

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 06/01/2015
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NAME OF PROVIDER OR SUPPLIER HEALTHWIN	STREET ADDRESS, CITY, STATE, ZIP CODE 20531 DARDEN RD SOUTH BEND, IN 46637
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F 0000 Bldg. 00	<p>This visit was for the Recertification and State Licensure Survey.</p> <p>Survey dates: May 26, 27, 28, 29 & June 1, 2015</p> <p>Facility number: 000073 Provider number: 155153 AIM number: 100288820</p> <p>Census bed type: SNF/NF: 129 Total: 129</p> <p>Census payor type: Medicare: 14 Medicaid: 88 Other: 27 Total: 129</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	<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. 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. 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.</p>	
F 0223 SS=D Bldg. 00	<p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from</p>			

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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	<p>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. Based on observation, interview and record review, the facility failed to prevent an ongoing situation of verbal and mental abuse for 2 of 2 residents observed. (Resident #127 and Resident #140)</p> <p>Finding includes:</p> <p>On 5-27-15 at 3:06 P.M., during an interview, Resident #140 indicated that she had trouble with one other resident in the facility (Resident #127). Resident #140 indicated that Resident #127, "...comes into my room uninvited every day, sometimes 2 or 3 times a day...I yell at him to leave and he does but I don't like it...they say he is confused but he knows more than they think...they [staff] tell me he won't hurt me and not to get upset about it but I am sick of it..." During this interview with Resident #140 in her private room, Resident #127 entered Resident #140's room, in his wheelchair. Resident #140 yelled, "Just get the H--- out of here...This isn't your room...Get out you A-- H---...Just get out...." Resident #127 remained in the</p>	F 0223	<p>Healthwin requests consideration for a desk review for all citations. It is the practice of Healthwin to ensure that all residents are free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>Corrective Action: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #127 was transferred to another unit during the survey. The transfer occurred to assure that resident #140 and resident #127 did not have any further contact thus eliminating any chance of any verbal interactions between them and to prevent Resident #127 from entering into Resident #140's room. Both residents have been monitored on a daily basis and are adjusting well to the new environments. They have had no further significant incidents of any verbal altercations with each other or with any other residents. Both residents care plans have been updated and staff have been re-trained to recognize verbal abuse between residents and how to report this</p>	06/19/2015			

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	<p>room until LPN (Licensed Practical Nurse) #7 came and pulled him and his wheelchair out of Resident #140's room. Resident #127 said to Resident #140, "They are going to come and get you" as he was being wheeled out of the room. Resident #140's face was red and she was shaking. Resident #140 indicated, "See what I mean...I have problems with my sight, I can only see things if I am looking straight at them...I don't even know he is in here sometimes and it startles me." No staff came into Resident #140's room after the incident.</p> <p>On 5-27-15 at 3:08 P.M., LPN #7 indicated that she had taken Resident #127 to the solarium and "...those 2 [Resident #140 and Resident #127] don't like each other and act that way all the time...Resident #127 wanders and goes into everyone's room...no one else is bothered by him and she [Resident #140] shouldn't be either...I tell her to calm down...." LPN #7 indicated that Resident #140 even yells at Resident #127 when she passes him in the hall on her way to the bathroom and tells him, "Get the H--- out of my way." LPN #7 indicated that she does not usually tell anyone about the incidents because they happen several times a day and it is never physical. LPN #7 indicated that she would let the Social Service person know this time. Resident</p>		<p>immediately to the Administrator. <u>How Others Identified/Corrective Action:</u> How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. All residents have the potential to be affected, therefore, a new resident alert system has been put into place to alert administration 24/7 of any resident behaviors that could potentially be verbal abuse and to identify any residents who are angry or upset so that immediate intervention can occur. <u>Preventative Measures Put in Place:</u> What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. New resident alert system to notify administration of any resident behaviors or incidents 24/7. Nursing supervisors are monitoring every shift and all incidents will be reviewed by the IDT (interdisciplinary team) and Administrator M-F. All staff have been re-trained in Abuse prevention, identification and reporting. An Abuse Prevention Task force has been created and will meet monthly. All departments will be represented. Discussions will be lead by the Assistant Administrator and membership will be on a rotation basis. <u>Monitoring and QI:</u></p>	

