STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155073	A. BUILDING 00 B. WING	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PILGRIM MANOR	222 PARKVIEW ST PLYMOUTH, IN 46563

(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 IN00441511, IN00441555, IN00440897, IN00440753, IN00439878, and IN00441571. Complaint IN00441511 - Federal/State deficiencies related to the allegations are cited at F689. Complaint IN00441555 - Federal/State deficiencies related to the allegations are cited at F604, F607, F609, and F610. Complaint IN00440897 - No deficiencies related to the allegations are cited. Complaint IN00440753 - No deficiencies related to the allegations are cited. Complaint IN00439878 - No deficiencies related to the allegations are cited. Complaint IN00441571 - No deficiencies related to the allegations are cited. Survey dates: August 21, 22, 23, 26, 27, & 28, 2024 Facility number: 000030 Provider number: 155073 AIM number: 100275260 Census Bed Type: SNF/NF: 64 SNF: 5 Total: 69 Census Payor Type: Medicare: 11 Medicaid: 34	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 these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective September 21, 2024, for the complaint survey completed August 28, 2024. Pilgrim Manor would like to respectfully request a desk review/paper compliance of this plan of correction.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
James Combs MBA HFA	Administrator	09/25/2024

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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	Other: 24 Total: 69 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on 9/4/2024			
F 0604 SS=D Bldg. 00	483.10(e)(1), 483.12(a)(2) Right to be Free from Physical Restraints Based on interviews and record review, the facility failed to ensure 1 of 1 residents reviewed for restraints were free from physical restraints, (Resident C). Finding includes: During an interview on 8/22/24 at 8:45 A.M., Employee 16 indicated Resident C, had been secured to his wheelchair with a sheet by two staff members. Employee 16 indicated on the evening of 8/13/24, Employees 4 and 5 placed a sheet around the Resident C while he was in his wheelchair and Employee 4 tied the sheet around the back of the chair, while the resident was on their wing (West Wing) for supervision. Employee 16 indicated when Employee 14 took the resident back to his room on the East Wing, it was discovered the sheet was tied around the back of the chair. Employee 14 then reported the incident to Employees 15 and 16. Employee 16 indicated Employee 15 reported the incident to the Administrator immediately, but neither Employee 4 nor Employee 5 were sent home pending an investigation. During an interview, on 8/22/24 at 1:00 P.M., Employee 5 indicated she had worked the day shift on 8/13/24 when Resident C was being	F 0604	It is the practice of this facility to treat residents with respect and dignity including the right to be free of physical restraints unless required to treat the resident's medical symptoms ***The corrective action(s) accomplished for the resident found to have been affected by the deficient practice:*** Resident C no longer resides in the facility. Employee 4 is no longer employed at the facility. *How are other residents having the potential to be affected by the same deficient practice identified and what corrective action(s) will be taken;* All residents have potential to be affected by the deficient practice. Facility-wide interviews of all residents and staff conducted with no restraint use identified. For those residents unable to be interviewed, families were interviewed regarding knowledge of any restraint use in the issues	09/21/2024

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	supervised on the west hall. Employee 5 indicated Resident C was reaching for things, was very active in his wheelchair, and he kept trying to stand up from the wheelchair. Employee 5 indicated she was giving shift report to Employee 4 while supervising Resident C, who was very active in his chair. Employee 5 indicated Employee 4 got a bed sheet from the linen closet and she and Employee 4 folded the sheet in a triangle shape and put it over the resident's lap while he was in his wheelchair. Employee 5 indicated Employee 4 then tied the ends of the sheet together around the back of the resident's wheelchair. Employee 5 demonstrated folding a flat bed sheet into an elongated triangle, then demonstrated how she and Employee 4 placed it over the Resident C's lap and how Employee 4 tied the sheet together behind the back of the wheelchair. Employee 5 indicated the resident was secured to the chair to keep the resident from falling forward and from getting up out of the wheelchair. During a telephone interview, on 8/22/24 at 4:06 P.M., Employee 4 indicated she and Employee 5 had placed a bed sheet over Resident C's lap to give him "dignity." Employee 4 indicated she tied the ends of the sheet together at the back of the wheelchair to secure the sheet and it was not intended to keep the resident from moving or from getting up out of the chair. Employee 4 indicated the resident was able to move around while seated in his chair with the sheet in place. Employee 4 indicated even though the sheet was over him and tied together at the back of his wheelchair, it was not meant to keep him from moving in the wheelchair and indicated it (the use of the tied bed sheet) was, "all in how you perceive it." During an interview, on 8/22/24 at 3:40 P.M., the		identified and skin checks completed ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;*** The facility policy on abuse, includi the use of restraints, was reviewed by the IDT and updated. An in-serviceconducted by the Administrator with all facility staff on the policy and its changes on or before 9/10/2024. Any employees who did not attend the in-service will be in-serviced by the Administrator or his/her designee before working. A performance improvement tool has been developed to monitor residents are free of restraint any allegations of abuse have been reported. The performance tool will also show staff understanding of the abuse policy and proper reporting. ***How the corrective actions will be monitored to ensure the deficient practice does not recur;*** Frequency and duration of reviews will be increased as needed if any areas of noncompliance are identified during the monitoring process. Frequency and duration of reviews will be increased as needed if any areas of noncompliance are	

