

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155066	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/03/2016
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NAME OF PROVIDER OR SUPPLIER EDGEWATER WOODS	STREET ADDRESS, CITY, STATE, ZIP CODE 1809 N MADISON AVE ANDERSON, IN 46011
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00194521.</p> <p>Complaint IN00194521 - Substantiated. Federal/State deficiency related to the allegations is cited at F323.</p> <p>Survey dates: March 1, 2 and 3, 2016</p> <p>Facility number: 000026 Provider number: 155066 AIM number: 100274820</p> <p>Census bed type: SNF/NF: 74 Total: 74</p> <p>Census payor type: Medicare: 20 Medicaid: 51 Other:3 Total: 74</p> <p>Sample: 4</p> <p>This deficiency also reflects state findings in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed by 11474 on March 4,</p>	F 0000		
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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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F 0323 SS=J Bldg. 00	<p>2016.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on interview and record review the facility failed to provide supervision for cognitively impaired residents on an unlocked memory care unit resulting in an sexual behaviors between two residents (Resident A and Resident B). This deficient practice had the potential to effect 1 of 17 male residents currently on the unlocked memory care unit.</p> <p>This deficient practice resulted in Immediate Jeopardy. The Immediate Jeopardy was identified on 3/2/16 and began on 2/28/16. The Executive Director and the Director of Nursing were notified of the Immediate Jeopardy on 3/2/16. The Immediate Jeopardy was removed on 3/3/16 as confirmed by the placement of a mirror in the hallway near the television room; the closing of the</p>	F 0323	<p>This provider respectfully requests that the 2567 plan of correction be considered the letter of credible evidence of compliance as of 3/3/2016. F323 - What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Residents were immediately separated and aggressor placed on 1 on 1 supervision. Both residents assessed for physical injury and psychosocial distress. Completed state reportable. Notified APS, Ombudsman, ISDH, Anderson Police Department, families and Physician. Mr. Funk transferred to Assurance Health for Psychevaluation. Upon discharge at Assurance Health, Resident will be admitted to Fairway Village dementia facility in Indianapolis. Mr. Wisewas evaluated by Psych Services with no recollection of event or signs and symptoms of distress. How</p>	03/03/2016

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	<p>television room bathroom; the locking of and limited access to the program room bathroom; the placement of an audio motion sensor in the television room; the placement of a video monitor in the television room and staff inservices on the changes for resident security</p> <p>Findings include:</p> <p>1. The clinical record for Resident A was reviewed on 3/1/16 at 3:29 p.m. Diagnoses included, but were not limited to, moderate mental retardation, Down's Syndrome, epilepsy, hypothyroidism and dementia.</p> <p>The most recent annual Minimum Data Set (MDS) assessment, dated 1/17/16, was reviewed on 3/1/16 at 3:29 p.m. The MDS indicated Resident A was severely cognitively impaired with a BIMS (Brief Interview for Mental Status Score) of 5. Resident A received the following Activities of Daily Living (ADL) assistance; transfer-extensive assist with 2 person physical assist, toilet use-extensive assist with 2 person physical assist. Resident A had no impairments to range of motion in all extremities. Resident A's height was documented as 60 inches and a weight of 152 pounds.</p> <p>Review of a nursing note, dated 2/28/16</p>		<p>other residents having thepotential to be affected by the same deficient practice will be identified andwhat corrective actions will be taken? No other residents affected by this allegedpractice. Bathroomin common area will be taken out of service. In-service all staff on Elder Justice Act, Abuse, Life-Pathsupervision prior to working next shift. Cameramonitor added to Life Path TV Lounge with portable monitor to be carried byCharge nurse while on med cart or at nurses station. Charge nurse/Designee on unit will complete15 minute checks of TV lounge when Residents are using the lounge. Mirror installed in hallway to provide line of sight toLounge. Alarm placed at entrance to TV lounge to alert staff that Resident has entered the area. Staff is to respond to alarm and initiate 15minute checks if Resident is using room. Staff being in-serviced prior to working on unit on expectations whenalarm sounds. TV loungeno longer has a communal restroom available for Resident use. In-servicecompleted by DNS/Designee on Elder Justice Act, Abuse, Life-Path Supervisionprior to working next shift. What measures will be put into place or what systemic changes will be made to ensure that he deficientpractice does not</p>		

