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	ALC000351	A. BUILDING B. WING	02/26/2025

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{L 0000}	Initial Comments. >>>>The purpose of this visit was to investigate intake # GA0050001358, GA50001359, and GA50001454. An onsite visit was made to the facility on 2/11/25. The investigation was started on 2/10/25 and was completed on 2/20/25.
{L 0711} SS= J	111-8-63-.07(2)(j) Owner Governance. At a minimum, the policies and procedures that are developed must provide direction for the staff and residents on the following: ... (j) the investigation and reporting of abuse, neglect, exploitation of residents, residents' wandering away from the community, accidents, injuries and changes in residents' conditions to required parties; ... This REQUIREMENT is not met as evidenced by: ****>>>>Based on record review and interview, the governing body failed to implement policies, procedures and practices in the community that support the core values of dignity, respect, choice, independence and privacy of the residents in a safe environment and in according with these rules including the safety and security precautions that would be employed by the home to protect residents from harm by other individuals not employed by the home who routinely come into the home. Findings include: A review of the facility incident report (FIR) submitted to the Dept by the

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	facility on 1/30/25, showed documentation that an agency caregiver was captured on facility video footage physically assaulting Resident #1 (R1) on 1/5/25 at 11:22 p.m. The FIR detailed that the executive director was notified on 1/28/25 by the family member of (R1) that (R1) died in the hospital and the cause of death was due to blunt force trauma to the head. The executive director reviewed video footage from the 1/5/25 incident after receiving notification from the family member of the cause of death of R1. The FIR revealed that the executive director had not previously searched the video footage, as the preliminary incident notes showed documentation of a different explanation for R1's injury. The preliminary incident report findings showed that on the day of the incident R1 was being combative with staff, lost his/her balance and fell when he/she tried to hit a staff member. A review of the facility video footage on 02/11/2025 at 1:22 p.m., R1 can be seen walking calmly down the hallway with no socks or shoes on. R1 displayed no signs of aggression. R1 was seen on the video going into another resident's bedroom and Agency Staff (AS) caregiver can be seen coming down the hallway going into the same room as R1. A shuffling noise is heard, and R1 is seen stumbling out of the room. R1 takes his right arm and swipes at AS. Then, AS blocks the swipe with his left arm and takes his/her closed right hand fist and forcefully punches R1 to the left side of the face causing R1 to fall to the floor in a fetal position. R1 lies still on the floor for about 10 minutes. Then AS stands over Resident#1 for about 2-3 minutes, and then goes to get Staff C and Staff D. Staff C approaches R1, who is still lying on the floor. R1 shifts his/her body, and a pooling of blood is visible on the floor where his/her head was resting. Staff C goes to call 911 while Staff B retrieves a pillow and places it under R1 for head support. R1 begins to move around on the floor and changes position to his/her stomach. Blood is seen on the floor, and on his/her arm. The video footage is twenty-three (23) minutes long. The emergency medical technicians (EMT) had not arrived prior to the video ending.

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	A review of the police report (PR) showed documentation on 1/29/25 at 16:05 p.m., of an assault that occurred on 1/5/25 at 11:15 p.m., between AS and Resident #1. The PR listed offenses included battery and exploitation of elderly or disabled person. Staff A reported that facility management learned of an assault incident between a nursing assistant (Agency Staff caregiver -AS) and a resident/patient (R1) that occurred at around 2320 hours (military time 11:20 p.m.) on 1/5/25. The PR showed the incident was originally reported internally as a fall and that the 82-year-old resident was transported to the hospital via ambulance for further evaluation and treatment. Staff A further reported that the facility has since learned that R1 was said to have passed away on 1/17/25, and upon viewing the footage of the incident, he/she observed that an assault occurred when AS struck R1 with a hand or fist, causing R1 to fall to the floor outside of room #314. A review of the facility abuse policy on 02/11/2025, showed all employees would receive training on the Long-Term Care Facility Resident Abuse Reporting Act. Policy showed that any employee who has knowledge that a resident or former resident has been abused or exploited while residing in their facility shall immediately report this to the Executive Director or Resident Services Director. A review of the facility's standards of conduct: disruptive behavior policy showed all team members are always expected to conduct themselves in a professional manner when in the workplace, treating residents served with dignity and respect. Team members who engage in disruptive behavior would be subject to disciplinary action, up to and including termination. A review of the file showed Resident #1 (R1) was admitted 1/02/2025 with diagnoses of unspecified dementia, severe, with anxiety. The physician's medical evaluation (PME) form dated 12/31/24 showed diagnosis of dementia, and that R1 required around the clock supervision when his/her spouse was not

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present. R1 was oriented to person, was incontinent, required full assistance with bathing, grooming, dressing, continence, redirection/reassurance, medication administration, had short term and long-term memory impairment, and was a high fall risk.

