

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 04/13/2016
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NAME OF PROVIDER OR SUPPLIER JEWEL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 607 VIRGINIA AVE MADISON, IN 47250
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R 0000 Bldg. 00	<p>This visit was for the Investigation of Complaints IN00196945 and IN00197469.</p> <p>Complaint IN00196945 - Substantiated. No deficiencies related to the allegation are cited.</p> <p>Complaint IN00197469 - Substantiated. State residential deficiencies related to the allegations are cited at R0029 and R0052.</p> <p>Unrelated deficiencies are cited at R0027 and R0214.</p> <p>Survey dates: April 12 and 13, 2016</p> <p>Facility number: 004352 Provider number: 004352 AIM number: N/A</p> <p>Census bed type: Residential: 24 Total: 24</p> <p>Census payor type: Other: 24 Total: 24</p> <p>Residential sample: 5</p>	R 0000	Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that the statement of deficiencies was correctly cited and is also not to be construed as an admission against interest by the residents or any employees, agents or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission agreement of any kind by the facility of the truth or any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. Jewel house would respectfully like to request paper compliance for the 4 tags listed below. All in-services have been completed and action plans put into place. Please see attached.	

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 0027 Bldg. 00	<p>These State findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed by 30576 on April 15, 2016.</p> <p>410 IAC 16.2-5-1.2(b) Residents' Rights - Deficiency (b) Residents have the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. Residents have the right to exercise their rights as a resident of the facility and as a citizen or resident of the United States. Based on interview and record review, the facility failed to ensure the preservation of dignity and self determination in a resident with significant behavior changes and failed to update assessments when the increased behaviors occurred for 1 of 3 residents reviewed for significant changes. (Resident #D)</p> <p>Findings include:</p> <p>The clinical record for Resident #D was reviewed on 4/12/16 at 3:00 p.m. Diagnosis included, but was not limited to dementia, anxiety, depression, and Parkinson's disease.</p>	R 0027	<p>Citation #1 R027 410 IAC 16.2-5-1.2(b) Residents' Rights CORRECTIVE ACTION: Investigation substantiated and reported to ISDH on 4-5-16 when it was first reported to management. Investigation conducted on 4-6-16. Upon receipt of the allegation (4-5-16) the ED and ALD immediately followed the facility policy and procedure relative to Abuse Prohibition. Executive Director and the Assisted Living Director conducted investigation and the accused staff member was no longer working at the community. Last day worked was on 3-14-16. Upon interviews with the residents, no other allegations founded for violating residents' rights. Resident D was no longer living at the community when</p>	04/14/2016

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	<p>The nurses notes for December, 2015 included the following:</p> <p>12/5/15 at 6:00 p.m. - "...Has attempted to exit through dining room doors x [times] 2...."</p> <p>12/6/15 at 2:00 p.m. - "...Wanderguard [device used to let staff know resident it attempting to leave facility] placed for elopement risk...."</p> <p>12/8/15 at 2:30 p.m. - "Resident went out laundry room door approx. [approximately] 15 feet...."</p> <p>12/11/15 at 1:00 p.m. - "PRN [as needed] Ativan [medication for anxiety] given for agitation...."</p> <p>12/11/15 at 8:20 p.m. - "...resident tearful [plus sign] [and] wandering...."</p> <p>12/12/15 at 2:30 p.m. - "Rsd [resident] exited building via [how] door...."</p> <p>12/12/15 at 4:00 p.m. - "Rsd [resident] opened exit door...staff redirected...."</p> <p>12/17/15 at 8:39 p.m. - "Wandering [plus sign] [and] restless...."</p> <p>12/21/15 at 1:35 p.m. - "Res. [resident] tried to exit out front door. Redirected back inside...."</p> <p>12/24/15 at 3:30 p.m. - "Res [resident] opened outer door but did not go out...."</p> <p>12/26/15 at 12:00 p.m. - "Rsd [resident] anxious [backwards 3 with a dot above and below] [and] wandering around facility...."</p> <p>12/27/15 at 7:30 p.m. - "Res [resident]</p>		<p>investigation was initiated. IDENTIFY OTHER RESIDENTS POTENTIALLY AFFECTED: No other residents were found to be effected. All staff at the Jewel House were re-educated by the Executive Director regarding residents' right and abuse. Upon interviews with the residents, no other allegations founded for violating residents' rights or abuse. SYSTEMATIC CHANGES: Upon hire, employees will be educated on Residents' Rights and the Abuse Prohibition Policy . ALD will review Elopement Risk Tool weekly x 2 months then monthly x 6 months. Elopement Risk Tools audited on 4-14-16. ALD reviewed Admission and Retention Criteria and will continue to follow policy. All staff will complete Abuse in-servicing upon hire, annually and PRN. MONITORING PROCESS: ALD or designee will review Elopement Risk Tool weekly x 2 months then monthly x 6 months. Elopement Risk Tools audited on 4-14-16. Elopement Risk Tool to be completed 24 hours or less after admission, quarterly and with a Change of Condition. This process will also be monitored through the QA monthly meeting x 8 months. Date of completion for the above, 4-14-16.</p>				

