STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155490	A. BUILDING 00 B. WING	06/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMBASSADOR HEALTHCARE	705 E MAIN ST CENTERVILLE, IN 47330

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00297207 and IN00298116. Complaint IN00297207 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00298116 - Substantiated. Federal/State deficiencies related to the allegations are cited at F607 and F609. Survey dates: June 17 and 18, 2019 Facility number: 000456 Provider number: 155490 AIM number: 100288750 Census Bed Type: SNF/NF: 115 Total: 115 Census Payor Type: Medicare: 7 Medicaid: 97 Other: 14 Total: 113 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 25, 2019	F 0000		
F 0607 SS=D Bldg. 00	483.12(b)(1)-(3) Develop/Implement Abuse/Neglect Policies §483.12(b) The facility must develop and implement written policies and procedures that:			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	§483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, Based on interview and record review, the facility failed to ensure a staff member implemented facility policies related to timely reporting of an allegation of verbal abuse which resulted in delayed protection to the alleged abuse victim(s), delayed investigation of the abuse allegation and delayed reporting to state agencies, including the Indiana State Department of Health (ISDH) for 1 of 3 residents reviewed for abuse. (Resident C) Findings include: The clinical record of Resident C was reviewed on 6-17-19 at 7:57 a.m. Her diagnoses included, but were not limited to acute and chronic respiratory failure, diabetes with diabetic neuropathy, COPD (chronic obstructive pulmonary disease), delusional disorders, anxiety and depression. Her most recent Minimum Data Set (MDS) assessment, dated 4-6-19, indicated she is severely cognitively impaired, requires extensive assistance of 1 or more persons with bed mobility, transfers from one surface to another, toileting, bathing and hygiene. She is non-ambulatory and is frequently incontinent of bowel and bladder. She has a tracheostomy and requires routine care for the tracheostomy and supplemental oxygen. In an interview with the Director of Nursing (DON) on 6-17-19 at 4:50 a.m., she indicated the	F 0607	By submitting the enclosed documents, we are not admitting the truth or accuracy of any specific findings or allegations as in any proceedings and submit these responses pursuant to our regulatory obligations. We are requesting a desk review for this survey. F 607 DEVELOP/ IMPLEMENT ABUSE/ NEGLECT POLICIES I. The administrator and DON were notified immediately that there was an allegation of abuse by RN 3 against CNA 5 and LPN 4 when it was brought to the attention of the ADON. A thorough investigation began immediately with interviews of residents and staff. CNA 5 and LPN 4 were suspended immediately pending the investigation. II. Current residents residing at the facility were interviewed and/or observed by the	07/18/2019

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	facility had an allegation of verbal abuse on 6-8-19, in which a new employee did not report the allegation until several hours after she left the facility for a dinner break at 10:00 p.m., and did not return to work. The orientee, RN 3, did send a text message approximately one hour after she left the facility to CNA 5, indicating she would not be back because she was having some personal issues and to let LPN 4 know she would not be returning to work. A 4:24 a.m. on 6-9-19, RN 3 sent a text message to the Assistant Director of Nursing (ADON). She indicated the ADON was asleep and did not receive the text message until she awakened later in the morning and informed the DON of the text message. "The text was not the least clear as to any details, something along the lines of she had witnessed abuse, but did not elaborate any details. No mention of who, what or where. Very unclear." She indicated the ADON was able to reach RN 3 after multiple phone calls and text messages and learned the allegation was of a verbal abuse towards Resident C by LPN 4 and CNA 5. RN 3 alleged during care for Resident C, with LPN 4 and CNA 5 to administer an injection, she observed Resident C mouth to them, "F-k you," and the allegation was that the CNA...told [name of Resident C], 'FU, too, b---h.' And it was alleged that the LPN took away her water cup and the aide told her that she would only get it back if she behaved." From the interviews with the aide and LPN, nothing was mentioned at all about any of these actions, whatsoever." The DON clarified RN 3 was a new employee with the facility and had begun her first shift of 6:00 p.m. on 6-8-19 to 6:00 a.m. on 6-9-19 and was orienting to her position with LPN 4. She indicated RN 3 had several years previous experience as a nurse in long term care nursing prior to being hired at the facility.		Director of Nursing to ensure that all other residents are being treated appropriately. CNA 5 and LPN 4 were suspended and a thorough investigation of the allegation was completed. III. A systematic change includes clarification of the abuse reporting policy and training. This training includes immediate notification of the Administrator when accessible, and the designee when the administrator is not accessible. The training also includes the immediate suspension of any identified or suspected staff members with allegations of mistreatment and the steps to determine that a thorough investigation is completed during the suspension of any identified staff. In addition, the full staff will complete abuse training to identify and report allegations of mistreatment at a minimum of twice a year and this same training will be provided to all staff during new hire orientation. IV. The Social Services/Designee will interview three residents per day (5 days a week) for 90 days, then three residents two times per week for 90 days, then 5 residents per month for an additional 180 days to total 12 months of monitoring. The interview questionnaire is completed with any areas of	

