STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155490	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ambassador Healthcare	705 E Main St Centerville, IN 47330

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 50436 Based on observation, interview, and record review the facility failed to ensure residents remained free from physical abuse for 2 of 13 residents reviewed for abuse. (Resident K and Resident M) Findings include: 1. The clinical record for Resident K, reviewed on 9/4/24 at 1:37 p.m., indicated diagnoses that included, but were not limited to, unspecified dementia, cognitive communication deficit, cardiovascular disease, and hypertension. An admission Minimum Data Set (MDS) assessment, dated 7/1/24, indicated Resident K had severe cognitive impairment. Resident K exhibited other behavioral symptoms not directed towards others one to three days during the lookback period. A progress note written by Licensed Practical Nurse (LPN) 2, dated 8/31/24 at 7:57 p.m., indicated, [Resident K] observed pacing unit making attempts to grab at peers. He did make contact to the wrist of one female peer and immediately let go when staff intervened. [Resident K] then repeated the grabbing of another female peer twisting her wrist. [Resident K] was redirected and he did let go after nursing staff intervened. He is currently in his assigned room. There were no progress notes and/or assessments referencing any follow-up being conducted to the resident-to-resident altercation on 8/31/24 at 7:57 p.m. The clinical record indicated the next progress note entered for Resident K, on 9/2/24 at 10:24 a.m., indicated, Resident had been up walking around the unit this morning. [Resident K] has been in view of staff for his recent behaviors. Cooperative at this time. A behavior note was entered by LPN 3, on 9/3/24 at 9:00 a.m., indicating, Resident very volatile this morning was going to pick up a chair and throw it at others, screaming in staffs face, intimidating, restless, refusing to cooperate and becomes angrier when approached by others. There were no progress notes or indication of what approaches were taken regarding Resident K exhibiting behaviors towards others on 9/3/24. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A care plan for behaviors, initiated on 9/4/24, indicated Resident K had a behavior problem related to assisting other residents in their wheelchairs, rubbing arms, holding hands of others in a consoling manner, and a history of kissing other female residents. The interventions included, but were not limited to, the following: - Assist resident to develop more appropriate methods of coping and interacting with others. - Encourage resident to express feelings appropriately. - Intervene, as necessary, to protect the rights and safety of others. - Divert attention, remove from situation, and take to alternate location as needed. A care plan for behaviors/agitation, initiated on 9/4/24, indicated Resident K had the potential to demonstrate physical behaviors and agitation at times related to dementia and poor impulse control. Resident K had a history of exhibiting verbal and physical aggression towards staff and redirection would be attempted. The interventions included, but were not limited to, the following: - Intervene before agitation escalates. - Guide away from source of distress. - Monitor, document, and report to physician of danger to self and others. During an interview on 9/4/24 at 11:10 a.m., Licensed Practical Nurse (LPN) 2 indicated Qualified Medication Aide (QMA) 4 told him Resident K had grabbed Resident M's wrist and QMA 4 had to pry their fingers off for Resident K to release. LPN 2 indicated there were no visible red marks or scratches noted to Resident M's wrist. LPN 2 indicated he attempted to call the Director of Nursing (DON) but had to leave a voice message. LPN 2 indicated he then notified the Administrator and was instructed to fill out an incident report sheet. LPN 2 indicated they did not report the incident to the physician or families because they thought that the QMA, who was working with him at the time of the incident, was also a nurse and handling the situation regarding follow-up. During an observation on 9/4/24 at 11:35 a.m., Resident M was lying in bed awake. LPN 3 indicated it was hard to determine if there were bruises on Resident M because she had petechiae (pinpoint, unraised, round spots under the skin caused by bleeding) on both arms and hands. During an observation on 9/4/24 at 11:40 a.m., Resident K was seen ambulating in the common area, talking with other residents. During an interview with LPN 3 on 9/4/24 at 11:45 a.m., they indicated Resident K had a tendency with agitation and, the day prior, had thrown a chair in the common area. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with QMA 4 on 9/4/24 at 1:50 p.m., they indicated Resident K had a hold of Resident M's hand and when Resident M tried to pull away from him, Resident K started yelling, smacking his own head, then grabbed Resident M's right arm and wrist, took both hands and started twisting and pulling them. QMA 4 instructed Resident K to let go of Resident M's arm but continued to yell. So, QMA 4 put their fingers between Resident K and Resident M to pry and pull them apart from one another. QMA 4 indicated Resident M did show facial signs of pain and saying, he is hurting me. Resident M was also rubbing her wrist after the incident. QMA 4 indicated Resident M's wrist was red after the incident. 