| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155769 | A. BUILDING 00<br>B. WING | 07/19/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| MORRISON WOODS HEALTH CAMPUS | 4100 N MORRISON RD<br>MUNCIE, IN 47304 |

| (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 |
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| R 0000<br><br>Bldg. 00 | This visit was for the Investigation of Complaint IN00412036.<br><br>Complaint IN00412036 - State deficiencies related to the allegations are cited at R0053.<br><br>Survey date: July 19, 2023<br><br>Facility number: 011596<br><br>Residential Census: 56<br><br>This State Residential Finding is cited in accordance with 410 IAC 16.2-5.<br><br>Quality review completed July 24, 2023. | R 0000 | | |
| R 0053<br><br>Bldg. 00 | 410 IAC 16.2-5-1.2(w)<br>Residents' Rights - Deficiency<br>(w) Residents have the right to be free from verbal abuse.<br>Based on interview and record review, the facility failed to prevent verbal abuse of a cognitively impaired resident by a staff member for 1 of 3 residents reviewed for abuse (Resident B).<br><br>Findings include:<br><br>Review of a report submitted to Indiana Department of Health (IDOH), dated 7/2/2023, indicated staff reported concerns with the approach used by CNA 1 while attempting to redirect Resident B.<br><br>Resident B's clinical record was reviewed on 7/19/2023 at 10:05 a.m. Diagnosis included Alzheimer's disease and dementia. | R 0053 | 1. Residents B was affected. No adverse occurrences noted. The resident was immediately assessed with concerns noted. Employee was suspended pending investigation. The investigation was completed prior to IDOH survey, with abuse being substantiated. Employee was terminated effective immediately.<br>2. All residents have the potential to be affected. All residents were assessed and interviewed without any allegations of abuse noted. Skin assessments completed on all non-interviewable residents with | 07/20/2023 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Amanda Crabill | Executive Director | 07/31/2023 |

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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| | Review of a facility "Investigation Summary", dated 7/2/2023, indicated the resident was assisted out of bed and directed to the dining room. The resident immediately began self propelling himself back to his room. CNA 1 attempted to redirect the resident back to the dining room table. The resident became agitated and began yelling. CNA 1 raised their voice in response to the resident and continued to attempt to place resident back at the dining room table. CNA 1's shift ended and they left the facility.<br><br>Review of Dietary Chef 2's statement, dated 7/2/2023, indicated she heard CNA 1 yelling at Resident B and told him to "shut up".<br><br>Review of CNA 3's statement, dated 7/2/2023, indicated she witnessed CNA 1 in the dining room with Resident B. CNA 1 as yelling at the resident and told them to be quite because he was having behaviors.<br><br>Review of CNA 4's statement, dated 7/2/2023, indicated Resident B was in his wheelchair and was sitting next to the activity area. The resident was trying to go back to his room and CNA 1 said "No you're not." and pushed the resident's wheelchair back to the table. They were both yelling at each other. CNA 4 did not remember CNA 1 telling the resident to shut up but she heard her telling the resident to stop screaming.<br><br>Review of CNA 1's statement, dated 7/2/2023, indicated she and CNA 3 had gotten the resident up and brought him to the dining room. As soon as the resident was in the dining room he started heading for the nurses station and stated he was going back to his room. She admitted to calling the resident an inappropriate name during the | | no concerns noted. All staff were educated on the abuse and neglect policy.<br>3. As a measure of ongoing compliance, the Executive Director (ED) or designee will complete resident interviews/skin assessments on 5 residents weekly for 4 weeks, then every other week for 2 months, and then monthly for 3 months.<br>4. 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. | |

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| | interaction. She also may have told the resident to shut up but said it under her breath and did not think the resident heard her. CNA 1 indicated the resident was attention seeking and he "plays his dementia diagnosis".<br><br>CNA 1 was unable to be reached for interview during the survey.<br><br>During an interview on 7/19/2023 at 10:39 a.m., CNA 3 indicated at the end of CNA 1's shift, she assisted Resident B to the dining room. The resident and CNA 1 were yelling at each other. CNA 3 indicated it was not appropriate for staff to yell at any resident.<br><br>During an interview on 7/19/2023 at 10:56 a.m., CNA 4 indicated when she arrived for her shift, Resident B was at the activity table and wanting to return to his room. CNA 1 told the resident no and pushed him back to the table. CNA 4 did not know why CNA 1 would not let the resident return to his room. The resident became agitated and they were both yelling.<br><br>During an interview on 7/19/2023 at 11:26 a.m., Dietary Chef 2 indicated she had walked out of the kitchen and heard CNA 1 screaming at Resident B. She told him to shut up. Dietary Chef 2 indicated it was very upsetting to witness. There were other staff members present so she returned to the kitchen and called her supervisor to report the incident.<br><br>During an interview on 7/19/202 at 1:06 p.m., the Dementia Unit Director indicated on the morning of 7/2/2023, she received a phone call from Dietary Chef 2. The Dietary Chef was upset and reported CNA 1 yelling at Resident B. The Dementia Unit Director reported the incident to Administrator. | | | |

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| | During an interview on 7/19/2023 at 1:25 p.m., the Administrator indicated she received a call from the Dementia Unit Director, who reported the incident between CNA 1 and Resident B. The Administrator indicated it was not acceptable for staff to yell at the residents. The Administrator initiated the investigation and suspended CNA 1 pending investigation.<br><br>During an interview on 7/19/2023 at 2:10 p.m., the Executive Director indicated it was inappropriate for staff to yell at residents or verbally abuse them. The Executive Director was on vacation at the time of the incident and indicated the Administrator handled the incident per their policy. The investigation was initialed and substantiated. CNA 1 was terminated.<br><br>Review of a current undated facility abuse education, titled "Preventing, Recognizing, and Reporting Abuse & Neglect" and provided by the Administrator on 7/19/2023 at 2:36 p.m. indicated the following: " .... There is ZERO Tolerance for any type of abuse or neglect to any of our residents. ...."<br><br>This state residential finding relates to Complaint IN00412036. | | | |