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	Director of Nursing indicated if Resident C had been secured to the wheelchair utilizing a bed sheet, the intervention was inappropriate and should have been reported to management. During an interview on 8/23/24 at 5:00 P.M., Employee 13 indicated, on 8/14/24, it was reported to her that on 8/13/24, Employee 4 had tied Resident C to his wheelchair with a sheet. . During an interview on 8/26/24 at 8:45 A.M., the Administrator, indicated the incident involving Resident C being tied to his wheelchair was reported to her around 8/13/24. She indicated it was reported Employee 5 had used a bed sheet to secure Resident C to his wheelchair. The Administrator indicated she believed on 8/7/24, Employee 16 had reported that Employee 4 had placed a sheet over Resident C's lap and tied the sheet behind his wheelchair. The Administrator indicated the Director of Nursing did interview Employee 4. The Administrator indicated the facility failed to investigate the allegations any further. The clinical record for Resident C was reviewed on 8/26/24 at 11:18 A.M. Diagnoses included, dementia, encephalopathy, seizure disorder, anxiety, and obstructive uropathy. An Admission Minimum Data Set (MDS) assessment dated 7/17/24, indicated Resident C was severely cognitively impaired, displayed behavioral symptoms not directed toward others and the behaviors did not put the resident at risk nor interfere with the resident's care, but did interfere with the resident's participation in social interactions. Resident C's behaviors did disrupt the living environment and the activities of others. Resident C demonstrated rejection of care,		identified during the monitoring process. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter for a total of 6 months. *By what date the systemic changes for the deficiency will be completed:¿* *9/21/2024*	

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	wandering, and significantly intruded on the privacy of others. Resident C was dependent on others for most activities of daily living, including eating, bathing, and toileting. The resident was dependent on a wheelchair and staff assistance for locomotion needs. A review of the, American Psychiatric Nurses Association (APNA), "APNA Standards of Practice: Seclusion and Restraint," dated 5/20 and revised 3/22, indicated, "...a restraint is initiated by qualified staff authorized by the organization to initiate seclusion or restraint in a behavioral emergency and must be followed by an order from a physician or Licensed Practitioner (LP) who is responsible for the care and treatment of the person..." This citation relates to Complaint IN00441555. 3.1-26(b)			
F 0607 SS=D Bldg. 00	483.12(b)(1)-(5)(ii)(iii) Develop/Implement Abuse/Neglect Policies Based on interviews, record review, and facility policy review, the facility failed to ensure their abuse policy was implemented when staff failed to report an allegation of abuse regarding an alleged use of a physical restraint, to the State Agency, for 1 of 3 residents reviewed for abuse, (Resident C). Finding includes: During an interview on 8/22/24 at 8:45 A.M., Employee 16 indicated Resident C, had been secured to his wheelchair with a sheet by two staff members. Employee 16 indicated on the evening of 8/13/24, Employees 4 and 5 placed a	F 0607	="" b=""> It is the practice of this facility to follow the abuse policy by reporting the use of an alleged physical restraint or any allegation of abuse to the State Agency. ***The corrective action(s) accomplished for the resident found to have been affected by the deficient practice:*** Resident C no longer resides in the facility. Employee 4 is no longer employed. ***How are other residents having***	09/21/2024