A review of facility incident report (FIR) dated 1/4/25 at 5:40 AM, RA called med tech to assist with calming R1 down, as R1 was agitated and tried to hit staff and go into another resident's room. Furthermore, the facility note showed that the doctor, manager on duty (MOD) and family member were called and notified of the incident. FIR dated 1/5/25 at 5:24 PM initially detailed the incident in the following sequence of events: R1 punched staff, R1 entered another resident's room, staff tried to redirect R1 out of room to dining room for dinner, and R1 proceeded to turn around and threaten to punch staff. As staff was backing up R1 punched staff in the chest and when staff turned R1 punched staff in the middle of his/her back. Staff was unable to redirect R1 after incident and R1 wandered around the memory care unit.

A review of the file for the AS showed no documentation of training in resident population: dementia/Alzheimer's, abuse, neglect and exploitation, residents rights, nor a physical examination or tuberculosis screening. GCHEXS roster showed no documentation of a criminal background check. Further review of the file showed AS began working in the facility on 9/28/24.

A review of the staff schedule on 01/05/2025, showed AS worked on the Memory Care Unit from 11:00 p.m.-7:00 a.m. Further review of the facility schedule from 9/2024 through 1/2025 showed AS worked in the facility on the following dates and times: 9/28/24 from 11:00 p.m. to 7:00 a.m., 10/4/24 from 3:00 p.m. to 7:00 a.m., 10/6/24 from 3:00 p.m. to 7:00 a.m., 11/28/24 from 7:00 a.m. to 3:00 p.m., 11/30/24 from 3:00 p.m. to 11:00 a.m. 1/3/25 from 11:00 p.m. to 7:00 a.m., and on 1/6/25 from 3:00 p.m. to 11:00 p.m.

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	During an interview on 02/10/25 at 4:20 p.m., AS stated that he/she worked for a medical staffing agency. AS stated, that on 01/05/2025, only he/she was working with Staff C and Staff D. AS stated that Resident #1 was walking down the hallway towards another resident's room. AS stated, that Resident #1 became aggressive and struck her/him in the eye. AS stated, that Resident #1 lost his/her balance and fell backwards into the hallway. AS stated, that he/she reported the fall to Staff C. Staff C assessed Resident #1 and called the ambulance. AS stated, facility (where the incident occurred) did not provide him/her training. AS stated, he/she started working in the facility in 2023 (prior to change of ownership), that the facility does not train staff to work in the facility, and when he/she started they only gave him/her a run-down of the residents that require one-to-one supervision or a higher level of care. During an interview on 02/20/2025 at 1:05 p.m., AS stated that after Resident#1 struck him/her in the eye the first time, Resident#1 tried to strike him/her again, but he/she blocked the punch. AS stated, that he/she never hit Resdient#1. During an interview on 02/13/2025 between 3:49 p.m. and 4:28 p.m., Staff A stated that there was no formal training for agency staff, and that there was only observation training, showing the agency staff the evacuation plan. On 2/19/25 at 2:13 PM, Staff A stated that AS was allowed to work in the facility because the contract that the facility had with the staffing agency required the agency to verify that staff are trained. Staff A stated he/she was aware that AS did not have the criminal background check, physical examination, tuberculosis screening, and memory care training in the file, but because of the agreement with the staffing agency, he/she felt AS had the training even though it was not in his/her file. During an interview on 02/13/2025 at 11:22 a.m., Staff D stated that he/she was working third shift with AS and Staff C. Staff D stated that AS asked him/her for help with Resident#1. According to Staff D, AS described the incident as an

