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	155432	A. BUILDING _____ B. WING _____	C 07/02/2025

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ALBANY HEALTH CARE & REHABILITATION CENTER	910 W WALNUT ST ALBANY, IN 47320

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F 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00462025. Complaint IN00462025 - Federal deficiencies related to the allegations are cited at F600 and F609. Survey dates: July 1 and 2, 2025 Facility number: 000309 Provider number: 155432 AIM number: 100288960 Census Bed Type: SNF/NF: 77 Total: 77 Census Payor Type: Medicare: 4 Medicaid: 55 Other: 18 Total: 77 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed July 8, 2025.	F 000		
F 600 SS=E	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from 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	F 600		

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

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F 600	Continued From page 1 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; This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a cognitively impaired resident was free from staff-to-resident abuse as a result of physical retaliation to a combative resident for 1 of 3 residents reviewed for abuse. (Resident B) This deficient practice had the potential to affect 19 of 77 residents in the facility who resided on the 300 Unit. The deficient practice was corrected on 6/27/25, prior to the start of survey, and was therefore past noncompliance. Finding includes: Review of a facility reported incident, dated 6/22/25 at 4:27 p.m., indicated the following: "Description added" On 6/22/25 the facility was notified Resident B reported to her daughter that she had bruising to bilateral hands due to a staff member holding onto her arms last night. CNA 3 was the staff member involved. "Type of Injury" included dark purple bruises to bilateral wrists and the left hand. The resident denied pain to the areas. "Immediate Action Taken" included notifications to the physician, family, DON, and the Administrator. The staff member involved was suspended pending an investigation. "Follow up" indicated the investigation was completed. Residents and staff interviews were conducted with no new concerns identified. The employee	F 600	Past noncompliance: no plan of correction required.	

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was terminated due to her failure to meet the facility's expectations and standards when handling the situation. The family, physician, Adult Protective Services (APS), Ombudsman, and local law enforcement were notified of the findings. All staff were re-educated on abuse prevention and the mandatory reporting protocol. Nursing staff were re-educated on de-escalation and safe handling of combative behaviors.

Resident B's clinical record was reviewed on 7/1/25 at 11:52 a.m. Diagnoses included the need for assistance with personal care, dementia, reduced mobility, and insomnia.

A 6/13/25, quarterly, Minimum Data Set (MDS) assessment indicated Resident B had moderate cognitive impairment. She had trouble falling or staying asleep, or she slept too much. Behaviors included verbal behavioral symptoms directed at others, other behavioral symptoms not directed towards others, and rejection of care. The resident used a walker and wheelchair for mobility. The resident required substantial/maximal staff assistance for all self-care tasks and mobility tasks, other than she needed supervision when walking ten feet and partial/moderate assistance with wheeling wheelchair 50 feet with two turns. The resident was frequently incontinent of bowel and bladder. There were no identified skin issues. She received a scheduled pain medication regimen, and her pain occasionally affected her sleep and day-to-day activities.

Resident B's current care plans included the following:

A 12/6/24 problem of behavioral symptoms

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presented as: combative with care, refusing care, yelling and cursing at staff, repetitively yelling out and name calling of staff. Interventions included the following: Social Services staff will intervene as necessary (12/6/24), You will encourage activities of interest (12/6/24), You will leave me alone and reapproach as necessary (12/6/24), Gently remind resident that her behavior/comments are inappropriate (12/8/24), You will assist me, as needed, with calling family when I am upset (4/26/25), I will be followed on the Behavioral Management Program (5/19/25)

A 1/6/25 problem of difficulty sleeping related to insomnia. Interventions included the following: staff is to offer non-pharmacological interventions such as back rub, warm drinks, soft music or tones, re-positioning, decreased stimuli, and a comfortable environment.

A 6/22/25 problem of distrusting her caregivers by displaying emotional distress, fearfulness, and anxiety, related to being handled roughly during care on 6/22/25. Interventions included the following: Staff is to approach resident from the front, avoid sudden movements or waking her up abruptly, describe steps to be taken before providing her personal care, if the resident is choosing not to have personal care, reapproach at a later time, and social services to follow up with her daily until she is seen by the mental health counselor.

