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	07/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WORTHINGTON PLACE	10799 ALLIANCE DR CAMBY, IN 46113

(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 IN00357494. Complaint IN00357494 - Substantiated. State Residential Finding related to the allegation is cited at R0052. Survey dates: July 20 and 21, 2021 Facility number: 003984 Residential Census: 89 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality Review completed on July 23, 2021.	R 0000	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 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. This provider respectfully requests the 2567 plan of correction be considered the letter of credible allegation and request a desk review for paper compliance in lieu of post survey review on or after 8/20/2021.	
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.			

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

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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	Based on observation, interview, and record review, the facility failed to ensure a resident (Resident B) was free from physical abuse by another resident (Resident C) for 1 of 1 resident reviewed for abuse, which resulted in facial petechiae, facial bruising and facial swelling. Findings include: On 7/21/21 at 10:30 A.M., Resident B was in her room in a broda chair. Resident B was observed to have a dime sized scabbed area to the forehead. Resident B was unable to be interviewed. Resident B's clinical record was reviewed on 7/20/21 at 10:00 A.M. Diagnoses included, but were not limited to, non-Alzheimer's dementia, depression and hypertension. A Folstein Mini Mental Exam, dated 5/28/21, indicated Resident B was severely cognitively impaired. Resident C's clinical record was reviewed on 7/20/21 at 11:40 A.M. Diagnoses included, but were not limited to, non-Alzheimer's dementia and history of falls. A Folstein Mini Mental Exam, dated 5/28/21, indicated Resident C was severely cognitively impaired. On 7/21/21 at 10:00 A.M., the Administrator provided a copy of an incident report, dated 7/2/21 at 3:05 A.M. A review of the incident report indicated at approximately 3:05 A.M. staff heard a distressed female voice (Resident B). Upon investigation female resident (Resident B) was observed in her room, in her bed. Male resident (Resident C) was standing over female resident	R 0052	1.) On 7/2/21, Resident B was evaluated by a team of clinicians, including resident's physician, with no major injuries noted. Identified skin discoloration and abnormalities have resolved, and resident B continues to reside in the community. On 7/2/21, Resident C was transferred out of the community for evaluation and no longer resides in the community. 2.) By 8/20/21, current residents without severe cognitive impairment will be interviewed by the Executive Director (ED) and/or designee to ensure Resident Rights are upheld including being free from physical abuse. By 8/20/21, current residents who are unable to participate in interview due to cognitive impairment will have skin observation completed by the Care Service Manager (CSM) and/or designee to ensure resident is free from injuries of unknown origin. Results of these findings will be reviewed with the Regional Director of Care Services, the resident's physician, and the department of health as necessary. 3.) On 8/6/21, current staff will be in-serviced on Resident's Rights, including abuse and reporting changes in behavior to nurse by CSM.	08/20/2021

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	(Resident B) calling her inappropriate names and repeatedly striking her in the face. Resident C was immediately removed from the room and Resident B was assessed to have a bruise to the right temple, a bruise under the right eye, a bruise with swelling to the right cheek, a bruise with swelling to the nose, and petechiae (more than one purple spot of bleeding under the skin) under the nose and on the upper lip. Resident C was sent to a local acute care hospital for evaluation. On 7/21/21 at 10:00 A.M., the Administrator provided a copy of a Sheriff's report, dated 7/2/21 at 1:45 P.M. A review of the investigation indicated, case number HP210005286, Sheriff was dispatched to the facility in reference to a battery investigation. The investigation indicated, Resident B had a black eye, possible broken nose and swelling on her face. Resident B was unable to be interviewed. The Sheriff took photos of Resident B's face. On 7/21/21 at 10:15 A.M., the Administrator provided a copy of a radiology report for multiple x-rays of Resident B's skull. A review of the radiology report indicated, Resident B had an unremarkable skull without linear or depressed fracture. During an interview, on 7/21/21 at 11:00 A.M., the Administrator indicated, Resident C had entered Resident B's room and hit her in the face. Resident C was sent out to a hospital and then admitted to a long-term care facility. On 7/21/21 at 10:15 A.M., the Administrator provided a copy of a facility policy, titled "Abuse, Neglect and Exploitation," dated 9/1/16, and indicated this was the current policy used by the facility. A review of the policy indicated, "It is our		By 8/13/21, the Life Enrichment Coordinator and/or designee will review Abuse, Neglect, and Resident Rights during Resident Council. 4.) The ED responsible for sustained compliance. The ED and/or designee will conduct interview of 3 residents weekly x 4 weeks, biweekly x 4 weeks, then monthly for one month to ensure Resident Rights are upheld including being free from physical abuse. The CSM and/or designee will conduct skin observations of 3 resident's unable to participate in interview due to cognitive impairment weekly x 4 weeks, biweekly x 4 weeks, then monthly for one month to ensure resident is free from injuries of unknown origin. Results of the audit will be discussed at monthly QI meetings. The QI committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be ongoing. 5.) Systemic changes will be completed by 08/20/2021	

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	duty to protect residents from physical abuse...physical abuse is the willful act of inflicting bodily injury of physical mistreatment." This State Residential Finding relates to Complaint IN00357494.			