STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 06/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTH AT WINDERMERE	9745 OLYMPIA DR FISHERS, IN 46038

(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
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: June 28, 29, and 30, 2016. Facility number: 002999 Provider number: N/A AIM number: N/A Census bed type: Residential: 118 Total: 118 Census payor type: Other: 118 Total: 118 Sample: 10 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-5. Quality review completed by 30576 on July 5, 2016	R 0000	**DISCLAIMER: "This plan of correction is submitted as required under State and Federal law. The submission of this Plan of Correction does not constitute an admission on the part of The Hearth at Windermere as to the accuracy of the surveyor's findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of theFederal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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			or affiliated companies."	
R 0051 Bldg. 00	410 IAC 16.2-5-1.2(u) Residents' Rights - Offense (u) Residents have the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident ' s medical symptoms. Based on interview and record review, the facility failed to ensure a resident remained free from a physical restraint when a staff member wrapped a bed sheet around a resident to prevent her from taking a "swing" at them for 1 of 1 residents reviewed for restraints (Resident #28). Findings include: The clinical record for Resident #28 was reviewed on 6/28/16 at 2:00 p.m. The diagnoses for Resident #28 included, but were not limited to, senile dementia/Alzheimer's type, anxiety, and depression. A Physician's Progress Note, dated 5/4/16, indicated "...Neurological: She is alert. She is disoriented. Follows simple commands poorly. Psychiatric: Cognition and memory are impaired. She exhibits abnormal recent memory and abnormal remote memory...." A Nursing Summary, dated 6/2/16,	R 0051	1.The corrective action that has been accomplished for Resident #28 was a nursing request to have physician assess the resident to determine if the aggression resulted from infection or decline in physical condition, to evaluate medications and advise on how best to deal with any further episodes of aggression. June 16th, 2016, an In-service on Abuse and Neglect was conducted for staff, along with re-training on Residents Rights. On June 29th, training held for staff on dementia/ dealing with behaviors and on July 11th, staff received training on how to deal appropriately with aggression/behaviors. 2.All residents in the Keepsake unit have the potential to be affected by the alleged deficient practice. All Keepsake residents were monitored for signs/symptoms of abuse by the ED or designee. The affected resident was monitored per the DON or designee for any physical or psychosocial issues that may have resulted from the alleged deficient practice. Nursing staff, including C.N.A.'s were trained on	07/31/2016

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	indicated Resident #28 "...ambulates alone...position: self...Emotional: friendly...Positioning Devices: No[:] Device must be treated as a restraint...." An Elopement Risk, dated 6/4/16, indicated Resident #28 was "...independently mobile...." A Nurse's Note, dated 6/7/16 at 3:50 p.m., indicated, "...writer received a note this am [sic] from an employee expressing some concerns of resident care on 6/3/16-6/4/16. Writer interviewed all parties involved...Resident does not seem to remember the incident involved due to cognitive ability...." A Physician Progress Note, dated 6/8/16, indicated, "...staff reported agitation on evening on 6/3/16...Neurological: She is alert...Psychiatric: cognition and memory are impaired....Some behaviors may have escalated because of staff response. Discussed with nursing staff...." A Nurse Practitioner Note, dated 6/15/16, indicated, "...Has been increasingly tearful at times...Psychiatric: Her mood appears anxious. Her speech is delayed. Cognition and memory are impaired. She expresses inappropriate judgment. Tearful-rapid mood swings..."		abuse/neglect and the how to deal appropriately with aggression during the care of dementia residents. 3.The measures to be put into place and systematic changes the facility will initiate to ensure that the deficient practice will not recur include ED or designee will monitor all Keepsake residents for signs/symptoms of abuse randomly 5 times weekly for 3 months, then 3 times weekly for 3 months, then once weekly until next survey. All newly hired employees will receive training during orientation to include resident's rights, abuse/neglect, including the use of chemical and physical restraints and how to deal appropriately with aggressive/combative residents. Staff will be trained on the immediate reporting of any concerns to the Executive Director, DON or department head. New hires will sign off on their training to assure that the required topics have been completed. Facility policy will continue to be enforced that any suspected allegations of abuse/neglect or resident rights violations will be reported immediately to the ISDH, alleged employee suspended immediately pending investigation and an investigation initiated. 4.The corrective action will be monitored by the Executive Director or designee who will be responsible for monitoring all	