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	In an interview with the ADON on 6-17-19 at 9:40 a.m., she shared she had received an incoming text message on her cell phone on 6-9-19 at 4:24 a.m., but did not see it to read it until around 7:30 a.m. on 6-9-19, from RN 3. "The text basically said she had witnessed abuse and neglect, but no details as to who was involved. She had not attempted to call me, just the text. So, I then tried to call and text her several times with no luck. I then called [name of LPN 4]. [Name of LPN 4] told me she [RN 3] had left on break around 10pm Saturday night to go home and let her dogs out and never returned. She said [name of RN 3] then texted [name of CNA 5] at 10:56 p.m. [on 6-8-19], to say she wasn't coming back because she had some personal issues to deal with. [Name of RN 3] did call me back around 8am on Sunday and was able to tell me what she had witnessed. I told her I would need her statement in writing and she said she would get it done as soon as she could and was adamant she would get it emailed to [name of DON] as soon as possible. We have not received it yet. I called and texted her multiple times on that Sunday and again on Monday, and she never has responded back." In a telephone interview with LPN 4 on 6-17-19 at 7:45 p.m., she recalled she was working on the east hall of the facility on 6-8-19 and was scheduled with a new nurse, RN 3, to orient that shift. She recalled between 8:00 p.m. and 9:00 p.m., during the bedtime medication pass, she prepared an antibiotic injection for Resident C. RN 3 requested to administer the injection. "Before we went in her room, I explained that [name of Resident C] has a history of behaviors, especially with new people, of hitting, cussing, biting and to be aware of those things. When we went in her room, I explained to [name of Resident C] what we were going to be doing and [name of		concern being brought to the attention of the Administrator/DON for follow up. V. The results of these interviews will be discussed at the facility Quality Assurance Performance Improvement meeting and frequency and duration of reviews will be adjusted as needed. Completion Date: July 18, 2019	

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	RN 3] introduced herself and showed [Resident C] the injection. [Name of Resident C] said it was fine to go ahead. I did move the over the bed table and her cup of water, because she has thrown it us before. We rolled her over onto her side and we were on each side of her. She immediately started to bite me and began kicking. [Name of CNA 5] had also come in the room and started to hold her legs to keep her from kicking us. As soon as we finished, we rolled the resident onto her back and [name of Resident C] looked at us and mouthed, 'F--k B---h,' and went on as if nothing happened. We moved her table back where it was and went on about the med pass. I did not see any hand gestures and the only cursing was from the resident, but that is not unusual for her. [Name of RN 3] did not mention anything about any actions in the room or even once we were done. The only thing unusual was that [name of RN 3] said she was going to take her 30 minute break around 10pm to go let her dogs out. But, she never came back. She sent a text to [name of CNA 5] around 11pm saying she couldn't come back because of some personal reasons and that she would let the ADON know in the morning. She sent another text to the CNA around 4am that mentioned she had witnessed some abuse, but didn't say what it was. It wasn't until the ADON called me after my shift ended that I learned the abuse allegation was about me and the CNA. I figured when the ADON called me it was about [name of RN 3] leaving and not coming back to work." In a telephone interview with CNA 5 on 6-18-19 at 5:30 a.m., she indicated she had followed LPN 4 and RN 3 into Resident C's room on 6-8-19 around 7:30 p.m. to 8:30 p.m. to assist with care if needed, due to the resident had a history of being rough towards staff with care. She indicated RN 3 told			

