STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	09/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM CROSSING	200 CONNIE AVE SALEM, IN 47167

(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 Complaints IN00207421 and IN00207593. Complaint IN00207421 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00207593 - Substantiated. Federal/State deficiencies related to the allegation are cited at F280 and F323. Survey dates: September 8 and 9, 2016 Facility number: 000223 Provider number: 155330 AIM number: 100267680 Census bed type: SNF/NF: 74 Total: 74 Census payor type: Medicare: 16 Medicaid: 51 Other: 7 Total: 74 Sample: 5 These deficiencies reflects State findings	F 0000	Please find the enclosed plan of correction for the survey ending September 9, 2016. Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. The documentation serves to confirm the facility's allegation of compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	cited in accordance with 410 IAC 16.2-3.1. Quality review completed by 34233 on September 19, 2016.			
F 0280 SS=D Bldg. 00	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on interview and record review, the facility failed to ensure appropriate plan of cares and interventions were in place to reflect potential behaviors for 2 of 5 residents reviewed for care plans.	F 0280	1.What corrective actions will be accomplished for those residents affected by the deficient practice: Resident #C and #F care plans and interventions were revised and include additional	10/07/2016

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	(Resident #C and #F) Findings include: 1. The clinical record for Resident #C was reviewed on 9/8/16 at 2:20 p.m. Diagnoses included, but were not limited to, dementia with behavior disturbance, depression, and schizoaffective disorder. The Admission MDS (Minimum Data Set) assessment, dated 8/12/16, indicated Resident #C had a BIMS (Brief Interview for Mental Status) score of 3, signifying severe impaired cognition and "Behavioral Symptoms - Presence & Frequency...2. Behavior of this type occurred 4 to 6 days...B. Verbal behavioral symptoms directed towards others (...hitting, kicking, pushing, scratching, grabbing...)" The incident, dated 8/14/16 at 8:30 a.m., included, but was not limited to, the following: "...Residents Involved... [Resident #C's name]...[Resident #D's name]...Brief Description of the Incident...[Resident #D]...yelling for staff. Upon nurse entering the room [sic] she witnessed [Resident #C] lying on...back and [Resident #D] holding [Resident #C's] arms down to keep [Resident #C] from hitting...As soon as staff entered the room, [Resident #D] got		interventions were implemented to reflect potential behaviors. 2.How other residents have the potential to be affected and what corrective actions will be taken: All residents with behaviors have the potential to be affected. Care plans were reviewed for residents with potential behavioral issues and revised as necessary by the interdisciplinary team to ensure accuracy of care plan. 3.What measures will be put into place to ensure the deficient practice does not occur: DNS or designee will in-service the Interdisciplinary Team on Care Plan Review policy by 10-6-16 (See Attachment A). IDT Quarterly Care Plan and Resident Review Tool will be completed by IDT weekly during care plan meetings to ensure care plan meets current needs (See Attachment B). MCF, SSD or designee will develop behavior care plans and interventions when residents are admitted/readmitted or experience a significant change to ensure care plans address any potential behaviors using the Behavior Management Audit Tool (See Attachment C). 4.How the corrective actions will be monitored to ensure it will not recur: The DNS or designee will complete a Care Plan Updating Audit Tool (See Attachment D) weekly times one month, then monthly times six months, and then quarterly on all residents	

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	up and let staff intervene with [Resident #C]...Type of Injury...Head laceration to right posterior head of[Resident #C] Skin tear to left elbow and abrasion to right cheek of [Resident #D]...Immediate Action Taken...[Resident #C] sent to hospital for evaluation and treatment...Preventative Measures...Will reevaluate [Resident #C] upon return from hospital...Follow Up...[Resident #C] remains in behavioral hospital for treatment. IDT [Interdisciplinary Team] will review medications, care plans, and new interventions upon return and update as needed..." The care plan for Resident #C included, but was not limited to, the following: "...Problem Start Date: 08/09/2016...Behavior 1: Resident has bx [behavior] of intrusive wandering (Rsd [resident] wanders into others room and tends to pick up and take others personal belonging)/exit seeking..." The care plan for Resident #C included, but was not limited to, the following: "...Problem Start Date: 08/09/2016...Behavior 2: Resident can be verbally aggressive towards staff..." The care plan for Resident #C included, but was not limited to, the following: "...Problem Start Date:		reviewed in care plan meetings for the week as well as newly admitted or readmitted residents. The audits will be reviewed during the facility's QAPI meetings and issues will be addressed and the above plan will be altered accordingly if the threshold is not 95% or above.	

