STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00441636 and IN00441104. Complaint IN00441636 - State deficiencies related to the allegations are cited at R0090. Complaint IN00441104 - No deficiencies related to the allegations are cited. Survey date: September 17, 2024 Facility number: 005616 Residential Census: 73 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on September 26, 2024.	R 0000		
R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency Based on observation, interview, and record review, the facility failed to ensure an allegation of sexual abuse was reported to the Indiana Department of Health, and failed to ensure a thorough investigation of the allegations was conducted for 1 of 3 residents reviewed for abuse. Findings include: On 9/17/24 at 10:15 a.m., Resident B was observed and interviewed. She was seated in a wheelchair in her apartment. She was dressed, neat, clean and odor free. Resident B pleasantly reminisced about meeting and marrying her husband, raising her two children, babysitting for a living, and her level	R 0090	A. With respect to the specific regulation cited: R210 IAC 16.2-5-1.3 (g) (1-6) Administration and Management - Deficiency B. With respect to what systemic measures to be put in place to address stated concern: Education to all staff regarding timely reporting of incidents and allegations of abuse. Education provided to the Resident Care Director on the investigation process and timely completion.	10/09/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Andy Black	Regional Director of Operations	10/17/2024

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	of education etc. Her short-term memory was limited as she repeated several of the same facts, verbatim, as if she had not already explained. Resident B indicated she was a very private and anxious person. Resident B indicated she thought she might have been raped at the facility and that someone might have "drugged her" because she would wake up to "someone poking around down there." She indicated, she thought she had been assaulted because when she woke up she was burning and sore, "down there." As Resident B spoke about the alleged rape, she lowered her voice and indicated, she needed to be quiet because her voice was being carried over the sound waves. She named her alleged perpetrator as a family member and indicated they had grown up together. Resident B indicated she had only been with her husband, and even though he passed away seven years ago, she felt bad this had happened now and felt disappointed and guilty. When asked if she felt safe now, that this had passed, Resident B indicated, "No, not as long as [the family member] keeps coming up here and visiting." During an interview on 9/17/24 at 11:00 a.m., Resident B's Power of Attorney (POA) indicated she had been notified by the facility, that Resident B had made an allegation of rape and was sent to the hospital for further exam and treatment. The POA indicated Resident B had some baseline dementia, but it seemed to have gotten a lot worse after a recent fall, and at the time of the allegation she had another urinary tract infection (UTI). The POA had never heard or been told of any kind of sexual trauma in Resident B's past. During an interview on 9/17/24 at 12:00 p.m., the Director of Nursing, (DON) indicated, she did not usually conduct abuse investigations. That task		Completion: 9/26/2024 Staff 10/8/2024 RCD C. With respect to how the plan of corrective measures will be monitored: Regional Director of Operations has obtained access to state reporting site in absence of an Executive Director. All incidents will be reported to the regional team in real time as to assist in timely reporting and completion of the investigation. The ED and RCD will review all incidents daily for next steps and weekly during the Care Services Meeting for completion and interventions. Completion: 10/9/2024 (RDO) Ongoing (ED and RCD) D. With respect to how the plan of corrective measures will be monitored: Ongoing incident management will be reviewed in the monthly QMPI meeting. Completion: Ongoing.	

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	was the Administrator's (ADM) responsibility, but since the facility had not hired a new administrator, she had been asked and guided through the abuse investigation procedure. The DON indicated the Regional Nurse Consultant (RNC) had provided her with a templated packet which she provided at this time. The DON indicated, the facility's investigation had been completed and unsubstantiated. It was not believed that Resident B experienced a rape at the facility, and her allegations were due to worsening dementia, and a UTI. On 9/17/24 at 12:15 p.m., the DON provided a copy of the facilities investigation packet which included the following undated, handwritten notes from Resident B: Note #1: Resident B indicated the family member whom she grew up with was always in trouble and he visited her. " ... I know he does, I am so sick of him now I know he always in trouble ...." Note #2: Resident B indicated she had problems with the family member and "... someone come and rape me. I need to go to the doctor's again, at that time they couldn't tell. This Morning I could not tell what's wrong when I get up, I can's [sic] hardly go, I feel dopey ...." Note #3: Resident B indicated the family member was coming and doing "this." A Police Report, dated 8/21/24 at 1:00 p.m., which indicated the allegation had been reported to the police and a responding officer assigned a Report number. A State Reportable Investigation Report Cover was dated 8/20/24, but lacked documentation that			