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	<p>trying to go into other res [resident] rooms. Wandering around facility...." 12/27/15 at 8:00 p.m. - Res. [resident] left room to sit in living room. Pulled pants down and peed [sic] [urinated] on chair and clothes...."</p> <p>12/28/15 at 9:00 p.m. - "Res [resident] has had multiple wandering bx [behaviors] this shift...Requires constant redirection...."</p> <p>The nurses notes for January 2016 included the following:</p> <p>1/3/16 at 4:00 a.m. -" Rsd [resident] continued [sic] confusion and wandering...."</p> <p>1/7/16 at 4:00 a.m. -" Rsd [resident] [up arrow] [up] this shift. confused [sic] [plus sign] [and]disoriented with some behaviors...."</p> <p>1/7/16 at 11:00 p.m. - "Res [resident] with [up arrow] [increased] wandering [plus sign] [and] agitation...."</p> <p>1/9/16 at 11:00 p.m. - "Rsd [resident] confused and wandering into [room #] [plus sign] [and] [room #]...."</p> <p>1/17/16 at 4:00 a.m. - "Rsd [resident] [up arrow] [up] and wandering this shift...."</p> <p>1/19/16 at 5:00 p.m. - "Contacted [physician name] R/T [related to] resident having inc [increased] agitation, wandering. rec'd [sic] [received] N.O. [new order] to inc [increase] Risperdal</p>			

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	<p>[anti-psychotic medication]...."</p> <p>1/21/16 at 4:00 a.m. - "Rsd [resident] [up arrow] [up] [c with line over it] [with] confusion...."</p> <p>1/22/16 at 1:30 p.m. - "Rsd [resident] [c with line over it] [with] some wandering...."</p> <p>1/26/16 at 6:30 p.m. - "Res [resident] [c with line over it] [with] [up arrow] [increased] anxiety/agitation noted...."</p> <p>1/26/16 at 9:00 p.m. - "Res [resident] cont [continues] [c with line over it] [up arrow] increased wandering [division sign] [and] agitation...."</p> <p>1/27/16 at 5:00 a.m. - "Resident [up arrow] [up] wandering...."</p> <p>1/27/16 at 9:15 a.m. - "Res [resident] cont [continues] to have [up arrow] [increased] wandering [plus sign] [and] increased agitation...."</p> <p>1/29/16 at 3:55 p.m. - "Contacted MD [medical doctor] R/T [related to] inc [increased] behaviors, wandering, difficult to redirect, attempting to open locked supply room doors, going toward exit doors...approaching other residents too close...."</p> <p>1/29/16 (no time) - "Rec'd [received] N.O. [new order] [sic] Depakote [mood stabilizer] 250 mg [milligrams] BID [twice daily]...."</p> <p>1/30/16 at 1:15 p.m. - "Rsd [resident] opened exit door by break room...."</p> <p>1/30/16 at 8:30 p.m. - "Rsd [resident] [c</p>			

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	<p>with line over it] [with] [up arrow] [increased] agitation noted this shift...." 1/30/16 at 9:40 p.m. - "Res [resident] back up, wandering, pushing doors to open cause [sic] alarms to sound...." 1/31/16 at 9:10 p.m. - "...wandering, pacing frequently...."</p> <p>The nurses notes for February 2016 included the following:</p> <p>2/1/16 at 5:00 a.m. - "Rsd [resident] [up arrow] [up] wandering until I put her to bed...." 2/2/16 at 2:30 p.m. - "...went out exit door by laundry room...." 2/2/16 at 4:20 p.m. - "Resident went to exit door at end of east hall [sic] opened door and stepped out...." 2/2/16 at 9-00 p.m. - "Rsd [resident] has been 1:1 [one on one] this shift...." 2/3/16 at 8:00 p.m. - "Rsd [resident] [c with line over it] [with] [up arrow] [increased] wandering [plus sign] [and] agitation...." 2/4/16 at 9:00 p.m. - "Rsd [resident] has had [up arrow] [increased] wandering....."</p> <p>The Elopement Risk Review Tool, dated 12/8/15, included, but was not limited to, the following: "...Instructions: To be completed within 24 hours of admission...and with change of condition...Risk rating:...Areas identified</p>			

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	<p>with an asterisk (*) indicates a resident has behaviors potentially putting them at a high risk for elopement and would warrant the need to a secure care environment...Date...12/8/15... [asterisk]...Wanders, looking for an exit, attempts to leave... [asterisk]...Emphatically proclaims they are leaving, or expresses they are going somewhere, when they are not... [asterisk]...Is paranoid/anxious about were they are, does not believe they live there, attempts to leave...."</p> <p>The clinical record lacked any other assessments related to Resident #D's changes in condition.</p> <p>During an interview on 4/13/16 at 12:00 p.m., the Director of Nursing indicated by reading the nurses notes, Resident #D was not appropriate for the facility.</p> <p>During an interview on 4/13/16 at 1:22 p.m., the Director of Nursing indicated she could not locate any updated assessments for Resident #D since the admission assessments were completed.</p> <p>On 4/13/16 at 1:32 p.m., the Director of Nursing provided a copy of the document titled, "Subject Admission & Retention Criteria", dated 12/14/2011 and indicated as current. It included, but was not</p>			