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	sheet around the Resident C while he was in his wheelchair and Employee 4 tied the sheet around the back of the chair, while the resident was on their wing (West Wing) for supervision. Employee 16 indicated when Employee 14 took the resident back to his room on the East Wing, it was discovered the sheet was tied around the back of the chair. Employee 14 then reported the incident to Employees 15 and 16. Employee 16 indicated Employee 15 reported the incident to the Administrator immediately, but neither Employee 4 nor Employee 5 were sent home pending an investigation. During an interview, on 8/22/24 at 1:00 P.M., Employee 5 indicated she had worked the day shift on 8/13/24 when Resident C was being supervised on the west hall. Employee 5 indicated Resident C was reaching for things, was very active in his wheelchair, and he kept trying to stand up from the wheelchair. Employee 5 indicated she was giving shift report to Employee 4 while supervising Resident C, who was very active in his chair. Employee 5 indicated Employee 4 got a bed sheet from the linen closet and she and Employee 4 folded the sheet in a triangle shape and put it over the resident's lap while he was in his wheelchair. Employee 5 indicated Employee 4 then tied the ends of the sheet together around the back of the resident's wheelchair. Employee 5 demonstrated folding a flat bed sheet into an elongated triangle, then demonstrated how she and Employee 4 placed it over the Resident C's lap and how Employee 4 tied the sheet together behind the back of the wheelchair. Employee 5 indicated the resident was secured to the chair to keep the resident from falling forward and from getting up out of the wheelchair. Employee 5 indicated it was Employee 4 who had tied the resident to his wheelchair.		***the potential to be affected by the same deficient practice identified and what corrective action(s) will be taken;*** All residents have the potential of being affected by the deficient practice. Employees involved in an abuse allegation will be removed from the schedule pending investigation. The Administrator or designee will report the allegation into Gateway following state reportable guidelines. ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;*** The facility policy on abuse, which includes reporting guidelines, was reviewed by the IDT and updated. An in-service was conducted by the Administrator with all facility staff on the policy and its changes on or before 9/10/2024. Any employees who did not attend the in-service will be in-serviced by the Administrator or his/her designee before working. A performance improvement tool has been developed to monitor that residents are free of restraint use, and that any allegations of abuse have been reported. The performance tool will also show staff understanding of the abuse policy and proper reporting. ***How the corrective actions will***	

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	Employee 5 indicated she had not reported the incident to the Director of Nursing or the Administrator because she would have gotten in trouble and feared for her job. Employee 5 indicated she had never been interviewed by management regarding the incident since it had occurred on 8/13/2024. During a telephone interview, on 8/22/24 at 4:06 P.M., Employee 4 indicated she and Employee 5 had placed a bed sheet over Resident C's lap to give him "dignity." Employee 4 indicated she tied the ends of the sheet together at the back of the wheelchair to secure the sheet and it was not intended to keep the resident from moving or from getting up out of the chair. Employee 4 indicated the resident was able to move around in his chair with the sheet in place. Employee 4 indicated even though the sheet was over him and tied together at the back of his wheelchair, it was not meant to keep him from moving in the wheelchair and indicated it (the use of the tied bed sheet) was, "all in how you perceive it." During an interview, on 8/22/24 at 3:40 P.M., the Director of Nursing indicated she had no prior knowledge of the incident involving Resident C until the suvey. She indicated if Resident C had been secured to the wheelchair utilizing a bed sheet, the intervention was inappropriate and should have been reported to management. During an interview on 8/23/24 at 5:00 P.M., Employee 13 indicated, on 8/14/24, it was reported to her that on 8/13/24, Employee 4 had tied Resident C to his wheelchair with a sheet. Employee 13 indicated the Director of Nursing was aware of the incident because on 8/14/24, the Director of Nursing had discussed suspending Employee 4. Employee 13 indicated she did not		***be monitored to ensure the deficient practice does not recur;*** Newly hired nursing associates will be provided with abuse education including use of restraints during the general orientation process as an ongoing process. Administrator/designee will complete routine staff interviews utilizing a questionnaire as to what constitutes a restraint to ensure they remain knowledgeable of reporting requirements regarding use of physical restraints. Interviews to occur: 5 random associates weekly x's 30 days, then 5 random associates monthly x's 6 months of monitoring. Any findings will be addressed. Frequency and duration of reviews will be increased as needed if any areas of noncompliance are identified during the monitoring process. The Administrator/designee will complete routine physical observations of residents to ensure physical restraints are not in use, unless appropriately ordered and if inappropriate use has been identified, that it was reported timely per reporting guidelines. Monitoring to occur: 5 random residents weekly x's 30 days, then 5 random residents monthly x's 5 months for a total of 6 months of monitoring. Any findings will be addressed	

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	report the incident to the Administrator because the Director of Nursing was aware of the incident. During an interview on 8/26/24 at 8:45 A.M., the Administrator, indicated the incident involving Resident C being tied to his wheelchair was reported to her around 8/1324. She indicated it was reported Employee 5 had used a bed sheet to secure Resident C to his wheelchair. The Administrator indicated she reviewed video footage of Employee 5 and observed her placing a bed sheet over Resident C's lap and tucking it in around his lap, but at no time did she observe on the video, Employee 5 tying the sheet or restraining Resident C to his wheelchair. The Administrator indicated she believed on 8/7/24, Employee 16 reported that Employee 4 put a sheet over Resident C's lap and tied the sheet behind the wheelchair. The Administrator indicated the Director of Nursing did interview Employee 4. The Administrator indicated the facility failed to investigate the allegation any further. The clinical record for Resident C was reviewed on 8/26/24 at 11:18 A.M. Diagnoses included, dementia, encephalopathy, seizure disorder, anxiety, and obstructive uropathy. An Admission Minimum Data Set (MDS) assessment dated 7/17/24, indicated Resident C was severely cognitively impaired, displayed behavioral symptoms not directed toward others and the behaviors did not put the resident at risk nor interfere with the resident's care, but did interfere with the resident's participation in social interactions. Resident C's behaviors did disrupt the living environment and the activities of others. Resident C demonstrated rejection of care, wandering, and significantly intruded on the privacy of others. Resident C was dependent on		Frequency and duration of reviews will be increased as needed if any areas of noncompliance are identified during the monitoring process. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter for a total of 6 months. *By what date the systemic changes for the deficiency will be completed:¿* *9/21/2024*	

