STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155522	A. BUILDING 00 B. WING	04/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ELWOOD HEALTH AND LIVING	2300 PARKVIEW LN ELWOOD, IN 46036

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00430395. Complaint IN00430395 - Federal/state deficiencies related to the allegations are cited at F550. Survey date: April 1, 2024. Facility number: 000372 Provider number: 155522 AIM number: 100289060 Census Bed Type: SNF/NF: 64 Total: 64 Census Payor Type: Medicare: 5 Medicaid: 44 Other: 15 Total: 64 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed April 4, 2024.	F 0000	Submission of this plan of correction shall not constitute or be construed as an admission by Elwood Health and Living that the allegation in the survey report are accurate or reflect accurately the provisions of care and services to the residents at Elwood Health and Living. The facility requests the following plan of correction be considered its allegation of compliance.	
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, including those specified in this section. §483.10(a)(1) A facility must treat each			

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

Penny | Broshar | 04/15/2024

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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	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 observation, interview, and record review, the facility failed to ensure staff treated a resident with respect and dignity for 1 of 3 residents reviewed for abuse. (Resident B) Findings include:	F 0550	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** One resident was found to have been affected by this deficient	04/15/2024

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	Resident B's clinical record was reviewed on 4/1/24 at 10:19 a.m. Diagnoses included morbid (severe) obesity due to excess calories, anxiety disorder, and depression. Her physicians orders included escitalopram oxalate (treat depression) 10 mg daily. A 12/22/23, significant change MDS (Minimum Data Set) assessment indicated she was cognitively intact. She required extensive assistance of one staff member for bed mobility and toilet use. Her care plan indicated she enjoyed when staff used terms of endearment with her (sugar, honey, darling, etc.) (11/16/23). Her interventions included encourage her to express other preferences (11/16/23) and honor her preferences (11/16/23). Review of her nurses notes indicated the following: On 3/12/24 at 2:30 p.m. (created on 3/13/24 at 8:34 a.m.), the resident reported to a CNA that on the prior shift, a CNA had called her a name that hurt her feelings and she didn't appreciate. The Administrator and the nurse manager followed up with her. She was upset that CNA called her a "heifer". As she retold the story, she added freaking or f---ing in front of heifer. An investigation was initiated. She said she was upset after the incident, but nursing staff indicated she had no distress. She would be observed for changes in mood, sleep patterns and meal intake. On 3/13/24 at 12:57 p.m., she indicated she was fine, and she had no other concerns. She held a		practice. Staff member involved was disciplined and educated on dignity and accepted behaviors. **Due to the low scope and severity of this tag, we are requesting paper compliance.** **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 the potential to be affected by this deficient practice. An all staff in-service was held on 4/12/24 and all staff was educated on dignity and respect for all residents. **Due to the low scope and severity of this tag, we are requesting paper compliance.** **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** All residents have the potential to be affected by this deficient practice. An all staff in-service was held on 4/12/24 and all staff was educated on dignity and respect for all residents. During each resident's quarterly assessment for MDS, the Social Service Director or designee will interview each resident and ask resident if they as treated with respect and dignity by staff. **Due to the low scope and severity of this tag, we are requesting paper compliance.**	

