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	04/19/2024

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 IN00430919 Complaint IN00430919. Federal/state deficiencies related to the allegations are cited at F600, F607 and F609. Survey dates: April 16, 17, 18 and 19, 2024 Facility number: 000456 Provider number: 155490 AIM number: 100288750 Census Bed Type: SNF/NF: 101 Total: 101 Census Payor Type: Medicare: 13 Medicaid: 70 Other: 18 Total: 101 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 23, 2024	F 0000	Plan and execution of the plan of correction for the survey does not constitute admission of agreement by this provider of the truth of facts alleged or the conclusion set forth in the statement of deficiencies. The plan of correction is prepared and executed solely because it is required by Federal and State law. This provider maintains that the alleged deficiency does not individually or collectively jeopardize the health and safety of its residents; nor are they of such character as to limit the provider's capacity to render adequate resident care. This plan of correction serves as the facility's written credible allegation that it will be in substantial compliance on or before 05/02/2024. Additional documentation will be sent upon request.	
F 0600 SS=J Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §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,			

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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	involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on interview and record review, the facility failed to protect the residents ' right to be free from sexual abuse for 3 of 3 male residents by a staff member while providing incontinence care. The staff member was on his first night of orientation without the presence of the regular staff member which he was paired with for his orientation for the shift. This action resulted in mental anguish for all 3 residents. (Residents B, C, D and CNA 3) This deficient practice resulted in an Immediate Jeopardy. The Immediate Jeopardy began on, 3-20-24 at approximately 2:00 a.m., when CNA 3 masturbated 1 of 3 residents. The Administrator and Director of Nursing were notified of the Immediate Jeopardy on 4-17-24 at 11:55 a.m. The Immediate Jeopardy was removed on 3-27-24, but noncompliance remained at the lower scope and severity level of no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. Findings include: The facility filed a reportable incident on 3-20-24 with the Indiana Department of Health, Long Term Care Division, citing concerns related to CNA 3, touching a male resident inappropriately while providing personal care to him during the night shift of 3-19-24 into 3-20-24. The report indicated	F 0600	The facility wishes to IDR this alleged deficient practice as it doesn't agree with the determined findings. 1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Immediately upon receiving the allegation of abuse CNA 3 was suspended pending investigation. Resident and staff interviews were conducted. Residents B, C, and D had skin assessments completed and were offered ongoing psychosocial support including but not limited to GuideStar psych services. CNA 3 was terminated. Local law enforcement was contacted, and officers completed their own investigation. The Area Ombudsman was contacted and performed follow up visits. 2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?	05/02/2024

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	an investigation had begun and CNA 3 had been suspended, pending results of the investigation. In an interview with the Executive Director (ED) on 4-16-24 at 2:43 p.m., he indicated on the morning of 3-20-24, he was informed by the Director of Nursing (DON) she had received a report from CNA 5 of an allegation of sexual abuse from Resident C. CNA 5 indicated she had noticed Resident C was acting different than usual. "I would say she had to pry it out of him what happened. He seemed reluctant to address it, like he had something bothering him." Resident C shared with CNA 5, that he was not sure he should mention it, but finally decided he should let the management of the facility be aware a male CNA had been providing care to him for incontinence "and then told him he was getting hard. Said the male CNA made him uncomfortable and the male CNA ended up leaving him alone." Resident C indicated the same CNA did return to his room later in the shift and the resident told him he didn't need anything and the male CNA did not offer to provide care at that time and left the room. The ED estimated the time of the inappropriate touching was around 2:00 a.m. The ED identified the male CNA as CNA 3. The ED indicated in interview with Resident C later in on 3-20-24, he detailed CNA 3 had physically contacted his penis and used vigorous hand movement. He did not indicate a time frame for the interaction. He said when the physical contact became uncomfortable, he mentioned it to CNA 3 and CNA 3 stopped. The ED indicated Resident C did not report the incident until around 8:00 a.m. to a day-shift staff, CNA 5, who in turn immediately reported the allegation to the DON. "We immediately began the investigation and called in the male CNA to speak to us. This was		Five male residents who resided on the unit CNA 3 worked and who were assigned to CNA 3 had the potential to be affected. These residents were interviewed with no findings outside Residents B, C, and D. 3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Reviewed current hiring practices including, but not limited to, the hiring policy and orientation policy. Revised Orientation policy with addition of new employee direct care staff training will be completed on day shift – length of time and duration will be evaluated case by case after review by DON and/or Administrator. DON, or designee, will perform follow up interviews, that will be documented as complete on orientation check-off sheet, with residents and staff to ensure that no abuse occurs. 4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? DON, or designee, will ensure that new nursing staff will	