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	<p>#140's room was observed to not have it's own restroom and the common restroom is 7 rooms away from Resident #140's room. Resident #140 must pass by Resident #127's room on the way to the common restroom. Resident #140 is able to propel herself in her wheelchair throughout the facility and is independent with her personal care.</p> <p>On 5-27-2015 at 3:38 P.M., Social Services indicated, "...if it is a daily behavior, they don't report it...he [Resident #127] has severe dementia and he does wander...he is not aggressive and if he wanders we pull him out of the other residents rooms and reassure the resident that he [Resident #127] doesn't know what he is doing...she [Resident #140] has cognitive deficits and you can't explain anything to her...."</p> <p>On 5-27-2015 at 4:21 P.M., during an interview, the Administrator indicated, "...I have talked with Resident #140...Resident #140 indicated that this happens every day, sometimes several times a day...."</p> <p>On 5-28-2015 at 10:38 A.M., an observation of Resident #140 propelling herself into her room. Resident #127 came down the hall and followed Resident #140 into her room. Resident</p>		<p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>All resident alerts will be reviewed every shift by nursing supervision and relayed to the Administrator immediately if necessary. All resident alerts will be reviewed by the IDT and Administrator M-F. All resident incidents reported to the ISDH will be reviewed as well as all resident alerts in QI (QAPI process) to assure the process is working properly and that all incidents have been reported according to our policy. This will occur on a monthly basis and quarterly with the medical director for one year. Training for all staff will occur on a quarterly basis and will be monitored by QI in the QAPI process. This training will be on-going. Abuse Prevention Task Force minutes will be forwarded to the Administrator for review. All meeting minutes and any followup will be reviewed by the Administrator and forwarded to QI for inclusion in the QI Quarterly meetings. Please refer to all attachments. By what date the systemic changes will be completed. 6/19/2015</p>		

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	<p>#140 was observed yelling out for help to get Resident #127 out of her room. Resident #140 yelled at Resident #127 to "...Get the H--- out of my room...you are an A-- H---...." LPN #9 came to Resident #140's room and pulled Resident #127 out of her room. Resident #127 yelled out, "Blah, blah, blah" as he was leaving Resident #140's room. LPN #9 took Resident #127 to the solarium and went to check on Resident #140 telling her, "I'm sorry." LPN #9 then went to the computer and continued charting on another resident. An interview with Resident #140 was conducted at this time. Resident #140 indicated, "...it happens all the time and I am sick of it...this is my room...why can't they keep him out of here...."</p> <p>On 5-29-2015 at 8:30 A.M., a record review for Resident #127 was conducted. Resident #127 diagnosis included, but were not limited to, "...dementia, Alzheimer's disease, altered mental status, and depression...." Resident #127's care plan indicated, "Focus...Wandering: [Resident name-Resident #127] sometimes wanders on the unit and through out the facility. He will go into other residents rooms on his unit...Interventions/Tasks...Try to re-direct [Resident name-Resident #127] with activities, snack, or 1:1 interaction</p>						

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	<p>such as taking him for a walk around the facility or the grounds, weather permitting, if he is repeatedly attempting to enter another resident's room...." The BIMS (Brief Interview for Mental Status- a tool used to evaluate cognition), completed on 4-29-2015, indicated a score of 2 out of a possible 15, indicating severe cognitive difficulties.</p> <p>On 5-29-2015 at 8:50 A.M., a record review for Resident #140 was conducted. Resident #140 diagnosis included, but were not limited to, "...atrial fibrillation, edema, depressive disorder, cerebrovascular disease...." Resident #140's care plan indicated, "Focus...Verbally abusive: [Resident name-Resident #140] does exhibit confusion and memory loss. She can be nasty to other residents. Using foul language...Interventions/Tasks...Intervene as necessary to ensure the dignity of other residents...." The BIMS, completed on 3-25-2015, indicated a score of 10 out of a possible 15, indicating moderate cognitive difficulties.</p> <p>Review of the current "Preventing Resident Abuse and Neglect" policy, received from the Administrator on 5-28-2015 at 9:20 A.M., indicated, "The resident has the right to be free from verbal, sexual, physical, mental abuse,</p>			

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	<p>corporal punishment, and involuntary seclusion....Procedure:...2. Our Abuse Prohibition Program includes...j. Assessing, care planning, and monitoring residents with needs and behaviors that may lead to conflict...k. Assessing residents with signs and symptoms of behavior problems and developing and implementing care plans to address behavioral issues...."</p> <p>Review of the current "Abuse-Suspected or Observed" policy, received from the Administrator on 5-28-2015 at 9:20 A.M., indicated, "...Verbal Abuse is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents...within their hearing distance, regardless of their age, ability to comprehend, or disability...Mental Abuse includes, but is not limited to,...harassment...Policy/Procedure: 1. If abuse is...observed: a. The Administrator must be contacted immediately...."</p> <p>There were no reported incidents of resident to resident abuse related to Resident #127 or Resident #140 to review.</p> <p>3.1-27(b)</p>			

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F 0225 SS=D Bldg. 00	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be</p>			

