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	10/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOW LAKE PLACE	2725 LAKE CIRCLE DR INDIANAPOLIS, IN 46268

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00392795. Complaint IN00392795 - Substantiated. State deficiencies related to the allegations are cited at R0052. Survey date: October 31, 2022 Facility number: 010234 Residential Census: 21 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on November 3, 2022.	R 0000		
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on observation, interview and record review, the facility failed to ensure a resident was free from neglect when the resident was found on the floor, in his room, and left to lay on the floor for approximately two (2) hours until assistance arrived via 911, to transfer him off the floor, for 1 of 4 residents reviewed for neglect. (Resident B) Finding includes:	R 0052	*Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other*	11/17/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jill Smith	Administrator	11/16/2022

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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	During an observation, on 10/31/22 at 9:33 a.m., Resident B was found resting in a low bed, eyes closed. There was a fall mat on the floor next to the bed. The resident appeared to be clean and dry. A full body mechanical lift was in the room. During an observation, on 10/31/22 at 10:38 a.m., Resident B was found resting in a low bed. The resident responded to his name. He was unable to recall the events related to his fall. A facility incident report indicated, on 10/15/22, Resident B was found on the floor in his apartment. The record for Resident B was reviewed on 10/31/22 at 11:20 a.m. Diagnosis included, but were not limited to, encephalopathy (any diffuse disease of the brain which alters brain function or structure), stroke and falls. A nursing note, dated 10/15/22, no time charted, indicated the resident placed himself on the floor and no injuries were noted at the time. The resident indicated he was looking for his pants at the time of placement. The resident was placed back into bed with assistance. There were no complaints of pain or discomfort and he would be monitored. During a telephone interview, on 10/31/22 at 12:47 p.m., QMA 1 indicated when Resident B fell, CNA 2 informed her of fall and she (QMA 1) did check the resident's vital signs and his body. She asked CNA 2 to help get the resident up and was told no. She asked CNA 3 to assist with the transfer and was again told no. She then remained with the resident until the fire department arrived, but was unable to say how long it took for the fire		*individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.* **R 052 410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights – Offense** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident B was evaluated by nursing on 10/19/2022 to ensure no injury had occurred. No abnormal findings identified during the assessment. QMA 1 was placed on administrative leave on 10/19/2022 and no longer provides services to the community. Current staff were re-educated on 10/20/2022 by the Executive Director (ED) regarding reporting of abuse, fall response, abuse and neglect, resident rights, lifting and transferring, and mechanical lift operation (Attachment 1). **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and**	

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	department to respond. During a telephone interview, on 10/31/22 at 12:49 p.m., CNA 5 indicated CNA 2 came to the Memory Care Unit and informed her of the resident's fall and she was not able to locate QMA 1. CNA 5 was not able to leave the unit to assist as the residents on the unit could not be left alone. During a telephone interview, on 10/31/22 at 4:01 p.m., CNA 2 indicated she was working with CNA 3 on the unit, but she was also assisting on the Memory Care Unit. She informed QMA 1 and CNA 3, Resident B was trying to get out of bed. At 4:30 p.m., she finished assisting residents to the dining room and went to check on Resident B. She found the resident on the floor. CNA 2 indicated she went to find help but was unable to locate QMA 1 or CNA 3. She did find QMA 1 about 30 minutes later and informed her of resident fall. QMA 1 went to the resident's room, but would not assist to get the resident off of the floor because she did not want to hurt her back. The QMA indicated she was going to call 911 and left the room and closed the door. The QMA did return but only to give the resident medicine and left again. CNA 2 indicated she did call an off duty nurse, and the nurse informed her QMA 1 had called her about the fall and she informed the QMA to call 911. CNA 2 indicated there was no response from 911 (no assistance arrived) at 5:00 p.m. CNA 2 contacted 911 herself at 5:55 p.m., after no response and they did respond quickly. CNA 2 indicated the resident did have a full body mechanical lift in another room but they had not been trained on how to use the lift. She indicated no one would help her get the resident up off the floor. He was wet, she had to change him on the floor; neither QMA 1 or CNA 3 would help her change the resident or assist to get him off the		**what corrective action will be taken:** On 10/21/2022, Regional Director of Care Services (RDCS) and designee conducted a chart audit of current residents to ensure residents are free from neglect, with no additional findings noted. By 11/14/2022, ED and designee will conduct an interview of cognitively intact residents to ensure resident are free from neglect. Results will be discussed with RDCS and appropriate interventions implemented at time of finding as necessary. By 11/14/2022, residents with cognitive deficit will be assessed by nursing for signs of potential neglect. Results will be discussed with RDCS and appropriate interventions implemented at time of finding as necessary.. **3. What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur:** The Regional Executive Director (RED) was re-educated on 10/20/2022 by the RDCS on Enlivant's reporting policy and the Indiana state reporting policy (Attachment 2). Current staff were in-serviced regarding resident rights, abuse, neglect, reporting policy, fall response, lifting and transferring and mechanical lift operation on 10/20/2022 by the	

