STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEMAREE CROSSING ASSISTED LIVING AND MEMORY CARE	1255 DEMAREE ROAD, GREENWOOD, , 46143

(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 Complaint IN00382559. Complaint IN00382559 - Substantiated. State deficiencies related to the allegations are cited at R52 and R349. Survey date: June 17, 2022 Facility number: 014079 Residential Census: 60 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed June 22, 2022.	R 0000		
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from:	R 0052	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**	07/07/2022

	(1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on interview and record review, the facility failed to ensure a resident was free from physical abuse. A resident hit another resident. (Resident B, Resident C) Finding includes: During an interview on 6/17/22 at 9:43 a.m., CNA 1 (Certified Nursing Aide) indicated she had worked one day last week when a QMA (Qualified Medication Aide) yelled for a CNA. When she walked in Resident B's room, she saw Resident B laying on the floor and Resident C was standing near Resident B. She asked Resident B what happened, he pointed at Resident C. At that time, Resident C told her if Resident B tried to get up he would kick him. The clinical record of Resident B was reviewed on 6/17/22 at 9:49 a.m. The diagnoses included, but were not limited to, dementia with behavioral disturbance, major depressive		Resident B and Resident C were transferred to Community Hospital South for evaluation and treatment. Resident C was transferred to a facility for Geri-psychiatric evaluation and treatment the following day. Resident B was monitored for signs/symptoms of distress. Resident C received medication adjustments and returned to Demaree Crossing. **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 on our Memory neighborhood had the potential to be affected. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur**:	

	disorder, and anxiety disorder. Resident B was not cognitively intact. The clinical record for Resident B lacked documentation of any incident with Resident C. The clinical record of Resident C was reviewed on 6/17/22 at 9:55 a.m. The diagnoses included, but were not limited to, dementia and hypertension. Resident C was not cognitively intact. The progress notes indicated: On 6/9/22 at 2:19 p.m., the CNA indicated Resident C was in the courtyard yelling and threatening another resident. Resident C also took clothes outside and said he was leaving. On 6/9/22 at 6:00 p.m., Resident C approached writer as she was counting medication. Resident C told writer to tell him where his group went. Writer told Resident C she was not sure but would try to help when she was finished. Resident C threatened writer that he would punch her teeth down her throat if she didn't tell him. The Unit Manager approached Resident C and tried to redirect him, but Resident C threatened her also to punch her in the face. Unit Manager continued to try to redirect resident and offered him		The Demaree team was educated on Abuse and prevention at our all staff meeting on June 29, 2022. There was a care conference with Resident C's family to discuss triggers and additional pleasurable activities on June 30, 2022. The Memory Support Director obtained painting supplies and the family provided his favorite music which will be included in interventions for staff to utilize. Clinical, Administration and Life Enrichment team members also participated in Rhythms Dementia training on 6-13-22 and 6-14-22. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, IE, what quality assurance program will be put into place?** The Memory Support Director or designee will monitor the resident interaction, triggers and interventions to provide direction to team members 5 times a week for 4 weeks, 3 times a week for 8	

	a drink and a snack as writer finished counting medications. Resident C approached writer again as she was trying to gather belongings to go home and threatened to come over the counter at her. Writer gave report to oncoming QMA and explained the incident. The Director of Nursing was notified. On 6/9/22 at 7:31 p.m., Staff call writer to report an incident. QMA reported hearing yelling coming from Resident B's room. When she entered, she observed Resident C standing over Resident B. Resident B was on the floor bleeding from an approximately 1-centimeter laceration on the back of his head and a large laceration or skin tear on his right forearm. Resident C was yelling at Resident B not to get up or he would hit him again. Resident C said several times, he was going to knock Resident B out. Staff was able to redirect Resident C to get him to come out of the room. Resident C continued to tell staff that he was going to hit him again if he got the chance. Resident C was transferred to hospital... On 6/9/22 at 9:14 a.m. The Administrator provided a copy of a facility policy, titled "Abuse Non-Tolerance of Resident Policy," dated 11/2019, and indicated this was the current policy used by the facility. A		weeks and 1 time a week for 12 weeks. These observations will be documented and submitted to the Quality Assurance Committee quarterly for review and recommendation regarding substantial compliance.	

review of the policy indicated "residents and clients must be free from abuse by anyone, including community associates, other residents or clients..."

This State Residential Finding relates to Complaint IN00382559.

Based on interview and record review, the facility failed to ensure a resident was free from physical abuse. A resident hit another resident. (Resident B, Resident C)

Finding includes:

During an interview on 6/17/22 at 9:43 a.m., CNA 1 (Certified Nursing Aide) indicated she had worked one day last week when a QMA (Qualified Medication Aide) yelled for a CNA. When she walked in Resident B's room, she saw Resident B laying on the floor and Resident C was standing near Resident B. She asked Resident B what happened, he pointed at Resident C. At that time, Resident C told her if Resident B tried to get up he would kick him.

The clinical record of Resident B was reviewed on 6/17/22 at 9:49 a.m. The diagnoses included, but were not limited to, dementia with behavioral disturbance, major depressive disorder, and anxiety disorder. Resident B was not cognitively

intact.

The clinical record for Resident B lacked documentation of any incident with Resident C.

The clinical record of Resident C was reviewed on 6/17/22 at 9:55 a.m. The diagnoses included, but were not limited to, dementia and hypertension. Resident C was not cognitively intact.