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	impulse reflex leading to Resident#1 falling on the floor. Staff D said he/she never saw the incident/fall. Staff D reported the incident to Staff C as per the established protocol. Staff D stated that he/she went to go help another resident in the unit. Staff D stated that usually there is only one med tech for the entire memory care unit and two aides, one for each unit. Staff D stated that he/she never talked to Staff A to give a statement of what happened on the night of the incident. Staff D reported that later 02/05/2025, she was told by Staff A that he/she was suspended and was not allowed to come to the facility. On 02/20/2025 at 12:44 p.m., Staff D stated that AS is a resident's aide. Staff D stated that they have the same title and AS has previously worked in the facility before, so he/she is trained in basic skills and is not supervised by facility aides. During an interview on 2/19/25 at 1:30 PM, Staff C stated on the night of the incident, he/she was reviewed morning medications when AS came over to the cart and stated R1 hit him/her in the eye. Staff C stated AS stated he/she played his/her defenses and R1 fell. Staff C stated he/she believed that when Staff C stated he/she was playing his/her defenses, he/she meant that he/she (AS) blocked R1 from hitting him and R1 fell. Staff C stated that AS said that R1 fell. Staff C stated he/she went to R1, stood over him/her and aroused R1 to see if he/she was alert and oriented and that R1 was alert and oriented. Staff C stated he/she called the manager on duty (MOD) and was informed the check vitals and call EMT's. Staff C stated he/she called 911 for EMS, checked R1's vitals conducted a skin assessment and wrote an incident report. Staff C stated he/she checked R1's blood pressure, pulse, and that R1 would not allow him/her to check his/her range of motion. Staff C stated in the midst of checking R1's vitals, he/she had another resident that had a fall. Staff C stated he/she did not witness the incident between AS and R1. Staff C stated he/she was not trained to handle such incident. Staff C stated his/her training consisted of a one-day observation of another med-tech on medications and medication administration.

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	Cross reference TAG 1922 -as it relates to the governing body's failure to provide the oversight to ensure that the memory care unit was staffed with specially trained staff to meet the needs of residents with memory impairments. Cross reference TAG 0925 - as it relates to the governing body's failure to provide the oversight to ensure that direct access caregivers received criminal background checks. Cross reference TAG 1928 -as it relates to the governing body's failure to provide the oversight to ensure that staff working in the memory care unit received required training. Cross reference TAG 2512 -as it related the governing body's failure to ensure to provide oversight to ensure residents remained free of physical abuse.
{L 0925} SS= J	111-8-63-.09(12) Criminal History Background Checks- Employees Criminal History Background Checks for Direct Access Employees Required. Prior to serving as a direct access employee, the community must obtain a satisfactory fingerprint records check determination for the person to be hired in compliance with the Rules and Regulations for Criminal Background Checks, Chapter 111-8-12. This REQUIREMENT is not met as evidenced by: ****>>>>Based on observation and interview, the community failed to obtain a criminal history background check for direct access employees. Findings include: A review of file for AS, an agency direct caregiver, assigned to work the Memory Care Unit on 1/5/25, showed no documentation of a criminal background check.

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	A review of the facility video footage on 02/11/2025 at 1:22 p.m., R1 can be seen walking calmly down the hallway with no socks or shoes on. R1 displayed no signs of aggression. R1 was seen on the video going into another resident's bedroom and AS can be seen coming down the hallway going into the same room as R1. A shuffling noise is heard, and R1 is seen stumbling out of the room. R1 takes his right arm and swipes at AS. Then, AS blocks the swipe with his left arm and takes his/her closed right hand fist and forcefully punches R1 to the left side of the face causing R1 to fall to the floor in a fetal position. R1 lies still on the floor for about 10 minutes. Then AS stands over Resident#1 for about 2-3 minutes, and then goes to get Staff C and Staff D. Staff C approaches R1, who is still lying on the floor. R1 shifts his/her body, and a pooling of blood is visible on the floor where his/her head was resting. Staff C goes to call 911 while Staff B retrieves a pillow and places it under R1 for head support. R1 begins to move around on the floor and changes position to his/her stomach. Blood is seen on the floor, and on his/her arm. The video footage is twenty-three (23) minutes long. The emergency medical technicians (EMT) had not arrived prior to the video ending A review of the police report (PR) showed a report date of 1/29/25 at 16:05PM for an assault. Occurred date of assault showed 1/5/25 at 11:15PM. PR showed offenses as battery and exploitation of elderly or disabled person. Subject was Staff B and Resident #1. PR narrative showed on 1/29/25 at 1605, DD responded to the facility in reference to a past assault. Staff A stated to DD that management learned of an assault incident between a nursing assistant (Staff B) and a resident/patient (R1) that occurred at around 2320 hours on 1/5/25. PR showed the incident was originally reported internally as a fall and that the 82-year-old resident/patient was transported to the hospital via ambulance for treatment. PR showed Staff A stated the facility has since learned that R1 was said to have passed away on 1/17/25, and upon viewing the footage of the

