

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155704	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/11/2016
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NAME OF PROVIDER OR SUPPLIER WALDRON HEALTH AND REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 505 N MAIN ST WALDRON, IN 46182
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00195749.</p> <p>Complaint IN00195749 -- Substantiated. Federal and state deficiency related to the allegations is cited at F223.</p> <p>Survey dates: May 9, 10 and 11, 2016</p> <p>Facility number: 000423 Provider number: 155704 AIM number: 100290450</p> <p>Census bed type: SNF/NF: 62 Total: 62</p> <p>Census payor type: Medicare: 9 Medicaid: 39 Other: 14 Total: 62</p> <p>Sample: 3</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 30576 on May 12, 2016</p>	F 0000	<p>Credible Allegation of Compliance</p> <p>This plan of correction is the facility's Credible Allegation of Compliance.</p> <p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the Federal and State law.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0223 SS=D Bldg. 00	<p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>Based on interview and record review, the facility failed to ensure Resident B did not subject Resident D to verbal and physical abuse for 1 of 3 residents reviewed for abuse in a sample of 3.</p> <p>Findings include:</p> <p>In a review of abuse-related incidents reported by the facility to the Indiana State Department of Health (ISDH) in 2016, two incidents of resident to resident verbal and/or physical abuse were present. Both incidents involved Resident #B and Resident #D.</p> <p>Review of an incident, dated 4-18-16 at 5:30 p.m., indicated Resident #D approached the dining table of Resident #B via wheelchair. "[Name of Resident #D] began feeling around the table surface due to his dementia and</p>	F 0223	<p>F223</p> <p>It is the practice of the facility to provide an environment that protects the residents rights to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>Resident B no longer resides at the facility and therefore Resident D is no longer at risk of being subjected to verbal or physical abuse from Resident B.</p> <p>No other residents are at risk of being subjected to verbal or physical abuse from Resident B as this resident no longer resides at the facility.</p> <p>The facility will continue to monitor resident behavior and review and revise plans of care to address negative behavior and protect resident(s) right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and</p>	05/19/2016

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	<p>extremely poor eyesight. [Name of Resident #B] began shouting at [name of Resident #D] to get away, he then used his rolled silverware and table centerpiece (small glass vase with artificial flowers) to hit at the hands of [name of Resident #D]. Staff in vicinity of incident alert [sic] [name of Resident #B] they would handle it and to stop hitting at [name of Resident #D] and that staff would remove [name of Resident #D] from table. [Name of Resident #B] who was now agitated began yelling at staff member. Staff did remove [name of Resident #D] from table with incident and informed [name of Resident #B] his behavior was unacceptable and he can not hit others." The report indicated Resident #D was assessed for injuries and none were found, as well as notification was made to the attending physicians and to the respective responsible parties of each resident and to the Executive Director.</p> <p>Review of an incident, dated 5-6-16 at 7:30 a.m., indicated Resident #D approached the dining table of Resident #B by wheelchair. It indicated Resident #D, "who is legally blind with cognitive impairment, was using his hands to feel around the table top." Staff observed Resident #B speak to Resident #D and then observed Resident #B "smack the</p>		<p>involuntary seclusion. Any allegation of abuse will be immediately reported and investigated per facility policy and federal regulation.</p> <p>The QA&A Committee will review all instances of alleged abuse monthly times 3 months and then quarterly thereafter to assure all allegations are acted on promptly and the facility maintains all efforts to protect all residents rights to be from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p>	

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	<p>right hand of [name of Resident #D]." Resident #D was immediately moved away from Resident #B by staff and assessed for injury. Staff noted Resident #D was calm, but had a reddened area to the top of his right hand, which had cleared by re-assessment several hours later. The Executive Director met with Resident #B and reminded him "to ask for staff assistance and not take matters into own hands," as staff members were in the vicinity for breakfast service. Notification was made to the attending physicians and to the respective responsible parties of each resident, as well as to the Executive Director who was present shortly after the incident and met with the resident. Documented follow up with Resident #D indicated the resident had no adverse effects related to the incident. It indicated continued staff education was provided to closely monitor both of the residents regarding proximity to one another as Resident #D "due to his cognitive status is not a candidate for educating him to avoid [name of Resident #B]'s table..."</p> <p>1. Review of the clinical record of Resident #B on 5-9-16 at 3:32 p.m., indicated his diagnoses included, but were not limited to, "other personality and behavior disorder due to known physiological condition," unspecified</p>			

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	<p>personality disorder, vascular dementia with behavioral disturbances and history of CVA (cerbrovascular accident or stroke). His most recent Minimum Data Set (MDS) assessment, dated 3-14-16, indicated he is cognitively intact, with behaviors of physical and verbal behaviors towards others on 4 to 6 days of the 7 day review (look back) period.</p> <p>2. Review of the clinical record of Resident #D on 5-11-16 at 10:11 a.m., indicated his diagnoses included, but were not limited to, Alzheimer's disease, legal blindness and macular degeneration. His most recent Minimum Data Set (MDS) assessment, dated 4-13-16, indicated he has problems with both short term and long term memory, is moderately cognitively impaired, has highly impaired vision and has minimal hearing impairment. It indicated he understands others, but sometimes is not understood by others. It indicated he displayed moods of sleep and concentration problems on 12-14 days of the 14 day look back period. It indicated he displayed behaviors of wandering and physical behaviors toward others daily, as well as behaviors on 1 to 3 days during the 7 day look back period of "other" behaviors toward others, intrusion of others, and behaviors which interferes with participation in activities/social</p>			

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	<p>interactions.</p> <p>In an interview with the Director of Nursing on 5-11-16 at 12:05 p.m., she indicated Resident #D is legally blind and cognitively impaired, and frequently uses his hands to help identify where he is within the facility.</p> <p>This Federal tag relates to Complaint IN00195749.</p> <p>3.1-27(a)(1) 3.1-27(b)</p>				