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	A "Incident" from the State Agency's Report System, dated 6/7/16, was received from the Administrator, on 6/28/16 at 12:30 p.m. The incident indicated, "...Incident Date: 6/3/16...Resident Involved...[Name of Resident #28]...Staff Involved...[Name of CNA #1]...Brief Description of Incident Description added-6/7/16 Was reported to writer 6/7/16 appr [approximately] 10am [sic], that the staff member was providing care to resident during the 10p-6a [sic] shift 6/3/16-6/4/16, and after care given, pulled resident's door shut and would not let resident out of her room, until another resident passed by...." During an interview on 6/28/16 at 2:05 p.m. with Unit Manager (UM) #4, UM #4 indicated Resident #28 can be aggressive if approached in a certain way, such as directing her what to do. A copy of the incident investigation was provided by the Director of Nursing, on 6/29/16 at 10:30 a.m. A document included in the file titled, "Documentation on [Name of CNA #1] 6/7/16" indicated, "DON [Director of Nursing] found a letter in her mailbox 6/7/16 from male cna detailing concerns about a female cna who worked night shift on 6/3/16. The letter explained that		Keepsake residents for signs/symptoms of abuse randomly 5 times a week for 3 months, then 3 times a week for 3 months, then once weekly until the next survey and assuring that the new employee orientation and training is completed in a timely manner. 5.The date that the systematic changes will be completed by is July 31st, 2016.	

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	the female cna had informed the oncoming shift that she pulled a memory care resident's door closed and refused to let her out for several minutes. The female cna was immediately suspended pending investigation and statements were requested from the staff members who had overheard the female cna's comments during report, along with the staff working Friday night. Investigation was initiated 6/7/16 and female cna was questioned about the events of 6/3/16. Female cna stated that she was with resident when resident started to 'swing' at her. She stated she wrapped a sheet around resident [sic] so she would not get hit as she guided resident to the toilet (where she removed the sheet). After toileting resident, female cna states she 'exited the room and closed the door behind her.' She stated the resident was getting ready to throw something at her, as another memory care resident walked past in the hallway. Female cna states she held the door closed until the male resident walked past (so that he would not be struck by the object). Female cna also stated that she had used her walkie talkie to request assist from AL [Assisted Living] nurse and cna. When questioned, AL nurse stated that she had not heard the cna call for help. AL cna stated, upon investigation, that she also had not heard m.c. [memory care] cna call for assist.			

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	She stated that the Memory Care cna informed her that she had called her on the walkie requesting help...." Another document included in the investigative file, was titled [name of CNA #1]-Interview via phone, dated 6/7/16. The document indicated, "Writer questioned employee of any events that may have happened during noc [night] shift Friday 6/3/16-6/4/16...When questioned about [room number of Resident #28], states resident got up and began to swing at her and employee wrapped sheet around her and took her to toilet. Resident was not wet, then CNA took her to the bathroom and removed sheet. Stated that she [name of CNA #1] left bathroom and resident was following her out and was going to throw something and CNA walked out into hallway and another resident was passing by, and [name of CNA #1] pulled the door shut, held the door shut so the resident could not come out until the other resident passed. [name of CNA #1] stated she tried to reach AL nurse et CNA via walkie talkie with no response. States she made a mistake, but did not know how to react and once the other resident passed she let the door go...." On 6/29/16 at 11:25 a.m., during an interview with the Director of Nursing			

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	and the Administrator, the DON indicated she initially thought the resident was not dressed appropriately, so CNA #1 used a sheet to cover her for modesty on the way to the toilet, but she didn't ask CNA #1 about it when she spoke with her (CNA #1) on the phone. After reviewing the investigative file documents with the DON, the DON indicated CNA #1 wrapped a sheet around Resident #28 to prevent Resident #28 from hitting her (CNA#1), as indicated above. A copy of the "letter" provided by the male cna [CNA #3] indicated above, was received from the DON, on 6/29/16 at 11:47 a.m. The letter, no date, indicated, "Concerns: Resident neglect, verbal statement of employee describing confinement, and possible physical abuse. In regards to [name of CNA #1], henceforth referred as 'the employee.' 6/3/16: The employee requested of me that I take her around the unit and explain resident needs for the night...During [indecipherable] shift the resident in [room number of Resident #28] has also been asleep or wandering about in a very stable and positive mood. She was asleep on the couch, but I stated that she wandered often and it was probably ok to leave her there...6/4/16: After leaving residents in what I believed to be a safe			

