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	12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROWN SENIOR LIVING	7960 SHADELAND AVENUE NORTH INDIANAPOLIS, IN 46250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00368157, IN00367141, and IN00364255. This visit included a Residential COVID-19 Quality Assurance Walk Through. Complaint IN00368157: Substantiated. State residential findings related to the allegations are cited at R0039, R0052, and R0057. Complaint IN00367141: Substantiated. No State Residential Findings related to the allegations were cited. Complaint IN00364255: Unsubstantiated due to lack of evidence. Unrelated deficiencies are cited. Survey dates: December 14, 15, and 16, 2021. Facility number: 013328 Residential Census: 47 These state residential findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on December 27, 2021	R 0000	This Plan of Correction constitutes a written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. We respectfully request consideration for granting the community paper compliance.	
R 0036 Bldg. 00	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed:			

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 determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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	(1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on record review and interview, the facility failed to provide updates of the conditions inside the facility related to COVID-19 to residents and their representatives weekly, or each subsequent time a confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms that occur within 72 hours and to include information on mitigating actions including if normal operations will be altered. Findings include: An interview with RCD (Regional Clinical Director) was conducted on 12/16/21 at 3:54 p.m. RCD indicated, the mechanism the facility used to communicate COVID-19 updates was a corporate newsletter sent out via email monthly. She indicated, they used to send out a newsletter weekly but that ceased back in July 2021 and have since then gone to a monthly newsletter. A copy of the monthly newsletter was provided by RCD on 12/16/21 at 3:54 p.m. The newsletter did not contain any updates to COVID-19 infection rates in the facility, mitigating factors used to decrease/prevent the spread of COVID-19 or what/if normal operations were altered at the facility. CMS (Centers for Medicare and Medicaid Services) QSO 20-26 last updated 4/19/20, indicated, "... updates to residents and their	R 0036	It is the intent of Crown Senior Living to provide updates of the conditions inside the facility related to COVID-19 to residents and their representatives weekly, or each subsequent time a confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms that occur within 72 hours and to include information on mitigating actions including if normal operations will be altered. This deficiency had the potential to affect all residents. The deficiency was corrected upon identification. The community will continue to send the weekly COVID-19 newsletter and follow COVID-19 notification policies and procedures for all confirmed cases. As a preventive measure, all staff members will be in-serviced on COVID-19 protocols by 2/8/22. To prevent reoccurrence, the DON, or her designee, will audit COVID-19 cases as they occur to ensure notification processes are followed daily for 7 days, weekly for 4 weeks, and monthly thereafter. Any findings will be reported to the Quality Assurance Committee.	02/08/2022

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	representatives must be provided weekly, or each subsequent time a confirmed infection of COVID-19 is identified and/or whenever three or more residents or staff with new onset of respiratory symptoms occurs within 72 hours. Facilities will include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations in the nursing home will be altered."			
R 0039 Bldg. 00	410 IAC 16.2-5-1.2(n) Residents' Rights- Deficiency (n) Residents may, throughout the period of their stay, voice grievances to the facility staff or to an outside representative of their choice, recommend changes in policy and procedure, and receive reasonable responses to their requests without fear of reprisal or interference. Based on interview and record review, the facility failed to provide an environment in which residents could report and/or voice grievances without the fear of reprisal, resulting in anxiety and decreased socialization for 4 of 5 residents reviewed for grievances. (Resident B, E, J and M). See R0052 for additional information regarding Resident B and Resident E. Findings include: 1. The clinical record for Resident E was reviewed on 12/14/2021 at 12:48 PM. The diagnoses included, but were not limited to, insomnia and depression. A Brief Interview for Mental Status (BIMS) was completed on 9/30/2021 for Resident E. The assessment indicated Resident E was cognitively intact.	R 0039	It is the intent of Crown Senior Living to provide an environment in which residents can report or voice grievances without fear of reprisal. This deficiency had the potential to affect all residents. The concern was corrected upon identification. The individual alleged is no longer employed at the community. As a preventive measure, all staff members will be re-educated on abuse prohibition policies and procedures by 2/8/2022. To prevent reoccurrence, the DON, or her designee, will offer open hours for residents to discuss any concerns or grievances daily for 7 days, weekly for 4 weeks and monthly thereafter. Any findings will be reported to the Quality Assurance	02/08/2022

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	Resident E was ordered Cymbalta (antidepressant) for depression. No further psychoactive medications were listed for Resident E. An interview with Resident E conducted on 12/14/2021 at 3:00 p.m., indicated he felt that the Executive Director (ED) was retaliating against him because he had brought concerns and issues to her. He stated he has brought problems, regarding himself and others, to her attention almost weekly for the last 3 months, but nothing ever gets done. During a service plan meeting on 12/7/2021, it was discussed that he needed to stop making complaints to the board of health. Resident E admitted during the meeting to calling the board of health once in the past but hasn't recently. He indicated the service meeting was focused solely on the condition of his room and his mental health. Every time he brought up something about his care, like call lights or medications, it was immediately directed back to his room condition by the Regional Director of Operations. Resident E indicated he knew he needed to clean his room. Resident E indicated prior to coming to this facility, he had a bought of situational depression that he felt this was managed with medication and was his only mental health issue. He indicated during this meeting that he was told if he didn't like it here, then the facility would find him somewhere else to go. After this meeting, he requested his medical records because he was confused why his mental health was the focus of his service plan. Upon receipt of his medical records, he indicated there were several behavioral notes on his chart that he did not agree with. One note was written by the DON on 10/19/2021, which he recalled the event differently than written. Four		Committee.	