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	others for most activities of daily living, including eating, bathing, and toileting. The resident was dependent on a wheelchair and staff assistance for locomotion needs. On 8/22/24 at 9:00 A.M., the Administrator provided a policy titled, "Abuse Prevention Policy & Procedure," dated 3/20/24 and indicated it was the current facility policy. The policy indicated, "...Abuse is the willful infliction of...unreasonable confinement...Investigation...Once an allegation is made...the employee will immediately be suspended, pending the investigation...Reporting/Response It is essential that all staff recognize the importance of allegations of abuse...and report immediately to the Administrator...Once the allegation has been made the facility is responsible to notify the appropriate officials..." This citation relates to Complaint IN00441555. 3.1-28(a) 3.1-28(c) 3.1-28(d) 3.1-28(e)			
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations Based on interviews and record review, the facility failed to report to the State Agency an allegation of abuse for 1 of 3 resident's reviewed for abuse, (Residents C). Finding includes: During an interview on 8/22/24 at 8:45 A.M., Employee 16 indicated Resident C, had been secured to his wheelchair with a sheet by two	F 0609	F 609 Reporting of Alleged Violations It is the practice of this facility to report all alleged violations involving abuse to the State Agency in the appropriate amount of time after any allegation is made. ***The corrective action(s)***	09/21/2024

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	staff members. Employee 16 indicated on the evening of 8/13/24, Employees 4 and 5 placed a sheet around the Resident C while he was in his wheelchair and Employee 4 tied the sheet around the back of the chair, while the resident was on their wing (West Wing) for supervision. Employee 16 indicated when Employee 14 took the resident back to his room on the East Wing, it was discovered the sheet was tied around the back of the chair. Employee 14 then reported the incident to Employees 15 and 16. Employee 16 indicated Employee 15 reported the incident to the Administrator immediately, but neither Employee 4 nor Employee 5 were sent home pending an investigation. During an interview, on 8/22/24 at 1:00 P.M., Employee 5 indicated she had worked the day shift on 8/13/24 when Resident C was being supervised on the west hall. Employee 5 indicated Resident C was reaching for things, was very active in his wheelchair, and he kept trying to stand up from the wheelchair. Employee 5 indicated she was giving shift report to Employee 4 while supervising Resident C, who was very active in his chair. Employee 5 indicated Employee 4 got a bed sheet from the linen closet and she and Employee 4 folded the sheet in a triangle shape and put it over the resident's lap while he was in his wheelchair. Employee 5 indicated Employee 4 then tied the ends of the sheet together around the back of the resident's wheelchair. Employee 5 demonstrated folding a flat bed sheet into an elongated triangle, then demonstrated how she and Employee 4 placed it over the Resident C's lap and how Employee 4 tied the sheet together behind the back of the wheelchair. Employee 5 indicated the resident was secured to the chair to keep the resident from falling forward and from getting up out of the		***accomplished for the resident found to have been affected by the deficient practice:*** The Administrator entered the allegations of abuse for Resident C in the Gateway portal on 8/26/24. ***How are other residents having the potential to be affected by the same deficient practice identified and what corrective action(s) will be taken;*** All residents have the potential of being affected by the deficient practice. A facility-wide audit was conducted to ensure there were no additional violations. No additional allegations found. ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;*** The facility policy on abuse, which includes reporting guidelines, was reviewed by the IDT and updated. An in-service was conducted by the Administrator with all facility staff on the policy and its changes on or before 9/10/2024. Any employees who did not attend the in-service will be in-serviced by the Administrator or his/her designee before working. A performance improvement tool has been developed to monitor residents are free of restraint use, and any allegations of abuse have been	