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	his first shift of orientation on the floor with us. He was paired with (name of CNA 4) that night. In interview, he indicated he and (name of CNA 4) did rounds together around 11pm and around 2am, he went in to care for (name of Resident C) by himself. The male CNA told us that he went in to do incontinence care on (name of Resident C), cleaned off 'some white gunk' and bowel movement from the resident's penis, and was in the room about 10 minutes. He said he was simply providing incontinence care, nothing more or less." The ED indicated in post-incident interviews of residents down that hall, there was a total of two male residents, Residents B and C, that reported physical contact and one male resident, Resident D, said he had made him feel uncomfortable, but said there was no physical contact by the aide. The ED indicated CNA 3 provided unsupervised care only to male residents. "We asked him how he selected the residents to care for by himself and he said that he went over (name of CNA 4)'s assignment ticket and selected people that were one person assistance for check and change (also called incontinence care)." The ED indicated CNA 3 shared he had not given it any thought that it happened to be all male residents that he provided unsupervised care to. The ED indicated a review of CNA 3's employee file, revealed he had current CNA certification in good standing on the Professional Licensing website and he had worked in a few nursing facilities in the area. "I had the our HR (Human Resources) person re-check all the references and we had no one give us anything other than good references." The ED provided information which indicated CNA 3 had completed abuse prohibition training on 3-13-24, and was signed by CNA 3 and		be placed on first shift for their initial floor training and ensure that follow up discussions with residents are performed after those shifts 3 times per week x 8 weeks, 5 residents weekly x 8 weeks, and 5 residents monthly thereafter for total of 6 months. The results of these audits will be reviewed at the monthly Quality Assurance and Performance Improvement (QAPI) meeting. 5 Date of compliance? 05/02/2024	

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	the Human Resources staff member. The ED indicated the facility did interview each of the residents which CNA 3 had provided care for that night by himself. Each of those residents were considered cognitively intact. "When the discussion with the residents got around to discussing the physical contact (by CNA 3) included hand grip (around the penis) and vigorous hand movement of the penis, their answers were very similar. I would like to think the male CNA was simply providing thorough care, but it seemed unusual their statements would be so similar." The ED indicated CNA 3 did return to the facility around 9:30 a.m., on of 3-20-23, to provide a statement of his own, as requested by the facility management. "When he was in my office, he did deny that he touched the residents inappropriately and said he was merely providing care to them. He seemed very matter of fact and did not seem flustered, didn't yell or anything." The ED indicated CNA 3 was terminated upon completion of that visit to the facility. The ED indicated interviews with the staff CNA 3 worked with that night did not result in any concerns. "Of course, he had only been on the floor the one shift. Nothing out of the ordinary or suggest any weird vibes." The ED indicated psycho-social follow-up visits were conducted with the residents that were identified as having a recollection of him working with him that night. He indicated the facility did follow their usual abuse prohibition policy recommendations as far as pre-employment license/certification verification, reference checking and provision of education on abuse			

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	prohibition. "To be honest, I am not sure what I could have done better or differently. I followed our normal policy as far as hiring with verification of his CNA license, checking references, providing on-boarding training prior to him going out on the floor. There were no red flags as far as his license or references. Not sure what else we could have done or done differently." In a telephone interview with CNA 3 on 4-17-24 at 2:28 p.m., he indicated he has been a CNA since 2022. He indicated he was paired with CNA 4 for his first orientation shift at the facility "Since I am an experienced aide, we were able to divide up the assignment, with her telling me some of the patients she thought that I would be able to check and change with just one person assist. The only person that I can think of that was a little harder than I expected was (name of Resident B). He is kind of heavy-set and partially paralyzed and he was harder to roll by myself. He was wet, plus he had some BM (bowel movement) on him; had to clean him up twice the first time I was in the room with him because he had BM on him to begin and did it again while I was cleaning him up. I can't say that I really had any problems with helping any of the residents...I don't remember him (Resident B) saying anything to me about being upset or anything. When I was called to come back in to talk to the administrator, they told me there had been an allegation about a patient saying I touched them. I've never had an allegation like that made about me. A couple of years ago, there was a patient who said I slapped them and that was not true. I didn't do anything that could have been mistook for touching a patient wrong. Later, I was told by Ambassador that another patient or two had said I had touched them, too."			

