STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155455	A. BUILDING 00 B. WING	08/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESLEYAN HEALTH CARE CENTER	729 WEST 35TH ST MARION, IN 46953

(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 IN00387608 and IN00387631. Complaint IN00387608 - Substantiated. Federal/State deficiencies related to the allegations are cited at F689. Complaint IN00387631 - Substantiated. Federal/State deficiencies related to the allegations are cited at F600. Survey dates: August 15 and 16, 2022. Facility number: 000557 Provider number: 155455 AIM number: 100291240 Census Bed Type: SNF/NF: 100 Residential: 6 Total: 106 Census Payor Type: Medicare: 13 Medicaid: 57 Other: 36 Total: 106 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 19, 2022.	F 0000	This plan of correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. The facility respectfully requests a desk review for compliance.	
F 0600 SS=D 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

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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 prevent resident to resident abuse for 2 of 4 residents reviewed for abuse (Resident B and Resident G). Findings include: 1. Resident B's clinical record was reviewed on 8/15/22 at 10:19 a.m. Diagnoses included, but were not limited to, unspecified dementia without behavioral disturbance, anxiety disorder, and problems related to living in residential institution. Her medications included, but were not limited to, donepezil (treat dementia) 10 mg (milligram) daily and buspirone (treat anxiety)10 mg twice daily. An admission MDS (Minimum Data Set), dated 7/11/22, indicated she was severely cognitively impaired. She wandered one to three days of the assessment period. She required limited assistance of one staff member for walking in her room and in the corridor. Her nurses notes indicated, but were not limited to, the following:	F 0600	Due to the nature of the survey, corrective actions for identified residents in the survey can not be completed. Residents are not identified in the survey. Residents that have a history of behaviors that may be considered aggressive have the potential to be affected by the alleged deficient practice. Residents that have a history of aggressive behaviors toward staff, visitors, or other residents will be reviewed and an audit of their care plan and social service follow up will be completed. Adjustments will be completed as indicated. Behaviors will be reviewed daily in the morning meeting and on weekends by nurse supervisor and care plans will be updated at that time. Social Services will follow up with residents after aggressive behaviors within 24 hours and document psychosocial well-being and again every week until	09/01/2022

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	On 7/18/22 at 5:15 p.m., Resident B was in hallway and Resident G went by and hit Resident B three times with closed fist in abdomen. They were easily separated by the CNA. No injuries or redness were noted to either resident. Resident B was removed from situation and continued to be up and about. She did not remember the event. A late entry, social service progress note, dated 7/19/22 at 10:00 a.m. and created on 7/25/22 at 4:29 p.m., indicated social services did a psycho-social follow up visit with Resident B and she showed no distress or recollection of the incident. On 8/9/22 at 3:45 p.m., staff witnessed Resident B, while she stood in dining room, when Resident F hit her across her left cheek. Staff immediately separated the residents without difficulty. No redness or bruising were noted to her left check. No signs of any discomfort. The DON, ADON and family were notified. On 8/9/22 at 6:59 p.m., Resident B was put on 15-minute checks. She still showed no signs of injury or distress of any kind. On 8/9/22 at 8:35 p.m., she had been rubbing her left eye and cheek. She had her eye very red and a very small scratch on left cheek from rubbing her face. The area was not there following the altercation. Her clinical record lacked a care plan related to the resident-to-resident altercations. 2. Resident G's clinical record was reviewed on 8/16/22 at 9:35 a.m. Diagnoses included, but were not limited to, anxiety disorder, unspecified dementia without behavioral disturbance, other		aggressive behaviors cease. Social Service will refer residents to Psych Services as indicated. Education will be completed with staff on abuse. Audits will be completed daily X 4 weeks, then 3 times weekly X 4 weeks, then weekly X 4 weeks, then 2 times monthly X 6 months or until QA determines alleged deficient practice is corrected. QA will review compliance for a minimum of 6 months. Non-compliance will results in re-education and/or discipline up to and including termination.	