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	<p>reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on observation, interview and record review, the facility failed report an ongoing situation of resident to resident verbal and mental abuse to the Administrator immediately for 2 of 2 residents observed. (Resident #127 and Resident #140)</p> <p>Finding includes:</p> <p>On 5-27-15 at 3:06 P.M., during an interview, Resident #140 indicated that she had trouble with one other resident in the facility (Resident #127). Resident #140 indicated that Resident #127, "...comes into my room uninvited every day, sometimes 2 or 3 times a day...I yell at him to leave and he does but I don't like it...they say he is confused but he knows more than they think...they [staff] tell me he won't hurt me and not to get upset about it but I am sick of it..."</p> <p>During this interview with Resident #140 in her private room, Resident #127 entered Resident #140's room, in his wheelchair. Resident #140 yelled, "Just</p>	F 0225	<p>Healthwin requests consideration for a desk review for all citations. It is the practice of Healthwin to ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). <u>Corrective Action: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</u> As soon as this incident was discovered during the survey, the Social Worker reported the incident to the Administrator. The Administrator reported the incident to the ISDH, APS, and Ombudsmans Office. Resident #127 was transferred to another unit during the survey. The transfer occurred to assure that resident #140 and resident #127 did not have any further contact thus eliminating any chance of any verbal interactions between</p>	06/19/2015

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	<p>get the H--- out of here...This isn't your room...Get out you A-- H---...Just get out...." Resident #127 remained in the room until LPN (Licensed Practical Nurse) #7 came and pulled him and his wheelchair out of Resident #140's room. Resident #127 said to Resident #140, "They are going to come and get you" as he was being wheeled out of the room. Resident #140's face was red and she was shaking. Resident #140 indicated, "See what I mean...I have problems with my sight, I can only see things if I am looking straight at them...I don't even know he is in here sometimes and it startles me." No staff came into Resident #140's room after the incident.</p> <p>On 5-27-15 at 3:08 P.M., LPN #7 indicated that she had taken Resident #127 to the solarium and "...those 2 [Resident #140 and Resident #127] don't like each other and act that way all the time...Resident #127 wanders and goes into everyone's room...no one else is bothered by him and she [Resident #140] shouldn't be either...I tell her to calm down...." LPN #7 indicated that Resident #140 even yells at Resident #127 when she passes him in the hall on her way to the bathroom and tells him, "Get the H--- out of my way." LPN #7 indicated that she does not usually tell anyone about the incidents because they happen several</p>		<p>them and to prevent Resident #127 from entering into Resident #140's room. Both residents have been monitored on a daily basis and are adjusting well to the new environments. They have had no further significant incidents of any verbal altercations with each other or with any other residents. Both residents care plans have been updated and staff have been re-trained to recognize verbal abuse between residents and how to report this immediately to the Administrator. <u>How Others Identified/Corrective Action:</u> How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. All residents have the potential to be affected, therefore, a new resident alert system has been put into place to alert administration 24/7 of any resident behaviors that could potentially be verbal abuse and to identify any residents who are angry or upset so that immediate intervention can occur. Staff will immediately report to the Administrator who will report the incident to the ISDH and other appropriate agencies. <u>Preventative Measures Put in Place:</u> What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. New</p>	

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	<p>times a day and it is never physical. LPN #7 indicated that she would let the Social Service person know this time. Resident #140's room was observed to not have it's own restroom and the common restroom is 7 rooms away from Resident #140's room. Resident #140 must pass by Resident #127's room on the way to the common restroom. Resident #140 is able to propel herself in her wheelchair throughout the facility and is independent with her personal care.</p> <p>On 5-27-2015 at 3:38 P.M., Social Services indicated, "...if it is a daily behavior, they don't report it...he [Resident #127] has severe dementia and he does wander...he is not aggressive and if he wanders we pull him out of the other residents rooms and reassure the resident that he [Resident #127] doesn't know what he is doing...she [Resident #140] has cognitive deficits and you can't explain anything to her...."</p> <p>On 5-27-2015 at 4:21 P.M., during an interview, the Administrator indicated, "...I have talked with Resident #140...Resident #140 indicated that this happens every day, sometimes several times a day...."</p> <p>On 5-28-2015 at 10:38 A.M., an observation of Resident #140 propelling</p>		<p>resident alert system to notify administration of any resident behaviors or incidents 24/7. Nursing supervisors are monitoring every shift and all incidents will be reviewed by the IDT (interdisciplinary team) and Administrator M-F. All staff have been re-trained in Abuse prevention, identification and reporting. An Abuse Prevention Task force has been created and will meet monthly. All departments will be represented. Discussions will be lead by the Assistant Administrator and membership will be on a rotation basis. Monitoring and QI: How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. All resident alerts will be reviewed every shift by nursing supervision and relayed to the Administrator immediately if necessary. All resident alerts will be reviewed by the IDT and Administrator M-F. All resident incidents reported to the ISDH will be reviewed as well as all resident alerts in QI (QAPI process) to assure the process is working properly and that all incidents have been reported according to our policy. This will occur on a monthly basis and quarterly with the medical director for one year. Training for all staff will occur on a quarterly basis and will be monitored by QI in the QAPI process. This training will</p>				

