STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155734	A. BUILDING 00 B. WING	01/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
THORNTON TERRACE HEALTH CAMPUS	188 THORNTON RD HANOVER, IN 47243

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00424598 and IN00424277. Complaint IN00424598 - Federal/State deficiency related to the allegations is cited at F550. Complaint IN00424277 - Federal/State deficiency related to the allegations is cited at F744. Survey dates: January 10 and 11, 2024. Facility number: 004075 Provider number: 155734 AIM number: 200491220 Census Bed Type: SNF/NF: 10 SNF: 28 Residential: 15 Total: 53 Census Payor Type: Medicare: 5 Medicaid: 25 Other: 8 Total: 38 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on January 22, 2024.	F 0000		
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			

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

Stephanie Miller | Executive Director | 02/05/2024

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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	communication with and access to persons and services inside and outside the facility, 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 ensure resident rights related to dignity	F 0550	Submission of this Plan of Correction does not indicate an	01/31/2024

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	for 1 of 3 residents reviewed for resident rights. (Resident B) Findings include: The record for resident B was reviewed on 1/10/23 at 11 33 AM. The diagnoses included, but were not limited to, incomplete lesion at C5 level of cervical spinal cord, quadriplegia C5 through 37 incomplete, attention deficit hyperactivity disorder, major depressive disorder, anxiety, paraplegia, reduce mobility, lack of coordination, muscle weakness, and difficulty in walking. The quarterly MDS (Minimum Data Set) assessment, Dated 12/27/23, indicated the resident was cognitively intact. The care plan initiated on 12/26/23 and last revised on 1/3/24 indicated the resident had a history of verbal behaviors directed towards staff such as threatening their jobs, accusing them of abuse, retaliatory behaviors, inappropriate attachment to staff, and recording conversations. The interventions included but were not limited to avoiding power struggles with resident conveying attitude of acceptance to resident, do not engage resident in sensitive topics, maintain a common environment, and approach to the resident in sensitive topics, maintain calm approach, provide care with two assistants, set expectations and limits for resident when a patient becomes verbally abusive stop, assure resident safety and reapproach at a later time. The State reportable incident, dated 12/21/23 at 12:01 p.m., indicated the resident reported a staff member called him a baby bird. The resident provided a recording of himself asking for a pop tart to be torn up into pieces. The CNA (Certified		admission by Thorton Terrace Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Thorton Terrace Health Campus. This facility recognized its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities. Attached you will find our Plan of Correction for Thorton Terrace Health Campus for our complaint survey conducted on January 10th and 11th 2024. We initiated immediate interventions when concerns were identified on this date. We respectfully request a paper review for this plan of correction. F550 **1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Resident B was affected by this alleged deficient practice. Resident B immediately assessed for psychosocial affects with no findings. Head to toe assessment completed without findings.	

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	Nurse Aide) asked the resident if he needed her to "baby bird" it. The typed statement of the ED (Executive Director) indicated, on 12/21/23 at noon, Resident B wanted to talk to her regarding an allegation of that night shift had hurt his feelings. He had a recording which the ED listened to. The resident was upset. The ED's note, dated 12/22/23, indicated the resident had psychosocial monitoring in place. He was visibly upset. The ED offered support which was declined. The resident declined to have anyone called or have counseling services. During an interview, on 1/10/24 at 12:09 p.m., CNA 5 indicated she recalled the incident vaguely. She remembered she was opening a pop tart for him and she was joking around and asked him if he wanted her to baby bird it to him. She described what she meant by stating, "It's just when you chew up someone's food and you feed it to them like a mommy bird. But I would never do that, absolutely. I would never do that." She confirmed she did state to the resident "Do you need me to baby bird it?" During an interview on 1/11/24 at 11:02 a.m., the ED indicated the resident had asked to speak with her and told her the incident had hurt his feelings. He initially told her CNA 5 told him she would chew his food up and spit it back into his mouth. She listened to the video immediately. The video showed Resident C had asked CNA 5 to tear up his poptart for him. CNA 5 responded, asking if the resident wanted her to "baby bird" it for him. The CNA was educated on professional language and approach.		**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 have potential to be affected from alleged deficient practice. All like residents interviewed for professional language and professional conduct from staff with no findings. **3 What measures will be put into place, and what systemic changes will be made to ensure the deficient practice does not recur?** As a measure of ongoing compliance, ED or designee will audit Health center residents to ensure professional conduct and language from staff, audit to include random interactions with residents and staff 5x/week x 4 weeks, 3x/week x 3 months, and 1x/week x 2 months. **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur?** As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan	