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	08/12/2016...Behavior 3: Resident becomes physically aggressive with staff during care..." The clinical record for Resident #C lacked documentation of a plan of care to address the potential for explosive behaviors upon admission to the facility on 8/5/16. During an interview on 9/9/16 at 12:20 p.m., when asked why interventions for Resident #C were not put into place regarding his/her explosive behaviors, the Memory Care Facilitator (MCF) indicated she was not there when he/she was admitted and did not approve Resident #C. During an interview on 9/9/16 at 12:30 p.m., the DON (Director of Nursing) indicated she was on vacation when Resident #C was admitted. The DON further indicated the facility does training with staff and they know how to handle situations. 2. The clinical record for Resident #F was reviewed on 9/9/16 at 10:50 a.m. Diagnosis included, but was not limited to, dementia with behavior disturbance. The Admission MDS assessment, dated 9/12/16, indicated Resident #C had a			

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	BIMS score of 11, mild cognition impairment. The care plan for Resident #F, dated 8/30/16, included, but was not limited to, the following: resident often had grandiose expressions and body movements. The interventions were to observe interactions with other residents and remove resident from negative situations if needed. The care plan lacked documentation of appropriate interventions to reflect the physical behaviors exhibited by Resident #F. The nurses note, dated 8/25/16 at 9:55 a.m., included, but was not limited to, the following: "Resident physically aggressive this am with staff. Resident didn't want roommate to leave room and sit with men in common area. This nurse tried to redirect resident and [he/she] still didn't want roommate to sit with male residents. This nurse was able to get roommate out of room. Resident was told that roommate was allowed to leave room when [he/she] wanted to. Will continue to observe". The progress note, dated 8/30/16 at 9:32 a.m., included, but was not limited to, the following: "IDT [Interdisciplinary Team]			

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	met regarding Behavior [sic]: Verbal aggression and possible physical aggression...Root cause: After talking to staff and investigation of event, Upon [sic] the tow other residents passing in the hall, with a walker in hallway(not in use) [sic] [Resident #F's first name] went around walker. [Resident #F's first name] yelled at them and told them they "better get the [h.ll] out of my way". [sic] After that this res [resident] attempted to slapped [sic] other res [resident]...in...face... Interventions: Both resident's separated immediately. This RSD [resident] went to therapy gym. No further behaviors or anger noted. Later, RSD [resident] was encouraged to socialize in activities of choice; [he/she] did without any box [behavior] issues and was back at baseline. Hallway was cleaned of used walker. This was root cause of situation..." During an interview on 9/9/16 at 1:37 p.m., LPN (Licensed Practical Nurse) #3 indicated she had to physically go into Resident #F's room and assist the roommate out. During an interview on 9/9/16 at 2:45 p.m., the Memory Care Facilitator (MCF) indicated she was not aware that Resident #F had not allowed his/her roommate to leave the room. The MCF further			

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	indicated there were no interventions put into place for the behavior because she was advised Resident #F was only verbally telling [his/her] roommate he/she could not leave. This Federal tag relates to Complaint IN 00207593 3.1-35(B)(1) 3.1-35(d)(2)(B)			
F 0323 SS=G Bldg. 00	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to ensure adequate supervision was in place for a newly admitted resident (Resident #C) with a history of violent behaviors and current escalating behaviors, which resulted in a resident to resident altercation with injury, for 1 of 3 residents reviewed for accidents. This deficient practice had the potential to affect 25 of 25 residents residing on the dementia unit. Findings include: The incident, dated 8/14/16 at 8:30 a.m.,	F 0323	1.What corrective actions will be accomplished for those residents affected by the deficient practice: Resident #C was sent to psychiatric hospital for evaluation and treatment. Upon readmission, resident was placed on increased supervision. Care plan and interventions was reviewed and updated to address the resident's behavior. 2.How other residents have the potential to be affected and what corrective actions will be taken: All residents residing on the dementia unit have the potential to be affected. Care plan reviews were conducted by IDT for all residents with behaviors to	10/07/2016

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	included, but was not limited to, the following: "...Residents Involved... [Resident #C's name]...[Resident #D's name]...Brief Description of the Incident...[Resident #D]...yelling for staff. Upon nurse entering the room [sic] she witnessed [Resident #C] lying on...back and [Resident #D] holding [Resident #C's] arms down to keep [Resident #C] from hitting...As soon as staff entered the room, [Resident #D] got up and let staff intervene with [Resident #C]...Type of Injury...Head laceration to right posterior head of[Resident #C] Skin tear to left elbow and abrasion to right cheek of [Resident #D]...Immediate Action Taken...[Resident #C] sent to hospital for evaluation and treatment...Preventative Measures...Will reevaluate [Resident #C] upon return from hospital...Follow Up...[Resident #C] remains in behavioral hospital for treatment. IDT [Interdisciplinary Team] will review medications, care plans, and new interventions upon return and update as needed..." The clinical record for Resident #C was reviewed on 9/8/16 at 2:20 p.m. Diagnoses included, but were not limited to, dementia with behavior disturbance, depression, and schizoaffective disorder. The admission MDS (Minimum Data Set) assessment, dated 8/12/16, indicated		ensure appropriate interventions/supervision are in place to prevent and manage behaviors. 3.What measures will be put into place to ensure the deficient practice does not occur: All staff will be in-serviced Abuse, Behavior Management, IDT Care Plan Review Policy and Procedures by the DNS or designee by 10-6-16 (See Attachment E, F, and A). MCF or designee will review behavior care plans when residents are admitted/readmitted or experience a significant change to ensure care plans and interventions address any potential behaviors using the Behavior Management Audit Tool (See Attachment C). The care plan will be reviewed by the IDT reflect the appropriate interventions to prevent and manage resident's behaviors. Care plans will also be updated with any new or worsening behaviors is identified in conjunction with the IDT assessment of the behavior. Rounds will be conducted each shift to ensure care plan/interventions/supervision is provided per plan of care for residents with identified behaviors. 4.How the corrective actions will be monitored to ensure it will not recur: The DNS or designee will complete a Care Plan Updating Audit Tool (See Attachment D)	

