STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	12/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYNDMOOR OF EVANSVILLE LLC	6521 GREENDALE DR, EVANSVILLE, , 47711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00367324 and IN00368180. Complaint IN00367324-Substantiated. State deficiencies related to the allegations are cited at R0053. Complaint IN00368180-Unsubstantiated due to a lack of evidence. Survey date: November 30, December 1, 2021. Facility number: 010681 Residential Census: 39 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on December 8, 2021.	R 0000		

R 0053	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(w) (w) Residents have the right to be free from verbal abuse. Based on interview and record review, the facility failed to ensure resident's were free from verbal abuse. An employee verbally abused a resident by cursing and calling names. (Resident B) Findings include: On 11/30/21 at 2:35 p.m. Resident B's clinical record was reviewed. Resident B had diagnoses that included, but not limited to, mild cognitive impairment, so stated, generalized anxiety disorder, major depressive disorder, recurrent. Progress notes indicated Resident B was alert and oriented, but forgetful. A progress behavior note dated 11/22/21 at 10:22 p.m., indicated Resident B engaged a dietary employee in a verbal altercation. On 11/30/21 at 3:30 p.m., a State Reportable was reviewed and indicated on 11/22/21 Dietary Aide 1 had left on a break before all residents had been fed their meal, was confronted by his supervisor upon return to the facility. Dietary Aide 1 went to the break room area to clock out and	R 0053	R -0053 Residents' Rights-Deficiency What corrective action will be accomplished for those residents found to have been affected by the deficient practice; Review resident rights and abuse policy at mandatory monthly employee meetings. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents were interviewed by management and responses documented. What measures will be put into place or what systematic changes the facility will make to ensure that the deficient practice does not recur;	12/17/2021

leave, Resident B was sitting in the break room doorway talking to a staff member. Per Resident B, Dietary Aide 1 pushed Resident B's wheelchair, to which Resident B told Dietary Aide 1 he could have excused himself. Dietary Aide 1 was reported to call Resident B a B-tch and told to get the F-ck out of the way. The two cursed each other more before he exited the facility, with Dietary Aide 1 calling Resident B a B-tch multiple times. The State Reportable indicated Dietary Aide 1 was terminated from his job.

On 12/1/21 AT 12:45 P.M., Resident B indicated they had an incident with Dietary Aide 1. Resident B indicated they were going out for a smoke break, had stopped to talk to an employee in the staff break room. Dietary Aide 1 came behind them and shoved the wheelchair they were sitting in into the wall and said get the f.ck out of the way, called them a b.tch. Resident B indicated Dietary Aide 1 had been fired and the codes to the facility changed.

On 12/1/21 at 2:45 p.m., the Administrator and DON indicated Dietary Aide 1 had been at the facility about a year and no concerns with his behavior toward residents until the incident with Resident B.

Ongoing
weekly resident interviews to be completed in manager rounds.
In-service with
all employees to educate on resident rights and abuse policies.

How the
corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and

Weekly
manager rounds to be reviewed by Executive Director and/or Health and Wellness Director within 24-hours of completion. This will be an ongoing practice.

By what
date the systematic changes will be completed.

All Staff
meeting held on 12/2/21 to review resident rights and abuse, with completion of in-service and education by Friday 12/17/2021 to included PRN staff.

Dietary Aide 1 was terminated, and the codes changed to the building.

On 12/1/21 at 12:57 p.m., the Administrator provided the current policy for abuse, neglect, and exploitation, with a revision date of 5/21/20. The policy included, but was not limited to, Wyndmoor is committed to maintain a safe environment for each resident, visitor and employee...abuse is defined in Indiana as a willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain, anguish, or deprivation by an individual of goods or services that are necessary to attain or maintain physical, mental, or psychosocial well-being. Abuse may also include sexual abuse and verbal abuse.

This State Finding relates to Complaint IN00367324.

Based on interview and record review, the facility failed to ensure resident's were free from verbal abuse. An employee verbally abused a resident by cursing and calling names. (Resident B)

Findings include:

On 11/30/21 at 2:35 p.m. Resident B's clinical record was reviewed. Resident B had diagnoses that included, but not

limited to, mild cognitive impairment, so stated, generalized anxiety disorder, major depressive disorder, recurrent. Progress notes indicated Resident B was alert and oriented, but forgetful. A progress behavior note dated 11/22/21 at 10:22 p.m., indicated Resident B engaged a dietary employee in a verbal altercation.

On 11/30/21 at 3:30 p.m., a State Reportable was reviewed and indicated on 11/22/21 Dietary Aide 1 had left on a break before all residents had been fed their meal, was confronted by his supervisor upon return to the facility. Dietary Aide 1 went to the break room area to clock out and leave, Resident B was sitting in the break room doorway talking to a staff member. Per Resident B, Dietary Aide 1 pushed Resident B's wheelchair, to which Resident B told Dietary Aide 1 he could have excused himself. Dietary Aide 1 was reported to call Resident B a B-tch and told to get the F-ck out of the way. The two cursed each other more before he exited the facility, with Dietary Aide 1 calling Resident B a B-tch multiple times. The State Reportable indicated Dietary Aide 1 was terminated from his job.

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

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