

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/27/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HAMILTON PLACE	STREET ADDRESS, CITY, STATE, ZIP COD 2116 BUTLER RD FORT WAYNE, IN 46815
--	--

(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
--------------------	---	---------------	---	----------------------

R 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00352612 and IN00353691.</p> <p>Complaint IN00352612- Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00353691- Substantiated. State deficiencies related to the allegations are cited at R0052.</p> <p>Survey date: May 27, 2021</p> <p>Facility number: 004686</p> <p>Residential Census: 20</p> <p>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed May 28, 2021</p>	R 0000		
R 0052 Bldg. 00	<p>410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (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.</p> <p>Based on record review, and interview, the facility failed to ensure all residents remained free from mental abuse for 1 of 3 residents reiewed (Resident B).</p> <p>Findings include</p>	R 0052	<p>Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an</p>	06/11/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 05/27/2021	
NAME OF PROVIDER OR SUPPLIER HAMILTON PLACE				STREET ADDRESS, CITY, STATE, ZIP COD 2116 BUTLER RD FORT WAYNE, IN 46815			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>The facility's policy titled "Resident Rights," # 2-1.2 and dated 9/1/2016, indicated "Each resident has the right to, at minimum: ... Be free from mental, ... abuse and neglect...."</p> <p>The facility's policy titled "Abuse, Neglect, and Exploitation," # 2-1.3 and dated 9/1/2016, indicated "Abuse is the willful action or inaction that inflicts injury, unreasonable confinement, ... with resulting physical harm or pain or mental anguish. ... Mental Abuse is the willful action or inaction of mental or verbal abuse. This includes but is not limited to, ... inappropriately isolating a resident from ... regular activity"</p> <p>The Indiana Department of Health (IDOH) received a facility reported incident dated 5/5/21. The report indicated residents in the dining room had been mean to and had been mocking Resident B. The resident had repetitive speech patterns. The facility notified family and discussed Resident B possibly needing some medication changes, and the facility would have Resident B eat meals in his apartment.</p> <p>The record for Resident B was reviewed on 5/27/21. Resident B had a diagnosis of Alzheimer's dementia. The document titled "Folstein Mini Mental Exam" indicated the Geriatric Depression Scale (GDS) score for Resident B was 17 out of 30 on 4/1/21. The Resident Services Notes dated 5/6/21 indicated the family was notified by the Regional Care Services Director (RCSD). The RCSD called hospice company to request an increase in Seroquel (an antidepressant) to start on 5/10/21.</p> <p>A Resident Services Note dated 5/7/21 at 6:00 P.M. by Employee 1 indicated Resident B was upset about being unable to eat in the dining</p>		<p>admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.</p> <p>R0052</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: On 6/11/2021, CSM implemented corrective actions for Resident B affected by this practice, including evaluating Resident B, and discussing with resident and resident's family resident's choice to have meals provided in communal dining area. As of 5/12/21 and ongoing, Resident B's meals are served in the communal dining area unless otherwise requested by Resident B.</p> <p>2. How the facility will identify other residents having the potential to be affected by the same deficient practice and</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/27/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HAMILTON PLACE	STREET ADDRESS, CITY, STATE, ZIP COD 2116 BUTLER RD FORT WAYNE, IN 46815
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>room, and had asked what he did wrong since everyone else got to eat in the dining room. Employee 1 gave the resident his room tray. There was no further note to indicate Resident B had been given an explanation regarding his need to eat in his room, or a discussion of his choice to eat in the dining area.</p> <p>A Resident Services Note dated 5/8/21 at 8:00 P.M. by Employee 1 indicated Resident B continued to be upset and anxious about meal set up. Ativan was given. The next note indicated Resident B went to bed early at 8:30 P.M. There was no note to indicate Resident B had discussed his choice to go to the dining area.</p> <p>A Resident Services Note dated 5/9/21 at 6:00 P.M. by Employee 1 indicated Resident B got 0.5 milligrams of Ativan at 4:00 P.M. for anxiety. The resident came out of his room to the dining room, asked why he could not eat with the other residents and was nearly in tears. Employee 1 sat him at a dining room table and sat with him while he ate his dessert.</p> <p>A Resident Services Note dated 5/10/21 at 2:00 P.M. by Employee 2 indicated Resident B had Ativan at 8:00 A.M. for increased anxiety stating desire to eat in dining room. At 1:00 P.M., he was given Ativan again for increased anxiety, and had went to the day room and wanted to go on the scenic ride but he had already gone last week and needed to let someone else go.</p> <p>A Resident Services Note dated 5/10/21 at 8:45 P.M. by Employee 1 indicated Ativan had been given at 4:00 P.M. for increased anxiety and that he had done much better eating in his room. Resident stated he did not understand why he had to eat in his room but he did not come out to</p>		<p>what corrective action will be taken: On 6/11/2021, CSM conducted audit of sample residents to ensure they were free from mental abuse and without violations of resident rights. No concerns identified through audit.</p> <p>3. What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: By 6/11/21, CSM or designee will provide re-education to current employees and current residents on Residents Rights including the right to be free from mental abuse.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Executive Director or designee will audit 5 residents weekly for four weeks, biweekly for four weeks, then monthly for one month to ensure their Resident Rights are not violated, including the right to be free from mental abuse. Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 05/27/2021	
NAME OF PROVIDER OR SUPPLIER HAMILTON PLACE				STREET ADDRESS, CITY, STATE, ZIP CODE 2116 BUTLER RD FORT WAYNE, IN 46815			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>the dining room.</p> <p>A Resident Services Note dated 5/11/21 at 8:00 P.M. by Employee 3 indicated Resident B ate in the dining room with another resident.</p> <p>A Resident Services Note dated 5/12/21 at 10:00 A.M. by the RCSD indicated the resident did not want to eat in his apartment so he would now be eating in the dining room, family aware.</p> <p>During an interview on 5/27/21 at 2:50 P.M., Resident B was observed in his room with a visitor; he kept repeating "It's okay... it's okay..." He would answer questions when asked, but indicated he did not recall anyone being mean to him and "they are not mean (residents), they just go to their rooms." The visitor was a family member and indicated they did agree to him eating in his apartment at first but they were not happy about it. The visitor indicated the family did feel he was safe here.</p> <p>This Federal tag relates to complaint IN00353691</p> <p>16.2-5-1.2(v)(1-6)</p>		<p>on-going</p> <p>5. By what date the systemic changes will be completed By 06/11/2021, the systemic changes will be complete</p>				