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	other notes were placed in his chart by the ED since 10/15/2021, that Resident E claimed did not happen. He stated he felt this was an assassination of his character and done so to label him as a "troublemaker" to make future placement difficult for him. A behavior note dated 10/19/2021 that was entered by the ED, stated "Resident noted in the Bistro laughing aloud and saying "State will be here tomorrow! We are gonna get rid of her [Redacted]". Not really talking to anyone in particular, just talking out loud." A behavior note dated 10/19/2021 that was entered by the ED, stated " ...I hope the administrator drives her car into a tree ..." A behavior note dated 10/19/2021 that was entered by the ED, stated "Resident noted making many complaints regarding parking and food service. Resident was asked to fill out a grievance form regarding his issues, and refused to do so, instead stating "I'm calling state". Resident continues to yell and be aggressive with staff regarding being asked to straighten his apartment earlier ..." No grievances were produced for Resident E since 10/15/2021. No grievance was produced regarding Resident E's verbal complaint documented in his medical record. There were no grievances filed under anonymous or for Resident Council since 10/15/2021. A behavior note dated 11/19/2021 and entered by the ED, stated "Staff filed report stating she heard [Resident E] talking to residents [Redacted] at that time he stated "Don't worry. I			

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	just called the state again. We're gonna get that black [Redacted] (administrator) out of here" CNA stated, "excuse me?" and [Resident E] replied "We're not talking to you". The facility did not produce this report when requested during survey. A behavior note written by the DON, dated 11/19/2021, indicated that Resident E was having a conversation with another resident and a staff member about the verdict of a case that was nationally publicized. The note stated, " ...This writer [DON] butted in the conversation and stated my opinion which was different ...once this writer expressed her opinion resident went into a tyrant. Resident then made a few more statements and writer chimed in one again. Resident begin yelling and becoming psychologically unstable and triggered ...Resident then tells this writer to shut up because I'm upsetting him and as this writer continues to talk ...he [Resident E] continues to hostile while yelling at the writer to shut up ...resident begin to yell at writer and try to put writer out of the facility ...resident was getting louder and louder yelling for this writer to get out of the building ...The writer then turned to mentioned resident that was having a conversation with resident [E], and stated I'll talk to you [other resident] ... Resident [E] begin to come closer to the front desk where writer was and told the resident to go ..." The nurse's note indicated the interaction continued with Resident E and that prior to him getting on the elevator, the DON informed him that the ED (Executive Director) would be called. An interview with the Regional Director of Operations on 12/14/2021 at 3:40 p.m.,			

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	indicated the concerns about retaliation and accuracy of behavior notes for Resident E were not brought up during Resident E's service plan on 12/7/2021. He stated the resident was "happy here." During this interview, he indicated the ED would only chart in the medical record to "add context". An interview from the Ombudsman on 12/15/2021 at 8:33 a.m., indicated she was present for a service plan meeting on 12/7/2021. During this meeting, Resident E did grow upset a couple of times, but had every right to do so. It is her opinion that Resident E does not have issues with his mental status, but the facility is targeting the Resident. The Regional Director of Operations stated Resident E had anxiety during the meeting and brought up Resident E seeking help from the facility's mental health provider. Resident E later declined. When Resident E had left the room after the service plan meeting, the Regional Director of Operations stated that the Resident E had "just proved his point." Resident E does not have a clinical diagnosis of anxiety. The most recent provider visit note for Resident E, dated 12/2/2021, indicated Resident E denied anxiety. An interview with the Business Office Manager on 12/16/21 at 9:20 a.m., indicated she had never seen Resident E be disrespectful, rude to anyone, or use racial disparities. An interview with CM 1 (case manager) on 12/16/2021 at 9:40 a.m., indicated she had been the CM for Resident E since August of 2021. She indicated that Resident E is a pleasant and			

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	interactive resident, priding himself on being active in resident committees. Resident E does have hoarding tendencies, but she has never witnessed any other behaviors such as being disrespectful or yelling. She did recall him growing upset during a service plan meeting on 12/7/2021. During that meeting, she indicated he was continually "pressed" about the state of his room and grew upset but did not yell or raise his voice. She indicated that she felt it was a very rational and understandable response to the situation discussed during the service plan. An interview with the Director of Maintenance on 12/16/2021, indicated that he had heard the ED tell management during staff meetings to avoid Resident E and not talk to him. He has heard other staff, including the DON and ADON, say to Resident E "that if they don't like it, they can leave." He has heard the ED threaten to get rid of residents if they do not do what she wants. An interview with the Social Worker (SW) on 12/16/2021 at 2:34 p.m., indicated he was not aware of Resident E being disrespectful or having any outbursts. SW confirmed he should be aware of behaviors or outbursts. SW was unfamiliar if Resident E had any behavioral service plans. 2. The clinical record for Resident M was reviewed on 12/14/21 at 2:55 p.m. The Resident's diagnosis included, but were not limited to, hemiplegia (weakness on one side of the body), anxiety and depression. He was admitted to the facility on 2/11/2021. A Level of Care Assessment completed 11/12/21 indicated he was alert and oriented to person, place, and time. He was able to function independently in familiar surroundings.			

