STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	03/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PRIMROSE MEMORY CARE OF ANDERSON	2101 N MADISON AVENUE ANDERSON, IN 46011

(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
R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00430519. Complaint IN00430519 - State deficiencies related to the allegations are cited at R0053 and R0090. Survey date: March 22, 2024 Facility number: 013811 Residential Census: 13 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed March 26, 2024.	R 0000		
R 0053 Bldg. 00	410 IAC 16.2-5-1.2(w) Residents' Rights - Deficiency (w) Residents have the right to be free from verbal abuse. Based on record review and interview, the facility failed to prevent the verbal abuse of a cognitively impaired resident by staff members for 1 of 1 resident reviewed for abuse. (Resident B and CNA 1) Findings include: The clinical record for Resident B was reviewed on 3/22/24 at 10:53 a.m. Diagnoses included dementia, chronic bilateral lower back pain with bilateral sciatica, depression, hearing loss, right foot drop, and lumbar spinal stenosis. Review of a facility self reportable, dated 3/14/24, indicated on 3/3/24 at 12:01 p.m., CNA 1 was	R 0053	Resident B was interviewed and assessed for s/s of emotional distress or physical harm. Resident B had no recollection of the event et shows no signs of emotional distress or physical harm. All residents were interviewed and assessed for emotional distress or physical harm. None of the residents showed s/s of emotional distress or physical harm. The community policy titled	04/11/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Hervey Lee Lawrence	Administrator	04/11/2024

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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	overheard yelling at Resident B and using inappropriate language. Review of the time punch on 3/22/24 at 1:30 p.m., indicated CNA 1 worked 3/2/24 from 6:59 a.m. to 3:17 p.m. CNA 1 did not work 3/3/24. CNA 1 worked for 3 hours and 17 minutes after the alleged incident. During an interview on 3/22/24 at 1:11 p.m., the Administrator indicated the incident happened on Sunday 3/3/24 around noon. She was informed of the incident on 3/4/24 between 7:00 a.m. and 8:00 a.m. Review of the facility's timeline and the time punches indicated the incident occurred on Saturday 3/2/24 at 12:01 p.m., not 3/3/24. The incident was reported to the Administrator on 3/4/24 between 7:00 a.m. and 8:00 a.m. The facility reported the incident to the State Agency on 3/14/24 at 12:31 p.m. CNA 1 was suspended pending investigation on 3/4/24. During an interview on 3/22/24 at 1:32 p.m., QMA 4 indicated, on 3/3/24 around lunch time, she overheard Resident B telling CNA 1 it was none of her business. QMA 4 then heard CNA 1 tell the resident it was her "f_ _ _ _ g" business. CNA 2 was also in the room with the resident and CNA 1. QMA 4 left the area and found Activity Assistant 3 in the dining room. She told the activity assistant her concerns and the activity assistant left the dining room in the direction of the resident's room and was able to intercept Resident B and CNA 1. The activity assistant stayed with Resident B. During an interview on 3/22/24 at 1:44 p.m., the DON indicated the facility would try to reach CNA		"Abuse/Neglect/Exploitation" was reviewed without change. CNA1 and CNA2 were discharged. QMA4 et LEC3 have been counseled and disciplined for not following community policy regarding reporting of abuse allegation. All employees were re-educated on this policy and procedure. All employees will report any allegation of abuse immediately to the ED et DON. The ED or his representative will report all allegations to the ISDH within 2 hours of learning of the incident. A thorough investigation will be conducted by the ED or his representative. During that investigation, all employees under suspicion will be immediately suspended until the investigation is complete. Depending on the results of the investigation, the employee (s) will either be re-instated or discharged. The ED or his representative will submit a report of findings within five (5) days of the initial report. The ED or his representative will conduct two (2) audits of employees, families, or residents 2X weekly X30 days, then 1X weekly X30 days, then 1X monthly X 90 days to ensure no other unreported incidents of abuse/neglect/exploitation have occurred. All audits will be reported to the QA committee for further monitoring.	

