STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155825	A. BUILDING _____ B. WING _____	C 01/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST AUGUSTINE HOME FOR THE AGED	2345 W 86TH ST INDIANAPOLIS, IN 46260

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F 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00449365. Complaint IN00449365-Federal/State deficiencies related to the allegations are cited at F600. Survey dates: January 10 and 13, 2025 Facility number: 000389 Provider number: 155825 AIM number: 100288920 Census bed type: SNF/NF: 18 Residential: 14 Total: 32 Census payor type: Medicaid: 18 Total: 18 This deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on January 22, 2025.	F 000		
F 600 SS=D	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 any physical or chemical restraint not required to	F 600		

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

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F 600	Continued From page 1 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 observation, interview and record review, the facility failed to protect the resident's right to be free from physical abuse by a CNA for 1 of 2 residents reviewed for abuse. (Resident B) The deficient practice was corrected on 9/25/24, prior to the start of the survey, and was therefore past noncompliance. Finding includes: A document, titled "Indiana State Department of Health Survey Report System," indicated on 9/17/24 at approximately 7:45 a.m., the Executive Director (ED) was notified Resident B alleged CNA 1 "knocked me out." The resident's description of the aide involved was consistent with the description of CNA 1. Later in the day on 9/17/24, a discoloration and raised area presented on Resident B's forehead. Staff interviews confirmed the raised area on Resident B's forehead was not present on the previous shift. The evidence pointed toward the resident's description of the incident to be accurate. CNA 1 was terminated. A handwritten facility statement dated 9/17/24 at 7:30 p.m. and signed by RN 2 indicated Resident B's left eye was slightly swollen. When asked if it hurt, he indicated no, but "that's where she hit me." He described the staff member who hit him	F 600	Past noncompliance: no plan of correction required.	

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as "that tall, big black one on night shift"

A handwritten facility statement, dated 9/17/24, and signed by CNA 3 indicated at approximately 2:30 a.m., CNA 3 was on her way to check on a resident when she observed CNA 1 coming out of Resident B's room. CNA 1 was complaining he called her N*****. RN 4 came from the west side of the facility and CNA 1 complained to her Resident B called her a N****** and lied on her indicating she had hit him on the face. CNA 1 and RN 4 went to Resident B's room at that time. When the two of them came back later, RN 4 indicated the resident was having a behavior and called her a N***** also and he did not want to see the two of them again. RN 4 indicated she would document his behavior.

A typed facility statement, dated 9/17/24, and signed by RN 5 indicated that morning just past 7:00 a.m., the Director of Nursing (DON) and herself was exiting the elevator when they were approached by CNA 1. CNA 1 was visibly upset, appeared to be crying or had been crying, and was loudly expressing her frustration regarding Resident B. She asked to speak to RN 5 and the DON. CNA 1 spoke about an incident which occurred that morning at approximately 3:00 a.m. When she answered Resident B's call light and he realized it was her, he called her a racial slur. The night nurse was in the hall listening to the exchange, entered the room and he called her a N***** as well. CNA 1 was expressing her frustration this was not the first time he had used this language directed at staff. She felt like he got away with it and nothing was done about it. The DON attempted to calm CNA 1 down. CNA 1 indicated the resident said she had hit him. CNA 1 continued to voice her frustrations because

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Resident B got away with calling staff racial slurs, lied on her, and almost got her fired. The DON reminded CNA 1; Resident B was on the list which required staff to "care in pairs" because he did have those known behaviors.

A handwritten facility statement, dated 9/17/24, and signed by CNA 1 indicated at approximately 3:00 or 3:30 a.m., Resident B turned his call light on, and she responded. When she opened his door, Resident B indicated "N***** I want the nurse get out of my room." She left his room and closed the door. RN 4 was a few feet away behind her and heard the interaction between the resident and CNA 1.

A handwritten facility statement, undated, and signed by CNA 7 indicated when she walked into Resident B's room to get him up, he indicated the big, tall girl hit him in the face. He placed his hand on his face where he indicated she hit him. He indicated he would only talk to another nurse, not the one that came in with the girl who hit him.

A handwritten facility statement, dated 9/17/24, and signed by RN 8 indicated at the start of her shift, a CNA indicated to her Resident B wanted to talk to the morning nurse. Resident B indicated to RN 8 his night shift CNA (CNA 1) hit him in his forehead. Upon assessing the area, there was no redness or bruise discovered. He indicated he was in the bathroom, pulled the call light, the night aide came into the bathroom, and stated "what the F do you want?" He indicated the same night shift CNA (CNA 1) was also mean to his wife when she was a resident at the facility.

A typed facility statement, undated, and signed by CNA 9 indicated she gave Resident B a shower

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on the evening of 9/16/24 around 9:00 p.m., and he did not have any skin issues. He did not have any bump or bruise anywhere on his face. On 9/17/24, she observed he had a bump on his forehead. She asked him if he fell. He indicated no he had not and late last night a big woman came into his room and told him to go to bed. She punched him with her fist.

