STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155620	A. BUILDING _____ B. WING _____	03/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ZIONSVILLE MEADOWS	675 S FORD RD ZIONSVILLE, IN 46077

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to timely report resident to resident abuse within 2 hours, for 2 of 2 residents reviewed for abuse (Residents B, and C). Finding includes: a. During a random observation on 3/9/2020 at 10:18 a.m., Resident B was observed lying on the bed with his eyes closed, Certified Nursing Assistant (CNA) 6 was sitting at the bedside holding a clipboard. CNA 6 indicated she was a sitter for the resident, and she thought he had 1:1 (one on one) supervision around the clock for sexual behaviors. She was to document on the clipboard if Resident B had any behaviors. During an observation of Resident B on 3/9/2020 at 10:22 a.m., the resident was walking in the hallway with CNA 6 and no behaviors were observed. During an observation of Resident B on 3/9/2020 at 11:42 a.m., the resident was lying on the bed watching television, CNA 6 at bedside. Resident B was alert, responded politely to an introduction, and indicated he had just returned from receiving therapy. Resident B indicated he thought the aide was sitting with him as it was a convenient place for her to work. During an observation of Resident B on 3/9/2020 at 2:18 p.m., the resident was lying on the bed with his eyes closed with the television on, and CNA 6 at bedside. The CNA 6 indicated, they had just returned to the resident's room and she was waiting to be relieved by another sitter. During an observation of Resident B on 3/10/2020 at 10:54 a.m., the resident was sitting on the side of the bed calmly watching television. The resident was pleasant when spoken to. CNA 18 was observed sitting in the hallway outside of the resident's door with a clip board in hand, and indicated she had been on 1:1 observation with Resident B since 7:00 a.m., she was unsure who had sat with him during the night. Review of a report, titled, Indiana State Department of Health Survey Reporting System, dated 03/02/2020 at 12:01 p.m., and submitted on 3/2/2020 at 3:32 p.m., indicated Resident B was in a common area, standing next to Resident C. Resident B was touching Resident C with one hand, his other hand was in his pants fondling himself. A record review completed for Resident B on 3/9/2020 at 3:02 p.m., indicated the resident [DIAGNOSES REDACTED]. A Progress Note for Resident B, dated 3/2/2020 at 9:00 a.m. by Licenses Practical Nurse (LPN) 10 indicated she approached the resident's table in the dining room that morning at breakfast to see if anything was needed. Resident B was then discovered with his hand to his crotch area, whilst glaring and stroking himself. Writer approached resident and asked if he was done eating. Resident then got up from his chair, physically aroused and walked back to the unit. Resident B's nurse was notified of the behavior. A Progress Note for Resident B on 3/2/2020 at 12:51 p.m., LPN 11 indicated the dining room nurse reported to her the resident was arousing himself during breakfast. Resident B was placed on 1:1 observation. While LPN 11 was passing medications this morning, the resident approached her and while standing approximately 5 foot way, asked if the distance was ok to make her feel comfortable. Resident B was asked if he needing something and he responded with no, then continued to stand there staring at LPN 11 for a long period of time. A Physician's Progress Note for Resident B, dated 2/18/2020, indicated the resident had been seen on 2/12/2020, 2/17/2020, and 2/18/2020 with no documentation of behaviors or behavior management. One on One Observation sheets for Resident B, dated 3/2/2020 - 3/10/2020, indicated the resident continued to make sexually inappropriate comments to caregivers, and was exposing himself to others. An Interdisciplinary Team (IDT) Behavior Review for Resident B, dated 3/4/2020, indicated the resident had been sexually inappropriate in public, and masturbating in his pants with no exposure. The resident remained on 1:1 care. Per an aide at the beginning of the shift, the resident at times rested his hand on her shoulder, and made comments such as suck me please. An Admission MDS (Minimum Data Set) assessment, completed on 2/17/2020, assessed Resident B as having the ability to make himself understood and to understand others. A BIMS, (Brief Interview for Mental Status), score of 3 indicated severe cognitive impairment. There were no behaviors, rejection of care, or wandering. A review of Resident B's care plans indicated, there was no initial care plan for behaviors upon admission. A behavioral care plan, dated 3/4/2020, indicated the resident had episodes of touching self inappropriately in common areas. A second care plan, dated 3/4/2020, indicated the resident made