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R 0029 Bldg. 00	<p>limited to, the following: "All Senior Lifestyle communities will follow the procedure below when admitting, readmitting , and retaining residents. For Admission and Readmission for Assisted Living and Memory Care:...Resident will be assessed in person by the Assisted Living Director or designee prior to admission...and with significant change...."</p> <p>410 IAC 16.2-5-1.2(d) Residents' Rights - Deficiency (d) Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality. Based on interview and record review, the facility failed to ensure residents were treated with respect and dignity by allowing abuse to occur for 2 of 3 resident reviewed for residents rights. (Resident's #C and #D)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #C was reviewed on 4/12/2016 at 1:15 p.m. Diagnosis included, but was not limited to, dementia.</p> <p>During an observation on 4/12/16 at 11:50 a.m., Resident #C was observed sitting in the dining room. Resident #C</p>	R 0029	<p>CITATION #2 R029 410 IAC 16.2-5-1.2(D) RESIDENTS' RIGHTS CORRECTIVE ACTION: Staff #7 no longer working at the community which completes the corrective action. Last day worked was 3-14-16 however, the allegation was brought to us on 3-31-16. The company policy on Abuse Prohibition was immediately followed. All staff in-serviced on policy and procedure for Residents' Rights and Abuse. Resident D was no longer living at the community when investigation was initiated. IDENTIFY OTHER RESIDENTS POTENTIALLY AFFECTED: No other residents were found to be effected. All staff at the Jewel</p>	04/14/2016			

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	<p>was alert to name only and unable to recall the date and time.</p> <p>The typed statement of the Executive Director, dated 3/3/16 and untimed, included, but was not limited to, the following: "...On behalf of the [facility name], the community respectfully confirms notification of an allegation of exploitation on 3/31/16 from staff at the [facility name] that had occurred as early on as September 2015. This was the first reporting of this allegation to the new administration who started employment with the [facility name] 2/2016...Upon receipt of the allegation (on 3/31/16), the Executive Director immediately followed the facility policy and procedure relative to abuse prohibition...The incident involved a Certified Nursing Assistant (staff #7's name) to a resident...(staff #7's name) last day of employment was March 14th...."</p> <p>The written statement of Staff #2, undated and untimed, included the following: "In a casual conversation with [staff #7] in the meeting room [sic] she told me that [Resident #C] grabbed her boob [plus sign] [and] "got a big handful." She then laughed [plus sign] [and] said "I told him it wasn't appropriate". Then she said don't tell anybody. This occurred [sic] approx.</p>		<p>House were re-educated by the Executive Director regarding residents' right and abuse. Upon interviews with the residents, no other allegations founded for violating residents' rights or abuse. Head to toe assessments completed by nurses on the residents that were not able to be interviewed. SYSTEMATIC CHANGES: Upon hire, employees will be educated on Residents' Rights and the Abuse Prohibition Policy . Background and reference checks are completed before the employee begins employment. The current and onboarding new employees have been educated on how to report allegations. All staff completes Abuse in-servicing upon hire, annually and PRN. MONITORING PROCESS: ED/ALD or designee will audit pre-employment files before offering a position to the prospective employee. This process will also be monitored through the QA monthly meeting x 8 months. Date of completion for the above, 4-14-16.</p>				

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	<p>[approximately] in Jan [January] 2016. [signature of staff #2]."</p> <p>The written statement of Staff #1, dated 3/31/16 and untimed, included the following: "On an outing in September 2015, while at [name of restaurant], I observed [Resident #C] grab [Staff #7] breast. She laughed about it, saying to me while laughing [sic] "don't tell [Resident #C's wife]!" [sic] She wouldn't like it if she knew. Then [sic] again [sic] on the same day [sic] as we were loading the residents in the van, [Staff #7] reached over [Resident #C] lap to buckle his seat belt and [sic] he grabbed her again and [sic] again she laughed. Neither time did she try to remove his hand nor tell him no. Also, when we returned to the community [sic] I made a statement to [Interim Executive Director] and he acting [sic] like I made it up. He didn't seem that is was believable. As well as numerous [sic] [numerous] occasions that she said things about him touching her in front of other staff members. [signature of Staff #1]."</p> <p>The written statement of Staff #3, undated and untimed, included the following: "Mid-January [sic] [Staff #7] reported to myself that upon getting Resident [sic] in room [room number]. [sic] [Resident #C's initials] sic he</p>						

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	<p>grabbed her breast. I told my supervisor [previous Director of Nursing] @ [at] the time. She did not say anything [sic] only laughed. [Staff #7] stated not to tell wife [arrow drawn to middle of page] and don't tell family [sic] that he does what she needs him to [sic] ie. [term used for example], [c with line over it] [with] taking shower etc. [signature of Staff #3]".</p> <p>During an interview on 4/12/16 at 12:30 p.m., the Executive Director (ED) indicated Staff #7 was letting Resident #C touch her inappropriately so Resident #C would do what she needed him to do, as in, taking showers. The ED indicated staff are struggling to get Resident #C to take showers now.</p> <p>During an interview on 4/13/16 at 9:47 a.m., Staff #1 indicated, while on an outing in September of 2015 at a restaurant, Resident #C touched Staff #7's breasts and Staff #7 laughed about it and didn't say anything to Resident #C. Staff #1 indicated Staff #7 told her not to say anything, it will kill his wife. Staff #1 also indicated, when leaving the restaurant, Staff #7 buckled Resident #C's seat belt and he grabbed her breasts again and she didn't do anything, just laughed. Staff #1 indicated Staff #7 did not redirect Resident #C or tell him it</p>			

