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	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LEGACY LIVING LEASING JASPER, LLC	1850 WEST STATE ROAD 56 JASPER, IN 47546

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R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN 00440174. Complaint IN00440174: State deficiencies related to the allegations are cited at R0052. Survey dates: August 5, 2024 Facility number: 014383 Residential Census: 109 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on August 13, 2024.	R 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies or any violation of regulation. T	
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense Based on observation, interview, and record review, the facility failed to ensure a cognitively impaired resident with increased confusion was free from sexual abuse perpetrated by a visitor and failed to ensure staff immediately intervened to separate the perpetrator and protect the resident for 1 of 3 residents reviewed for sexual abuse. (Resident D) This deficient practice resulted in Resident D being sexually assaulted and not provided adequate supervision to prevent further abuse. Finding includes: On 8/5/24 at 9:35 A.M. a facility reported incident, dated 8/2/24 at 12:40 P.M., included a pending	R 0052	IDR scheduled for 9/18/24 at 12:00pm For the resident who was affected by this practice, a no trespassing order was issued by the Jasper Police Department the night of the incident. No other residents have been found to be affected by this deficiency. This deficiency was the result of a personal relationship that was formed many years ago from a past marriage. In the event of other residents, if there are relationship dynamics	09/10/2024

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

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	sexual assault investigation involving Resident D. The report indicated a resident with moderate cognitive impairment received a visitor on 8/1/24 at 10:00 P.M. Staff checked Resident D in her room approximately two hours later to find the resident and visitor in bed together undressed. Resident D indicated they had sexual intercourse, which the visitor denied. During an interview on 8/5/24 at 9:45 A.M., the Director of Nursing (DON) indicated Resident D had received several visitors on 8/1/24 for a celebration. Staff did not question the late visitation due to the celebration and escorted the visitor to Resident D's room. Resident D appeared happy to see the visitor. During a routine night shift safety check, CNA 4 observed Resident D on the side of the bed without clothing and the visitor was in the bed under the covers. CNA 4 left the room to notify the nurse on duty. The Facility Administrator, DON, resident's Power of Attorney (POA), and local police department were notified immediately. Resident D was sent to the hospital for examination the morning of 8/2/24. During an observation and interview on 8/5/24 at 10:00 A.M., Resident D was observed sitting in her room on the locked dementia unit. Resident D was wearing a WanderGuard bracelet (a device to prevent wander-prone residents from leaving unattended) to the right wrist. A printed sign was hung inside of the room next to the door with an arrow and the words, "Dining Room." During the interview, Resident D did not know how long she had resided in the facility but denied abuse and indicated feeling safe in the facility. Resident indicated recently having a celebration with visitors but could not describe or recall who had visited. Resident D acknowledged having had a visitor later that night (8/1/24) and being tired of		the facility should be aware of, that information should be given upon move in. The facility has incorporated a new visiting hours policy for Memory Care. No visitors will be permitted from 10pm to 6am unless otherwise approved by administration. Information regarding the new policy will be distributed to staff and family. Staff will sign acknowledgement of understanding of new policy by Tuesday, September 10th. The corrective action will be monitored through verifying compliance with charge nurse for 10pm -6am shift 3 times per week the first 4 weeks, 2 times per week the next 4 weeks and 1 time per week the next 4 weeks.	

