUAPI by Administrator of Designee, updated monthly x 6 months to	11/07/2022

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	intact on both residents. Resident was assisted back to his side of the room et female resident removed from room et brought to corridor. Resident placed on q [every] 15 min [minute] checks. Family, DON, et NP [Nurse Practitioner] made aware". On 9/26/22 at 11:22 A.M., IDT (Interdisciplinary Team) note "Resident was found sitting on roommates bed and had a female's legs on his lap and he was rubbing her legs. She was removed from the room by staff ... SW [Social Worker] met with resident and he does not recall the incident ..." During an interview on 10/5/22 at 1:32 P.M., CNA 6 indicated they did not observe the incident firsthand, but did hear from other staff that Resident F was found lying in Resident C's roommate's bed and Resident C was rubbing Resident F's legs. CNA 6 further indicated that Resident C was wearing underwear only and Resident F was fully clothed. CNA 6 also indicated RN (Registered Nurse) 7 was the nurse on staff during the incident. CNA 6 indicated should an incident like that occur, staff should contact the unit manager, Administrator, and DON. During an interview on 10/6/22 at 9:36 A.M., SW 2 indicated she was aware of an incident involving Resident C and Resident F where Resident C was rubbing Resident F's legs. SW 2 indicated when Resident C was interviewed, they had no recollection of the incident. SW 2 indicated the incident happened on a weekend and was immediately reported to the unit manager who then discussed with SW 2. She then indicated all parties were assessed and monitored after the incident.		monitor for compliance.	

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	During an interview on 10/6/22 at 10:06 A.M., the Administrator indicated him and the DON were made aware of an incident involving Resident C on 9/24/22 which was the day it occurred. However, the Administrator and DON were both out of town from 9/25/22 through 9/28/22, and could not personally investigate the incident. The Administrator indicated the information relayed to them on 9/24/22 did not indicate Resident C was exposed in any way. Upon returning to the facility on 9/28/22, the information relayed and progress notes in Resident C's clinical record were reviewed and indicated both parties involved were fully dressed. The IDT note, dated 9/26/22, lacked documentation related to the resident's clothing at the time of the incident, but the Administrator indicated it was discussed during that meeting that Resident C was not fully clothed. He then indicated on 10/5/22 he received 2 (two) handwritten statements, dated 9/24/22, from staff that witnessed the incident that indicated Resident C was not fully dressed. The Administrator indicated the facility was currently in the process of investigating the incident as the additional information given would require that incident to be reported to the state. He indicated the nursing supervisor was in possession of the statements and was disappointed he did not receive them sooner, as they contraindicated the information he was given previously. During an interview on 10/6/22 at 10:42 A.M., HR (Human Resources) 4 indicated she spoke with CNA 8 who witnessed the incident with Resident C, and provided a statement to the nurse on duty. CNA 8 indicated although the information about Resident C dressed only in underwear was relayed to the nurse on duty, that nurse failed to pass that information on to the Administrator and DON. At			

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	that time, the Administrator indicated because of the conflicting information received about the incident, the nursing supervisor eventually dropped the matter. On 10/6/22 at 11:20 A.M., a current Resident Abuse and Neglect Prevention and Reporting, revised 3/2019 was reviewed. The policy indicated the facility would provide training to all employees that included, but was not limited to, to whom to report any allegation or actual abuse, neglect, or misappropriation and the employees responsibility upon witnessing abuse, neglect or misappropriation of resident property. This Federal tag relates to Complaint IN00391154. 3.1-28(a) 3.1-28(c)			