A handwritten statement, dated 9/17/24, and signed by RN 4 indicated Resident B requested the nurse at approximately 4:00 a.m. Upon entering the resident's room, he showed frustration and verbalized he did not feel I was the nurse. He began to explain he was knocked out cold just prior to the nurse's arrival. He indicated RN 4 would not believe him either because "you're a N***** too." The nurse assessed the resident with no visible injuries to his face, chest or arms. He indicated CNA 1 hit him in the head. The resident did not know the nurse was standing outside of his room observing the interaction between he and CNA 1. RN 4 overheard the resident referring to CNA 1 as the racial slur "N*****" and a "Big black girl." Both staff members exited his room after completing the tasks which needed to be completed.

A document, titled "PCE-Skin Assessment," dated 9/18/24 at 1:56 p.m., indicated a skin assessment was completed on Resident B. The skin evaluation indicated his left side of his forehead had a 1.5 cm (centimeter) by 1.5 cm brown discoloration with a 0.5 cm circular area of protrusion observed.

The record for Resident B was reviewed on 1/13/25 at 12:14 p.m. The diagnoses included,

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but were not limited to,
moderate dementia with mood disturbance, osteoarthritis, abnormal weight loss, nutritional anemia, major depressive disorder, and adult failure to thrive.

A nursing progress note, dated 9/17/24 at 3:39 a.m., indicated Resident B pulled his call light and immediately upon the staff member's entrance into his room, he referred to the staff member as a N*****. He indicated he did not need help from either one of them and "you people are all alike." "You are going to h*** for being a N*****." He continued to demean staff and say cruel things to staff, so they exited the room.

A nursing progress note, dated 9/17/24 at 9:08 a.m., indicated the resident voiced being upset with the night shift staff last night.

A nursing progress note, dated 9/18/24 at 7:00 a.m., indicated the resident had some slight discoloration to his left frontal forehead observed with tenderness when touched.

A nursing progress note, dated 9/18/24 at 8:43 p.m., indicated there was slight swelling observed above his left eye.

A nursing progress note, dated 9/19/24 at 7:08 a.m., indicated there was slight swelling observed above his left eye.

During an interview, on 1/10/25 at 1:01 p.m., the Human Resource Director indicated CNA 1 was terminated due to the facility's findings during the investigation. Resident B had called CNA 1 a name and he had a mark on his head discovered through their investigation.

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During an interview, on 1/10/25 at 1:09 p.m., the Executive Director (ED) indicated CNA 1 was terminated for abuse. Resident B's story stayed consistent every time he told it. A knot with discoloration did form on his forehead the day after CNA 1 took care of him, which was not there on the previous shift.

During an interview, on 1/13/25 at 11:15 a.m., Resident B indicated he was hit by a staff member, but it was so long ago he did not remember the description of the girl. He heard she no longer worked at the facility, and he was glad.

During an interview, on 1/13/25 at 2:15 p.m., the Human Resource Director indicated CNA 1 was terminated for abuse for hitting Resident B on the forehead above his eye. There were inconsistencies in CNA 1 and RN 4's statements, while Resident B's statement stayed consistent and never changed.

During an interview, on 1/13/25 at 2:15 p.m., the Director of Nursing (DON) indicated a consideration looked at prior to terminating CNA 1, was the resident was supposed to be cared for in pairs and there was no one else in the room with her to verify she did not hit Resident B. CNA 1 did not follow their policy and procedure of caring for residents in pairs when it was care planned to do so.

A document, titled "CNA 1's Status for 9/19/2024," dated 9/19/24, indicated CNA 1 was terminated on 9/19/24. She was not eligible for rehire. Her termination was involuntary. She was terminated at the conclusion of an abuse investigation and

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the abuse allegations against her were found to be substantiated.

A current facility policy, titled "Abuse, Neglect, Mistreatment and Misappropriation of Resident Property," dated 1/2018 and provided by the ED on 1/10/25 at 1:09 p.m., indicated "...Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish...Abuse includes...physical abuse...Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm...Physical abuse: includes hitting, slapping, pinching, and kicking. It also includes controlling behavior through corporal punishment...."

A current facility policy, titled "Resident's Bill of Rights," dated 4/2017 and provided by the ED on 1/10/25 at 1:09 p.m., indicated "The Resident has the right to a dignified existence that will provide and maintain a supportive environment to promote self-esteem and personal dignity and to ensure that the Resident and civil rights are respected and protected...Personal Rights 1. The Resident has the right to honor and respect at all times and under all circumstances, to courteous and equal consideration from all with whom they come in contact in view of God's creative love for them. Thus, the Resident has the right to expect available care, treatment, services or accommodation to be provided when indicated without consideration based on race, color, creed, sexual orientation, national origin or the nature of the source of payment for care...."

The deficient practice was corrected, by 9/25/24,

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F 600	Continued From page 8 after the facility implemented a systemic plan that included resident interviews, staff interviews, CNA 1 was terminated and a resident abuse in-service was completed for all employees. This citation relates to Complaint IN00449365. 3.1-27(a)(1)	F 600		