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	the state had been notified, therefore a state report was not available. An undated Timeline coversheet which indicated, "start of investigation to conclusion." No timeline was included. An undated Ombudsman Report which lacked documentation the Ombudsman had been notified. Adult Protective Services cover sheet which indicated APS had been contacted 8/21/24 but lacked documentation of follow-up and/or outcome. A coversheet for Perpetrator Information which was blank and lacked documentation of the family member. A cover sheet for "Other Resident Interviews," which was left blank, and no additional interviews were included or provided by the time of the survey exit. A cover sheet for "Staff Interviews," which was left blank, and no additional interviews were included or provided by the time of the survey exit. A PCC Incident Report, which was blank and did not include an attachment. In-Service/Education, which was blank and did not include an attachment. During a follow up interview on 9/17/24 at 2:50 p.m., the DON indicated, no other residents were interviewed because the allegations were not believed to be true. There were no staff			

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	statements, other than what was documented in PCC and an in-service had not been provided for staff to ensure that abuse allegations are always investigated/taken seriously and/or that Resident B should have received peri-care/feminine hygiene assistance from female caregivers. On 9/17/24 at 12:30 p.m., Resident B's medical record was reviewed. She was had been a resident since 2022 and had diagnoses which included, but were not limited to, repeated falls and history of complicated UTIs. A nursing progress note, dated 8/20/24 at 2:00 p.m., indicated, " ...Abuse allegations reported by [Resident B]. Resident reports burning sensation to genital areas. Increased confusion observed. BIMs [brief interview for mental status] score of 9 [9 out of 15 indicates moderate impairment]. Resident believes it's the year of 1989. Resident states her husband's [family member] is coming up from the basement while she's sleeping. No basement on campus. Resident denies witnessing physical evidence during the act. States, she knows it happened because she always starts burning really bad "down there" after when she wakes up. Difficult to redirect. Resident becomes increasingly agitated with RCD [Resident Clinical Director/DON] and expresses verbal aggression stating, "I could slap you", while gritting her teeth and shaking her fist. Easily redirected. MD/POA notified. New orders requested to collect UA. Sample sent to lab STAT. RDRC and RDO notified. Investigation initiated. VS WNL. Request made that resident be evaluated in ER or office. Awaiting MD response. Stable. Will continue to monitor ..." A nursing progress note, dated 8/21/24 at 3:09 p.m., indicated, " ...UA results reported abnormal.			

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	New orders received to start ABT [antibiotic medication]. APS called and notified of abuse allegations. Doctor called back to obtain report at approx. 1pm. POA called at approx. 1:30p reporting doctor's orders to send resident to the ER to be evaluated and that they notified APS as well. POA request resident be sent to IU Methodist. 911 called and resident transported by EMT to hospital at approximately 2:30p. Police arrives, and reports made at the time of ambulance arrival. Police reports she doesn't believe nothing will come about the incident due to the severity of resident's cognitive status and hx of paranoia/delusions. RDRC/MD/POA made aware. Stable. Will follow up ..." A nursing progress note, dated 8/23/24 at 12:34 p.m., indicated, " ...Spoke with Detective ... Case concluded invalid resulting in the disease process of Alzheimer's/dementia. Case being closed ... Spoke with [POA] about investigation process and she agrees that the allegations are a result of exacerbation of the disease process ...." On 09/18/2024 9:40 a.m., a Social Service case worker for the hospital, (MSW) provided a copy of Resident B's hospital summary which was dated 8/21/24 and indicated, " ...[Resident B] with a history of dementia ... recurrent falls, recurrent UTIs ... she was brought into the ED by EMS from her assisted living facility because she thought she was raped 3 days ago. The details of the incident will be provided by the FNE [Forensic Evidence Nurse]. She has had burning in her genitals region for the past three days. The burning had gotten better, especially since yesterday after she started her Macrobid for her UTI. She denies bleeding, discharge or apparent injury in this region ... she went to her PCP [primary care provider] yesterday for similar			