A 6/24/25 problem of a bruise to her left hand related to trauma. Interventions included the following: the resident will have two staff members in her room and staff members will take a break if the resident is experiencing behaviors.

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A 6/24/25 problem of a bruise to her left wrist related to trauma. Interventions included the following: the resident will have two staff members in her room and staff members will take a break if the resident is experiencing behaviors.

A 6/24/25 problem of a bruise to her right wrist related to trauma. Interventions included the following: the resident will have two staff members in her room and staff members will take a break if the resident is experiencing behaviors.

A skin assessment, dated 6/20/25 at 9:55 a.m., indicated the resident did not have any skin concerns.

A skin assessment, dated 6/23/25 at 3:20 p.m. indicated the resident had a dark purple bruise on the left wrist and measured 3 centimeters (cm) by 3.5 cm. The area was closed and dry. A dark purple bruise was on the right wrist and measured 2.5 cm by 2.5 cm. The area was closed and dry. A dark purple bruise was on the left hand and measured 3 cm by 3 cm. The area was closed and dry. No other skin concerns were identified.

The clinical record lacked documentation of maladaptive behavior expressions for Resident B from 6/21/25 through 7/2/25. The last behavior expression documented in the clinical record was on 6/12/25.

A Nurse's note, dated 6/22/25 at 2:30 p.m., indicated the provider was notified of an allegation and bruising.

A Social Services note, dated 6/23/25 at 9:00 a.m., indicated the resident denied any distress

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and reported she felt safe. She was unable to recall the incident.

A Nurse's note, dated 6/24/25 at 1:59 p.m., indicated the resident and daughter were spoken to. Bruising was assessed on Resident B's bilateral wrists and left hand on 6/22 and again on 6/24/25. The bruises were not tender to touch and the resident denied any pain related to the bruises.

A Social Services note, dated 6/24/25 at 3:23 p.m., indicated during a follow up with the Resident B, she indicated she had a good day. When the resident was asked about the bruises on her arms, she was able to recall the incident. The resident explained that when she saw other people going out, she wanted to go too. The "fat girl" grabbed her arms right there and said she could not go. The resident denied any fear or anxiety related to the incident. The resident was informed CNA 3 would no longer provide her care.

A review of the facility investigation file, provided by the DON on 7/1/25 at 11:04 a.m., contained the following information:

A hand written statement from RN 8, dated 6/22/25 at 2:00 p.m., indicated the resident's family member asked RN 8 if there were any incident reports from last night. The resident told the family member the CNA held her down and she had bruises to both wrists. The resident had purple bruising to bilateral wrists and to the left hand. The resident stated, "a short fat CNA with dark hair came in during the middle of the night, started to do something and grabbed both arms." The resident was unable to give an exact time.

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She shook her head and repeated "middle of night." The resident was unable to provide any further details. RN 8 notified the DON at 2:17 p.m.

A typed statement from the Administrator, dated 6/22/25 at 2:29 p.m., indicated the Administrator was informed of an allegation between a CNA and a resident. Staff explained a resident's family member reported bruising on a resident's wrists. When the resident was asked by the family member what happened, the resident explained that a "short fat staff grabbed her wrists". An investigation was immediately initiated. The Administrator attempted to reach CNA 3, the perpetrator, and left a voicemail. On 6/22/25 at 3:03 p.m., the resident representative was notified and made aware an investigation was underway. The Administrator called the family member who reported the concern. She explained Resident B pointed out bruises on her arms during the visit and told the family member, "the Nurse Aide grabbed my arms and there is bruising." Another attempt to reach CNA 3 was made from a different number, and left another voicemail. On 6/22/25 at 4:20 p.m., the Administrator and DON was able to reach CNA 3 via telephone for a statement. CNA 3 was notified an investigation was underway and she was suspended pending the investigation. When asked to explain what happened on 6/22/25, CNA 3 explained the resident was upset and up all night. The resident started swinging when CNA 3 tried to care for her. CNA 3 used a shirt to wrap the resident's hands to keep her from hitting. When asked to explain, CNA 3 would not elaborate. CNA 3 denied grabbing the resident's wrists or holding the resident down. She was informed the facility would notify her of the

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investigation outcome.

