

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 05/20/2014
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NAME OF PROVIDER OR SUPPLIER HEARTH AT JUDAY CREEK LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 6330 N FIR RD GRANGER, IN 46530
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R000000	<p>This visit was for an Investigation of Complaint IN00149010.</p> <p>Complaint IN00149010 - Substantiated. State residential deficiency related to the allegations is cited at R051 .</p> <p>Unrelated deficiency is cited.</p> <p>Survey Date: May 20, 2014</p> <p>Facility Number: 012229 Provider Number: 012229 Aim Number: N/A</p> <p>Survey Team: Shelly Miller-Vice, RN</p> <p>Census Bed Type: Residential: 108 Total: 108</p> <p>Census Payor Type: Other: 108 Total: 108</p> <p>Sample: 3</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	R000000	<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>	

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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R000052	<p>Quality Review completed on May 23, 2014, by Brenda Meredith, R.N.</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 record reviews and interviews, the facility failed to prevent physical abuse of Resident B. This affected 1 of 3 incidents reviewed.</p> <p>Findings included:</p> <p>On 5/20/14 at 2:30 p.m., a record review was completed of a written reportable of resident-to-resident abuse dated "5/7/2014." The report indicated that Resident B had been physically abused by Resident C in his private room on the Memory Care Unit. Resident C had entered the private room of Resident B on 5/7/2014, torn off the window blind coverings, and pushed Resident B to the floor causing an injury of a broken hip requiring hospitalization. Resident C was discharged to a psychiatric hospital for evaluation on the same day following the incident.</p>	R000052	<p>R 052 Residents' Rights –</p> <p>1. Staff immediately intervened upon occurrence of the resident-to-resident incident. Resident#B was assessed and sent to the ER for evaluation and treatment. Resident B was admitted for further treatment. Resident #C was supervised by 1:1 treatment until admission to an area geri-psych hospital for further treatment. Facility leadership subsequently assessed resident C and determined he was no longer appropriate for the facility. He did not return to the facility. The facility also reported the incident in accordance with ISDH policy and procedure.</p> <p>2. All residents have the potential to be affected by this alleged deficient practice. The facility nursing leadership reviewed current resident charts for any other incidents of aggressive behavior. Any concerns were addressed</p>	07/01/2014

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	<p>On 5/20/14 at 2:45 p.m., an interview was conducted with the Director of Nursing(DNS) of the Memory Care Unit and indicated she had been working on the 5/7/2014 and was familiar with this occurrence. The DNS indicated Resident's B and C had been located on the Memory Care Unit in separate private rooms. After breakfast on the 5/7/2014, Resident C entered the unlocked door of Resident B's room where Resident B was located. A Certified Nurse Aid (CNA) found Resident B and C in the private room of Resident B, with Resident B to be sitting on the floor and Resident C standing over Resident B. A call was made by the staff with their personal walky-talky and other staff immediately intervened. The emergency 911 was immediately called, and Resident B was taken to the hospital where a fractured hip was diagnosed. The DNS indicated Resident B was cognitively intact to say what had occurred prior to the CNA arriving at the room. Resident C had entered his room, torn the window blinds off the window and proceeded to attempt to remove the private television. Resident B intervened and was pushed to the floor by Resident C and this is where the CNA found the situation. The DNS indicated that Resident C had not had a psychiatric history prior to his admission</p>		<p>and incorporated into the resident's plan of care. 3. The administrator and wellness directors will in-service staff regarding resident behaviors and the facility abuse policy and procedure including resident to resident incidents. Staff were also trained on the use of the communication form to relay non nursing observations and concerns about residents. The wellness directors also in-serviced nursing staff regarding behavior management and appropriate interventions and reporting, including use of the 24 hour report form, pertinent charting form and use and updating of resident service plans. The facility QA Committee will review the policy and procedures pertaining to resident behaviors for possible changes in the procedures for tracking and addressing resident behaviors. 4. The administrator and/or designee will conduct an audit of ten randomly selected resident charts for behaviors, interventions and use of service plan. Review will be conducted weekly x4, monthly x1 and quarterly thereafter. 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>These systematic changes will</p>				

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	<p>to the facility on April 24, 2014 and there had not been indications of behaviors prior to this event with Resident B on 5/7/2014. The DNS indicated Resident C was on the list to see the facility's psychiatrist for 5/7/14, "...we [the facility] just offer this service to everyone that comes into the memory Care Unit... the Resident doesn't have to have psych-issues for this, but the family [of Resident C] liked the idea, so [Resident C] was set to be seen... the Psychiatrist comes to the facility every other Wednesday...."</p> <p>On 5/20/14 at 3:05 p.m., a Clinical Medical Record Review was conducted of Resident C indicating the following: "ER Physician Report. [Resident C's name]. Dated 4/14/2014. Historical data: The patient is an [age] old male sent to the Emergency Department for decreased level of consciousness and responsiveness. He came by ambulance from [local psychiatric hospital name]. He was inpatient there....He has a past medical history of Alzheimer's dementia with behavioral problems. He had been at [another residential care provider] previously...."</p> <p>The facility "Progress Notes:... 4/25/14....Res seems to be adjusting well to facility...</p>		be completed by July 1, 2014.				