2. The clinical record for Resident M, reviewed on 9/4/24 at 3:00 p.m., indicated diagnoses that included, but were not limited to, end stage renal disease, unspecified dementia, anxiety, dependence on renal dialysis, and cerebral infarction. A quarterly MDS assessment, dated 7/8/24, indicated Resident M was severely cognitively impaired. She was dependent on staff for activities of daily living and utilized a wheelchair. Resident M's clinical record indicated there were no progress notes entered about the incident involving Resident K. No follow up documentation, including assessments, were present in the clinical record. During an interview with the Administrator on 9/4/24 at 2:56 p.m., he indicated he could not answer if the Interdisciplinary team (IDT) had implemented any interventions for Resident K. The Administrator indicated Resident M's physician and family were not notified because there was no injury, redness, or swelling to Resident M. During an interview with Social Services 1 on 9/4/24 at 3:30 p.m., they indicated Resident K did not have a care plan for aggressive behaviors with interventions because she had not gotten to them yet. The incident was sitting on her desk. Social Services 1 indicated she was made aware of the incident on Tuesday, 9/3/24, in the morning. She indicated she reviewed the clinical records every morning and progress notes to look for any new behaviors that needed to be addressed. During an interview with the Director of Nursing (DON) on 9/5/24 at 12:00 p.m., she indicated there were no assessments in the clinical record completed for Resident M, only an incident report sheet. The DON indicated the nurse on duty was responsible for follow-up assessments. The DON indicated they never received a call or voicemail about the incident from LPN 2. The abuse policy provided by the Administrator, on 9/3/24 at 11:20 a.m., indicated the facility shall prohibit and prevent abuse. The abuse definition included, but were not limited to, the willful infliction of pain. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. The Behavioral Assessment, Intervention, and Monitoring Policy provided by the Director of Nursing (DON), on 9/4/24 at 4:05 p.m., indicated, . Appropriate assessment and treatment of behavioral symptoms .The nursing staff will identify, document, and inform the physician about specific details regarding changes in an individual's mental status, behavior, and cognition . This citation relates to Complaints IN00442082, IN00442125, IN00442039. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-27(a)(1)

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(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. 25054 Based on interview and record review, the facility failed to thoroughly report an allegation of sexual abuse and report resident to resident physical altercations to the Indiana Department of Health (IDOH) for 4 of 13 residents reviewed for abuse (Resident N, Resident P, Resident K and Resident M). Findings include: 1. The incident report filed by the facility to IDOH, dated 9/2/24 at 2:35 a.m., indicated there was an alleged altercation between Resident N and Resident P. During an interview with the Administrator on 9/3/24 at 2:32 p.m., he indicated, on 9/2/24 during third shift, Qualified Medication Aide (QMA) 10 reported to Registered Nurse (RN) 11 that Resident N reported to QMA 10 he had entered Resident P's room and touched her genitalia. RN 11 reported the incident to the Administrator and called the police. RN 11 assessed Resident P and there were no findings. Resident N was placed on 1 to 1 with staff. This was an ongoing investigation. During an interview with the Police Chief on 9/3/24 at 2:38 p.m., they indicated the police had obtained a standard Deoxyribonucleic Acid (DNA) (genetic test) on Resident P and fingerprints, palm prints and saliva test on Resident N. The Police Chief indicated the police report was not completed yet and it could be months before the DNA testing came back from the lab. During an interview with the Administrator on 9/4/24 at 9:53 a.m., he indicated when he filed the incident report to IDOH, he did not report the allegation of sexual abuse. 50436 2. The clinical record for Resident K, reviewed on 9/4/24 at 1:37 p.m., indicated diagnoses that included, but were not limited to, unspecified dementia, cognitive communication deficit, cardiovascular disease, and hypertension. A progress note, dated 8/31/24 at 7:57 p.m., indicated, [Resident K] observed pacing unit making attempts to grab at peers. He did make contact to the wrist of one female peer and immediately let go when staff intervened. [Resident K] then repeated the grabbing of another female peer twisting her wrist. [Resident K] was redirected, and he did let go after nursing staff intervened. He is currently in his assigned room. During an interview on 9/4/24 at 11:10 a.m., Licensed Practical Nurse (LPN) 2 indicated he attempted to call the Director of Nursing (DON) but had to leave a voice message. LPN 2 indicated he then notified the Administrator and was instructed to fill out an incident report sheet. LPN 2 indicated they did not report the incident to the physician or families because they thought that the Qualified Medication Aide (QMA) who was working with him, at that time, was also a nurse and handled the situation and follow-up. (continued on next page)

