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	09/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ELKHART PLACE	2024 COUNTY ROAD 24 ELKHART, IN 46517

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R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00390431. Complaint IN00390431 - Substantiated. State Residential Findings related to the allegations are cited at R0052. Survey date: September 26 & 27, 2022 Facility number: 004353 Residential Census: 32 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed 10/3/22.	R 0000	*Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.*	
R 0052 Bldg. 00	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. Based on observation, interview and record review, the facility failed to ensure 1 of 5 residents reviewed for abuse were free from physical abuse. (Resident F) Finding includes:	R 0052	**R 052 Resident Rights – Offense** ="" span Resident F was discharged to a memory care unit on 10/3/22. The local police department was notified of the abuse allegation on	10/27/2022

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

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	A facility self- reported incident #136, dated 9/14/22, indicated Resident F had reported physical abuse and feeling unsafe with a care provider, on 9/13/22 at 9:01 P.M. The incident indicated the resident was assessed for injury, provided emotional support and agency QMA 2 was removed from the premises. Resident F had a 13 x 2 centimeter reddened area/abrasion to right midback. The physician, POA (Power of Attorney) and a third- party provider were notified. The resident was provided a one- on- one caregiver, from the facility, the staff were educated on abuse and the third- party staff member was unauthorized to be on the premises. On 9/27/22 at 10:48 A.M., a review of the clinical record for Resident F was conducted. The record indicated the resident was admitted on 2/17/22. The resident's diagnoses included, but were not limited to: memory loss, orthostatic hypertension and osteopenia. A Progress Note, dated 9/13/22 at 7:56 P.M., indicated the resident had no complaints of pain or a headache, " ...now has a scratch on her back. Resident made a statement that her "husband" slammed her twice ...." The next Progress Note was dated 9/14/22 at 1:10 P.M., and indicated resident continued one on one care for safety, no signs of symptoms of acute distress and had complained of right hip area and lower back pain. A Progress Noted, dated 9/14/22 at 4:00 P.M., written by the Director of Nursing (DON), indicated she had been notified, on 9/13/22 at 9:00 P.M., of a resident reporting physical abuse. The Note indicated the resident "...being scared of male caregiver being aggressive c [with] her.		9/26/2022 by the Executive Director (ED). QMA 2 is not an employee of the community and was terminated by the home health agency. **2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** Skin assessments of current residents and interviews with current staff and residents were completed on 10/17/2022 by the ED and the Care Services Manager (CSM) to ensure residents are free from physical abuse. No concerns identified. **3 What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** The ED and CSM were re-educated on 10/13/2022 by the Regional Director of Care Services on abuse and resident rights. Current staff were re-educated on 10/17/2022 by the ED on abuse and resident rights **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:**	

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	Resident noted c [with] red abrasion on r [right] back ...." The abrasion measured 13 x 2 centimeters. The Note indicated the male care giver was removed from the resident's care and the facility staff provided one- on- one care and comforted the resident until she was able to rest. The resident's physician assessed the resident and ordered an x-ray. The family member was notified yesterday, day of the occurrence. The x-ray revealed pneumonia and the resident was placed on an antibiotic. Requested a Mini Mental State Exam form prior to the incident but was not provided, however received one, dated 9/21/22, which indicated a score of 1 with a score of 24 or above considered normal cognition. During an observation, on 9/26/22 at 1:33 P.M., CNA 6 was in Resident F's room. The resident was sitting on the couch facing the TV. CNA 6 indicated the resident was sleepy but refused to lie down in bed. She indicated she worked as private duty CNA through a home care company. CNA 6 indicated she had had abuse training and resident rights training. She indicated the resident never acted fearful or scared of her and was a very pleasant lady. She had been working the day shift, with her, for about 3 weeks now. She had a notebook and indicated she made notes on the residents happenings, each day, for the other health care workers and family. The resident was observed to interact with CNA 6 and there was no indication she was fearful of this person. She was relaxed, as her eyes drifted shut at times with the conversation. There was no odor in the room and the resident's clothes were clean. The resident indicated the lady taking care of her was nice. A contract with the third- party caregiver		Effective 10/24/2022, the ED or designee will complete 5 skin assessments, interview 2 staff members, and interview 2 residents to ensure residents are free from physical abuse. The skin assessments and interviews will occur weekly for four weeks, biweekly for four weeks, then monthly. Interviews will be reviewed at monthly QI meeting. The QI Committee will determine if continued interviews are necessary based on 3 consecutive months of compliance. Monitoring will be on-going. **5 By what date the systemic changes will be completed** Completion date: 10/27/2022	