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	A service plan, initiated on 8/25/21, indicated he had a psychosocial well-being problem related to family discord. He had a history of making false allegations against staff and other residents. The goal was to identify the reasons for his feelings of anger and the intervention, initiated 8/25/21, was to encourage, assist and support him to set realistic goals. The were no other behavioral or psychosocial services plans present in the clinical record. A behavior note, dated 11/19/21 at 10:23 a.m., indicated that he was continuing to exhibit anger, bullying, and anxiety toward administration. He had been heard yelling in the hallways that he had filed a complaint with the Attorney General and laughing. He had stated to the concierge that the administrator looked like a character off a Disney movie based in Africa. He had refused a psychiatric consult and was continuing to be monitored by social services and nursing. A behavior note, dated 12/5/21 at 5:34 p.m. by the ADON (Assistant Director of Nursing), indicated that he had inquired if she would be at his meeting. He went on to state he felt like the ED was trying to kick him out because he was the only one in the meeting. She had assured him that was not the case. He believed that she and the administrator were friends and was told that was not the case. During an interview on 12/14/21 at 3:00 p.m., Resident M indicated that he had been told by the DON (Director of Nursing) earlier in the day that if he did not like it at the facility he should move. He felt he was being blamed for the "State" being in the building. There had been a meeting earlier			

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	in the month where the RDO (Regional Director of Operations) and the SW (Social Worker) had accused him of calling the department of health to voice complaints against the facility multiple times. He had called the "State" once but denied calling them again. He believed he had the right to call and voice his concerns if he chooses. He felt that the facility was targeting him because he was vocal and stood up for his rights. He had decided to try to stay away from the ED (Executive Director) and was just trying to stay "out of trouble". He did not want to move to a different facility, as he had developed friendships with some of the residents at this facility and felt this was his home. A service plan note, dated 12/7/21 at 10:35 a.m., indicated that a meeting had been held to go over Resident M's service plan and to follow up with any issues that he may have had the with ED. He denied further issues with the ED and was staying in his room and trying not to speak to her. He had disagreed with entries which had been added to his service plan after an incident when he called the state. During an interview on 12/5/21 at 8:33 a.m., the Ombudsman indicated she had attended the service plan meeting on 12/7/21. The CDO had accused him of "calling the state all the time". He had encouraged him to use the internal grievance process. He had offered to find him alternate placement if he they could not meet his needs and he felt that he needed the to continue to call the state because his needs could not be met. He informed the CDO that he had called the Indiana Department of Health to voice a complaint one time. He had not called them other than that one time. He was happy living at the facility and did not want to move. On			

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	8/26/21 his care plan had been changed to include that he made false accusations against the staff. He had no knowledge that this had been added. She felt the meeting had an intimidating tone. She had questioned the CDO during the meeting about the resident having the right to contact outside agencies to voice grievances and was informed that they did have the right to do so, the facility would prefer to use the internal process first, prior to him calling an outside agency. During an interview on 12/15/21 at 1:55 p.m., CM (Case Manager) 2 indicated she had attended the service plan meeting on 12/7/21. During the meeting, it was implied that he was filing multiple complaints with the Indiana Department of Health and encouraging others to do so. In her opinion, the meeting was intended to intimidate Resident M and that he had remained calm throughout the meeting. She was unaware of any behavioral concerns or episodes of paranoia. As the case manager, she should have been made aware of those things so that she could assist in finding him care if needed. She worked closely with him and corresponded with him frequently. She had observed no episodes of paranoia or inappropriate behavior. She had not observed him being derogatory towards staff or another resident. He has informed her that he is pay his rent and trying to stay in his room so that he doesn't have to deal with the tension. During an interview on 12/16/21 at 8:55 a.m., the DM (Director of Maintenance) indicated he had never heard Resident M be rude or inappropriate with anyone. He was very helpful to both staff and residents. He had not seen him act in a paranoid manner or be delusional. He had witnessed the DON (Director of Nursing) and			

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	the ADON (Assistant Director of Nursing) tell him that if he does not like the facility he should just leave. During an interview on 12/16/21 at 9:20 a.m., the BOM (Business Office Manager) indicated she had never heard him talk disrespectfully or use racial disparities against any of the staff members or management at the facility. She had not seen him display paranoia or delusional behavior. During an interview on 12/16/21 at 10:45 a.m., Concierge 1 indicated she had been employed at the facility since October 202. She had not seen or heard Resident M be rude or disrespectful to any staff or resident at the building. He talks with her frequently and was polite and respectful. He had mentioned that he did not like the ED once but was not disrespectful or rude when he mentioned it. She had never heard him refer to the ED as a Disney character. During an interview on 12/16/21 at 10:54 a.m., Concierge 2 indicated she had never heard Resident M or anyone else refer to the ED as a character off a Disney movie and there were only 2 concierge who worked at the building. During an interview on 12/16/21 at 2:25 p.m., the SW (Social Worker) indicated he had been present at the service plan meeting on 12/7/21. The meeting had been held due to his multiple complaints and his dislike of the ED. He felt that due to Resident M diagnoses of anxiety, depression, and post-traumatic stress disorder, he tended to exaggerate, lie, and manipulate things to gain an advantage. He had been witnessed looking at the facility survey binder on many occasions, which lead the facility to			