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	and hygenic [sic] condition at about 10:15 pm [sic] I went home to sleep from about 11 pm [sic] to 5:30 am [sic]. I then returned at about 6 am [sic]. The employee was immediately very confrontational, stating that I had severely misinformed her in regards to as changes [sic] in condition of [room number of Resident #28]. She stated that [room number of Resident #28] had awoken in front of her, immediately lunged towards her, and attempted to harm her without any reasonable intent. She then stated directly, verbally and clearly to me that she had shut the resident in her room after battling with her, and held the door closed until the resident no longer attempted to open the door. She then stated that she had not attended to the resident or attempted to enter the room for the rest of the of the night...Perhaps the most concerning was the state of [room number of Resident #28], as the condition of the room did not match the story communicated by the employee, nor was the condition of the non-combative resident at all acceptable. When I entered the room, all lights were off and the resident was asleep and actively shivering. This was likely due to the fact that she had kicked off all 4 layers...all of which were completely soiled The resident was lying in a visible puddle of urine, naked from the waist			

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	down. Although I had given her a new brief before the end of my previous shift...fitted sheet was also missing from the resident's room, indicating that someone had entered [indecipherable] room and removed both a brief and a fitted sheet. Upon awakening the resident [room number of Resident #28] did not wake up suddenly or become alarmed or combative. Instead, she willingly got up and headed straight for the toilet when I pointed towards it. She dressed herself with minimal assistance and did not resist assistance at all...." During a phone interview with CNA #3, on 6/29/16 at 3:05 p.m., CNA #3 indicated he gave report for the evening shift, on 6/3/16, to CNA #1 and was immediately confronted in the morning by CNA #3 when he came back (on 6/4/16). CNA #3 indicated CNA #1 told him that Resident #28 leapt up from the couch in a confrontational manner, so she put Resident #28 in her room and held the door closed until the resident stopped trying to get out of the room. CNA #3 further indicated Resident #28 appeared to wrapped up in sheets when he went to check on her in the morning (6/4/16), she was missing sheets in her room, and was her bed "soaked." CNA #3 also indicated Resident #28 can walk herself to the bathroom and toilet herself, if directed			

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	appropriately. At 12:42 p.m., on 6/29/16, the Administrator felt that when CNA #1 wrapped Resident #28 in a sheet, so she (CNA #1) would not get hit by Resident #28, it was considered a restraint. During an interview with the Administrator, on 6/29/16 at 12:55 p.m., the Administrator indicated the facility was a restraint free facility. During an interview with UM #4, on 6/30/16 at 8:50 a.m., UM #4 indicated Resident #28 was independent, only required cueing to ambulate to the bathroom, and to use the toilet. On 6/30/16 at 9:10 a.m., the Administrator indicated the facility did not have a specific policy related to being a restraint free facility, but the facility followed the regulations.			
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse;			

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	(4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on interview and record review, the facility failed to ensure a resident remained free from abuse in the form of involuntary seclusion when a staff member held a resident's door closed preventing a resident the ability to exit their room for 1 of 1 residents reviewed for involuntary seclusion (Resident #28) Findings include: The clinical record for Resident #28 was reviewed on 6/28/16 at 2:00 p.m. The diagnoses for Resident #28 included, but were not limited to, senile dementia/Alzheimer's type, anxiety, and depression. A Physician's Progress Note, dated 5/4/16, indicated "...Neurological: She is alert. She is disoriented. Follows simple commands poorly. Psychiatric: Cognition and memory are impaired. She exhibits abnormal recent memory and abnormal remote memory...." A Nursing Summary, dated 6/2/16, indicated Resident #28 "...ambulates alone...position: self...Emotional: friendly...Positioning Devices: No[:] Device must be treated as a restraint....	R 0052	1.The corrective action(s) that has been accomplished for Resident #28 was a nursing request for primary physician to assess the resident in order to determine if the aggression was the result of infection or decline in physical condition, to evaluate resident medications and advise on how best to deal with further episodes of aggression. June 16th, 2016, an In-service on Abuse and Neglect was conducted for staff to include the definition of “Involuntary Seclusion”, along with re-training on Residents Rights. On June 29th,staff were trained on dementia and dealing with behaviors. July 11th,, staff received training on appropriate handling of aggression/behaviors. 2.All residents in the Keepsake unit have the potential to be affected by the alleged deficient practice. All Keepsake residents were monitored for signs/symptoms of abuse by the ED or designee. The affected resident was monitored per the DON or designee for any physical or psychosocial issues that may have resulted from the alleged deficient practice. Nursing staff and C.N.A.’s were trained on abuse/neglect, including the definition of “Involuntary Seclusion” and how appropriately	07/31/2016