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	(independent contractor) was received, on 9/27/22, from the Administrator. The Administrator indicated he had contacted the contractor and had requested a copy of QMA's criminal background check and education on abuse and neglect. The contractor refused to provide the requested information. During an interview, on 9/27/22 at 11:50 A.M., the DON indicated she was notified, on 9/13/22 at 9:00 P.M., about the allegation of abuse towards Resident F. She indicated she had observed the abrasion and was it redden in color. She indicated the resident had had a fall on the 12th and thought maybe the abrasion had occurred from the fall. However, the DON indicated the resident had never talked of anyone abusing her before. QMA 2 had only been assigned to the resident a few times by the Home Health Agency, hired by the family due to multiple falls. The resident had no history of having a husband who was abusive towards her. She indicated the QMA was asked to leave the facility, around 9:00 P.M., even though he was to stay until the next morning. When she contacted the Agency they reported to DON he was a new employee and had no previous record of abuse. The Agency terminated him from theircompany. The DON indicated the local police department had not been notified of the incident until today. During an interview, on 9/27/22 at 1:48 P.M., CNA 4 indicated she had worked the night of the incident with Resident F and a private duty QMA 2. She indicated after the QMA 2 had been asked to leave the facility the resident acted fearful and kept asking her if "he was coming back". She indicated she checked on the resident numerous times even though another staff member was providing one- on- one care, to reassure her that			

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	caregiver was not coming back. CNA 4 indicated she had never had Resident F act fearful before, nor make false statements about other staff members. When she returned to work 2 days later the resident was back to herself. During an interview, on 9/27/22 at 2:26 P.M., QMA 3 indicated she had gone into Resident F's room to get her blood pressure, when the resident showed her an abrasion on her back. The Agency staff person (QMA2) was sitting in front of the door, not saying anything. The resident's walker was in the bathroom, and she needed it to walk around in the room. She told QMA 2 she was taking the resident for a walk. When they were walking the resident revealed to her QMA 2 had caused the abrasion and informed her, QMA 2 had been rough with her. She indicated the resident was visibly upset and had never made false statements before. She contacted the DON and the Administrator and was told to ask him to leave, which he did. The resident was taken back to her room and reassured he would not return. QMA 3 indicated one of the CNAs who was working, that night, provided the one -on- one care. During an interview, on 9/27/22 at 3:06 P.M., HHA (Home Health Aide) 5 indicated was asked to go to Resident F's room to do one on one care. HHA 5 indicated the resident made statements that she had never had a husband treat her like that, he pushed her into the ground. HHA indicated the resident was acting fearful and kept watching the door asking if he was coming back. She indicated the resident was tearful at times and kept calling QMA 2 her husband. On 9/27/22 at 11:05 A.M., the Administrator provided a policy titled, " Abuse, Neglect and			

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	Exploitation Policy - Indiana Communities", dated 3/1/22, and indicated the policy was the one currently used by the facility. The policy indicated "...Abuse means any physical or mental injury or sexual assault inflicted on a resident in the community, other than by accidental means...Procedure...d. In the event there is reasonable suspicion that a crime has occurred, the Community shall promptly contact law enforcement. On 9/27/22 at 2:45 P.M., the Administrator provided an agreement titled, "Caregiver Access and Standards Agreement, dated 9/1/22. The Agreement indicated the Private Duty Agency would "...perform a criminal background check for all Caregiver Personnel prior to the Caregivers Personnel's commencement of service at the Community...Caregiver shall provide Operator with copies of relevant background checks if required under applicable law or upon Operator's request...." Included in the contract was a policy titled, "Annex A Certain Policies and Procedures", undated. The Annex indicated "...Prohibited Activities and Conduct. Activities and conduct prohibited on Community premises included: a. Verbal or physical abuse, neglect, financial exploitation, or misappropriation of property (i.e.theft)...k. Violating Resident Rights...." This State Residential finding relates to Complaint IN00390431.			