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

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155491	A. BUILDING 00 B. WING	03/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF CONNERSVILLE	1029 E 5TH STREET CONNERSVILLE, IN 47331

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00402708, IN00402727 and IN00403638. Complaint IN00402727-Federal/state deficiencies related to the allegations are cited at F607 and F609. Complaint IN00402708-No deficiencies related to the allegation are cited Complaint IN00403638-No deficiencies related to the allegation are cited Survey dates: March 9, 10 and 13, 2023 Facility number: 000316 Provider number: 155491 AIM number: 100286370 Census Bed Type: SNF/NF: 102 Total: 102 Census Payor Type: Medicare: 7 Medicaid: 74 Other: 21 Total: 102 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 17, 2023	F 0000		
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			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mandi Paul	Regional Nurse Consultant	03/31/2023

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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	implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §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 follow policies and procedures related to the timely reporting of an allegation of verbal and physical abuse and failed to notify the family of 1 of 3 residents reviewed for an allegation of abuse in a timely manner. (Resident C) Findings include:	F 0607	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1. Resident C was identified at the time of observation and no longer resides at the facility. Resident C did not experience any psychosocial effects from the	04/05/2023

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	A review of an Indiana State Department of Health reportable incident, dated 1-19-23, indicated the Administrator (ADM) had received an allegation of verbal abuse that date by QMA 3 towards Resident C. The follow-up report, dated 1-25-23, indicated the facility was unable to substantiate the abuse allegation. In an interview on 3-9-23 at 3:05 p.m., with CNA 2, indicated on 1-6-23, around 6:00 p.m., she observed QMA 3 be verbally abusive towards Resident C. She indicated she shared this information with the Assistant Director of Nursing (ADON) shortly thereafter, as well as informing the ADON she felt like QMA 3 would pick on her when she worked with him. CNA 2 indicated on 1-12-23, she observed QMA 3 being rough in his treatment towards Resident C and yelling at him. She indicated at that time, she texted the Administrator-in-Training (AIT) at 8:30 p.m. She indicated her text said she needed to address something with him when he had time. "I just assumed he would know what I was talking about because [name of the ADON] had told me she had talked to him about this. He responded that tomorrow would be fine when I came on shift. The next day, I didn't speak with him because I couldn't find him." CNA 2 indicated she worked with QMA 3 on 1-14-23. She indicated on this evening, she again witnessed QMA 3 being rough with Resident C and speaking to him in a hateful manner. "I texted [name of the AIT] again on 1-14-23 at 8:54 p.m., telling him I needed to speak to him about the situation." CNA 2 was queried as to the content of the text to the AIT and she indicated she did not explicitly say what her concerns were or use the term abuse. She indicated this all went back to		alleged abuse. 2. CNA 2 was suspended on 1/20/23 for failure to report an allegation of abuse timely and in the appropriate manner. CNA 2 returned to work on 1/26/23 with a written corrective action and abuse reporting re-education. CNA 2 no longer works at the facility. 3. QMA 3 was suspended on 1/19/23 for the allegation of abuse. Investigation was unable to substantiate the allegation of abuse and QMA 3 was terminated on 1/25/23 for poor customer service. 4. Family of resident C was notified of the abuse allegation on or around 1/24/23 by the Memory Care Facilitator. How other residents having the potential to be affected by the same deficient practice will be identified and what correction action(s) will be taken? 1. All Residents have the potential to be affected. 2. DNS or designee will educate all staff on Abuse Prevention Program on/by 4/4/23. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? 1. ED or designee will audit all reported allegations of abuse to ensure timeliness of reporting and family notification 2x/week for 4 weeks, weekly for 4 weeks, and then monthly for 6 months. This	

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the initial report she made to the ADON on 1-6-23. "I just assumed [name of the AIT] knew what I was talking about." She indicated the AIT responded on the same date at 11:26 p.m., that he would be able to speak with both staff members the next week.