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	The facility's most current Resident Rights policy, included, but was not limited to, "... Resident Rights... The resident has a right to a dignified existence... (e) Respect and dignity. The resident has a right to be treated with respect and dignity..." This citation relates to Complaint IN0424598. 3.1-3(a)		will be reviewed and updated as warranted and will continue until 100% compliance is maintained.	
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on observation, record review, and interview, the facility failed to ensure appropriate interventions and response for dementia related behaviors for 1 of 3 residents reviewed for dementia care. (Resident C) Findings include: During an observation on 1/10/24 at 10:35 a.m., Resident C was in his bed. He was pleasantly confused and very hard of hearing. When asked his name he indicated a name which was not his. He was not able to be interviewed. He appeared pleasantly confused and in no distress. He had no visible bruising at this time. The record for Resident C was reviewed on 1/10/24 at 11:16 a.m. The diagnoses included, but were not limited to, unspecified psychosis, hallucinations, altered mental status, visual disturbance, unsteadiness on feet, and muscle	F 0744	Submission of this Plan of Correction does not indicate an admission by Thorton Terrace Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Thorton Terrace Health Campus. This facility recognized its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities. Attached you will find our Plan of Correction for Thorton Terrace Health Campus	01/31/2024

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	weakness. The Quarterly MDS (Minimum Data Set) assessment, dated 11/24/23, indicated the resident was rarely or never understood and was not assessed for cognitive status. The nurses note, dated 9/26/23 at 12:49 a.m., indicated the resident was being verbally and physically aggressive that night. He refused his medications and began swinging and cussing at the nurse. The CNA (Certified Nurse Aide) was trying to check and change him that morning and the resident began swinging, pinching, cursing and yelling. The record lacked documentation of any interventions or their effectiveness for this incident. The nurse's note, dated 10/10/23 at 12:17 a.m., indicated the CNA was trying to change the resident and he became angry. He swung and hit her in the side. The resident calmed back down when left alone. The physician's note, dated 10/12/23 at 8:15 a.m., indicated the resident was seen for a follow-up to his conditions which included, but were not limited to, dementia. The resident was on medication for anxiety. He had no behavioral concerns and was eating and sleeping well. He was tolerating all medications. All chronic problems were stable. The nurse's note, dated 10/21/23 at 4:00 a.m., indicated while staff were changing the resident he began swinging and punched a CNA in the face three times.		for our complaint survey conducted on January 10th and 11th 2024. We initiated immediate interventions when concerns were identified on this date. We respectfully request a paper review for this plan of correction. F744 **1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Resident C was affected by alleged deficient practices. Resident C immediately assessed for pain or injury with no new findings. **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 like residents have the potential to be affected by the alleged deficient practice. All like resident assessed head to toe for any skin tears or bruising with no new findings. Skilled Staff educated on dementia and behaviors of disease process. **3 What measures will be put into place, and what systemic changes will be made to ensure the deficient practice does not recur?** As a measure of ongoing	

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	The Social Services note, dated 10/23/23 at 4:17 p.m., indicated the resident had an episode of being combative with care at 4:00 a.m., when attempting to change the resident. He had significantly impaired hearing and cognition. His care plan was updated to recommend staff approach him slowly and calmly when performing care as to do their best to not startle or agitate the resident who may be confused about what care was being performed and why. The care plan, initiated 10/23/23, indicated the resident demonstrated combative and resistive behaviors with staff during hands on care related to dementia. Goal was for the resident to not result in injury to self or others. The interventions included, but were not limited to, approach the resident in a calm and unhurried manner to deliver care and provide services, explain care process prior to delivery of care as needed, observe for signs of over stimulation, and encourage to move to less stimulating environments as needed. The care plan indicated the resident's showers were on Thursday and Sunday on third shift with a the the assistance of two staff members for transfers. The nurse's note, dated 11/1/23 at 5:48 a.m., indicated the resident became very agitated with staff when routine bed checks were completed that morning. He began swinging and stating "I don't want to stand up." Staff reassured him he did not have to stand up, she just needed him to roll to the side. The resident rolled over and called the staff member a b***h and would not let go of the rail to roll back. When staff convinced the resident to roll back so they could finish changing his brief, he began to swing at staff. They were eventually able to complete the change and the		compliance, ED or designee will audit Health center residents to ensure dementia plan of care and appropriate behavior interventions in place and conducted, audit to include random interactions with residents and staff for 3 residents 3x/week x 4 weeks, 1x/week x 3 months, and then every other week x 2 months. **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur?** As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained.	