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	wheelchair. Employee 5 indicated it was Employee 4 who had tied the resident to his wheelchair. Employee 5 indicated she had not reported the incident to the Director of Nursing or the Administrator because she would have gotten in trouble and feared for her job. Employee 5 indicated she had never been interviewed by management regarding the incident since it had occurred on 8/13/2024. During a telephone interview, on 8/22/24 at 4:06 P.M., Employee 4 indicated she and Employee 5 had placed a bed sheet over Resident C's lap to give him "dignity." Employee 4 indicated she tied the ends of the sheet together at the back of the wheelchair to secure the sheet and it was not intended to keep the resident from moving or from getting up out of the chair. Employee 4 indicated the resident was able to move around in his chair with the sheet in place. Employee 4 indicated even though the sheet was over him and tied together at the back of his wheelchair, it was not meant to keep him from moving in the wheelchair and indicated it (the use of the tied bed sheet) was, "all in how you perceive it." During an interview, on 8/22/24 at 3:40 P.M., the Director of Nursing indicated she had no prior knowledge of the incident involving Resident C until the suvey. She indicated if Resident C had been secured to the wheelchair utilizing a bed sheet, the intervention was inappropriate and should have been reported to management. During an interview on 8/23/24 at 5:00 P.M., with Employee 13 indicated, on 8/14/24, it was reported to her that on 8/13/24, Employee 4 had tied Resident C to his wheelchair with a sheet. Employee 13 indicated the Director of Nursing was aware of the incident because on 8/14/24, the		reported. The performance tool will also show staff understanding of abuse policy and proper reporting. ***How the corrective actions will be monitored to ensure the deficient practice does not recur;*** Administrator/designee will complete routine staff interviews utilizing a questionnaire as to what constitutes a restraint to ensure they remain knowledgeable of reporting requirements regarding use of physical restraints. Interviews to occur: 5 random associates weekly x's 30 days, then 5 random associates monthly x's 6 months of monitoring. Any findings will be addressed. Frequency and duration of reviews will be increased as needed if any areas of noncompliance are identified during the monitoring process. The Administrator/designee will complete routine physical observations of residents to ensure physical restraints are not in use, unless appropriately ordered and if inappropriate use has been identified, that it was reported timely per reporting guidelines. Monitoring to occur: 5 random residents weekly x's 30 days, then 5 random residents monthly x's 5 months for a total of 6 months of monitoring. Any findings will be addressed *By what date the systemic*	

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	155073	A. BUILDING 00 B. WING	08/28/2024

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	Director of Nursing had discussed suspending Employee 4. Employee 13 indicated she did not report the incident to the Administrator because the Director of Nursing was aware of the incident. During an interview, on 8/26/24 at 8:45 A.M., the Administrator, indicated the incident involving Resident C being tied to his wheelchair was reported to her around 8/13/24. She indicated it was reported Employee 5 had used a bed sheet to secure Resident C to his wheelchair. The Administrator indicated she reviewed video footage of Employee 5 and observed her placing a bed sheet over Resident C's lap and tucking it in around his lap, but at no time did she observe. on the video, Employee 5 tying the sheet or restraining Resident C to his wheelchair. The Administrator indicated she believed on 8/7/24, Employee 16 had reported that Employee 4 had placed a sheet over Resident C's lap and tied the sheet behind his wheelchair. The Administrator indicated the Director of Nursing did interview Employee 4 regarding the incident. The Administrator indicated the facility failed to investigate the allegation any further and had not reported the allegation of abuse to the State. The clinical record for Resident C was reviewed on 8/26/24 at 11:18 A.M. Diagnoses included, but were not limited to, dementia, encephalopathy, seizure disorder, anxiety, and obstructive uropathy. An Admission Minimum Data Set (MDS) assessment, dated 7/17/24, indicated Resident C was severely cognitively impaired, displayed behavioral symptoms not directed toward others and the behaviors did not put the resident at risk nor interfere with the resident's care, but did interfere with the resident's participation in social		*changes for the deficiency will be completed:¿* ¿9/21/2024	

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	interactions. Resident C's behaviors did disrupt the living environment and the activities of others. Resident C demonstrated rejection of care, wandering, and significantly intruded on the privacy of others. Resident C was dependent on others for most activities of daily living, including eating, bathing, and toileting. The resident was dependent on a wheelchair and staff assistance for locomotion needs. On 8/22/24 at 9:00 A.M., the Administrator provided a policy titled, "Abuse Prevention Policy & Procedure," dated 3/20/24 and indicated it was the current facility policy. The policy indicated, "...Abuse is the willful infliction of...unreasonable confinement...Investigation...Reporting/Response It is essential that all staff recognize the importance of allegations of abuse...and report immediately to the Administrator...Once the allegation has been made the facility is responsible to notify the appropriate officials..." This citation relates to Complaint IN00441555. 3.1-28(c)			
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation Based interviews, and record review, the facility failed to ensure a thorough investigation was completed for an allegation of abuse for 1 of 3 residents reviewed for abuse, (Resident C). Finding includes: During an interview on 8/22/24 at 8:45 A.M., Employee 16 indicated Resident C, had been secured to his wheelchair with a sheet by two staff members. Employee 16 indicated on the	F 0610	It is the practice of this facility to follow the abuse policy by reporting the use of an alleged physical restraint or any allegation of abuse to the State Agency. ***The corrective action(s) accomplished for the resident found to have been affected by the deficient practice**:* Resident C no longer resides in	09/21/2024

