

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155153	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/17/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTHWIN	STREET ADDRESS, CITY, STATE, ZIP CODE 20531 DARDEN RD SOUTH BEND, IN46637
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F0000	<p>This visit was for the Investigation of Complaint IN00099651.</p> <p>Complaint IN00099651 - Substantiated. Federal/state deficiencies related to the allegation are cited at F223.</p> <p>Survey date: November 17, 2011</p> <p>Facility number: 000073 Provider number: 155153 AIM number: 100288820</p> <p>Survey team: Vicki Manuwal, RN-TC Bobbie Costigan, RN</p> <p>Census bed type: SNF/NF 133 Total 133</p> <p>Census payor type: Medicare 25 Medicaid 80 Other 28 Total 133</p> <p>Sample: 3</p> <p>Healthwin was found to be in substantial compliance with 42 CFR Part 483, Subpart B in regard to the Investigation</p>	F0000		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155153	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/17/2011
NAME OF PROVIDER OR SUPPLIER HEALTHWIN			STREET ADDRESS, CITY, STATE, ZIP CODE 20531 DARDEN RD SOUTH BEND, IN46637		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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	
F0223 SS=A	<p>of Complaint IN00099651. This state finding is cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 11/22/11 by Jennie Bartelt, RN.</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>Based on interviews and record reviews, the facility failed to protect residents from verbal abuse by facility staff for 1 of 3 residents reviewed for abuse in a sample of 3. (Resident #B)</p> <p>Findings include:</p> <p>A record review was completed for Resident #B on 11/17/11 at 11:47 a.m., and indicated diagnoses of, but not limited to, depression, severe dysphagia, hypertension, and anxiety.</p> <p>A report faxed to the Indiana State Department of Health dated 9/18/11 indicated, "...Incident Date 09/17/11 Incident Time 5:15 p.m....Brief Description of Incident (Name-CNA #12)</p>	F0223	<p>This plan of correction also represents the facility's allegation of compliance. The following combined plan of correction and allegations of compliance is submitted solely because it is required by law and is not an admission to any of the alleged deficiencies or violations.</p> <p>Furthermore, none of the actions taken in this plan of correction are an admission that additional steps should have or could have been taken by the facility to prevent the alleged deficiency. These steps are only included because a plan of correction is required by law.</p> <p>The facility was in compliance with all licensure and certification requirements at the time of the survey and disputes that any alleged deficiency or violation existed. The Administrator followed the Healthwin Policy</p>	12/06/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155153	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/17/2011
NAME OF PROVIDER OR SUPPLIER HEALTHWIN			STREET ADDRESS, CITY, STATE, ZIP CODE 20531 DARDEN RD SOUTH BEND, IN46637		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>CNA reported to the Nursing Supervisor, (Name-RN #13), RN that she witnessed CNA, (Name-CNA #14) say to resident, (Name-Resident #B), "You know you've got to hurry up, we cannot go to dinner without you two." (Name-CNA #14) turned to (Name-CNA #12) and stated "They're attached at the hips...like two lesbians." (Name-CNA #14) then walked down the hall and said out loud, "Do any of you want another girlfriend?" This statement was made by (Name-CNA #14) in reference to two residents that request to eat meals together in the Main Dining Room per the residents' choice. (Name-CNA #12) proceeded to assist the two residents to the Main Dining Room. (Name-Resident #B) asked (Name-CNA #12) on the elevator, "Did she say lesbians to me?" (Name-CNA #12) reassured (Name-Resident #B) this was inappropriate, assisted (Name-Resident #B) to the dining room, and contacted the Nursing Supervisor, (Name-RN #13), RN. Resident, (Name-Resident #B) reported to Nursing Supervisor upon supervisor's interview, that (Name-CNA #14) came to the Main Dining Room and stated to (Name-Resident #B) that (Name-Resident #B) should not report this because (Name-CNA #14) could lose her job. (Name-Resident #B) stated (Name-CNA #14) stated, "Don't report this, I don't want you to make me lose my job...."