CNA 2 indicated on the evening shift of 1-18-23, she had unpleasant words with QMA 3. She indicated QMA 3 reported this interaction to the facility's management team. She shared the next day, 1-19-23, the ADM spoke with her around 2:00 p.m., before she went on duty. She indicated the ADM told her QMA 3 had reported her for speaking to him rudely and CNA 2 was asked if she had anything to say. "I just kind of laid into him. I told him that I had attempted to report all the stuff...from January 6th, 12th and 14th. [I] Told him everything at that time. He told me, 'Are you sure you are trying to insinuate a report of abuse, are you sure?' I told him that was exactly what I was trying to report." She indicated her statement was taken at that time. "I know I could have done things better, now...I found out, since, even though I tried to report it, I didn't use the correct terms. I was suspended the next day due to not reporting it properly and having my phone on the floor."

CNA 2 indicated she had "accidentally" informed a family of Resident C about the abuse allegation, she estimated to have occurred around 2-14-23. She indicated she mentioned to one of Resident C's children she had not been in the facility for a short time due to her suspension related to the abuse allegation involving Resident C. "I just assumed the family would have been notified."

A "Statement of Witness," report, dated 1-20-23, from CNA 2, indicated on 1-14-23, she texted the

plan will be revised as warranted.
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?

1. For quality assurance, the ED or Designee will review any findings 5 days a week during clinical meeting, with subsequent correction action and education for identified staff members.

2. Findings will be reported at the QA meeting monthly x6 months and will continue until 100% compliance is achieved.

The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation.
This provider respectfully requests that State Report Plan of Correction be considered the Letter of Credible Allegation.
This provider alleges compliance as of 04/05/2023.
The facility respectfully requests a desk review for this Plan of Correction relative to the low scope and severity of this survey in lieu of a post-survey revisit.

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	AIT "told him I needed to speak with him about the way [name of QMA 3] was speaking to residents...I had reported him to [name of ADON] and tried reporting to [name of AIT]." In an interview on 3-9-23 at 4:18 p.m., with the ADON, she indicated on 1-6-23, she was scheduled to work 6:00 p.m., to 6:00 a.m., of 1-7-23. She indicated after she arrived to work, CNA 2 "came to me in the West building and said there had been some issues between her and [name of QMA 3]...She never mentioned anything about any concerns for any resident and certainly no mention of any suspected or observed abuse. She may have thought she said something, but she did not...I have been in long term care for many years. If I had any concerns about any abuse, I know how to handle it." She indicated on 1-7-23, sometime between 3:00 p.m. and 5:00 p.m., CNA 2 came to speak with her in her office. She clarified CNA 2 "vented" about the issues between her and QMA 3. She explained CNA 2 gave her some examples of what she felt was unfair treatment, but, "never once did she mention anything about any residents or abuse, only just the problems she saw between her and [name of QMA 3.]" A "Statement of Witness," report, dated 1-19-23, from the ADON, she indicated in the week of 1-9-23, CNA 2 came to her in her office and addressed concerns she had with a care team member. "At NO time before or since my conversation with [name of CNA 2], did she bring up a specific resident's name or allegation of abuse into the conversation. Had that been the case, it is my responsibility and duty to report such accusations immediately." A "Statement of Witness," report, dated 1-20-23,			

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from the AIT, he indicated CNA 2 "has never reported abuse to me," but had she voiced concerns regarding QMA 3 "needs to work on his communication towards residents."

In an interview on 3-9-23 at 1:05 p.m., with the Corporate Social Services staff, she indicated she was involved with an allegation of abuse investigation, involving CNA 2 and Resident C. She shared CNA 2 was initially suspended, related to a failure to follow the facility's policies and procedures of abuse, specifically about reporting any allegations of abuse as she had sent a text message to the AIT in which the text message did not come across as being an allegation of abuse. The Corporate Social Services staff indicated she found the details and dates of CNA 2's statements to not be consistent from one time to another. "She kept adding to her statements more allegations or potential allegations with each interview from me or others. We finally asked her to give us a statement with any possible concerns." The Corporate Social Services staff indicated she had viewed the cell phone video, from CNA 2, alleging QMA 3 was verbally inappropriate. "What I saw looked like it was shot from maybe hip level of a male care team member standing at the med cart in the hallway, saying something to the effect of he would be down there to deal with something. There were no residents in the video. He did not appear to be rude, maybe a little gruff sounding, but nothing inappropriate was heard by me."

