

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155666	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/18/2013
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NAME OF PROVIDER OR SUPPLIER WESLEY HEALTHCARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1751 WESLEY ROAD AUBURN, IN 46706
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F000000	<p>This visit was for the Investigation of Complaints IN00137896 and IN00138156.</p> <p>Complaint IN00137896 Substantiated. Federal/state deficiencies related to the allegations are cited at F-224, F-225, and F-226. Complaint IN00138156 Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: October 17, 18, 2013</p> <p>Facility number: 000307 Provider number: 155666 AIM number: 100285660</p> <p>Survey team: Tim Long, RN-TC Rick Blain, RN Carol Miller, RN Diane Nilson, RN</p> <p>Census bed type: SNF/NF: 45 Total: 45</p> <p>Census Payor type: Medicare: 8 Medicaid: 33 Other: 4 Total: 45</p>	F000000	<p>This plan of correction is prepared and executed because the state and federal law require it. This plan of correction shall not be deemed an admission to or agreement with the state allegations. Wesley Healthcare LLC maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. Wesley Healthcare LLC further maintains that the allegations set forth herein do not substantiate or constitute substandard quality of care. Please accept the last date noted on the plan of correction as the facility's credible allegation of compliance. Wesley Healthcare LLC requests a paper compliance for F224, F225 and F226. These were found to be low severity. There was no actual citation of harm to any of the residents.</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>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on October 21, 2013 by Randy Fry RN.</p>			
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F000224 SS=D	<p>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATE</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interviews, the facility failed to ensure 2 allegations of alleged abuse were thoroughly investigated and reported to the Indiana State Department of Health. This affected 2 of 6 residents interviewed for the abuse protocol, Residents #J and #K.</p> <p>Findings include:</p> <p>CNA #1 was interviewed, at 12:45 p.m., on 10/17/13, and indicated on 10/13/13, Resident #J had asked her if she could put the resident to bed at 2:00 p.m., when she worked, because she didn't want CNA #2 to put her to bed because she was mean. CNA #1 indicated the resident told her CNA #2 had told the resident, on 10/12/13, if she had to do heavy lifting, it would hurt her baby. CNA #1 indicated she reported this to the Assistant Director of Nursing (ADNS), by text message, on 10/13/13.</p> <p>CNA #1 also indicated Resident #K told her, on 10/13/13, that CNA #2</p>	F000224	F224 It is the intent of this facility for all residents to be free from any and all forms of abuse. The facility will take corrective action for those residents having the potential to be affected by the same deficit practice. All residents have the potential to be affected by this alleged deficient practice. All residents requiring assist with peri care have the potential from CNA # 2 to be treated roughly during care. CNA #2 was spoken to along with the nurse that was on that evening, no abuse was indicated. All residents that require being lifted have the potential from CNA # 2 to not be cared for due to the heavy lifting and CNA #2 being pregnant. CNA #2 was spoken to along with the nurse that was on that evening, no abuse was indicated. Corrective action taken: All staff in-serviced on October 25, 2013, defined abuse and neglect, regulations for reporting incidents, and facility policy and procedures. All staff received a new abuse policy and signed that they received and where trained on the policy. Monitoring: The Administrator and	10/25/2013			

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	<p>had been mean and rough with her during care on 10/12/13. CNA #1 indicated she reported this to the ADNS on 10/13/13.</p> <p>The ADNS was interviewed, at 1:00 p.m., on 10/12/13, and confirmed CNA #1 had reported the incident to her on 10/13/13, and the ADNS indicated she had reported the 2 incidents to the Director of Nursing Services (DNS) and the Administrator on 10/13/13.</p> <p>The DNS was interviewed, at 1:20 p.m., on 10/17/13 and indicated she was notified about the 2 incidents on 10/13/13. She indicated CNA #2 had been contacted and given her verbal statement about the incidents, however, the DNS indicated she had not interviewed Residents J or K, any other residents who the CNA may have taken care of, or any other staff regarding the allegations. She indicated she had talked to the nurse on duty on 10/12/13, but the nurse had told her she was unaware of any incidents. She indicated Resident #K was interviewable, but Resident #J was not interviewable and had been more confused.</p> <p>She indicated she had not reported the incidents of alleged abuse to the Indiana State Department of health</p>		<p>DON will monitor during weekly rounds to ensure all staff are aware of the proper policies and procedures and all immediate steps are properly conducted to ensure the safety of the residents. Rounds will include sampling of staff and residents to ensure all residents are free from abuse. This will be a continuous monitoring for the next 12 months. Date of completion: This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is October 25, 2013.</p>		

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	<p>(ISDH).</p> <p>Resident #K was interviewed, at 1:45 p.m., on 10/17/13, and indicated CNA #2 was providing personal care to her "the other night" and was hurting her. She told the CNA to stop several times, but she didn't. The resident indicated she told the CNA, "you're being mean to me", and the resident also indicated, "finally, I raised up my leg and pushed her away. " The resident indicated CNA #2 was normally a very good aide and she had not had any problems with her. She indicated the CNA then left and the nurse came in the room, and she told the nurse about the incident, but she could not remember the nurse's name.</p> <p>The Resident's Rights and Abuse/Neglect Policy, dated as revised on July, 2013, reviewed at 8:30 a.m., on 10/18/13, indicated the following: "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. " In addition, the policy indicated, "If an employee is being investigated, that</p>				

