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	12/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON AT KOKOMO THE	2800 S DIXON RD KOKOMO, IN46902

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R0000	This visit was for the Investigation of Complaint IN00101449. Complaint IN00101449 - Substantiated. State deficiencies related to the allegation are cited at R026, R029, R035, R051, R052 and R086. Unrelated deficiencies cited. Survey date: December 21, 2011 Facility number: 011366 Provider number: 011366 AIM number: n/a Survey team: Toni Maley, BSW, TC Linn Mackey, RN Shelley Reed, RN Census bed type: Residential: 34 Total: 34 Census payor type: Other: 34 Total: 34 Sample: 3 These state findings are cited in	R0000	Preparation and implementation of this Plan of Correction does not constitute admission or agreement by The Wellington at Kokomo of the truth or accuracy of the facts, findings, or other statements as alleged by the preparer of the survey findings for the Complaint Survey concluded on December 21, 20121. The Wellington at Kokomo specifically reserves the right to move to strike or exclude this document as evidence in any civil, administrative, or other legal action. This Plan of Correction is prepared and submitted for the purpose of complying with The Wellington at Kokomo's obligation to submit a Plan of Correction in accordance with the instructions set forth in the January 3, 2012 correspondence from the ISDH Directgor of Long Term Care.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	accordance with 410 IAC 16.2. Quality review 12/30/11 by Suzanne Williams, RN			
R0026	(a) Residents have the right to have their rights recognized by the licensee. The licensee shall establish written policies regarding residents ' rights and responsibilities in accordance with this article and shall be responsible, through the administrator, for their implementation. These policies and any adopted additions or changes thereto shall be made available to the resident, staff, legal representative, and general public. Each resident shall be advised of residents ' rights prior to admission and shall signify, in writing, upon admission and thereafter if the residents ' rights are updated or changed. There shall be documentation that each resident is in receipt of the described residents ' rights and responsibilities. A copy of the residents ' rights must be available in a publicly accessible area. The copy must be in at least 12-point type and a language the resident understands. Based on interview and record review, the facility failed to ensure the Administrator implemented facility policies regarding resident rights, abuse prevention and abuse investigation for 1 of 3 residents reviewed for the prevention of abuse and recognition of rights in a sample of 3 (Resident B). This deficient practice had the potential to impact 34 of 34 facility residents.	R0026	Tag R 0026Mandatory in-services will be conducted for all management staff and Reflections Memory Care staff. The information to be reviewed will include: · Residents' Rights Policy · Abuse Prevention Policy · Accident / Incident and Unusual Occurrence Policy · A review of the ISDH Forms for reporting. The Director of Memory Care will be responsible for presenting the mandatory in-services to both the management staff and the	02/03/2012

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	Findings include: 1.) During an 12/21/11, 9:15 a.m., interview, the Memory Care Director indicated she had received a, 12/15/11, allegation of abuse by the Director of Nursing against Resident B. The Memory Care Director indicated the allegation involved forced care, wheeling a wheelchair with the wheelchair tipped extremely back, holding a resident in a chair and wheelchair, forcing a resident to leave her room, wedging a wheelchair behind a resident chair to prevent free movement, not allowing a resident to return to her room, tipping back a recliner to prevent a resident from standing and physically forcing a resident who wanted to stand to sit. Additionally, the allegation included the denial of the resident's right to refuse care and treatment when said services were not required to ensure resident safety or immediate well being. During this same interview the Memory Care Director indicated the facility currently had 34 residents who all had a diagnosis of dementia or a related disorder. The facility was designated as a dementia unit. During an 12/21/11, 12:00 p.m., interview, the Memory Care Director		Reflections Memory Care staff. The mandatory management in-service was be held on January 12, 2012. The management personnel who are required to attend are: Executive Director, Director of Memory Care, Activities Director, Dietary Manager, Housekeeping Supervisor, Maintenance Director and Marketing Director. Please note that the Business Office Manager is on FMLA and will returning to the facility on February 7, 2012. The BOM will be in-serviced by Friday, February 10, 2012. The mandatory in-services for the Reflections Memory Care staff will be completed by February 3, 2012. With regards to new employees, a review of these policies is included in the new employee orientation program. With regards to ongoing monitoring, annual mandatory in-services covering these policies is required of all personnel. In conclusion, please note that the Nurse Manager who was involved in the abuse incident submitted her resignation on December 27, 2011with her last day of employment being January 10, 2012 which was accepted. The Nurse Manager was suspended on Friday, December 29, 2011 and did not work in the facility again. **Plan of Correction Addendum – January 20, 2012** All allegations and/or	

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	indicated she had been the person who was assigned to investigate the allegation of abuse by the Director of Nursing to Resident B on 12/15/11. When queried, the Memory Care Director indicated she had recommended to the Administrator that the Director of Nursing be suspended pending the outcome of the investigation. She indicated the Administrator did not feel the suspension was necessary. The Memory Care Director indicated she had completed the investigation and determined abuse had occurred. When queried, she indicated her conclusion was based on facility policy, witness statements and the indication of unreasonable confinement, intimidation and resident mental anguish. When questioned, the Memory Care Director indicated she reported her findings to the Administrator. She indicated the Administrator had disagreed with her findings. The Memory Care Director indicated the Director of Nursing was not working on 12/21/11 due to a requested personal leave by the employee. However, the Director of Nursing had worked 12/15/11, 12/17/11, and 12/19/11. She additionally indicated the Director of Nursing was scheduled to return from her requested leave on Friday, she believed.		incidents of abuse, neglect or misappropriation of property are thoroughly and accurately investigated and are reported timely to the required agencies by the Executive Director, the Director of Memory Care and/or the Nurse Manager. A report summarizing all allegations and/or incidents of abuse, neglect or misappropriation of property and the results of all investigations will be submitted to the Quality Assurance Committee at every scheduled committee meeting and will become a standard agenda item. The monitoring process for this plan of correction will be ongoing through the Quality Assurance Committee. In addition, all allegations and/or incidents of abuse, neglect or misappropriation of property and the subsequent investigations will be reported to the Executive Director, the Director of Memory Care and/or the Nurse Manager in a timely manner, both the occurrence and the completed investigation.	

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	2.) During a 12/21/11, 11:20 a.m., confidential employee interview, E#2 indicated she/he had witnessed an event with the Director of Nursing and Resident B on 12/15/11. E#2 believed, based on his/her facility training regarding abuse, the event was abuse. E#2 indicated Resident B had experienced distress during the events and had screamed NO! NO! and resisted the actions of the Director of Nursing. E#2 indicated he/she had given a written statement of the event to the Memory Care Director as part of an investigation. 3.) During a 12/21/11, 11:00 a.m., confidential employee interview, E#3 indicated she/he had witnessed an event with the Director of Nursing and Resident B on 12/15/11. E#3 believed based on his/her facility training regarding abuse, the event was abuse. E#3 indicated Resident B had experienced distress during the events and had screamed NO! NO! and resisted the actions of the Director of Nursing. E#3 indicated he/she had given a written statement of the event to the Memory Care Director as part of an investigation. 4.) During a 12/21/11, 11:10 a.m., confidential employee interview, E#4 indicated she/he had witnessed an event			

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	with the Director of Nursing and Resident B on 12/15/11. E#4 believed based on his/her facility training regarding abuse, the event was abuse. E#4 indicated Resident B had experienced distress during the events and had screamed NO! NO! and resisted the actions of the Director of Nursing. E#4 indicated he/she had given a written statement of the event to the Memory Care Director as part of an investigation. 5.) During a 12/21/11, 11:35 a.m., confidential employee interview, E#6 indicated she/he had witnessed an event with the Director of Nursing and Resident B on 12/15/11. E#6 believed based on his/her facility training regarding abuse, the event was abuse. E#6 indicated Resident B had experienced distress during the events and had screamed NO! NO! and resisted the actions of the Director of Nursing. E#6 indicated he/she had given a written statement of the event to the Memory Care Director as part of an investigation. 6.) During a 12/21/11, 12:17 p.m., confidential employee interview, E#14 indicated she/he had witnessed an event with the Director of Nursing and Resident B on 12/15/11. E#14 believed based on his/her facility training regarding abuse, the event was abuse. E#14 indicated			

