STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155455	A. BUILDING 00 B. WING	11/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESLEYAN HEALTH CARE CENTER	729 WEST 35TH ST MARION, IN 46953

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00365985. This visit resulted in a Partially Extended Survey-Substandard Quality of Care - Immediate Jeopardy. Complaint IN00365985 - Substantiated. Federal/State deficiency related to the allegation is cited at F600. Survey dates: October 28, 29, November 1, 2021. Facility number: 0000557 Provider number: 155455 AIM number: 100291240 Census Bed Type: SNF/NF: 104 SNF: 7 Residential: 1 Total: 112 Census Payor Type: Medicare: 7 Medicaid: 70 Other: 34 Total: 111 This deficiency reflects State Finding cited in accordance with 410 IAC 16.2-3.1. Quality review completed on November 5, 2021.	F 0000	This plan of correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. The facility respectfully requests a desk review for compliance.	
F 0600 SS=J 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 protect cognitively impaired residents from a resident with sexually aggressive behaviors in 2 of 2 encounters (Resident B, Resident C, and Resident D). This deficient practice resulted in a non consensual sexual act with a cognitively impaired resident. The immediate jeopardy began on 10/27/21 when Resident B was observed to be touching and rubbing a female residents leg (Resident D) while attempting to place her hand on his private area. The Administrator was notified of the immediate jeopardy on 10/29/21 at 12:42 p.m. Findings include: Review of a behavior sheet, dated 10/27/21 at 1:01 p.m., indicated Resident B was observed to be touching and rubbing a female resident's leg while attempting to place her hand on his private area. Resident B was asked to stop by staff and he left the area. An undated, written statement by the Social Service Director (SSD) was provided by the Director of Nursing (DON) on 10/29/21 at 10:12	F 0600	· Resident B was placed on one-on-one monitoring immediately. Resident C was moved to another area of the facility. Resident D was interviewed by SSD and was not negatively affected by the behavior. Resident B was moved to another area of the facility. Social Service Well-being checks will be completed on both female residents to ensure they feel safe. An Audit was completed on male residents that have a history of any type of sexual aggression to ensure behavior plans are in place and effective. · Female residents that reside in the facility are at risk for the alleged deficient practice. Female residents residing on the hall that the male resident resided on received skin assessments to ensure there were no signs of sexual aggression. · In-servicing will be completed with the Department	11/02/2021

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	a.m. The statement indicated she received a call from a nurse who stated she did not witness the interaction between Resident B and Resident D. Other staff reported Resident B was rubbing Resident D's leg in the lounge and she did not respond back. She did not feel this was inappropriate but informed the nurse to separate them and to keep an eye on them. She did not feel the behavior warranted an urgent intervention. A behavior sheet, dated 10/27/21 at 3:36 p.m., indicated Resident B was in Resident C's room. Resident C was sitting on the bed and Resident B was standing in front of her with his pants and brief down. He was guiding the residents head to his penis and his penis was in the resident's mouth. Resident B was removed from the room by staff and taken to the SSD office. A SSD progress note, dated 10/27/21 at 3:53 p.m., indicated she was made aware of the sexually inappropriate behaviors. The female residents that Resident B was pursuing were not able to state they would consent to his touch. Resident B was placed on security checks and the female residents were removed from the situation. A SSD progress note, dated 10/28/21 at 8:29 a.m., indicated Resident B was noted to be in the lounge touching Resident D's legs in a sexual manner and later found in Resident C's room with his pants down and his penis in her mouth. An Indiana Department of Health (IDOH) reportable was provided by the DON on 10/28/21 at 2:00 p.m. The reportable, dated 10/27/21 at 3:01 p.m., indicated a male resident was found in a female residents room with his penis in her mouth. The residents were separated and the Administrator was notified. The male resident		managers on investigations and reporting any suspicious behavior to the Administrator immediately. Staff will be in-serviced on abuse and when to report any behaviors to the administrator. Care plans have been updated on all residents affected by the alleged deficient practice. Male resident will remain on one-on-one monitoring until he is transferred to another facility. Social Service will work on admitting resident to an acute psych facility and will then request they find a facility that is able to handle the type of behaviors he is having. Residents that are noted to have any sexual type behaviors will have a review by Psych Services immediately completed. Visual rounding is completed each shift by the licensed nurse or management on duty and managers have been in-serviced on what behaviors to observe for during rounds. Managers will educate and review behavioral interventions with staff. · Behaviors will be discussed in Clinical Morning meeting daily and discussions will include investigations and if appropriate or not. A tracking form will be maintained to ensure behaviors are addressed with Administrator and Director of Nursing. The tracking tool will be reviewed Monday – Friday X 4 weeks, then 3X week for 4 weeks, then weekly	