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	<p>herself into her room. Resident #127 came down the hall and followed Resident #140 into her room. Resident #140 was observed yelling out for help to get Resident #127 out of her room. Resident #140 yelled at Resident #127 to "...Get the H--- out of my room...you are an A-- H---...." LPN #9 came to Resident #140's room and pulled Resident #127 out of her room. Resident #127 yelled out, "Blah, blah, blah" as he was leaving Resident #140's room. LPN #9 took Resident #127 to the solarium and went to check on Resident #140 telling her, "I'm sorry." LPN #9 then went to the computer and continued charting on another resident. An interview with Resident #140 was conducted at this time. Resident #140 indicated, "...it happens all the time and I am sick of it...this is my room...why can't they keep him out of here...."</p> <p>On 5-29-2015 at 8:30 A.M., a record review for Resident #127 was conducted. Resident #127 diagnosis included, but were not limited to, "...dementia, Alzheimer's disease, altered mental status, and depression...." Resident #127's care plan indicated, "Focus...Wandering: [Resident name-Resident #127] sometimes wanders on the unit and through out the facility. He will go into other residents rooms on his</p>		<p>be on-going. Abuse Prevention Task Force minutes will be forwarded to the Administrator for review. All meeting minutes and any followup will be reviewed by the Administrator and forwarded to QI for inclusion in the QI Quarterly meetings. Please refer to all attachments. By what date the systemic changes will be completed. 6/19/2015</p>	

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NAME OF PROVIDER OR SUPPLIER HEALTHWIN	STREET ADDRESS, CITY, STATE, ZIP CODE 20531 DARDEN RD SOUTH BEND, IN 46637
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	<p>unit...Interventions/Tasks... Try to re-direct [Resident name-Resident #127] with activities, snack, or 1:1 interaction such as taking him for a walk around the facility or the grounds, weather permitting, if he is repeatedly attempting to enter another resident's room...." The BIMS (Brief Interview for Mental Status- a tool used to evaluate cognition), completed on 4-29-2015, indicated a score of 2 out of a possible 15, indicating severe cognitive difficulties.</p> <p>On 5-29-2015 at 8:50 A.M., a record review for Resident #140 was conducted. Resident #140 diagnosis included, but were not limited to, "...atrial fibrillation, edema, depressive disorder, cerebrovascular disease...." Resident #140's care plan indicated, "Focus...Verbally abusive: [Resident name-Resident #140] does exhibit confusion and memory loss. She can be nasty to other residents. Using foul language...Interventions/Tasks...Intervene as necessary to ensure the dignity of other residents...." The BIMS, completed on 3-25-2015, indicated a score of 10 out of a possible 15, indicating moderate cognitive difficulties.</p> <p>Review of the current "Preventing Resident Abuse and Neglect" policy, received from the Administrator on</p>			

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	<p>5-28-2015 at 9:20 A.M., indicated, "The resident has the right to be free from verbal, sexual, physical, mental abuse, corporal punishment, and involuntary seclusion....Procedure:...2. Our Abuse Prohibition Program includes...j. Assessing, care planning, and monitoring residents with needs and behaviors that may lead to conflict...k. Assessing residents with signs and symptoms of behavior problems and developing and implementing care plans to address behavioral issues...."</p> <p>Review of the current "Abuse-Suspected or Observed" policy, received from the Administrator on 5-28-2015 at 9:20 A.M., indicated, "...Verbal Abuse is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents...within their hearing distance, regardless of their age, ability to comprehend, or disability...Mental Abuse includes, but is not limited to,...harassment...Policy/Procedure: 1. If abuse is...observed: a. The Administrator must be contacted immediately...."</p> <p>There were no reported incidents of resident to resident abuse related to Resident #127 or Resident #140 to review.</p>			

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F 0226 SS=D Bldg. 00	<p>3.1-28(c)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on observation, interview and record review, the facility failed to implement their abuse policy by not immediately notifying the Administrator of an ongoing situation of resident to resident verbal and mental abuse for 2 of 2 residents observed. (Resident #127 and Resident #140)</p> <p>Finding includes:</p> <p>On 5-27-15 at 3:06 P.M., during an interview, Resident #140 indicated that she had trouble with one other resident in the facility (Resident #127). Resident #140 indicated that Resident #127, "...comes into my room uninvited every</p>	F 0226	<p>Healthwin requests consideration for a desk review for all citations. It is Healthwin's practice to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. <u>Corrective Action:</u> What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #127 was transferred to another unit during the survey. The transfer occurred to assure that resident #140 and resident #127 did not have any further contact thus eliminating any chance of any verbal interactions between</p>	06/19/2015