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	specified disorders of brain, Alzheimer's disease with late onset and major depressive disorder, single episode. Her medications included, but were not limited to, sertraline (treat depression) 50 mg daily and memantine (treat dementia) 5 mg daily. A quarterly MDS, dated 6/21/22, indicated she was unable to complete the interview. No behaviors were exhibited. She required extensive assistance of one staff member for locomotion on and off the unit. She used a wheelchair for mobility. She had a 7/19/22 revised care plan that indicated she had anxiety as evidenced by trying to get out of her wheelchair and having a change in her environment. Her mood also fluctuated at times. She had been known to be combative with staff during care, to kick at things while she wheeled up and down the hallway and to strike out at another resident when passing by in the hallway. Her goal was her symptoms were anxiousness and mood fluctuation, they would be managed through her care plan interventions, and she would continue to respond to redirection when she had those behaviors. Her interventions included, but were not limited to, mental health services as needed initiated on 11/16/21. She would like to reminiscence on past vacations, staff would sit and talk with her about those times for redirection initiated on 3/21/22. Staff would ensure that all her needs had been met i.e., she had been toileted and hunger. Meet her immediate needs initiated on 7/19/22. Her nurses notes indicated, but was not limited to the following:			

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	A behavior sheet, dated 7/18/22 at 5:14 p.m., indicated she slapped a resident. She was removed from the situation and her behavior improved. In the comment section it indicated she was in the hallway and when Resident B went by her, she hit Resident B three times with a closed fist. They were easily separated by the CNA. No injuries or redness were noted to either resident. She was removed from situation and put on 15-minute checks. A social service behavior note, dated 7/19/22 at 9:28 p.m., indicated she was noted to be in the hallway and struck out at Resident B when she walked by. The residents were easily separated and she was redirected to another location. The behavior ceased and she continued to be observed her for behaviors and they continued to respect the resident's right to choose and her preferences. Resident F's clinical record was reviewed on 8/16/22 at 8:44 a.m. Diagnoses included, but were not limited to, other amnesia, anxiety disorder, Alzheimer's disease with late onset, unspecified dementia with behavioral disturbance and unspecified mood [affective] disorder. Her medications included, but was not limited to, valproic acid solution (mood stabilizer) 250 mg/5 ml (milliliters) 2.5 ml twice daily. She had a quarterly MDS, dated 7/13/22, indicated she was severely cognitively impaired. She had delusions. She had physical behavioral symptoms directed towards others that occurred one to three days during the assessment period. She required supervision while walking in her room and locomotion on the unit.			

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	She had a 7/31/22 revised care plan that indicated she had behavioral symptoms such as getting easily annoyed at others and had been noted to have agitation with others. (She tended to stay to by herself. She was very guarded due to history of abuse). She had also been noted to swing at staff and urinate on the floor in the dining room. She had been known to resist care from staff often. She had been noted to misunderstand other's body language and mannerisms such as thinking others are spitting at me when they are getting food out of their teeth. My mood and behaviors fluctuate day to day. I am combative with staff during ADL (Activities of Daily Living) Care. Her goal was she would be free of any further physical or verbal aggression towards other. Her interventions included, but were not limited to, assess me for pain, discomfort, environmental factors to see if it contributes to her annoyance, engage her in folding and sorting activities as she was a homemaker and avoid sitting me next to others that display repetitive verbalization and movements at mealtimes and redirect her behavior by taking her to a quieter area initiated on 5/13/22. Mental health services as indicated initiated on 6/6/22. Report her changes in behavior and mood to the social worker and social service visits as needed initiated on 6/8/22. Provide her with security checks and one on one visits were warranted initiated 6/17/22. A behavior management team review note, dated 7/25/22 at 12:49 p.m., indicated she grabbed other residents, resistant to care from staff and combative with staff during care. She had four behaviors in the last 30 days. Her medical consideration for behaviors were that she had dementia. Her precipitating and contributing factors were personal hygiene/modest. Her personality was very guarded. She was sent to a			