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	believe he was frequently calling the Indiana Department of Health. The facility was able to determine which residents called in complaints to the Indiana Department of Health by reading the reports they received and comparing what had been said to the staff with the reports received and could tell who was calling. He believed he needed medications for his anxiety and depression, but that he refused treatment. He did not have service plans for his depression or anxiety. He was encouraged to allow the facility to resolve issues prior to calling the department of health. During an interview on 12/16/21 at 4:00 p.m., the CDO indicated that the facility was working on doing service plan meetings more routinely and had started with Resident E and Resident M since they had multiple concerns which needed addressed. During an interview on 12/16/21 at 4:05 p.m., the DON indicated that she had never told him that if he did not like it at the facility to just leave, however, she had reiterated what the CDO had told him in the service plan meeting. 3. The clinical record for Resident B was reviewed on 12/15/21 at 2:20 p.m. The Resident's diagnoses included, but were not limited to, depression and post-traumatic stress disorder. A level of care assessment, dated 9/27/21, indicated she was alert and oriented to person, place, and time. She was able to function independently in familiar surroundings. A psychiatric progress note, dated 10/5/21 at 4:23 p.m., indicated that she was reporting to			

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		A. BUILDING 00 B. WING	12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROWN SENIOR LIVING	7960 SHADELAND AVENUE NORTH INDIANAPOLIS, IN 46250

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	have continued anxiety and requested that her anxiety medications be increased. It was worse during the evening hours, and it was mostly related to her post traumatic stress disorder. Her thought process during the visit was logical and she had no observed or reported delusions or hallucinations. During an interview on 12/15/21 at 2:32 p.m., Resident B indicated that she did not feel that she could voice any concerns or grievances to staff due to fear of retaliation. This was due to being yelled at by the ED for talking with the BOM in September of 2021. She just didn't know who to trust at the facility and was afraid of getting staff members in trouble if she talked with them about concerns. She tried to not socialize with anyone but her close friends at the facility, who she feels she could trust. 4. The clinical record for Resident J was reviewed on 12/15/21 at 2:10 p.m. The Resident's diagnoses included, but were not limited to, heart failure and anxiety. A Level of Care Assessment, dated 12/8/21, indicated she was alert and oriented with no confusion and able to function independently in a familiar environment. During an interview on 12/15/21 at 2:40 p.m., she indicated that she did not feel comfortable with voicing grievances to anyone. She was having increased anxiety due to the overall climate at the facility. She did not know who, in management, she could trust. She did not feel safe in the environment. During the interview she was observed to start shaking and her respirations increased. She put her hands on her chest and voiced that her anxiety was increasing			

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	just thinking about voicing grievances, due to her fear of retaliation or being kicked out of the facility she did not feel safe there. She did not feel grievances were kept personal or confidential and indicated there was no one to trust and no one she felt safe going to if issues were to arise. A confidential written statement was provided on 12/16/2021. The statement indicated the person overhearing the ED and the Regional Director of Operations referring to Resident E and Resident M as a "problem" because they were calling the state and that they "need to fix the problem." The person heard the Regional Director of Operations instructing the ED that every outburst or comment that either resident made, should be documented as a "psych issue" so they then can "set up a care plan meeting and bring up these psych issues to get them [Resident E and Resident M] out of the building." On 12/16/21 at 4:35 p.m., an attempt was made to interview the ED, who was unavailable. On 12/14/21 at 12:30 p.m., the ED provided the current Resident Rights Policy which read "...Residents rights and responsibilities shall include, but not be limited to the following...D Every resident, resident's representative, and resident's legal representative, in any, shall have the right to present grievances on behalf of himself or herself or others. To the Residence's staff, administrator, or assisted living operator, to governmental officials, to long term care ombudsman, or to any other person without fear of reprisal, and to join with other residents or individuals within or outside of the residence to work for improvements in resident care..."			

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	A policy entitled, "Grievances, was provided by the Regional Clinical Director on 12/16/2021 at 1:10 p.m. The policy indicated, "Residents have the right to express their complaints and dissatisfactions without the fear of reprisal." This Residential tag relates to Complaint IN00368157.			
R 0042 Bldg. 00	410 IAC 16.2-5-1.2(p) Residents' Rights - Noncompliance (p) Residents have the right to the examination of the results of the most recent annual survey of the facility conducted by the state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. Based on observation, interview, and record review, the facility failed to assure the plan of correction for the annual survey, and a subsequent survey plan of correction were available for examination by residents potentially affecting 47 of 47 residents residing at the facility. Findings include: The clinical record for Resident M was reviewed on 12/14/21 at 2:55 p.m. The Resident's diagnosis included, but were not limited to, hemiplegia (weakness on 1 side of the body), anxiety and depression. He was admitted to the facility on 2/11/2021. A Level of Care Assessment completed 11/12/21 indicated he was alert and oriented to person, place, and time. He was able to function independently in familiar surroundings.	R 0042	It is the intent of Crown Senior Living to assure that the plan of correction for the annual survey, and subsequent surveys, are available for examination by residents. The deficient practice had the potential to affect all residents. The concern was corrected upon identification. The binder has been updated. As a preventive measure, all staff members will be in-serviced on survey posting requirements by 2/8/22. To prevent reoccurrence, the Executive Director, or designee, will audit the binder monthly or as needed. Any findings will be reported to the Quality Assurance Committee.	02/08/2022