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	Resident B had experienced distress during the events and had screamed NO! NO! and resisted the actions of the Director of Nursing. E#14 indicated he/she had given a written statement of the event to the Memory Care Director as part of an investigation. 7.) During a 12/21/11, 12:50 p.m., interview, the Administrator reviewed the facility "Abuse Prevention Policy" and indicated his personal interpretation of the word "willful" was the perpetrator of any allegation of abuse must do an action for the "purpose of harming the resident." After reading the facility policy definition of abuse and "willful", the Administrator again indicated his personal interpretation differed from facility policy. He indicated based on his personal interpretation, the 12/15/11 allegation of abuse by the Director of Nursing was not abuse. He additionally indicated, he did not report the 12/15/11 allegation of abuse to Resident B by the Director of Nursing to the Indiana State Department of Health (ISDH) as an allegation of abuse, because he did not believe the event to have been abuse. When queried if abuse had been alleged,			

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	he indicated yes. When queried if all allegations of abuse whether substantiated or unsubstantiated must be reported to the state department of health, he indicated he believed all allegations must be reported. When questioned why the, 12/15/11, allegation of abuse to Resident B had not been reported as an allegation of abuse to the ISDH, the Administrator again indicated the allegation was not reported as abuse because he did not believe abuse had occurred. When queried if there was a conflict with his statement that all allegations must be reported to ISDH and his failure to report the, 12/15/11, abuse allegation, he indicated perhaps he had been an error. When queried if he personal had completed the investigation of the 12/15/11, allegation of abuse to Resident B by the Director of Nursing or assigned to task to a designee, he indicated he had delegated the investigation to the Memory Care Director. He additionally indicated the Memory Care Director had determined abuse had occurred. He then indicated he had disagreed with the investigation based on his personal interpretation of "willful" and had determined the event was a failure to implement the resident re-direction policy by the Director of Nursing.			

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	When questioned if the Director of Nursing had been suspended pending the outcome of the 12/15/11, allegation of abuse, in accordance with facility policy, the Administrator indicated he had not suspended the Director of Nursing, because he did not believe the event to be abuse. When queried if the Memory Care Director had recommended the suspension of the Director of Nursing pending the investigation of the Abuse allegation, he indicated he did not remember this suggestion being made. When questioned if the facility policy was to suspend employees pending the outcome of the investigation, he indicated he was unsure but believed suspension to be the policy. 8.) Resident B's record was reviewed on 12/21/11 at 10:45 a.m. Resident B's current diagnoses included, but were not limited to, dementia-Alzheimer's type, anxiety and macular degeneration. Resident #B had a current 12/17/11 Interdisciplinary Team Note which indicated the resident's weight was stable. Resident #B had a current 7/11 care plan with indicated she was able to ambulate independently.			

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	9.) Review of a current, 9/2011, facility policy titled "Abuse Prevention Policy", which was provided by the Memory Care Director on 12/21/11 at 9:15 a.m., included, but was not limited to, the following: "...Reflections Memory Care at Kokomo will comply with state regulations for reporting suspected or actual acts." "Definitions: Abuse-Means the willful infliction of injury, unreasonable confinement, intimidation of punishment with resulting physical harm, pain or mental anguish..." "Willful-An intentional act (in contrast to an accidental or involuntary act) done by one who is or should be aware of the act's consequences." "The Nurse Manager and nursing personnel are responsible for initiating interventions to protect residents from any further abusive acts while any reported incidents are being investigated. Measures may include but not be limited to:...staff suspension..." Review of a current, undated, facility policy titled "Resident Rights", which was provided by the Memory Care Director on 12/21/11 at 9:15 a.m., included, but was			

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	not limited to, the following: "Residents have the right to exercise their rights as a resident of the facility and as a citizen or resident of the United States." "Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality." "Residents have the right to the following: ...Refuse any service or treatment..." "Residents have the right to be free from sexual, physical, mental or verbal abuse, corporal punishment, neglect and involuntary seclusion." "Residents have the right to be free from any physical or chemical restraint proposed for the purpose of discipline or convenience..." This State Residential tag related to complaint IN00101449.			
R0029	(d) Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality. Based on interview and record review, the facility failed to ensure a resident was treated with dignity regarding refusal of	R0029	Tag R 0029Mandatory in-services will be conducted for all management staff and Reflections Memory Care staff.	02/03/2012

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	food, the ability to move freely, being wheeled in a manner to promote respect, and the desire to be in one's room for 1 of 3 residents reviewed for dignified treatment in a sample of 3 (Resident B). Findings include: 1.) During an 12/21/11, 9:15 a.m., interview, the Memory Care Director indicated she had received a, 12/15/11, allegation of abuse by the Director of Nursing against Resident B. The Memory Care Director indicated the allegation involved forced care, wheeling a wheelchair with the wheelchair tipped extremely back, holding a resident in a chair and wheelchair, forcing a resident to leave her room, wedging a wheelchair behind a resident chair to prevent free movement, not allowing a resident to return to her room, tipping back a recliner to prevent a resident from standing and forcing a resident who wanted to stand to sit. The allegation included the denial of the resident's right to refuse care and treatment when said services were not required to ensure resident safety or well-being. During this same interview, the Memory Care Director indicated the facility currently had 34 residents who all had a diagnoses or dementia or a related		The information to be reviewed will include: · Residents' Rights Policy · Abuse Prevention Policy · Accident / Incident and Unusual Occurrence Policy · A review of the ISDH Forms for reporting. The Director of Memory Care will be responsible for presenting the mandatory in-services to both the management staff and the Reflections Memory Care staff. The mandatory management in-service was be held on January 12, 2012. The management personnel who are required to attend are: Executive Director, Director of Memory Care, Activities Director, Dietary Manager, Housekeeping Supervisor, Maintenance Director and Marketing Director. Please note that the Business Office Manager is on FMLA and will returning to the facility on February 7, 2012. The BOM will be in-serviced by Friday, February 10, 2012. The mandatory in-services for the Reflections Memory Care staff will be completed by February 3, 2012. With regards to new employees, a review of these policies is included in the new employee orientation program. With regards to ongoing monitoring, annual mandatory in-services covering these policies is required of all personnel. In conclusion, please note that the Nurse Manager who was involved in the abuse incident submitted her resignation	

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	disorder. The facility was designated as a dementia unit. 2.) Resident B's record was reviewed on 12/21/11 at 10:45 a.m. Resident B's current diagnoses included, but were not limited to, dementia-Alzheimer's type, anxiety and macular degeneration. Resident #B had a current 12/17/11 Interdisciplinary Team Note which indicated the resident's weight was stable. Resident #B had a current 7/11 care plan with indicated she was able to ambulate independently. 3.) During a 12/21/11, 11:20 a.m., confidential employee interview, E#2 indicated she/he had witnessed an event with the Director of Nursing and Resident B on 12/15/11. E#2 indicated the Director of Nursing wheeled a screaming Resident B down the hallway in a wheelchair which was extremely tipped back like a "wheely." E#2 indicated tipping the wheelchair was contrary to all training the employee had ever received. E#2 had been taught wheelchair tipping was a very unsafe practice. E#2 was greatly concerned that the person accompanying Resident B and tipping the		on December 27, 2011with her last day of employment being January 10, 2012 which was accepted. The Nurse Manager was suspended on Friday, December 29, 2011 and did not work in the facility again. **Plan of Correction Addendum – January 20, 2012** All allegations and/or incidents of abuse, neglect or misappropriation of property are thoroughly and accurately investigated and are reported timely to the required agencies by the Executive Director, the Director of Memory Care and/or the Nurse Manager. A report summarizing all allegations and/or incidents of abuse, neglect or misappropriation of property and the results of all investigations will be submitted to the Quality Assurance Committee at every scheduled committee meeting and will become a standard agenda item. The monitoring process for this plan of correction will be ongoing through the Quality Assurance Committee. In addition, all allegations and/or incidents of abuse, neglect or misappropriation of property and the subsequent investigations will be reported to the Executive Director, the Director of Memory Care and/or the Nurse Manager in a timely manner, both the occurrence and the completed investigation.	