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	evening of 8/13/24, Employees 4 and 5 placed a sheet around the Resident C while he was in his wheelchair and Employee 4 tied the sheet around the back of the chair, while the resident was on their wing (West Wing) for supervision. Employee 16 indicated when Employee 14 took the resident back to his room on the East Wing, it was discovered the sheet was tied around the back of the chair. Employee 14 then reported the incident to Employees 15 and 16. Employee 16 indicated Employee 15 reported the incident to the Administrator immediately, but neither Employee 4 nor Employee 5 were sent home pending an investigation. During an interview, on 8/22/24 at 1:00 P.M., Employee 5 indicated she had worked the day shift on 8/13/24 when Resident C was being supervised on the west hall. Employee 5 indicated Resident C was reaching for things, was very active in his wheelchair, and he kept trying to stand up from the wheelchair. Employee 5 indicated she was giving shift report to Employee 4 while supervising Resident C, who was very active in his chair. Employee 5 indicated Employee 4 got a bed sheet from the linen closet and she and Employee 4 folded the sheet in a triangle shape and put it over the resident's lap while he was in his wheelchair. Employee 5 indicated Employee 4 then tied the ends of the sheet together around the back of the resident's wheelchair. Employee 5 demonstrated folding a flat bed sheet into an elongated triangle, then demonstrated how she and Employee 4 placed it over the Resident C's lap and how Employee 4 tied the sheet together behind the back of the wheelchair. Employee 5 indicated the resident was secured to the chair to keep the resident from falling forward and from getting up out of the wheelchair. Employee 5 indicated it was Employee		the facility. The staff member failing to report allegation of abuse is no longer employed at the facility. ***How are other residents having the potential to be affected by the same deficient practice identified and what corrective action(s) will be taken;*** All residents have the potential of being affected by the deficient practice. Employees involved in an abuse allegation will be removed from the schedule pending investigation. The Administrator or designee will report the allegation into Gateway following state reportable guidelines. ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;*** The facility policy on abuse, which includes reporting guidelines, was reviewed by the IDT and updated. An in-service was conducted by the Administrator with all facility staff on the policy and its changes on or before 9/10/2024. Any employees who did not attend the in-service will be in-serviced by the Administrator or his/her designee before working. A performance improvement tool has been developed to monitor residents are free of restraint use, and that any allegations of abuse have been	

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	4 who had tied the resident to his wheelchair. Employee 5 indicated she had not reported the incident to the Director of Nursing or the Administrator because she would have gotten in trouble and feared for her job. Employee 5 indicated she had never been interviewed by management regarding the incident since it had occurred on 8/13/2024. During a telephone interview, on 8/22/24 at 4:06 P.M., Employee 4 indicated she and Employee 5 had placed a bed sheet over Resident C's lap to give him "dignity." Employee 4 indicated she tied the ends of the sheet together at the back of the wheelchair to secure the sheet and it was not intended to keep the resident from moving or from getting up out of the chair. Employee 4 indicated the resident was able to move around in his chair with the sheet in place. Employee 4 indicated even though the sheet was over him and tied together at the back of his wheelchair, it was not meant to keep him from moving in the wheelchair and indicated it (the use of the tied bed sheet) was, "all in how you perceive it." During an interview, on 8/22/24 at 3:40 P.M., the Director of Nursing indicated she had no prior knowledge of the incident involving Resident C until the suvey. She indicated if Resident C had been secured to the wheelchair utilizing a bed sheet, the intervention was inappropriate and should have been reported to management. During an interview on 8/23/24 at 5:00 P.M., Employee 13 indicated, on 8/14/24, it was reported to her that on 8/13/24, Employee 4 had tied Resident C to his wheelchair with a sheet. Employee 13 indicated the Director of Nursing was aware of the incident because on 8/14/24, the Director of Nursing had discussed suspending		reported. The performance tool will show staff understanding of the abuse policy and proper reporting. ***How the corrective actions will be monitored to ensure the deficient practice does not recur;*** The Administrator/designee will complete routine auditing to ensure that allegations of abuse are completely investigated within the 5 day follow up time period. The facility will utilize an abuse checklist for allegations of abuse. Auditing to occur: 5 abuse allegations weekly if they occur x's 30 days, then 5 abuse allegations, if they occur monthly x's 5 months for a total of 6 months of monitoring. Any findings will be addressed Frequency and duration of reviews will be increased as needed if any areas of noncompliance are identified during the monitoring process. *By what date the systemic changes for the deficiency will be completed:¿* *9/21/2024*	

