STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155760	A. BUILDING 00 B. WING	02/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD CROSSING	1332 WATERFORD CIR GOSHEN, IN 46526

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00398501. Complaint IN00398501 - Substantiated. Federal/State deficiencies related to the allegations are cited at F550, F609, and F610. Survey dates: 2/22/23 Facility number: 011150 Provider number: 155760 AIM number: 200831020 Census Bed Type: SNF/NF: 65 SNF: 43 NF: 22 Total: 130 Census Payor Type: Medicare: 18 Medicaid: 22 Other: 90 Total: 130 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed 3/1/23.	F 0000	/p>	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility,			

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

Cassie Dunlap 03/10/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on record review and interview, the facility failed to protect a residents' right to participate in a religious activity in the privacy of their own room, (Resident B).	F 0550	1-What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice	03/10/2023

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	Findings include: On 2/22/23 at 10:30 A.M., the Executive Director (ED) provided an email communication dated 11/30/22 at 11:34 A.M., and indicated it was received from Resident B's family member and Emergency Contact 2. The email indicated, on 11/20/22 at approximately 4:00 P.M., the family member and a family friend were visiting Resident B in his room and, "...[family friend] began praying for [Resident B]...in an elevated tone. After some time [Registered Nurse (RN) 2] came back in and said that [family friend] was being too loud and she needed to quiet down as she could be heard out to the nurse's station (the door was closed). I again closed the door and [family friend] got quieter. A couple minutes later, [RN 2] was at the door again. She said that we had to leave as religious ceremonies were not allowed in the rooms..." On 2/22/23 at 10:13: A.M., the clinical record for Resident B was reviewed. Resident B was admitted on 10/26/22 with diagnoses that included but were not limited to, metabolic encephalopathy, pneumonitis, sepsis, bipolar disorder, and dementia. The most recent Minimum Data Set (MDS) dated 10/12/22, was an admission assessment that indicated Resident B had minimal difficulty in hearing and utilized hearing aids, was usually able to understand others, had moderate cognitive impairment, frequently felt depressed and hopeless. The resident demonstrated behaviors of rejection of care on 1-3 days in the previous 7 day look back period. The staff assessment of daily activity preferences indicated Resident B preferred to have family or significant other		Resident B no longer resides at the facility and had necessary care provided while in the care of the facility. Resident B experienced no negative outcomes related to this alleged deficient practice. 2-How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. All residents had the potential to be affected. A copy of resident rights was distributed to all residents on Health Center. 3-What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; The Director of health services (DHS) or designee will complete in-services with nursing staff on resident rights. SSD and/or designee will interview 3 residents to ensure the facility is honoring their resident rights 3x's a week for 4 weeks, then weekly for 4 weeks, then monthly for 3 months. 4-How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; As a quality measure, the DHS or designee will review any findings and corrective action at least	

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	involved in his care discussions. Resident B's care plans included but were not limited to Activities, dated 10/13/22. The care plan indicated, "While in this campus, it is important that I have the opportunity to engage in activities and opportunities that are meaningful to me. My interests include reading, music, and church...My faith is important to me, and it is important that I continue to engage in religious services or practices..." 2/22/23 at 9:45 A.M., during an interview with the Executive Director, she indicated on 11/20/22 RN 2 heard loud noises in Resident B's room and was concerned. The Executive Director indicated RN 2 went to the residents room and a family friend and the resident's son were praying the demons out of the resident and became concerned because the resident was not able to give his consent to what was going on because he had a diagnosis of dementia. The Executive Director indicated Resident B did not have a roommate at the time. On 2/22/23 at 10:30 A.M., during an interview conducted with RN 2, the RN indicated she had gone to Resident B's room to administer care and the resident's son was at the bedside. Upon RN 2's entry, the family friend also came to the bedside. RN 2 indicated when she completed care and exited the room, she could hear the family friend's raised voice from the Nurse's station so returned to the room, knocked on the closed door and, "...said I could still hear her at the nurses station and we could not have that here...she continued being loud after I left the room so I went back to the room and heard her say, 'I rebuke you.' [Resident B's] hands were raised and he was getting upset and I said [the		quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.	

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	son and family friend] had to leave the facility... [Resident B's] Bible was on his chest...I told them to take it off his chest..." RN 2 indicated the resident was not asking for help or telling the family friend to stop praying, but that she felt the resident was agitated. RN 2 indicated Resident B's son was not happy with her when she had them leave. RN 2 indicated no other residents complained about the noise level in Resident B's room. RN 2 indicated Resident B was not wearing his hearing aids that evening. RN 2 indicated she did not document the events of the evening, her concerns, the resident's reactions, and she did not report the incident because,"...I thought I nipped it in the bud." On 2/22/23 at 10:30 A.M., the Executive Director provided a policy titled, Resident Rights Guidelines, with an effective date of 11/21 with a revised date of 5/11/17 and indicated it was the current facility policy. The policy indicated,"...Residents shall not leave their individual personalities or basic human rights behind when they move to a health campus...Our residents have the right to...Exercise choice in attending and participating in activities, including religious services..." This Federal tag related to complaint IN00398501. 3.1- 3(m)			
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect,			