In an interview on 3-10-23 at 4:25 p.m., with the Vice President of Operations (Corporate VP), he indicated he had been in contact with the family of Resident C several times since becoming aware of the abuse allegations on 1-19-23. The Corporate VP indicated the family of Resident C wanted to

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know why there was a delay in notifying their family about the abuse investigation. He explained the reasons that corporate staff took over the investigation of this situation was to avoid any accusations of possible nepotism due to one of the care team members involved in the abuse allegation was related to a member of the facility's management team. "Then we had the issue of the one staff member videotaping another employee. There were no residents in the video, but it was done without the other staff's permission. The staff member being taped did use explicit language while being derogatory towards a resident while speaking to the person taping it."

In an interview on 3-10-23 at 2:02 p.m., with the Memory Care Unit Facilitator, she indicated at the time the allegations of abuse were made, she was off work and when she returned to work, "because the corporate people were handling the investigation, I asked if anything needed to be done. I will say I did not specifically ask if the family had been notified, because to me, that is a normal part of the investigation. I was told everything had been done." She recalled speaking to a family member of Resident C on or around 1-24-23, and he told her CNA 2 had told him there had been an allegation of abuse by her (CNA 2), several weeks before that, but the facility staff had not spoken to him or any of the family about this. "I was very surprised. I apologized several times to him." She indicated she not did not ask the date the family member was informed of the abuse allegations.

In an interview on 3-9-23 at 10:45 a.m., with the ADM, he indicated the facility recently experienced a rather complicated abuse investigation for Resident C. He indicated the facility was somewhat delayed in notification to

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the family, regarding the 1-19-23, allegation of abuse, with the family "not getting notified until sometime in February of the allegation." He indicated during this time, the Memory Care Unit Facilitator was off work and one of the care team members involved with the abuse allegation was related to a member of the facility's management team, so the corporate staff became involved in the investigation. He indicated
the facility was not able to substantiate any abuse, specific to the 1-19-23, allegations. He indicated the initial allegation was "inappropriate verbiage toward a resident," on the higher functioning memory care unit.

On 3-9-23 at 11:20 a.m., the Director of Nursing provided a copy of a policy entitled, "Abuse Prevention Program," with a revision date of 2-22-2018. This policy indicated, "Our residents have the right to be free from abuse, neglect, misappropriation of resident property, exploitation, corporal punishment and involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptom. (Collectively, hereinafter "abuse")...Comprehensive policies and procedures have been developed to aid in our facility in preventing abuse...Timely and thorough investigations of all reports and allegations of abuse...The Administrator must be immediately notified of alleged abuse/neglect or incidents of abuse/neglect. If such incidents occur or are discovered after hours, the Administrator and Director of Nursing Services must be called at home or must be paged and informed of such incident. When an alleged or suspected case of mistreatment, neglect, injuries of unknown source, or abuse is reported, the facility Administrator, DON, or individuals designated will immediately (not to exceed 24 hours if the event does not

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	result in serious bodily injury. No later than 2 hours if the event is an allegation of abuse or where there is significant injury or neglect where there is significant bodily injury) notify the following persons...The Resident's Representative (Sponsor) of Record...Any individual observing an incident of resident abuses or suspecting resident abuse must immediately report such incident to the Administrator or Director of Nursing or designee...The Administrator will keep the resident and his/her representative (sponsor) informed of the progress of the investigation." This Federal tag relates to Complaint IN00402727. 3.1-28(a) 3.1-28(c)			
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			

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	care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to ensure an allegation of physical and verbal abuse was reported in a clear manner to the Administrator within two hours or less of occurrence for 1 of 3 residents reviewed for abuse. (Resident C) Findings include: A review of an Indiana State Department of Health reportable incident, dated 1-19-23, indicated the Administrator (ADM) had received an allegation of verbal abuse that date by QMA 3 towards Resident C. The follow-up report, dated 1-25-23, indicated the facility was unable to substantiate the abuse allegation. In an interview on 3-9-23 at 3:05 p.m., with CNA 2, she indicated on 1-6-23, around 6:00 p.m., QMA 3 told her to put Resident C in his room. She indicated QMA 3 told her he "did not want to f-----g deal with him that evening and for me to put him in his room and told [name of Resident C], to his face, to go to his f-----g room." CNA 2 indicated she went to the Assistant Director of Nursing (ADON), who was working in the facility's other building, shortly thereafter to let her know what QMA 3 had said to Resident C and that he said he (QMA 3) wasn't in the mood to	F 0609	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1. Resident C was identified at the time of observation and no longer resides at the facility. Resident C did not experience any psychosocial effects from the alleged abuse. 2. CNA 2 was suspended on 1/20/23 for failure to report an allegation of abuse timely and in clear and appropriate manner. CNA 2 returned to work on 1/26/23 with a written corrective action and abuse reporting re-education. CNA 2 no longer works at the facility. 3. QMA 3 was suspended on 1/19/23 for the allegation of abuse. Investigation was unable to substantiate the allegation of abuse and QMA 3 was terminated on 1/25/23 for poor customer service. How other residents having the potential to be affected by the same deficient practice will be	04/05/2023