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	<p>day, sometimes 2 or 3 times a day...I yell at him to leave and he does but I don't like it...they say he is confused but he knows more than they think...they [staff] tell me he won't hurt me and not to get upset about it but I am sick of it..."</p> <p>During this interview with Resident #140 in her private room, Resident #127 entered Resident #140's room, in his wheelchair. Resident #140 yelled, "Just get the H--- out of here...This isn't your room...Get out you A-- H----...Just get out...." Resident #127 remained in the room until LPN (Licensed Practical Nurse) #7 came and pulled him and his wheelchair out of Resident #140's room. Resident #127 said to Resident #140, "They are going to come and get you" as he was being wheeled out of the room. Resident #140's face was red and she was shaking. Resident #140 indicated, "See what I mean...I have problems with my sight, I can only see things if I am looking straight at them...I don't even know he is in here sometimes and it startles me." No staff came into Resident #140's room after the incident.</p> <p>On 5-27-15 at 3:08 P.M., LPN #7 indicated that she had taken Resident #127 to the solarium and "...those 2 [Resident #140 and Resident #127] don't like each other and act that way all the time...Resident #127 wanders and goes</p>		<p>them and to prevent Resident #127 from entering into Resident #140's room. Both residents have been monitored on a daily basis and are adjusting well to the new environments. They have had no further significant incidents of any verbal altercations with each other or with any other residents. Both residents care plans have been updated and staff have been re-trained to recognize verbal abuse between residents and how to report this immediately to the Administrator. <u>How Others Identified/Corrective Action:</u> How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. All residents have the potential to be affected, therefore, a new resident alert system has been put into place to alert administration 24/7 of any resident behaviors that could potentially be verbal abuse and to identify any residents who are angry or upset so that immediate intervention can occur.</p> <p><u>Preventative Measures Put in Place:</u> What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. New resident alert system to notify administration of any resident behaviors or incidents 24/7. Nursing supervisors are</p>				

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	<p>into everyone's room...no one else is bothered by him and she [Resident #140] shouldn't be either...I tell her to calm down...." LPN #7 indicated that Resident #140 even yells at Resident #127 when she passes him in the hall on her way to the bathroom and tells him, "Get the H--- out of my way." LPN #7 indicated that she does not usually tell anyone about the incidents because they happen several times a day and it is never physical. LPN #7 indicated that she would let the Social Service person know this time. Resident #140's room was observed to not have it's own restroom and the common restroom is 7 rooms away from Resident #140's room. Resident #140 must pass by Resident #127's room on the way to the common restroom. Resident #140 is able to propel herself in her wheelchair throughout the facility and is independent with her personal care.</p> <p>On 5-27-2015 at 3:38 P.M., Social Services indicated, "...if it is a daily behavior, they don't report it...he [Resident #127] has severe dementia and he does wander...he is not aggressive and if he wanders we pull him out of the other residents rooms and reassure the resident that he [Resident #127] doesn't know what he is doing...she [Resident #140] has cognitive deficits and you can't explain anything to her...."</p>		<p>monitoring every shift and all incidents will be reviewed by the IDT (interdisciplinary team) and Administrator M-F. All staff have been re-trained in Abuse prevention, identification and reporting. An Abuse Prevention Task force has been created and will meet monthly. All departments will be represented. Discussions will be lead by the Assistant Administrator and membership will be on a rotation basis. Monitoring and QI: How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. All resident alerts will be reviewed every shift by nursing supervision and relayed to the Administrator immediately if necessary. All resident alerts will be reviewed by the IDT and Administrator M-F. All resident incidents reported to the ISDH will be reviewed as well as all resident alerts in QI (QAPI process) to assure the process is working properly and that all incidents have been reported according to our policy. This will occur on a monthly basis and quarterly with the medical director for one year. Training for all staff will occur on a quarterly basis and will be monitored by QI in the QAPI process. This training will be on-going. Abuse Prevention Task Force minutes will be forwarded to the Administrator for review. All meeting minutes and</p>		