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	In a telephone interview with CNA 4 on 4-16-24 at 10:00 p.m., she indicated she was paired with CNA 3 on the night shift of 3-19-24 at 10:00 p.m. until 6:00 a.m. on 3-20-24. She indicated CNA 3 shared he was experienced aide with three years of experience. She indicated, "He and I would go into a room to do patient care and he would leave the room and not say anything to me and I would not know where he was. He would seem to just disappear. Several times that night, I would ask the other aide or the nurses if they had seen him and I even thought maybe he had left. The others told me they hadn't seen him...I haven't oriented very many people, but when I was on orientation, I was paired with one of the other aides for several shifts before I had an assignment on my own. This was his first night on the floor and he was not familiar with our patients. I just thought it was odd that he just kept disappearing. At shift change and in between patients, he talked some about his family and things he did and he certainly sounded pretty normal to me. I haven't really been interviewed by the DON or Administrator about any of this stuff." CNA 4 indicated she was "absolutely shocked" when she learned of the allegations against CNA 3. She indicated the facility provided an inservice training on reporting of actual or suspected abuse shortly after the incident. In an interview with the ED on 4-19-24 at 11:30 a.m. The ED clarified CNA 4, was not formally interviewed by the management team during the active investigation, nor did she come forward with any concerns related to concerns for the allegation of abuse. "With what we have learned since then, her concerns were more related to where the other CNA was, certainly not any abuse concerns. Going forward, we will certainly try to make sure we get those interviews conducted			

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	more quickly whenever there is an abuse allegation." In interview on 4-19-24 at 12:05 p.m., with the ED, he added, "At the time of the investigation, we acknowledged the abuse allegation had not been made known to CNA 4, but to CNA 5, later on the morning of 3-20-24. (Name of Resident C) even told us when we spoke with him that he had not mentioned anything to anyone else prior to speaking with CNA 5. At the time of the investigation, we focused more on the people who were made aware of the abuse." In an interview on 4-17-24 at 1:35 p.m., with the Human Resources (HR) staff, she indicated she has 15 years of experience in HR at the facility. She indicated, "During his (CNA 3) on-boarding process and all the references were all excellent and there were absolutely no red flags...I was dumb-founded when I found out the allegations. We do not have a particular policy about what to expect during the [working on the] floor orientation. We base their orientation on what their past experience is and what they need help with. We try to personalize it to the needs of the new employee." In an interview with the ED on 4-19-24 at 9:35 a.m., he indicated the facility does have a specific policy regarding the on-boarding of new employees. The policy indicated all new employees must participate in an orientation program within the first five days of employment and includes training for both general orientation as well as for each department. In interview with the ED on 4-19-24 at 11:26 a.m., he indicated the departmental orientation follows the job description for each position as well as the task-specific checklist associated with each department and takes into consideration each employees work experience, level of education			

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	and needs for further training. He indicated the facility does follow all regulatory guidelines related to abuse, specific to verification of licensure or certification, background checks for criminal background and sexual abuse registry and provision abuse prohibition education. Additionally, the potential employee's experience is taken into consideration. The ED indicated each employee will review and sign acknowledgement of receipt of the specific job description and each specific job will have a sign-off for the majority of common tasks associated with that specific position. He indicated CNA 3 received a task-associated document to sign off on as he completed each CNA-related task, but the facility did not receive this from him prior to his termination. The ED indicated the facility does not have strict guidelines for the length of direct supervision or training, it is based on the specific needs of each new employee. The ED provided a copy of CNA 3's job description, signed and dated on 3-13-24 by CNA 3 and the Human Resources staff. Additionally, CNA 3 signed an acknowledgement of receipt of training/education for abuse prohibition, including mandatory reporting, sexual harassment awareness, resident rights, elder justice act and ethics in long-term care on 3-13-24. A. The clinical record of Resident B was reviewed on 4-17-24 at 8:48 a.m. His diagnoses included, but were not limited to, hemiplegia and hemiparesis following a cerebral infarction affecting left non-dominant side, diabetes, urge incontinence, depression and anxiety. His most recent Minimum Data Set assessment, dated 3-23-24, indicated he is cognitively intact. It indicated he is frequently incontinent of his			