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	<p>was inappropriate.</p> <p>During an interview on 4/13/16 at 9:55 a.m. Staff #2 indicated, during a conversation with Staff #7 (Staff #2 could not remember the date or time), Staff #7 indicated Resident #C grabbed her breast and told him it wasn't allowed. Staff #2 also indicated Staff #7 told her Resident #C had done before and to not tell anyone.</p> <p>During an interview on 4/13/16 at 10:00 a.m., Staff #3 indicated, on several occasions (Staff #3 was unable to provide dates and times), Staff #7 told her Resident #C would touch her breasts before he would get in the shower and asked Staff #3 not to tell his wife. Staff #3 indicated Staff #7 told her she would let Resident #C touch her breasts because that was how she got Resident #C to take a shower.</p> <p>During an interview on 4/13/16 at 10:13 a.m., Staff #4 indicated she overheard Staff #7 say she had no problems getting Resident #C to take a shower because she let Resident #C touch her boobs in order to get him to take a shower.</p> <p>On 4/12/16 at 4:12 p.m., the Director of Nursing provided a copy of the policy and procedure titled, "Subject Abuse and</p>			

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NAME OF PROVIDER OR SUPPLIER JEWEL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 607 VIRGINIA AVE MADISON, IN 47250
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	<p>Neglect Reporting-Including suspected/confirmed Resident-Resident abuse", and indicated as current. It included, but was not limited to, the following: "...Physical Abuse - Intentionally inflicting or allowing injury on a vulnerable adult by an act or failure to act...Psychological Abuse - Deliberately subjecting a vulnerable adult to threats or harassment or other forms of intimidating behavior causing fear, humiliation, degradation, agitation, confusion or other forms of serious emotional distress...Exploitation - Causing or requiring a vulnerable adult to engage in activity or labor which is improper, illegal or against the reasonable and rational wishes of the vulnerable adult..."</p> <p>2. The clinical record for Resident #D was reviewed on 4/12/16 at 3:00 p.m. Diagnosis included, but was not limited to dementia, anxiety, depression, and parkinson's disease.</p> <p>The written statement from Staff #4, dated 4/5/16 and untimed, included, but was not limited to, the following: "February Time Frame...I saw [Staff #7] being very rough with [Resident #D] when she was here. She jerked clothes that were too tight over [Resident #D] head [plus sign] [and] [Resident #D]</p>			

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	<p>screamed for her to stop because she was hurting her. She had the top the sweater so tight around {Resident #D} head that [Resident #D] was clawing to get it off. Finally [sic] when she got it off of her head, [Resident #D] said, "you hurt me". [sic] Staff #7] said, "It is your own fault. You should have set [sic] still and let me work." [sic] Then [Resident #D] started to cry."</p> <p>During an interview on 4/13/16 at 10:13 a.m., Staff #4 indicated she entered Resident #D's room (Staff #4 unsure of date and time, sometime in February 2016) to ask Staff #7 what she needed to do because she was new. Staff #4 indicated, when she walked in the bathroom, Staff #7 was attempting to remove Resident #D's sweater. Staff #4 indicated the sweater was stuck under Resident #D's chin and Staff #7 pulled the sweater back, hard, three times and it jerked Resident #D's head back each time. Staff #4 indicated Resident #D told Staff #7 to stop because she was hurting her. Staff #4 indicated, after the 4th time, Staff #7 got the sweater off and then it got stuck on Resident #D's earring. Staff #4 indicated Staff #7 pulled real hard to get it off. Staff #4 indicated Resident #D told Staff #7, "you hurt me" and pushed away from Staff #7. Staff #4 indicated Staff #7 told Resident #D, "well, you</p>			

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R 0052 Bldg. 00	<p>shouldn't have been fighting me and I wouldn't have hurt you." Staff #4 indicated she did not report the incident because she was new and saw what happened when things were reported related to Staff #7. Staff #4 also indicated she did not know she could call corporate and she did not have access to those numbers. Staff #4 indicated if she would have told the previous Director of Nursing, nothing would have been done.</p> <p>This State tag relates to complaint #IN00197469.</p> <p>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; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion.</p> <p>Based on observation, interview and record review, the facility failed to ensure residents were free from abuse (Resident #C and Resident #D) for 2 of 3 residents reviewed for abuse.</p> <p>Findings include:</p>	R 0052	<p>CITATION #3 R052 410 IAC 16.2-5-1.2(v)(1-6) RESIDENTS' RIGHTS-OFFENSE CORRECTIVE ACTION: Staff #7 no longer working at the community which completes the corrective action. Last day worked was 3-14-16 and the allegation was brought to management on 3-31-16. The</p>	04/14/2016			