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	6/28/16 at 12:30 p.m. The incident indicated, "...Incident Date: 6/3/16...Resident Involved...[Name of Resident #28]...Staff Involved...[Name of CNA #1]...Brief Description of Incident Description added-6/7/16 Was reported to writer 6/7/16 appr [approximately] 10am [sic], that the staff member was providing care to resident during the 10p-6a [sic] shift 6/3/16-6/4/16, and after care given, pulled resident's door shut and would not let resident out of her room, until another resident passed by...." During an interview on 6/28/16 at 2:05 p.m. with Unit Manager (UM) #4, UM #4 indicated Resident #28 can be aggressive if approached in a certain way, such as directing her what to do. A copy of the incident investigation was provided by the Director of Nursing, on 6/29/16 at 10:30 a.m. A document included in the file titled, "Documentation on [Name of CNA #1] 6/7/16" indicated, "DON [Director of Nursing] found a letter in her mailbox 6/7/16 from male cna detailing concerns about a female cna who worked night shift on 6/3/16. The letter explained that the female cna had informed the oncoming shift that she pulled a memory care resident's door closed and refused to let her out for several minutes. The		responsible for monitoring all Keepsake residents for signs/symptoms of abuse randomly 5 times a week for 3 months, then 3 times a week for 3 months, then once weekly until the next survey and ensuring the new employee orientation and training are completed in a timely manner. 5.The date that the systematic changes will be completed by is July 31st, 2016.	

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	female cna was immediately suspended pending investigation and statements were requested from the staff members who had overheard the female cna's comments during report, along with the staff working Friday night. Investigation was initiated 6/7/16 and female cna was questioned about the events of 6/3/16. Female cna stated that she was with resident when resident started to 'swing' at her. She stated she wrapped a sheet around resident [sic] so she would not get hit as she guided resident to the toilet (where she removed the sheet). After toileting resident, female cna states she 'exited the room and closed the door behind her.' She stated the resident was getting ready to throw something at her, as another memory care resident walked past in the hallway. Female cna states she held the door closed until the male resident walked past (so that he would not be struck by the object). Female cna also stated that she had used her walkie talkie to request assist from AL [Assisted Living] nurse and cna. When questioned, AL nurse stated that she had not heard the cna call for help. AL cna stated, upon investigation, that she also had not heard m.c. [memory care] cna call for assist. She stated that the Memory Care cna informed her that she had called her on the walkie requesting help...."			

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	Another document included in the investigative file, was titled [name of CNA #1]-Interview via phone, dated 6/7/16. The document indicated, "Writer questioned employee of any events that may have happened during noc [night] shift Friday 6/3/16-6/4/16...When questioned about [room number of Resident #28], states resident got up and began to swing at her and employee wrapped sheet around her and took her to toilet. Resident was not wet, then CNA took her to the bathroom and removed sheet. Stated that she [name of CNA #1] left bathroom and resident was following her out and was going to throw something and CNA walked out into hallway and another resident was passing by, and [name of CNA #1] pulled the door shut, held the door shut so the resident could not come out until the other resident passed. [name of CNA #1] stated she tried to reach AL nurse et CNA via walkie talkie with no response. States she made a mistake, but did not know how to react and once the other resident passed she let the door go...." A document titled, "Interview with nurse [name of RN #2]," dated 6/7/16 was also in the investigative file. The document indicated, "...States that [name of CNA #1] did inform her later of trying to notify her and [name of CNA #5] via walkie			

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	and they both denied hearing her, they checked walkies and was able to her during the walkie talkie check...Stated [name of CNA #1] did tell her about closing door on resident later...." A document titled, "Interview with [name of CNA #5], dated 6/7/16, indicated, "States she did go check [room number of Resident #28] due to her call light on and [room number of Resident #28] and [name of CNA #5] fixed the pullcord...Stated she did not hear [name of CNA #1] call for help via walkie talkie...." An additional document in the investigative file was titled, Termination Checklist. It was dated 6/8/16 and indicated, "...Date of Hire: 3/25/14...Description of incident: Resident rights violation. 6/7/16 Reported to writer per male cna of care concerns on [unit which Resident #28 resides]. Closed door of residents [sic] room and held door shut so resident could not come out into hallway. Your recommendation: 6/7/16 suspended pending investigation. 6/8/16 Termination recommended...." The investigative file also indicated CNA #1 completed abuse training on 10/21/15 and 6/5/16.			