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	Employee 4. Employee 13 indicated she did not report the incident to the Administrator because the Director of Nursing was aware of the incident. During an interview on 8/26/24 at 8:45 A.M., the Administrator, indicated the incident involving Resident C being tied to his wheelchair was reported to her around 8/1324. She indicated it was reported Employee 5 had used a bed sheet to secure Resident C to his wheelchair. The Administrator indicated she reviewed video footage of Employee 5 and observed her placing a bed sheet over Resident C's lap and tucking it in around his lap, but at no time did she observe on the video, Employee 5 tying the sheet or restraining Resident C to his wheelchair. The Administrator indicated she believed on 8/7/24, Employee 16 reported that Employee 4 put a sheet over Resident C's lap and tied the sheet behind the wheelchair. The Administrator indicated the Director of Nursing did interview Employee 4. The Administrator indicated the facility failed to investigate the allegation any further. The clinical record for Resident C was reviewed on 8/26/24 at 11:18 A.M. Diagnoses included, dementia, encephalopathy, seizure disorder, anxiety, and obstructive uropathy. An Admission Minimum Data Set (MDS) assessment dated 7/17/24, indicated Resident C was severely cognitively impaired, displayed behavioral symptoms not directed toward others and the behaviors did not put the resident at risk nor interfere with the resident's care, but did interfere with the resident's participation in social interactions. Resident C's behaviors did disrupt the living environment and the activities of others. Resident C demonstrated rejection of care, wandering, and significantly intruded on the			

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	privacy of others. Resident C was dependent on others for most activities of daily living, including eating, bathing, and toileting. The resident was dependent on a wheelchair and staff assistance for locomotion needs. On 8/22/24 at 9:00 A.M., the Administrator provided a policy titled, "Abuse Prevention Policy & Procedure," dated 3/20/24 and indicated it was the current facility policy. The policy indicated, "...Abuse is the willful infliction of...unreasonable confinement...Investigation...Once an allegation is made...the employee will immediately be suspended, pending the investigation..." This citation relates to Complaint IN00441555. 3.1-28(d)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on observation, interview, and record review, the facility failed to monitor the temperatures of coffee and hot water before serving the fluids to residents and failed to assess a resident for hot fluid safety for 1 of 3 residents reviewed for accidents. (Resident B) This deficient practice resulted in a resident spilling hot liquid onto her lap and sustaining ;second degree burns on her legs. (Resident B) Finding includes: During an observation on 8/22/24 at 2:00 P.M., with Employee 5, Resident B was laying in her bed with her eyes open but she did not respond to vocal stimuli. Employee 5 pulled the covers back to expose burned areas on both of Resident B's thighs. The upper left thigh had a reddened area	F 0689	F 689 Free of Accident Hazards/Supervision/Devices It is the practice of this facility that the resident's environment remains as free of accident hazards as possible and residents are assessed when accidents occur. ***The corrective action(s) accomplished for the resident found to have been affected by the deficient practice:*** Resident B no longer resides in the facility. ***How are other residents having the potential to be affected by***	09/21/2024

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	approximately 10 cm x 5 cm that covered the top of the thigh and into the inner thigh. A fluid filled blister approximately 6 cm x 6 cm was noted to the top and inner part of the thigh. The tissue surrounding the blister was red and raw. The right thigh had an open area approximately 10 cm x 5 cm. During an interview, on 8/23/24 at 5:00 P.M., Employee 13 indicated on 8/18/24, Resident B was having breakfast in the dining room when she spilled her mug containing hot tea and burned her lap area. Employee 13 indicated the resident enjoyed using her personal, large mug for coffee, and required only minimal assistance to set up her meal. During an interview on 8/26/24 at 2:00 P.M., Employee 23 indicated she takes care of Resident B frequently. Employee 23 indicated Resident B was capable of holding her own cup without difficulty. Employee 23 indicated the mug must have been too hot for the resident to hold, so she had spilt the hot tea in her lap. During an interview on 8/26/24 at 2:14 P.M., Employee 22 indicated he had been employed in the kitchen for six years. Employee 22 indicated the kitchen and dining staff had never checked the temperatures of the hot liquids accessed from the hot water and coffee dispensers in the kitchen. Employee 22 indicated kitchen staff began checking and logging hot beverage temperatures from the kitchen dispenser approximately 2 weeks ago. During an interview on 8/26/24 at 3:04 P.M., the Dietary Manager indicated on 8/18/24 Resident B was having breakfast in the main dining room by the kitchen. The Dietary Manager indicated		***the same deficient practice identified and what corrective action(s) will be taken;*** All residents are at potential risk for injury while handling hot liquids. A hot liquid safety evaluation was completed on all residents. All residents determined to be at risk were referred to therapy for screening and appropriate interventions. Resident care plans updated. Temperature checks of hot liquids are completed at each meal by dietary department. Hot liquid mugs with lids have also been ordered. The hot liquid machine was serviced and temperatures adjusted. ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;*** The facility policy on safety of hot liquids was reviewed by the IDT. An in-service was conducted with all facility staff on the policy and licensed nurses were in-serviced on assessing residents immediately after anA performance improvement tool has been developed to monitor residents are evaluated on admission and at least quarterly for risk for injury while handling hot liquids and referred to therapy for screening and results added to care plan.	