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	Resident #C had a BIMS Brief Interview for Mental Status) score of 3, which signified severely impaired cognition. "Behavioral Symptoms - Presence & Frequency...2. Behavior of this type occurred 4 to 6 days...B. Verbal behavioral symptoms directed towards others (...hitting, kicking, pushing, scratching, grabbing...)" The psychiatric hospital history and physical, dated 7/26/16 at 11:59 p.m., included, but was not limited to, the following: "...[Resident #C's name]...History of Present Illness...According to the...report...was sent from [name of previous facility] to the emergency room for medical clearance...According to staff, the patient has had a violent episode today...Mental Status Exam...was seen to be very dazed, confused...moving constantly...speech quick and fast...." The document titled "Psych (Psychiatric) Initial Assessments", dated 7/27/16 at 5:11 p.m., included, but was not limited to, the following: "...[Resident #C's name]...History of Present Illness...Pt [patient] admitted through [name of hospital] ED [emergency department]. Pt [patient] became agitated at [name of previous long term care facility]. Report given by Pt's [patient's] [family member]		weekly times 1 month, then monthly times 6 months, and then quarterly on all residents reviewed in care plan meetings for the week as well as newly admitted or readmitted residents. The audits will be reviewed during the facility's QAPI meetings and issues will be addressed and the above plan will be altered accordingly if the threshold is not 95% or above.	

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	was that Pt [patient] became agitated with 1:1 [one on one] staff member in his bathroom, ripped towel bar of wall and struck staff member...Pt [patient] has been getting increasingly more verbally aggressive for last month since...was attacked by...roommate...sustained several large bruises...[family member] reports Pt [patient] has had increased anxiety, paranoia, fear someone is going to hurt them [sic]...Mental Status Exam...Appearance: disheveled...Behavior: restless, agitated...Speech: pressured...Thought Process: incoherent, indecisive...Thought Content: preoccupation, blaming...Affect: angry, sad...Eye Contact: poor..." The psychiatric hospital document titled "SBAR (Situation, Background, Assessment, Recommendation) Handoff Communication", dated 8/3/16, included, but was not limited to, the following: "...pt [patient] has been agitated, refused to change, trying to hit staff. Refused meds [medications]. Wandering [plus sign] [and] hard to redirect..." The hospital discharge instructions, dated 8/5/16 at 10:12 a.m., indicated Resident #C refused all morning medications. The care plan for Resident #C included, but was not limited to, the following:			

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	"...Problem Start Date: 08/09/2016...Behavior 1: Resident has bx [behavior] of intrusive wandering (Rsd [resident] wanders into others room and tends to pick up and take others personal belonging)/exit seeking..." The care plan for Resident #C included, but was not limited to, the following: "...Problem Start Date: 08/09/2016...Behavior 2: Resident can be verbally aggressive towards staff..." The care plan for Resident #C included, but was not limited to, the following: "...Problem Start Date: 08/12/2016...Behavior 3: Resident becomes physically aggressive with staff during care..." During an interview on 9/9/16 at 12:20 p.m., when asked why interventions for Resident #C were not put into place regarding his/her explosive behaviors, the Memory Care Facilitator (MCF) indicated she was not there when he/she was admitted and did not approve Resident #C. During an interview on 9/9/16 at 12:30 p.m., the DON (Director of Nursing) indicated she was on vacation when Resident #C was admitted. The DON further indicated the facility does training			

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	with staff and they know how to handle situations. The current " Abuse Prohibition, Reporting, and Investigation " policy, dated July, 2015 included, but was not limited to, the following: " ...It is the policy of American Senior Communities to protect residents from abuse including physical abuse ...Physical Abuse - a willful act against a resident by another resident ...Examples: hitting ...slapping, punching ...Policy/Procedure ...1. American Senior Communities will not permit residents to be subjected to abuse by anyone, including ...other residents ...Resident-To-Resident Abuse ...Policy: It is the policy of American Senior Communities to assure appropriate interventions are in place and followed to assure safety of the resident (s) is maintained ...10. The Behavior Management team will assess the situation and make recommendations for further interventions... " This Federal tag relates to Complaint IN00207593 3.1-27(a)(1)			