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	During an interview with the DON, on 6/29/16 at 10:20 a.m., the DON indicated a staff member held a resident's door shut to a resident's room, while the resident was in the room. The staff member held the door shut because she thought the resident was upset during care and thought the resident might throw something at a resident walking by. On 6/29/16, at 10:43 a.m., the DON indicated CNA #1 was terminated due to a violation of resident's right to be free from involuntary seclusion. The DON further indicated residents have the right to leave their room. At 11:25 a.m., on 6/29/16, during an interview with the DON and the Administrator, the DON indicated she was unsure how long CNA #1 held the door shut and she did not ask CNA #1 when she spoke to her, but the DON did not feel like it was very long, maybe a couple minutes or less. The DON further indicated the situation described above met the definition of involuntary seclusion. A copy of the "letter" provided by the male cna [CNA #3] indicated above, was received from the DON, on 6/29/16 at 11:47 a.m. The letter, no date, indicated,			

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	"Concerns: Resident neglect, verbal statement of employee describing confinement, and possible physical abuse. In regards to [name of CNA #1], henceforth referred as 'the employee.' 6/3/16: The employee requested of me that I take her around the unit and explain resident needs for the night...During [indecipherable] shift the resident in [room number of Resident #28] has also been asleep or wandering about in a very stable and positive mood. She was asleep on the couch, but I stated that she wandered often and it was probably ok to leave her there...6/4/16: After leaving residents in what I believed to be a safe and hygenic [sic] condition at about 10:15 pm [sic] I went home to sleep from about 11 pm [sic] to 5:30 am [sic]. I then returned at about 6 am [sic]. The employee was immediately very confrontational, stating that I had severely misinformed her in regards to as changes [sic] in condition of [room number of Resident #28]. She stated that [room number of Resident #28] had awoken in front of her, immediately lunged towards her, and attempted to harm her without any reasonable intent. She then stated directly, verbally and clearly to me that she had shut the resident in her room after battling with her, and held the door closed until the resident no longer attempted to open the			

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	door. She then stated that she had not attended to the resident or attempted to enter the room for the rest of the of the night...Perhaps the most concerning was the state of [room number of Resident #28], as the condition of the room did not match the story communicated by the employee, nor was the condition of the non-combative resident at all acceptable. When I entered the room, all lights were off and the resident was asleep and actively shivering. This was likely due to the fact that she had kicked off all 4 layers...all of which were completely soiled The resident was lying in a visible puddle of urine, naked from the waist down. Although I had given her a new brief before the end of my previous shift...fitted sheet was also missing from the resident's room, indicating that someone had entered [indecipherable] room and removed both a brief and a fitted sheet. Upon awakening the resident [room number of Resident #28] did not wake up suddenly or become alarmed or combative. Instead, she willingly got up and headed straight for the toilet when I pointed towards it. She dressed herself with minimal assistance and did not resist assistance at all...." During a phone interview with CNA #3, on 6/29/16 at 3:05 p.m., CNA #3 indicated he gave report for the evening			

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	shift, on 6/3/16, to CNA #1 and was immediately confronted in the morning by CNA #3 when he came back (on 6/4/16). CNA #3 indicated CNA #1 told him that Resident #28 leapt up from the couch in a confrontational manner, so she put Resident #28 in her room and held the door closed until the resident stopped trying to get out of the room. CNA #3 further indicated Resident #28 appeared to wrapped up in sheets when he went to check on her in the morning (6/4/16), she was missing sheets in her room, and her bed was "soaked." CNA #3 also indicated Resident #28 can walk herself to the bathroom and toilet herself, if directed appropriately. During an interview with UM #4, on 6/30/16 at 8:50 a.m., UM #4 indicated Resident #28 was independent, only required cueing to ambulate to the bathroom, and to use the toilet. A policy titled, Abuse Prevention Policy, no date, was received from the DON on 6/30/16 at 9:10 a.m. The policy indicated, "Purpose: To establish guidelines and procedures for preventing, investigating, resolving, and reporting abuse, neglect, involuntary seclusion...It is the policy of [name of facility] to protect residents from abusive acts and to adequately train facility personnel in			

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	methods of detection and prevention of abuse...Definitions:...Involuntary Seclusion-means separation of the resident from other residents or from his/her room against the resident's will or the will of the resident's legal representative...10. Any staff member who has knowledge of or reasonable cause to believe a resident has been or is being abused...shall make an immediate oral report to Administrator, Director of Nursing or their supervisor...."			
R 0091 Bldg. 00	410 IAC 16.2-5-1.3(h)(1-4) Administration and Management - Noncompliance (h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request. Based on interview and record review, the facility to ensure an abuse policy was implemented by not keeping a resident free from involuntary seclusion or by a staff member not immediately reporting	R 0091	1.The corrective action(s) that has been accomplished for Resident #28 was June 16th, 2016, an In-service on Residents Rights and Abuse and Neglect was conducted for staff, including the importance of immediate	07/31/2016