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	<p>employee will be placed on suspension pending conclusion of the investigation. The Administrator will be notified and resident will be immediately examined for any new bruises, cuts, etc, conducive to the alleged abuse. Moreover, during the time, the director will speak with and obtain statements from the resident and/or family as well as the staff on duty, and the suspended employee. After conclusion of the investigation, the director will again meet with the Administrator and review the investigation. The entire report is then faxed to the State Department of Health, Adult Protective Services, and the Ombudsman. "</p> <p>This Federal tag relates to Complaint #IN00137896.</p> <p>3.1-28(a)</p>			

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F000225 SS=D	<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 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 record review and</p>	F000225	F225 It is the intent of this facility	10/25/2013			

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	<p>interviews, the facility failed to ensure 2 allegations of alleged abuse were thoroughly investigated and reported to the Indiana State Department of Health. This affected 2 of 6 residents interviewed for the abuse protocol, Residents #J and #K.</p> <p>Findings include:</p> <p>CNA #1 was interviewed, at 12:45 p.m., on 10/17/13, and indicated on 10/13/13, Resident #J had asked her if she could put the resident to bed at 2:00 p.m., when she worked, because she didn't want CNA #2 to put her to bed because she was mean. CNA #1 indicated the resident told her CNA #2 had told the resident, on 10/12/13, if she had to do heavy lifting, it would hurt her baby. CNA #1 indicated she reported this to the Assistant Director of Nursing (ADNS), by text message, on 10/13/13.</p> <p>CNA #1 also indicated Resident #K told her, on 10/13/13, that CNA #2 had been mean and rough with her during care on 10/12/13. CNA #1 indicated she reported this to the ADNS on 10/13/13.</p> <p>The ADNS was interviewed, at 1:00 p.m., on 10/12/13, and confirmed CNA #1 had reported the incident to her on 10/13/13, and the ADNS</p>		<p>that all allegations of abuse are immediately reported to the administrator and other officials, all allegations are thoroughly investigated and further potential abuse is prevented. All residents have the potential to not have abuse investigated and reported in a timely fashion. Social services will conduct interviews with all residents to identify any further complaints of abuse.</p> <p>Corrective action taken: The administrator and DON will be in serviced on reporting abuse in accordance with state law by the nurse consultant, included is reporting all allegations of abuse in a timely fashion to the appropriate authorities. All staff in-serviced on October 25, 2013, defined abuse and neglect, regulations for reporting incidents, and facility policy and procedures. All staff received a new abuse policy and signed that they received and where trained on the policy. Monitoring: The administrator will monitor that all allegations of abuse are reported to the proper authorities in a timely fashion. The Administrator and DON will monitor during weekly rounds to ensure all staff are aware of the proper policies and procedures and all immediate steps are properly conducted to ensure the safety of the residents. Rounds will include sampling of staff and residents to ensure all residents are free from abuse. This will be a continuous</p>				

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	<p>indicated she had reported the 2 incidents to the Director of Nursing Services (DNS) and the Administrator on 10/13/13.</p> <p>The DNS was interviewed, at 1:20 p.m., on 10/17/13 and indicated she was notified about the 2 incidents on 10/13/13. She indicated CNA #2 had been contacted and given her verbal statement about the incidents, however, the DNS indicated she had not interviewed Residents J or K, any other residents who the CNA may have taken care of, or any other staff regarding the allegations. She indicated she had talked to the nurse on duty on 10/12/13, but the nurse had told her she was unaware of any incidents. She indicated Resident #K was interviewable, but Resident #J was not interviewable and had been more confused.</p> <p>She indicated she had not reported the incidents of alleged abuse to the Indiana State Department of health (ISDH).</p> <p>Resident #K was interviewed, at 1:45 p.m., on 10/17/13, and indicated CNA #2 was providing personal care to her "the other night" and was hurting her. She told the CNA to stop several times, but she didn't. The resident indicated she told the CNA, "you're</p>		<p>monitoring for the next 12 months. Date of completion: This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is October 25, 2013.</p>				

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	<p>being mean to me", and the resident also indicated, "finally, I raised up my leg and pushed her away. " The resident indicated CNA #2 was normally a very good aide and she had not had any problems with her. She indicated the CNA then left and the nurse came in the room, and she told the nurse about the incident, but she could not remember the nurse's name.</p> <p>The Resident's Rights and Abuse/Neglect Policy, dated as revised on July, 2013, reviewed at 8:30 a.m., on 10/18/13, indicated the following: "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. " In addition, the policy indicated, "If an employee is being investigated, that employee will be placed on suspension pending conclusion of the investigation. The Administrator will be notified and resident will be immediately examined for any new bruises, cuts, etc, conducive to the alleged abuse. Moreover, during the time, the director will speak with and obtain statements from the resident</p>			

