STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155238	A. BUILDING 00 B. WING	03/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
YORKTOWN MANOR	2000 S ANDREWS RD YORKTOWN, IN 47396

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 IN00402934, IN00402792 and IN00401735. Complaint IN00402934 - No deficiencies related to the allegations are cited. Complaint IN00402792 - Federal/state deficiencies related to the allegations are cited at F600. Complaint IN00401735 - No deficiencies related to the allegations are cited. Survey dates: March 1 and 2, 2023. Facility number: 000143 Provider number: 155238 AIM number: 100283890 Census Bed Type: SNF/NF: 56 Total: 56 Census Payor Type: Medicare: 10 Medicaid: 40 Other: 6 Total: 56 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed March 9, 2023.	F 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit this and submit this response pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective March 24, 2023, to the complaint Survey completed on March 2, 2023. The facility also respectfully requests that our plan of correction be considered for paper review compliance. The facility will submit any evidence as requested to validate compliance.	
F 0600 SS=E Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jennifer Bailey	Administrator	03/24/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on observation, interview, and record review, the facility failed to protect the resident's rights to be free from physical abuse by Resident E and Resident D for 3 of 4 residents reviewed for abuse (Resident D, Resident F and Resident G). Findings include: Resident E's clinical record was reviewed on 3/2/23 at 9:15 a.m. Diagnoses included unspecified dementia, moderate, with agitation and mood disturbance and other recurrent depressive disorders. Her orders included nortriptyline (treat depression) 25 mg (milligrams) daily. A quarterly MDS (Minimum Data Set), dated 1/30/23, indicated she was rarely or never understood. She required limited assistance for bed mobility, transfers, walk in room and corridor, locomotion on the unit, and personal hygiene. She required supervision for locomotion off the unit. She required extensive assistance for dressing and toilet use. She used a walker and a wheelchair. She had physical behavioral symptoms directed	F 0600	F 600 It is the practice of this facility to ensure that all residents are free from abuse and neglect. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Each resident to resident allegation of abuse on the memory care unit was investigated by the IDT to determine the root cause. Person centered interventions were added to the care plans of resident E and D based on the investigation. Behavior monitoring books with interventions were developed for the memory care unit for all staff to utilize at the time a behavior occurs. Social Services followed up with each affected resident, including resident F and G, until mood and behavior returned to baseline. How other resident having the potential to be affected by the	03/24/2023

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	towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually), which occurred one to three days during the assessment period. She had a current care plan for yelling. She would start to yell for no apparent reason at times (10/28/22). Her interventions initiated on 10/28/22 included one on ones with her, to attempt to explore her being upset and reason for yelling, assess for pain, remove her to outer areas away for other peers to a quiet area, and IDT (Interdisplinary Team) to review behavior management program quarterly and PRN (as needed). She had a current care plan for dementia with agitation/ behavioral disturbance/mood instability/anxiety. She could become agitated with physical aggression, striking out at the staff, verbal aggression, she made threats to the staff that she would hit them in the mouth (8/5/22). On 12/30/22 she banged her hands on the table and threw food to the floor (revised on 1/20/23). Her interventions included dementia with behavioral disturbance: IDT to review behavior management program quarterly and PRN (revised 8/5/22), one on one with attempt to divert her thought process (8/5/22), remove her from groups or over stimulated area, sit with her to attempt to divert her thoughts/behavior (revised 12/13/22), sought psychiatric in patient stay at psychiatric hospital, inpatient for several days (12/29/22), remove her away from others, place on one on ones if indicated (12/29/22), her Depakote (mood stabilizer) was readjusted on 12/9/22. Her antidepressant was started during a psychiatric inpatient stay. Her Depakote was stopped during inpatient stay. Ativan (treat anxiety) was ordered as needed on 12/30/22 and was discontinued, due		same deficient practice will be identified and what corrective action(s) will be taken:All residents who reside in the facility have the potential to be affected by the deficient practice. All chart notes have been reviewed and eligible residents interviewed with no further allegations. Care plans have been reviewed on all residents that behavior care plans are present if indicated and appropriate person-centered interventions are in place. Behavior monitoring with interventions have been included in the behavior book for all residents on the memory care unit who have identified behaviors. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The policies on Abuse and Neglect and Behavior Assessment, Intervention and Monitoring were reviewed by the IDT. A facility in-service occurred with all staff regarding abuse and neglect and behavior monitoring. New hire orientation to include information regarding abuse and neglect and behavior monitoring, and annual training to occur with all staff. A performance improvement tool has been developed to monitor potential allegations of abuse and appropriate person centered interventions.	