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	chair was the Director of Nursing (DON). E#2 indicated Resident B screamed No! No! and attempted to get out of the wheelchair. The DON told Resident B if she would eat, the resident could go to her room. Resident B did eat some, but cried out, screamed "no" and asked to go to her room throughout the meal. During the entire meal, a wheelchair was wedged behind Resident B. Although the DON told the resident she could go to her room after eating, when Resident B was done eating, the DON did not take the resident to her room as the resident kept asking, but instead took her to the living room. 4.) During a 12/21/11, 11:05 a.m., interview, PT #18 indicated "I entered the living room area due to calling out by [Resident B]." The DON and another employee forcefully transferred Resident B to the recliner. Resident B resisted and caused the recliner to tip forward. After Resident B tipped the recliner forward, PT #18 asked if she could please assist Resident B to her room because the resident was greatly distressed, standing firmly, refusing to sit and asking repeatedly to go to her room. The Director of Nursing, after multiple			

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	requests, allowed the PT to walk Resident B to her room. The DON also walked with Resident B as the PT assisted the resident. PT #18 indicated as soon as being told she could go to her room, Resident B walked calmly to her room. Resident B entered her room and reclined calmly on her bed. PT #18 indicated Resident B walked calmly and safely enough as she went to her room that a 1 person assist was all that was needed. 5.) During a 12/21/11, 11:10 a.m., confidential employee interview, E#4 indicated she/he had witnessed an event with the Director of Nursing and Resident B on 12/15/11. E#4 indicated the DON wheeled a screaming, resisting Resident B down the hallway in a wheelchair which had the front wheels kicked up and the Resident leaning way back. After placing the resident at the table, then the DON wedged a wheelchair behind the resident to prevent her from standing or pushing back her chair. The DON herself held the resident down in the chair and instructed two other employees press down on the resident's shoulders or hold her pant leg during the meal. At one point, the DON instructed the housekeeper to sit in the wheelchair behind the resident to keep the resident			

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		A. BUILDING 00 B. WING	12/21/2011

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	forced up close to the table and prevent her from standing. The DON left the area for about 10 minutes and left the housekeeper sitting behind Resident B to keep her in the chair. Resident B was not fed during the time the DON was gone from the area to complete another task. The DON came back and continued to tell the resident she must eat. The DON told the resident if she ate she could go back to her room. The resident refused and cried out saying NO! NO! NO! and asking to go to her room. The resident did eventually eat some. 6.) During a 12/21/11, 11:35 a.m., confidential employee interview, E#6 indicated she/he had witnessed an event with the Director of Nursing and Resident B on 12/15/11. E#6 indicated this employee was instructed by the DON to sit in the wheelchair, which was behind the resident. E#6 was told to sit in the chair to prevent Resident B from standing or pushing her chair back. Resident B was distressed, called out and trying to get away from the table. The DON left the area and instructed E#6 sit in the wheelchair until she returned. The DON was away from the dining area about 10 minutes. No one fed Resident B during this time. The resident was			

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	distressed during the whole event. E#6 was uncomfortable with following the DON's instructions but didn't know what to do because she was the DON. 7.) During a 12/21/11, 12:17 p.m., confidential employee interview, E#14 indicated she/he had witnessed an event with the Director of Nursing and Resident B on 12/15/11. E#14 indicated the DON had wheeled and screaming, resisting, Resident B down the hallway in a wheelchair which was tipped back on two wheels. Resident B screamed NO, NO! During the meal, Resident B was often held down in the chair, by the DON or people instructed by her to do so. At one point, the DON called the housekeeper over and told the house keeper to sit in the back wedged wheelchair to keep the resident from getting up. The DON left the area for about 10 minutes. Resident B was not fed during this time but was forced to sit in her chair with the housekeeper sitting behind her. 8.) A 12/21/11, 9:45 a.m., review of witness statements by E#2, E#3, E#4, PT#18, and E#14, which were provided by the Director of Memory Care,			

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	indicated all interviews were consistent with witness written statements. 9.) During an 12/21/11, 12:00 p.m., interview, the Memory Care Director indicated she had been the person who was assigned to investigate the allegation of abuse by the Director of Nursing to Resident B on 12/15/11. She indicated the wheelchair should never be wheeled when tipped back, the resident should have been allowed to remain in her room, a resident should not be held in a chair, a wheelchair should not have been used as a barrier to maintain the resident in her chair and a resident had the right to refuse a meal. The best approach would have been to offer the resident a meal in her room. 10.) Review of a current, undated, facility policy titled " Resident Rights", which was provided by the Memory Care Director on 12/21/11 at 9:15 a.m., included, but was not limited to, the following: "Residents have the right to exercise their rights as a resident of the facility and as a citizen or resident of the United States." "Residents have the right to be treated with consideration, respect, and recognition of their dignity and			

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	individuality." "Residents have the right to the following: ...Refuse any service or treatment..." This State Residential tag related to complaint IN00101449.			

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R0035	(j) Residents have the right to the following: (1) Participate in the development of his or her service plan and in any updates of that service plan. (2) Choose the attending physician and other providers of services, including arranging for on-site health care services unless contrary to facility policy. Any limitation on the resident ' s right to choose the attending physician or service provider, or both, shall be clearly stated in the admission agreement. Other providers of services, within the content of this subsection, may include home health care agencies, hospice care services, or hired individuals. (3) Have a pet of his or her choice, so long as the pet does not pose a health or safety risk to residents, staff, or visitors or a risk to property unless prohibited by facility policy. Any limitation on the resident ' s right to have a pet of his or her choice shall be clearly stated in the admission agreement. (4) Refuse any treatment or service, including medication. (5) Be informed of the medical consequences of a refusal under subdivision (4) and have such data recorded in his or her clinical record if treatment or medication is administered by the facility. (6) Be afforded confidentiality of treatment. (7) Participate or refuse to participate in experimental research. There must be written acknowledgement of informed consent prior to participation in research activities. Based on interview and record review, the facility failed to ensure a resident had the right to refuse a meal and refuse to be seated in the dining room or living room for 1 of 1 resident reviewed for the right to refuse treatment or services in a sample	R0035	Tag R 0035Mandatory in-services will be conducted for all management staff and Reflections Memory Care staff. The information to be reviewed will include: · Residents' Rights Policy · Abuse Prevention Policy · Accident / Incident and Unusual	02/03/2012

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	of 3 (Resident B). Findings include: During an 12/21/11, 9:15 a.m., interview, the Memory Care Director indicated she had received a, 12/15/11, allegation of abuse by the Director of Nursing against Resident B. The Memory Care Director indicated the allegation included the denial of the resident's right to refusing care and treatment when said services were not required to ensure resident safety or well being. During this same interview, the Memory Care Director indicated the facility currently had 34 residents who all had a diagnoses or dementia or a related disorder. The facility was designated as a dementia unit. 2.) Resident B's record was reviewed on 12/21/11 at 10:45 a.m. Resident B's current diagnoses included, but were not limited to, dementia-Alzheimer's type, anxiety and macular degeneration. Resident #B had a current 12/17/11 Interdisciplinary Team Note which indicated the resident's weight was stable.		Occurrence Policy · A review of the ISDH Forms for reporting. The Director of Memory Care will be responsible for presenting the mandatory in-services to both the management staff and the Reflections Memory Care staff. The mandatory management in-service was be held on January 12, 2012. The management personnel who are required to attend are: Executive Director, Director of Memory Care, Activities Director, Dietary Manager, Housekeeping Supervisor, Maintenance Director and Marketing Director. Please note that the Business Office Manager is on FMLA and will returning to the facility on February 7, 2012. The BOM will be in-serviced by Friday, February 10, 2012. The mandatory in-services for the Reflections Memory Care staff will be completed by February 3, 2012. With regards to new employees, a review of these policies is included in the new employee orientation program. With regards to ongoing monitoring, annual mandatory in-services covering these policies is required of all personnel. In conclusion, please note that the Nurse Manager who was involved in the abuse incident submitted her resignation on December 27, 2011with her last day of employment being January 10, 2012 which was accepted. The Nurse	