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	resident calmed down. Staff were able to avoid being struck by the resident. The physician's note, dated 11/7/23 at 8:28 a.m., indicated the patient was seen for conditions including, but was not limited to, dementia. The resident was still on buspar 10 mg (milligrams) twice daily for anxiety. He had no new or acute complaints. He had no behavioral concerns and his chronic problems were otherwise stable. The physician's note, dated 12/12/23 at 8:28 a.m., indicated the resident was seen for a follow-up for health conditions which included, but were not limited to dementia. The resident's dementia was slowly declining, he was clinically comfortable, continue treatment. He had anxiety and Parkinson features which were controlled. The nurse's note dated 12/16/23 at 5:25 a.m.,,. indicated the resident had not slept for the past two nights. He had been yelling in the room and trying to get out of bed. He was brought to the living room to be more closely monitored. His roommate was angry about being woken up. The skin tear event, dated 12/17/23, indicated the resident had a skin tear to the left upper interior arm measuring 2 cm (centimeters) in L (length) by 2.5 cm in W (width), which was shallow, had a small amount of blood, irregular edges, and no pain. The activity during the occurrence was bathing and transferring. The area was cleansed with soap and water and first aid was given. The bruise event, dated 12/17/23, indicated the resident four areas of bruising. Bruise number 1 to his left upper arm was red, blue. Bruise number 2 to his forearm was red, blue. Bruise number 3 to his right forearm was red-blue and measured 1.5			

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	cm in length by 4 cm in width. Bruise number 4 to his right outer upper arm was 2.5 cm in L by 2 cm in W and was red, blue. The bruises were obtained during bathing and transfer. The IDT note, dated 12/18/23 at 9:17 a.m., indicated the resident had a new skin tear and bruise noted. The skin areas occurred while care was being provided. Treatments and monitoring were in place. There was no further documentation with regards to how the resident obtained the bruising and skin tear during his bathing and transfer. The handwritten statement of LPN 4 dated 12/17/23 at 11:15 AM indicated at approximately 11:10 a.m., LPN (Licensed Practical Nurse) 4 was contacted by CNA 7 and it was reported that resident C was presenting with new bruising and a skin tear. Assessment of the resident was conducted, and the left arm showed new bruising and skin tears. The resident had no memory of how it happened. During report it was mentioned that the resident hit staff during showering. The typed statement of CNA 7, dated 12/17/23 at 7:19 PM, indicated on 12/17/23 during report, CNA 5 and CNA 6 stated Resident C was being combative so they two-person body lifted him out of the shower chair into bed. At 8:15 a.m., herself and another staff member went in to check on the resident and set him up for breakfast. He was dry so they sat the head of the bed up so he could eat. Family arrived at 10:00 a.m. and he had a few people in there, so they waited until family left to go back and check on him again. At 11:00 a.m. herself and another staff member went in to change him because he was wet and rolled him over and saw blood on the Chuck and draw sheet.			

