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
	155283		11/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINTERSONG VILLAGE	1005 S EDGEWOOD DR KNOX, IN 46534

(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
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00183862. Complaint IN00183862-Substantiated. Federal/State deficiencies related to the allegations were cited at F223, F225, and F226. Survey dates: November 4 & 5, 2015 Facility number: 000181 Provider number: 155283 AIM number: 100266860 Census bed type: SNF/NF: 37 Total: 37 Census payor type: Medicare: 4 Medicaid: 31 Other: 2 Total: 37 Sample: 7 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	Submission of this Plan of Correction does notconstitute an admission to or an agreement with facts alleged on the surveyreport. Submission of this Plan of Correction does not constitute anadmission or an agreement by the provider of the truth of facts alleged orcorrections set forth on the statement of deficiencies. The Plan of Correction is prepared and submitted because ofrequirements under State and Federal law. Please accept this Plan of Correction as our credible allegationof compliance.	

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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	Quality review completed by 26143, on November 12, 2015.			
F 0223 SS=D Bldg. 00	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on record review and interview, the facility failed to ensure a resident was free from verbal abuse, related to a CNA speaking in a mean manner and threatening a resident, for 1 of 3 residents reviewed for abuse in a total sample of 7. (Resident #C) Finding includes:	F 0223	Submission of this Plan of Correction does notconstitute an admission to or an agreement with facts alleged on the surveyreport. Submission of this Plan of Correction does not constitute anadmission or an agreement by the provider of the truth of facts alleged orcorrections set forth on the statement of deficiencies. The Plan of Correction is prepared and	12/05/2015

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	An Indiana State Department of Health (ISDH) Reportable Incident, dated 09/25/15, indicated the incident occurred 09/25/15 at 10:01 a.m. The report indicated: CNA #1 had assisted Resident #C with her shower and asked CNA #2 to help assist with transferring the resident from the shower chair to the wheelchair. The resident had been a transfer with a mechanical lift and received therapy and could now be transferred with assistance of two for pivot transfers. CNA #2 entered the shower room and informed the resident, "If you don't stand up and bear weight I will go get the hoyer (mechanical lift) and you will stay on it". CNA #1 indicated CNA #2 had said this with an "attitude" and the resident was tearful and voiced being upset. CNA #1 immediately reported the incident and CNA #2 was placed on suspension during the investigation and then terminated. Resident #C's record was reviewed on 11/05/15 at 10:15 a.m. The resident's diagnoses included, but were not limited to, hypertension and dementia. A Quarterly Minimum Data Set assessment, dated 10/15/15, indicated the resident's cognition was intact, had no behaviors, and required extensive assistance of two for transfers.		submitted because ofrequirements under State and Federal law. Please accept this Plan of Correction as our credible allegationof compliance. F 223 1. Resident #C has been reassessed and remains free ofany mental anguish or distress. CNA #2is no longer employed by the facility. 2. All residents have the potential to be affected. Residents and staff were interviewed by thefacility's administration on 11/18/2015 and no other allegations of abuse wereidentified. 3. The facility's abuse policy and procedure has beenreviewed and no changes are indicated at this time. The facility staff has been re-educated onthe policy. A resident interview formand a staff interview form has been initiated. 4. TheAdministrator or designee will interview 5 residents and 5 staff members onscheduled work days as follows: dailyfor two weeks, weekly for two weeks, then monthly thereafter to ensure allegationsof abuse are acted upon immediately. Should a concern be noted, immediate corrective action will occur. Results of the interviews and any correctiveactions will be reviewed during the facility's QA meetings on an ongoing basisfor a minimum of six months and the plan adjusted if indicated.	

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	During an interview on 11/04/15 at 9:46 a.m., Resident #C indicated she never liked using the mechanical lift and therapy had worked with her so the mechanical lift would not have to be used. Resident #C indicated when concerns are voiced, the facility will investigate and take care of the problem. During an interview on 11/04/15 at 10:48 a.m., the Administrator indicated the facility had substantiated the abuse and CNA #2 was no longer employed by the facility. During an interview on 11/04/15 at 10:54 a.m., CNA #1 indicated she felt CNA #2 had been abusive. CNA #1 indicated as soon as the resident was calmed and safe, she reported the allegation to her supervisor. This Federal Tag relates to Complaint IN00183862. 3.1-28(a)			

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F 0225 SS=D Bldg. 00	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 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. 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). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. 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			