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	<p>On 5-27-2015 at 4:21 P.M., during an interview, the Administrator indicated, "...I have talked with Resident #140...Resident #140 indicated that this happens every day, sometimes several times a day...."</p> <p>On 5-28-2015 at 10:38 A.M., an observation of Resident #140 propelling herself into her room. Resident #127 came down the hall and followed Resident #140 into her room. Resident #140 was observed yelling out for help to get Resident #127 out of her room. Resident #140 yelled at Resident #127 to "...Get the H--- out of my room...you are an A-- H---...." LPN #9 came to Resident #140's room and pulled Resident #127 out of her room. Resident #127 yelled out, "Blah, blah, blah" as he was leaving Resident #140's room. LPN #9 took Resident #127 to the solarium and went to check on Resident #140 telling her, "I'm sorry." LPN #9 then went to the computer and continued charting on another resident. An observation of Resident #140 at this time was made. Resident #140 indicated, "...it happens all the time and I am sick of it...this is my room...why can't they keep him out of here...."</p> <p>On 5-29-2015 at 8:30 A.M., a record</p>		any followup will be reviewed by the Administrator and forwarded to QI for inclusion in the QI Quarterly meetings. Please refer to all attachments. By what date the systemic changes will be completed. 6/19/15	

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	<p>review for Resident #127 was conducted. Resident #127 diagnosis included, but were not limited to, "...dementia, Alzheimer's disease, altered mental status, and depression...." Resident #127's care plan indicated, "Focus...Wandering: [Resident name-Resident #127] sometimes wanders on the unit and through out the facility. He will go into other residents rooms on his unit...Interventions/Tasks...Try to re-direct [Resident name-Resident #127] with activities, snack, or 1:1 interaction such as taking him for a walk around the facility or the grounds, weather permitting, if he is repeatedly attempting to enter another resident's room...." The BIMS (Brief Interview for Mental Status- a tool used to evaluate cognition), completed on 4-29-2015, indicated a score of 2 out of a possible 15, indicating severe cognitive difficulties.</p> <p>On 5-29-2015 at 8:50 A.M., a record review for Resident #140 was conducted. Resident #140 diagnosis included, but were not limited to, "...atrial fibrillation, edema, depressive disorder, cerebrovascular disease...." Resident #140's care plan indicated, "Focus...Verbally abusive: [Resident name-Resident #140] does exhibit confusion and memory loss. She can be nasty to other residents. Using foul</p>						

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	<p>language...Interventions/Tasks...Intervene as necessary to ensure the dignity of other residents...." The BIMS, completed on 3-25-2015, indicated a score of 10 out of a possible 15, indicating moderate cognitive difficulties.</p> <p>Review of the current "Preventing Resident Abuse and Neglect" policy, received from the Administrator on 5-28-2015 at 9:20 A.M., indicated, "The resident has the right to be free from verbal, sexual, physical, mental abuse, corporal punishment, and involuntary seclusion....Procedure:...2. Our Abuse Prohibition Program includes...j. Assessing, care planning, and monitoring residents with needs and behaviors that may lead to conflict...k. Assessing residents with signs and symptoms of behavior problems and developing and implementing care plans to address behavioral issues...."</p> <p>Review of the current "Abuse-Suspected or Observed" policy, received from the Administrator on 5-28-2015 at 9:20 A.M., indicated, "...Verbal Abuse is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents...within their hearing distance, regardless of their age, ability to comprehend, or disability...Mental Abuse</p>			

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F 0250 SS=D Bldg. 00	<p>includes, but is not limited to,...harassment...Policy/Procedure: 1. If abuse is...observed: a. The Administrator must be contacted immediately...."</p> <p>There were no reported incidents of resident to resident abuse related to Resident #127 or Resident #140 to review.</p> <p>3.1-28(a)</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. A. Based on observation, interview and record review, the facility failed to ensure behaviors were identified and monitored for 2 of 2 residents observed. (Resident #127 and Resident #140) B. Based on record review and interview, the facility failed to ensure that a care plan was developed related to depression and the use of antidepressant medication</p>	F 0250	<p>Healthwin requests consideration for a desk review for all citations. It is Healthwin's practice to provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. <u>Corrective Action:</u> What corrective action(s) will be accomplished for those residents found to have been</p>	06/19/2015

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	<p>for 1 of 20 residents reviewed for care plans. (Resident #3)</p> <p>Finding includes:</p> <p>A.1. On 5-27-15 at 3:06 P.M., during an interview, Resident #140 indicated that she had trouble with one other resident in the facility (Resident #127). Resident #140 indicated that Resident #127, "...comes into my room uninvited every day, sometimes 2 or 3 times a day...I yell at him to leave and he does but I don't like it...they say he is confused but he knows more than they think...they [staff] tell me he won't hurt me and not to get upset about it but I am sick of it..." During this interview with Resident #140 in her private room, Resident #127 entered Resident #140's room, in his wheelchair. Resident #140 yelled, "Just get the H--- out of here...This isn't your room...Get out you A-- H---...Just get out...." Resident #127 remained in the room until LPN (Licensed Practical Nurse) #7 came and pulled him and his wheelchair out of Resident #140's room. Resident #127 said to Resident #140, "They are going to come and get you" as he was being wheeled out of the room. Resident #140's face was red and she was shaking. Resident #140 indicated, "See what I mean...I have problems with my sight, I can only see things if I am</p>		<p>affected by the deficient practice? A. Social Services has identified common behaviors in both Resident #127 and #140 and these are included in the residents care plans. Both Social Workers are monitoring behavior documentation in the charts at least once a week and monitoring the resident alerts daily. B. Resident #3's care plan was updated to include the diagnosis of depression as he is administered antidepressant medications. <u>How Others Identified/Corrective Action:</u> How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. A. All staff have been re-trained on identifying behaviors as all residents could be affected. Social Services will monitor Resident Alerts on a daily basis M-F. All behaviors identified by staff will be monitored by the nursing supervisors 24/7. Social Service Alert forms will be completed by nursing supervisors to alert Social Services of any behavior issues. Social Services will monitor all residents behavior reports on a weekly basis to assure proper care planning and that interventions are implemented. B. All care plans were reviewed on any resident with a diagnosis of depression. Care plans on any resident with a diagnosis of depression</p>				