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	Resident #B had a current 7/11 care plan with indicated she was able to ambulate independently. 3.) During a 12/21/11, 11:20 a.m., confidential employee interview, E#2 indicated she/he had witnessed an event with the Director of Nursing and Resident B on 12/15/11. E#2 indicated the Director of Nursing wheeled a screaming Resident B down the hallway in a wheelchair which was extremely tipped back like a "wheely." E#2 indicated Resident B screamed NO! NO! and attempted to get out of the wheelchair. E#2 indicated Resident B stated she wanted to stay in her room and did not want to eat in the dining room. The Director of Nursing would not allow Resident B to stay in her room and insisted she must come to the dining room and eat. Throughout the meal she told the resident she must eat even when the resident screamed no. When Resident B was done eating, the DON did not take the resident to her room as the resident kept asking but instead took her to the living room. The DON and another staff member forced Resident B to sit in the recliner. Resident B screamed no and fought being transferred and was calling out to go to her room. Resident B fought the transfer to the		Manager was suspended on Friday, December 29, 2011 and did not work in the facility again. **Plan of Correction Addendum – January 20, 2012** All allegations and/or incidents of abuse, neglect or misappropriation of property are thoroughly and accurately investigated and are reported timely to the required agencies by the Executive Director, the Director of Memory Care and/or the Nurse Manager. A report summarizing all allegations and/or incidents of abuse, neglect or misappropriation of property and the results of all investigations will be submitted to the Quality Assurance Committee at every scheduled committee meeting and will become a standard agenda item. The monitoring process for this plan of correction will be ongoing through the Quality Assurance Committee. In addition, all allegations and/or incidents of abuse, neglect or misappropriation of property and the subsequent investigations will be reported to the Executive Director, the Director of Memory Care and/or the Nurse Manager in a timely manner, both the occurrence and the completed investigation.	

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	recliner "planted her feet" and screamed NO! NO! 4.) During a 12/21/11, 11:00 a.m., confidential employee interview, E#3 indicated she/he had witnessed an event with the Director of Nursing and Resident B on 12/15/11. The DON and another employee forcefully lift and place a resisting Resident B in a recliner while the resident called out NO! and asking to go to her room. After removing Resident B from the tipped forward recliner, the DON and another staff member used physical strength and pressure to try to force Resident B to sit in a wheelchair. Resident B was standing firmly, locking her knees and refusing to sit. The DON applied pressure and tried to force the resident to sit. 5.) During a 12/21/11, 11:05 a.m., interview, PT #18 indicated "I entered the living room area due to calling out by [Resident B]." The DON and another employee forcefully transferred Resident B to the recliner. Resident B resisted and caused the recliner to tip forward. After Resident B tipped the recliner forward, PT #18 asked if she could please assist Resident B to her room because the resident was greatly distressed, standing			

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	firmly refusing to sit and asking repeatedly to go to her room. The Director of Nursing after multiple requests allowed the PT to walk Resident B to her room. The DON also walked with Resident B as the PT assisted the resident. PT #18 indicated as soon as being told she could go to her room Resident B walked calmly to her room. Resident B entered her room and reclined calmly on her bed. PT #18 indicated Resident B walked calmly and safely enough as she went to her room that a 1 person assist was all that was needed. 6.) During a 12/21/11, 11:10 a.m., confidential employee interview, E#4 indicated she/he had witnessed an event with the Director of Nursing and Resident B on 12/15/11. E#4 believed based on his/her facility training regarding abuse, the event was abuse. E#4 indicated the DON wheeled a screaming resisting Resident B down the hallway in a wheelchair which had the front wheels kicked up and the resident leaning way back. The DON refused to let the resident stay in her room and insisted she must come to the dining room at eat. The DON told the resident if she ate she could go back to her room. The resident refused and cried out saying NO! NO! NO! and asking to go to her room. The			

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	resident did eventually eat some. 7.) During a 12/21/11, 12:17 p.m., confidential employee interview, E#14 indicated she/he had witnessed an event with the Director of Nursing and Resident B on 12/15/11. E#14 indicated the DON had wheeled and screaming, resisting, Resident B down the hallway in a wheelchair which was tipped back on two wheels. Resident B screamed NO, NO! The Resident was asking to stay in her room and refusing to go to the dining room. The DON insisted the resident must leave her room and must eat in the dining room. 8.) During an 12/21/11, 12:00 p.m., interview, the Memory Care Director indicated she had been the person who was assigned to investigate the allegation of abuse by the Director of Nursing to Resident B on 12/15/11. She indicated Resident B should have been allowed to exercise her right to refuse to leave her room and been offered a meal in her room. 9.) Review of a current, undated, facility policy titled " Resident Rights", which was provided by the Memory Care Director on 12/21/11 at 9:15 a.m., included, but was not limited to, the following:			

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	"Residents have the right to exercise their rights as a resident of the facility and as a citizen or resident of the United States." "Residents have the right to the following: ...Refuse any service or treatment..." This State Residential tag related to complaint IN00101449.			
R0051	(u) Residents have the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident ' s medical symptoms. Based on interview and record review, the facility failed to ensure a resident had the right to be free from being held down and restrained, forced to sit in a chair or being held in a chair by the use of a physical barrier for 1 of 1 resident reviewed for freedom from restraints in a sample of 3 (Resident B). Findings include: 1.) Resident B's record was reviewed on 12/21/11 at 10:45 a.m. Resident B's current diagnoses included, but were not limited to, dementia-Alzheimer's type, anxiety and macular degeneration.	R0051	Tag R0051Mandatory in-services will be conducted for all management staff and Reflections Memory Care staff. The information to be reviewed will include: · Residents' Rights Policy · Abuse Prevention Policy · Accident / Incident and Unusual Occurrence Policy · A review of the ISDH Forms for reporting. The Director of Memory Care will be responsible for presenting the mandatory in-services to both the management staff and the Reflections Memory Care staff. The mandatory management in-service was be held on January 12, 2012. The management personnel who are required to attend are: Executive Director, Director of Memory Care, Activities Director, Dietary Manager, Housekeeping	02/03/2012

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	Resident B had a current 12/17/11 Interdisciplinary Team Note which indicated the resident's weight was stable. Resident B had a current 7/11 care plan with indicated she was able to ambulate independently. Resident B's record lacked an order for any form of physical restraint. 2.) During an 12/21/11, 9:15 a.m., interview, the Memory Care Director indicated she had received a, 12/15/11, allegation of abuse by the Director of Nursing against Resident B. The Memory Care Director indicated the allegation involved holding a resident in a chair and wheelchair, wedging a wheelchair behind a resident chair to prevent free movement, and tipping back a recliner to prevent a resident from standing. 3.) During a 12/21/11, 11:20 a.m., confidential employee interview, E#2 indicated she/he had witnessed an event with the Director of Nursing and Resident B on 12/15/11. The DON placed Resident B at a dining room table and wedged a wheelchair behind the resident's chair to prevent the resident from standing or sliding back her chair. At one time the DON instructed the housekeeper to sit in the second wheelchair to make it more		Supervisor, Maintenance Director and Marketing Director. Please note that the Business Office Manager is on FMLA and will returning to the facility on February 7, 2012. The BOM will be in-serviced by Friday, February 10, 2012. The mandatory in-services for the Reflections Memory Care staff will be completed by February 3, 2012. With regards to new employees, a review of these policies is included in the new employee orientation program. With regards to ongoing monitoring, annual mandatory in-services covering these policies is required of all personnel. In conclusion, please note that the Nurse Manager who was involved in the abuse incident submitted her resignation on December 27, 2011with her last day of employment being January 10, 2012 which was accepted. The Nurse Manager was suspended on Friday, December 29, 2011 and did not work in the facility again. **Plan of Correction Addendum – January 20, 2012** All allegations and/or incidents of abuse, neglect or misappropriation of property are thoroughly and accurately investigated and are reported timely to the required agencies by the Executive Director, the Director of Memory Care and/or the Nurse Manager. A report summarizing all allegations	