A "STAFF TO RESIDENT ABUSE" form indicated Resident B was assessed for injury on 6/22/25 at 2:45 p.m. Dark purple bruises were present to the back of the left hand and on bilateral wrists.

Typed statements obtained by the DON, on 6/22/25 from 3:30 p.m. - 4:00 p.m., indicated the following:

LPN 4 stated that CNA 3 got Resident B up, into her wheelchair, and brought her to the North television lounge next to LPN 4. Resident B told LPN 4, "She's not nice! She's a b****! She bruised me all over! I am covered in bruises!" LPN 4 had assisted the resident with her blanket and did not notice any discoloration on her hands and wrists at that time. He was educated that Resident B's comments should have been reported immediately to the Administrator as suspicious in nature for initiation of an investigation. He verbalized understanding.

CNA 6 stated she noticed bruising to the resident's hands when she was providing care at approximately 2:00 a.m. on 6/22/25. Regarding the bruises, Resident B stated, "She did it to me!" The resident told CNA 6 she could not wait to tell her daughter what had been done to her. CNA 6 also heard a conversation between CNA 3 and LPN 4 during which CNA 3 told LPN 4 she had to be stern with Resident B and told her to stop her yelling. CNA 6 was educated that the information should have been reported immediately as an allegation of abuse. CNA 6 verbalized understanding.

CNA 7 stated he started his shift after CNA 3. On

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his first interaction with Resident B, he noticed the resident had bruises. The resident told him, "This fat a** girl grabbed me." The resident demonstrated to CNA 7 how the perpetrator treated her by taking two hands and holding onto CNA 7's hands/wrists. CNA 7 was educated that this should have been immediately reported as an allegation of abuse. CNA 7 verbalized understanding.

Resident B was interviewed with her family member present. When asked about the bruising on her hands and wrists, the resident stated "That girl grabbed my hands and held them last night." The resident was unable to identify the specific time but indicated it was the short fat girl with long dark hair." The resident denied any pain from the bruising and her range of motion was per usual. The chart revealed the resident was on aspirin daily.

Four "Abuse" in-service attendance logs, dated 6/22/25, contained 74 signatures. The education included information about identifying types of abuse to include questionable actions or statements, stress and burnout related to abuse, and protection of the residents from staff involved in an abuse allegation.

On 6/23/25, thirteen alert and oriented residents were interviewed with no identified concerns of abuse.

On 6/23/25, six non-interviewable residents received full skin assessments, with no other suspicious skin impairments found other than the bruising to Resident B's wrists and hand.

Review of an email, dated 6/24/25 at 3:52 p.m.,

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indicated the facility notified the Ombudsman of an abuse allegation, the investigation findings, and the outcome.

On 6/24/25 at 4:45 p.m., the facility provided the resident's representative with the Ombudsman contact information.

A "Handling difficult behaviors" in-service attendance log, dated 6/25/25, contained 10 signatures.

A "Corrective Action Form," dated 6/25/25, indicated CNA 3 was terminated from employment due to violations of facility policies regarding appropriate resident care, abuse prevention, and the management of challenging behaviors.

The local police department was notified on 6/25/25 at 10:14 a.m. The police report indicated Resident B reported a CNA, with a description of the CNA, pushed her back into her wheelchair, held her by her wrists, and told her she was not to get up. The report indicated light bruising remained to the resident's left wrist. The resident did not want to file charges.

On 6/27/25 at 11:21 a.m., the facility notified the Adult Protective Services (APS) of the abuse investigation.