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(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	The clinical record for Resident M, reviewed on 9/4/24 at 3:00 p.m., indicated diagnoses included, but were not limited to, end stage renal disease, unspecified dementia, anxiety, dependence on renal dialysis, and cerebral infarction. During an interview with the Administrator on 9/4/24 at 2:56 p.m., he indicated Resident M's physician and family were not notified because there were no injuries, redness, or swelling to Resident M. The Administrator indicated he did not report this to IDOH because when the incident was reported to him, Resident K had a hold of Resident M's wrist. Resident K did not attack Resident M. There were no red marks on Resident M nor were any malicious intent towards Resident M. There were no indications of any type of abuse. An Unusual Occurrence/Incident Reporting Policy provided by the DON, on 9/4/24 at 1:30 p.m., indicated, .1. Our facility will report the following events to appropriate agencies: g. Allegations of abuse .2. Unusual occurrences shall be reported to appropriate agencies as required by current law and/or regulations as required by federal and state regulations An Abuse Prohibition, Reporting, and Investigation Policy provided by the DON, on 9/3/24 at 11:20 a.m., indicated .14. The Administrator is responsible to notify the following agencies, as applicable: State Department of Health This citation relates to Complaints IN00442082, IN00442125, IN00442039. 3.1-28(c)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 25054 Based on observation, interview, and record review, the facility failed to complete initial assessments after a fall and follow-up assessments after residents had a fall with injury for 2 of 3 residents reviewed for accidents. (Resident D and Resident C) Findings include: 1. Review of the clinical record of Resident D, on 9/3/24 at 11:40 a.m., indicated the diagnoses included, but were not limited to, schizoaffective disorder, bipolar disorder, dementia, unsteadiness on feet, muscle weakness, abnormal gait and anxiety. The quarterly Minimum Data Set (MDS) assessment for Resident D, dated 6/8/24, indicated the resident was severely cognitively impaired. A progress note for Resident D, dated 8/23/24 at 9:01 a.m., indicated the Interdisciplinary Team (IDT) met to discuss the resident's fall on 8/22/24. Resident D went into another resident's room and the other resident was helping Resident D leave her room and Resident D fell to the ground. The resident sustained a skin tear to her right elbow and voiced complaints of pain to the elbow. Range of motion (ROM) was per usual. An order was obtained for an x-ray of the right elbow and placed on 15-minute checks to divert resident from going into other residents' rooms. A progress note for Resident D, dated 8/24/24 at 9:57 a.m., indicated the x-ray of the right elbow was negative. There was no further documentation of the fall, on 8/22/24, and no assessments, neurological assessments, nor follow up assessments were noted in the clinical record. During an observation on 9/3/24 at 3:17 p.m., Resident D was ambulating throughout the memory care unit with no assistive device. During an interview with the Director of Nursing (DON) on 9/4/24 at 10:38 a.m., she indicated when a fall occurred the process was for staff to document the incident on an incident/accident form which was not part of the residents' clinical record. The goal was to gather all the information and then the interdisciplinary team (IDT) would document the fall event in the clinical record. During an interview with Licensed Practical Nurse (LPN) 12 on 9/4/24 at 3:22 p.m., she indicated she was the nurse caring for Resident D when she fell . Resident D was found, on 8/22/24, sitting on her buttocks in the doorframe of Resident B's room. Resident B said she pushed Resident D, but did not hurt her, and if she wanted to hurt her, she would have. Resident D sustained a skin tear to her right elbow and complained of pain. An x-ray of the right elbow was obtained. LPN 12 indicated she documented her findings on an incident form. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DON on 9/5/24 at 2:52 p.m., she indicated Resident D's fall was documented on a risk management form and it was not part of the resident's clinical record or a legal form. The Indiana Department of Health was not allowed access to this form. IDT documents the falls in the clinical record. The DON indicated Resident D did not have any follow-up assessments completed after the fall, on 8/22/24, and the floor nurses were responsible to complete these assessments. 2. Review of the clinical record of Resident C, on 9/4/24 at 1:37 p.m., indicated the diagnoses included, but were not limited to, hypertension, chronic pain, dementia, osteoporosis and adjustment disorder. The admission MDS assessment, dated 7/16/24, indicated the resident was severely impaired for daily decision making. A progress note for Resident C, dated 8/15/24 at 4:52 a.m., indicated resident fell in the hallway, had possible injuries, and notification completed to the family, the Assistant Director of Nursing (ADON), the DON, and the Administrator. The progress note was electronically signed by LPN 13. A progress note, dated 8/15/24 at 4:54 a.m., indicated resident left the facility via stretcher. The progress note was electronically signed by LPN 13. A progress note, dated 8/15/24 at 9:00 a.m., indicated the following, This was not a fall. Resident did