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	During an interview on 12/14/21 at 3:00 p.m., Resident B indicated that the facility survey binder did not contain some of the recent survey results or plans of corrections which were done by the facility. On 12/15/21 at 11:30 a.m., the survey binder was observed in the front lobby of the facility. It did not contain the written plan of correction which was written in response to the Annual Recertification Survey, completed 6/11/21. It also did not contain the written results or written plan of correction in response to a complaint survey conducted on 8/25/21. During an interview on 12/15/21 at 2:00 p.m., the Director of Clinical Services indicated she would expect to see the survey reports and written plan of corrections for the Annual Recertification Survey and subsequent Complaint Surveys available in the facilities survey binder for review by residents or visitors.			
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on observation, interview, and record review the facility failed to ensure a resident was free from mental abuse and to protect a resident's psychological wellbeing after verbal by a staff member. This deficient practice resulted in increased anxiety, mental distress, self-isolating behavior, and increased trouble	R 0052	It is the intent of Crown Senior Living to ensure residents are free from mental abuse and to protect residents' psychological wellbeing after verbal abuse by a staff member. The deficient practice had the potential to affect all residents. The concern was	02/08/2022

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	sleeping for 2 of 5 residents reviewed for abuse (Resident B and Resident E). Findings include: 1. The clinical record for Resident B was reviewed on 12/15/21 at 2:20 p.m. The Resident's diagnosis included but were not limited to depression and post-traumatic stress disorder. A level of care assessment, dated 9/27/21, indicated she was alert and oriented to person, place, and time. She was able to function independently in familiar surroundings. A psychiatric progress note, dated 10/5/21 at 4:23 p.m., indicated that she was reporting to have continued anxiety and requested that her anxiety medications be increased. It was worse during the evening hours, and it was mostly related to her post traumatic stress disorder. Her thought process during the visit was logical and she had no observed or reported delusions or hallucinations. During an interview on 12/15/21 at 2:32 p.m., she indicated that in the middle to late September 2021, she was in the BOM's (Business Office Manager) office speaking to her privately with the door shut. She was discussing a concern she had with another resident. She was upset because the other resident reminded her of a person who had abused her when she was young. She had spoken to the BOM about this before and was seeking her advice about the problem. During the conversation, the door was "flung" open, and the ED (Executive Director) stepped into the office, without knocking. The ED then told her that she had no business being in the BOM's		corrected upon identification. The staff member alleged is no longer employed at the community. As a preventive measure, all staff members will be re-educated on abuse policies and procedures by 2/8/2022. To prevent reoccurrence, the DON, or her designee, will offer open hours for residents to discuss any concerns or grievances daily for 7 days, weekly for 4 weeks and monthly thereafter. Any findings will be reported to the Quality Assurance Committee.	

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	office and talking to her about personal issues. She was wasting the BOM's time and that she was not her counselor. If she was so concerned about this other resident, then maybe she should just move to a different facility. Her business office manager had better things to do, and she could not "save" her. The ED then instructed her to leave the office so that the BOM could do her work. She left the office and was crying due to the way she had been spoken to by the ED. She was very upset and felt threatened and belittled by the way she was spoken to by the ED. She sat in the lobby and cried. She felt alone and isolated after the encounter and had increased flashbacks due to her post traumatic stress disorder. During an interview on 12/16/21 at 9:20 a.m., the BOM indicated she recalled the above incident with Resident B. It had happened on or about 9/21/21. They had been talking privately in her office about concerns she had with another resident. She had spoken with Resident B about this in the past, as she had overseen the grievance process prior to the ED being hired. The ED had "burst" into the room and told Resident B that she was not her counselor and could not help her. She should stop wasting her time and that she could do nothing for her anymore. She was now in charge of the building. When it happened, she was shocked and Resident B began crying and shaking, she was very upset. It was abusive. I did not report the incident, because I was unsure who to report it to. We are to report resident abuse to the ED. 2. The clinical record for Resident E was reviewed on 12/14/2021 at 12:48 PM. The diagnoses included, but were not limited to, insomnia and depression.			

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	A Brief Interview for Mental Status (BIMS) was completed on 9/30/2021 for Resident E. The assessment indicated Resident E was cognitively intact. No behavioral services plans documented for Resident E. A service plan for cognition, last updated 9/10/2019, indicated Resident E had no apparent memory loss. An interview conducted on 12/14/2021 at 3:00 p.m., Resident E indicated an event that happened between himself and the Director of Nursing (DON) on November 19, 2021. Resident E indicated he was sitting in the main lobby, speaking with Resident K and a former employee. They were discussing a nationally aired trial when the DON interjected into the conversation across from the lobby with her opinion. The conversation started as opposing views, but Resident E felt it began to escalate. Resident E then asked the DON to be quiet multiple times and told the DON that he was getting upset. The DON continued to talk to Resident E after these requests. Resident E then asked the DON if she was on the clock. The DON did not answer Resident E's question. Resident E then admitted to raising his voice because he was frustrated. He yelled at the DON asking if she was on the clock and to leave. Resident E and Resident K then began to leave the lobby area towards the elevator. Resident E indicated that the DON continued to yell at. Resident E was upset after the event and talked to Resident K for some time before going to his room. Resident E indicated he has had increased issues with sleeping and worsening self-isolation. This event was reported to the Regional Director			