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	general conversation about her family and an upcoming doctor's appointment. On 3/18/24 at 2:58 p.m., she did not appear to have any changes in mood, psychosocial well-being, meal intake, sleep patterns, or activity participation. She appeared to be in a good mood and smiled during the conversation. When she retold last week's incident, it appeared to change each time she retold the incident to a different staff member. During an interview with CNA 34, on 4/1/24 at 10:29 a.m., she indicated Resident B told her that she had her call light on. LPN 5 answered her call light to give her a pain pill, but she needed incontinent care. The nurse gave her a pain pill and provided the care. Then, CNA 21 came in and called her a "f---ing heifer" because she had just been in her room to see if she needed anything. While Resident B was telling CNA 34 about the incident, CNA 21 came into Resident B's room to pass ice water. CNA 21 said she didn't call her a "f---ing heifer," she called her a "freaking heifer." Resident B was upset, she wanted to lose weight and she got mad at the nurses because she wasn't losing more weight. Resident B told her it hurt her feelings and she was afraid to say something. Resident B also told CNA 13 about the incident and CNA 13 reported it to the Administrator. CNA 34 felt like it was abuse and she wouldn't use that kind of language with the residents. She didn't report it and should have reported it to the Administrator right away. She was educated on reporting abuse immediately. During an interview with Resident B, on 4/1/24 at 11:03 a.m., she was observed crying and indicated she had just had a loud conversation with her family member on the phone. She didn't have any		**How the corrective action(s) will be monitored to ensure the deficient practice will not recur ie, what quality assurance program will be put into place?** Results from Social Service interviews will be shared with Administrator or designee and Administrator or designee will follow up with staff for any results that are not favorable. Administrator or designee will also conduct random observations of staff having interactions with a resident over the next 3 months to ensure that staff are promoting and maintaining resident dignity. All results from the interviews and observations will be reviewed during Quarterly QAPI meeting until team feels substantial compliance has been reached. **Due to the low scope and severity of this tag, we are requesting paper compliance.**	

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	concerns with staff members, until three to four weeks ago. Between 2:00 a.m. and 2:30 a.m., she turned on her call light, the nurse came to her room with a pain pill, but she just needed changed. The nurse gave her a pain pill and changed her. Then CNA 21 came into her room and said, "You f---king heifer, I was just in here!" The word "heifer" went straight through her, she couldn't tolerate that word. She told her she was not a heifer. She indicated she struggled with her weight, and she laid there and cried the rest of the night. CNA 21 had called her "tubby" and "chunky monkey" in the past or while she rolled her in bed, she would say to her, "get your big butt over here." She waited until morning and told CNA 34 what had happened. She asked her what she should do, if she should report it or leave it alone because she was afraid of CNA 21, she was as big as she was. About that time, CNA 21 came in her room and said she supposed she was telling CNA 34 about calling her a heifer, she didn't call her a "f---king heifer," she called her a "freaking heifer." It absolutely hurt her feelings, and still hurt her feelings. During an interview with CNA 13, on 4/1/24 at 2:14 p.m., she indicated Resident B told her around lunchtime (between 11:00 a.m. and 1:00 p.m.) that CNA 21 walked in her room and called her a "f---ing heifer" after the nurse had provided care on third shift. She immediately told Unit Manager 3 and she directed her to go to the Administrator. During an interview with CNA 21, on 4/1/24 at 2:18 p.m., she indicated she went into Resident B's room between 10:00 p.m. and 10:30 p.m., she was sleeping. The nurse answered her call light while she was in another room. She went to Resident B's room and said to her "Hey you heifer, you were snoozing away." They talked about things and			

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	before she left her room, she told her if she needed anything to call. Then CNA 34 was in her room and when she walked in, she said to CNA 34 that she couldn't believe she said I called her a freaking heifer, she did not say the word "f---king or freaking to Resident B. She just said heifer. Resident B wanted to lose weight, but she was not referring to a cow or referencing her weight. She didn't intend it to hurt her feelings. She even called her children heifers. It was normal for her and Resident B to joke around. During an interview with the Social Service Director, on 4/1/24 at 4:11 p.m., she indicated when she followed up with Resident B after the incident. For the most part she was fine, but when she brought up the incident, she was acting upset. Her story changed a little each time, she changed the wording, at first, CNA 21 called her a "f---ing heifer", then a "freaking heifer," then a "heifer." Resident B was the "joking type." During an interview with the Administrator, with the DON and Unit Manger 3 present, on 4/1/24 at 4:21 p.m., she indicated CNA 34 knew about the incident sooner, but didn't report it. The incident was reported around 1:30 p.m. When she and Unit Manager 3 interviewed Resident B, she was upset about being called heifer. She was focused on her weight loss. Heifer wasn't a good word to use. A current facility policy dated 4/1/19 and titled "Promoting/Maintaining Resident Dignity," was provided by the Administrator, on 4/1/24 at 4:12 p.m., indicated the following: "...It is the practice of this facility to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect. Compliance Guidelines...10. Speak respectfully to residents...."			

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	3.1-3(t) This citation relates to Complaint IN00430395.			