</p>		<p>titled Abuse-Suspected or Observed. Upon report, an investigation began immediately. The CNA #14 was suspended and clocked out immediately upon report to the Administrator. This was to prevent any further comment or potential of verbal abuse by this CNA #14 towards residents or staff. The Resident #B was interviewed by the Nursing Supervisor and assessed if she felt comforted and safe. Resident #B was informed of the actions taken by the facility in regards to this employee's comment. Resident #B stated she appreciated the information and feels safe. Upon further investigation by the Administrator and interviews with CNA #14, it was determined to terminate CNA #14's employment with Healthwin. Resident interviews were conducted on this unit regarding approach to care, treatment, respect of resident rights and dignity. Residents were asked if they had been treated rough or rude or had any concerns with approach to care and treatment. Residents also were asked if they felt safe. One resident, (name), confirmed that CNA #14 had accused her of being prejudiced. Resident (name) stated she had denied that she was prejudice, but CNA #14 continued accusing her of this. This was reported on interviews conducted on 9/18/11. Both residents were informed of</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155153	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/17/2011
NAME OF PROVIDER OR SUPPLIER HEALTHWIN			STREET ADDRESS, CITY, STATE, ZIP CODE 20531 DARDEN RD SOUTH BEND, IN46637		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>The "Nursing Notes" dated 9/18/11 at 1:45 p.m., stated, "Late entry 9/17/11 17:00 Resident became very upset after being referred to as a lesbian by a nurse aide. After I spoke with the aide about the incident, she approached the resident and informed her that "you better not make me lose my job." The resident advised me that she became scared by that comment. Administration was contacted immediately and the aide was escorted out of the building."</p> <p>The "Nursing Notes" dated 9/18/11 at 1:55 p.m., stated, "Late entry 9/18/11 0800 Spoke with resident and advised that the aide was no longer welcome at Healthwin and assured her that she was safe. Resident said thank-you and agreed that she feels safe now."</p> <p>A review of the facility's form "Reportable Unusual Occurrence" was completed for Resident #B on 11/17/11 at 11:47 a.m. and indicated, "...Follow up to Reportable Occurrence of 09/17/11...reported to ISDH (Indiana State Department of Health), APS (Adult Protective Services), and Ombudsman on 9/18/11...1. Upon request of the incident report, (Name-CNA #14), CNA was suspended pending further investigation. 2. Results of the investigation concluded</p>		<p>Healthwin's interventions and determination of termination of employment. Both residents were monitored for their psychosocial well being. No adverse outcomes were noted as a result of this incident and the interviews. Both residents state they feel safe and are comfortable with Healthwin's interventions, communication, and monitoring of their safety and well being. Routine Quarterly CNA Competency testing with return demonstrations occurred for this quarter on 9/19/11 through 9/23/11 for all CNA's at Healthwin. Residents Rights and dignity, approach to care, and Abuse prohibition and reporting were taught and presented in these competency testing and training sessions. Healthwin has implemented a system of conducting routine resident interviews to surface any resident concerns, improve quality of care, promotion of choice, and support our abuse prohibition system. These interview results are reviewed monthly and quarterly in our Quality Assurance Committee meetings. The facility will continue to practice our systems of communication, reporting, investigation, interventions, and proper care and treatment of residents at Healthwin Specialized Care. The facility will continue to conduct on-going Abuse prevention training to all</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155153	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/17/2011
NAME OF PROVIDER OR SUPPLIER HEALTHWIN			STREET ADDRESS, CITY, STATE, ZIP CODE 20531 DARDEN RD SOUTH BEND, IN46637		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	by interview with resident (Name-Resident #B) and statement from CNA, (Name-CNA #12), that (Name-CNA #14) made inappropriate verbal comments to this resident. On the day of the occurrence and upon knowing that this incident was being reported to the Nursing Supervisor, (Name-CNA #14) approached resident (Name) and requested she not tell anyone of this incident or she will lose her job. 3. (Name-CNA #14) employment was terminated on 9/18/11 due to inappropriate verbal comments to residents. 4. (Name-CNA #14) upon telephone interview stated she did not make any of these comments. This writer informed (Name-CNA #14) that there were too many confirmed concerns with her verbal approach to care with residents, so the decision to terminate her employment at Healthwin would stand. 