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incident, he/she observed that an assault occurred which Staff B struck R1 with a hand or fist, causing R1 to fall outside of room #314. PR showed Staff B was no longer working at the facility and that he/she was temp who was hired or placed through a contracting staffing agency. PR showed EMS responded to the facility on 1/5/25 at 2346 hours in reference to R1. Police report showed no documentation of charges or arrest.

A review of facility incident report (FIR) dated 1/4/25 at 5:40 AM, RA called med tech to assist with calming R1 down, as R1 was agitated and tried to hit staff and go into another resident's room. Note showed doctor, manager on duty (MOD) and family member was called. FIR dated 1/5/25 at 5:24 PM showed R1 punched staff, R1 entered another resident's room, staff tried to redirect R1 out of room to dining room for dinner, and R1 proceeded to turn around and threaten to punch staff. As staff was backing up R1 punched staff in the chest and when staff turned R1 punched staff in the middle of his/her back. Staff was unable to redirect R1 after incident and R1 wandered around the neighborhood, Staff was able to redirect R1 to dinner.

During an interview on 02/11/2025 at 12:00 p.m., Staff A stated that he/she did not run a criminal background check on AS because it was the staffing agency's responsibility to conduct a criminal background check. On 2/19/25 at 2:13 PM, Staff A stated that AS was allowed to work in the facility due to the contract that they had with the staffing agency verifying that agency staff are trained. Staff A stated he/she was aware that AS did not have the criminal background check, physical examination, tuberculosis screening, and memory care training in the file, but because of the agreement with the staffing agency, he/she felt AS had the training even though it was not in his/her file.

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{L 1922} SS= J	111-8-63-.19(1)(c) Staffing Requirements. Staffing Requirements. The assisted living community must ensure that the memory care center is staffed with sufficient specially trained staff to meet the unique needs of the residents in the center. This REQUIREMENT is not met as evidenced by: ****>>>>Based on record and interview, the community failed to ensure that the contained memory care unit was staffed with sufficient specially trained staff to meet the unique needs of the residents in the unit for 2 of 2 sampled direct caregivers (AS and Staff C). Findings include: A review of the facility incident report (FIR) submitted to the Dept on 1/30/25 showed documentation that an agency direct caregiver was captured on video footage physically assaulting R1 on 1/5/25 at 11:22 PM. R1 died on 1/17/25 as a result of blunt force trauma to his/her head. On 1/5/25, AS, an agency direct caregiver, was assigned to work in the Memory Care Unit. A review of file for AS showed no documentation of the following training: 1. The assisted living community's philosophy related to the care of residents with dementia in the unit 2. The assisted living community's policies and procedures related to care in the unit and the staff's particular responsibilities including wandering and egress control 3. An introduction to common behavior problems characteristic of residents residing in the unit and recommended behavior management and techniques. 4. Evacuation procedure training

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	5. Resident Population training 6. Resident Rights training 7. Abuse, neglect, and exploitation training 8. Infection Control training 9. Employment history 10. Physical Exam 11. Tuberculosis Test 12. Satisfactory Criminal Record check A review of file for Staff C, hired 12/14/24 showed no documentation of the following training: 1. Evacuation procedure training 2. Resident Population training 3. Resident Rights training 4. Abuse, neglect, and exploitation training 5. Infection Control training During an interview on 2/10/25 at 4:20 p.m., AS stated that he/she worked for a medical staffing agency and that the facility did not provide him/her training. Staff B stated he/she started taking work assignments in the facility in 2023, and that the facility staff only gave him/her general information on the residents that required one-to-one supervision or a higher level of care. On 2/20/25, AS stated that he/she had prior basic nursing skills knowledge, he/she is a certified nursing aide. AS stated, that he/she never received any training directly from the facility. A review of the staff schedule on 01/05/2025, showed documentation that AS worked on the Memory Care Unit from 11:00 p.m.-7:00 a.m. Further review of the facility schedule from 9/2024 through 1/2025 showed AS worked in the facility on the following dates and times: 9/28/24 from 11:00 p.m. to 7:00 a.m., 10/4/24