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	of Operations on 12/14/2021 at 3:40 p.m. A behavior note written by the DON on 11/19/2021 for Resident E, indicated that Resident E was having a conversation with another resident and a staff member about the verdict of a case that was nationally publicized. The note stated, " ...This writer [DON] butted in the conversation and stated my opinion which was different ...once this writer expressed her opinion resident went into a tyrant. Resident then made a few more statements and writer chimed in one again. Resident begin yelling and becoming psychologically unstable and triggered ...Resident then tells this writer to shut up because I'm upsetting him and as this writer continues to talk ...he [Resident E] continues to hostile while yelling at the writer to shut up ...resident begin to yell at writer and try to put writer out of the facility ...resident was getting louder and louder yelling for this writer to get out of the building ...The writer then turned to mentioned resident that was having a conversation with resident [E], and stated I'll talk to you [other resident] ... Resident [E] begin to come closer to the front desk where writer was and told the resident to go ..." The nurse's note indicated the interaction continued with Resident E and that prior to him getting on the elevator, the DON informed him that the ED (Executive Director) would be called. An interview with Resident K was conducted on 12/16/2021 at 10:34 a.m. Resident K indicated that Resident E, a kitchen staff, and himself were talking about a recent trial on the evening of 11/19/2021 outside the dining room near the mailboxes. Resident K indicated the DON was behind the counter that is located across the lobby when she entered the conversation.			

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	Resident K indicated Resident E and DON engaged into a conversation at that time, but he just stood back and listened for a bit since that's his nature. Resident K indicated the conversation became "heated" and he heard Resident E say, "be quiet, you're upsetting me.". Resident K indicated the DON continued with her line of conversation after that request when Resident E repeated himself again, louder this time. Resident K indicated the situation was becoming increasingly uncomfortable. Resident E then asked DON if she was on the clock, but the DON did not answer. Resident K said Resident E then yelled, "Are you on the clock? 'Cause if not, you need to go home." Resident K stated the interaction with the DON continued while Resident E and himself headed towards the elevator. After Resident K and Resident E got upstairs, Resident K spent some time talking with Resident E, who was noticeably upset. When asked if he felt the event was appropriate, Resident K indicated, "Not at all." An interview with the Social Worker (SW) on 12/16/2021 at 2:34 p.m., indicated he was not aware of Resident E being disrespectful or having any outbursts. SW confirmed he should be aware of behaviors or outbursts. SW was unfamiliar if Resident E had any behavioral service plans. An interview with the DON was conducted on 12/16/2021 at 4:01 p.m. During this interview, the DON was asked if she had reached out the primary physician or psychiatric health provider for Resident E after the interaction on 11/19/2021 due to her charting he was "psychologically unstable". She indicated she did not that evening, but she saw the psychiatric nurse practitioner the next day and let that			

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	provider know about the event. No psychiatric note was on the record for 11/19/2021 or 11/20/2021. The DON indicated that she did not feel Resident E was a danger to himself or others that evening. When asked if she continued to engage with Resident E had he had told her to "shut up" because she was upsetting him, she confirmed she did continue the interaction. An interview with CM 1 (case manager) on 12/16/2021 at 9:40 a.m., indicated she had been the CM for Resident E since August of 2021. She indicated that Resident E is a pleasant and interactive resident, priding himself on being active in resident committees. Resident E does have hoarding tendencies, but she has never witnessed any other behaviors such as being disrespectful or yelling. She did recall him growing upset during a service plan meeting on 12/7/2021. During that meeting, she indicated he was continually "pressed" about the state of his room and grew upset but did not yell or raise his voice. She indicated that she felt it was a very rational and understandable response to the situation discussed during the service plan. An interview from the Maintenance Director on 12/16/2021, indicated that Resident E usually stays in his room, but when Resident E does come out that he is always respectful. During this interview, Maintenance Director indicated that the ED in morning meetings told staff to avoid Resident E and not to talk to him. An interview from the Ombudsman on 12/15/2021 at 8:33 a.m., indicated she was present for a service plan meeting on 12/7/2021. During this meeting, Resident E did grow upset a couple of times, but had every right to do so. It is her opinion that Resident E does not have issues			

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	with his mental status. On 12/14/21 at 11:45 a.m., the ED provided the current Elder Abuse Policy and Procedure which read "... Purpose: Each resident has the right to be free from abuse, corporal punishment, mistreatment, and involuntary seclusion. Resident must not be subjected to abuse by anyone including but not limited to community staff, other resident, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. Policy: Residents have the right to be free from physical, verbal, sexual, mental abuse, misappropriation of property, corporal punishment, and involuntary seclusion. Definitions: Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish...Mental abuse- includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation..." A policy entitled, "Resident Rights", was provided by the ED on 12/14/2021 at 12:30 p.m. This policy indicated, "Every resident shall have the right to receive courteous, fair, and respectful care and treatment ..." This Residential tag relates to complaint IN00368157.			
R 0057 Bldg. 00	410 IAC 16.2-5-1.2(aa)(1-2) Residents' Rights - Deficiency (aa) Residents have the right to privacy in written communications, including the right to: (1) send and promptly receive mail that is unopened unless the administrator has been instructed otherwise in writing by the			