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	talking about it. Resident D indicated not knowing who the visitor was the night of 8/1/24, but later indicated they had met before. Resident D did not recall going to the hospital for evaluation the morning of 8/2/24. During record review on 8/5/24 at 10:30 A.M., Resident D's diagnoses included, but were not limited, dementia, anxiety, and depression. A Speech Therapy Discharge Note & Plan of Treatment, dated 9/18/23, indicated Resident D was independent up until a few months ago. Resident D had recently moved to the memory care unit due to increased confusion and required care/assistance with daily tasks and activity completion. A "History of Present Complaint" indicated Resident D had a significant increase in confusion in the past month as well as a general decline in function. A level of care assessment, dated 4/4/24, included Resident D required hands on assistance with dressing and undressing daily and required reminders, redirection, and/or orientation daily. A nurse's progress note, dated 8/2/24 at 6:00 A.M., indicated CNA 4 messaged to meet in the locked dementia unit to discuss something. CNA 4 reported Resident D and a visitor were in bed together, not dressed, appeared to be touching each other, and possibly more. Nurse went to Resident D's room to find visitor standing in the room with sweat dripping from his face. The lights were off and a blanket had been placed over the television screen. The visitor informed the nurse of how he knew Resident D. The visitor indicated that Resident D was getting a shower. Resident D was located fully nude standing in the middle of the bathroom looking lost/confused. Resident told nurse that the visitor was somehow related to her			

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	first husband but could not tell the nurse the visitor's name. Resident informed nurse that they had sex, he touched her "down there and the boobs" and resident told nurse not to tell anyone. Resident D's POA was contacted and instructed nurse to call the police and Resident D was taken to the hospital for tests. A hospital Emergency Department (ED) physical exam on 8/2/24 at 7:37 A.M., included Resident D's neurological note of "Alert & pleasantly demented..." An ED triage assessment on 8/2/24 at 8:10 A.M., indicated "Patient presents in ED via triage with her daughter and POA... Patient resides in the aforementioned [facility] and daughter is requesting evaluation for sexual assault... Patient has dementia at baseline and had difficulty verbalizing understanding. According to daughter, staff called her at an unspecified time this morning and reported finding the patient naked in bed with an adult male... Upon exam, patient displays confusion regarding date/time, situation, and place but is oriented to self. Patient provided history of events by confirming there was a man in her bed last night, but she was unable to recall his name and relation to her. Patient reports she had consensual sex with the man. Patient is unable to recall details regarding their sexual interaction but states he did penetrate her vagina with his penis. Patient denies any physical pain as well as injury. Patient agrees to pelvic exam, swab collection, and STD testing..." A hospital ED note, dated 8/2/24 at 8:18 A.M., included "SANE (Sexual Assault Nurse Examiner) kit opened... Visual exam of external genitalia revealed excoriation to bilateral folds of patient's groin area as well as excoriation to the peri-anal area. Patient verbalized some pain with speculum			

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	insertion. Redness and excoriation noted to vaginal os (opening in center of cervix). Upon removal of speculum following internal vaginal exam, a small amount of bleeding was noted. No discernable injury noted during exam. Swabs collected and packaged appropriately..." The facility's investigation of the incident included a signed handwritten statement by CNA 4, dated 8/2/24. The statement included, "At 10:00 P.M., I let [visitor] in [locked dementia unit], he said that he was her (sic) to see [Resident D] so I took him back to her room and said that [Resident D] you have a visitor then I shut the door. I went on to do my duties then at 12:40 A.M., I went back to her room knocked on the door said [Resident D's] name, opened the door [and] saw [Resident D] on the side of the bed nude. The man was lying on the other side of the bed. I immediately shut the door [and] went to the commons area [to call] the nurse..." During an interview on 8/5/24 at 12:50 P.M., the Dementia Director indicated if staff observes an event they perceive to be abuse, the staff should intervene, they should stay with the resident to ensure safety, and they should immediately notify the Facility Administrator. On 8/5/24 at 12:35 P.M., the DON supplied a facility policy titled, Resident Neglect, Abuse, and Misappropriation of Property Policy, dated 11/14/23. The policy indicated, "Residents will be free from ... sexual abuse... Sexual Abuse: Includes ... sexual assault... Sexual contact that result from threats, force or the inability of the person to give consent, including but not limited to assault, rape, and sexual harassment. Examples of Sexual Abuse... 2. Any sexual activity that occurs when one or both parties cannot or do not			

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	consent..." This citation relates to Complaint IN00440174.			