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	be taken. Based on record review and interview the facility failed to report an allegation of abuse timely to the Administrator of the facility. The facility failed to start the investigation of the allegation immediately after the allegation was reported, for 1 of 3 residents reviewed for abuse, in a total sample of 7. (Resident #H) Finding includes: An Indiana State Department of Health (ISDH), "Report of Reasonable suspicion of a Crime Against a Resident" form, dated 10/05/15, indicated: The Administrator was informed by the Director of Nursing (DoN) on 10/05/15 at 9 a.m., of an abuse allegation, which was brought to her attention by a nurse. The DoN had indicated LPN #3 had overheard CNA #4 tell another employee (CNA #6) that she witnessed CNA #5 hit a resident (Resident #H) during care, "a couple of months ago". An investigation was initiated immediately and CNA #5 had been suspended pending the investigation. The investigation indicated CNA #4 was questioned and she had alleged CNA #5 had punched Resident #H in the jaw	F 0225	F 225 1. Resident #H has been reassessed and remains free ofany signs of alleged abuse. Facilitystaff, including CNA #4, #5, #6, LPN #3, and RN #7, have been re-educated onthe abuse policy with a special focus on immediately reporting andinvestigating abuse. 2. All residents have the potential to be affected. Residents and staff were interviewed by thefacility's administration on 11/23/2015 and no other allegations of abuse wereidentified. 3. The facility's abuse policy and procedure has beenreviewed and no changes are indicated at this time. The facility staff has been re-educated onthe policy with a special focus on immediately reporting and investigatingabuse. A resident interview form and astaff interview form has been initiated. 4. The Administrator or designeewill interview 5 residents and 5 staff members on scheduled work days asfollows: daily for two weeks, weekly fortwo weeks, then monthly thereafter to ensure allegations of abuse are actedupon, reported, and investigated immediately. Should a concern be noted, immediate corrective action will occur. Results of the interviews and any	12/05/2015

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	during care. A behavior memo had been filled out, which indicated the resident had become physically aggressive with care on 08/01/15 at 7 p.m. when CNA #4 and CNA #5 had provided care. CNA #4 indicated to the Administrator this was when CNA #5 had "punched" Resident #H in the jaw. CNA #4 indicated she had informed RN #7 what had happened. RN #7 was interviewed and indicated she had not been informed of CNA #5 hitting Resident #H, but had been informed Resident #H had hit CNA #5 in the jaw. CNA #5 was interviewed and indicated she had not hit Resident #H, but the resident had hit her in the jaw. CNA #4 had indicated she had thought RN #7 would report the allegation and she had waited two months to report it, she indicated, "I don't know, I guess it was eating at me." Resident #H's record was reviewed on 11/05/15 at 9:43 a.m. The resident's diagnoses included, but were not limited to, Dementia with behavioral disturbance and osteoarthritis. An Annual Minimum Data Set (MDS) assessment, dated 06/18/15, indicated the resident's cognition was impaired, had physical behaviors daily, and required extensive assistance of two for transfers, toileting, and hygiene.		correctiveactions will be reviewed during the facility's QA meetings on an ongoing basisfor a minimum of six months and the plan adjusted if indicated	

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	During an interview on 11/04/15 at 10:03 a.m., the DoN indicated CNA #4 had informed her she had not reported the allegation of abuse timely because she was "scared" the afternoon staff would be mad at her. The DoN indicated the Abuse Policy had not been followed. During an interview on 11/04/15 at 10:48 a.m., the Administrator indicated CNA #5 had been suspended as soon as he was informed of the allegation then the CNA resigned from the facility. The Administrator indicated after the investigation, the allegation of abuse was unsubstantiated. During an interview on 11/04/15 at 1:16 p.m., CNA #4 indicated CNA #5 had "punched" Resident #H in the face. She indicated they had been providing incontinence care to the resident, he became aggressive and hit CNA #5 and CNA #5 hit him back. CNA #4 indicated she had not reported the allegation because she knew she would have problems with the other evening CNA's and was fearful the other CNA's would be mean to her. During an interview on 11/05/15 at 8:37 a.m., the DoN indicated CNA #4 had been standing at the Nurses' Station, on			

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	10/04/15 and talking to another CNA (CNA #6) and LPN #3 had heard the conversation and contacted her (DoN). The DoN indicated it was not clear if the event CNA #4 was talking about was "historic or just happened". The DoN indicated she had spoken with LPN #3 the next morning on 10/05/15, and was told about the allegation. The DoN indicated when LPN #3 had contacted her on 10/04/15, she had indicated something had happened and there was no mention of CNA #5 hitting Resident #H. The DoN indicated LPN #3 informed her, "something happened between (Resident #H) and (CNA #5)". She indicated the investigation and Administrator had not been notified until 10/05/15 because no allegation had been voiced, and was just told, "something had happened". During an interview on 11/05/15 at 8:50 a.m., the Administrator indicated he was informed of the allegation 10/05/15 in the morning. The Administrator indicated he was informed it was an "episode" and was not informed of CNA #5 hitting the resident until the investigation had been started. During an interview on 11/05/15 at 9:03 a.m., LPN #3 indicated on 10/04/15, CNA #4 and CNA #6 were talking about an incident with Resident #H and CNA			