During an interview on 7/1/25 at 1:56 p.m., the DON indicated on 6/22/25 at approximately 2:30 p.m., RN 8 notified her Resident B told the resident's daughter that she received bruises to her hand and both wrists due to a staff member on night shift having grabbed her hands and held her down. The resident had given a physical

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description of CNA 3. This was reported to RN 8 by the resident's daughter when she inquired about the bruises. The DON immediately notified the Administrator of the abuse allegation and began the investigation. The resident was in the dining room with her daughter when the DON approached the resident and noticed the bruises on her wrists and hand. Upon asking the resident what happened regarding the bruises, her allegations remained unchanged. As the DON obtained statements from RN 8, Resident B, LPN 4, CNA 6, and CNA 7, the allegations of abuse remained consistent. The physical description of the perpetrator matched CNA 3 who was assigned to provide the resident's care when the alleged event occurred during night shift sometime before 6:00 a.m. on 6/22/25. When the DON and the Administrator reached CNA 3 via telephone for a statement, CNA 3 reported the resident had been combative during care that night. The resident was swinging at CNA 3. In response, CNA 3 wrapped a shirt around the resident's hands. The DON educated CNA 3 "you can't do that" when residents display behaviors. CNA 3 was suspended pending the investigation. The investigation did not identify any further instances of abuse or any adverse effects by staff members' actions. During the investigation interviews, LPN 4, CNA 6, CNA 7, were educated regarding observed abuse, reported abuse, and/or any suspicion of abuse and the importance of an immediate investigation for the resident safety. They were educated on their role of identifying and reporting while administrations role of investigating the allegations and determining if it was abuse. The facility determined that CNA 3 had been abusive to the resident because she admitted to wrapping the resident's hands in a shirt when the resident was

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combative and the resident had bruises following the event. The resident was known to be verbally and physically aggressive with staff at times. This made the resident at higher risk for being abused.

During a phone interview on 7/1/25 at 4:14 p.m., CNA 3 indicated on 6/22/25, sometime after midnight and in the early morning hours, Resident B was screaming all night and wanted her family. CNA 3 was in the resident's room without any other staff. She sat in her room for a minute but that did not calm the resident. CNA 3 assisted the resident into the wheelchair and the resident became combative and started swinging at CNA 3. Before she took the resident to the lounge, CNA 3 pulled the residents shirt around her arms in a manner to restrict the residents arms from hitting. The resident accused CNA 3 of being abusive to her and she was going to report it to her daughter. CNA 3 did not see any bruising on the resident and she did not know why the resident had bruises that morning after the interaction between CNA 3 and Resident B. CNA 3 should have gone to get someone else to provide Resident B's care rather than restricting the resident's arms. CNA 3 reported Resident B's statement of abuse to LPN 4 the night it occurred on 6/22/25.

During a phone interview on 7/1/25 at 4:45 p.m., LPN 4 indicated on 6/22/25 Resident B had been awake throughout the night shift and LPN 4 and other staff had been in and out of the resident's room. The resident kept saying she wanted to get up. At approximately 2:00 a.m., after his break he noticed CNA 3 was sitting in a wheelchair outside of Resident B's room. He thought it was weird, but CNA 3 told him she thought it might help the

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resident relax if she was out of the room. LPN 4 instructed CNA 3 to get the resident up, since she had requested to get up and bring her down to the lounge. At approximately 3:00 a.m., when CNA 3 brought the resident to the lounge, Resident B told LPN 4 that CNA 3 had "bruised her all up." LPN 4 did not complete a head to toe assessment nor report the alleged abuse to anyone until the DON called him during the day after his shift and questioned him about any abuse concerns on the night shift. The resident had been pleasant during interactions with LPN 4. Resident B was known to be challenging at times due to her behaviors. He had not documented any behaviors on 6/22/25, because her behaviors were not as bad as they had been on other days. CNA 3 continued to work her shift after the allegation was made. CNA 3's shift ended at 6:00 a.m. The DON provided LPN 4 with education regarding abuse,timely reporting, and protecting the residents by sending involved staff home.