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	to non-use (1/20/23). She became physically aggressive towards another female resident and had pushed her. No injuries were caused (1/3/23). She became upset when a female peer accidentally touched her while she was sitting in the lounge and hollered stop, with no other behavior displayed (1/11/23). She was physically aggressive towards the staff, she attempted to hit them with open hand (1/20/23). She was resistant to care and tried to hit and swung at the staff (2/6/23). She was very resistive to care, calling staff inappropriate names, pulling staff hair, hitting, and kicking (2/9/23). She made contact with a female peer's cheek causing no injury (initiated on 12/19/22 and revised 2/9/23). Her interventions were her daughter was notified and an inpatient stay was set up for her (12/19/22). She was immediately removed from the female resident, the area and placed on one on ones right away (12/19/22). Monitor her location when out of her room (12/19/22). Sit her with others but not too close to others to give her space (initiated on 12/19/22, revised on 1/3/23). Her medication was adjusted per MD (Medical Doctor) (1/4/23). Offer her a lounge chair, recline her with a blanket (1/11/23). Leave her safe and reproach at a later time (2/6/23). Offer her an alternative care giver (2/6/23). The police were notified per the Administrator (2/9/23). Her daughter was notified and a call was placed for the psychiatric inpatient stay (2/9/23). Staff immediately removed from resident involved and other residents and placed on one on ones with staff. She will remain on one on ones until she exited the facility (2/9/23). Her nurses notes indicated the following: On 12/15/22 at 8:30 a.m., the QMA and the CNA were walking on each side of Resident . Resident		How the corrective actions will be monitored to ensure the deficient practice does not recur:A performance improvement tool has been initiated that randomly audits five (5) residents to ensure that they are free from abuse and neglect. This Quality Assurance Audit Tool will be completed by the Administrator/ Designee weekly for four (4) weeks; then monthly for three (3) months, then quarterly x 3. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly.By what date the systemic changes will be made: March 24, 2023	

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	E was walking around tables and approached Resident D and staff, and made contact with Resident D with her open hand and pushed her towards the wall. The Administrator was able to redirect her off the unit. On 12/15/22 at 1:55 p.m., the psychiatric hospital was contacted. On 12/15/22 at 5:55 p.m., she was transferred via psychiatric hospital EMS via a stretcher. On 2/9/23 at 11:10 a.m., she was sitting at a table in the dining room, when Resident G approached her to have a conversation. She became upset and made contact, with a closed fist, to Resident G's left upper cheek. Resident G began to cry. She continued to call out to Resident G and the staff members she wanted to fight them. On 2/9/23 at 12:44 p.m., one on ones with staff were initiated. On 2/9/23 at 3:14 p.m., she would not allow staff to take her to the bathroom to get cleaned up, so she could be picked up by her family, to be taken to the hospital. In the process, she bit the nurse on the top of her right wrist. A social service note, dated 2/9/23 at 5:17 p.m., indicated she was transported to local hospital at approximately 3:45 p.m. to get labs and a urinalysis for medical clearance for an inpatient psychiatric stay. On 2/23/23 at 1:54 p.m., she arrived back to the facility. She was taken off the gurney and immediately began walking around the unit. She was pleasantly confused.			