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	was placed on 15-minute checks and the female resident was moved to the Memory Care Unit. A resident to resident abuse form was provided by the DON on 10/28/21 at 3:30 p.m. The form indicated the incident occurred on 10/27/21 at 3:00 p.m. A QMA found a male resident in a female resident's room with his penis in her mouth. The residents were separated and the female resident was moved to another hall and the male resident was placed on 15-minute checks. A statement by QMA 3, dated 10/27/21, indicated the resident would not stay out of female resident rooms during the first-shift and when 2nd shift started, he continued the behaviors. When she entered the room, she saw Resident B being inappropriate with Resident C. During an interview on 10/28/21 at 4:33 p.m., QMA 3 indicated she came in for second shift and was counting narcotics with the nurse while the other nurses' were receiving report. The second shift CNA asked the day-shift nurse to come and help get Resident B out of Resident C's room. The nurse asked her to help the aide while she paged the SSD. When she got to the room she saw what was happening because the door was open. She told Resident B they don't do that here and to have a seat. While taking the resident to see the SSD, they met her in the hallway and he was placed on 15-minute checks. A review of the 15-minute check-off sheet, the first documented location of the resident was on 10/27/21 at 1:45 p.m. Resident B remained in his room until 10/28/21 at 1:00 p.m. when he was moved to another hall and the 15-minute checks continued. During an interview on 10/29/21 at 9:57 a.m.,		X 3 months. Tracking will be reviewed at least quarterly by QA Committee until 100% compliance achieved on behaviors needing investigation has been completed. · Administrator and Director of Clinical Services/Designee is responsible for monitoring · Date of Compliance: 11/2/2021	

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	Housekeeper 4 indicated she was cleaning Resident D's room while Resident D was sitting in the lounge. She saw Resident B go to the lounge. She kept an eye on him and noticed him attempt 2-3 times to move Resident D's hand towards his groin area. She did not actually see her hand on his groin. She indicated Resident B may be declining. The resident did wander but she did not recall seeing any sexual behaviors in the past. During an interview on 10/29/21 at 9:25 a.m., Resident B indicated he used to live at the facility with his wife, but she has since died. He indicated it was his first day in current room and he slept there the prior night. He did have a lady friend but she lived on another level. The name of the lady friend he provided was not a current or former resident. a. The record for Resident B was reviewed on 10/28/21 at 2:03 p.m. Diagnoses included, but were not limited to, heart failure, diabetes mellitus, dementia with behavioral disturbances, adjustment disorder with depressed mood and Alzheimer's disease with late onset. A quarterly Minimum Data Set (MDS) assessment, dated 10/6/21, indicated the resident admitted to the facility on 3/26/19. The resident was moderately cognitively impaired. A health care plan, dated 11/14/19 and revised 6/10/21, indicated the resident had behavioral symptoms such as disturbing others, wandering around the hall when he could not sleep and waking up his roommate. Interventions included, but were not limited to, allow resident to express his feelings and observe for changes in behavior. b. Resident C's record was reviewed on 10/28/21 at			

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	2:31 p.m. Diagnoses included, but were not limited to, cerebrovascular disease, vascular dementia, aphasia and depressive disorder. A quarterly MDS assessment, dated 9/28/21, indicated the resident was severely cognitively impaired. During an interview on 10/29/21 at 9:15 a.m., Resident D indicated she was admitted less than 2 months ago. She did not have any relationships with male residents because she was married. c. Resident D's record was reviewed 10/29/21 at 9:35 a.m. A review of her most recent MDS assessment, dated 9/11/21, indicated she was moderately cognitively impaired. Review of a current facility policy, dated 4/15 and revised 6/20, titled "Abuse, Neglect and Misappropriation of Resident Property," which was provided by the DON on 10/28/21 at 2:04 p.m., indicated the following: "Policy: This facility's policy is the resident has the right to be free from verbal, sexual, physical and mental abuse...but not limited to, facility staff, other residents, consultants...other individuals. ...Sexual Abuse: Is non-consensual sexual act of any type with a resident lacking the capacity to consent.... ...Policy Interpretation and Implementation ...5. The facility shall prevent abuse by.... (iv) Ongoing assessment, care planning and monitoring of residents with needs and behaviors...." The Immediate Jeopardy (IJ) that began on			

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	10/27/21 was removed on 10/29/21 when the facility began inservicing staff on abuse and the reporting process. The noncompliance remained at the lower scope and severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy because monitoring was on-going. This Federal tag relates to Complaint IN00365985. 3.1-27(b)			