During a phone interview on 7/2/25 at 9:48 a.m., CNA 6 indicated she came in early at 6:00 p.m. on 6/21/25 and worked until 10:00 p.m. on the 300 Unit, where she provided care for Resident B. She had not seen any skin impairments to the residents skin when she was assigned to the resident during those four hours. At 10:00 p.m., CNA 3 came in and was assigned to the 300 Unit. CNA 6 began the CNA float position at that time and covered the different units for their breaks. Some time between approximately 2:30 a.m. and 3:30 a.m., she relieved CNA 3 for a break. When CNA 3 gave report to CNA 6, CNA 3 reported that Resident B was up in the lounge watching television. CNA 3 did not mention in report the resident was combative with her. Resident B started yelling out after CNA 6 was floating on her

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unit so CNA 6 asked the resident what she was wanted to do. The resident requested to go back to bed, so she took her to her room and assisted her into her bed. The resident was cooperative with care when CNA 6 assisted her. Resident B held up her hands and showed CNA 6 the bruising. Resident B commented she could not wait to tell her daughter that she did this to me. CNA 6 thought the daughter had caused the bruising. CNA 6 had gone down to the 300 Unit at another time on the night of 6/22/25 and she heard CNA 3 tell LPN 4 that she had to get stern with Resident B because Resident B had to be told six times that she needed to go to bed and stop waking up other residents. CNA 6 did not report the bruising or Resident B's allegation that someone had caused the bruising to her. The DON provided CNA 6 with education regarding abuse and timely reporting via phone.

During a phone interview on 7/2/25 at 10:32 a.m., RN 8 indicated on 6/22/25 Resident B's daughter approached RN 8 and asked if there were any incidents reported last night. The resident's daughter noticed bruising on the resident's wrists and hand. Resident B had informed her daughter the aide that held her down last night caused the bruising. RN 8 then asked Resident B what happened. The resident explained that sometime in the night last night the short, fat, CNA, with long dark hair held her down. As a result, her wrists and her hand was bruised.

During a phone interview on 7/2/25 at 10:46 a.m., CNA 7 indicated during the 6/22/25 morning shift report, CNA 3 did not report any allegations of abuse or bruising to him that occurred on night shift. On 6/22/25, at approximately 6:45 a.m., he observed bruising on Resident B's wrists and

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hand. Resident B accused a staff member of grabbing her by the hands during the night shift. CNA 7 failed to report the allegation of abuse at that time. On 6/22/25, between 10:00 and 10:30 a.m., Resident B mention the allegation of abuse to CNA 7 again. CNA 7 indicated it was unusual for Resident B to remember vivid details. The DON provided him with education regarding abuse and protecting the resident. RN 8 provided education to CNA 7 regarding behavior responses.

On 7/2/25 at 11:51 a.m., the Administrator indicated the DON notified her on 6/22/25 at 2:25 p.m. of an abuse allegation by CNA 3 to Resident B. Restraining of the resident's arms was considered abusive. The facility should have protected Resident B from abuse. The facility in-serviced on behavior techniques. They have in-servicing scheduled for the second Thursday of every month to include re-education on abuse and reporting with examples to review.

An auditing tool, titled "Systemic Actions to Prevent Reoccurrence," provided by the Corporate Nurse Consultant on 7/2/25 at 12:14 p.m., indicated the following: "Staff Education and Retraining: All direct care staff have received re-education on trauma-informed care, de-escalation techniques, safe physical care methods... Resident Monitoring - Interviewable Residents: The Social Service Director (or designee) will interview four alert and oriented residents weekly for four weeks, then monthly for five months, to assess perceptions of care, concerns about rough handling, or unreported injuries. Interviews will be documented and reviewed during QAPI. Resident monitoring - Non-Interviewable Residents: The nursing team

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will conduct weekly head-to-toe skin assessments on all non-interviewable residents for 6 months to monitor for unexplained bruising or injury. Any findings will immediately be reviewed by the DON and HFA for investigation and follow-up. Employee Monitoring and Engagement: The Director of Nursing or designee will interview 5 employees weekly for four weeks, then monthly for five months, to assess their understanding of behavioral management... and comfort and escalating concerns to leadership. Behavioral Care Oversight: The IDT (Interdisciplinary Team) will review the care plans for residents with the history of combative behaviors to ensure: Appropriate interventions and de-escalation strategies are included. Staff assignments consider training and experience ...QAPI: An ad hoc QAPI project will be initiated to monitor patterns of injuries... and training efficiency. The team will review trends monthly, evaluate the effectiveness of interviews and skin assessments, and modify interventions as needed." A "Staff Interview and Education Validation Tool," "Resident Interview Audit Tool," and "Compliance with Reporting Allegations of Abuse/Neglect/Exploitation Validation Checklist" were tools used for ongoing monitoring.