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	bladder and requires substantial to maximal assistance of staff with toileting. In an interview with Resident B on 4-17-24 at 10:28 a.m., he recalled about one month ago, a new male aide "Sometime around 11:30 p.m., or could have been later on the third shift, I'm not sure, he came in by himself to check and change me. That part was pretty normal, because that's just part of the normal routine. After he got done cleaning me up, he tried to masturbate me. To be honest, I wasn't sure what to think, I guess I was just kind of in shock somebody would do that. I can't tell you right now exactly what time he did that, but it kind of weirded me out. I know I ended up telling him to leave me alone and he did...I was not sure what to think, still don't. I thought about busting his head, but I knew that was wrong. It still upsets me, makes me mad that somebody would do that to somebody else." Resident B shared later that morning, he told the day-shift aide what had happened. Resident B indicated he could not recall the exact date or the name of the day-shift aide. B. The clinical record of Resident C was reviewed on 4-17-24 at 4:28 p.m. His diagnoses included, but were not limited to surgical amputation of the right leg below the knee, diabetes, nontraumatic intracerebral hemorrhage and end-stage kidney disease with hemodialysis. His most recent Minimum Data Set assessment, dated 1-16-24, indicated he is cognitively intact. It indicated he is frequently incontinent of his bladder and bowel and requires substantial to maximal assistance of staff with toileting. In interview with Resident C on 4-17-24 at 3:00 p.m., he indicated on the night-shift of 3-19-24 until the morning of 3-20-24, the nursing staff on			

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	duty had introduced a new male aide to him around 11:00 p.m., and said it was his first shift at the facility. "A little while later, I was not asleep, he came back in, not sure what time it was, and he asked if I needed changed. I told him that I didn't think I did. My incontinence is more with my stool. I told him he could check me, after he asked me several times. He had me roll over on my side, like the nurses normally do. I helped pull my sweats down and pulled the brief down. Don't know if he even looked at my bottom to check. He immediately started touching my penis from one side of the bed and then walked around and continued masturbating me. He leaned down at one point to near my ear and said, 'You're as hard as a rock.' I was shocked, actually not sure if I had heard him right. You have to understand I haven't had an erection in a long time because of my health problems. I asked him what he said and he, about that time, he had his head down close to my penis. I told him to just finish cleaning me up and he left. I worried about it off and on that night as to if I should tell anybody about it. When my day shift aide, [name of CNA 5] came in, I did mention it to her." Resident C indicated not long after he reported the incident to CNA 5, he was interviewed by the facility management team and by the local law enforcement several days later. C. The clinical record of Resident D was reviewed on 4-17-24 at 4:44 p.m. His diagnoses included, but were not limited to, pathological hip fracture, right kidney cancer and secondary bone cancer. His most recent Minimum Data Set assessment, dated 3-17-24, indicated he is cognitively intact. It indicated he is occasionally incontinent of his bladder and always continent of bowel and requires partial to moderate assistance of staff with toileting.			