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	On 2/23/23 at 7:02 p.m., a raised voice was heard, and she was standing in front of, and pointing at, a resident and stated "You get the h--- up right now, right now!" The QMA was able to redirect her into the hallway and prevented her from re-entering lounge area, but she continued to glare at the other resident. The door was opened to the skilled side of the facility, in the attempt to redirect her off the unit. She refused and stated, "Shut the d--- door." She began making negative comments to QMA stating, "Just you wait and see, I'm not going out, you go out, you go that way," (pointed down 200 hall). The QMA continued to stand in doorway with her standing behind the QMA. The lights in the hallway were requested to be turned off. After approximately five minutes, the other resident got up and walked out of lounge. The QMA followed behind the other resident and Resident E followed behind the QMA. The other resident entered her room and the QMA again stood in doorway preventing Resident E from entering. Resident E watched the other resident for a couple of seconds and then stated, "Okay, thank you, I appreciate you" and continued to walk down the hallway. The QMA walked with her and showed her where her room was located, she entered her room and allowed the QMA to assist her to sit in her recliner and the QMA turned on the television. On 2/24/23 at 2:39 p.m., she was sitting in recliner in dining room, when a peer walked by her and she attempted to grab the peer by her shirt, but was too far away to make contact. She began to yell out "Stupid a--, stupid dumb son of a b----, I don't want you." and was pointing her finger up and down. She was calmed and asked to please come with staff down the hall. She stood up and stated, "Oh, dumb a--es." She followed staff to the spa room. She refused to sit on the toilet, then she			

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	was walked down the hallway to her bedroom. She was assisted to sit in her recliner and rest her feet and the TV was turned on. On 2/27/23 at 11:55 a.m., she made contact with Resident D's right mid back/flank, as Resident D was walking by her table. She was placed on 15-minute checks. 1. Resident D's clinical record was reviewed on 3/2/23 at 8:36 a.m. Diagnoses included Parkinson's disease, major depressive disorder, recurrent, mild, and unspecified dementia, unspecified severity, with other behavioral disturbance. A quarterly MDS, dated 1/27/23, indicated she was severely cognitively impaired. She required limited assistance for bed mobility limited, transfers, walk in her room and corridor, locomotion on and off the unit, and personal hygiene. She required extensive assistance for dressing and toilet use. Her orders included duloxetine (treat depression and anxiety) 90 mg daily, divalproex sodium (mood stabilizer)125 mg daily and memantine - donepezil (treat dementia) 28-10 mg daily. She was on behavior monitoring for physical aggression and for raising her voice and calling other people names. She had a current care plan for her raising her voice and calling others' names. She became angry and raised her voice on 1/8/22, and she yelled at the nurse. On 6/1/22, she yelled down the hall telling another peer that she was a stupid idiot. There was no evidence of the other peer had noticed that she had spoken to her (revised on 1/10/23). Her interventions initiated on 10/11/22, included keep her family informed, one on one			

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	verbal redirection, provide her with emotional support. The interventions for her raised voice were initiated on 1/10/23, and included one on one with verbal redirections away from area, psychiatrist to continue to follow her behavior and remove her to a quiet area with less stimuli and IDT (Interdisplinary Team) to review behavior management program quarterly and PRN. She had a current care plan problem due to she had reached out while walking in the main lounge in the evening and made contact with another female's shoulder and chin (2/1/22). Her interventions were initiated on 2/1/23 and included physical aggression, the family, MD, appropriate staff and the police were notified right away, she was immediately removed away from all other residents and staff placed with her, monitor her for emotional distress or agitated disposition and address immediately with her, possibly removing her away from other peers to less stimulation and she was placed on every 15-minute checks after the incident. Her nurses notes indicated the following: On 12/15/22 at 8:33 a.m., the QMA and the CNA were assisting Resident D out of the lounge and towards the bathroom. Resident E was walking around the tables and approached her and staff. Resident E made contact open handed and pushed her towards the wall. Staff immediately intervened, the CNA continued walking her to the bathroom and the QMA redirected Resident E to the lounge area. On 1/31/23 at 6:36 p.m., she was observed walking past a peer in the lounge. She reached out and with her open hand, swatted at Resident F and made contact with her upper shoulder/lower chin			