not cause fall. Resident fell to the ground due to an outside force. The progress note was electronically signed by the DON. A progress note for Resident C, dated 8/15/24 at 9:22 a.m., indicated the resident was admitted to the hospital. The resident did not have a fracture but did have something going on with his hip and would be evaluated. A progress note, dated 8/15/24 at 12:55 p.m., indicated the resident returned from the hospital. A progress note for Resident C, dated 8/15/24 at 2:30 p.m., indicated the resident could not sleep and was wandering in the hallway towards another resident's room and the other resident slammed her door. It surprised Resident C and he fell . The resident was sent to the hospital and returned with no fracture. Resident C had no complaints when he returned, but did opt to say in bed for a while. The progress note was electronically signed by the Social Worker. A progress note for Resident C, dated 8/16/24 at 5:42 a.m., indicated the resident had bruising to the right hip and was guarding the right hip. No further documentation regarding fall follow up was noted in the clinical record. During an interview with the DON on 9/4/24 at 4:06 p.m., she indicated the nurse was responsible to complete fall assessments and follow up for Resident C. The IDT did not complete a root cause of Resident C's fall because it was not considered a fall. Resident B slammed her door causing Resident C to fall. It was from an outside source and the door caused Resident C to fall. The DON indicated Resident B had not been physically aggressive towards other residents, there had been assumptions that she had been, but no witness of physical abuse. This citation relates to Complaints IN00442039, IN00442082 & IN00442125. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-45(a)(1) 3.1-45(a)(2)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. 25054 Based on observation, interview, and record review, the facility failed to monitor and supervise a resident with dementia resulting in the potential for resident-to-resident interaction and failed to monitor and supervise residents on the memory care unit, assess residents, conduct follow-up, and notify family and the physician of inappropriate sexual contact between two residents for 4 of 13 residents reviewed for abuse. (Resident N, Resident P, Resident K and Resident L) Findings include: 1a. Review of the clinical record of Resident N, on 9/5/24 at 1:34 p.m., indicated the diagnoses included, but were not limited to, schizoaffective disorder, osteoarthritis, major depressive disorder and insomnia. The quarterly Minimum Data Set (MDS) assessment for Resident N, dated 6/14/24, indicated the resident was cognitively intact for daily decision making. 1b. Review of the clinical record of Resident P, on 9/5/24 at 1:55 p.m., indicated the diagnoses included, but were not limited to, dementia, weakness, need for personal care, unsteadiness on feet, chronic obstructive pulmonary disease, Alzheimer's disease, anxiety, major depressive disorder and insomnia. A significant change MDS assessment for Resident P, dated 7/15/24, indicated the resident was moderately impaired for daily decision making. The resident had little interest or pleasure, feeling down, depressed or hopeless for the last 2-6 days (several days). A care plan, dated 7/26/24, indicated Resident P required medication related to Alzheimer's/dementia. A care plan, dated 9/3/24, indicated Resident P was at risk for psychosocial well-being problem related to a male resident allegedly coming into her room and touched her inappropriately. The interventions included, but were not limited to, male placed on 1 to 1 staff observation. During an interview with Certified Nursing Assistant (CNA) 9 on 9/3/24 at 1:55 p.m., they indicated Resident N went into Resident P's room and sexually abused her. CNA 9 did not witness this but was told about it from another staff member. During an interview with the Administrator on 9/3/24 at 2:32 p.m., he indicated, on 9/2/24 during third shift, Qualified Medication Aide (QMA) 10 reported to Registered Nurse (RN) 11 that Resident N reported to QMA 10 that he had entered Resident P's room and touched her genitalia. RN 11 reported the incident to the Administrator and called the police. RN 11 assessed Resident P and there were no findings. Resident N was placed on one to one with staff. This was an ongoing investigation. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview with Resident N on 9/4/24 at 9:57 a.m., he indicated, on 9/2/24, Resident P asked him (Resident N) to come into her room. Resident P then pulled her nightgown up and exposed the lower part of her body. Resident N held Resident P's hand and there was no physical contact besides holding hands. Resident N was observed to be on one to one with staff and was ambulating independently. During an observation and interview with Resident P on 9/5/24 at 11:08 a.m., the resident was lying in bed eating grapes. The resident indicated she was doing so so today. During an interview with Resident P's family on 9/5/24 at 11:13 a.m., they indicated, on 9/2/24 early in the morning, she was awakened by the police knocking at her door. The Police reported that another resident had entered her family member's room and touched her inappropriately. The police reported there was no visible trauma to the outside of her body. The family indicated her family member was bed ridden and was unable to stand or walk. She was