The progress notes indicated:

On 6/9/22 at 2:19 p.m., the CNA indicated Resident C was in the courtyard yelling and threatening another resident. Resident C also took clothes outside and said he was leaving.

On 6/9/22 at 6:00 p.m., Resident C approached writer as she was counting medication. Resident C told writer to tell him where his group went. Writer told Resident C she was not sure but would try to help when she was finished. Resident C threatened writer that he would punch her teeth down her throat if she didn't tell him. The Unit Manager approached Resident C and tried to redirect him, but Resident C threatened her also to punch her in the face. Unit Manager continued to try to redirect resident and offered him a drink and a snack as writer finished counting medications.

	Resident C approached writer again as she was trying to gather belongings to go home and threatened to come over the counter at her. Writer gave report to oncoming QMA and explained the incident. The Director of Nursing was notified. On 6/9/22 at 7:31 p.m., Staff call writer to report an incident. QMA reported hearing yelling coming from Resident B's room. When she entered, she observed Resident C standing over Resident B. Resident B was on the floor bleeding from an approximately 1-centimeter laceration on the back of his head and a large laceration or skin tear on his right forearm. Resident C was yelling at Resident B not to get up or he would hit him again. Resident C said several times, he was going to knock Resident B out. Staff was able to redirect Resident C to get him to come out of the room. Resident C continued to tell staff that he was going to hit him again if he got the chance. Resident C was transferred to hospital... On 6/9/22 at 9:14 a.m. The Administrator provided a copy of a facility policy, titled "Abuse Non-Tolerance of Resident Policy," dated 11/2019, and indicated this was the current policy used by the facility. A review of the policy indicated "residents and clients must be			

	free from abuse by anyone, including community associates, other residents or clients..." This State Residential Finding relates to Complaint IN00382559.			
R 0349	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(a)(1-4) (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on interview and record review, the facility failed to ensure a resident's clinical record was accurate for a resident that was involved in a resident-to-resident altercation and was sent to the emergency department. (Resident B) Finding includes: During an interview on 6/17/22 at 9:43 a.m., CNA 1 (Certified Nursing Aide) indicated she had worked one day last week when a QMA (Qualified Medication	R 0349	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The QMAs and LPNs were educated on accuracy of documentation of incidents, discharges and including information on the 24-hour report. **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 on the Memory neighborhood had the potential to be affected. **What measures will be put into place or what systemic changes the facility will make**	07/07/2022

Aide) yelled for a CNA. When she walked in Resident B's room, she saw Resident B lying on the floor and Resident C was standing near Resident B. She asked Resident B what happened and he pointed at Resident C. At that time, Resident C told her if Resident B tried to get up, he would kick him.

The clinical record of Resident B was reviewed on 6/17/22 at 9:49 a.m. The diagnoses included, but were not limited to, dementia with behavioral disturbance, major depressive disorder, and anxiety disorder. Resident B was not cognitively intact.

The clinical record for Resident B lacked documentation of any incident with Resident C nor that Resident B was transferred to the hospital.

During an interview on 6/17/22 at 10:37 a.m., the Director of Nursing indicated Resident B was sent to the emergency room the day of the altercation because he had the lacerations. The resident-to-resident altercation and hospital transfer should have been documented in Resident B's chart.

On 6/17/22 at 12:05 p.m., the facility was unable to provide a policy regarding accuracy of documentation.

to ensure that the deficient practice does not recur:

The QMAs and LPNs were educated on accuracy of documentation of incidents, discharges and including information on the 24-hour report.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, IE, what quality assurance program will be put into place?

The Health & Wellness Director or designee will monitor the documentation of 4 random resident records for documentation weekly for 4 weeks, 2 random resident records for documentation weekly for 12 weeks and 1 random resident records weekly for 12 weeks.
These audits will be presented to the Quality Assurance Committee quarterly for review and recommendation regarding substantial compliance.

This State Residential Finding relates to Complaint IN00382559.

Based on interview and record review, the facility failed to ensure a resident's clinical record was accurate for a resident that was involved in a resident-to-resident altercation and was sent to the emergency department. (Resident B)

Finding includes:

During an interview on 6/17/22 at 9:43 a.m., CNA 1 (Certified Nursing Aide) indicated she had worked one day last week when a QMA (Qualified Medication Aide) yelled for a CNA. When she walked in Resident B's room, she saw Resident B lying on the floor and Resident C was standing near Resident B. She asked Resident B what happened and he pointed at Resident C. At that time, Resident C told her if Resident B tried to get up, he would kick him.

The clinical record of Resident B was reviewed on 6/17/22 at 9:49 a.m. The diagnoses included, but were not limited to, dementia with behavioral disturbance, major depressive disorder, and anxiety disorder. Resident B was not cognitively intact.

The clinical record for Resident B lacked documentation of any

	incident with Resident C nor that Resident B was transferred to the hospital. During an interview on 6/17/22 at 10:37 a.m., the Director of Nursing indicated Resident B was sent to the emergency room the day of the altercation because he had the lacerations. The resident-to-resident altercation and hospital transfer should have been documented in Resident B's chart. On 6/17/22 at 12:05 p.m., the facility was unable to provide a policy regarding accuracy of documentation. This State Residential Finding relates to Complaint IN00382559.			

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