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	secure and prevent the resident from getting up from the table. Throughout the meal, the DON put her hands on the residents shoulder(s) to prevent her from standing. During the entire meal, a wheelchair was wedged behind Resident B. . 4.) During a 12/21/11, 11:00 a.m., confidential employee interview E#3 indicated she/he had witnessed an event with the Director of Nursing and Resident B on 12/15/11. Following the meal, E#3 witnessed the DON and another employee forcefully lift and place a resisting Resident B in a recliner while the resident called out NO! and was asking to go to her room. After placing Resident B in the recliner, the DON tipped the recliner back and raised the footrest. Resident B attempted to exit the recliner and tipped it forward. 5.) During a 12/21/11, 11:10 a.m., confidential employee interview E#4 indicated she/he had witnessed an event with the Director of Nursing and Resident B on 12/15/11. The locks on the wheelchair wouldn't lock so the DON and another staff member transferred a screaming resisting Resident B to a another chair. Then the DON wedged the wheelchair behind the resident to prevent her from standing or pushing back her		and/or incidents of abuse, neglect or misappropriation of property and the results of all investigations will be submitted to the Quality Assurance Committee at every scheduled committee meeting and will become a standard agenda item. The monitoring process for this plan of correction will be ongoing through the Quality Assurance Committee. In addition, all allegations and/or incidents of abuse, neglect or misappropriation of property and the subsequent investigations will be reported to the Executive Director, the Director of Memory Care and/or the Nurse Manager in a timely manner, both the occurrence and the completed investigation.	

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	chair. The DON herself held the resident down in the chair and instructed 2 other employees press down on the resident's shoulders or hold her pant leg during the meal. The DON instructed the housekeeper to sit in the wheelchair behind the resident to keep the resident forced up close to the table and prevent her from standing. 6.) During a 12/21/11, 11:35 a.m., confidential employee interview E#6 indicated she/he had witnessed an event with the Director of Nursing and Resident B on 12/15/11. E#6 indicated this employee was instructed by the DON to sit in the wheelchair, which was behind the resident. E#6 was told to sit in the chair to prevent Resident B from standing or pushing her chair back. Resident B was distressed called out and trying to get away from the table. 7.) During a 12/21/11, 12:17 p.m., confidential employee interview E#14 indicated she/he had witnessed an event with the Director of Nursing and Resident B on 12/15/11. E#14 and the DON transferred a screaming resisting Resident B to another chair. The DON then wedged a wheelchair behind Resident B's chair to keep the resident from standing or sliding her chair back from the table. During the meal, Resident B was often			

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		A. BUILDING 00 B. WING	12/21/2011

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	held down in the chair, by the DON or people instructed by her to do so. The DON called the housekeeper over and told the house keeper to sit in the back wedged wheelchair to keep the resident from getting up. 8.) During an 12/21/11, 12:00 p.m., interview, the Memory Care Director indicated she had been the person who was assigned to investigate the allegation of abuse by the Director of Nursing to Resident B on 12/15/11. When queried, the Memory Care Director indicated Resident B had been restrained by wedging a wheelchair, holding the resident down and tipping a recliner back to prevent rising. She decanted this practice violated facility policy. 9.) Review of a current, undated, facility policy titled " Resident Rights", which was provided by the Memory Care Director on 12/21/11 at 9:15 a.m., included, but was not limited to, the following: "Residents have the right to be free from any physical or chemical restraint proposed for the purpose of discipline or convenience..." This State Residential tag related to complaint IN00101449.			

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R0052	(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. Based on interview and record review, the facility failed to ensure a resident was free of abuse, related to being physically forced to leave her room, held in a chair by a person and physical barrier, forced to eat a meal and physically forced to sit when she wanted to stand, for 1 of 3 residents reviewed for the prevention of abuse in a sample of 3 (Resident B). This deficient practice had the potential in impact 34 of 34 residents. Findings include: 1.) During an 12/21/11, 9:15 a.m., interview, the Memory Care Director indicated she had received a, 12/15/11, allegation of abuse by the Director of Nursing against Resident B. The Memory Care Director indicated the allegation involved forced care, wheeling a wheelchair with the wheelchair tipped extremely back, holding a resident in a chair and wheelchair, forcing a resident to leave her room, wedging a wheelchair behind a resident chair to prevent free movement, not allowing a resident to	R0052	Tag R0052Mandatory in-services will be conducted for all management staff and Reflections Memory Care staff. The information to be reviewed will include: · Residents' Rights Policy · Abuse Prevention Policy · Accident / Incident and Unusual Occurrence Policy · A review of the ISDH Forms for reporting. The Director of Memory Care will be responsible for presenting the mandatory in-services to both the management staff and the Reflections Memory Care staff. The mandatory management in-service was be held on January 12, 2012. The management personnel who are required to attend are: Executive Director, Director of Memory Care, Activities Director, Dietary Manager, Housekeeping Supervisor, Maintenance Director and Marketing Director. Please note that the Business Office Manager is on FMLA and will returning to the facility on February 7, 2012. The BOM will be in-serviced by Friday, February 10, 2012. The mandatory in-services for the Reflections Memory Care staff will be completed by February 3,	02/03/2012

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	return to her room, tipping back a recliner to prevent a resident from standing and forcing a resident who wanted to stand to sit. The allegation included the denial of the resident's right to refusing care and treatment when said services were not required to ensure resident safety or well-being. During this same interview, the Memory Care Director indicated the facility currently had 34 residents who all had a diagnoses or dementia or a related disorder. The facility was designated as a dementia unit. 2.) Resident B's record was reviewed on 12/21/11 at 10:45 a.m. Resident B's current diagnoses included, but were not limited to, dementia-Alzheimer's type, anxiety and macular degeneration. Resident #B had a current 12/17/11 Interdisciplinary Team Note which indicated the resident's weight was stable. Resident #B had a current 7/11 care plan with indicated she was able to ambulate independently. 3.) During a 12/21/11, 11:20 a.m., confidential employee interview, E#2		2012. With regards to new employees, a review of these policies is included in the new employee orientation program. With regards to ongoing monitoring, annual mandatory in-services covering these policies is required of all personnel. In conclusion, please note that the Nurse Manager who was involved in the abuse incident submitted her resignation on December 27, 2011with her last day of employment being January 10, 2012 which was accepted. The Nurse Manager was suspended on Friday, December 29, 2011 and did not work in the facility again. **Plan of Correction Addendum – January 20, 2012** All allegations and/or incidents of abuse, neglect or misappropriation of property are thoroughly and accurately investigated and are reported timely to the required agencies by the Executive Director, the Director of Memory Care and/or the Nurse Manager. A report summarizing all allegations and/or incidents of abuse, neglect or misappropriation of property and the results of all investigations will be submitted to the Quality Assurance Committee at every scheduled committee meeting and will become a standard agenda item. The monitoring process for this plan of correction will be ongoing through the Quality Assurance	

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	indicated she/he had witnessed an event with the Director of Nursing and Resident B on 12/15/11. E#2 believed, based on his/her facility training regarding abuse, the event was abuse. E#2 indicated the Director of Nursing wheeled a screaming Resident B down the hallway in a wheelchair which was extremely tipped back like a "wheely." E#2 indicated tipping the wheelchair was contrary to all training the employee had ever received. E#2 had been taught wheelchair tipping was a very unsafe practice. E#2 was greatly concerned that the person accompanying Resident B and tipping the chair was the Director of Nursing (DON). E#2 indicated Resident B screamed NO! NO! and attempted to get out of the wheelchair. The DON placed Resident B at a dining room table and wedged a wheelchair behind the resident's chair to prevent the resident from standing or sliding back her chair. At one time the DON instructed the housekeeper to sit in the second wheelchair to make it more secure and prevent the resident from getting up from the table. Throughout the meal, the DON put her hands on the resident's shoulder(s) to prevent her from standing. E#2 could not		Committee. In addition, all allegations and/or incidents of abuse, neglect or misappropriation of property and the subsequent investigations will be reported to the Executive Director, the Director of Memory Care and/or the Nurse Manager in a timely manner, both the occurrence and the completed investigation.	