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	Resident C she was getting ready to give her the injection. "[Name of Resident C told her, well mouthed, it was okay and to go ahead," and she(Resident C) began to attempt to bite LPN 4 and kick RN 3, "so I held her leg still because the needle was already in her hip and I didn't want the resident or the nurses to get hurt." She indicated prior to starting the injection, she witnessed LPN 4 tell Resident C she was moving the over the bed table with her water on it, but would put it back when they were done and that it was replaced upon completion of the care. "I have seen [name of Resident C] throw water and ice at different staff members in the past." CNA 5 indicated she did not observe any actions or words out of the ordinary during the care at this time or throughout the remainder of the shift with the residents. She recalled between 10:00 p.m. and 10:30 p.m., RN 3 mentioned she was going on break to let her dogs out and would be back in about 30 minutes. CNA 5 received a text message approximately one hour later from RN 3 indicating she was not returning to work due to personal issues, to inform LPN 4 and that she (RN 3) would inform the ADON on Sunday. In an interview on 6-17-19 at 8:40 a.m., with the Administrator, she estimated she submitted the allegation of abuse to ISDH between 1:00 p.m. to 1:30 p.m. on Sunday, 6-9-19. She indicated RN 3, "an RN with several years of LTC [long term care] experience, alleged on Sunday morning [6-9-19] that the previous evening, around 9:00 p.m., she had witnessed a verbal abuse by staff towards [name of Resident C]. "She did not address this with anyone until she sent a text to the ADON on 6-9-19 at about 4:34 a.m. My expectation is that any staff member, let alone an RN with experience, would make sure the resident is safe and then phone me as soon as possible, not send a text in			

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	the middle of the night. My phone number is located at every nursing station and other places to be able to reach me at any time. From our investigation, she did not address this abuse with anyone prior to her leaving on break around 10pm and then, ended up not coming back from that break. This nurse had received abuse training here upon hire...I was very shocked that she ended up not clocking out for her break and did not show back up and, even worse, left without informing anyone of the abuse allegation for hours. We could not substantiate the abuse, but our job is to protect the residents from abuse and her actions did not allow us to protect that resident or the others from potential abuse. We have tried multiple times since Sunday to reach her, and other than the one call back, she has not responded to any calls or texts since then." On 6-17-19 at 12:30 p.m., the Human Resource Manager provided a copy of form entitled, "Reporting of Abuse," signed and dated 6-5-19 by RN 3. This document indicated, "If you witness any form of abuse you are to report it immediately to your supervisor. Your supervisor is to notify the Administrator and the D.O.N. immediately...All alleged reports of abuse must be reported to the Indiana State Department of Health. These include verbal, physical, sexual and financial. They must be reported within 2 hours of the occurrence. The Administrator and/or D.O.N. must be notified immediately after occurrence. If it happens after normal working hours you must notify the Administrator and D.O.N. via phone or cell phone (numbers are located at the nurse's stations). The facility only has 2 hours to notify the police of physical or sexual abuse...If it is Staff to Resident, the staff member must be pull [sic] off the floor and suspended pending investigation. A staff member needs to accompany the staff			

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	member out of the building. An initial report will be sent to ISDH within 2 hours if it is physical, sexual, or financial and 24 hours for verbal or resident to resident altercation...Failure to report abuse, makes you as responsible as the one the commented [sic] the actual abuse. You could end up with the consequences as one who commented [sic] the abuse, because you did not report it immediately." On 6-17-19 at 11:40 a.m., the Administrator provided a copy of the a policy entitled, "Abuse Investigation and Reporting." This policy was identified as the current policy utilized by the facility and had a revision date of July, 2017. This policy indicated, "All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source ("abuse") shall be promptly reported to local state, and federal agencies (as defined by current regulations) and thoroughly investigated by facility management...The Administrator will suspend immediately any employee who has been accused of resident abuse, pending the outcome of the investigation. The Administrator will ensure that any further potential abuse, neglect, exploitation or mistreatment is prevented...An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than: Two (2) hours if the alleged violation involves Physical abuse OR has resulted in serious bodily injury..." This Federal tag relates to Complaint IN00298116. 3.1-28(a)			