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	#4 had indicated CNA #5 had hit the resident. LPN #3 indicated CNA #4 had said it had been awhile since this happened and CNA #4 could not remember when it occurred. LPN #3 indicated she notified the DoN and informed the DoN CNA #4 had made the allegation of CNA #5 hitting Resident #H on 10/04/15. LPN #3 indicated the DoN had informed her she was aware the resident had hit CNA #5. LPN #3 indicated she had not notified the Administrator. During an interview on 11/05/15 at 9:09 p.m., RN #7 indicated CNA #4 had not made an allegation of abuse to her. She indicated she had been told by CNA #4 and CNA #5, Resident #H had become physically aggressive and hit CNA #5. During an interview on 11/05/15 at 9:17 a.m., the DoN indicated she had not been informed of CNA #5 hitting Resident #H from LPN #3, until the next morning on 10/05/15, and at that time CNA #5 was suspended. The DoN indicated she was texted "something happened", and she had texted back to LPN #3 asking what had happened and LPN #3 texted back to her, "something during care" and had implied it was historic. The DoN indicated she had not saved the text. The DoN indicated the morning of 10/05/15,			

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	CNA #6 had informed her CNA #4 had told her CNA #5 had "punched" Resident #H. During an interview on 11/05/15 at 9:21 a.m., CNA #6 indicated on 10/04/15, CNA #4 had informed Resident #H had hit CNA #5 and CNA #5 hit the resident in his face. CNA #6 indicated she had reported the allegation to LPN #3. CNA #6 indicated she had not reported the allegation to the Administrator. CNA #5's time sheets indicated CNA #5 had continued working with the residents in the facility from 08/01/15 to 10/05/15 when she had been suspended at 8:52 a.m. This Federal Tag relates to Complaint IN00183862. 3.1-28(c) 3.1-28(d)			
F 0226 SS=D Bldg. 00	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement			

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	written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to ensure the facility's abuse policy was followed, related to not ensuring a resident was free from abuse, not immediately reporting an allegation of abuse to the Administrator of the facility and not immediately investigating an allegation abuse, for 2 of 3 residents reviewed for abuse in a total sample of 7. (Resident #C and #H) Findings include: 1. An Indiana State Department of Health (ISDH) Reportable Incident, dated 09/25/15, indicated the incident occurred 09/25/15 at 10:01 a.m. The report indicated: CNA #1 had assisted Resident #C with her shower and asked CNA #2 to help assist with transferring the resident from the shower chair to the wheelchair. The resident had been a transfer with a mechanical lift and received therapy and could now be transferred with assistance of two for pivot transfers. CNA #2 entered the shower room and informed the resident, "If you don't stand up and bear weight I will go get the hoyer	F 0226	F 226 1. Resident #C and#H have been reassessed and remain free of any signs of alleged abuse. CNA #2 is no longer employed by thefacility. Facility staff, including CNA#4, #5, #6, LPN #3, and RN #7, have been re-educated on the abuse policy with aspecial focus on following the policy, immediately reporting, and investigatingabuse. 2. All residents have the potential to be affected. Residents and staff were interviewed by thefacility's administration on 11/23/2015 and no other allegations of abuse wereidentified. 3. The facility's abuse policy and procedure has beenreviewed and no changes are indicated at this time. The facility staff has been re-educated onthe policy with a special focus on following the policy, immediately reporting,and investigating abuse. A residentinterview form and a staff interview form has been initiated. 4. TheAdministrator or designee will interview 5 residents and 5 staff members onscheduled work days as follows: dailyfor two weeks, weekly for two weeks, then monthly	12/05/2015

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	(mechanical lift) and you will stay on it". CNA #1 indicated CNA #2 had said this with an "attitude" and the resident was tearful and voiced being upset. CNA #1 immediately reported the incident and CNA #2 was placed on suspension during the investigation and then terminated. During an interview on 11/04/15 at 10:48 a.m., the Administrator indicated the facility had substantiated the abuse and CNA #2 was no longer employed by the facility. 2. An Indiana State Department of Health (ISDH), "Report of Reasonable suspicion of a Crime Against a Resident" form, dated 10/05/15, indicated: The Administrator was informed by the Director of Nursing (DoN) on 10/05/15 at 9 a.m., of an abuse allegation, which was brought to her attention by a nurse this morning. The DoN had indicated LPN #3 had overheard CNA #4 tell another employee (CNA #6) that she witnessed CNA #5 hit a resident (Resident #H) during care, "a couple of months ago". An investigation was initiated immediately and CNA #5 had been suspended pending the investigation. The investigation indicated CNA #4 was questioned and she had alleged CNA #5 had punched Resident #H in the jaw		thereafter to ensureallegations of abuse are acted upon, reported, and investigatedimmediately. Should a concern be noted,immediate corrective action will occur. Results of the interviews and any corrective actions will be reviewedduring the facility's QA meetings on an ongoing basis for a minimum of sixmonths and the plan adjusted if indicated.	