A current facility policy, revised 10/17/22, titled "Freedom from Abuse, Neglect, Exploitation and Misappropriation of Property," provided by the DON on 7/1/25 at 10:30 a.m., indicated the following: "Policy Statement... The resident has the right to be free from abuse... 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. Policy Interpretation and Implementation... Each

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F 600	Continued From page 16 resident has the right to be free from abuse, neglect, and corporal punishment or any type by anyone... ABUSE: ...The facility must provide a safe resident environment and protect residents from abuse... Staff to Resident Abuse of Any Type...When a nursing home accepts a resident for admission, the facility assumes the responsibility of ensuring the safety and well-being of the resident... It is the facility's responsibility to ensure that all staff are trained and are knowledgeable in how to react and respond appropriately to resident behavior... All staff are expected to be in control of their own behavior, are to behave professionally, and should appropriately understand how to work with the nursing home population... Retaliation by staff is abuse, regardless of whether harm was intended, and must be cited...." The deficient practice was corrected by 6/27/25 after the facility implemented a systemic plan that included a thorough investigation, facility in-service regarding abuse/reporting/protecting, responses to staff burnout, and an in-service regarding handling challenging behaviors. This citation relates to Complaint IN00462025.	F 600		
F 609 SS=D	3.1-27(a) Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §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	F 609		

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F 609	Continued From page 17 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 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. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to identify and immediately report alleged abuse to the administrator for 1 of 3 residents reviewed for resident abuse. (Resident B) This deficient practice had the potential to affect 19 out of 77 residents in the facility who resided on the 300 Unit. The deficient practice was corrected on 6/27/25, prior to the start of survey, and was therefore past noncompliance. Findings include: Review of a facility reported incident, dated 6/22/25 at 2:35 p.m., indicated Resident B's daughter had reported Resident B had bruising to	F 609	Past noncompliance: no plan of correction required.	

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her bilateral hands as a result of a staff member "holding onto her arms last night". It was noted Resident B had bruises on her left hand and wrist and to her right wrist. CNA 3 was suspended pending an investigation.

During a review of the facility abuse investigation, on 7/1/25 at 11:04 a.m., 13 resident interviews were held with no identified concerns and six non-interviewable residents had skin assessments completed. Statements from Resident B, the perpetrator, and four additional staff members were included. No additional abuse concerns were identified by other residents or staff during the investigation. A skin assessment was completed on 6/23/25 at 3:20 PM on Resident B. The skin assessment indicated Resident B had bruising to her bilateral hands and right wrist. Staff statements indicated Resident B had reported alleged abuse by CNA 3 to several staff members, who all failed to immediately report the alleged abuse to the Administrator. A facility-wide investigation was carried out and abuse inservicing was completed. The education included "Resident Care Expectations" and "Abuse and Protecting your Profession." Four inservicing signature sheets, dated 6/22/25, contained 74 staff signatures. An employee roster indicated 45 staff members were called and were given the inservicing information via phone. The Ombudsman was notified regarding an abuse allegation, the investigation findings, and outcome via email on 6/24/25 at 3:52 p.m. Resident B's daughter was provided with Ombudsman information on 6/24/25 at 4:45 p.m. The local police department was notified on 6/25/25 at 10:14 a.m. CNA 3 was terminated on 6/25/25. Adult Protective Services (APS) was notified via email 6/27/25 at 11:21 a.m.

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During an interview on 7/1/25 at 1:56 p.m., the DON indicated on 6/22/25 at approximately 2:30 p.m., RN 8 notified her Resident B told the resident's daughter that she received bruises to her hands and both wrists due to a staff member on night shift having grabbed her hands and held her down. The DON was not notified by any other staff members regarding the alleged abuse prior to the notification she received from RN 8. The DON immediately notified the Administrator of the abuse allegation and began the investigation. CNA 3 was suspended pending the investigation. The investigation did not identify any further instances of abuse or any adverse effects by staff members' actions. During the investigation interviews LPN 4, CNA 6, CNA 7, were educated regarding abuse and any suspicion, reported or observed abuse was to be reported immediately to the administrator.

