

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/30/2023
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NAME OF PROVIDER OR SUPPLIER INDEPENDENCE VILLAGE OF WEST ZIONSVILLE	STREET ADDRESS, CITY, STATE, ZIP COD 6800 CENTRAL BOULEVARD ZIONSVILLE, IN 46077
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R 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00411530.</p> <p>Complaint IN00411530 - State deficiencies related to the allegations are cited at R0052 and R0090.</p> <p>Survey date: June 29, and 30, 2023</p> <p>Facility number: 014059</p> <p>Residential Census: 38</p> <p>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed on July 13, 2023.</p>	R 0000	Submission of this plan of correction shall not constitute or be construed as an admission by Independence Village of West Zionsville that the allegations contained in this survey report are accurate or reflect accurately the provision of service to residents of Independence Village of West Zionsville.	
R 0052 Bldg. 00	<p>410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion.</p> <p>Based on observation, interview, and record review, the facility failed to assess, document, and conduct a thorough investigation of a staff to resident abuse allegation for 1 of 3 residents reviewed for abuse (Residents B).</p> <p>Findings include:</p> <p>An Indiana State Department of Health Survey Report System report, dated 6/23/23 at 4:38 p.m., indicated on 6/13/23 at 12:01 p.m., a private</p>	R 0052	<p>What corrective action(s) will be accomplished for those resident(s) found to be affected by the deficient practice(s)? Resident assessed for any potential signs of abuse and interviewed to assess her psychosocial wellbeing.</p> <p>How will the facility identify other residents having the potential to be affected by the same deficient</p>	08/01/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jim Gepp	Executive Director	08/01/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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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	<p>caregiver for another resident observed Certified Nursing Assistant (CNA) 9 striking Resident B on the head. CNA 9 was suspended on 6/13/23 pending investigation and was ultimately terminated on 6/22/23. The incident was not reported by the facility until 6/22/23.</p> <p>On 6/29/23 at 10:28 a.m., Resident B was observed sitting at a table in the secured memory care unit with another resident and Qualified Medication Aide (QMA) 4 who was prompting the residents to color. Resident B was fidgeting with her clothing ignoring those around her and occasionally softly muttering. When addressed resident returned smile and wave, then quickly returned to prior quiet fidgeting behavior.</p> <p>On 6/29/23 at 11:17 a.m., Resident B was observed in dining room area of the secured memory care unit with the Life Enrichment Coordinator who was prompting the resident to put a puzzle together. Resident was quietly picking at clothing.</p> <p>Resident B's record was reviewed on 6/29/23 at 9:43 a.m. Diagnoses on Resident B's profile included, but were not limited to, Alzheimer's disease and anxiety.</p> <p>A Brief Cognitive Rating Scale (BCRS), dated 6/5/23, a score of 6.8 indicated stage 7 very severe cognitive decline.</p> <p>The resident record lacked documentation of evaluations having been completed in the electronic medical record (EMR) after 6/5/23.</p> <p>The resident record lacked documentation of vital signs having been recorded in the EMR after 2/1/23.</p>		<p>practice and what corrective action will be taken? What measures will be put in place or what systemic changes will the facility make to ensure that the deficient practice does not recur?</p> <p>Upon receiving a report of abuse or suspected abuse ED or designee will interview any other potentially affected residents in a non-leading manner as appropriate to their cognitive functioning and/or family members as appropriate. Where appropriate Wellness Director or designee(s) will examine any potentially affected residents for signs of abuse. Results of the examinations will be reported to the ED for the investigation file for any appropriate further action. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?</p> <p>ED and WD or designee will conference daily during any ongoing abuse investigation to ensure that any potentially affected resident is identified.</p>	