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	In an interview with Resident D on 4-17-24 at 10:38 a.m., he indicated he had an incident about a month ago in which a male attendant was taking care of him, assisting him to get up in the middle of the night to use the bathroom. "I can't walk well, so I use the urinal. After doing my business, he was helping me clean up in my private parts. I didn't think that I had made any kind of a mess with just urinating. He seemed to spend more time than I would have anticipated for the job at hand. I think he used some kind of wipe. I finally told him, 'We're done here,' and he said okay and left. I wasn't sure what to think about, but it seemed unusual, at the very least, to me. Later in the morning, (name of Social Services Designee), came in and asked me if I had had any type of incidents with any staff members. I had kind of struggled with trying to decide if I should say something or not, and then told her about what had happened with the one guy. She told me she would check into it. I had only been here a few weeks at that time and wasn't sure who or what to do about it. I think he had been in earlier in the shift, but not sure. I can't say anything happening or unusual conduct with him prior. I did not see him any more after that...I can't say that he caused me any harm, but I will say that guy certainly came across as weird to me." On 4-16-24 at 2:20 p.m., the ED provided a copy of a policy entitled, "Abuse Prohibition, Reporting and Investigation." This policy was identified as the current policy utilized by the facility and had a revision date of 9/2017. This policy indicated, "This facility shall prohibit and prevent abuse, neglect, misappropriation of resident property, and exploitation...Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or			

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	mental anguish...Instances of abuse of a resident, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse...Sexual Abuse - Non-consensual sexual contact of any type with a resident...Any staff to resident sexual contact and/or sexual relationship is considered abuse. The relationship between a resident and their caregiver is a professional relationship. The facility strictly prohibits relationships between an employee and a resident of any type beyond professional caregiver-to-resident interaction. Should there ever be a time when a caregiver acts or speaks in a manner which would be considered trying to establish a relationship beyond that of a professional caregiver, the caregiver must report to the nurse or supervisor immediately...Residents shall be questioned about the nature of the incident and their statements placed in writing. Investigation shall be conducted to assure other residents have not been affected by the incident or inappropriate behavior and the results documented. Statements shall be taken including, but not limited to, facts and observations by involved employee(s); facts and observations by witnessing employee(s), facts and observations by witnessing non-employee(s); facts and observations by any others who might have pertinent information; facts and observations by the licensed nurse or individual to whom the initial report was made..." On 4-19-24 at 11:10 a.m., the ED provided a copy of a policy entitled, "Orientation Program for Newly Hired Employees, Transfers, Volunteers," with a revision date of January, 2008. This policy indicated, "An orientation program shall be conducted for all newly hired employees...All newly hired personnel...must attend an orientation program within the first five (5) days of			

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	employment...Our orientation program includes, but is not limited to...An introduction to resident care procedures...A review of the facility's Nursing Assistant's Training Program...A review of our organized staff including an introduction to each department supervisor; An overview of each department's services; A review of the employee's job description; A review of the resident rights including abuse prohibition...In addition to our general orientation, each department will orient the newly hired employee...to his or her department's policies and procedures, as well as other data that will aid him/her in understanding the team concept, attitudes and approaches to resident care. Our orientation program is an in-depth review of our facility's policies and procedures. A checklist is used to record materials reviewed with each employee..." The Immediate Jeopardy, that began on 3-20-24, was removed on 3-27-24 when the facility inserviced the facility staff on abuse policies, but the noncompliance remained at the lower scope and severity of no actual harm with potential for more than minimal harm that is not Immediate Jeopardy because a systemic plan of correction had not been developed and implemented to prevent recurrence. This Federal tag relates to Complaint IN00430919. 3.1-27(a)(1)			
F 0607 SS=D Bldg. 00	483.12(b)(1)-(5)(ii)(iii) Develop/Implement Abuse/Neglect Policies §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse,			

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	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, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act.			
	Based on interview and record review, the facility failed to ensure their policies and procedures related to abuse prohibition were implemented for the prohibition of staff to resident abuse, for reporting of an allegation of abuse within two hours of the facility learning of the abuse allegation to the Indiana Department of Health's Long Term Care Division and for ensuring all persons with any facts or observations who might have pertinent information related to the alleged abuse were included in the investigation for 3 of 3 residents reviewed for staff to resident abuse. (Residents B, C, D and CNA 3)	F 0607	1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Administrator counselled on reporting allegations of abuse in a timely manor according to regulations. 2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?	05/02/2024