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	an allegation of abuse for 1 of 1 abuse allegations reviewed. (Resident #28) Findings include: The clinical record for Resident #28 was reviewed on 6/28/16 at 2:00 p.m. The diagnoses for Resident #28 included, but were not limited to, senile dementia/Alzheimer's type, anxiety, and depression. A Nurse's Note, dated 6/7/16 at 3:50 p.m., indicated, "...writer received a note this am [sic] from an employee expressing some concerns of resident care on 6/3/16-6/4/16. Writer interviewed all parties involved...Resident does not seem to remember the incident involved due to cognitive ability...." A Physician Progress Note, dated 6/8/16, indicated, "...staff reported agitation on evening on 6/3/16...Neurological: She is alert...Psychiatric: cognition and memory are impaired....Some behaviors may have escalated because of staff response. Discussed with nursing staff...." A "Incident" from the State Agency's Report System, dated 6/7/16, was received from the Administrator, on 6/28/16 at 12:30 p.m. The incident		reporting of any suspected allegations of abuse and neglect to Executive Director, DON or department head. On June 29th, staff attended training on how to handle behaviors in dementia residents and on July 11th, were taught how to appropriately deal with aggression/combative behaviors during the care of dementia residents. 2.All residents in the Keepsake unit have the potential to be affected by the alleged deficient practice. Nursing staff, including C.N.A.'s received training on abuse/neglect and the importance of immediate reporting of any suspected abuse and neglect to the Executive Director, DON or department head. 3.The measures to be put into place and systematic changes the facility will initiate to ensure that the deficient practice will not recur include the Corporate Nurse will review with the ED and DON abuse prohibition and abuse/neglect reporting. All staff will be trained on abuse annually per state regulations. ED or designee will randomly question 5 staff members regarding what to do if they witness abuse of a resident every week for 3 months, then question 3 staff every week for 3 months, then 1 staff member every week until next survey. Executive Director or designee then shall provide all newly hired employees training to include resident's rights,	

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	indicated, "...Incident Date: 6/3/16...Resident Involved...[Name of Resident #28]...Staff Involved...[Name of CNA #1]...Brief Description of Incident Description added-6/7/16 Was reported to writer 6/7/16 appr [approximately] 10am [sic], that the staff member was providing care to resident during the 10p-6a [sic] shift 6/3/16-6/4/16, and after care given, pulled resident's door shut and would not let resident out of her room, until another resident passed by...." A copy of the incident investigation was provided by the Director of Nursing, on 6/29/16 at 10:30 a.m. A document included in the file titled, "Documentation on [Name of CNA #1] 6/7/16" indicated, "DON [Director of Nursing] found a letter in her mailbox 6/7/16 from male cna detailing concerns about a female cna who worked night shift on 6/3/16. The letter explained that the female cna had informed the oncoming shift that she pulled a memory care resident's door closed and refused to let her out for several minutes. The female cna was immediately suspended pending investigation and statements were requested from the staff members who had overheard the female cna's comments during report, along with the staff working Friday night. Investigation was initiated 6/7/16 and female cna was		abuse/neglect, including the importance of immediate reporting of any suspected abuse/neglect to the Executive Director, DON or department head. All new hires will sign off on their training to assure that the required topics have been completed. All new hires will sign off on their training to assure that the required topics have been completed. Facility policy will continue to be enforced that any suspected allegations of abuse/neglect or resident rights violations will be reported immediately to the ISDH, alleged employee suspended immediately pending investigation and investigation initiated. 4.The corrective action will be monitored by the Executive Director or designee who will be responsible to assuring that 5 staff will be randomly questioned regarding what to do if they witness abuse of a resident every week for 3 months, then 3 every week for 3 months, then 3 every week until next survey. The ED or designee will ensure that all staff are trained on abuse and neglect annually and the new employee orientation and training be completed in a timely manner. 5.The date that the systematic changes will be completed by is July 31st, 2016.	