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	<p>A progress notes for Resident B, dated 6/13/23 at 2:53 p.m., indicated apply ice and do warm water soaks with Epsom salt (helps alleviate discomfort of muscle aches or minor wounds such as papercuts), to wound to right hand ring finger three times a day until healed. The resident record lacked documentation to describe what type of wound or how the wound occurred.</p> <p>Progress notes dated 6/13/23 - 6/29/23, indicated resident record lacked documentation of resident being hit by a staff member on 6/13/23, resident being assessed for injury, the physician or resident representative being notified of the incident, or of the resident being followed up for psychosocial trauma.</p> <p>A witness statement, signed Concerned Caregiver, dated 6/13/23, indicated on June 10, 2023, she was at work and observed CNA 9 sexually harassing CNA 15. "And I have been noticing him elderly abuse one of the resident. Walking past her hitting her in the head and doing other things he should not be doing to her. On June 10, 2023, up in Independence Village it was crazy the residents was [sic] so afraid up in here it was hollering loud not work talking on phones. Residents was complaining about the loud talk."</p> <p>A typed witness statement from the Memory Care Director, not signed or dated, indicated, "I was informed of the allegations on CNA 9 on 6/13/23. The prior week I had witnessed CNA 9 come up behind a resident and cup her face with his hands and was trying to get her to go to entertainment in the main dining room. She did not want to go. I told him she needed to stay back and to let her be. I did not witness him hit her. I was going to have a conversation with our wellness director on Monday about the proper way to approach a</p>			

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	<p>resident, but she did not come in until Tuesday and that is when we found out about the other unrelated allegations.</p> <p>A typed witness statement from the Executive Director, dated 6/21/23, indicated, "I interviewed the private care giver for Resident E the day following the allegation being brought to my attention. She confirmed that the resident she referenced is Resident B. She had not witnessed any other potentially abusive behavior toward any other resident by CNA 9 or other staff. She was not aware of any other staff being witness to CNA 9's behavior towards Resident B."</p> <p>The follow up investigation lacked documentation like-residents on the secured memory care unit had been interviewed or assessed for potential injury, or that staff working or resident representatives visiting the secured memory care unit on the date of the incident had been interviewed.</p> <p>During an interview on 6/29/23 at 10:35 a.m., QMA 4 indicated she had not heard of Resident B being hit by a staff member, but that was abuse. If she had been told about a resident being hit, she would have reported that to her director immediately.</p> <p>During an interview on 6/20/23 at 10:44 a.m., the Memory Care Coordinator (MCC) indicated on Tuesday 6/13/23 the Wellness Director told her she had a written statement from a private caregiver who said Resident B was being physically abused by CNA 9 either hitting or clapping her face. The prior Friday the MCC had observed CNA 9 coming up behind Resident B and cupping her ears gently, she had not spoken to him about his approach with the residents</p>			

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	<p>before he was suspended for hitting the resident. The MCC had received abuse training per Relias electronic training system upon hire.</p> <p>During an interview on 6/29/23 at 11:32 a.m., the Wellness Director indicated on Tuesday 6/13/23 a private caregiver had informed her that over the weekend she had observed CNA 9 using sexually inappropriate language towards CNA 15 in the dining/kitchen area where everyone could hear, and she had also seen CNA 9 "bop Resident B in the head". The caregiver provided a written statement upon request. Then that morning before she could report the sexual harassment and resident abuse to the Executive Director (ED), she received a call from the Vice President of Support and Integration (VPSI) asking if she knew anything about Qualified Medication Aide (QMA) 11 having sent a letter to corporate over the weekend about CNA 9's behaviors, and she explained about the statement she had received from the caregiver. A copy of the statement from the caregiver was then sent to the VPSI on 6/13/23 at 10:37 a.m. The Wellness Director then assumed the VPSI sent the caregiver statement to Human Resources (HR) who took over the sexual investigation and abuse allegation. She did not notify the ED.</p> <p>During an interview on 6/29/23 at 11:58 a.m., the ED indicated all staff involved in the sexual harassment of staff and abuse allegation towards a resident had been immediately suspended on 6/13/23 and interviewed by HR, but as of this time he was not in possession of any information related to the investigation. The ED indicated he had been told about the sexual harassment allegations on 6/13/23 by QMA 13, but he did not see the written statement from the private caregiver which also documented a resident abuse</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/29/2023

