

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 06/17/2022
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NAME OF PROVIDER OR SUPPLIER DEMAREE CROSSING ASSISTED LIVING AND MEMORY CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1255 DEMAREE ROAD GREENWOOD, IN 46143
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R 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00382559.</p> <p>Complaint IN00382559 - Substantiated. State deficiencies related to the allegations are cited at R52 and R349.</p> <p>Survey date: June 17, 2022</p> <p>Facility number: 014079</p> <p>Residential Census: 60</p> <p>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed June 22, 2022.</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 interview and record review, the facility failed to ensure a resident was free from physical abuse. A resident hit another resident. (Resident B, Resident C)</p> <p>Finding includes:</p> <p>During an interview on 6/17/22 at 9:43 a.m., CNA 1 (Certified Nursing Aide) indicated she had worked one day last week when a QMA (Qualified</p>	R 0052	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident B and Resident C were transferred to Community Hospital South for evaluation and treatment. Resident C was transferred to a facility for</p>	07/07/2022

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.

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	<p>Medication Aide) yelled for a CNA. When she walked in Resident B's room, she saw Resident B laying on the floor and Resident C was standing near Resident B. She asked Resident B what happened, he pointed at Resident C. At that time, Resident C told her if Resident B tried to get up he would kick him.</p> <p>The clinical record of Resident B was reviewed on 6/17/22 at 9:49 a.m. The diagnoses included, but were not limited to, dementia with behavioral disturbance, major depressive disorder, and anxiety disorder. Resident B was not cognitively intact.</p> <p>The clinical record for Resident B lacked documentation of any incident with Resident C.</p> <p>The clinical record of Resident C was reviewed on 6/17/22 at 9:55 a.m. The diagnoses included, but were not limited to, dementia and hypertension. Resident C was not cognitively intact.</p> <p>The progress notes indicated:</p> <p>On 6/9/22 at 2:19 p.m., the CNA indicated Resident C was in the courtyard yelling and threatening another resident. Resident C also took clothes outside and said he was leaving.</p> <p>On 6/9/22 at 6:00 p.m., Resident C approached writer as she was counting medication. Resident C told writer to tell him where his group went. Writer told Resident C she was not sure but would try to help when she was finished. Resident C threatened writer that he would punch her teeth down her throat if she didn't tell him. The Unit Manager approached Resident C and tried to redirect him, but Resident C threatened her also to punch her in the face. Unit Manager continued to</p>		<p>Geri-psychiatric evaluation and treatment the following day. Resident B was monitored for signs/symptoms of distress. Resident C received medication adjustments and returned to Demaree Crossing.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>All residents on our Memory neighborhood had the potential to be affected.</p> <p>What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:</p> <p>The Demaree team was educated on Abuse and prevention at our all staff meeting on June 29, 2022. There was a care conference with Resident C's family to discuss triggers and additional pleasurable activities on June 30, 2022. The Memory Support Director obtained painting supplies and the family provided his favorite music which will be included in interventions for staff to utilize.</p> <p>Clinical, Administration and Life Enrichment team members also participated in Rhythms Dementia training on 6-13-22 and 6-14-22.</p> <p>How the corrective action(s)</p>	

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R 0349 Bldg. 00	<p>try to redirect resident and offered him a drink and a snack as writer finished counting medications. Resident C approached writer again as she was trying to gather belongings to go home and threatened to come over the counter at her. Writer gave report to oncoming QMA and explained the incident. The Director of Nursing was notified.</p> <p>On 6/9/22 at 7:31 p.m., Staff call writer to report an incident. QMA reported hearing yelling coming from Resident B's room. When she entered, she observed Resident C standing over Resident B. Resident B was on the floor bleeding from an approximately 1-centimeter laceration on the back of his head and a large laceration or skin tear on his right forearm. Resident C was yelling at Resident B not to get up or he would hit him again. Resident C said several times, he was going to knock Resident B out. Staff was able to redirect Resident C to get him to come out of the room. Resident C continued to tell staff that he was going to hit him again if he got the chance. Resident C was transferred to hospital...</p> <p>On 6/9/22 at 9:14 a.m. The Administrator provided a copy of a facility policy, titled "Abuse Non-Tolerance of Resident Policy," dated 11/2019, and indicated this was the current policy used by the facility. A review of the policy indicated "residents and clients must be free from abuse by anyone, including community associates, other residents or clients..."</p> <p>This State Residential Finding relates to Complaint IN00382559.</p> <p>410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be</p>		<p>will be monitored to ensure the deficient practice will not recur, IE, what quality assurance program will be put into place?</p> <p>The Memory Support Director or designee will monitor the resident interaction, triggers and interventions to provide direction to team members 5 times a week for 4 weeks, 3 times a week for 8 weeks and 1 time a week for 12 weeks. These observations will be documented and submitted to the Quality Assurance Committee quarterly for review and recommendation regarding substantial compliance.</p>	

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	<p>maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows:</p> <ol style="list-style-type: none"> (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. <p>Based on interview and record review, the facility failed to ensure a resident's clinical record was accurate for a resident that was involved in a resident-to-resident altercation and was sent to the emergency department. (Resident B)</p> <p>Finding includes:</p> <p>During an interview on 6/17/22 at 9:43 a.m., CNA 1 (Certified Nursing Aide) indicated she had worked one day last week when a QMA (Qualified Medication Aide) yelled for a CNA. When she walked in Resident B's room, she saw Resident B lying on the floor and Resident C was standing near Resident B. She asked Resident B what happened and he pointed at Resident C. At that time, Resident C told her if Resident B tried to get up, he would kick him.</p> <p>The clinical record of Resident B was reviewed on 6/17/22 at 9:49 a.m. The diagnoses included, but were not limited to, dementia with behavioral disturbance, major depressive disorder, and anxiety disorder. Resident B was not cognitively intact.</p> <p>The clinical record for Resident B lacked documentation of any incident with Resident C nor that Resident B was transferred to the hospital.</p> <p>During an interview on 6/17/22 at 10:37 a.m., the</p>	R 0349	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The QMAs and LPNs were educated on accuracy of documentation of incidents, discharges and including information on the 24-hour report.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>All residents on the Memory neighborhood had the potential to be affected.</p> <p>What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?</p> <p>The QMAs and LPNs were educated on accuracy of documentation of incidents, discharges and including information on the 24-hour report.</p>	07/07/2022
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	<p>Director of Nursing indicated Resident B was sent to the emergency room the day of the altercation because he had the lacerations. The resident-to-resident altercation and hospital transfer should have been documented in Resident B's chart.</p> <p>On 6/17/22 at 12:05 p.m., the facility was unable to provide a policy regarding accuracy of documentation.</p> <p>This State Residential Finding relates to Complaint IN00382559.</p>		<p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, IE, what quality assurance program will be put into place?</p> <p>The Health & Wellness Director or designee will monitor the documentation of 4 random resident records for documentation weekly for 4 weeks, 2 random resident records for documentation weekly for 12 weeks and 1 random resident records weekly for 12 weeks. These audits will be presented to the Quality Assurance Committee quarterly for review and recommendation regarding substantial compliance.</p>		