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	<p>1. The clinical record for Resident #C was reviewed on 4/12/2016 at 1:15 p.m. Diagnosis included, but was not limited to, dementia.</p> <p>During an observation on 4/12/16 at 11:50 a.m., Resident #C was observed sitting in the dining room. Resident #C was alert to name only and unable to recall the date and time.</p> <p>The typed statement of the Executive Director, dated 3/3/16 and untimed, included, but was not limited to, the following: "...On behalf of the [facility name], the community respectfully confirms notification of an allegation of exploitation on 3/31/16 from staff at the [facility name] that had occurred as early on as September 2015. This was the first reporting of this allegation to the new administration who started employment with the [facility name] 2/2016...Upon receipt of the allegation (on 3/31/16), the Executive Director immediately followed the facility policy and procedure relative to abuse prohibition...The incident involved a Certified Nursing Assistant (staff #7's name) to a resident...(staff #7's name) last day of employment was March 14th...."</p> <p>The written statement of Staff #2, undated and untimed, included the</p>		<p>company policy on Abuse Prohibition was immediately followed. All staff in-serviced on policy and procedure for Residents' Rights and Abuse. Resident D was no longer living at the community when investigation was initiated. Alleged allegations was reported on 3-31-16 and 4-5-16. In-servicing completed with all staff regarding reporting guidelines. IDENTIFY OTHER RESIDENTS POTENTIALLY AFFECTED: No other residents were found to be effected. All staff at the Jewel House were re-educated by the Executive Director regarding residents' right and abuse. Upon interviews with the residents by the ED, no other allegations founded for violating residents' rights or abuse. Head to toe assessments completed by nurses on the residents that were not able to be interviewed. SYSTEMATIC CHANGES: All staff completes Abuse in-servicing upon hire, annually and PRN. Upon hire, employees will be educated on Residents' Rights and the Abuse Prohibition Policy . Background and reference checks are completed before the employee begins employment. The current new hires as well as the staff at the Jewel House have been educated on how and when to report allegations. Also educated on where the phone numbers are posted for reporting purposes. MONITORING PROCESS: Head</p>				

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	<p>following: "In a casual conversation with [staff #7] in the meeting room [sic] she told me that [Resident #C] grabbed her boob [plus sign] [and] "got a big handful." She then laughed [plus sign] [and] said "I told him it wasn't appropriate". Then she said don't tell anybody. This occurred [sic] approx. [approximately] in Jan [January] 2016. [signature of staff #2]."</p> <p>The written statement of Staff #1, dated 3/31/16 and untimed, included the following: "On an outing in September 2015, while at [name of restaurant], I observed [Resident #C] grab [Staff #7] breast. She laughed about it, saying to me while laughing [sic] "don't tell [Resident #C's wife]!" [sic] She wouldn't like it if she knew. Then [sic] again [sic] on the same day [sic] as we were loading the residents in the van, [Staff #7] reached over [Resident #C] lap to buckle his seat belt and [sic] he grabbed her again and [sic] again she laughed. Neither time did she try to remove his hand nor tell him no. Also, when we returned to the community [sic] I made a statement to [Interim Executive Director] and he acting [sic] like I made it up. He didn't seem that is was believable. As well as numerous [sic] [numerous] occasions that she said things about him touching her in front of other staff members.</p>		<p>to toe assessments will be completed on those residents unable to be interviewed weekly x 30 days and monthly x 6 months. The Ombudsman has been notified and is planning a date to conduct an abuse in-service for all staff and residents. This process will also be monitored through the QA process monthly x 8 months. Date of completion for the above, 4-14-16.</p>				

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	<p>[signature of Staff #1]."</p> <p>The written statement of Staff #3, undated and untimed, included the following: "Mid-January [sic] [Staff #7] reported to myself that upon getting Resident [sic] in room [room number]. [sic] [Resident #C's initials] sic he grabbed her breast. I told my supervisor [previous Director of Nursing] @ [at] the time. She did not say anything [sic] only laughed. [Staff #7] stated not to tell wife [arrow drawn to middle of page] and don't tell family [sic] that he does what she needs him to [sic] ie. [term used for example], [c with line over it] [with] taking shower etc. [signature of Staff #3]".</p> <p>During an interview on 4/12/16 at 12:30 p.m., the Executive Director (ED) indicated Staff #7 was letting Resident #C touch her inappropriately so Resident #C would do what she needed him to do, as in, taking showers. The ED indicated staff are struggling to get Resident #C to take showers now. The ED indicated staff were aware of what Staff #7 was doing, however, did not report it to the Interim ED or previous Director of Nursing/Assisted Living Director for fear of reprisal.</p> <p>During an interview on 4/13/16 at 9:47</p>			