FORM APPROVED

OMB NO. 0938-039

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	<p>allegation. When he became aware of the abuse allegations on 6/20/23, he interviewed the private caregiver who told him no one else was involved. As of this time the ED had no further information to share until after he spoke with HR via phone conference and received written statements and information collected during their investigation.</p> <p>During an interview on 6/23/23 at 12:03 p.m., QMA 11 indicated CNA 9 had been sexually harassing her and other female employees for weeks. She had not reported the situation to the ED or Wellness Director as she was newer to the facility and not comfortable with them. She had no firsthand knowledge of an incident between CNA 9 and Resident B.</p> <p>During an interview on 6/30/23 at 12:20 p.m., CNA 15 indicated CNA 9 had been sexually harassing her. She had not reported to the ED or Wellness Nurse as she felt she should be sensitive to other cultures and not be "tattling." She had no knowledge of CNA 9 being inappropriate to residents.</p> <p>During an interview on 6/30/23 at 1:49 p.m., CNA 14 indicated CNA 9 had been sexually harassing her. She had not reported to the ED or Wellness Nurse but told QMA 11 instead. She had not seen CNA 9 being inappropriate with residents.</p> <p>On 6/30/23 at 10:20 a.m., the ED provided an Abuse, Neglect, or Exploitation policy, last reviewed 6/7/23, and indicated the policy was the one currently being used by the facility. The policy indicated, "Abuse, neglect, or exploitation of any resident will not be tolerated. All allegations, suspicions, and incidents of abuse, neglect, or exploitation will be promptly investigated ...Initial Response: 1. Protect the</p>			

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	<p>resident ...b. If the staff member is accused or suspected of abuse, neglect, or exploitation, the staff member will be immediately removed from the community and work schedule pending the outcome of the investigation. c. The resident's responsible party will be notified of the incident, and the resident's attending physician ...2. Initial Reports: a. Employees are to immediately report any witnessed or suspected incidents of abuse, neglect, or exploitation to the supervisor on duty and the Wellness Director or designee. For the purposes of this policy, immediately means as soon as possible, but will not exceed twenty-four [24] hours after the incident or discovery of injury ...3. a. Documentation in the resident's chart should include results of resident's ROM [range of motion], results of the body check, vital signs, notification of the physician and the responsible party, treatment provided. b. Incident/Accident report will be completed by staff prior to leaving their shift ..."</p> <p>Long-Term Care Abuse and Incident Reporting Policy, effective 12/8/22, indicated, "Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish ...Physical abuse includes, but not limited to, hitting, slapping, punching, biting, and kicking ...1. State Rules ...(g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident...Staff treatment of residents ...(c) The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source,</p>			

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R 0090 Bldg. 00	<p>and misappropriation of resident property, are reported immediately to the administrator of the facility and other officials in accordance with state law through established procedures, including to the state survey and certification agency. (d) The facility must have evidence that all alleged violations are thoroughly investigated and must prevent further potential abuse while the investigation is in progress. (e) The results of the investigation must be reported to the administrator or the administrator's designated representative and to other officials in accordance with state law ...within five (5) working days of the incident ...Staff to resident abuse: all allegations of staff to resident abuse must be reported. Staff may receive allegations from any source, including other staff, residents, family members, or other health care providers"</p> <p>This State tag relates to Complaint IN00411530.</p> <p>410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B) poisonings; (C) fires; or</p>			

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	<p>(D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division.</p> <p>(2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative.</p> <p>(3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility.</p> <p>(4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months.</p> <p>(5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability.</p> <p>(6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request</p> <p>Based on interview, and record review, the facility failed to timely report staff to resident abuse within 2 hours for 1 of 3 residents reviewed for abuse (Residents B).</p> <p>Findings include:</p> <p>An Indiana State Department of Health Survey Report System report, dated 6/23/23 at 4:38 p.m.,</p>	R 0090	<p>What corrective action(s) will be accomplished for those resident(s) found to be affected by the deficient practice(s)? Report of abuse was made by ED within 24 hours of ED being informed. How will the facility identify other residents having the potential to</p>	08/11/2023