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	Findings include: A. The facility filed a reportable incident on 3-20-24 with the Indiana Department of Health, Long Term Care Division, citing concerns related to CNA 3, touching two male residents inappropriately while providing personal care to them during the night shift of 3-19-24 into 3-20-24. The report indicated an investigation had begun and CNA 3 had been suspended, pending results of the investigation. In an interview with the Executive Director (ED) on 4-16-24 at 2:43 p.m., he indicated on the morning of 3-20-24, he was informed by the Director of Nursing (DON) she had received a report from CNA 5 of an allegation of sexual abuse from Resident C. He indicated the investigation revealed two other male residents were identified as having been affected by the actions of CNA 3. Resident B was identified as being touched in a sexual manner by CNA 3 and Resident D was identified as feeling uncomfortable in the presence of CNA 3 while incontinence care was provided. The ED indicated the abuse allegations against CNA 3 occurred on his first shift of orientation, being paired with a current employee for that shift and while CNA 3 was providing unsupervised one-person assistance incontinence care to the three male residents. B. The facility filed a reportable incident on 3-20-24 with the Indiana Department of Health, Long Term Care Division, citing concerns related to CNA 3, touching two male residents inappropriately while providing personal care to him during the night shift of 3-19-24 into 3-20-24. The report indicated an investigation had begun and CNA 3 had been suspended, pending results		All residents have the potential to be affected by the alleged deficiency. An audit on future reportable incidents will be performed to ensure compliance. 3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? All future reportable incidents will be initially filed through the IDOH Gateway within the appropriate timeframe per regulation. 4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Executive Director, or designee, will audit the timeliness of reportable incidents, five days x 4 weeks, then 3 times per week x 8 weeks, weekly x 8 weeks, and monthly thereafter for total of 6 months. The results of these audits will be reviewed at the monthly Quality Assurance and Performance Improvement (QAPI) meeting.	

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	of the investigation. In an interview with the Executive Director (ED) on 4-16-24 at 2:43 p.m., he indicated on the morning of 3-20-24, he was informed by the Director of Nursing (DON) she had received a report of an allegation of sexual abuse regarding Resident C by CNA 3. On 4-16-24 at 4:55 p.m., the ED provided a copy of a timeline of events surrounding this incident. It indicated the DON received the allegation of abuse on 3-20-24 at approximately 8:00 a.m., and the ED received the information regarding the allegation of abuse shortly thereafter. During the investigation, nd Resident B and Resident D were identified as being touched in a sexual manner by CNA 3. In an interview with the ED on 4-17-24 at 9:45 a.m., the ED indicated the copy of the email confirmation of submission of the reportable incident, dated 3-20-24 at 4:28 p.m., was the date and time of the initial submission of the reportable incident to the Indiana Department of Health, Long Term Care Division. C. In a telephone interview with CNA 4 on 4-16-24 at 10:00 p.m., she indicated she was paired with CNA 3 on the night shift of 3-19-24 at 10:00 p.m. until 6:00 a.m. on 3-20-24 to assist with CNA 3's orientation. She indicated CNA 3 shared he was experienced aide with three years of experience. She indicated, "He and I would go into a room to do patient care and he would leave the room and not say anything to me and I would not know where he was. He would seem to just disappear. Several times that night, I would ask the other aide or the nurses if they had seen him and I even thought maybe he had left. The others told me they hadn't seen him...This was his first night on the floor and he was not familiar with our patients.			

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	I just thought it was odd that he just kept disappearing. At shift change and in between patients, he talked some about his family and things he did and he certainly sounded pretty normal to me. I haven't really been interviewed by the DON or Administrator about any of this stuff." In an interview with the ED on 4-19-24 at 11:30 a.m. The ED clarified CNA 4, was not formally interviewed by the management team during the active investigation, nor did she come forward with any concerns related to concerns for the allegation of abuse. "With what we have learned since then, her concerns were more related to where the other CNA was, certainly not any abuse concerns. Going forward, we will certainly try to make sure we get those interviews conducted more quickly whenever there is an abuse allegation." In interview on 4-19-24 at 12:05 p.m., with the ED, he added, "At the time of the investigation, we acknowledged the abuse allegation had not been made known to CNA 4, but to CNA 5, later on the morning of 3-20-24. (Name of Resident C) even told us when we spoke with him that he had not mentioned anything to anyone else prior to speaking with CNA 5. At the time of the investigation, we focused more on the people who were made aware of the abuse. On 4-16-24 at 2:20 p.m., the ED provided a copy of a policy entitled, "Abuse Prohibition, Reporting and Investigation." This policy was identified as the current policy utilized by the facility and had a revision date of 9/2017. This policy indicated, "This facility shall prohibit and prevent abuse, neglect, misappropriation of resident property, and exploitation...Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or			