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	floor. During an interview, on 10/31/22 at 4:27 p.m., the Director of Health Services indicated staff need to be trained and checked off on the full body mechanical use for each resident related to different types of lifts and the staff had not been trained/checked off on Resident B's lift. During a telephone interview, on 11/1/22 at 9:38 a.m., CNA 3 indicated she was assisting another resident at the time of fall. CNA 2 did locate her and inform her of Resident B's fall. QMA 1 did respond and told them not to touch the resident, left him on the floor and left the room, she indicated she was going to call 911. CNA 2 and CNA 3 took turns staying with the resident as each had to leave the room. CNA 3 indicated she did not believe QMA 1 placed the call to 911 because they did not show up. CNA 3 indicated they (CNA 2 and CNA 3) contacted 911 at about 6:00 p.m., and the fire department responded approximately five (5) minutes later. The resident had been left on the floor for about 2 hours. CNA 3 did not observe the QMA check the resident's vital signs or administer medications when she was with the resident. CNA 3 indicated the full body mechanical lift was not used to transfer the resident from the floor because CNA 2 did not know how to use the lift and it was a two-person transfer with the lift. During a telephone interview, with 911 Dispatch, on 11/01/22 at 9:51 a.m., Dispatch 4 indicated one call was placed on October 15, 2022 at 5:57 p.m., for an assist to the facility for Resident B's apartment. A facility policy, titled "Resident Rights Policy," dated as effective 03/01/22 and provided by the		ED (Attachment 1). Resident B's care plan was updated on 10/20/2022 by RDCS to include the appropriate fall interventions and the use of the mechanical lift in the event of a fall. **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:** The Executive Director is responsible for sustained compliance. The ED/designee will complete audits by interviewing 3 residents and 3 staff weekly for 4 weeks, biweekly for 4 weeks, then monthly for 1 month to ensure residents are free from neglect. The audit willbe discussed at monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be on-going **5. By what date will the systemic changes be completed?** November 17, 2022	

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	Director of Health Services on 10/31/22 at 10:41 a.m., indicated "...Each resident has the right to, at minimum...To receive care, treatment and services which are adequate and appropriate...Be free from...neglect...." A facility policy, titled "Abuse, Neglect and Exploitation Policy," dated as effective 03/01/22 and provided by the Director of Health Services on 10/31/22 at 10:41 a.m., indicated "..."Neglect" means...depriving the resident of necessary support...." A facility policy, titled "Non-Emergent Resident Fall Response Policy," effective 03/01/22 and provided by the Director of Health Services on 10/31/22 at 3:40 p.m., indicated "...If unable to reach Care Services Manager or designee, call 9-1-1 immediately...." This State Finding relates to Complaint IN00392795.			