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	tell if she was holding Resident B down, but it did not appear to be the case. The DON told Resident B if she would eat, the resident could go to her room. Resident B did eat some, but cried out, screamed "no" and asked to go to her room throughout the meal. During the entire meal, a wheelchair was wedged behind Resident B. When Resident B was done eating, the DON did not take the resident to her room as the resident kept asking, but instead took her to the living room. The DON and another staff member forced Resident B to sit in the recliner. Resident B screamed "no" and fought being transferred and was calling out to go to her room. Resident B fought the transfer to the recliner, "planted her feet," and screamed NO! NO! Resident B tried to get out of the recliner and flipped the recliner forward. E#2 did not know what all happened next, but Resident B did end up back in her room. E#2 felt the DON had not followed the facility behavior program. E#2 indicated Resident B should have been allowed to eat in her room. E#2 thought Resident B should have been able to refuse care and treatment as her resident right.			

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	4.) During a 12/21/11, 11:00 a.m., confidential employee interview, E#3 indicated she/he had witnessed an event with the Director of Nursing and Resident B on 12/15/11. E#3 believed, based on his/her facility training regarding abuse, the event was abuse. E#3 indicated Resident B had experienced distress during the events and had screamed NO! NO! and resisted the actions of the Director of Nursing. E#3 indicated her education, training and work history allowed the employee to identify Resident B was at risk for injury. E#3 witnessed the DON and another employee forcefully lift and place a resisting Resident B in a recliner while the resident called out NO! and asked to go to her room. After placing Resident B in the recliner, the DON tipped the recliner back, and raised the footrest. Resident B attempted to exit the recliner and tipped it forward. After removing Resident B from the tipped forward recliner, the DON and another staff member used physical strength and pressure to try to force Resident B to sit in a wheelchair. Resident B was standing firmly, locking her knees and refusing to sit. The DON applied pressure and tried to force the resident to sit. E#3 felt this action put			

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	Resident B at risk for injury. 5.) During a 12/21/11, 11:05 a.m., interview, PT #18 indicated after Resident B tipped the recliner forward, PT #18 asked if she could please assist Resident B to her room, because the resident was greatly distressed, standing firmly refusing to sit and asking repeatedly to go to her room. The Director of Nursing, after multiple requests, allowed the PT to walk Resident B to her room. The DON also walked with Resident B as the PT assisted the resident. PT #18 indicated as soon as being told she could go to her room, Resident B walked calmly to her room. Resident B entered her room and reclined calmly on her bed. PT #18 indicated Resident B walked calmly and safely enough as she went to her room that a 1 person assist was all that was needed. 6.) During a 12/21/11, 11:10 a.m., confidential employee interview, E#4 indicated she/he had witnessed an event with the Director of Nursing and Resident B on 12/15/11. E#4 believed, based on his/her facility training regarding abuse, the event was abuse. E#4 indicated the DON wheeled a screaming resisting Resident B down the hallway in a wheelchair which had the front wheels kicked up and the Resident leaning way			

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	back. After placing Resident B at the table, the locks on the wheelchair wouldn't lock. The DON and another staff member then transferred a screaming resisting Resident B to another chair. During the transfer, the resident resisted by making herself "dead weight." After placing the resident at the table, then the DON wedged a wheelchair behind the resident to prevent her from standing or pushing back her chair. The DON herself held the resident down in the chair and instructed two other employees press down on the resident's shoulders or hold her pant leg during the meal. At one point, the DON instructed the housekeeper to sit in the wheelchair behind the resident to keep the resident forced up close to the table and prevent her from standing. The DON left the area for about 10 minutes and left the housekeeper sitting behind Resident B to keep her in the chair. Resident B was not fed during the time the DON was gone from the area to complete another task. The DON came back and continued to tell the resident she must eat. The DON told the resident if she ate she could go back to her room. The resident refused and cried			

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	out saying NO! NO! NO! and asking to go to her room. The resident did eventually eat some. There were other residents in the area. The other residents appeared to be distressed and agitated as these events took place. 7.) During a 12/21/11, 11:35 a.m., confidential employee interview, E#6 indicated she/he had witnessed an event with the Director of Nursing and Resident B on 12/15/11. E#6 believed, based on his/her facility training regarding abuse, the event was abuse. E#6 indicated this employee was instructed by the DON to sit in the wheelchair, which was behind the resident. E#6 was told to sit in the chair to prevent Resident B from standing or pushing her chair back. Resident B was distressed called out and trying to get away from the table. The DON left the area and instructed E#6 sit in the wheelchair until she returned. The DON was away from the dining area about 10 minutes. No one fed Resident B during this time. The resident was distressed during the whole event. E#6 was uncomfortable with following the DON's instructions but didn't know what			

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	to do because she was the DON. When E#6 became concerned this was abuse, and E#6 informed the QMA who was the charge on second floor. 8.) During a 12/21/11, 12:17 p.m., confidential employee interview, E#14 indicated she/he had witnessed an event with the Director of Nursing and Resident B on 12/15/11. E#14 believed, based on his/her facility training regarding abuse, the event was abuse. E#14 indicated she witnessed and followed instructions to assist the DON during the event. E#14 indicated the action and instructions of the DON troubled E#14, and E#14 should have told the DON that the practices were wrong and stopped the event. E#14 indicated when the event and instructions come from the DON, an employee can be in conflict and shock and just go along even as the employee was feeling troubled inside. E#14 indicated this would not happen in the future regardless of who gave the instructions. E#14 indicated the DON had wheeled and screaming, resisting, Resident B down the hallway in a wheelchair which was tipped back on two wheels. Resident B screamed NO, NO!			

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	Under the DON's instruction, E#14 and the DON transferred a screaming resisting Resident B to another chair. The DON then wedged a wheelchair behind Resident B's chair to keep the resident from standing or sliding her chair back from the table. During the meal, Resident B was often held down in the chair, by the DON or people instructed by her to do so. At one point, the DON called the housekeeper over and told the housekeeper to sit in the back wedged wheelchair to keep the resident from getting up. The DON left the area for about 10 minutes. Resident B was not fed during this time but was forced to sit in her chair with the housekeeper sitting behind her. Other residents were in the area. "I felt sorry for them." "They were uncomfortable with all that was happening." "I felt forced to follow orders because they were given by the DON." 9.) A 12/21/11, 9:45 a.m., review of witness statements by E#2, E#3, E#4, PT#18, and E#14, which were provided by the Director of Memory Care, indicated all interviews were consistent with witness written statements.			