inappropriate verbalization directed towards staff. b. An observation of Resident C on 3/9/2020 at 2:33 p.m., the resident was lying on the bed with her eyes closed. During conversation the resident was alert, but had difficulty articulating words, details or answering questions. Resident C indicated, there had been a recent incident with an unnamed male resident when she was in the laundry putting clothing from the washer to the dryer. Resident C initially indicated the male resident had touched her, and gestured by placing her hand over her breast. Resident C indicated, she was not afraid of the gentleman, she saw him in the facility and he was with someone else. When asked to clarify the event with the male resident, Resident C did not say she had been touched, responded by talking about a lady helping her. Resident C seemed to be getting frustrated, possibly with her inability to answer versus being questioned. She had been teary at one point, but unclear if due to the topic or her inability to answer. An observation of Resident C on 3/10/2020 at 12:54 p.m., the resident was at the nurse's station getting her medications. Resident C was alert, smiling and talkative. She indicated Resident B was not her boyfriend. She was ok, not afraid, happy, and wanted to stay in this facility. A record review completed for Resident C on 3/10/2020 at 9:21 a.m., indicated the resident [DIAGNOSES REDACTED]. A Progress Note for Resident C, dated 03/02/2020 at 11:48 a.m., indicated RN 14 observed Resident B in Resident C's personal space. Resident C had an awkward appearance. The nurse asked what was wrong and Resident C answered she felt uncomfortable. Resident C was removed from the situation, will report immediately to supervisor. The quarterly MDS assessment, in progress and dated for 3/4/2020, assessed Resident C a BIMS score of 15 and indicated cognitively intact. During an interview on 3/9/2020 at 2:46 p.m., the Director of Nursing Services (DNS) indicated, Resident B was on 1:1 supervision due to being on sexual overdrive at this time. There had been a recent incident that was State reported, but had since been debunked. There were however incidents of touching staff and masturbating. Resident B was being followed by his physician, psychiatric services, he'd had medication changes, was 1:1 supervision, and the facility had been trying to get him into an all-male behavioral unit. During an interview on 3/10/2020 at 9:48 a.m., the Executive Director (ED) indicted there had been a one time incident on 3/2/2020 with Resident B when both he and Resident C had been in the activity area on Pine Hall. Resident C had been in the hallway sitting in her wheelchair and Resident B was standing next to her chair. The nurse looked up and saw Resident C with an uncomfortable expression, so the nurse intervened and separated the residents. RN 14 initially thought Resident B was pleasuring himself, but later did not think so. Resident B had been put on 1:1 supervision as a preventative measure. The Social Service Designee (SSD) spoke with both Resident B and Resident C, and both had no concerns. As a safeguard Resident B was made 1:1 as he ambulated. He had made comments to and touched the shoulder of the nurse consultant, and the ED was not sure if Resident B was looking to befriend others. Resident B was not showing any signs or symptoms, his daughter indicated, he had no prior history or symptoms of behaviors. Nurse 14 thought he was pleasuring himself, so the facility took the initiative to do 1:1. Resident B indicated he had his hands in his pockets and the nurse perceived him as maybe pleasuring himself. Both Resident B and Resident C denied any concern when interviewed by the SSD. By interviews with

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) Resident B, Resident C, other residents, and staff, it was determined nothing happened. The DNS conducted interviews. Resident B was redirected after the issue in the dining room, there was no reason to document as other residents would have been directed to their room to masturbate if not involving others. The facility state reported the incident after the IDT discussion to be proactive, but did not report to police as it had not been determined it was abuse. If there was a suspicion of crime, or there was a crime, police were to be called. There was no contact between Resident B and Resident C, it was a dignity thing, he did not touch her, so was not thought to be abuse. If the resident had felt it was abuse, the ED would have reacted differently. RN 14 thought he was masturbating while standing next to Resident C, but it was later determined he had not. Both residents were alert and oriented and stated it didn't happen. During an interview on 3/10/2020 at 11:15 a.m., LPN 11 indicated she had been working on 3/2/2020 when Resident B had been observed fondling himself during breakfast. It