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	<p>at 4:00 p.m., indicated Resident A was observed by CNA #1 sitting on a sofa in the television room while Resident B was sitting on a sofa opposite Resident A. The note indicated, within a few minutes, CNA #1 noticed both Resident A and Resident B were no longer on the sofas and the television room bathroom door was closed. CNA #1 knocked on the door and received no answer. CNA #1 opened the door and observed the residents engaged in oral sexual behavior.</p> <p>Review of CNA #1's written statement indicated the following: "I was walking past the TV room and I didn't see (Resident A's name) or (Resident B's name), but noticed the bathroom door was closed. I knocked on the door no one said anything. I went in and (Resident B's name) was pushing his penis in (Resident A's name) mouth. (Resident A's name) was trying to push away. I called (Resident B's name) he jumped and pulled his pants up. I sent (Resident B's name) to his [sic] and (Resident A's name) to the program room and told the nurse."</p> <p>During an interview on 3/2/16 at 3:37 p.m., CNA #1 indicated both residents were sitting in the television room on separate couches. "I walked past and they were gone and the bathroom door</p>		<p>recur? Bathroom in common area will be taken out of service. In-service all staff on Elder Justice Act, Abuse, Life-Pathsupervision prior to working next shift. Cameramonitor added to Life Path TV Lounge with portable monitor to be carried byCharge nurse while on med cart or at nurses station. Charge nurse/Designee on unit will complete15 minute checks of TV lounge when Residents are using the lounge. Mirror installed in hallway to provide line of sight toLounge. Alarm placed at entrance to TV loungeto alert staff that Resident has entered the area. Staff is to respond to alarm and initiate 15minute checks if Resident is using room. Staff being in-serviced prior to working on unit on expectations whenalarm sounds. TV loungeno longer has a communal restroom available for Resident use. All staff will be in-serviced quarterly and more often asneeded regarding prevention, Identification, Investigation, and Reporting ofabuse and the Elder Justice Act. Staffis expectedto Separate, report and investigate per policy. ED upon permission will attend the monthly resident councilmeeting to discuss reporting any concerns to staff members. Customer Care Repswill continue daily customer care rounds with their specific</p>		

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	<p>was closed." CNA #1 indicated when the bathroom door was opened "I saw (Resident B's name) holding (Resident A's name) head down and putting his penis in (Resident A's name) mouth. (Resident A's name) was pushing (Resident B's name) away. (Resident B's name) did not react until I called his name. I think (Resident B's name) was forcing it on (Resident A's name). After that (Resident B's name) went to his room and took a nap. I reported it to (RN #2's name) and she assessed both residents." CNA #1 indicated Resident A appeared to be upset at that time.</p> <p>During an interview on 3/3/16 at 1:36 p.m., RN #2 indicated Resident B walked past the nursing station going to his room and shortly after she was informed by CNA #1 of the incident observed in the bathroom. "I assessed (Resident A's name) in the bathroom. Resident A went to the program room." RN #2 indicated the program room was supervised by staff. "The program room has someone in there to watch the residents. Some of our residents require close supervision. (Resident B's name) wanted to go to the television room not the program room." RN #1 indicated the television room was not supervised unless both male and female residents were present. "In the TV room if there is mixed company there</p>		<p>assigned residents. Results will be reviewed in morning meeting. Employee meetings will be held monthly to discuss any concerns regarding reporting abuse, neglect and/or misappropriation of property at least monthly. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Utilize Abuse CQI tool weekly x 4 weeks, Monthly x 3, Quarterly thereafter. Results will be reviewed at monthly continuous quality improvement meeting. Action plans will be developed as indicated. If threshold of 100% is not achieved, an action plan will be developed. By what date will the systemic changes will be completed? Corrective actions are complete effective 3/3/16. Requesting IDR due to evidence does not support the scope and severity of citation</p>	

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	<p>is usually a staff member present." RN #2 indicated if the television room were occupied by all males or all females, no staff member would be present.</p> <p>During an observation on 3/1/16 at 4:00 p.m., Resident A was observed in the television room with several other residents present. A staff member was also present. Resident A was sitting on a sofa with a coloring book. Resident A was unable to answer screening questions but wanted to talk about his coloring book. Resident A indicated he did not remember the incident. "I don't remember anything bad." Resident A was pleasant and smiled and waved to others during the observation.</p> <p>2. The clinical record for Resident B was reviewed on 3/1/16 at 2:36 p.m. Diagnoses included, but were not limited to, dementia with behavioral disturbances, depression, anxiety, moderate intellectual disability, mental retardation, and chronic pulmonary edema.</p> <p>The most recent annual Minimum Data Set (MDS) assessment, dated 12/23/15, was reviewed on 3/1/16 at 2:36 p.m. The MDS indicated Resident B was moderately cognitively impaired with a BIMS (Brief Interview for Mental Status</p>			

