

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/10/2023
NAME OF PROVIDER OR SUPPLIER SWEET GALILEE AT THE WIGWAM		STREET ADDRESS, CITY, STATE, ZIP CODE 1315 JOHN STREET, ANDERSON, , 46016			
(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 IN00402565 and IN00400751. Complaint IN00402565 - No State Residential Findings related to the allegations are cited. Complaint IN00400751 - State deficiency related to the allegations cited at R0052. Unrelated deficiencies are cited. Survey dates: March 8 and 10, 2023 Facility number: 014706 Residential Census: 75 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed March 14, 2023.	R 0000	This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by state and federal law. Sweet Galilee at the Wigwam desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective: 3/31/23 Sweet Galilee respectfully asks for Paper Compliance		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (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. Based on interview and record review, the facility failed to ensure a resident (Resident C) received the appropriate care and response to falls from a staff member (HHA [Home Health Aide]) 1. Findings include: The clinical record for Resident C was reviewed on 3/8/2023 at 1:36 p.m. Diagnoses included, anxiety, diabetes type 2, anemia, hypertension, and dementia. Review of a progress note, dated 1/25/2023 at 1:30 p.m., indicated the resident's family member had called 911. The family reported to LPN 3 the resident appeared to be more confused than normal. The resident reported to LPN 3 their legs were weak, and they felt	R 0052	- Although all residents had the potential to be harmed by the alleged deficient practice, no other resident was found to have been affected and HHA 1 is no longer employed. - Resident C has no lasting affects from alleged deficient practice. - All nursing staff, department heads, and housekeeping staff (all staff who enter resident apartments) were re-educated on proper fall policy and procedure on 3/8/23 through 3/10/23. - DON or designee will audit all falls within 24hours of fall to ensure proper fall policy and procedure was followed monthly x6 months. - Audits and recommendations will be discussed during QA x6 months. - Back in compliance as of	03/11/2023
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

they would fall if they tried to walk. Review of a progress note, dated 2/11/2023 at 10:20 a.m., indicated the resident was transitioned from the hospital back to the facility. Diagnoses documented as stroke or TIA (transient ischemic attack) and deep vein thrombosis. During an interview, on 3/8/2023 at 2:27 p.m., a family member indicated on 1/25/2023, family had been talking to Resident C on the phone. The resident was talking gibberish and not making any sense. The resident was able to tell them he had fallen and had crawled to his recliner. While on the phone, family heard someone enter the room and ask how the resident was doing. The resident was heard telling the unknown person he had fallen. The unknown person was heard telling the resident to use his call light if he needed help and left the room. The family member went to the facility to check on the resident. When they entered the resident's apartment, they thought something was wrong, and the resident appeared to more confused than normal. They then called 911. The family member indicated they had not reported their concern to the Executive Director. During an interview, on 3/8/2023			3/11/23	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

at 3:05 p.m., LPN 3 indicated on 1/25/2023, when she arrived to the facility, someone told her Resident C was being sent out to the hospital and they needed to be assessed. LPN 3 gathered her equipment and assessed the resident. The LPN stayed with the resident until the ambulance arrived.

During an interview, on 3/10/2023 at 9:42 a.m., the Director of Nursing indicated the facility was able to determine who would have been the staff member who entered the resident's room while they were on the phone with family. The facility reviewed the staffing assignments for 1/25/2023 on second shift, and determined HHA 1 was assigned to the resident. HHA 1 was no longer employed by the facility. The DON indicated HHA 1 should have never left the resident alone and should have called for a nurse immediately once they were told the resident had fallen.

Review of a current policy, dated 2/2022, titled "Fall Prevention and Management Policy" was provided by the DON on 3/8/2023 at 3:00 p.m. The policy indicated the following: "...C. Upon a resident fall event, an immediate assessment (if by a licensed clinician) and/or evaluation (if by a non-licensed, trained staff

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

member) of the resident will be completed to determine any possible injury...."

This Residential Tag relates to Complaint IN00400751.

Based on interview and record review, the facility failed to ensure a resident (Resident C) received the appropriate care and response to falls from a staff member (HHA [Home Health Aide]) 1.