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	during care. A behavior memo had been filled out, which indicated the resident had become physically aggressive with care on 08/01/15 at 7 p.m. when CNA #4 and CNA #5 had provided care. CNA #4 indicated to the Administrator this was when CNA #5 had "punched" Resident #H in the jaw. CNA #4 indicated she had informed RN #7 what had happened. RN #7 was interviewed and indicated she had not been informed of CNA #5 hitting Resident #H, but had been informed Resident #H had hit CNA #5 in the jaw. CNA #5 was interviewed and indicated she had not hit Resident #H, but the resident had hit her in the jaw. CNA #4 had indicated she had thought RN #7 would report the allegation and she had waited two months to report it, she indicated, "I don't know, I guess it was eating at me." During an interview on 11/04/15 at 10:03 a.m., the DoN indicated CNA #4 had informed her she had not reported the allegation of abuse timely. The DoN indicated the Abuse Policy had not been followed. During an interview on 11/05/15 at 8:37 a.m., the DoN indicated CNA #4 had been standing at the Nurses' Station, on 10/04/15 and talking to another CNA (CNA #6) and LPN #3 had heard the			

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NAME OF PROVIDER OR SUPPLIER WINTERSONG VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 1005 S EDGEWOOD DR KNOX, IN 46534	

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	conversation and contacted her (DoN). The DoN indicated it was not clear if the event CNA #4 was talking about was "historic or just happened". The DoN indicated she had spoken with LPN #3 the next morning on 10/05/15, and was told about the allegation. The DoN indicated when LPN #3 had contacted her on 10/04/15, she had indicated something had happened and there was no mention of CNA #5 hitting Resident #H. The DoN indicated LPN #3 informed her, "something happened between (Resident #H) and (CNA #5)". She indicated the investigation and Administrator had not been notified until 10/05/15 because no allegation had been voiced, and was just told, "something had happened". During an interview on 11/05/15 at 9:03 a.m., LPN #3 indicated on 10/04/15, CNA #4 and CNA #6 were talking about an incident with Resident #H and CNA #4 had indicated CNA #5 had hit the resident. LPN #3 indicated CNA #4 had said it had been awhile since this happened and CNA #4 could not remember when it occurred. LPN #3 indicated she notified the DoN and informed the DoN CNA #4 had made the allegation of CNA #5 hitting Resident #H on 10/04/15. LPN #3 indicated the DoN had informed her she was aware the resident had hit CNA #5. LPN #3			

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	indicated she had not notified the Administrator. During an interview on 11/05/15 at 9:17 a.m., the DoN indicated she had not been informed of CNA #5 hitting Resident #H from LPN #3, until the next morning on 10/05/15, and at that time CNA #5 was suspended. The DoN indicated she was texted "something happened", and she had texted back to LPN #3 asking what had happened and LPN #3 texted back to her, "something during care" and had implied it was historic. The DoN indicated she had not saved the text. The DoN indicated the morning of 10/05/15, CNA #6 had informed her CNA #4 had told her CNA #5 had "punched" Resident #H. A facility policy, dated 10/14, titled, "Abuse Prohibition, Reporting and Investigation", received from the Administrator as current, indicated, "...This facility will not permit residents to be subjected to abuse by anyone...This facility will ensure that all alleged violations...are reported immediately to the administrator (sic) of the facility...The Administrator shall initiate and direct the investigation immediately...All reports of abuse must be reported to the Administrator immediately...The individual who witnessed the incident or			

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	155283		11/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINTERSONG VILLAGE	1005 S EDGEWOOD DR KNOX, IN 46534

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	who was informed of the allegation shall immediately notify a charge nurse assigned to the unit on which the resident resides...the charge nurse is responsible to notify the facility Administrator and Director of Nursing immediately. 4. Any facility personnel implicated in the alleged abuse will be immediately removed from resident care and will remain suspended until an investigation is completed. A thorough investigation will be initiated..." This Federal Tag relates to Complaint IN00183862. 3.1-28(a)			