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	from 3:00 p.m. to 7:00 a.m., 10/6/24 from 3:00 p.m. to 7:00 a.m., 11/28/24 from 7:00 a.m. to 3:00 p.m., 11/30/24 from 3:00 p.m. to 11:00 a.m. 1/3/25 from 11:00 p.m. to 7:00 a.m., and on 1/6/25 from 3:00 p.m. to 11:00 p.m. During an interview on 02/11/2025 at 12:00 p.m., Staff A stated that it was the responsibility of the staffing agency to make sure that AS was trained, and a criminal background check was conducted. Staff A did not offer an explanation as to why the facility chose to staff the contained memory care unit with an agency staff caregiver who had not received special memory care training. Staff A stated that he/she was not sure why Staff C had not completed trainings. During an interview on 2/19/25 at 1:30 p.m., Staff C stated he/she was not trained to handle resident care service incidents similar to the incident involving R1 that occurred on 1/5/25. Staff C further stated that his/her training consisted of a one-day observation with another med-tech on medications and medication administration.
{L 1928} SS= J	111-8-63-.19(1)(d)1. Staff Training. The memory care center shall meet the following training requirements: Within the first six months of employment, staff assigned to the unit shall receive training in the following topics: (i) General Orientation. All staff, regardless of role, shall receive at least four (4) hours of dementia-specific orientation within the first thirty (30) days of working in the center. Such orientation shall include: (A) Basic information about the nature, progression, and management of Alzheimer's and other

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	dementias; (B) Techniques for creating an environment that minimizes challenging behavior from residents with Alzheimer's and other dementias; (C) Methods of identifying and minimizing safety risks to residents with Alzheimer's and other dementias; and (D) Techniques for successful communication with individuals with Alzheimer's and other dementias. This REQUIREMENT is not met as evidenced by: ****>>>>Based on record review and interview, the community failed to ensure that all staff are properly trained initially and on an annual basis to provide safe, quality care to residents in memory care center. Findings include: A review of the facility incident report (FIR) submitted to the Dept on 1/30/25 showed documentation that an agency direct caregiver was captured on video footage physically assaulting R1 on 1/5/25 at 11:22 PM. The FIR showed that on 1/28/25, ED (Staff A) reviewed video footage from the 1/5/25 incident after receiving a message from the family member of R1 that the cause of Resident #1's (R1) demise was blunt force trauma to the head. A review of the file for AS, and Staff C hired 12/14/24 showed no documentation of training in dementia-specific orientation. A review of the staff schedule on 01/05/2025, showed the agency direct caregiver (AS) and Staff C worked from 11:00 p.m.-7:00 a.m. Further review of the facility schedule from 9/28/2024 through 1/2025 showed AS worked the following dates and times: 9/28/24 from 11 PM to 7 AM, 10/4/24 from 3PM to 7AM, 10/6/24 from 3PM to 7AM, 11/28/24 from 7AM to 3PM, 11/30/24 from 3PM to 11AM, 1/3/25 from 11PM to 7AM, and on 1/6/25 from 3PM to 11AM. During an interview on 02/10/25 at 4:20 p.m., AS stated that he/she worked for a

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	medical staffing agency and that the facility did not provide him/her training. AS stated, he/she began to take work assignments in the facility in 2023. AS further stated, that when he/she started he/she was only given a general overview of the residents that required one-to-one supervision or a higher level of care. During an interview on 2/19/25 at 1:30 PM, Staff C stated he/she was not trained to handle the incident that occurred that night. Staff C stated his/her training consisted of a one-day observation with another med-tech on medications and medication administration. During an interview on 02/13/2025 between 3:49 p.m. and 4:28 p.m., Staff A stated that there was no formal training for agency staff. Staff A stated that there was an observation training, showing the agency staff the evacuation plan. On 2/19/25 at 2:13 PM, Staff A stated that AS was allowed to work in the facility due to the contract the facility had with staffing agency verifying that agency staff are trained. Staff A stated he/she was aware that AS did not have the criminal background check, physical examination, tuberculosis screening, and memory care training in the file, but because of the agreement with the staffing agency he/she felt AS had the training even though it was not in his/her file.