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	1 and CNA 2. The DON and Administrator also indicated Activity Assistant 3 was a volunteer. Neither CNA was able to be reached for interview during the survey. During an interview on 3/22/24 at 1:51 p.m., Activity Assistant 3 indicated on 3/3/24 CNA 1 asked her to sit in the dining room with the residents while she got residents up. QMA 4 came to her crying and shaking. QMA 4 indicated CNA 1 was in Resident B's room and cussing and using inappropriate language. Activity Assistant 3 left the dining room and heard the tail end of the staff to resident interaction. She indicated CNA 1 was calling Resident B a "mother f_ _ _ _ g" and Resident B was calling CNA 1 a "w_ _ _ e". CNA 1 responded "It takes one to know one". There were two CNAs with the resident. Activity Assistant 3 intercepted Resident B, CNA 1, and CNA 2 on the way to the dining room. Resident B was shaking and asked her if she saw them trying to fight him. Activity Assistant 3 reported the incident to QMA 4 (who was in charge). Activity Assistant 3 indicated abuse should be reported to the supervisor immediately. A current policy, dated 1/1/20215, titled "Abuse/Neglect/Exploitation" was provided by the Administrator on 3/22/24 at 12:20 p.m. The policy indicated the following: "...Purpose: To establish guidelines/expectations to ensure personal care and support to Residents who , due to physical and cognitive conditions, are unable to manage independently. .... Procedure A. Suspected Abuse/Neglect/Exploitation 1. Any complaints of abuse, neglect or exploitation should be viewed as very serious and			

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	must be reported to your Executive Director/Director of Nursing immediately...." This citation relates to complaint IN00430519.			
R 0090 Bldg. 00	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 (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (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. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and			

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	(B) dates and hours worked during the past twelve (12) months. (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. (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 Based on interview and record review, the facility failed to ensure staff members reported allegations of verbal abuse of a cognitively impaired resident (Resident B) to the Administrator in a timely manner per the facility policy. The facility also failed to report the allegation of verbal abuse to the the appropriate state agencies in a timely manner and perform a thorough and complete investigation of abuse allegations according to facility policy for 1 of 1 residents reviewed for abuse (Resident B). Findings include: The clinical record for Resident B was reviewed on 3/22/24 at 10:53 a.m. Diagnoses included dementia, chronic bilateral lower back pain with bilateral sciatica, depression, hearing loss, right foot drop, and lumbar spinal stenosis. Review of a facility self reportable, dated 3/14/24, indicated on 3/3/24 at 12:01 p.m., CNA 1 was overheard yelling at Resident B and using inappropriate language.	R 0090	Resident B was interviewed and assessed for s/s of emotional distress or physical harm. Resident B had no recollection of the event et shows no signs of emotional distress or physical harm. All residents were interviewed and assessed for emotional distress or physical harm. None of the residents showed s/s of emotional distress or physical harm. The community policy titled “Abuse/Neglect/Exploitation” was reviewed without change. CNA1 and CNA2 were discharged. QMA4 et LEC3 have been counseled and disciplined for not following community policy regarding reporting of abuse allegation. All employees were	04/11/2024

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	Review of the time punch on 3/22/24 at 1:30 p.m., indicated CNA 1 worked 3/2/24 from 6:59 a.m. to 3:17 p.m. CNA 1 did not work 3/3/24. CNA 1 worked 3 hours and 17 minutes after the alleged incident. Review of the time punch on 3/22/24 at 1:30 p.m., indicated QMA 4 worked 3/3/24 from 6:46 a.m. to 3:29 p.m. This was the only shift QMA 4 and CNA 1 worked together. During an interview on 3/22/24 at 1:11 p.m., the Administrator indicated the incident happened on Sunday 3/3/24 around noon. She was informed of the incident on 3/4/24 between 7:00 a.m. and 8:00 a.m. Review of the timeline and the time punches indicated the incident occurred on Saturday 3/2/24 at 12:01 p.m. not 3/3/24. The incident was reported to the Administrator on 3/4/24 between 7:00 a.m. and 8:00 a.m. (approximately 37 hours after the incident). The facility reported the incident to state agencies on 3/14/24 at 12:31 p.m. (approximately 11 days after the incident was reported to the Administrator). Review of the facility investigation indicated a lack of assessments of other vulnerable residents, staff interviews or interviews of other potential witnesses, according to facility policy. The investigation did contain a typed statement from an anonymous staff member indicating they had witnessed verbal abuse of Resident B form CNA 1. During an interview on 3/22/24 at 1:30 p.m., the Administrator and DON indicated they had not reported the allegation of abuse to the state agency in a timely manner per facility policy and		re-educated on this policy and procedure. All employees will report any allegation of abuse immediately to the ED et DON. The ED or his representative will report all allegations to the ISDH within 2 hours of learning of the incident. A thorough investigation will be conducted by the ED or his representative. During that investigation, all employees under suspicion will be immediately suspended until the investigation is complete. Depending on the results of the investigation, the employee (s) will either be re-instated or discharged. The ED or his representative will submit a report of findings within five (5) days of the initial report. The ED or his representative will conduct two (2) audits of employees, families, or residents 2X weekly X30 days, then 1X weekly X30 days, then 1X monthly X 90 days to ensure no other unreported incidents of abuse/neglect/exploitation have occurred. All audits will be reported to the QA committee for further monitoring.	