5. (Name-CNA #14) became very emotional and stated that she had worked as a CNA for 11 years and no one can tell me how to do my job. (Name-CNA #14) was counseled to consider her behavior and continuance in this industry. She was also advised all policies would be applied in regards to reporting occurrences. 6. Resident interviews were conducted on this unit regarding approach to care, treatment, respect of resident rights and dignity. Residents were asked if they had		staff upon orientation, annually, and as needed. CNA competencies are conducted quarterly. This plan of correction was completed by 9/23/11 and systemic changes are in place as of 12/6/11.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155153	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/17/2011
NAME OF PROVIDER OR SUPPLIER HEALTHWIN			STREET ADDRESS, CITY, STATE, ZIP CODE 20531 DARDEN RD SOUTH BEND, IN46637		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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	
	<p>been treated rough or rude or had any concerns with approach to care and treatment. Residents also were asked if they felt safe. One resident, (Name), confirmed that (Name-CNA #14) had accused her of being prejudice (sic). Resident stated she had denied that she was prejudice (sic), but (Name-CNA #14) continued accusing her of this. This was reported on interviews conducted on 9/18/11. Both residents were informed of (Name-CNA #14)'s interventions and determination of termination of employment. 7. There were no further interventions needed for follow up as a result of these interviews.</p> <p>(Name-Resident #B) and the other resident, (Name) will be monitored and their psychosocial needs will continue to be addressed and assessed. Both residents expressed that they feel safe and are doing well. Both stated they are content with the handling of this employee and situation. 8. (Name-CNA #14) was advised not to return to the building due to her inappropriate verbal approach to residents and staff. 9. Routine Quarterly CNA Competency testing with return demonstrations began on 9/19/11 through 9/23/11 for all CNA's at Healthwin.</p> <p>Resident Rights and dignity, approach to care, and Abuse prohibition and reporting are also being re-emphasized in these competency testing and training sessions.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155153	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/17/2011
NAME OF PROVIDER OR SUPPLIER HEALTHWIN			STREET ADDRESS, CITY, STATE, ZIP CODE 20531 DARDEN RD SOUTH BEND, IN46637		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>10. The facility will continue to practice our systems of communication, reporting, investigation, interventions, and proper care and treatment of residents at Healthwin. The facility will continue to conduct on-going Abuse prevention training to all staff upon Orientation, annually, and as needed. 11. This incident was reported to the Indiana State Department of Health, Adult Protective Services, and the Ombudsman...."</p> <p>Review of a facility policy titled "Abuse Reporting and Investigation", dated 5/15/01, revised last 10/24/11, indicated, "...Purpose...assure the residents will be free of verbal, metal (sic), sexual, or physical abuse, corporal punishment, or involuntary seclusion by implementing procedures for screening, training, prevention, identification, investigation, protection and reporting/response to all allegations of abuse....The facility will not permit a resident to be subjected to abuse by anyone, including staff members, other residents, consultants, volunteers, and staff of other agencies serving the resident, family members, legal guardians, sponsors, friends, or other individuals...."</p> <p>During interview on 11/17/11 at 2:00 p.m., the Administrator indicated CNA #12 reported inappropriate verbal comments made by CNA #14 toward</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155153	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/17/2011
NAME OF PROVIDER OR SUPPLIER HEALTHWIN			STREET ADDRESS, CITY, STATE, ZIP CODE 20531 DARDEN RD SOUTH BEND, IN46637		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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	
	<p>Resident #B to her supervisor, RN #13, on 9/17/11 at approximately 5:15 p.m. The Administrator indicated the supervisor, RN #13, sent CNA #14 home from her shift immediately, notified the Administrator, and an investigation began.</p> <p>This federal tag is related to Complaint IN00099651.</p> <p>3.1-27(b)</p>				