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	symptoms and was diagnosed with a UTI after the urine was found to be growing E coli and was given Macrobid ..." The FNE reported: " ... Called by RN for patient reporting a sexual assault ... per chart review, patient has a baseline of dementia and was recently diagnosed with a UTI on 8/20/24. FNE met with patient at bedside and introduced self and role. Patient stated, "Well about 3 nights ago, I think someone might've raped me." When asked to elaborate, patient states "I was burning in the morning" while pointing to her genitals. When asked what time of day this occurred, patient states "I can't remember. Maybe around midnight." When asked if she recalls seeing anyone coming into her room around that time, patient denies and states, "I think I was asleep and I'm a sound sleeper." FNE then asked if she believed the assailant was a staff member or someone she knows, patient states "well must've been [family member] ...." Patient then clarified that she did not see the family member recently but "He's been around and up visiting from ... I remember my dad always saying to keep a lookout for him, so he must've known about him... [POA] states patient has had a major fall recently, which she believes has exacerbated her dementia ... POA reports that she does not believe it is in the patient's best interest to pursue aggressive legal action against [family member] at this time. To POA's knowledge, [family member] is an elderly man that is bed bound in [name of another state] .... Patient's POA declined MFE [medical forensic exam], body mapping and photography ...." During an interview on 9/18/24 at 9:50 a.m., the Hospital MSW indicated, Resident B's case had been referred to her by the FNE and as a mandated reporter, she notified IDOH. The Hospital MSW indicated, she had not visited			

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	Resident B and relied on the FNE's interview of the resident and her POA. She reviewed the FNE's notes and indicated, it did not appear that Resident B had been asked if she would like a rape kit conducted, that decision had been left to her POA who declined. During an interview on 9/18/24 at 3:11 p.m., the Sargent Supervisor of the local police department Sex Crimes Division indicated, he received an allegation of rape from a responding officer who was called to Resident B's assisted living facility. Upon review of evidence submitted by the responding officer and a follow up call with the facilities' DON, the Sargent Supervisor did not assign the case and inactivated the allegation with no assignment. Sargent Supervisor indicated he called the facility and spoke with the DON who informed him that the allegations had been reported to the State Department of Health and thoroughly investigated by the staff there. The facility staff determined the allegations were due to exacerbated symptoms of her dementia from a UTI infection. The Sargent Supervisor indicated he relied on the facilities information. If an investigation and report had not been filed with the state and something had happened, this resident would have fallen through the cracks and had not received due diligence. On 9/17/24 at 1:00 p.m., the DON provided a copy of current facility policy titled, "Resident Abuse Policy," revised 1/4/22. The policy indicated, "Century Park is committed to protecting the physical well-being, emotional well-being and personal possessions of every resident. Each community has systems procedures and a program of associate training and supervision in place to foster dignified treatment, respect and			

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	compassion for residents. Any form of mistreatment of residents including but not limited to abuse, neglect, exploitation, involuntary seclusion or misappropriation of property is strictly prohibited. Century Park associates serve as resident advocated and champion resident rights without fear of reprisal. Any allegations of neglect or abuse whether verbal, physical, mental or sexual will be investigated and reported appropriately per state guidelines ... Procedure: 1. Accountability: Executive Director has overall responsibility and accountability for implementing the Resident Protection and Abuse Prohibition policy ... Mandated Reporter. Each associate is a mandated reporter and has a duty as an individual to report any actual/known, alleged, suspected incident of physical abuse, neglect, exploitation, financial abuse, abandonment or isolation to the office of the Mandatory State Regulatory Reporting, Ombudsman and local law enforcement within 24 hours of suspicion or allegation ... Investigative Steps. Step 1: Associate immediately communicates the information to General Manager/Designee and completes a Resident Incident Report of all incidents of alleged neglect, exploitation or abuse. Step 2: Executive Director immediately (within 24 hours) reports the suspicion or allegation to mandated State Regulatory office ... office of Ombudsman ... Step 3: Executive Director ensure an investigation is initiated with documentation of investigation outcome. Step 4: Executive Director notified Regional Director of Operations who then shares with Home Office. Step 5: Executive Director (with involvement of Resident Care Director) interviews and investigates promptly, confidentially and thoroughly via private interviews with residents, witnesses and associated ...." This citation relates to Complaint IN00441636.			

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