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	behavioral hospital during this review. She was new to behavior management. She was resistant to care and challenging to do care with. A social service behavior note, dated 8/3/22 at 9:20 a.m., indicated she was redirected out of other resident's room where she was taking things, she became physically combative with staff, hitting the QMA multiple times and refused medications. All interventions by staff were unsuccessful, she was offered fluids and redirection. The outcome and prevention were the interventions were unsuccessful and care plans were in place for behaviors. Social Service would reach out to family to see if they have decided on another memory care per prior care plan meeting with the DON. A behavior sheet, dated 8/9/22 at 3:45 p.m., indicated she hit another resident and she was removed from the situation and her behavior improved. In the comment section it indicated she was in dining room when staff seen her hit another resident across left cheek. Staff separated them without any difficulty. Neither resident had any injuries. She was put on one on one. The family, physician, DON and ADON aware. A social service behavior note, dated 8/10/22 at 4:22 p.m., indicated she was noted to be seen striking at another Resident B in the common area. Staff separated both residents immediately, and Resident F was put on one on ones. Social Service made a referral to a behavioral hospital. She was accepted and picked up on this day. She was care planned for behaviors and social service was assisting the behavioral hospital in finding new placement for her. Staff continued to respect residents right to choose.			

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	During an interview with CNA 6, on 8/15/22 at 4:37 p.m., he indicated he tried to keep the residents engaged with activities to keep from having problems with residents and sometimes it was hard with one CNA and a nurse to watch all the residents. During an interview with Activity Aide 7, on 8/16/22 at 1:26 p.m., she indicated Resident F was in a really good mood, she had her nails done and she was dancing. Resident B walked up to her and said to Resident F my family is going kick you out of here and Resident F smacked her across the face. Resident F walked away from Resident B and sat down in the common area, crossed her legs, and said "now". Resident B went up to Resident F while she was sitting in the chair, Resident F got up and moved to the dining room and staff followed her and then Resident B approached her again. During an interview with CNA 6, on 8/16/22 at 2:00 p.m., he indicated he was pushing Resident G, in her wheelchair, through the hall to the dining room and Resident B walk passed her. Resident G tapped Resident B in the abdomen a couple of times, it was not hard but like love taps. Resident B just kept walking. With Resident B and Resident F, Resident F hit Resident B with a closed fist and back fisted her in the left side of her face. He was the only CNA in the unit at the time, there also was one nurse and an activity aide. A CNA came to the unit to sit with Resident F. Resident F sat in a chair in the common area and Resident B was going up to her while she sat in the chair, then Resident F moved to the dining room. Resident B was antagonizing the situation. Resident F's family came in and sat with her for a while. A CNA sat with her the rest of the night by her bed.			

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	A current policy, titled "Abuse, Neglect and Misappropriation of Resident Property," provided by the DON, on 8/16/22 at 1:06 p.m., indicated the following: "Policy: This facility's policy is the resident has the right to be free from ...physical...abuse...Residents must not be subjected to abuse by anyone, including but not limited to...other residents...." This Federal tag relates to complaint IN00387631. 3.1-27(a)(1)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed provide adequate supervision for a cognitively impaired resident from ingesting ear cleaner solution for 1 of 4 resident reviewed for accidents (Resident B). Findings include: Resident B's clinical record was reviewed on,8/15/22 at 10:19 a.m. Diagnoses included, but were not limited to, unspecified dementia without behavioral disturbance, anxiety disorder, and problems related to living in residential institution. Her medications included, but were not limited to,	F 0689	Due to the nature of the survey, corrective actions for identified residents in the survey cannot be completed. Residents are not identified in the survey. Residents that have a BIMS of 8 or less and reside in the facility have the potential to be affected by the alleged deficient practice. An audit of the resident rooms and drawers of residents with a BIMS of 8 or less has been completed and personal hygiene products and any potentially harmful items have been locked in their bedside	09/01/2022