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	As they were looking at the arm to see where the bleeding was coming from, they noticed he had several new bruises on both his left and right arms and open skin on both arms around the elbows. The other staff member stayed with the resident while CNA 7 went to grab LPN 4 to come take a look. He examined the resident and immediately went to call the ED and DON. The typed statement of CNA 5, dated 12/16/23, indicated the aid went into the room to check on the resident and see if the other aid needed help after the resident had his shower. The other aide stated the resident had struck her in the face multiple times during the shower and she couldn't get him hooked back up to the full body lift lift due to him being combative. They body lifted him back into bed and proceeded to try and check and change the resident she was at his hips trying to hold him over while the other aide was at the top holding him over while trying to wipe the resident clean of his bowel movement. The resident kept forcefully pushing back against the wall. CNA 5 told the other aide to just put a brief on him and come back later when the resident had calmed down. They didn't put a top on him at the time, they covered him up and made sure he was warm and safe. They gave him his call light, put up the side rail, and then put the bed at the lowest position. The resident was re-approached later by the other aid and care was provided. The typed statement of CNA 6, dated 12/17/23, indicated on 12/16/23 CNA 6 entered the resident's room to give the resident a shower. She turned on the light and spoke loud enough so the resident would understand and let him know that it was his shower day. She offered him his shower and he seemed understanding and willing to participate although he was a little agitated from			

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	being woken up. She rolled the resident over and placed the full body lift pad underneath him with the help of another aide. The resident seemed to be getting more agitated from being rolled, but generally liked showers. She thought once he saw the shower and maybe understood what was going on more that he would deescalate. As the other aide and she were trying to help the resident into the shower chair using the full body lift the resident was flailing his arms around and trying to hit and bite both of them. The other aide asked if she would be OK to give him his shower by him herself and she said yes that he should calm down once he was in the shower as he usually did. This time however the resident did not deescalate and was still very agitated as she was trying to shower him. The resident was still flailing around his arms and trying to hit and bite. The resident hit her in the face and arms as she was trying to bathe him. Her goal at this point was to get the resident clean and out of the shower as quickly as possible while also keeping himself and herself safe. Once she got him out of the shower, he was still very agitated and combative, so she called in another aide to assist her in putting him to bed. The resident was too escalated to safely use the full body lift, so the other aide and she had to underarm him into the bed. As they were trying to reposition and change the resident, he was still very escalated and was using his arms to push up against the wall as they were putting his brief on him. The other aide suggested that they leave his shirt off for now due to how he was being combative. They made sure he was clean safe and comfortable as best as they could at the time and then checked on him later and were able to provide care for him as he had deescalated. During an interview on 1/10/23 at 12:33 p.m., LPN 4 indicated he was familiar with Resident C and			

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	recalled opening new skin events on him. He was not the first person to identify the skin impairments. Two of his CNAs (Certified Nurse Aides) had brought it to his attention. They told him that they wanted me to make sure he saw them because it was new events of bruising and skin tears on his bilateral elbows. They did not tell him how they obtained them. They didn't move him and there was nothing that would have caused them. He'd had a shower the shift prior. CNA 5 and CNA 6 had been talking about giving him a shower. CNA 6 indicated he'd hit her and become combative in the shower which was not out of the ordinary for the resident. His typical response would be to switch it to a bed bath and make it as comfortable as possible and if still agitated then he would separate and give the resident to calm down. There was no sense in agitating the resident. During an interview on 1/10/24 at 12:46 p.m., CNA 7 indicated she and another staff member had gone in to care for Resident C and had pulled back the sheet and were getting ready to change him. They saw blood on his bed pad and saw a skin tear under his elbow. They looked even further and there was new bruising on his arms and skin tears under both elbows. They finished changing him and had LPN 4 come in to look at him. She told the nurse she wasn't sure what had gone on, but it didn't look too hot. He had little circle red dots on his back all over the top part of his back, and he had bruising on his hands. When they looked at him, they didn't know how he got that many bruises. He had them all over his arms and hands. It was very concerning to them. It was concerning because there was a ton of bruising and the skin tear looked like a nail had dug under it, his skin was fragile any ways. She was told that he was given a shower on third shift the night			

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	155734	A. BUILDING 00 B. WING	01/11/2024