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	resident; and (2) have access to stationery, postage, and writing implements at the resident ' s own expense. Based on interview, observation, and record review, the facility failed to protect a resident's written correspondence from interception for 1 of 3 residents reviewed for privacy of written correspondence. (Resident E) Findings include: The clinical record for Resident E was reviewed on 12/14/2021 at 12:48 PM. The diagnoses included, but were not limited to, insomnia and depression. A Brief Interview for Mental Status (BIMS) was completed on 9/30/2021 for Resident E. The assessment indicated Resident E was cognitively intact. During an observation of Resident E's door on 12/15/2021 at 2:32 p.m., it was noted that Resident E has signs placed outside of his door to not enter unless given permission. An interview conducted with Resident E, on 12/14/2021 at 3:00 p.m., indicated the Director of Housekeeping had called him this morning and asked if he had received the letter she slid under his door. He indicated he had not received the letter in question and had not given anyone permission to enter his room or remove the letter. An interview with Director of Housekeeping on 12/14/2021 at 5:42 p.m., indicated she had written Resident E a letter and slipped it under	R 0057	It is the intent of Crown Senior Living to protect a resident's written correspondence from interception. The deficient practice had the potential to affect all residents. The concern was corrected upon identification. The staff members alleged are no longer employed in the community. As a preventive measure, all staff will be re-educated on resident's rights by 2/8/2022. To prevent reoccurrence, the Activity Director, or her designee, will follow-up with residents daily for 7 days, weekly for 4 weeks and monthly thereafter to ensure no concerns with mail delivery. Any findings will be reported to the Quality Assurance Committee.	02/08/2022

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROWN SENIOR LIVING	7960 SHADELAND AVENUE NORTH INDIANAPOLIS, IN 46250

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	his door. She was told by another employee that the Assistance Director of Nursing (ADON) had removed the letter from Resident E's room. An interview with the ADON on 12/15/2021 at 3:48 p.m., indicated that she did remove the letter from Resident E's room. She indicated she did not enter the room, that she was able to remove the letter from outside of the door and was instructed to place it in the Executive Director's (ED) mailbox. She was unaware of what happened to the letter after that. An interview with the Director of Maintenance on 12/16/2021, indicated he had witnessed the Director of Housekeeping slide a letter in question under Resident E's door. The Director of Maintenance indicated that there were no call lights going off or indication of an emergency as to why Resident E's room should have been opened. A policy entitled, "Resident Rights", was provided by the ED on 12/14/2021 at 12:30 p.m. This policy indicated, "Every Resident shall have the right to receive or to send personal mail or any other correspondence without interception or interference by the operator or any person affiliate with the operator." This Residential tag relates to Complaint IN00368157.			
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms.			

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	(2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on observation, record review, and interview, the facility failed to maintain an infection control practice to properly prevent and/or contain COVID-19 by not ensuring all residents and staff were tested for COVID during an outbreak for 47 out of 47 residents residing in the facility, not quarantine residents who refused testing during an outbreak (Resident L) staff not wearing the proper mask and/or face shield when within 6 feet of residents, not performing a COVID screening prior to allowing a home health aide to enter the facility (Resident P), and not wearing a beard guard in the kitchen. Findings include: 1. A quality assurance (QA) walkthrough was performed on 12/16/21. As part of the QA walkthrough, a review of the facility's routine testing based on CDC's (Centers for Diseases and Control) county transmission rate was completed. The facility's routine testing results for November and December 2021 were provided by RCD (Regional Clinical Director) on 12/16/21. On 11/28/21, KS (kitchen staff) 12 tested positive for COVID-19. The CMS (Centers for Medicare and Medicaid) QSO-20-38-NH last updated on 9/10/2021	R 0407	It is the intent of Crown Senior Living to maintain an infection control practice to properly prevent and/or contain COVID-19 by ensuring all residents and staff are tested as required by policies and procedures. The deficient practice had the potential to affect all residents. The concern was corrected upon identification. As a preventive measure, all staff will be re-educated on COVID-19 testing protocols by 2/8/2022. To prevent reoccurrence, the DON, or her designee, will audit testing requirements and results daily for 7 days, weekly for 4 weeks and monthly as needed. Any findings will be reported to the Quality Assurance Committee.	02/08/2022

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	indicated, "A new COVID-19 infection in any staff or any nursing home-onset COVID-19 infection in a resident triggers an outbreak investigation." An interview with DON (Director of Nursing) conducted on 12/16/21 at 4:01 p.m. indicated, the nurse on duty on 11/28/21 called her at home to inform her that a staff member, who worked in the kitchen, just tested positive for COVID. DON instructed the nurse on duty to test the other kitchen staff members and to send them all home regardless of the COVID tests outcome because they had been in contact with each other. When asked if the facility initiated outbreak testing, DON stated, she didn't believe they did but instead of testing weekly, they started testing twice a week. DON further indicated, the testing of staff and residents was the responsibility of nursing and that being herself, the scheduler, and ADON (Assistant Director of Nursing). DON indicated, contact tracing for the positive staff member was not completed and she was unaware when the positive staff member had last worked or whom she may have come into contact with previous to her testing positive for COVID-19. The State of Indiana's SOP (Standard Operating Procedure) last updated on 11/24/21 indicated, "Option 2: If a facility does not have the expertise, resources, or ability to identify all close contacts, they should instead investigate the outbreak at a facility-wide or group-level (e.g., unit, floor, or other specific area(s) of the facility). · Unvaccinated residents and HCP: o Unvaccinated residents should generally be restricted to their rooms, even if testing is negative, and cared for by HCP using an N95 or			