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	exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to assure that an allegation of abuse was reported to the State Survey Agency (SSA) for 1 of 3 residents reviewed for abuse (Resident B). Findings include: On 2/22/23 at 10:30 A.M., the Executive Director (ED) provided an email communication dated 11/30/22 at 11:34 A.M., and indicated it was received from Resident B's family member and Emergency Contact 2. The email indicated, on 11/20/22 at approximately 4:00 P.M., the family member and a family friend were visiting Resident B in his room and, "...[family friend] began praying	F 0609	1-What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Resident B no longer resides at the facility and had necessary care provided while in the care of the facility. Resident B experienced no negative outcomes related to this alleged deficient practice. 2-How other residents having the potential to be affected by the same deficient practice will be	03/10/2023

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	for [Resident B]. She was still holding hands with him as he did not let go of her hands. [Family friend] was praying in an elevated tone. After some time [Registered Nurse (RN) 2] came back in and said that [family friend] was being too loud and she needed to quiet down as she could be heard out to the nurse's station (the door was closed). I again closed the door and [family friend] got quieter. A couple minutes later, [RN 2] was at the door again. She said that we had to leave as religious ceremonies were not allowed in the rooms. She said, 'What you are doing is abuse.'..As [family friend tried to leave and let go of [Resident B's] hands go, he held on to her hands and [RN 2] had to separate herself from his hands... As we were walking out, she said, 'This is inappropriate.' I asked her, 'what is inappropriate?' 'what you are doing is abusive, struggling with a patient,' she said..." On 2/22/23 at 10:13: A.M., the clinical record for Resident B was reviewed. Resident B was admitted on 10/26/22 with diagnoses that included but were not limited to, metabolic encephalopathy, pneumonitis, sepsis, bipolar disorder, and dementia. The most recent Minimum Data Set (MDS) dated 10/12/22, was an admission assessment that indicated Resident B had moderate cognitive impairment, frequently felt depressed and hopeless. The resident demonstrated behaviors of rejection of care on 1-3 days in the previous 7 day look back period. 2/22/23 at 9:45 A.M., during an interview with the Executive Director, she indicated on 11/20/22 RN 2 heard loud noises in Resident B's room and was concerned. The Executive Director indicated RN 2 went to the residents room and a family friend and		identified and what corrective action(s) will be taken. All residents had the potential to be affected. Inservice's were completed regarding types of abuse and reporting procedures. 3-What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; DHS or designee will continue education on types of abuse and reporting procedures 3x's a week at huddles for 4 weeks, then weekly for 4 weeks, then monthly for 3 months. 4-How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.	

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	the resident's son were praying the demons out of the resident and became concerned because the resident was not able to give his consent to what was going on because he had a diagnosis of dementia. On 2/22/23 at 10:30 A.M., during an interview conducted with RN 2, the RN indicated she had gone to Resident B's room to administer care and the resident's son was at the bedside. Upon RN 2's entry, the family friend also came to the bedside. RN 2 indicated when she completed care and exited the room, she could hear the family friend's raised voice from the Nurse's station so returned to the room, knocked on the closed door and, "...said I could still hear her at the nurses station and we could not have that here...she continued being loud after I left the room so I went back to the room and heard her say, 'I rebuke you.' [Resident B's] hands were raised and he was getting upset and I said [the son and family friend] had to leave the facility...RN 2 indicated the resident was not asking for help or telling the family friend to stop praying, but that she felt the resident was agitated. RN 2 indicated Resident B's son was not happy with her when she had them leave. RN 2 indicated she did not document the events of the evening, her concerns, the resident's reactions, and she did not report the incident because,"...I thought I nipped it in the bud." 2/22/23 at 12:37 P.M. during a second interview with the Executive Director, she indicated she did not believe the email received from Resident B's family member was an allegation of abuse and did not initiate an investigation in response to the email and did not report the allegation of abuse to the State Agency.			

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	On 2/22/23 at 3:15 P.M., the Executive Director provided a policy titled, Abuse and Neglect Procedural Guidelines, with an effective date of 8/29/19 with a revised date of 8/29/19 and indicated it was the current facility policy. The policy indicated,"...The Executive Director and Director of Health Services are responsible for the implementation and ongoing monitoring of abuse standards and procedures...Mental/Emotional Abuse-Mental abuse is the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience...agitation...Investigation...the Executive Director is accountable for investigating and reporting...Ensure that all alleged violations involving abuse...are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse...to the administrator of the facility and to other officials (including to the State Survey Agency...in accordance with State law through established procedures...." This Federal tag related to complaint IN00398501. 3.1- 28(c)			
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.			