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	10.) During an 12/21/11, 12:00 p.m., interview, the Memory Care Director indicated she had been the person who was assigned to investigate the allegation of abuse by the Director of Nursing to Resident B on 12/15/11. The Memory Care Director indicated she had completed the investigation and determined abuse had occurred. When queried, she indicated her conclusion was based on facility policy, witness statements and the indication of unreasonable confinement, intimidation and resident mental anguish. When questioned, the Memory Care Director indicated she reported her findings to the Administrator. 11.) Review of a current, 9/2011, facility policy titled "Abuse Prevention Policy", which was provided by the Memory Care Director on 12/21/11 at 9:15 a.m., included, but was not limited to, the following: "...Reflections Memory Care at Kokomo will comply with state regulations for reporting suspected or actual acts." "Definitions: Abuse-Means the willful infliction of injury, unreasonable confinement, intimidation of punishment with resulting physical harm, pain or			

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	mental anguish..." "Willful-An intentional act (in contrast to an accidental or involuntary act) done by one who is or should be aware of the act's consequences." This State Residential tag related to complaint IN00101449.			
R0086	The licensee: (1) is responsible for compliance with all applicable laws; and (2) has full authority and responsibility for the: (A) organization; (B) management; (C) operation; and (D) control; of the licensed facility. The delegation of any authority by the licensee does not diminish the responsibilities of the licensee. Based on interview and record review, the facility failed to manage the operations of the facility in a manner to prevent abuse, identify abuse, ensure resident safety by suspending an employee during an abuse investigation, ensure a resident was permitted to exercise her rights to refuse treatment or services, ensure employee criminal screening upon hire and the implementation of facility policies regarding resident rights and abuse for 1 of 3 residents reviewed to ensure the facility managed it's operation to prevent	R0086	Tag R0086Mandatory in-services will be conducted for all management staff and Reflections Memory Care staff. The information to be reviewed will include: · Residents' Rights Policy · Abuse Prevention Policy · Accident / Incident and Unusual Occurrence Policy · A review of the ISDH Forms for reporting. The Director of Memory Care will be responsible for presenting the mandatory in-services to both the management staff and the Reflections Memory Care staff. The mandatory management in-service was be held on January	02/03/2012

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	abuse and the exercise of rights (Resident B). This deficient practice has the potential to impact 34 of 34 residents. Findings include: 1.) During an 12/21/11, 9:15 a.m., interview, the Memory Care Director indicated she had received a, 12/15/11, allegation of abuse by the Director of Nursing against Resident B. The Memory Care Director indicated the allegation involved forced care, wheeling a wheelchair with the wheelchair tipped extremely back, holding a resident in a chair and wheelchair, forcing a resident to leave her room, wedging a wheelchair behind a resident chair to prevent free movement, not allowing a resident to return to her room, tipping back a recliner to prevent a resident from standing and forcing a resident who wanted to stand to sit. The allegation included the denial of the resident's right to refusing care and treatment when said services were not required to ensure resident safety or well being. During an 12/21/11, 12:00 p.m., interview, the Memory Care Director indicated she had been the person who was assigned to investigate the allegation of abuse by the Director of Nursing to Resident B on 12/15/11. When queried,		12, 2012. The management personnel who are required to attend are: Executive Director, Director of Memory Care, Activities Director, Dietary Manager, Housekeeping Supervisor, Maintenance Director and Marketing Director. Please note that the Business Office Manager is on FMLA and will returning to the facility on February 7, 2012. The BOM will be in-serviced by Friday, February 10, 2012. The mandatory in-services for the Reflections Memory Care staff will be completed by February 3, 2012. With regards to new employees, a review of these policies is included in the new employee orientation program. With regards to ongoing monitoring, annual mandatory in-services covering these policies is required of all personnel. In conclusion, please note that the Nurse Manager who was involved in the abuse incident submitted her resignation on December 27, 2011with her last day of employment being January 10, 2012 which was accepted. The Nurse Manager was suspended on Friday, December 29, 2011 and did not work in the facility again. In addition, we will follow the timeframes identified in our facility policy with regards to obtaining Limited Criminal History Checks. Our monitoring process will be ongoing as we are	

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		A. BUILDING 00 B. WING	12/21/2011

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	the Memory Care Director indicated she had recommended to the Administrator that the Director of Nursing be suspending pending the outcome of the investigation. She indicated the Administrator did not feel the suspension was necessary. The Memory Care Director indicated she had completed the investigation and determined abuse had occurred. When queried, she indicated her conclusion was based on facility policy, witness statement and the indication of unreasonable confinement, intimidation and resident mental anguish. When queried, the Memory Care Director indicated she reported her findings to the Administrator. She indicated the Administrator had disagreed with her findings, and he believed the actions by the Director of Nursing were a failure to follow policy. The Memory Care Director indicated the Director of Nursing was not working on 12/21/11 due to a requested personal leave by the employee. However, the Director of Nursing had worked 12/15/11, 12/17/11, and 12/19/11. She additionally indicated the Director of Nursing was scheduled to return from her requested leave on Friday, she believed. 2.) During a 12/21/11, 11:20 a.m., confidential employee interview, E#2		required to obtain a Limited Criminal History Check on all employees.**Plan of Correction Addendum – January 20, 2012** All allegations and/or incidents of abuse, neglect or misappropriation of property are thoroughly and accurately investigated and are reported timely to the required agencies by the Executive Director, the Director of Memory Care and/or the Nurse Manager. A report summarizing all allegations and/or incidents of abuse, neglect or misappropriation of property and the results of all investigations will be submitted to the Quality Assurance Committee at every scheduled committee meeting and will become a standard agenda item. The monitoring process for this plan of correction will be ongoing through the Quality Assurance Committee. In addition, all allegations and/or incidents of abuse, neglect or misappropriation of property and the subsequent investigations will be reported to the Executive Director, the Director of Memory Care and/or the Nurse Manager in a timely manner, both the occurrence and the completed investigation.	

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	indicated she/he had witnessed an event with the Director of Nursing and Resident B on 12/15/11. E#2 believed, based on his/her facility training regarding abuse, the event was abuse. E#2 indicated Resident B had experienced distress during the events and had screamed NO! NO! and resisted the actions of the Director of Nursing. E#2 indicated he/she had given a written statement of the event to the Memory Care Director as part of an investigation. 3.) During a 12/21/11, 11:00 a.m., confidential employee interview E#3 indicated she/he had witnessed an event with the Director of Nursing and Resident B on 12/15/11. E#3 believed, based on his/her facility training regarding abuse, the event was abuse. E#3 indicated Resident B had experienced distress during the events and had screamed NO! NO! and resisted the actions of the Director of Nursing. E#3 indicated he/she had given a written statement of the event to the Memory Care Director as part of an investigation. 4.) During a 12/21/11, 11:10 a.m., confidential employee interview E#4 indicated she/he had witnessed an event with the Director of Nursing and Resident B on 12/15/11. E#4 believed, based on his/her facility training regarding abuse,			

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	the event was abuse. E#4 indicated Resident B had experienced distress during the events and had screamed NO! NO! and resisted the actions of the Director of Nursing. E#4 indicated he/she had given a written statement of the event to the Memory Care Director as part of an investigation. 5.) During a 12/21/11, 11:35 a.m., confidential employee interview E#6 indicated she/he had witnessed an event with the Director of Nursing and Resident B on 12/15/11. E#6 believed, based on his/her facility training regarding abuse, the event was abuse. E#6 indicated Resident B had experienced distress during the events and had screamed NO! NO! and resisted the actions of the Director of Nursing. E#6 indicated he/she had given a written statement of the event to the Memory Care Director as part of an investigation. 6.) During a 12/21/11, 12:17 p.m., confidential employee interview E#14 indicated she/he had witnessed an event with the Director of Nursing and Resident B on 12/15/11. E#14 believed, based on his/her facility training regarding abuse, the event was abuse. E#14 indicated Resident B had experienced distress during the events and had screamed NO! NO! and resisted the actions of the			

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	Director of Nursing. E#14 indicated he/she had given a written statement of the event to the Memory Care Director as part of an investigation. 7.) During a 12/21/11, 12:50 p.m., interview, the Administrator reviewed the facility "Abuse Prevention Policy" and indicated his personal interpretation of the word "willful" was the perpetrator of any allegation of abuse must do an action for the "purpose of harming the resident." After reading the facility policy definition of abuse and "willful", the Administrator again indicated his personal interpretation differed from facility policy. He indicated based on his personal interpretation, the 12/15/11 allegation of abuse by the Director of Nursing was not abuse. He additional indicated, he did not report the 12/15/11, allegation of abuse to Resident B by the Director of Nursing to the Indiana State Department of Health (ISDH) as an allegation of abuse, because he did not believe the event to have been abuse. When queried if abuse had been alleged, he indicated yes. When queried if all allegations of abuse whether substantiated or unsubstantiated must be reported to the state department of health, he indicated he believed all allegations must be reported. When queried why the 12/15/11, allegation of abuse to Resident			