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	Resident B had a mug of hot tea and she had spilled the tea onto her lap. The Dietary Manager indicated a local food service provider maintained the hot fluid machines and regulated the temperatures. The Dietary Manager indicated the kitchen routinely filled two carafes at meal time from the hot liquid dispensers, one with coffee the other with hot water. Resident were then served coffee and hot water from the carafes but the temperature of the liquids in the carafes had not been checked. The Dietary Manager indicated after Resident B sustained burns, they began monitoring the temperature of the liquids in the carafes to ensure the temperature of the fluid was under 180 degrees, which was the facility's acceptable serving temperature for hot fluids. The Dietary Manager indicated on 8/20/24, she requested the local food service provider check the facility's coffee maker and hot water dispenser but was informed the local food service provider was short handed so a technician had not come to the facility until 8/26/24. Facility temperatture logs of the hot liquids for July 2024 through August 18, 2024 were requested on 8/26/24 at 3:00 P.M. There were no temperature logs provided. During an interview with the Administrator, on 8/26/24 at 3:32 P.M., she indicated there were no temperature logs completed prior to Resident B sustaining burns on 8/18/24. The Admiistrator indicated the facility should have been monitoring and assessinig the temperatures of hot liquids from the dispensers and the carafes to ensure they were safe. During an interview, on 8/26/24 at 3:32 P.M., the Administrator indicated a hot liquid safely evaluation assessment had not been completed for Resident B until after the resident had spilled		***How the corrective actions will be monitored to ensure the deficient practice does not recur;*** The Food Service Director/designee will complete routine auditing to ensure liquids are within the appropriate range. Auditing to occur: 5 random residents weekly x's 30 days, 5 ransom residents monthly x's 5 months for a total of 6 months of monitoring. DON/designee to complete routine auditing designee to ensure hot liquid safety evaluations have been completed and at risk residents have interventions in place on the care plan. Auditing to occur: 5 random residents weekly x's 30 days, then 5 random residents monthly x's 5 months for a total of 6 months of monitoring. Any findings will be addressed Frequency and duration of reviews will be increased as needed if any areas of noncompliance are identified during the monitoring process. *By what date the systemic changes for the deficiency will be completed:* 9/21/2024	

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	her tea and burned her lap. The Administrator indicated the facility staff had not checked the temperatures of hot liquids until after Resident B sustained burns on 8/18/24. The Administrator indicated the local food service was not responsible for the monitoring of hot liquid temperatures. The Administrator indicated Resident B utilized her own personal mug that held 2.5 cups of liquids Resident B's clinical record was reviewed on 8/21/24 at 4:00 P.M. Diagnosis included, but were not limited to, dementia, delusional disorder, anxiety, and mild cognitive impairment. A Quarterly Minimum Data Set (MDS) assessment, dated 7/12/24, indicated Resident C was rarely or never understood and her cognitive skills for daily decision making was impaired, decision making ability was poor, and had disorganized thinking. The resident had impaired vision and was unable to see regular book print and required corrective lenses. Resident B required set-up assistance for eating and required moderate assistance for most activities of daily living. Review of Resident B's Hot Liquid Safety Evaluation, dated 8/22/24, indicated the resident had cognitive impairment or drowsiness that impacted the resident's perception and awareness to hot liquids and safety measures including but not limited to; altered comprehension and/or memory impairment. The resident had episodes of behavior which could cause injury if occurring while the resident was handling hot liquids. Measures put in place were a cup with lid or other adaptive cup. Review of a Physician History and Physical, dated			

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	8/22/24 at 7:40 P.M., indicated Resident B had second degree burns to both thighs above the knees with blistering, inflammation, redness with the surrounding skin non-blanchable with drainage. On 8/26/24 at 3:11 P.M., the Administrator provided a policy titled, "Safety of Hot Liquids," dated 3/4/21, indicating it was the current facility policy. The policy indicated residents would be evaluated for safety concerns and potential for injury from hot liquids and appropriate precautions would be implemented too maximize choice of beverage while minimizing the potential for injury. The potential for burns from hot liquids was an ongoing concern among residents with impaired cognition and musculoskeletal conditions. Residents who preferred hot beverages with meals would not be restricted form the options. Instead, staff would conduct regular Hot Liquids Safety Evaluations as indicated, and document the risk factors for scalding and burns in the care plan. Food service staff was to monitor and maintain food temperatures that complied with food safety requirements but did not exceed recommended temperatures to prevent scalding. This citation relates to Complaint IN00441511. 3.1-45(a)(1)(2)			