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	questioned about the events of 6/3/16. Female cna stated that she was with resident when resident started to 'swing' at her. She stated she wrapped a sheet around resident [sic] so she would not get hit as she guided resident to the toilet (where she removed the sheet). After toileting resident, female cna states she 'exited the room and closed the door behind her.' She stated the resident was getting ready to throw something at her, as another memory care resident walked past in the hallway. Female cna states she held the door closed until the male resident walked past (so that he would not be struck by the object. Female cna also stated that she had used her walkie talkie to request assist from AL [Assisted Living] nurse and cna. When questioned, AL nurse stated that she had not heard the cna call for help. AL cna stated, upon investigation, that she also had not heard m.c. [memory care] cna call for assist. She stated that the Memory Care cna informed her that she had called her on the walkie requesting help...." Another document included in the investigative file, was titled [name of CNA #1]-Interview via phone, dated 6/7/16. The document indicated, "Writer questioned employee of any events that may have happened during noc [night] shift Friday 6/3/16-6/4/16...When			

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	questioned about [room number of Resident #28], states resident got up and began to swing at her and employee wrapped sheet around her and took her to toilet. Resident was not wet, then CNA took her to the bathroom and removed sheet. Stated that she [name of CNA #1] left bathroom and resident was following her out and was going to throw something and CNA walked out into hallway and another resident was passing by, and [name of CNA #1] pulled the door shut, held the door shut so the resident could not come out until the other resident passed. [name of CNA #1] stated she tried to reach AL nurse et CNA via walkie talkie with no response. States she made a mistake, but did not know how to react and once the other resident passed she let the door go...." A document titled, "Interview with nurse [name of RN #2]," dated 6/7/16 was also in the investigative file. The document indicated, "...States that [name of CNA #1] did inform her later of trying to notify her and [name of CNA #5] via walkie and they both denied hearing her, they checked walkies and was able to her during the walkie talkie check...Stated [name of CNA #1] did tell her about closing door on resident later...." A document titled, "Interview with [name			

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	of CNA #5], dated 6/7/16, indicated, "States she did go check [room number of Resident #28] due to her call light on and [room number of Resident #28] and [name of CNA #5] fixed the pullcord...Stated she did not hear [name of CNA #1] call for help via walkie talkie...." An additional document in the investigative file was titled, Termination Checklist. It was dated 6/8/16 and indicated, "...Date of Hire: 3/25/14...Description of incident: Resident rights violation. 6/7/16 Reported to writer per male cna of care concerns on [unit which Resident #28 resides]. Closed door of residents [sic] room and held door shut so resident could not come out into hallway. Your recommendation: 6/7/16 suspended pending investigation. 6/8/16 Termination recommended...." During an interview with the DON, on 6/29/16 at 10:20 a.m., the DON indicated the incident happened the night of 6/3-4/16 and was not reported until 6/7/16. The DON further indicated the "late reporting" was addressed with CNA #3. At 11:25 a.m., on 6/29/16, during an interview with the DON and the			

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	Administrator, the DON indicated when there was an allegation of abuse, staff should report it immediately to management. A copy of the "letter" provided by the male cna [CNA #3] indicated above, was received from the DON, on 6/29/16 at 11:47 a.m. The letter, no date, indicated, "Concerns: Resident neglect, verbal statement of employee describing confinement, and possible physical abuse. In regards to [name of CNA #1], henceforth referred as 'the employee.' 6/3/16: The employee requested of me that I take her around the unit and explain resident needs for the night...During [indecipherable] shift the resident in [room number of Resident #28] has also been asleep or wandering about in a very stable and positive mood. She was asleep on the couch, but I stated that she wandered often and it was probably ok to leave her there...6/4/16: After leaving residents in what I believed to be a safe and hygenic [sic] condition at about 10:15 pm [sic] I went home to sleep from about 11 pm [sic] to 5:30 am [sic]. I then returned at about 6 am [sic]. The employee was immediately very confrontational, stating that I had severely misinformed her in regards to as changes [sic] in condition of [room number of Resident #28]. She stated that			

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	[room number of Resident #28] had awoken in front of her, immediately lunged towards her, and attempted to harm her without any reasonable intent. She then stated directly, verbally and clearly to me that she had shut the resident in her room after battling with her, and held the door closed until the resident no longer attempted to open the door. She then stated that she had not attended to the resident or attempted to enter the room for the rest of the of the night...Perhaps the most concerning was the state of [room number of Resident #28], as the condition of the room did not match the story communicated by the employee, nor was the condition of the non-combative resident at all acceptable. When I entered the room, all lights were off and the resident was asleep and actively shivering. This was likely due to the fact that she had kicked off all 4 layers...all of which were completely soiled The resident was lying in a visible puddle of urine, naked from the waist down. Although I had given her a new brief before the end of my previous shift...fitted sheet was also missing from the resident's room, indicating that someone had entered [indecipherable] room and removed both a brief and a fitted sheet. Upon awakening the resident [room number of Resident #28] did not wake up suddenly or become			