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	deal with him (Resident C). She added that she also told the ADON she felt like QMA 3 would pick on her when she worked with him. CNA 2 indicated the ADON responded she would speak with QMA 3 before she left that evening. She indicated the next day, 1-7-23, she was scheduled to work with QMA 3 again on the Memory Care Unit (MCU). She indicated she clarified with the ADON if she had spoken with QMA 3 yet and the ADON told her she had not spoken with him yet. CNA 2 indicated on 1-12-23, she observed QMA 3 walking down the hallway with his medication cart and observed Resident C walking towards QMA 3. She indicated QMA 3 again told her to take Resident C to his room. "I recorded [cell phone video] [name of QMA 3] saying 'J---s C----t, take him to his room, I don't want to deal with it'...Did not set well with me. I told him I had taken him to his room and got him ready for bed. This was around 8:00 p.m., but told him he had gotten back up. This was not unusual for [name of Resident C.] He asked if I had taken his shoes off. He told [name of Resident C] to follow him and he took [name of Resident C] down to his room. I saw him take him by the shoulders, unsure of what force was used, and pushed him down into a seated position and removed his shoes. He told me then, 'This is how you make him f'ing stay.' CNA 2 indicated at that time, she texted the Administrator-in-Training (AIT) at 8:30 p.m. She indicated her text said she needed to address something with him when he had time. "I just assumed he would know what I was talking about because [name of the ADON] had told me she had talked to him about this. He responded that tomorrow would be fine when I came on shift. The next day, I didn't speak with him because I couldn't find him. Not sure if I worked with [name		identified and what correction action(s) will be taken? 1. All Residents have the potential to be affected. 2. DNS or designee will educate all staff on Abuse Prevention Program on/by 4/5/23. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? 1. ED or designee with audit all reported allegations of abuse daily Monday through Friday to ensure reporting was completed timely and in a clear manner. This plan will be revised as warranted. 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? 1. For quality assurance, the ED or Designee will review any findings 5 days a week during clinical meeting, with subsequent correction action and education for identified staff members. 2. Findings will be reported at the QA meeting monthly x6 months and will continue until 100% compliance is achieved. **The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation.**	

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	155491	A. BUILDING 00 B. WING	03/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF CONNERSVILLE	1029 E 5TH STREET CONNERSVILLE, IN 47331

(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
	of QMA 3] on the 13th, but did work with him 1-14-23." She shared on the evening of 1-14-23, Resident C had wandered into another resident's room and when QMA 3 found Resident C, "[Name of QMA 3] came down there, pulled [name of Resident C] by his shirt at his shoulder" and yelled at Resident C. "His voice was elevated and sounded hateful to me. I texted [name of the AIT] again on 1-14-23 at 8:54 p.m., telling him I needed to speak to him about the situation." CNA 3 was queried as to the content of the text to the AIT was and she indicated she did not explicitly say what her concerns were or use the term abuse. She indicated this all went back to the initial report she made to the ADON on 1-6-23. "I just assumed [name of the AIT] knew what I was talking about." She indicated the AIT responded on the same date at 11:26 p.m., that he would be able to speak with both staff members the next week. CNA 2 indicated on the evening shift of 1-18-23, she had unpleasant words with QMA 3. She indicated QMA 3 reported this interaction to the facility's management team. She shared the next day, 1-19-23, the ADM spoke with her around 2:00 p.m., before she went on duty. She indicated the ADM told her QMA 3 had reported her for speaking to him rudely and CNA 2 was asked if she had anything to say. "I just kind of laid into him. I told him that I had attempted to report all the stuff...from January 6th, 12th and 14th. [I] Told him everything at that time. He told me, 'Are you sure you are trying to insinuate a report of abuse, are you sure?' I told him that was exactly what I was trying to report." She indicated her statement was taken at that time. "I know I could have done things better, now...I found out, since, even though I tried to report it, I didn't use the correct terms. I was suspended the next day due to not reporting it properly and having my phone		**This provider respectfully requests that State Report Plan of Correction be considered the Letter of Credible Allegation. This provider alleges compliance as of 04/05/2023. The facility respectfully requests a desk review for this Plan of Correction relative to the low scope and severity of this survey in lieu of a post-survey revisit.**	

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on the floor."