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	<p>looking straight at them...I don't even know he is in here sometimes and it startles me." No staff came into Resident #140's room after the incident.</p> <p>On 5-27-15 at 3:08 P.M., LPN #7 indicated that she had taken Resident #127 to the solarium and "...those 2 [Resident #140 and Resident #127] don't like each other and act that way all the time...Resident #127 wanders and goes into everyone's room...no one else is bothered by him and she [Resident #140] shouldn't be either...I tell her to calm down...." LPN #7 indicated that Resident #140 even yells at Resident #127 when she passes him in the hall on her way to the bathroom and tells him, "Get the H--- out of my way." LPN #7 indicated that she does not usually tell anyone about the incidents because they happen several times a day and it is never physical. LPN #7 indicated she only documents behaviors during a scheduled assessment. LPN #7 indicated she thought the CNA's chart the behaviors but she is not sure who sees the charting. Resident #140's room was observed to not have it's own restroom and the common restroom is 7 rooms away from Resident #140's room. Resident #140 must pass by Resident #127's room on the way to the common restroom. Resident #140 is able to propel herself in her wheelchair throughout the</p>		<p>regardless of antidepressant medication administration will address their diagnosis with goals and interventions. The Assistant Administrator will monitor all care plans of residents with a diagnosis of depression on a monthly basis to assure completeness and that goals and interventions have been established. <u>Preventative Measures Put in Place: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</u> A. Behavior reports on all residents will be reviewed weekly by Social Services. These reports will be reviewed by the Assistant Administrator to assure that all behaviors have been addressed in the care plans and interventions are being carried out. The Behavior reports will be forwarded to QI to be reviewed at the Quarterly QI meeting. Monitoring of Behaviors will occur for one year or until all behaviors are being addressed 100% of the time for all residents. Training for all staff was conducted and will occur quarterly on an ongoing basis. B. The Assistant Administrator will review all residents with the diagnosis of depression on a monthly basis to assure that each has a care plan to reflect that diagnosis with goals and that interventions are in place and being carried out. Monthly reviews will be forwarded to the</p>				

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	<p>facility and is independent with her personal care.</p> <p>On 5-27-2015 at 3:38 P.M., Social Services indicated, "...if it is a daily behavior, they don't report it...he [Resident #127] has severe dementia and he does wander...he is not aggressive and if he wanders we pull him out of the other residents rooms and reassure the resident that he [Resident #127] doesn't know what he is doing...she [Resident #140] has cognitive deficits and you can't explain anything to her...."</p> <p>On 5-27-2015 at 4:21 P.M., during an interview, the Administrator indicated, "...I have talked with Resident #140...Resident #140 indicated that this happens every day, sometimes several times a day...."</p> <p>On 5-28-2015 at 10:38 A.M., an observation of Resident #140 propelling herself into her room. Resident #127 came down the hall and followed Resident #140 into her room. Resident #140 was observed yelling out for help to get Resident #127 out of her room. Resident #140 yelled at Resident #127 to "...Get the H--- out of my room...you are an A-- H---...." LPN #9 came to Resident #140's room and pulled Resident #127 out of her room. Resident #127 yelled</p>		<p>Administrator and QI for review in the Quarterly QI meeting. These reviews will occur monthly for 6 months and then quarterly thereafter. <u>Monitoring and QI: How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</u> A. Behavior reports on all residents will be reviewed weekly by Social Services. These reports will be reviewed by the Assistant Administrator to assure that all behaviors have been addressed in the care plans and interventions are being carried out. The Behavior reports will be forwarded to QI to be reviewed at the Quarterly QI meeting. Monitoring of Behaviors will occur for one year or until all behaviors are being addressed 100% of the time for all residents. Training for all staff was conducted and will occur quarterly on an ongoing basis. B. The Assistant Administrator will review all residents with the diagnosis of depression on a monthly basis to assure that each has a care plan to reflect that diagnosis with goals and that interventions are in place and being carried out. Monthly reviews will be forwarded to the Administrator and QI for review in the Quarterly QI meeting. These reviews will occur monthly for 6 months and then quarterly thereafter. Please refer to all attachments. By what date</p>				