had been reported to her he had his hands in his pants, and maybe made a remark to another staff member when she walked up to him. LPN 11 documented what she had been told in the Resident B's medical record. Interventions put into place after the incident included notifying the DNS, Unit Manager, physician, and placing the resident on 1:1 supervision. The documentation in the EMR (Electronic Medical Record) was placed later in the day as directly after being told of the incident with Resident C, another resident coded and required all staff intervention. During an interview on 3/10/2020 at 12:01 p.m., the DNS indicated she had been informed of an incident on 3/2/2020 between Resident B and Resident C before a meeting, she was not sure of the exact time but it could have been around 10:00 a.m. to 10:30 a.m. as residents were involved in an activity in the activity room on Pine Hall. The DNS indicated, she had been stopped in the hallway and informed Resident B was up against Resident C, had one hand in his pants, and the other hand on Resident C's shoulder. The DNS indicated, she knew whatever time the incident happened she was within her 2 hour window to report. The ED indicated the incident was not abuse, and as they needed to wait and investigate there was no need for a 2 hour window, and they had 24 hours to report when not abuse. The DNS indicated, with the information, Resident B was put on 1:1 supervision, she turned in a state reportable incident, the SSD was involved, the DNS completed interviews either that day or the next day, staff interviews were done the next day, and the resident kept on 1:1. On 3/3/2020 the DNS got hold of RN 14 who had seen the incident in the activity room, and got her statement. RN 14 indicated, Resident B was standing close to Resident C with his hands in his pockets, swaying, he denied touching Resident C. RN 14 indicated, she had separated the residents due to Resident C had an uncomfortable look on her face. RN 14 again indicated, Resident B had not touched Resident C, and Resident B had not been masturbating. When asked what drew her the nurse's attention, RN 14 indicated it was due to Resident B standing close to Resident C swaying. The DNS had no knowledge of previous verbal or physical behaviors with staff or peers from Resident B. The DNS indicated, she was not given report of Resident B masturbating in the dining room, she found the documentation during reading progress notes. LPN 10 that re-directed Resident B out of the dining room did the right thing due to nothing was exposed. The DNS had not been aware of CNA 12 observing Resident B masturbating in the hallway after leaving the dining room at breakfast. Staff were educated to report alleged abuse immediately to the charge nurse and ED. Agency staff were educated on the abuse policy as if they were facility staff and knew the policy. The DNS reported the incidents to Resident B's family, and left a phone message with Resident C's family although she didn't get a return call. The DNS was not sure who had contacted Resident B's physician, or if Resident C's physician had been notified. On 3/20/2020 at 10:30 a.m., the Executive Director provided the Abuse Prohibition, Reporting, and Investigation policy, dated February 2020, and indicated the policy was the one currently being used by the facility. The policy indicated, It is the policy of (company name) to provide each resident with an environment that is free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to verbal abuse, sexual abuse, physical abuse, mental abuse, corporal punishment, and involuntary seclusion .Sexual abuse - non-consensual contact of any type. Examples may include but not be limited to fondling, touching, rubbing, exposing, licking, kissing, gestures .The Executive Director is the designated individual responsible for coordinating all efforts in the investigation of abuse allegations, and for assuring that all policies and procedures are followed .1. Any individual who witnesses resident-to-resident abuse will immediately separate and protect the residents involved. 2. Staff member(s) will maintain the resident initiating the abuse under direct supervision until the investigation is completed and resident safety is maintained. 3. The individual who witnessed the abuse will report the situation immediately to his/her supervisor and Executive Director. 4. The staff member in charge will initiate the investigation immediately. 5. The Executive Director will be notified immediately of the report and the initiation of the investigation .9. It is the responsibility of the Administrator/Director of Nursing to report the abuse, or allegations of abuse, immediately, within 2 hours to the Indiana State Department of Health via the ISDH gateway system .19. If staff suspect a crime has occurred, refer to reporting suspicion of a crime policy . 3.1-28(c)