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	donepezil (treat dementia) 10 mg (milligram) daily and buspirone (treat anxiety)10 mg twice daily. An admission MDS (Minimum Data Set), dated 7/11/22, indicated she was severely cognitively impaired. She wandered one to three days of the assessment period. She required limited assistance of one staff member for walk in her room and corridor. A social service behavior note, dated 8/5/22 at 8:45 a.m. indicated she attempted to remove cleaning supplies off a housekeeping cart when a CNA stopped her and she became angry. The intervention was staff removed her from the situation and the behavior improved. The outcome and prevention was staff would make sure housekeeping carts are out of reach and watch closely moving forward on the unit. Her behavior improved with the intervention, staff continue to respect resident's right to choose. A nurses note, dated 8/9/22 at 3:00 p.m. indicated a CNA saw her in another resident's room and she was tipping up a bottle of ear cleaning solution to her mouth, the CNA rushed over and grabbed the bottle. No irritation to her oral cavity was noted and she did not complain of any bitterness or burning to her mouth. The ADON was summoned to the unit and the Indiana Poison Control was called and was instructed to just encourage fluids and that she might experience nausea and to just monitor her for a couple hours. A nurses note, dated 8/9/22 at 3:28 p.m., indicated her family and the nurse practitioner was notified. A nurses note, dated 8/9/22 at 3:30 p.m., indicated all rooms on the unit were searched for hazardous liquids or any other article that might prove		drawers. Residents scoring an 8 on their BIMS will have personal hygiene and any potentially harmful products will be secured using safety latches on one of the drawers at the bedside. There will be one drawer that is locked using a standard lock on the bedside stands for personal hygiene products and potentially harmful products in the memory care unit. Housekeeping carts will be locked at all times and cleaning supplies will not be left outside of the housekeeper's line of vision. , will be educated on the importance of maintaining these potentially harmful products secured. An audit of the locked and secured drawers, housekeeping carts, and units for potentially harmful products will be completed daily X 4 weeks, then 3 X weekly X 4 weeks, then monthly X 3 months. Results of the audits will be followed in QA until QA determines compliance is achieved. Non-compliance will result in re-education and/or discipline up to and including termination.	

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	harmful. A social service behavior note, dated 8/10/22 at 4:17 p.m., indicated she went into another resident's room and found to be trying to ingest what appeared to be ear solution for ear piercing. The intervention was staff redirected her and she moved to another area. The outcome and prevention was the ADON contacted poison control and removed her from the situation. Staff would continue to observe her for further behaviors. Staff continued to respect her right to choose. Care plans were in place for behaviors. A care plan was initiated, on 8/10/22, that indicated she displayed behaviors, such as going into other's rooms and searched through their items, and she tried to ingest things that she thought were edible related to her diagnosis of dementia, initiated on 8/10/22. Her goal was that her behavior would occur no more than one time per month. Her interventions included, she would receive medications as ordered, social service staff would intervene as necessary, encourage activities of interest, encourage family visits, offer her snacks or drinks, and redirect her when her behavior begins. During an interview with the DON and the with the ADON present, on 8/15/22 at 11:11 a.m., the DON indicated she got a call from the facility, and they indicated Resident B was seen in another resident's room and tipped up a bottle of ear cleaner to her mouth and when Resident B saw staff she threw the bottle back into the drawer. They called poison control and indicated it was mostly detergent and she could have some nausea or vomiting. The ear cleaner was for pierced ears. The ADON indicated the bottle had about a quarter of liquid left in it. They were not			

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	sure if she even drank any of it but the bottle was open when she threw it back into the drawer. She did not have any side effects from it. During an interview with CNA 6, on 8/15/22 at 4:37 p.m., he indicated he saw Resident B tip the bottle up to her mouth like she was drinking it, when she seen him, she threw it into the drawer. The bottle was a flip top and was open when he got it from the drawer. He didn't know the top drawers were supposed to be locked, but now he does and there was a key at the nurses station. He tried to keep the residents engaged with activities to keep from having problems with residents and sometimes it was hard with one CNA and a nurse to watch all the residents. During an interview with Housekeeper 12, on 8/16/22 11:36 a.m., she indicated that she always kept her cart locked and in the housekeeping closet and takes what she needs with her to the rooms. The residents tried to come up to the cart and that was why she kept the housekeeping cart in the housekeeping closet. During an interview with Activity Aide 7, on 8/16/22 at 1:26 p.m., she indicated she was not sure where Resident B got the bottle of ear solution cleaner. She wandered into other resident's rooms and would go through people's drawers of clothes or snacks and she would eat the snacks. During an interview with the DON, on 8/16/22 at 1:06 p.m., she indicated they did not have a policy on bringing in items into the facility, they can bring whatever they want to. In Memory Care they should had checked in the bottle of ear cleaner solution at the nurses station.			

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	This Federal tag relates to complaint IN00387608. 3.1-45(a)			