STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	01/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTH WOODS VILLAGE AT EDISON LAKES	1409 E DAY ROAD MISHAWAKA, IN 46545

(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	This visit was for the Investigation of Complaints IN00449541 and IN00448040. Complaint IN00449541 - State deficiency related to the allegations is cited at R0052. Complaint IN00448040 - No deficiencies related to the allegations are cited. Survey date: January 13, 2025 Facility number: 013236 Residential Census: 45 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on 1/21/25.	R 0000		
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense Based on observation, interview, and record review, the facility failed to protect a cognitively impaired resident's right to be free from physical and mental abuse for 1 of 6 residents reviewed for abuse. (Resident B) This deficient practice resulted in the resident sustaining bruises on the bilateral arms and with a skin tear on the left arm and had the likelihood for negative psychosocial harm, manifested by a fear-inducing situation. Finding includes: On 1/13/25 at 10:20 A.M., a review of the clinical record for Resident B was conducted. The	R 0052	1. After thorough investigation, staff members appropriately followed company policies and procedures to help with the process of preventing abuse and/or neglect. Staff members immediately reported the incident and got the resident to safety quickly. 2. Immediately after this incident, North Woods Village re-educated staff on resident abuse and neglect. Additionally, North Woods reviewed all other	01/31/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Deejra Lee	Administrator	02/13/2025

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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	resident's diagnoses included, but were not limited to, dementia. An Incident Report #150 and investigation, dated 12/10/24, indicated at 10:20 A.M., a staff member reported LPN 5 was rough with Resident B during care and Resident B received '...slight bruising to left forearm and skin tear to left elbow slight bruising to inside upper arm...." LPN 5 was immediately suspended from his duties pending the investigation. The follow up report indicated LPN 5 had been rough with the resident during care which resulted in bruising and a skin tear. LPN 5 was terminated on day of occurrence. A Shower sheet, dated 12/10/24, indicated Resident B had bruising to left frontal forearm and right posterior upper forearm. And a skin tear to his left elbow. A typed statement of LPN 5's account of the incident, dated 12/10/24 at 11:10 A.M., indicated he was called into the residents room to help. LPN 5 indicated he had to wrestle with the resident as he had pooped all over himself. "...He had to fight with him and hold him down...I asked [name of CNA 4] to put the brief on him while I held him down...I can't remember how he stood up. I came back into the room because he had a skin tear on left elbow. I asked him if I could help and he said No. I tried to clean it up and had to lay him back on bed. I just laid him on the bed. I did have to hold him down on the bed...he was very angry the whole time, but I did have to hold him down to get these things done...." HHA 4's undated statement indicated she had went to get Resident B up and needed some assistance and called CNA 3. As HHA 4 bent down to put residents pants, on the resident, he		residents and did not identify any other residents with concerns. 3. North Woods will continue to in-service all new employees upon hire and all employees annually on resident abuse and neglect. 4. The Executive Director/desginee will monitor education and training on a monthly basis for 6 months to ensure 100% compliance via quality assurance meetings. 5. All changes will be made by 1/31/25	

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	punched her in the hip, so she called LPN 5 to assist them. LPN 5 entered the room and grabbed the resident by his arms and put them behind his back and both the resident and LPN went to the ground. LPN 5 stated the resident went "wet noodle" on him. LPN 5 held the resident's arms down and told us put the resident's pants on him. LPN 5 then pulled the resident off the ground and he left the room. CNA 3 mentioned to HHA 4 the resident had a skin tear. LPN 5 returned to the room and asked to see the resident's arm but the resident refused. LPN 5 shoved him forward unto the bed and held his arms behind his back. The resident was heard asking LPN 5 if he was the police. LPN 5 then flipped the resident onto his back to dress the skin tear. Both the HHA 4 and CNA 3 told LPN 5, that's enough and LPN 5 left the room. During an interview, on 1/13/25 at 12:02 P.M., CNA 3 indicated she had worked at the facility for three years. She indicated she was working in another area and Home Health Aide (HHA) 4 called her to help with a Resident B. When she entered the room the resident was being resistant to care and had BM (bowel movement) on his sheets and himself. So they decided to call the nurse, LPN 5, to assist them. LPN 5 came into the room and grabbed the resident, who was standing up, from behind and the next thing she saw was the resident and LPN 5 were on the floor. LPN 5 told CNA 3 the resident went limp-said like a "wet noodle". LPN 5 then pulled the resident to a standing position and noted a skin tear, then left the room. CNA 3 explained both she and the HHA were trying to calm the resident and provided him with a cupcake (which he had in his room and liked to eat). When LPN 5 re-entered the room he asked the resident to show him his arm, which the resident refused to do so. So, LPN 5 shoved the			

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	resident forward, onto the bed, and held his hands behind his back, which smashed the cupcake onto the resident and the floor. LPN 5 flipped the resident over and held his arms with one hand and applied a Band-Aid to the skin tear, with the other. CNA 3 heard Resident 5 asking the LPN 5 if he was the police as LPN 5 walked out of the room. CNA 3 indicated she was in shock at what she had just witnessed but proceeded to calm and clean the resident. Then both CNA 3 and HHA 4 went straight to the Director of Nursing (DON) and told her what they had witnessed. On 1/13/25 at 2:02 P.M., Resident B was observed in an activity room. He was alert and oriented to self only. He was pleasant and spoke to the Director of Nursing when she addressed him. During an interview, on 1/13/25 at 2:14 P.M., the Administrator indicated LPN 5 was walked out of the facility less than an hour after the incident occurred. The Administrator indicated after the interviewing the two CNAs who witnessed the situation and taking his statement she concluded LPN 5 could not maintain his employment with the facility. On 1/13/25 at 2:15 P.M., the Administrator provided a current policy titled, "Unusual Occurrences/Reportable Events", dated 10/1/24, and indicated the policy pertained to abuse. The policy indicated "Abuse: Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain, or mental anguish...." The policy provided did not include any language referring to ensuring residents were free from abuse. This citation relates to Complaint IN00449541.			