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	state residential regulation. The investigation and follow up had been completed before the incident was reported. They also indicated family members of another resident had been present, but this information had not been part of the investigation report. This family was unable to be reached for interview during the survey. During an interview on 3/22/24 at 1:32 p.m., QMA 4 indicated on 3/3/24 around lunch time she overheard Resident B telling CNA 1 it was none of her business. QMA 4 then heard CNA 1 tell the resident it was her "f_ _ _ _ g" business. There had been another CNA (CNA 2) in the room. QMA 4 left the area and found Activity Assistant 3 in the dining room. She told the activity assistant her concerns and the activity assistant left the dining room in the direction of the resident's room and was able to intercept Resident B and CNA 1. The activity assistant stayed with Resident B. QMA 4 indicated CNA 2 was also in the room at the time of the incident. During an interview on 3/22/24 at 1:44 p.m., the DON indicated the facility would try to reach CNA 1 and CNA 2. The DON and Administrator also indicated Activity Assistant 3 was a volunteer. Neither CNA was able to be reached for interview during the survey. During an interview on 3/22/24 at 1:51 p.m., Activity Assistant 3 indicated on 3/3/24 CNA 1 asked her to sit in the dining room with the residents while she got residents up. QMA 4 came to her crying and shaking. QMA 4 indicated CNA 1 was in Resident B's room and cussing and using inappropriate language. Activity Assistant 3 left the dining room and heard the tail end of the staff to resident interaction. She indicated CNA 1			

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	was calling Resident B a "mother f_ _ _ _ g" and Resident B was calling CNA 1 a "w_ _ _ e". CNA 1 responded "It takes one to know one". There were 2 CNAs with the resident. Activity Assistant 3 intercepted Resident B, CNA 1 and CNA 2 on the way to the dining room. Resident B was shaking and asked her if she saw them trying to fight him. Activity Assistant 3 reported the incident to QMA 4 (who was in charge). Activity Assistant 3 indicated abuse should be reported to the supervisor immediately. A current policy, dated 1/1/20215, titled "Abuse/Neglect/Exploitation" was provided by the Administrator on 3/22/24 at 12:20 p.m. The policy indicated the following: " .... Procedure A. Suspected Abuse/Neglect/Exploitation 1. Any complaints of abuse, neglect or exploitation should be viewed as very serious and must be reported to your Executive Director/Director of Nursing immediately. .... 4. If abuse, neglect or exploitation is suspected, act immediately to protect the Resident from additional harm. This may require someone to remain with the Resident at all times, or it may require a move to another apartment. Call you Executive Director./Director of Nursing for assistance as soon as possible. 5. Act quickly to gather pertinent information.. If an employee is suspected of the abuse, the employee must be suspended pending the outcome of an investigation, for the employee's protection as well as the protection of the Resident. A staff person suspected or accused of abuse, neglect or exploitation should not have access to any Resident until the property investigates and takes action to assure Resident safety. .... 7. Initiate an investigation. All staff on duty at			

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	the time of the alleged abuse occurred must be interviewed prior to leaving there respective shift. This applies to all staff, as well as other Residents in the area. Remind theses individuals that they should report facts rather than opinions or speculation. Written statements by staff are not advised unless directed otherwise by legal staff. Such statements may lack adequate information or objectivity. Instead, the investigator should take written notes about the facts reported during the interview. ...." This citation relates to complaint IN00430519.			