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	§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to ensure a thorough investigation was completed for an allegation of abuse for 1 of 3 residents reviewed for abuse, (Resident B). Findings include: On 2/22/23 at 10:30 A.M., the Executive Director (ED) provided an email communication dated 11/30/22 at 11:34 A.M., and indicated it was received from Resident B's family member and Emergency Contact 2. The email indicated, on 11/20/22 at approximately 4:00 P.M., the family member and a family friend were visiting Resident B in his room and, "...[family friend] began praying for [Resident B]. She was still holding hands with him as he did not let go of her hands. [Family friend] was praying in an elevated tone. After some time [Registered Nurse (RN) 2] came back in and said that [family friend] was being too loud and she needed to quiet down as she could be heard out to the nurse's station (the door was closed). I again closed the door and [family friend] got quieter. A couple minutes later, [RN 2] was at the door again. She said that we had to leave as religious ceremonies were not allowed in the rooms. She said, 'What you are doing is abuse.'..As [family friend tried to leave and let go of [Resident B's] hands go, he held on to her hands and [RN 2] had to separate herself from his hands... As we were walking out, she said, 'This is inappropriate.' I asked her, 'what is inappropriate?'	F 0610	1-What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Resident B no longer resides at the facility and had necessary care provided while in the care of the facility. Resident B experienced no negative outcomes related to this alleged deficient practice. 2-How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. All residents had the potential to be affected. Inservice's were completed regarding reporting procedures and investigations. 3-What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; ED and/or designee will continue education on types of abuse and reporting procedures with timely reporting 3x's a week at huddles for 4 weeks, then weekly for 4 weeks, then monthly for 3	03/10/2023

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	'what you are doing is abusive, struggling with a patient,' she said..." On 2/22/23 at 10:13: A.M., the clinical record for Resident B was reviewed. Resident B was admitted on 10/26/22 with diagnoses that included but were not limited to, metabolic encephalopathy, pneumonitis, sepsis, bipolar disorder, and dementia. The most recent Minimum Data Set (MDS) dated 10/12/22, was an admission assessment that indicated Resident B had minimal difficulty in hearing and utilized hearing aids, was usually able to understand others, had moderate cognitive impairment, frequently felt depressed and hopeless. The resident demonstrated behaviors of rejection of care on 1-3 days in the previous 7 day look back period. The staff assessment of daily activity preferences indicated Resident B preferred to have family or significant other involved in his care discussions. Resident B's care plans included but were not limited to Activities, dated 10/13/22. The care plan indicated, "While in this campus, it is important that I have the opportunity to engage in activities and opportunities that are meaningful to me. My interests include reading, music, and church...My faith is important to me, and it is important that I continue to engage in religious services or practices..." 2/22/23 at 9:45 A.M., during an interview with the Executive Director, she indicated on 11/20/22 RN 2 heard loud noises in Resident B's room and was concerned. The Executive Director indicated RN 2 went to the residents room and a family friend and the resident's son were praying the demons out of the resident and became concerned because the		months. Audits will 4-How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.	

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	resident was not able to give his consent to what was going on because he had a diagnosis of dementia. The Executive Director indicated Resident B did not have a roommate at the time. On 2/22/23 at 10:30 A.M., during an interview conducted with RN 2, the RN indicated she had gone to Resident B's room to administer care and the resident's son was at the bedside. Upon RN 2's entry, the family friend also came to the bedside. RN 2 indicated when she completed care and exited the room, she could hear the family friend's raised voice from the Nurse's station so returned to the room, knocked on the closed door and, "...said I could still hear her at the nurses station and we could not have that here...she continued being loud after I left the room so I went back to the room and heard her say, 'I rebuke you.' [Resident B's] hands were raised and he was getting upset and I said [the son and family friend] had to leave the facility...RN 2 indicated the resident was not asking for help or telling the family friend to stop praying, but that she felt the resident was agitated. RN 2 indicated Resident B's son was not happy with her when she had them leave. RN 2 indicated she did not document the events of the evening, her concerns, the resident's reactions, and she did not report the incident because,"...I thought I nipped it in the bud." 2/22/23 at 12:37 P.M. during a second interview with the Executive Director, she indicated she did not believe the email received from Resident B's family member was an allegation of abuse and did not initiate an investigation in response to the email. On 2/22/23 at 3:15 P.M., the Executive Director			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155760	A. BUILDING 00 B. WING	02/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD CROSSING	1332 WATERFORD CIR GOSHEN, IN 46526

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	provided a policy titled, Abuse and Neglect Procedural Guidelines, with an effective date of 8/29/19 with a revised date of 8/29/19 and indicated it was the current facility policy. The policy indicated,"...The Executive Director and Director of Health Services are responsible for the implementation and ongoing monitoring of abuse standards and procedures...Mental/Emotional Abuse-Mental abuse is the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience...agitation...Investigation...the Executive Director is accountable for investigating and reporting...Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations...Focusing the investigation on determining if abuse...has occurred, the extent, and cause..." This Federal tag related to complaint IN00398501. 3.1- 28(d)			