During a phone interview on 7/1/25 at 4:14 p.m., CNA 3 indicated on 6/22/25, sometime after midnight and in the early morning hours, Resident B had accused CNA 3 of being abusive and she was going to report it to her daughter. CNA 3 reported Resident B's statement to LPN 4 the night it occurred. She did not report the allegation to anyone else.

During a phone interview on 7/1/25 at 4:45 p.m., LPN 4 indicated on 6/22/25 at approximately 3:00 a.m., Resident B told him that CNA 3 had "bruised her all up." CNA 3 continued to work her shift after the allegation was made. Her shift ended at 6:00 a.m. LPN 4 did not report the alleged abuse to anyone until the DON called him the next day and questioned him about abuse concerns. The DON provided him with education

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regarding abuse and timely reporting.

During a phone interview on 7/2/25 at 9:48 a.m., CNA 6 indicated that on the night of 6/22/25 she had heard CNA 3 tell LPN 4 that she had to get stern with Resident B because CNA 3 had to tell Resident B six times that she needed to go to bed and stop waking up other residents. On 6/22/25, between 2:30 and 3:30 a.m., Resident B held up her hands and showed CNA 6 the bruising on them. Resident B commented she could not wait to tell her daughter that she did this to me. CNA 6 had thought the daughter had caused the bruising. CNA 6 did not report the bruising or Resident B's allegation that someone had caused the bruising to her. The DON provided her with education regarding abuse and timely reporting via phone.

During a phone interview on 7/2/25 at 10:32 a.m., RN 8 indicated on 6/22/25 Resident B's daughter informed her that the resident had accused a staff member of holding her down last night and caused bruising to her wrist and hands. RN 8 immediately notified the DON.

During a phone interview on 7/2/25 at 10:46 a.m., CNA 7 indicated during the 6/22/25 shift report, CNA 3 did not report any allegations of abuse or bruising to him. On 6/22/25, at approximately 6:45 a.m., he observed bruising on Resident B's wrists and hand. Resident B accused a staff member of grabbing her by the hands during the night shift. CNA 7 failed to report the allegation of abuse at that time. On 6/22/25, between 10:00 and 10:30 a.m., Resident B continued to mention the allegation. CNA 7 reported the allegation to RN 9 who was assisting as a CNA that day. CNA 7 did not report the allegation or bruising to

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management until he was called into the DON's office later that day. The DON provided him with education regarding abuse and timely reporting.

On 7/2/25 at 11:51 a.m., the Administrator indicated the DON notified her on 6/22/25 at 2:25 p.m. of an Abuse allegation. She arrived at the facility one and a half hours later. She was not notified of the alleged abuse by anyone else prior to the DON's call. She should have been notified immediately when it happened on night shift.

An auditing tool, titled "Systemic Actions to Prevent Reoccurrence," provided by the Corporate Nurse Consultant on 7/2/25 at 12:14 p.m., indicated the following: "Staff Education and Retraining: All direct care staff have received re-education ...Employee Monitoring and Engagement: The Director of Nursing or designee will interview 5 employees weekly for four weeks, then monthly for five months, to assess their understanding of behavioral management, reporting requirements, and comfort and escalating concerns to leadership ...QAPI:.. The team will review trends monthly ...and modify interventions as needed."

A current policy, last revised on 9/17, titled "Incident Investigating and Reporting", provided by the DON on 7/2/25 at 8:49 a.m., indicated the following: "Policy: It is the policy of this facility to ensure that reportable incidents are investigated, recorded, and reported in accordance with the state and federal laws ... Facility Reporting and Investigation Instructions: 1. The facility will ensure that all allegations of mistreatment, neglect or abuse, including injuries of unknown source, are reported immediately to the Administrator of the facility and to other officials in

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F 609	Continued From page 22 accordance with state law through established procedures (including to the State survey and certification agency)...." Cross reference F600. This citation relates to Complaint IN00462025. 3.1-28(c)	F 609		