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	<p>out, "Blah, blah, blah" as he was leaving Resident #140's room. LPN #9 took Resident #127 to the solarium and went to check on Resident #140 telling her, "I'm sorry." LPN #9 then went to the computer and continued charting on another resident. An observation of Resident #140 at this time was made. Resident #140 indicated, "...it happens all the time and I am sick of it...this is my room...why can't they keep him out of here...."</p> <p>On 5-29-2015 at 8:30 A.M., a record review for Resident #127 was conducted. Resident #127 diagnosis included, but were not limited to, "...dementia, Alzheimer's disease, altered mental status, and depression...." Resident #127's care plan indicated, "Focus...Wandering: [Resident name-Resident #127] sometimes wanders on the unit and through out the facility. He will go into other residents rooms on his unit...Interventions/Tasks...Try to re-direct [Resident name-Resident #127] with activities, snack, or 1:1 interaction such as taking him for a walk around the facility or the grounds, weather permitting, if he is repeatedly attempting to enter another resident's room...." The BIMS (Brief Interview for Mental Status- a tool used to evaluate cognition), completed on 4-29-2015, indicated a</p>		<p>the systemic changes will be completed. 6/19/15</p>				

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	<p>score of 2 out of a possible 15, indicating severe cognitive difficulties. A review of the "Behavior Symptoms" recorded by the CNA's each shift, dated 2/27/2015 to 5/27/2015, indicated, 10 shifts charted "Wandering", 3 shifts charted "Threatening Behavior" and 1 shift charted "Grabbing."</p> <p>On 5-29-2015 at 8:50 A.M., a record review for Resident #140 was conducted. Resident #140 diagnosis included, but were not limited to, "...atrial fibrillation, edema, depressive disorder, cerebrovascular disease..." Resident #140's care plan indicated, "Focus...Verbally abusive: [Resident name-Resident #140] does exhibit confusion and memory loss. She can be nasty to other residents. Using foul language...Interventions/Tasks...Intervene as necessary to ensure the dignity of other residents...." The BIMS, completed on 3-25-2015, indicated a score of 10 out of a possible 15, indicating moderate cognitive difficulties. A review of the "Behavior Symptoms" recorded by the CNA's each shift, dated 2/26/2015 to 5/27/2015, indicated, "None of the above observed or Not Applicable" for each shift charted.</p> <p>On 6-1-2015 at 9:34 A.M., during an interview, Social Service Employee #6</p>			

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	<p>indicated, "...the CNA's chart in the PCC [Point Click Care, electronic charting] system each shift. I am not sure who sees the CNA charting...we don't review all the behaviors every day for every resident...we can't do that...we are made aware of behaviors by the staff through alerts...they can call and leave a message, email or write us a note...the interventions are in the care plans...the CNA's can see the care plans in PCC...or the interventions are on the CNA sheets...the MDS [Minimum Data Set-an assessment tool] nurses update the care plans...."</p> <p>Record review of the current "Behavior Interventions" policy, revised 8/22/08, indicated, "A resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem...Procedure: 14. Monitor resident closely. Document residents behavior, interventions and treatment...15. Update the care plan as needed...."</p> <p>B.1. On 5/27/15 at 4:40 P.M., the clinical record review was conducted for Resident #3. Resident #3 was admitted to the facility on April 30, 2015. Diagnosis included, but was not limited to, depressive disorder not elsewhere</p>			

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	<p>classified. Review of Resident #3 MAR (Medication Administration Record) indicated " ... Escitalopram Oxalate [antidepressant] 5 mg [milligrams], by mouth in the morning related to Depressive Disorder Not Elsewhere Classified."</p> <p>Care plans for Resident #3 indicated that a care plan was not developed for the diagnosis of depression or for the use of antidepressants.</p> <p>During an interview on 6/1/15 at 9:17 A.M., Social Services #6 indicated "... a care plan should be developed within 5 days of admission...."</p> <p>On 6/1/15 at 12:30 P.M., review of the current and undated policy titled, "Care Plan," provided by the Administrator indicated " ... The plan identifies nursing diagnosis after assessment... must develop a interim care plan as soon as possible after admission to the facility [typically within 24 hours]"</p> <p>During an interview on 6/1/15 at 12:53 A.M., the CCO (Chief Clinical Officer) indicated " ... a resident with a diagnosis of depression and on depression medications should have a care plan for depression...."</p>			

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