

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/11/2016
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NAME OF PROVIDER OR SUPPLIER HEARTH AT SYCAMORE VILLAGE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 611 W COUNTY LINE RD S FORT WAYNE, IN 46814
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R 0000 Bldg. 00	<p>This visit was for the investigation of complaint IN00195191.</p> <p>Complaint IN00195191- Substantiated, State deficiency cited at R006.</p> <p>Survey Dates: March 10 & 11, 2016</p> <p>Facility number: 011804 Provider number: N/A AIM number: N/A</p> <p>Census bed type: Residential: 107 Total: 107</p> <p>Census payor type: Other: 107 Total: 107</p> <p>Sample: 3</p> <p>This state finding is cited in accordance with 410 IAC 16.2-5.</p> <p>QR completed on March 14, 2016 by 17934.</p>	R 0000	<p>The statements made in this Plan of Correction are not an admission to, nor does it constitute an agreement with the alleged deficiencies herein. To remain in compliance with all state regulations, the community has taken or is planning to take the actions set forth in the following Plan of Correction. All alleged deficiencies cited have been or are to be corrected by the date or dates indicated.</p>	
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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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R 0006 Bldg. 00	<p>410 IAC 16.2-5-0.5(f)(1-5) Scope of Residential Care - Deficiency (f) The resident must be discharged if the resident:</p> <p>(1) is a danger to the resident or others; (2) requires twenty-four (24) hour per day comprehensive nursing care or comprehensive nursing oversight; (3) requires less than twenty-four (24) hour per day comprehensive nursing care, comprehensive nursing oversight, or rehabilitative therapies and has not entered into a contract with an appropriately licensed provider of the resident ' s choice to provide those services; (4) is not medically stable; or (5) meets at least two (2) of the following three (3) criteria unless the resident is medically stable and the health facility can meet the resident ' s needs: (A) Requires total assistance with eating. (B) Requires total assistance with toileting. (C) Requires total assistance with transferring.</p> <p>Based on observation, record review and interview, the facility failed to ensure the safety of residents on 1 of 2 memory care units due to the behaviors of one Resident. (Resident B)</p>	R 0006	<p>R006 Scope of Residential Care 1. Executive Director and Wellness Director reviewed resident #B's current status, plan of care and interventions with physician, psychiatric services and</p>	04/08/2016

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	<p>Finding includes:</p> <p>On 3/10/16 at 9:50 a.m. during an observation on the South Memory Care Unit, resident (B) was observed running from one end of the hallway to the other on the back hallway. This writer asked the resident his name and he replied and continued to run from one end of the hall to the other. Resident (B) would push on the exit doors, causing the alarm to sound. Resident (B) was observed to grab the handrails at the end of the hall and pull them in an upward motion and also hold onto the handrails and lean forward while placing one foot backwards as if to be stretching his muscles.</p> <p>Interview with employee #1 indicated the resident runs up and down the halls a lot. She indicated they give him finger foods to eat as he will not sit for any length of time to eat in the dining room.</p> <p>Observation of resident (B) at 10:30 a.m. indicated he was running from one end of the hallway to the other on the back hallway, pushing on the doors.</p> <p>On 3/10/16 from 11:35 a.m. until 12 noon resident (B) was observed to be running from one end of the hallway to</p>		<p>family. Resident had also been on 1:1 supervision; responsibilities shared by resident's family members, third party provider and facility staff, with limited success. Upon further evaluation and discussion, all parties agreed to resident admission for inpatient Geriatric Psychiatric treatment. Resident remains hospitalized at this time. When resident is ready for discharge, facility leadership will assess Resident B to determine whether he is appropriate to return or if alternate placement will be required. 2. All residents on Keepsake Village will be screened by Wellness Director, Executive Director and Regional Clinical staff for appropriateness of continued residency per facility policy. Any concerns will be addressed according to facility and state guidelines. 3. Aggressive or disruptive behaviors by residents will be addressed per plan of care and/or reviewed for appropriate continued residency per facility policy by interdisciplinary team. The team will review possible solutions including changes in programming, use of 1:1 supervision, medication management or placement in another care facility. Interdisciplinary team members include ED, Wellness Directors, Activities and Medical Director. An in-service will be conducted by the Regional Director of Clinical</p>				