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	<p>indicated on 6/13/23 at 12:01 p.m., a private caregiver for another resident observed Certified Nursing Assistant (CNA) 9 striking Resident B on the head. CNA 9 was suspended on 6/13/23 pending investigation and was ultimately terminated on 6/22/23. The incident was not reported by the facility until 6/22/23.</p> <p>During an interview on 6/29/23 at 1:54 p.m., the Executive Director (ED) indicated,</p> <p>a. On 6/13/23 Human Resources (HR) suspended CNA 9 related to sexual allegation based on Qualified Medication Aide (QMA) 11's note to HR. HR had not seen the private caregivers note and were not aware of the abuse allegations involving CNA 9 and Resident B until 6/14/23. The ED thought it was the Wellness Director who reported to HR but was later informed it was QMA 11 who reported to HR via a note over the weekend.</p> <p>b. On 6/13/23 the Wellness Director gave the caregivers note to HR and HR then opened the investigation regarding the sexual harassment. HR assumed since the Wellness Director was aware of the allegations to the ED was also aware.</p> <p>c. On 6/20/23 the Wellness Director, Regional Wellness Director, and QMA 13 had a meeting to determine the disposition of CNA 9 regarding the sexual harassment allegations. After the meeting the ED received a phone call and was asked if he was aware of the caregiver note and abuse allegations regarding Resident B, and until that time he was not. QMA 13 initially reported to the ED the sexual allegations report. QMA 13 told the Wellness Director he had a discussion with the ED and told him the reason for CNA 9's suspension, which was true on his part, but QMA 13 only knew about the sexual harassment.</p> <p>d. On 6/13/23 the HR department had initiated an investigation regarding the sexual harassment by</p>		<p>be affected by the same deficient practice and what corrective action will be taken? What measures will be put in place or what systemic changes will the facility make to ensure that the deficient practice does not recur?</p> <p>All employees in all departments are being retrained on what abuse is, how to recognize it, who to report abuse or suspected abuse to and when.</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?</p> <p>All new hires to be trained on what abuse is, how to recognize it, who to report abuse or suspected abuse to and when. All employees in all departments will be retrained annually on what abuse is, how to recognize it, who to report abuse or suspected abuse to and when. ED will review status of trainings quarterly to ensure compliance.</p>	