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	<p>4/30/14. 5:40 p.m. Behaviors. QMA [Qualified Medication Aid] called to activity area. Resident was trying to remove another resident from her chair. Contacted nurse regarding resident behavior. PRN [as needed] Ativan [anti-anxiety] given. Over the course of the next hour, resident paced halls kicking doors, elbowing windows and pounding the walls. Nurse was called to this unit. Nurse was walking with resident in the halls. A call was placed to the resident daughter to come and sit with one on one per nurse. Resident then grabbed nurse and bent her fingers back. Resident was then assisted back to his room. Upon entering his room, resident called staff 'F----- super!' ...</p> <p>5/1/14. 1:00 p.m., daughter requested for us to get info from [local psychiatric hospital name] regarding resident being sent out to [local hospital name] for [facility's psychiatrist name] to review on Wednesday. copy filed in chart...</p> <p>5/2/14. (not time documented). Another resident's son came into facility today and stated that [Resident C's name] came up to his 9 year old daughter and said, 'I don't care what anyone says, your a woman to me'...</p> <p>5/4/14. 2 p.m.. Resident displayed inappropriate behavior at 11:30 a.m.- CNA was taking [Resident B's room number/ name] to dining room for lunch,</p>			

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	<p>as they approached thru [Resident B's] doorway, [Resident C's name] grabbed [Resident B's name] walker very quickly and started to yell at resident [B]- telling Resident [B] that this is his room- the two began to argue and CNA intervened by getting between them. [Resident C] attempted to shove [Resident B's name] walker that Resident [B] had a hold of and then tried to push walker backwards. CNA intervened and prevented Resident [B] from falling backwards. Resident [C] then released the walker of Resident [B], went into Resident [B's name] room, kicked at the closet doors and tried to pull the blinds off the windows...."</p> <p>5/5/14. 9:45 p.m., Resident trying to open all doors thru out unit. Sounding of door alarms several times this shift..</p> <p>5/6/14. 9:40 a.m., resident walking around with ten one-dollar bills in his hand.... staff concerned he might have taken from someone else...</p> <p>5/7/14 at 9:30 a. new orders to send to [local psychiatric hospital]..."</p> <p>"Resident Transfer Information Form. Dated: 5/7/14. Reason for transfer: Dementia- aggressive behavior. Condition and reason for transfer: aggressive- pushed another resident resulted in injury..."</p> <p>There was not a service plan supporting the continued monitoring of this</p>						

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	<p>Residents behavior to prevent further insult to the other residents on the Memory Care Unit.</p> <p>On 5/20/2014 at 5:00 p.m., an interview was conducted with the DNS in regards to the progress notes indicating an earlier altercation on 5/4/2014, between Resident B and C mirroring the actual incident of abuse on 5/7/2014 in which Resident C sustained a fractured hip. The DNS indicated interventions of PRN Ativan and using the family to sit with the resident 1:1 were provided and the doors to the residents rooms were locked to disallow residents to roam/ wander from room to room. The DNS did indicate on the 5/4/14 and 5/7/14 incidents, Resident C had entered Resident B's unlocked door to the private room.</p> <p>On 5/20/14 at 4:00 p.m., a record review was conducted of the Policy and Procedure titled, "Abuse Prevention. Neglect... Failure to protect an elder from health and safety hazards...."</p> <p>On 5/20/2014 at 4:10 p.m., an interview was conducted with the Administrator. A list of reportable allegations of abuse from Resident to Resident was reviewed. A report for the incident on 5/4/2014 between Resident B and C was not</p>			

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R000116	<p>included.</p> <p>This Federal tag relates to Complaint IN00149010.</p> <p>410 IAC 16.2-5-1.4(a) Personnel - Noncompliance (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. Based on record reviews and interview, the facility failed to provide reference checks of 2 of 5 newly hired staff.</p> <p>Findings included:</p> <p>On 5/20/2014 at 3:00 p.m., record reviews were conducted of Staff 3 and 4 indicating no personal reference checks had been conducted.</p> <p>On 5/20/14 at 3:30 p.m., an interview was conducted with he Business Office Manager (BOM). The BOM indicated Staff 3 and 4 did not have personal</p>	R000116	<p>R 116 Personnel – reference checks</p> <p>1. Upon identification of the concern references for Staff 3 and Staff 4 were completed and added to the personnel file. No concerns were identified and the employees remain employed by the community.</p> <p>2. All residents have the potential to be affected by this alleged deficient practice. The facility office manager reviewed the personnel file of every current facility employee for completion of reference checks and related</p>	07/01/2014			

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	reference checks. On 5/20/14 at 3:45 p.m., a record review was conducted of the Policy and Procedure titled: "Reference checks. Procedure: A. A minimum of two reference checks will be made on each applicant being considered for any position...."		required pre-employment screening. Any concerns were addressed. 3. The facility pre-screening employment hiring procedure was better defined; department managers are now assigned the responsibility of conducting the required references for each candidate. The Business Office Manager and Administrator will also verify that references have been completed as part of new hire paperwork review. The administrator in-serviced leadership staff regarding the revised reference check policy and procedures. 4. The administrator and/or designee will conduct a review of ten employee resident charts for completed references. Review will be conducted weekly x4, monthly x1 and quarterly thereafter. Results of these audits will be reviewed by the QA Committee, who will establish the threshold of compliance and make further recommendations accordingly. These systematic changes will be completed by July 1, 2014.				