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	area. She then walked to a table and sat down. The staff was placed with her immediately and she was placed on 15-minute checks. On 2/27/23 at 11:30 a.m., as she was walking to the table, Resident E had entered the lounge and made contact with Resident D's right flank/mid back. 2. Resident F's clinical record was reviewed on 3/2/23 at 10:37 a.m. Diagnoses included Alzheimer's disease with early onset, degenerative disease of nervous system, unspecified, dementia in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, epilepsy, unspecified, intractable, with status epilepticus, repeated falls, and muscle weakness (generalized). Her orders included rivastigmine (treat dementia) patch 24-hour 9.5 mg/24 hour apply daily, levetiracetam (treat seizures) 500 mg twice daily, memantine (treat dementia) 10 mg twice daily, check every two hours and leave door open at all times (11/18/22), and behavior monitoring for yelling out/negative comments- she made comments "Get away from me my mom said so." (8/30/22) A quarterly MDS, dated 1/30/23, indicated she was rarely or never understood. She required extensive assistance of one staff member for bed mobility. She required extensive assistance of two staff member for transfers, walking in her room and the corridor and dressing. She had a care plan problem of a female peer reached out as she passed her and swatted at her (2/1/23). Her interventions were the family, the			

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	MD (Medical Doctor) and the appropriate staff as well as the police were notified immediately and monitor her for emotional upset and or tearfulness with signs of discomfort being out of her room and address with her immediately. (2/1/23) Her nurses notes indicated the following: On 1/31/23 at 6:45 p.m., Resident D walked past her in the lounge, she reached out and with an open hand swatted at her making contact with her upper shoulder/lower chin area. Resident D walked to the table and sat down. The staff were placed with the Resident D immediately. The MD, family, DON, Administrator, and the police were notified of the incident. She was assessed with no injury or discoloration. On 2/1/23 at 8:59 a.m., IDT met and reviewed the incident that Resident D swatted at her. She was up per her normal and ate her breakfast in the main lounge. No noted signs of emotional distress or tearfulness. 3. Resident G's clinical record was reviewed on 3/2/23 at 11:14 a.m. Diagnoses included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, disorientation, and depression. Her orders included donepezil (treat dementia) 10 mg daily and buspirone (treat anxiety) 7.5 mg twice daily. Behavior monitoring for anxiety, she could not sit still for longer than a few seconds. She was always into others personal space and areas of the facility where she was not invited into. She could not appear to sit and relax without continuing to talk or get other person's attention. (11/14/22)			

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	She had a care plan, initiated on 2/9/23, that she was struck by another female peer in the face, unprovoked. she had a red area, per the staff, on her upper cheek. She became tearful with this altercation. Her interventions were initiated on 2/9/23 and included administration placed a call to the police, the aggressor was taken off the unit and placed on one on ones with a staff member, the family and the MD was made aware, she was immediately separated away from the aggressor and she would be monitored for signs or symptom of emotional upset or not wanting to come out of her room. Her nurses notes indicated the following: On 2/9/23 at 11:05 a.m., she went up to another resident who was sitting at the table in the dining room, to have a conversation with her. Resident E made contact with a closed fist to her upper cheek area and she began to cry. She had a small red area on left upper cheek area. A social service note, dated 2/9/23 at 1:59 p.m., indicated she was involved in an altercation with another female peer with no injuries. Per the staff, she had begun to cry. During an interview with CNA 45, on 3/2/23 at 12:21 p.m., Resident E was observed in the common area, going through a drawer in an end table. She placed the piece of paper she pulled from there into her pants. CNA 45 indicated this was normal for her, and they tried to keep an eye on her, with 15-minute checks. She liked to sit in the dining room. They tried to keep her busy, and did their best to keep her separated from other residents.			