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	mental anguish...Instances of abuse of a resident, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse...Sexual abuse - Non-consensual sexual contact of any type with a resident by another resident or visitor...Any staff to resident sexual contact and/or sexual relationship is considered to be abuse...The facility shall have evidence that all alleged violations are thoroughly investigated and shall prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. The individual coordinating the investigation shall report the results of all investigations to the administrator or his or her designated representative, who shall report to other officials in accordance with State law, including the State Survey Agency, within 5 working days of the incident, if the alleged violation is verified appropriate corrective action shall be taken...This facility shall report all reportable incidents, which shall include allegations of abuse, immediately to the Long Term Care Division of the State Department of Health. Upon completion of the investigation, which must occur within 5 working days of the reporting of an allegation/incident, a report of the investigation must be forwarded to the Long Term Care Division of the Indiana State Department of Health...The Administrator shall initiate and direct the investigation immediately and the findings of the investigation must be completed by the Administrator within 5 days of the initial notification of the incident...Investigation shall be conducted to assure other residents have not been affected by the incident or inappropriate behavior and the results documented. Statements shall be taken including, but not limited to facts and observations by involved employee(s); facts and observations by witnessing employee(s);			

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	facts and observations by witnessing non-employee(s); facts and observations by any others who might have pertinent information; facts and observations by the licensed nurse or individual to whom the initial report was made...The Administrator, Director of Nursing, or designee, is responsible to notify the following agencies, as applicable: State Department of Health, Adult Protective Services, Ombudsman, Applicable Licensing Agency." This Federal tag relates to Complaint IN00430919. 3.1-28(a)			
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(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.			

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	§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 report an allegation of staff to resident sexual abuse to the Indiana Department of Health's Long Term Care Division and other state agencies within two hours of the facility being made aware of the abuse. (Residents B, C, D and CNA 3) Findings include: The facility filed a reportable incident on 3-20-24 with the Indiana Department of Health, Long Term Care Division, citing concerns related to CNA 3, touching two male residents inappropriately while providing personal care to him during the night shift of 3-19-24 into 3-20-24. The report indicated an investigation had begun and CNA 3 had been suspended, pending results of the investigation. In an interview with the Executive Director (ED) on 4-16-24 at 2:43 p.m., he indicated on the morning of 3-20-24, he was informed by the Director of Nursing (DON) she had received a report of an allegation of sexual abuse regarding Resident C by CNA 3. On 4-16-24 at 4:55 p.m., the ED provided a copy of a timeline of events surrounding this incident. It indicated the DON received the allegation of abuse on 3-20-24 at approximately 8:00 a.m., and the ED received the information regarding the allegation of abuse shortly thereafter.	F 0609	1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Administrator counselled on reporting allegations of abuse in a timely manor according to regulations. 2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by the alleged deficiency. An audit on future reportable incidents will be performed to ensure compliance. 3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? All future reportable incidents will be initially filed through the IDOH Gateway within the appropriate timeframe per regulation. 4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance	05/02/2024

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	allegations of abuse, immediately to the Long Term Care Division of the State Department of Health. Upon completion of the investigation, which must occur within 5 working days of the reporting of an allegation/incident, a report of the investigation must be forwarded to the Long Term Care Division of the Indiana State Department of Health...The Administrator shall initiate and direct the investigation immediately and the findings of the investigation must be completed by the Administrator within 5 days of the initial notification of the incident...Investigation shall be conducted to assure other residents have not been affected by the incident or inappropriate behavior and the results documented. Statements shall be taken including, but not limited to facts and observations by involved employee(s); facts and observations by witnessing employee(s); facts and observations by witnessing non-employee(s); facts and observations by any others who might have pertinent information; facts and observations by the licensed nurse or individual to whom the initial report was made...The Administrator, Director of Nursing, or designee, is responsible to notify the following agencies, as applicable: State Department of Health, Adult Protective Services, Ombudsman, Applicable Licensing Agency." This Federal tag relates to Complaint IN00430919. 3.1-28(c)			