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	before, they did not say anything, they said he was fine. It was later in the day they said he was being combative and that he was yelling out no he didn't want to get it, but they continued and put him in the shower. They said he was punching CNA 6 in the face. The other aide involved was CNA 5. CNA 9 had told her this. She said she had been in the room when Resident C was punching CNA 6 in the face. She had been in there when they were transferring him and putting him in the shower, and he was refusing. During a confidential interview, between 1/10/24 and 1/11/24, Staff E indicated she had seen blood on Resident C's draw sheet and clear fluid. They got to looking and he had a skin tear on both elbows, and they observed bruising. They immediately told LPN 4. He also had what looked like purple petechia on his back. She was very concerned. They were told he was being combative, and the aides proceeded to shower him anyway. The shower sheet had indicated CNA 6 had given the resident his shower. CNA 9 had told her and CNA 7 the resident had been combative, and she held his hands down. CNA 5 and 6 had put him in the shower chair with the full body lift but because he was being so combative and was hitting CNA 6 in the face, they transferred him back without a lift. During an interview on 1/10/24 at 1:57 p.m., CNA 9 indicated the night of the incident the resident was due for a shower. He was normally a bed bath. CNA 6 was in there and she was trying to put the full body lift pad underneath of him. He was trying to hit her, and she was grabbing his arms for him to not hit her. The call button went off and she went in there and helped her. CNA 6 was kind of rough. She did think she should have re-approached and came back later. That was what			

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	they did when a resident was resistive to care, they came back later. She helped her put him in the shower chair and then once she got him in the shower, she left the room. She did not assist in holding down his hands. CNA 6 was holding his arms down a little so she could turn him. She did try to encourage her to stop the care. She told CNA 6 since he was combative and not wanting to do anything maybe they should come back later, but third shift was very persistent about getting showers done. CNA 6 didn't really say anything and continued with care. CNA 5 was in there after the shower and the call light went off again. They were trying to get the pad out from underneath him. He was being aggressive with them. They "two-armed" him from the chair to the bed. They didn't put a shirt on him, they just covered him up. was in there with her after the shower and the call light went off again, they were trying to get the pad out from underneath him, he was being aggressive with them. She didn't think CNA 6 meant anything by it, but she should have stopped what she was doing and came back later. During an interview on 1/10/24 at 2:05 p.m., the DON indicated she had been contacted by the ED, who said LPN 4 had contacted her with a concern about some areas on Resident C's skin. He did have some bruises, but nothing appeared to be malicious. He had little dots on his back from the shower chair, he was bruising very easily. CNA 6 had been the one in the room and she said she had gotten him up for the shower just fine but once he got in the chair, he got combative and resistive. CNA 6 indicated he would do that but then once he was in the shower, he would calm down, so she proceeded. However, while he was in the shower, he did strike her. She finished the shower and had CNA 5 come back in and help put him back to bed. They felt he was being too			

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	combative to get back in the full body lift and his orders were for a two person assist so they did stand him up. She would have recommended an alternate caregiver and if that didn't help give him space and time to calm down and re-approach. He had dementia and had resistive behaviors to care and things like that, but he was more resistive in the nights and evenings. One of the very first interventions were to switch him to a day shift shower. With dementia approach was very important. During an interview on 1/11/23 at 11:33 a.m., the ED indicated they had not done specific interventions when the resident had combative behaviors in September, or on 10/22/23. They were more worried about his refusal from a weight loss perspective and that's what they had focused on. They had failed to implement specific interventions to address his behaviors. The facility's most current education, titled "Solving Difficult situations the Best Friends Way", included, but was not limited to, "... Step 1: Be a Detective Stop, Look, and Listen for Triggers... Stop... Ask the person what's wrong... Sit with him or her for a bit... Show concern or affection... Remember to walk a mile in his or her shoes - be empathetic... The facility's most current Communication and Dementia policy, included, but was not limited to, "... Communication is at the heart of our relationships with our loved ones... 8. Do not argue, confront, or correct. If conflict arises, treat it with a warm, tender attitude, and give gentle cues to your lobed one if they're making a mistake... 9. Do not give orders or make demands. Your loved one may take this as a sign of aggression and respond negatively..."			

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	The facility's most current Comprehensive Care Plan Guideline policy, included, but was not limited to, "... Should new identified areas of concern arise during the resident's stay, they should be addressed on the care plan...6. Comprehensive care plans need to remain accurate and current. a. New interventions will be added and updated during or directly following the CCM [Care coordination meeting]..." This citation relates to Complaint IN00424277. 3-1.37(a)			