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	During an interview with QMA 23, on 3/2/23 at 12:23 p.m., Resident F was sitting in the dining room, at a table, in a chair. QMA 23 indicated the resident was totally dependent on staff. She was really limited on walking, but walked as much as she could. She had a nervous system disorder. Another resident had hit her. She was not normally physically aggressive. Regarding Resident G, she was active, and she was in and out of other resident's rooms. She layered her clothing and played in water. She yelled and screamed in the evening, and tried to get other residents to do things. She had a prior resident-to-resident altercation with Resident E, where Resident E had hit her. During the interview with QMA 23 at 12:27 p.m., Resident D was observed in the dining room, sitting in a chair, with the back of it up against the wall. QMA 23 indicated the resident had her good and bad days; she had been aggressive a few times. She had previously walked up to Resident F, who had been sitting in a recliner, and back handed her. She sundowned. Unlike Resident E, who was aggressive all of the time, they took her out to walk, up and down the hallway. They did one on ones with her, and read to her, and would take her off the unit to the activities room to cool down. Snacks worked good with her. On 3/2/23 at 12:27 p.m., Resident G was in her room with a family member. During an interview with CNA 18, on 3/2/23 at 3:25 p.m., she indicated they would send Resident E to her room, as she got ticked off really easy. Resident D was harmless, and Resident F never even got upset. Resident G did well when her family was at the facility, otherwise she ran in and out of resident's rooms, Resident G called it			

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	155238	A. BUILDING 00 B. WING	03/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
YORKTOWN MANOR	2000 S ANDREWS RD YORKTOWN, IN 47396

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	"shopping". During an interview with CNA 33, on 3/2/23 at 3:33 p.m., she indicated Resident E usually went to the other residents, and she was hard to re-direct. Resident G got lonely and liked someone with to sit with her, and her family visited her daily. Resident F did not say too much, but she was cheerful and happy. Her family came in daily as well. Resident E thought Resident D was a man. During an interview with the SSD, on 3/2/23 at 4:00 p.m., she indicated Resident E needed observed closely, was currently on 15-minute checks, and had been to an inpatient psychiatric stay twice. While she was at the psychiatric hospital, they did a "med wash". She had not had any behaviors, and was sleeping eight to ten hours a night. She had asked them if she had been around other patients, and they indicated to her that she had. It was just sporadic with Resident E, today she was in a good mood, but then out of the blue...she was fine one minute. She knew they needed to keep the other residents, and her, safe. She thought they recently did a small increase in her nortriptyline, and hoped it was the answer. With Resident D, a lot of people mistook her for a man, and maybe Resident E thought Resident D was a man. With regards to the 1/31/23 altercation between Resident D and Resident F, she did not feel it was intentful. Resident D was pretty progressed with her dementia. Resident G wandered a lot, and her "current thing" was she liked to go into the bathroom to play in water, and she could not speak concrete sentences besides cursing. They were very aware of the altercations and had immediately separated the residents. They followed their behavior protocol, and during every morning meeting, they looked at risk management. They came up with interventions			

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	and made a note in the clinical record. Resident E, D and G all received psychiatric services. The DON would go through every note from the day before. When there was an incident, they updated the care plan for each resident. Care plan problems would include emotional distress and isolation, crying, being upset, negative comments and worry. She was not able to find a care plan update for Resident D for the 12/15/22 altercation. They typically followd up with the residents for five to seven days after the incident for distress. She had been on vacation when the 2/27/23 altercation happened between Resident E and D, but she had updated the care plan today. The MDS Coordinator and Consultant would normally fill in for her when she was on vacation. A current, 9/2022 revised, facility policy, titled "ABUSE POLICY," provided by the Administrator at entrance to the facility, indicated the following: "The resident has the right to be free from abuse...Residents must not be subjected to abuse by anyone, including...other residents...." This Federal tag relates to complaint IN00402792. 3.1-27(a)(1)			