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	<p>Score) of 8. Resident B received the following Activities of Daily Living (ADL) assistance; transfer-extensive assist with 1 person physical assist, toilet use- extensive assist with 2 person physical assist. Resident B had no impairments to range of motion in all extremities. Resident B's height was documented as 68 inches and a weight of 141 pounds.</p> <p>Review of a Behavioral Medicine progress note, dated 1/15/16, indicated the following: "...Inappropriate behaviors of masturbation in common areas. Re directs easily. Staff transports to bathroom for privacy. Behavior has been occurring x several weeks approx 1-2 x/wk. No hx (history) psych meds. No current psych meds...Clinical Status and Impressions: Mental Retardation challenges POC (point of care). Inappropriate masturbation in common areas x several weeks ago with occurrence rate 1-2 x/week. Will start SSRI [an antidepressant] to attempt to control behavior such that he refrains until he is in private area eg [sic] bathroom to maintain personal integrity...." Resident B was started on Lexapro 5 mg daily for 7 days on 1/16/16 through 1/23/16. Lexapro 10 mg daily was started on 1/24/16.</p>			

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	<p>Review of a current behavior care plan, dated 3/13/15, indicated Resident B initiated physical contact with female residents when in close proximity. Interventions included, but were not limited to, "staff to encourage resident to sit in program room after meals and offering resident to watch television in his room."</p> <p>Review of a current behavior care plan, dated 7/18/14, indicated Resident B exhibited socially inappropriate behavior as evidenced by masturbating in common areas. Interventions included, but were not limited to, "staff to assist resident to his room if observe me masturbating in public areas and assist to his room in the afternoon for quiet time."</p> <p>An Immediate Jeopardy was identified on 3/2/16 at 3:22 p.m. The IJ began on 2/28/16 when the facility failed to provide supervision for cognitively impaired residents on an unlocked memory care unit resulting in an oral sexual behavior between two male residents. The Immediate Jeopardy was removed on 3/3/16, when the surveyor confirmed the facility had implemented the plan of action submitted and approved to abate the Immediate Jeopardy.</p>			

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	<p>During an interview on 3/3/16 at 12:05 p.m., CNA #7 indicated an inservice on the changes in security was provided today. Changes included:</p> <ol style="list-style-type: none"> 1. A mirror in the hallway near the television room was placed to make supervision from the hallway possible. 2. A video monitor was placed in the television room. The nurse carried the monitor for visual access, 3. A motion sensor monitor to detect entry and exit into and out of the television room had been placed. 4. The bathroom located in the television room was now closed and was not to be used. The door is locked and maintenance had the only key. 5. The bathroom located in the program room was locked and the nurse carried the key. <p>During an interview on 3/3/16 at 12:10 p.m., RN #11 indicated the same inservice education and interventions for resident security on the Life Path unit. In addition, CNA #14, LPN #8, and CNA #15 indicated the same inservice education and interventions for resident security on the Life Path unit.</p> <p>During a tour of the Life Path unit on 3/3/16 at 11:45 p.m., the following was observed:</p> <ol style="list-style-type: none"> 1. Half circle mirror in the hallway near 			

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	<p>the television room, allowing visual supervision of the television room from anywhere in the hallway.</p> <p>2. Video monitor in the television room that the nurse carried for visual access. The monitor was portable.</p> <p>3. Motion sensor monitor with audio alert to detect entry and exit to and from the television room had been placed to alert staff of activity in the television room.</p> <p>4. The bathroom located in the television room was now locked and was not to be used. The door was locked and maintenance had the only key.</p> <p>5. The bathroom located in the program room was locked and the nurse carried the key.</p> <p>During a tour of the Life Path unit on 3/3/16 at 1:40 p.m., 13 residents were observed in the television room with 3 staff members present. The Unit Director was present and indicated she was providing the supervision at that time.</p> <p>This Federal tag relates to Complaint IN00194521.</p> <p>3.1-45(a)(2)</p>			

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