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	<p>a.m., Staff #1 indicated, while on an outing in September of 2015 at a restaurant, Resident #C touched Staff #7's breasts and Staff #7 laughed about it and didn't say anything to Resident #C. Staff #1 indicated Staff #7 told her not to say anything, it will kill his wife. Staff #1 also indicated, when leaving the restaurant, Staff #7 buckled Resident #C's seat belt and he grabbed her breasts again and she didn't do anything, just laughed. Staff #1 indicated Staff #7 did not redirect Resident #C or tell him it was inappropriate. Staff #1 indicated she reported the incident to the Interim ED, who did not believe it happened.</p> <p>During an interview on 4/13/16 at 9:55 a.m. Staff #2 indicated, during a conversation with Staff #7 (Staff #2 could not remember the date or time), Staff #7 indicated Resident #C grabbed her breast and told him it wasn't allowed. Staff #2 also indicated Staff #7 told her Resident #C had done before and to not tell anyone.</p> <p>During an interview on 4/13/16 at 10:00 a.m., Staff #3 indicated, on several occasions (Staff #3 was unable to provide dates and times), Staff #7 told her Resident #C would touch her breasts before he would get in the shower and asked Staff #3 not to tell his wife. Staff</p>			

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	<p>#3 indicated Staff #7 told her she would let Resident #C touch her breasts because that was how she got Resident #C to take a shower. Staff #3 indicated she reported this to the previous Director of Nursing/Assisted Living Director, and was laughed at.</p> <p>During an interview on 4/13/16 at 10:13 a.m., Staff #4 indicated she overheard Staff #7 say she had no problems getting Resident #C to take a shower because she let Resident #C touch her boobs in order to get him to take a shower. Staff #4 indicated she did not report to the Interim ED because other staff had reported incidents with Staff #7 and he ignored everything.</p> <p>On 4/13/16 at 1:07 p.m., the ED provided a copy of the document titled, "Mandatory Learner Transcript Report", dated 1/1/16 - 12/31/16, and indicated was documentation for inservices. It included, but was not limited to, the following: "...Last Name [Staff #7 last name]...First Name [Staff #7 first name]...Facility Name [facility name]...Record Name...Abuse, Neglect and Exploitation...Original Completion Date...01/01/2016...."</p> <p>On 4/13/16 at 1:25 p.m., the ED provided a copy of the document titled,</p>						

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	<p>"Mandatory Learner Transcript Report", dated 1/1/15 - 12/31/15, and indicated was documentation for inservices. It included, but was not limited to, the following: "...Last Name [Staff #7 last name]...First Name [Staff #7 first name]...Facility Name [facility name]...Record Name...Abuse, Neglect and Exploitation...Original Completion Date...03/26/2015...."</p> <p>On 4/12/16 at 4:12 p.m., the Director of Nursing provided a copy of the policy and procedure titled, "Subject Abuse and Neglect Reporting-Including suspected/confirmed Resident-Resident abuse", and indicated as current. It included, but was not limited to, the following: "Policy: It is the policy of Senior Lifestyle to ensure that all reporting of abuse and neglect is handled in accordance with state rules and regulations. This policy will insure [sic] that proper reporting procedures are followed when a case of abuse, neglect, or exploitation is reported. All cases of confirmed or suspected cases of resident abuse will be immediately reported to the corporate office via Significant Event Call Line and incident Reporting policies and procedures...Physical Abuse - Intentionally inflicting or allowing injury on a vulnerable adult by an act or failure to act...Psychological Abuse -</p>			

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	<p>Deliberately subjecting a vulnerable adult to threats or harassment or other forms of intimidating behavior causing fear, humiliation, degradation, agitation, confusion or other forms of serious emotional distress...Exploitation - Causing or requiring a vulnerable adult to engage in activity or labor which is improper, illegal or against the reasonable and rational wishes of the vulnerable adult...The act of alleged abuse, neglect or exploitation must be reported within the first 24-hours or the next business day, either written or orally, to...the appropriate state office...Prevention-Protection...The Abuse Policies and Procedures of this community are developed to promote a safe living environment for all residents. Residents must not be subjected to abuse, neglect, or mistreatment by anyone, including, but not limited to facility or agency staff...Prevention of abuse/neglect requires involvement of all staff to monitor, observe, intervene, and report any behaviors/situations that may lead to conflict or neglect...."</p> <p>2. The clinical record for Resident #D was reviewed on 4/12/16 at 3:00 p.m. Diagnosis included, but was not limited to dementia, anxiety, depression, and parkinson's disease.</p>			

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	<p>The written statement from Staff #4, dated 4/5/16 and untimed, included, but was not limited to, the following: "February Time Frame...I saw [Staff #7] being very rough with [Resident #D] when she was here. She jerked clothes that were too tight over [Resident #D] head [plus sign] [and] [Resident #D] screamed for her to stop because she was hurting her. She had the top the sweater so tight around {Resident #D} head that [Resident #D] was clawing to get it off. Finally [sic] when she got it off of her head, [Resident #D] said, "you hurt me". [sic] Staff #7 said, "It is your own fault. You should have set [sic] still and let me work." [sic] Then [Resident #D] started to cry."</p> <p>During an interview on 4/13/16 at 10:13 a.m., Staff #4 indicated she entered Resident #D's room (Staff #4 unsure of date and time, sometime in February 2016) to ask Staff #7 what she needed to do because she was new. Staff #4 indicated, when she walked in the bathroom, Staff #7 was attempting to remove Resident #D's sweater. Staff #4 indicated the sweater was stuck under Resident #D's chin and Staff #7 pulled the sweater back, hard, three times and it jerked Resident #D's head back each time. Staff #4 indicated Resident #D told Staff #7 to stop because she was hurting</p>			