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F 0609 SS=D Bldg. 00	483.12(c)(1)(4) Reporting of Alleged Violations §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 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. Based on interview and record review, the facility failed to ensure an allegation of abuse was reported to the Indiana State Department of Health (ISDH) within two (2) hours occurrence or within two (2) hours of the facility being made aware of the abuse allegation for 1 of 3 residents reviewed for abuse. (Resident C)	F 0609	F 609 REPORTING OF ALLEGED ABUSE I. The Administrator and DON were notified immediately that there was an allegation of abuse by RN 3	07/18/2019

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	Findings: In an interview with the Director of Nursing (DON) on 6-17-19 at 4:50 a.m., she indicated the facility had an allegation of verbal abuse on 6-8-19, in which a new employee did not report the allegation until several hours after she left the facility for a dinner break at 10:00 p.m., and did not return to work. The orientee, RN 3, did send a text message approximately one hour after she left the facility to CNA 5, indicating she would not be back because she was having some personal issues and to let LPN 4 know she would not be returning to work. A 4:24 a.m. on 6-9-19, RN 3 sent a text message to the Assistant Director of Nursing (ADON). She indicated the ADON was asleep and did not receive the text message until she awakened later in the morning and informed the DON of the text message. "The text was not the least clear as to any details, something along the lines of she had witnessed abuse, but did not elaborate any details. No mention of who, what or where. Very unclear." She indicated the ADON was able to reach RN 3 after multiple phone calls and text messages and learned the allegation was of a verbal abuse towards Resident C by LPN 4 and CNA 5. RN 3 alleged during care for Resident C, with LPN 4 and CNA 5 to administer an injection, she observed Resident C mouth to them, "F-k you," and the allegation was that the CNA...told [name of Resident C], 'FU, too, b---h.' And it was alleged that the LPN took away her water cup and the aide told her that she would only get it back if she behaved." From the interviews with the aide and LPN, nothing was mentioned at all about any of these actions, whatsoever." The DON clarified RN 3 was a new employee with the facility and had begun her first shift of 6:00 p.m. on 6-8-19 to 6:00 a.m. on 6-9-19		against CNA 5 and LPN 4 when it was brought to the attention of the ADON. A thorough investigation began immediately with interviews of residents and staff. CNA 5 and LPN 4 were suspended immediately pending the investigation. II. Current residents residing at the facility were interviewed and/or observed by the Director of Nursing to ensure that all other residents are being treated appropriately. CNA 5 and LPN 4 were suspended and a thorough investigation of the allegation was completed. III. A systematic change includes clarification of the abuse reporting policy and training. This training includes immediate notification of the Administrator when accessible, and the designee when the administrator is not accessible. The training also includes the immediate suspension of any identified or suspected staff members with allegations of mistreatment and the steps to determine that a thorough investigation is completed during the suspension of any identified staff. In addition, the full staff will complete abuse training to identify and report allegations of mistreatment at a minimum of twice a year and this same training will be provided to all staff during new hire orientation. IV. The Administrator	