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	B had not been reported as an allegation of abuse to the ISDH, the Administrator again indicated it was not reported as abuse because he did not believe abuse had occurred. When queried if there was a conflict with his statement that all allegations must be reported to ISDH and his failure to report the 12/15/11 allegation, he indicated perhaps he had been an error. When queried if he personally had completed the investigation of the 12/15/11, allegation of abuse to Resident B by the Director of Nursing or assigned to task to a designee, he indicated he had delegated the investigation to the Memory Care Director. He additionally indicated the Memory Care Director had determined abuse had occurred. He then indicated he had disagreed with the investigation based on his personal interpretation of "willful" and had determined the event was a failure to implement the resident re-direction policy by the Director of Nursing. When questioned if the Director of Nursing had been suspended pending the outcome of the 12/15/11, allegation of abuse, in accordance with facility policy, The Administrator indicated he had not suspended the Director of Nursing because he did not believe the event to be			

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	abuse. When queried if the Memory Care Director had recommended the suspension of the Director of Nursing pending the investigation of the Abuse allegation, he indicated he did not remember this suggestion being made. When questioned if the facility policy was to suspend employees pending the outcome of the investigation, he indicated he was unsure but believed suspension to be the policy. 8.) Review of employee records on 12/21/11 at 4:00 p.m., indicated E#15, E#16 and E#17 all hired 12/16/11 did not have an employee criminal history check completed. During a 12/21/11, 4:45 p.m., interview, the Memory Care Director indicated an error had occurred resulting in E#15, E#16 and E#17's criminal history check not being completed within three days of hire. 9.) Review of a current, 9/2011, facility policy titled "Abuse Prevention Policy", which was provided by the Memory Care Director on 12/21/11 at 9:15 a.m., included, but was not limited to, the following: "...Reflections Memory Care at Kokomo will comply with state regulations for			

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	reporting suspected or actual acts." "Definitions: Abuse-Means the willful infliction of injury, unreasonable confinement, intimidation of punishment with resulting physical harm, pain or mental anguish..." "Willful-An intentional act (in contrast to an accidental or involuntary act) done by one who is or should be aware of the act's consequences." "A request shall be submitted within three (3) days of employment for an Adult Criminal History Information." "The Nurse Manager and nursing personnel are responsible for initiating interventions to protect residents from any further abusive acts while any reported incidents are being investigated. Measures may include but not be limited to:...staff suspension..." This State Residential tag related to complaint IN00101449.			

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R0090	(g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a			

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	notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request Based on interview and record review, the facility failed to ensure an allegation of abuse was reported to the Indiana State Department of Health for 1 of 1 resident reviewed for promptly reporting abuse in a sample of 3 (Resident B). Findings include: 1.) During an 12/21/11, 9:15 a.m., interview, the Memory Care Director indicated she had received a 12/15/11, allegation of abuse by the Director of Nursing against Resident B. The Memory Care Director indicated the allegation involved forced care, wheeling a wheelchair with the wheelchair tipped extremely back, holding a resident in a chair and wheelchair, forcing a resident to leave her room, wedging a wheelchair behind a resident chair to prevent free movement, not allowing a resident to return to her room, tipping back a recliner to prevent a resident from standing and forcing a resident who wanted to stand to sit. The allegation included the denial of the resident's right to refusing care and treatment when said services were not required to ensure resident safety or well	R0090	Tag R0090Mandatory in-services will be conducted for all management staff and Reflections Memory Care staff. The information to be reviewed will include: · Accident / Incident and Unusual Occurrence Policy · A review of the ISDH Forms for reporting. The Director of Memory Care will be responsible for presenting the mandatory in-services to both the management staff and the Reflections Memory Care staff. The mandatory management in-service was be held on January 12, 2012. The management personnel who are required to attend are: Executive Director, Director of Memory Care, Activities Director, Dietary Manager, Housekeeping Supervisor, Maintenance Director and Marketing Director. Please note that the Business Office Manager is on FMLA and will returning to the facility on February 7, 2012. The BOM will be in-serviced by Friday, February 10, 2012. The mandatory in-services for the Reflections Memory Care staff will be completed by February 3, 2012. With regards to new employees, a review of these policies is included in the new	02/03/2012

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	being. 2.) During a 12/21/11, 12:50 p.m., interview, the Administrator indicated, he did not report the 12/15/11, allegation of abuse to Resident B by the Director of Nursing to the Indiana State Department of Health (ISDH) as an allegation of abuse because he did not believe the event to have been abuse. When queried if abuse had been alleged, he indicated yes. When queried if all allegations of abuse whether substantiated or unsubstantiated must be reported to the state department of health, he indicated he believed all allegations must be reported. When queried why the, 12/15/11, allegation of abuse to Resident B had not been reported as an allegation of abuse to the ISDH, the Administrator again indicated it was not reported as abuse because he did not believe abuse had occurred. When queried if there was a conflict with his statement that all allegations must be reported to ISDH and his failure to report the 12/15/11 allegation, he indicated perhaps he had been an error. 3.) Review of a current, 9/2011, facility policy titled "Abuse Prevention Policy", which was provided by the Memory Care Director on 12/21/11 at 9:15 a.m., included, but was not limited to, the following:		employee orientation program. With regards to ongoing monitoring, annual mandatory in-services covering these policies is required of all personnel. In conclusion, please note that the Nurse Manager who was involved in the abuse incident submitted her resignation on December 27, 2011with her last day of employment being January 10, 2012 which was accepted. The Nurse Manager was suspended on Friday, December 29, 2011 and did not work in the facility again. **Plan of Correction Addendum – January 20, 2012** All allegations and/or incidents of abuse, neglect or misappropriation of property are thoroughly and accurately investigated and are reported timely to the required agencies by the Executive Director, the Director of Memory Care and/or the Nurse Manager. A report summarizing all allegations and/or incidents of abuse, neglect or misappropriation of property and the results of all investigations will be submitted to the Quality Assurance Committee at every scheduled committee meeting and will become a standard agenda item. The monitoring process for this plan of correction will be ongoing through the Quality Assurance Committee. In addition, all allegations and/or incidents of abuse, neglect or	

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	"...Reflections Memory Care at Kokomo will comply with state regulations for reporting suspected or actual acts."		misappropriation of property and the subsequent investigations will be reported to the Executive Director, the Director of Memory Care and/or the Nurse Manager in a timely manner, both the occurrence and the completed investigation.	
R0116	(a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. Based on interview and record review, the facility failed to complete criminal history screening of new employees for 3 of 5 employees reviewed for pre-employment screening (E#15, E#16 and E#17). This deficient practice had the potential to impact 34 of 34 residents. Findings include: Review of employee records on 12/21/11 at 4:00 p.m., indicated E#15, E#16 and E#17 all hired 12/16/11 did not have an employee criminal history check completed. During a 12/21/11, 4:45 p.m., interview, the Memory Care Director indicated an error had occurred resulting in E#15, E#16 and E#17's criminal history check not being completed within three days of	R0116	Tag R 0116We will follow the timeframes identified in our facility policy with regards to obtaining Limited Criminal History Checks. Our monitoring process will be ongoing as we are required to obtain a Limited Criminal History Check on all employees. **Plan of Correction Addendum – January 20, 2012** All allegations and/or incidents of abuse, neglect or misappropriation of property are thoroughly and accurately investigated and are reported timely to the required agencies by the Executive Director, the Director of Memory Care and/or the Nurse Manager. A report summarizing all allegations and/or incidents of abuse, neglect or misappropriation of property and the results of all investigations will be submitted to the Quality Assurance Committee at every scheduled committee meeting and will become a standard agenda item. The	02/03/2012

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	hire. Review of a current, 9/2011, facility policy titled "Abuse Prevention Policy", which was provided by the Memory Care Director on 12/21/11 at 9:15 a.m., included, but was not limited to, the following: "A request shall be submitted within three (3) days of employment for an Adult Criminal History Information."		monitoring process for this plan of correction will be ongoing through the Quality Assurance Committee. In addition, all allegations and/or incidents of abuse, neglect or misappropriation of property and the subsequent investigations will be reported to the Executive Director, the Director of Memory Care and/or the Nurse Manager in a timely manner, both the occurrence and the completed investigation.	