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	<p>her. Staff #4 indicated, after the 4th time, Staff #7 got the sweater off and then it got stuck on Resident #D's earring. Staff #4 indicated Staff #7 pulled real hard to get it off. Staff #4 indicated Resident #D told Staff #7, "you hurt me" and pushed away from Staff #7. Staff #4 indicated Staff #7 told Resident #D, "well, you shouldn't have been fighting me and I wouldn't have hurt you." Staff #4 indicated she did not report the incident because she was new and saw what happened when things were reported related to Staff #7. Staff #4 also indicated she did not know she could call corporate and she did not have access to those numbers. Staff #4 indicated if she would have told the previous Director of Nursing, nothing would have been done.</p> <p>On 4/13/16 at 1:07 p.m., the ED provided a copy of the document titled, "Mandatory Learner Transcript Report", dated 1/1/16 - 12/31/16, and indicated was documentation for inservices. It included, but was not limited to, the following: "...Last Name [Staff #7 last name]...First Name [Staff #7 first name]...Facility Name [facility name]...Record Name...Abuse, Neglect and Exploitation...Original Completion Date...01/01/2016...."</p> <p>This State tag relates to complaint</p>			

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R 0214 Bldg. 00	<p>#IN00197469.</p> <p>410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident.</p> <p>Based on interview and record review, the facility failed to re-assess a resident due to significant changes in behavior to determine if the resident was still appropriate for assisted living for 1 of 3 residents reviewed for assessments. (Resident #D)</p> <p>Findings include:</p> <p>The clinical record for Resident #D was reviewed on 4/12/16 at 3:00 p.m. Diagnosis included, but was not limited to dementia, anxiety, depression, and Parkinson's disease.</p> <p>The nurses notes for December, 2015 included the following:</p> <p>12/5/15 at 6:00 p.m. - "...Has attempted to exit through dining room doors x [times] 2...."</p>	R 0214	<p>CITATION #4 R214 410 IAC 16.2-5-1.2(v) EVALUATION DEFICIENCY CORRECTIVE ACTION: In-serviced the nurses on when assessments are to be completed. ALD or designee will be responsible for the assessments. IDENTIFY OTHER RESIDENTS POTENTIALLY AFFECTED: One resident affected by former ED and ALD by not re-assessing resident upon admission and change of condition as per policy. Current ALD or designee will ensure assessments will be completed upon admission, 30 days after, every 6 months and with significant change to ensure resident is appropriate for the community and following community policies and procedures. In accordance with the Senior Lifestyle Policy, the Elopement Risk Tool will be completed within 24 hours of admission, quarterly and with a</p>	04/14/2016			

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	<p>12/6/15 at 2:00 p.m. - "...Wanderguard [device used to let staff know resident it attempting to leave facility] placed for elopement risk..."</p> <p>12/8/15 at 2:30 p.m. - "Resident went out laundry room door approx. [approximately] 15 feet...."</p> <p>12/11/15 at 1:00 p.m. - "PRN [as needed] Ativan [medication for anxiety] given for agitation...."</p> <p>12/11/15 at 8:20 p.m. - "...resident tearful [plus sign] [and] wandering...."</p> <p>12/12/15 at 2:30 p.m. - "Rsd [resident] exited building via [how] door...."</p> <p>12/12/15 at 4:00 p.m. - "Rsd [resident] opened exit door...staff redirected...."</p> <p>12/17/15 at 8:39 p.m. - "Wandering [plus sign] [and] restless...."</p> <p>12/21/15 at 1:35 p.m. - "Res. [resident] tried to exit out front door. Redirected back inside...."</p> <p>12/24/15 at 3:30 p.m. - "Res [resident] opened outer door but did not go out...."</p> <p>12/26/15 at 12:00 p.m. - "Rsd [resident] anxious [backwards 3 with a dot above and below] [and] wandering around facility...."</p> <p>12/27/15 at 7:30 p.m. - "Res [resident] trying to go into other res [resident] rooms. Wandering around facility...."</p> <p>12/27/15 at 8:00 p.m. - Res. [resident] left room to sit in living room. Pulled pants down and peed [sic] [urinated] on chair and clothes...."</p>		<p>change of condition. Should this show that resident is not appropriate for an assisted living environment, arrangements will be made with the family to relocate the resident.</p> <p>SYSTEMATIC CHANGES: ALD or designee will review Elopement Risk Tool weekly x 2 months then monthly x 6 months. Elopement Risk Tools audited on 4-14-16. ALD reviewed Admission and Retention Criteria and will continue to follow policy.</p> <p>MONITORING PROCESS: Residents are monitored through a program that was developed by Senior Lifestyle so that no deficient assessments will occur. This process will also be monitored through the QA process monthly x 8 months. Date of completion for the above, 4-14-16.</p>	