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	<p>the other on the back hall. Resident (B) was observed to push on the exit doors, pull on the handrails and stop and grab the handrails and stretch his muscles. At 12:00 p.m. the resident was observed to walk through the dining room and move resident walkers from one place to another.</p> <p>Review of the clinical record for resident (B) on 3/10/16 at 1:30 p.m. indicated he was admitted to the facility on 11/27/15 with Diagnoses including but not limited to Dementia, Hypertension, Depression, Anxiety, Insomnia and Mania with Mood Disorder.</p> <p>Interview with staff on 3/10/16 at 1:50 p.m. indicated the following:</p> <p>Staff #1-Resident (B) will grab other resident's wheelchairs from behind to steady himself. Staff #1 stated "this probably scares the residents".</p> <p>Staff #2-Has observed resident (B) pull on other resident's walkers trying to get them to do something. Has observed resident (B) push residents who are in wheelchairs and the residents will put their feet down on the floor. Staff #2 was concerned this could cause residents to fall out of their wheelchairs but does not know of any injuries happening.</p>		<p>Service to the Interdisciplinary team including the Wellness Directors and Administrator, regarding the facility policy for residency requirements. Wellness Directors will retrain the nursing staff on the facility's behavior management protocols including use of Mosher Gardens Method and Care Connect principles. 4. Executive Director/Wellness Directors/designee will review all residents in the weekly Resident Rounding meeting, and at other times as needed, to ensure that each resident continues to meet the facility's residency requirements. This meeting will be an ongoing weekly meeting. Results of these audits will be reviewed by the QA committee, who will establish the threshold of compliance and make further recommendations accordingly.</p> <p>Date of Compliance: April 8, 2016.</p>	

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	<p>Staff #3-Has observed resident (B) "bug" other residents who will then "swat" at him to get him to go away. Has observed resident (B) move other resident's walkers.</p> <p>Staff #4-Has observed resident (B) pushing residents in their wheelchairs. Staff #4 indicated she observed resident (B) push another resident who was standing but indicated the other resident did not fall on the floor.</p> <p>Staff #5-Has observed resident (B) push residents in their wheelchairs and indicated he takes walkers away from other residents. Staff #5 indicated resident (B) goes in and out of resident rooms and it intimidates the ladies. Staff #5 indicated resident (B) has been observed to massage resident (C's) head which irritates resident (C). Staff #5 indicated resident (B) set off the fire alarm on 3rd shift when he pulled the alarm and the fire department came to the building.</p> <p>Staff #6-Indicated resident (B) "head butted" her in the left eye when she was trying to provide care. Staff #6 indicated her skin was discolored around her eye from the incident.</p>			

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	<p>Staff #7-Indicated resident (B) straight punched resident (D) in the chest causing the resident to cry. Staff #7 indicated she reported the incident to the nurse. Staff #7 indicated she was walking resident (E) down the hallway and put out her arms to stop resident (B) as he was approaching and then resident (B) punched resident (E) in the arm. Staff #7 was queried if the "punch" hurt resident (E) and she indicated she did not know but did know it startled resident (E). Further interview with Staff #7 indicated resident (B) urinates on the walls and the floors and she has seen him eat soap and feces.</p> <p>Staff #8-Indicated resident (B) hit resident (E) in the chest. Staff #8 when queried did not know if it hurt resident (E). Staff #8 indicated resident (B) urinates on other resident's doors and in the hallways, takes other resident's food and drinks but will not sit down in the dining room.</p> <p>Review of the initial tour on 3/10/16 at 9:20 a.m. indicated the "South Memory Care Unit" had a census of 24 residents of which 10 were ambulatory per self with a cane or walker.</p> <p>The Wellness Director was queried on 3/10/16 at 3:00 p.m. if resident (B) had head butted a staff member, torn off and</p>			

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	<p>broken pictures from the walls, broke the push bar off the door, and broke the exit signs in the ceiling and the cover on a fire alarm. The Wellness Director confirmed these incidents had happened.</p> <p>This state deficiency is related to complaint IN00195191.</p>			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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