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{L 2512} SS= J	111-8-63-.25(1)(i) Supporting Residents' Rights. Each resident must have the right to be free from mental, verbal, sexual and physical abuse, neglect and exploitation. This REQUIREMENT is not met as evidenced by: ****>>>>Based on observation, record review and interview, the assisted living community failed to ensure that each resident was free from physical abuse for 1 of 1 resident (Resident #1). Findings include: A review of the facility incident report (FIR) submitted to the Department on 1/30/25, showed documentation that AS, an agency caregiver, was captured on facility video footage physically assaulting Resident #1 (R1) on 1/5/25 at 11:22 p.m. The FIR detailed that the executive director was notified on 1/28/25 by the family member of (R1) that (R1) died in the hospital and the cause of death was due to blunt force trauma to the head. The executive director reviewed video footage from the 1/5/25 incident after receiving notification from the family member of the cause of death of R1. The FIR revealed that the executive director had not previously searched the video footage, as the preliminary incident notes showed documentation of a different explanation for R1's injury. The preliminary incident report findings showed that on the day of the incident R1 was being combative with staff, lost his/her balance and fell when he/she tried to hit a staff member. R1 was taken to the hospital immediately after the fall. The FIR showed R1’s health continued to deteriorate, and the family reported that R1 died in the hospital on 1/17/25. A view of the facility video footage on 02/11/2025 at 1:22 p.m., showed R1 walking calmly down the hallway without wearing socks or shoes and showing no

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signs of aggression. R1 was seen on the video going into a room and AS can be seen coming down the hallway going into the same room as R1. A shuffling noise is heard, and R1 is seen stumbling out of the room. R1 takes his right arm and swipes at AS. AS blocks the swipe with his left arm and takes his/her closed right hand fist and forcefully punches R1 to the left side of the face causing R1 to fall to the floor in a fetal position. R1 lies still on the floor for about 10 minutes. AS stands over Resident#1 for about 2-3 minutes, and then goes to get Staff C and Staff D. Staff C approaches R1, who is still lying on the floor. R1 shifts his/her body, and a pool of blood is visible on the floor where his/her head was resting. Staff C goes to call 911 while AS retrieves a pillow and places it under R1 for head support. R1 begins to move around on the floor and changes position to his/her stomach. Blood is seen on the floor, and on his/her arm. The video footage is twenty-three (23) minutes long. The emergency medical technicians (EMT) had not arrived prior to the video ending.

A review of the resident file showed Resident #1 (R1) was admitted 1/02/2025 with diagnoses that included unspecified dementia, severe, with anxiety. The physician's medical evaluation (PME) form dated 12/31/24 showed diagnoses of dementia, no physical limitations, and that R1 required around the clock supervision.

A review of the staff schedule dated 1/05/2025, showed AS worked on the Memory Care Unit from 11:00 p.m. to 7:00 a.m. Further review of the facility schedule from 9/2024 through 1/2025 showed AS worked in the facility on the following dates and times: 9/28/24 from 11:00 p.m. to 7:00 a.m., 10/4/24 from 3:00 a.m. to 7:00 a.m., 10/6/24 from 3:00 p.m. to 7:00 a.m., 11/28/24 from 7:00 a.m. to 3:00 p.m., 11/30/24 from 3:00 p.m. to 11:00 a.m., 1/3/25 from 11:00 p.m. to 7:00 a.m., and on 1/6/25 from 3:00 p.m. to 11:00 a.m.

During an interview on 02/10/25 at 4:20 p.m., AS stated that he/she worked for a medical staffing agency. AS stated that on 1/05/2025, he/she worked with Staff

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C and Staff D. AS stated that R1 was walking down the hallway towards another resident's room. AS stated that R1 became aggressive and struck her/him in the eye. AS stated that R1 lost his/her balance and fell backwards into the hallway. AS stated that he/she reported the fall to Staff C. Staff C assessed R1 and called the ambulance. AS stated the facility staff did not provide him/her training.

During an interview on 2/13/2025 at 11:22 a.m., Staff D stated that he/she worked the third shift with AS and Staff C. Staff D stated that AS asked him/her for help with Resident#1. According to Staff D, AS said R1 hit him/her in the eye. Staff D stated that AS told him/her that R1 went to hit him/her again and he/she blocked the punch, R1 lost his/her balance and fell on the floor. Staff D reported the incident to Staff C as per the established protocol. Staff D stated that he/she did not see the incident between AS and Resident#1. Staff D stated that he/she went to go help another resident in the unit. Staff D stated that she never talked to Staff A to give a statement of what happened on the night of the incident. Staff D stated that on 2/05/2025, she was told by Staff A that she was suspended and was not allowed to come to the facility. On 02/20/2025 at 12:44 p.m., Staff D stated that AS never said he/she hit Resident#1.