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	alarmed or combative. Instead, she willingly got up and headed straight for the toilet when I pointed towards it. She dressed herself with minimal assistance and did not resist assistance at all...." During a phone interview with CNA #3, on 6/29/16 at 3:05 p.m., CNA #3 indicated he gave report for the evening shift, on 6/3/16, to CNA #1 and was immediately confronted in the morning by CNA #3 when he came back (on 6/4/16). CNA #3 indicated CNA #1 told him that Resident #28 leapt up from the couch in a confrontational manner, so she put Resident #28 in her room and held the door closed until the resident stopped trying to get out of the room. CNA #3 further indicated Resident #28 appeared to wrapped up in sheets when he went to check on her in the morning (6/4/16), she was missing sheets in her room, and her bed was "soaked." CNA #3 also indicated Resident #28 can walk herself to the bathroom and toilet herself, if directed appropriately. The employee file of CNA #3 was reviewed on 6/30/16 at 10:30 a.m. The employee file contained an acceptance letter of the position signed on 12/18/15. The file also indicated CNA #3 completed abuse and resident rights training on 12/23/15.			

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	A policy titled, Abuse Prevention Policy, no date, was received from the DON on 6/30/16 at 9:10 a.m. The policy indicated, "Purpose: To establish guidelines and procedures for preventing, investigating, resolving, and reporting abuse, neglect, involuntary seclusion...It is the policy of [name of facility] to protect residents from abusive acts and to adequately train facility personnel in methods of detection and prevention of abuse...Definitions:...Involuntary Seclusion-means separation of the resident from other residents or from his/her room against the resident's will or the will of the resident's legal representative...10. Any staff member who has knowledge of or reasonable cause to believe a resident has been or is being abused...shall make an immediate oral report to Administrator, Director of Nursing or their supervisor...."			
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows:			

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	(1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on interview and record review, the facility failed to maintain a record of all fire drills conducted in the past year for 3 of 12 months of fire drills reviewed. Findings include: On 6/28/16, at 11:00 a.m., the fire drills for the past year were requested from the ED (Executive Director). On 6/28/16, at 11:15 a.m., the ED provided records of fire drills for the past year. On 6/29/16, at 11:15 a.m., the Maintenance Director provided a red binder that included records of fire drills for the past year. Between the binder provided by the Maintenance Director	R 0092	1.A tracking tool was created to ensure the fire drills are conducted in accordance with State Regulations and Facility Polilcy, to include drills conducted quarterly on each shift and 12 times during the year. The Maintenance Director was retrained on the State Regulations and Facility protocol for fire safety and disaster preparedness and a the Fire/Evacuation Binder update to include the new tracking mechanism. 2.All residents have the potential to be affected by the alleged deficient practice. The Maintenance Director was retrained on the State Regulations and Facility protocol for fire safety/disaster	07/31/2016

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	and records provided by the ED, there was only documentation of 9 fire drills conducted in the past 12 months, with 3 of the 9 on second shift and 2 of the 9 on third shift. An interview was conducted with the Maintenance Director on 6/29/16 at 1:50 p.m. He indicated the documentation of fire drills did not indicate the actual number of fire drills actually conducted. An interview was conducted with the ED on 6/29/16 at 2:00 p.m. She indicated she received copies of all fire drill documentation. She reviewed her binder of fire drills. There was only documentation of 9 drills in the past year, with 3 of the 9 on second shift and 2 of the 9 on third shift. At the time of exit from the facility, on 6/30/16 at 11:30 a.m., no additional fire drills for the past year had been provided. Page 32 of the facility Life Safety Operations Manual was provided by the Director of Nursing on 6/30/16 at 9:10 a.m. It indicated, "Fire drills must be conducted quarterly on each shift and with at least one drill conducted each month....Be prepared to show documentation of Fire Safety Training and certified inspection results."		preparedness and the importance of monthly and quarterly fire drills. 3.The Executive Director will meet with the Maintenance Director twice weekly for 3 months and then weekly until the next survey, to go over the Fire/Disaster Preparedness binder and ensure compliance with the State Regulations and facility policy regarding fire drills. 4.Executive Director will monitor the Fire/Disaster Preparedness binder twice weekly for 3 months and then weekly until the next survey, to ensure compliance with State Regulations that fire drills are being completed quarterly on each shift and monthly fire drills are being held. 5.The date that the systematic changes will be completed by is July 31st, 2016.	

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