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	and was orienting to her position with LPN 4. She indicated RN 3 had several years previous experience as a nurse in long term care nursing prior to being hired at the facility. In an interview with the Assistant Director of Nursing (ADON) on 6-17-19 at 9:40 a.m., she shared she had received an incoming text message on her cell phone on 6-9-19 at 4:24 a.m., but did not see it to read it until around 7:30 a.m. on 6-9-19, from RN 3. "The text basically said she had witnessed abuse and neglect, but no details as to who was involved. She had not attempted to call me, just the text. So, I then tried to call and text her several times with no luck. I then called [name of LPN 4]. [Name of LPN 4] told me she [RN 3] had left on break around 10pm Saturday night to go home and let her dogs out and never returned. She said [name of RN 3] then texted [name of CNA 5] at 10:56 p.m. [on 6-8-19], to say she wasn't coming back because she had some personal issues to deal with. [Name of RN 3] did call me back around 8am on Sunday and was able to tell me what she had witnessed. I told her I would need her statement in writing and she said she would get it done as soon as she could and was adamant she would get it emailed to [name of DON] as soon as possible. We have not received it yet. I called and texted her multiple times on that Sunday and again on Monday, and she never has responded back." In an interview on 6-17-19 at 8:40 a.m., with the Administrator, she estimated she submitted the allegation of abuse to ISDH between 1:00 p.m. to 1:30 p.m. on Sunday, 6-9-19. She indicated RN 3, "an RN with several years of LTC [long term care] experience, alleged on Sunday morning [6-9-19] that the previous evening, around 9:00 p.m., she had witnessed a verbal abuse by staff towards		and/or designee will audit all reportable incidents to ensure timely notification is made to the Indiana State Department of Health Long Term Care Division on all reportable incidents. V. The results of these audits will be discussed at the facility Quality Assurance Performance Improvement meeting and frequency and duration of reviews will be adjusted as needed. Completion Date: July 18, 2019	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	[name of Resident C]. "She did not address this with anyone until she sent a text to the ADON on 6-9-19 at about 4:34 a.m. My expectation is that any staff member, let alone an RN with experience, would make sure the resident is safe and then phone me as soon as possible, not send a text in the middle of the night. My phone number is located at every nursing station and other places to be able to reach me at any time. From our investigation, she did not address this abuse with anyone prior to her leaving on break around 10pm and then, ended up not coming back from that break. This nurse had received abuse training here upon hire...I was very shocked that she ended up not clocking out for her break and did not show back up and, even worse, left without informing anyone of the abuse allegation for hours. We could not substantiate the abuse, but our job is to protect the residents from abuse and her actions did not allow us to protect that resident or the others from potential abuse. We have tried multiple times since Sunday to reach her, and other than the one call back, she has not responded to any calls or texts since then." On 6-17-19 at 12:30 p.m., the Human Resource Manager provided a copy of form entitled, "Reporting of Abuse," signed and dated 6-5-19 by RN 3. This document indicated, "If you witness any form of abuse you are to report it immediately to your supervisor. Your supervisor is to notify the Administrator and the D.O.N. immediately...All alleged reports of abuse must be reported to the Indiana State Department of Health. These include verbal, physical, sexual and financial. They must be reported within 2 hours of the occurrence. The Administrator and/or D.O.N. must be notified immediately after occurrence. If it happens after normal working hours you must notify the Administrator and D.O.N. via phone or			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155490	A. BUILDING 00 B. WING	06/18/2019

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	cell phone (numbers are located at the nurse's stations). The facility only has 2 hours to notify the police of physical or sexual abuse...If it is Staff to Resident, the staff member must be pull [sic] off the floor and suspended pending investigation. A staff member needs to accompany the staff member out of the building. An initial report will be sent to ISDH within 2 hours if it is physical, sexual, or financial and 24 hours for verbal or resident to resident altercation...Failure to report abuse, makes you as responsible as the one the commented [sic] the actual abuse. You could end up with the consequences as one who commented [sic] the abuse, because you did not report it immediately." On 6-17-19 at 11:40 a.m., the Administrator provided a copy of the a policy entitled, "Abuse Investigation and Reporting." This policy was identified as the current policy utilized by the facility and had a revision date of July, 2017. This policy indicated, "All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source ("abuse") shall be promptly reported to local state, and federal agencies (as defined by current regulations) and thoroughly investigated by facility management...The Administrator will suspend immediately any employee who has been accused of resident abuse, pending the outcome of the investigation. The Administrator will ensure that any further potential abuse, neglect, exploitation or mistreatment is prevented...An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than: Two (2) hours if the alleged violation involves Physical abuse OR has resulted in serious bodily injury..."			

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	This Federal tag relates to Complaint IN00298116. 3.1-28(c)			