Findings include:

The clinical record for Resident C was reviewed on 3/8/2023 at 1:36 p.m. Diagnoses included, anxiety, diabetes type 2, anemia, hypertension, and dementia.

Review of a progress note, dated 1/25/2023 at 1:30 p.m., indicated the resident's family member had called 911. The family reported to LPN 3 the resident appeared to be more confused than normal. The resident reported to LPN 3 their legs were weak, and they felt they would fall if they tried to walk.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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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 a resident (Resident B) was free from verbal abuse by a staff member (HHA [Home Health Aide] 1). Findings include: The clinical record for Resident B was reviewed on 3/8/2023 at 1:36 p.m. Diagnoses included, anemia, dementia, polyneuropathy, and chronic obstructive pulmonary disease. Review of a facility investigation	R 0053	*All residents have the potential to be affected by this deficient practice. All residents were interviewed regarding any abuse allegations. No other residents were found to be affected. s. Resident "B" has shown no adverse effects and feels safe with the corrective action taken by the facility. *All residents were interviewed and no other resident alleged abuse. All staff were interviewed regarding witnessing of any abuse and no other staff alleged witnessing of abuse. All staff were reeducated on abuse reporting protocols and praised for following protocol to protect our residents.	03/31/2023

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED

OMB NO. 0938-0391

indicated on 2/25/2023, CNA (Certified Nursing Aide) 2 reported verbal abuse of Resident B by HHA 1. The resident's statement indicated they were spoken to in a degrading manner by HHA 1. The HHA made statements like "you're p****, you smell," and followed the resident into their room, repeating the inappropriate statements.

During an interview, on 3/8/2023 at 12:27 p.m., CNA 2 indicated she had worked 3:00 p.m. to 11:00 p.m. on the day in question. At approximately 8:45 p.m. Resident B put his light on. When CNA 2 and HHA 1 were in the training room, CNA 2 opened the door, and the resident was standing there, and had requested assistance. As soon as the HHA saw the resident, she said something about his "*issy *ss". The resident asked for help to his room. As they walked to the resident's room, HHA 1 continued to "bad mouth" the resident, calling him stinky and nasty. When they arrived to the resident's room, the resident stated they did not want HHA 1 to enter the room. HHA 1 stated "I don't give a f *** what you want." The resident stated several times he did not want HHA 1 in their room. CNA 2 was in the bathroom with the resident and heard the door open and close. CNA 2 thought

*The facility will continue to perform background checks on all potential employees as well as check the nurse registry on potential nursing staff. The Administrator and/or designee will continue monthly education of Staff and Residents on abuse prohibition, Resident Rights and reporting protocols.

*The Administrator or Designee, will keep monthly audit regarding Resident Rights and Abuse Reporting education x's 12 months. QA committee will review audits x 6 months and make recommendations for need of ongoing education.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

HHA 1 had left. When CNA 2 and Resident B exited the bathroom, HHA 1 was sitting in a chair. HHA 1 resumed the rude comments, saying the resident was stinky and nasty again.

During an interview, on 3/8/2023 at 3:53 p.m., Resident B indicated there had been an issue with an aide that no longer worked in the facility. "She was not nice. She said mean things."

During an interview, on 3/10/2023 at 9:42 a.m., the Director of Nursing (DON) indicated the facility did not tolerate any type of abuse. When contacted about the facility investigation, HHA 1 had informed the facility they would not be returning to the facility.

Review of a current policy, dated 2/12/2021, titled "Abuse, Neglect, and Financial Exploitation Prevention" was provided by the Executive Director on 3/10/2023 at 9:20 a.m. The policy indicated the following: "...Residents of the community have the right to be free of abuse, neglect and financial exploitation. Staff member will conduct themselves in a manner that is respectful and courteous at all times. Staff behavior that is abusive, neglectful or exploits residents will not be tolerated by the management of the

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

community...."

No further information was provided.

Based on interview and record review, the facility failed to ensure a resident (Resident B) was free from verbal abuse by a staff member (HHA [Home Health Aide] 1).

Findings include:

The clinical record for Resident B was reviewed on 3/8/2023 at 1:36 p.m. Diagnoses included, anemia, dementia, polyneuropathy, and chronic obstructive pulmonary disease.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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No further information was provided.

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
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