A "Statement of Witness," report, dated 1-20-23, from CNA 2, indicated on 1-14-23, she texted the AIT "told him I needed to speak with him about the way [name of QMA 3] was speaking to residents...I had reported him to [name of ADON] and tried reporting to [name of AIT]."

In an interview on 3-9-23 at 4:18 p.m., with the ADON, she indicated on 1-6-23, she was scheduled to work 6:00 p.m., to 6:00 a.m. on 1-7-23. She indicated after she arrived to work, CNA 2 "came to me in the West building and said there had been some issues between her and [name of QMA 3]...She never mentioned anything about any concerns for any resident and certainly no mention of any suspected or observed abuse. She may have thought she said something, but she did not...I have been in long term care for many years. If I had any concerns about any abuse, I know how to handle it." She indicated on 1-7-23, sometime between 3:00 p.m. and 5:00 p.m., CNA 2 came to speak with her in her office. She clarified CNA 2 "vented" about the issues between her and QMA 3. She explained CNA 2 gave her some examples of what she felt was unfair treatment, but, "never once did she mention anything about any residents or abuse, only just the problems she saw between her and [name of QMA 3.]"

A "Statement of Witness," report, dated 1-19-23, from the ADON, she indicated in the week of 1-9-23, CNA 2 came to her in her office and addressed concerns she had with a care team member. "At NO time before or since my conversation with [name of CNA 2], did she bring up a specific resident's name or allegation of abuse into the conversation. Had that been the

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case, it is my responsibility and duty to report such accusations immediately."

A "Statement of Witness," report, dated 1-20-23, from the AIT, he indicated CNA 2 "has never reported abuse to me," but had she voiced concerns regarding QMA 3 "needs to work on his communication towards residents."

In an interview on 3-9-23 at 1:05 p.m., with the Corporate Social Services staff, she indicated she was involved with an allegation of abuse investigation, involving CNA 2 and Resident C. She shared CNA 2 was initially suspended, related to a failure to follow the facility's policies and procedures of abuse, specifically about reporting any allegations of abuse as she had sent a text message to the AIT in which the text message did not come across as being an allegation of abuse. The Corporate Social Services staff indicated she found the details and dates of CNA 2's statements to not be consistent from one time to another. "She kept adding to her statements more allegations or potential allegations with each interview from me or others. We finally asked her to give us a statement with any possible concerns." The Corporate Social Services staff indicated she had viewed the cell phone video, from CNA 2, alleging QMA 3 was verbally inappropriate. "What I saw looked like it was shot from maybe hip level of a male care team member standing at the med cart in the hallway, saying something to the effect of he would be down there to deal with something. There were no residents in the video. He did not appear to be rude, maybe a little gruff sounding, but nothing inappropriate was heard by me."

On 3-9-23 at 11:20 a.m., the Director of Nursing provided a copy of a policy entitled, "Abuse

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	Prevention Program," with a revision date of 2-22-2018. This policy indicated, "Our residents have the right to be free from abuse, neglect, misappropriation of resident property, exploitation, corporal punishment and involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptom. (Collectively, hereinafter "abuse)...Comprehensive policies and procedures have been developed to aid in our facility in preventing abuse..Timely and thorough investigations of all reports and allegations of abuse....The Administrator must be immediately notified of alleged abuse/neglect or incidents of abuse/neglect. If such incidents occur or are discovered after hours, the Administrator and Director of Nursing Services must be called at home or must be paged and informed of such incident...Any individual observing an incident of resident abuses or suspecting resident abuse must immediately report such incident to the Administrator or Director of Nursing or designee..." This Federal tag relates to Complaint IN00402727. 3.1-28(c)			