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	<p>and/or family as well as the staff on duty, and the suspended employee. After conclusion of the investigation, the director will again meet with the Administrator and review the investigation. The entire report is then faxed to the State Department of Health, Adult Protective Services, and the Ombudsman. "</p> <p>This Federal tag relates to Complaint #IN00137896.</p> <p>3.1-28(c) 3.1-28(d) 3.1-28(e)</p>			

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F000226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interviews, the facility failed to ensure 2 allegations of alleged abuse were thoroughly investigated and reported to the Indiana State Department of Health. This affected 2 of 6 residents interviewed for the abuse protocol, Residents #J and #K.</p> <p>Findings include:</p> <p>CNA #1 was interviewed, at 12:45 p.m., on 10/17/13, and indicated on 10/13/13, Resident #J had asked her if she could put the resident to bed at 2:00 p.m., when she worked, because she didn't want CNA #2 to put her to bed because she was mean. CNA #1 indicated the resident told her CNA #2 had told the resident, on 10/12/13, if she had to do heavy lifting, it would hurt her baby. CNA #1 indicated she reported this to the Assistant Director of Nursing (ADNS), by text message, on 10/13/13.</p> <p>CNA #1 also indicated Resident #K told her, on 10/13/13, that CNA #2 had been mean and rough with her</p>	F000226	<p>F226 It is the intent of this facility to implement written policies and procedures for suspected abuse of residents, by immediately reporting the occurrence to the Administrator, by a thorough investigation of all staff and residents involved and prevention of further abuse during investigations by not allowing staff with allegations to work until the investigation has been completed and resolution has been obtained.</p> <p>All residents have the potential to not have abuse investigated and reported in a timely fashion. Social services will conduct interviews with all residents to identify any further complaints of abuse. Corrective action taken: The administrator and DON will be in serviced on reporting abuse in accordance with state law by the nurse consultant, included is reporting all allegations of abuse in a timely fashion to the appropriate authorities. All staff in-serviced on October 25, 2013, defined abuse and neglect, regulations for reporting incidents, and facility policy and procedures. All staff received a new abuse policy and signed that they received and where trained on</p>	10/25/2013			

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	<p>during care on 10/12/13. CNA #1 indicated she reported this to the ADNS on 10/13/13.</p> <p>The ADNS was interviewed, at 1:00 p.m., on 10/12/13, and confirmed CNA #1 had reported the incident to her on 10/13/13, and the ADNS indicated she had reported the 2 incidents to the Director of Nursing Services (DNS) and the Administrator on 10/13/13.</p> <p>The DNS was interviewed, at 1:20 p.m., on 10/17/13 and indicated she was notified about the 2 incidents on 10/13/13. She indicated CNA #2 had been contacted and given her verbal statement about the incidents, however, the DNS indicated she had not interviewed Residents J or K, any other residents who the CNA may have taken care of, or any other staff regarding the allegations. She indicated she had talked to the nurse on duty on 10/12/13, but the nurse had told her she was unaware of any incidents. She indicated Resident #K was interviewable, but Resident #J was not interviewable and had been more confused.</p> <p>She indicated she had not reported the incidents of alleged abuse to the Indiana State Department of health (ISDH).</p>		<p>the policy. Each new hire will receive the abuse training prior to employment. Monitoring: The administrator will monitor that all allegations of abuse are reported to the proper authorities in a timely fashion. The Administrator and DON will monitor during weekly rounds to ensure all staff are aware of the proper policies and procedures and all immediate steps are properly conducted to ensure the safety of the residents. Rounds will include sampling of staff and residents to ensure all residents are free from abuse. This will be a continuous monitoring for the next 12 months. All new employees' personal files will be inspected for proper documentation including abuse training. Date of completion: This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is October 25, 2013.</p>				

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	<p>Resident #K was interviewed, at 1:45 p.m., on 10/17/13, and indicated CNA #2 was providing personal care to her "the other night" and was hurting her. She told the CNA to stop several times, but she didn't. The resident indicated she told the CNA, "you're being mean to me", and the resident also indicated, "finally, I raised up my leg and pushed her away. " The resident indicated CNA #2 was normally a very good aide and she had not had any problems with her. She indicated the CNA then left and the nurse came in the room, and she told the nurse about the incident, but she could not remember the nurse's name.</p> <p>The Resident's Rights and Abuse/Neglect Policy, dated as revised on July, 2013, reviewed at 8:30 a.m., on 10/18/13, indicated the following: "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. " In addition, the policy indicated, "If an employee is being investigated, that employee will be placed on</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155666	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/18/2013
NAME OF PROVIDER OR SUPPLIER WESLEY HEALTHCARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1751 WESLEY ROAD AUBURN, IN 46706		
(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>suspension pending conclusion of the investigation. The Administrator will be notified and resident will be immediately examined for any new bruises, cuts, etc, conducive to the alleged abuse. Moreover, during the time, the director will speak with and obtain statements from the resident and/or family as well as the staff on duty, and the suspended employee. After conclusion of the investigation, the director will again meet with the Administrator and review the investigation. The entire report is then faxed to the State Department of Health, Adult Protective Services, and the Ombudsman. "</p> <p>This Federal tag relates to Complaint #IN00137896.</p> <p>3.1-28(e)</p>				