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	<p>CNA 9, under the assumption the ED knew about both the sexual harassment charges and abuse allegations and was investigating the abuse allegation regarding Resident B.</p> <p>e. On 6/21/23 the ED sent in a state reportable incident after he spoke with the private caregiver. The caregiver note did not mention CNA 9 by name, did not give resident's name, or date of the incident. CNA 9 was terminated on 6/22/23.</p> <p>During an interview on 6/30/23 at 12:35 p.m., a HR representative indicated on 6/13/23 the Regional Wellness Director was on vacation and had received a note from an employee at the facility (she thought it was the Wellness Director), so passed the note on to the Vice President of Support and Integration (VPSI), who in turn contacted her in HR. The note was from a private caregiver at the facility with allegations of sexual harassment regarding CNA 9 towards female staff at the facility, so for her it was a sexual allegation claim. She did not follow up or investigate the alleged abuse as she thought at the time it pertained to a conversation, she'd had with the MCC Coordinator the prior week which was not deemed resident abuse. On 6/19/23 the HR representative spoke with the private caregiver who stated, "he slapped her across the face." This was the first she realized it was additional information she did not have regarding CNA 9 and Resident B. CNA 9 had been suspended on 6/13/23 regarding allegations of sexual harassment towards staff. On 6/19/23 the Regional Wellness Director returned to work and gave guidance to the ED and Wellness Director on follow up and reporting the alleged resident abuse to state.</p> <p>During an interview on 6/30/23 at 1:30 p.m., the Regional Wellness Director indicated, she had been on vacation when the situation regarding</p>			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>CNA 9 surfaced. When she returned to work on 6/19/23 there was a conference call with her, a HR representative and the Wellness Director to discuss what to do with CNA 9. After the conversation HR had called her back to ask if she was aware there was an allegation of abuse against a resident on the note also which she was not. The Regional Wellness Director then called the ED and informed him. A phone call was pulled together for 6/20/23 as she was trying to get a copy of the original note from the private caregiver to get details. The ED did not report to state until after he got facts of the event, and he was the one who completed the abuse allegation follow up. CNA 9 was terminated for sexual harassment before the ED became aware of the abuse allegation.</p> <p>The Regional Wellness Director then completed an investigation on why the ED was not made aware of the abuse allegation immediately. To her knowledge the note was originally given to the Wellness Director who sent it to HR, it should have been given to the ED at that time.</p> <p>During an interview on 6/30/23 at 2:35 p.m., the ED indicated him not being told about the alleged abuse timely was due to a series of miscommunication. The Wellness Director had told QMA 13 about the sexual harassment as part of his job. QMA 13 then told the ED about the sexual harassment, then told the Wellness Director the ED was aware of issues with CNA 9. The Wellness Director then told HR, and HR thought the ED already knew. The Wellness Director and the ED never had a direct conversation regarding CNA 9 until 6/19/23 after the ED had received a call from the Regional Wellness Director. The ED indicated during the follow-up investigation of the abuse of Resident B</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/30/2023
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	<p>by CNA 9, there were no other staff, residents, or resident representatives' questioned or assessed for injury as the private caregiver had not given an exact date the alleged abuse to Resident B had occurred.</p> <p>On 6/30/23 at 10:20 a.m., the ED provided an Abuse, Neglect, or Exploitation policy, last reviewed 6/7/23, and indicated the policy was the one currently being used by the facility. The policy indicated, "Abuse, neglect, or exploitation of any resident will not be tolerated. All allegations, suspicions, and incidents of abuse, neglect, or exploitation will be promptly investigated ...Initial Response: 1. Protect the resident ...b. If the staff member is accused or suspected of abuse, neglect, or exploitation, the staff member will be immediately removed from the community and work schedule pending the outcome of the investigation. c. The resident's responsible party will be notified of the incident, and the resident's attending physician ...2. Initial Reports: a. Employees are to immediately report any witnessed or suspected incidents of abuse, neglect, or exploitation to the supervisor on duty and the Wellness Director or designee. For the purposes of this policy, immediately means as soon as possible, but will not exceed twenty-four [24] hours after the incident or discovery of injury ...3. a. Documentation in the resident's chart should include results of resident's ROM [range of motion], results of the body check, vital signs, notification of the physician and the responsible party, treatment provided. b. Incident/Accident report will be completed by staff prior to leaving their shift ..."</p> <p>Long-Term Care Abuse and Incident Reporting Policy, effective 12/8/22, indicated, "Abuse is the willful infliction of injury, unreasonable</p>			

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	<p>confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish ...Physical abuse includes, but not limited to, hitting, slapping, punching, biting, and kicking ...1. State Rules ...(g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident...Staff treatment of residents ...(c) The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property, are reported immediately to the administrator of the facility and other officials in accordance with state law through established procedures, including to the state survey and certification agency. (d) The facility must have evidence that all alleged violations are thoroughly investigated and must prevent further potential abuse while the investigation is in progress. (e) The results of the investigation must be reported to the administrator or the administrator's designated representative and to other officials in accordance with state law ...within five (5) working days of the incident ...Staff to resident abuse: all allegations of staff to resident abuse must be reported. Stay may receive allegations from any source, including other staff, residents, family members, or other health care providers ..."</p> <p>This State tag relates to Complaint IN00411530.</p>			