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	higher-level respirator, eye protection (goggles or a face shield that covers the front and sides of the face), gloves and gown. They should not participate in group activities. o Close contacts, if known, should be managed as described in Exposure Section. · Fully vaccinated residents and HCP: o Fully vaccinated residents should be tested; they do not need to be restricted to their rooms or cared for by HCP using the full PPE recommended for the care of a resident with SARS-CoV-2 infection unless they develop symptoms of COVID-19, are diagnosed with SARS-CoV-2 infection... · If no additional cases are identified during the broad-based testing, room restriction and full PPE use by HCP caring for unvaccinated residents can be discontinued after 14 days and no further testing is indicated. · If additional cases are identified, testing should continue on affected unit(s) or facility-wide every 3-7 days in addition to room restriction and full PPE use for care of unvaccinated residents, until there are no new cases for 14 days." The clinical record for Resident L was reviewed on 12/16/21. It indicated; Resident L was not vaccinated for COVID-19. A review of Resident L's COVID-19 testing was conducted on 12/16/21. It indicated, Resident L had refused COVID-19 testing on 11/29/21 nor were there any testing results for Resident L for 12/2/21 or 12/6/21. An interview with DON (Director of Nursing) conducted on 12/16/21 at 4:01 p.m. indicated, residents who refused COVID-19 testing were not placed in contact precaution isolation.			

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	The COVID-19 testing results for 11/28-11/29/21 were reviewed on 12/16/21. The following resident's COVID testing sheets did not have a result indicated on their sheets: Residents M, N, P, Q, and R. An interview with DON (Director of Nursing) conducted on 12/16/21 at 4:01 p.m. indicated, she would not be able to say with certainty if the residents who did not have a result indicated on their testing sheets were negative or positive for COVID-19. A list of residents who were not vaccinated for COVID-19 was provided by RCD on 12/16/21 at 2 p.m. According to the list provided, Residents N and P were not vaccinated for COVID-19. A list of staff members who were not vaccinated for COVID-19 was provided by RCD on 12/16/21 at 1:33 p.m. It indicated, DM (Director of Maintenance) and DA (Dietary Aide) 5 were not vaccinated for COVID-19. The facility was unable to provide documentation indicating if DM or DA 5 had been tested for COVID-19 on 11/29/21 when the outbreak began. 2. An observation was made on 12/14/21 at 12:13 p.m. of MT (Maintenance Technician) 15 wearing a cloth mask inside the facility. An observation was made on 12/14/21 at 12:19 p.m. of DM wearing a cloth mask inside the facility. An observation was made on 12/14/21 at 12:21 p.m. of DA 6 in the dining room taking food orders from residents with his mask pulled down			

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	below his nose and not wearing a face shield. An observation was made on 12/14/21 at 12:26 p.m. of DA 5 serving residents in the dining room without wearing a face shield. DA 5 was wearing gloves when he served the resident. He then pushed the kitchen door open with his right hand while still wearing the gloves. Once in the kitchen, he opened a potato chip bag then reached in the bag with the same gloved hand he had just touched the kitchen door with and pulled out a handful of chips and placed them on a plate to serve to a resident. 3. An observation was made on 12/16/21 at 10:22 a.m. of HH (home health aide) 8 inside Resident P's room and within 6 feet of the resident not wearing a face shield. An interview was conducted with HH 8 on 12/16/21 at 10:22 a.m. She indicated; she was not aware that she needed to wear a face shield when within 6 feet of the resident when providing care. An interview with Concierge 1 was conducted on 12/16/21 at 10:23 p.m. She indicated, the facility utilized a screening form to screen staff and visitors for signs/symptoms and potential exposure to COVID-19. However, she was unable to locate the COVID-19 screening form for HH 8. The facility failed to screen HH 8 prior to her coming in contact with Resident P. State of Indiana's SOP last updated on 11/24/21 indicated, "Screening could be done by an individual or by implementing an electronic monitoring system in which an individual can self-report before entering the facility. · Screen all healthcare personnel (HCP) each			

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	shift, and screen all visitors and vendors entering the facility for known diagnosis or symptoms of COVID-19 and for any history of being a close contact or exposed to COVID-19 positive or symptomatic person in the preceding 14 days." An observation was made on 12/16/21 at 10:34 a.m. of HN (Hospice nurse) 7 inside Resident M's room and within 6 feet of the resident. HN 7 was not wearing a face shield. The CDC's Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic last updated Sept. 10, 2021, indicated, "Implement Universal Use of Personal Protective Equipment for HCP If SARS-CoV-2 infection is not suspected in a patient presenting for care (based on symptom and exposure history), HCP working in facilities located in counties with substantial or high transmission should also use PPE as described below:... Eye protection (i.e., goggles or a face shield that covers the front and sides of the face) should be worn during all patient care encounters". 4. An observation of DSM (Dietary Services Manager) was made on 12/14/21 at 12:03 p.m. DSM had walked out of the kitchen into the dining room during lunch service. DSM was not wearing a beard covering despite having facial hair that exceeded 1/4 inch in length. An interview with DSM was conducted on 12/14/21 at 12:03 p.m. He indicated; they were out of beard coverings so he could not put one on. The Indiana Retail Food Manual indicated,			

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	"Effectiveness of hair restraint Sec. 138. (a) Except as provided in subsection (b), food employees shall wear hair restraints, such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting: (1) exposed food; (2) clean equipment, utensils, and linens; and (3) unwrapped single-service and single-use articles".			