totally dependent on staff for all care. The family member indicated she prays her family member did not remember the incident. The family member worried had this occurred before or will it occur again. The family member told the Administrator the facility needed to protect her family member. During an observation of the facility's camera with the Administrator on 9/4/24 at 11:59 a.m., Resident N walked into Resident P's room, on 9/2/24 at 12:11 a.m., and left Resident P's room at 12:14 a.m. Resident N returned into Resident P's room again, at 12:15 a.m. RN 11 came down the hallway and stopped at Resident P's room and Resident N came out of the room at 12:18 a.m. 50436 2a. The clinical record for Resident K was reviewed on 9/4/24 at 1:37 p.m. The diagnoses included, but were not limited to, unspecified dementia, cognitive communication deficit, cardiovascular disease, and hypertension. An admission MDS assessment, dated 7/1/24, indicated Resident K had severe cognitive impairment. Resident K exhibited other behavioral symptoms not directed towards others one to three days during the lookback period. A care plan for behaviors, initiated on 9/4/24, indicated Resident K had a behavior problem related to assisting other residents in their wheelchairs, rubbing arms, holding hands of others in a consoling manner, and a history of kissing other female residents. The interventions included, but were not limited to, the following: - Assist resident to develop more appropriate methods of coping and interacting with others. - Encourage resident to express feelings appropriately. - Intervene, as necessary, to protect the rights and safety of others. - Divert attention, remove from situation, and take to alternate location as needed. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A care plan for behaviors/agitation, initiated on 9/4/24, indicated Resident K had the potential to demonstrate physical behaviors and agitation at times related to dementia and poor impulse control. Resident K had a history of exhibiting verbal and physical aggression towards staff and redirection would be attempted. The interventions included, but were not limited to, the following: - Intervene before agitation escalates. - Guide away from source of distress. - Monitor, document, and report to physician of danger to self and others. A nurses note for Resident K, dated 8/10/24 at 3:36 p.m., indicated, Aide reported that resident was found in another residents room, kissing other resident. Nurse reported to DON [Director of Nursing]. Will keep residents separated. No further assessments or nurses' notes were documented following this incident. The next progress note for Resident K, dated 8/12/24 at 7:30 a.m., indicated, Resident left on an appointment with staff to Indianapolis. Family will meet him there. 2b. The clinical record for Resident L reviewed, on 9/4/24 at 3:50 p.m., indicated diagnoses included, but were not limited to, Alzheimer's disease, major depressive disorder, anxiety, hypertension, and paranoid personality disorder. A quarterly MDS assessment, dated 6/29/24, indicated Resident L was mildly cognitively impaired. A nurses note for Resident L, dated 8/10/24 at 3:35 p.m., indicated, aid reported resident [Resident L] was in her room kissing another resident. this resident's shirt was lifted up on her stomach. this nurse reported to DON [Director of Nursing]. will keep residents separated at this time. No further assessments or nurses' notes were documented following the incident. The next progress note was a psychiatry follow up note dated 8/27/24. During an interview with Licensed Practical Nurse (LPN) 3 on 9/4/24 at 11:45 a.m., they indicated Resident K's wife had passed away not long ago and he was known to get a little close to the female residents and was looking for companionship. During an interview with LPN 7 on 9/4/24 at 4:00 p.m., she indicated she was told by CNA 8, Resident K was in Resident L's room kissing her and had her shirt up. LPN 7 reported incident to the DON. The DON had her and CNA 8 fill out incident reports. LPN 7 indicated they did not remember contacting the family so they must have forgotten. During an interview with CNA 8 on 9/4/24 at 4:40 p.m., indicated they saw Resident K kissing Resident L's hand as they passed by the room. Resident L's shirt was up. The bottom half of her breast was exposed, but Resident K was not touching her. Resident K just had Resident L's hand and was kissing it. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155490	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ambassador Healthcare	705 E Main St Centerville, IN 47330

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DON on 9/5/24 at 12:05 p.m., she indicated she did not think it was pertinent to do assessments on Resident L after the incident because they were separated, and Resident K was placed on fifteen-minute checks. The DON indicated it was the nurse's responsibility to ensure assessments were completed on Resident K and Resident L. The DON indicated it was social services responsibility for implementing interventions to prevent sexually inappropriate behaviors for Resident K. A facility assessment, undated, provided by the DON, on 9/5/24 at 2:52 p.m., indicated the following, . Services of Care We Offer Based on our Resident's needs .identify and treat new or worsening behaviors, search for root cause This citation relates to Complaints IN00442082, IN00442125, and IN00442039. 3.1-37(a)