During an interview on 2/19/25 at 1:30 PM, Staff C stated on the night of the incident, he/she was reviewing morning medications when AS came over to the cart and stated R1 hit him in the eye. Staff C stated AS stated he/she played his/her defenses and R1 fell. Staff C stated she did not see the incident between AS and R1. Staff C stated he/she believed that when Staff C stated he/she was playing his/her defenses, he/she meant that he/she (AS) blocked R1 from hitting him and R1 fell.

A review of the police report (PR) showed the date of an assault on 1/5/25 at 11:15PM. The PR showed offenses as battery and exploitation of elderly or

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	disabled person. The subjects involved in the incident were AS (agency staff direct caregiver) and Resident #1. The PR narrative showed on 1/29/25 at 1605, law enforcement (LE) responded to the facility in reference to a past assault. Staff A stated to LE that management learned of an assault incident between a nursing assistant (AS) and a resident/patient (R1) that occurred at around 2320 hours on 1/5/25. PR showed the incident was originally reported internally as a fall and that the 82-year-old resident was transported to the hospital via ambulance for treatment. PR showed Staff A stated the facility has since learned that R1 was said to have passed away on 1/17/25, and upon viewing the footage of the incident, he/she observed that an assault occurred when AS struck R1 with a hand or fist, causing R1 to fall outside of room #314. PR showed AS was no longer working at the facility and that he/she was a temporary worker who was hired or placed through a contracting staffing agency. PR showed EMS responded to the facility on 1/5/25 at 2346 hours in reference to R1. A review of the hospital discharge summary showed documentation that R1 presented to the hospital on 1/6/25 after sustaining a fall at the facility. He/she was diagnosed with a right-side intracranial hemorrhage and was treated in the intensive care unit. However, R1's condition continued to decline and ultimately was made do not resuscitate (DNR) with comfort care. R1 passed away eleven (11) days after being hospitalized on 1/17/25. A review of the coroner's death certificate showed documentation that R1 was declared deceased on 1/17/25 and the cause of death was listed as follows: Immediate cause of death - intracranial hemorrhage due to, or as a consequence of blunt force head trauma; due to, or as a consequence of ground level fall; due to, or as a consequence of struck in the face by another.

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{L 3003} SS= D	111-8-63-.30(2)(b) Reports to the Department. The serious incidents that must be reported to the Department include the following: ... (b) any serious injury to a resident that requires medical attention; ... This REQUIREMENT is not met as evidenced by: >>>>Based on record review and interview, the facility failed to report whenever a serious incident involving a resident occurs, the assisted living community must report in a format acceptable to the Department within 24 hours after the incident has occurred when any serious injury to a resident that requires medical attention for one resident (Resident #1). Findings include: A review of the facility incident report (FIR) submitted to the Dept by the facility on 1/30/25, showed documentation that AS, an agency caregiver, was captured on facility video footage physically assaulting Resident #1 (R1) on 1/5/25 at 11:22 p.m. The FIR detailed that the executive director was notified on 1/28/25 by the family member of (R1) that (R1) died in the hospital and the cause of death was due to blunt force trauma to the head. The executive director reviewed video footage from the 1/5/25 incident after receiving notification from the family member of the cause of death of R1. The FIR revealed that the executive director had not previously searched the video footage, as the preliminary incident notes showed documentation of a different explanation for R1's injury. The preliminary incident report findings showed that on the day of the incident R1 was being combative with staff, lost his/her balance and fell when he/she tried to hit a staff member. R1 was taken to the hospital immediately after the fall. The FIR showed R1’s health continued to deteriorate, and the family reported that R1 died in the hospital on 1/17/25.

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	During an interview on 02/26/2025 at 10:20 a.m., Staff A provided no explanation for not reporting to the Department prior to 1/30/25, notification of Resident#1 being sent to the hospital for a fall incident on 01/05/2025 and Resident #1's death. According to Staff A, he/she was informed by the family member of Resident #1 on 1/28/25 that Resident #1 had died on 1/17/25.