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	<p>12/28/15 at 9:00 p.m. - "Res [resident] has had multiple wandering bx [behaviors] this shift...Requires constant redirection...."</p> <p>The nurses notes for January 2016 included the following:</p> <p>1/3/16 at 4:00 a.m. - " Rsd [resident] continued [sic] confusion and wandering...."</p> <p>1/7/16 at 4:00 a.m. -" Rsd [resident] [up arrow] [up] this shift. confused [sic] [plus sign] [and]disoriented with some behaviors...."</p> <p>1/7/16 at 11:00 p.m. - "Res [resident] with [up arrow] [increased] wandering [plus sign] [and] agitation...."</p> <p>1/9/16 at 11:00 p.m. - "Rsd [resident] confused and wandering into [room #] [plus sign] [and] [room #]...."</p> <p>1/17/16 at 4:00 a.m. - "Rsd [resident] [up arrow] [up] and wandering this shift...."</p> <p>1/19/16 at 5:00 p.m. - "Contacted [physician name] R/T [related to] resident having inc [increased] agitation, wandering. rec'd [sic] [received] N.O. [new order] to inc [increase] Risperdal [anti-psychotic medication]...."</p> <p>1/21/16 at 4:00 a.m. - "Rsd [resident] [up arrow] [up] [c with line over it] [with] confusion...."</p> <p>1/22/16 at 1:30 p.m. - "Rsd [resident] [c with line over it] [with] some</p>			

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	<p>wandering...."</p> <p>1/26/16 at 6:30 p.m. - "Res [resident] [c with line over it] [with] [up arrow] [increased] anxiety/agitation noted...."</p> <p>1/26/16 at 9:00 p.m. - "Res [resident] cont [continues] [c with line over it] [up arrow] increased wandering [division sign] [and] agitation...."</p> <p>1/27/16 at 5:00 a.m. - "Resident [up arrow] [up] wandering...."</p> <p>1/27/16 at 9:15 a.m. - "Res [resident] cont [continues] to have [up arrow] [increased] wandering [plus sign] [and] increased agitation...."</p> <p>1/29/16 at 3:55 p.m. - "Contacted MD [medical doctor] R/T [related to] inc [increased] behaviors, wandering, difficult to redirect, attempting to open locked supply room doors, going toward exit doors...approaching other residents too close...."</p> <p>1/29/16 (no time) - "Rec'd [received] N.O. [new order] [sic] Depakote [mood stabilizer] 250 mg [milligrams] BID [twice daily]...."</p> <p>1/30/16 at 1:15 p.m. - "Rsd [resident] opened exit door by break room...."</p> <p>1/30/16 at 8:30 p.m. - "Rsd [resident] [c with line over it] [with] [up arrow] [increased] agitation noted this shift...."</p> <p>1/30/16 at 9:40 p.m. - "Res [resident] back up, wandering, pushing doors to open cause [sic] alarms to sound...."</p> <p>1/31/16 at 9:10 p.m. - "...wandering,</p>						

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	<p> pacing frequently...."</p> <p>The nurses notes for February 2016 included the following:</p> <p>2/1/16 at 5:00 a.m. - "Rsd [resident] [up arrow] [up] wandering until I put her to bed...."</p> <p>2/2/16 at 2:30 p.m. - "...went out exit door by laundry room...."</p> <p>2/2/16 at 4:20 p.m. - "Resident went to exit door at end of east hall [sic] opened door and stepped out...."</p> <p>2/2/16 at 9-00 p.m. - "Rsd [resident] has been 1:1 [one on one] this shift...."</p> <p>2/3/16 at 8:00 p.m. - "Rsd [resident] [c with line over it] [with] [up arrow] [increased] wandering [plus sign] [and] agitation...."</p> <p>2/4/16 at 9:00 p.m. - "Rsd [resident] has had [up arrow] [increased] wandering...."</p> <p>The Elopement Risk Review Tool, dated 12/8/15, included, but was not limited to, the following: "...Instructions: To be completed within 24 hours of admission...and with change of condition...Risk rating:...Areas identified with an asterisk (*) indicates a resident has behaviors potentially putting them at a high risk for elopement and would warrant the need to a secure care environment...Date...12/8/15... [asterisk]... Wanders, looking for an exit,</p>						

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	<p>attempts to leave... [asterisk]...Emphatically proclaims they are leaving, or expresses they are going somewhere, when they are not... [asterisk]...Is paranoid/anxious about were they are, does not believe they live there, attempts to leave...."</p> <p>The clinical record lacked any other assessments related to Resident #D's changes in condition.</p> <p>During an interview on 4/13/16 at 12:00 p.m., the Director of Nursing indicated by reading the nurses notes, Resident #D was not appropriate for the facility.</p> <p>During an interview on 4/13/16 at 1:22 p.m., the Director of Nursing indicated she could not locate any updated assessments for Resident #D since the admission assessments were completed.</p> <p>On 4/13/16 at 1:32 p.m., the Director of Nursing provided a copy of the document titled, "Subject Admission & Retention Criteria", dated 12/14/2011 and indicated as current. It included, but was not limited to, the following: "All Senior Lifestyle communities will follow the procedure below when admitting, readmitting , and retaining residents. For Admission and Readmission for Assisted Living and Memory Care:...Resident will</p>			

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

PRINTED: 04/27/2016
FORM APPROVED
OMB NO. 0938-0391

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	be assessed in person by the Assisted Living Director or designee prior to admission...and with significant change...."				