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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00362249 and IN00362608. Complaint IN00362249 - Substantiated. Federal/state deficiencies related to the allegations are cited at F740. Complaint IN00362608 - Substantiated. Federal/state deficiencies related to the allegations are cited at F740. Survey dates: September 16, 2021. Facility number: 000393 Provider number: 155383 AIM number: 100289340 Census Bed Type: SNF/NF: 41 Total: 41 Census Payor Type: Medicare: 3 Medicaid: 33 Other: 5 Total: 41 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 29, 2021.	F 0000		
F 0740 SS=D Bldg. 00	483.40 Behavioral Health Services §483.40 Behavioral health services. Each resident must receive and the facility			

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 determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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	must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. Based on observation, interview, and record review, the facility failed to ensure person-centered, behavioral health management interventions were implemented for a resident with mental health diagnoses and known explosive behaviors for 1 of 3 residents reviewed for behavioral mental health services (Resident B). Findings include: A confidential interview during the survey indicated, on 9/1/21, Resident B was heard screaming across the building. Someone indicated, "[Resident B] is going crazy!" Resident B and Licensed Practical Nurse (LPN) 8 were observed at the ice machine. The resident stood there and screamed at LPN 8. The interviewee indicated they knew it had something to do with his items because he had done that before. Resident B screamed and yelled until he was able to tell them what happened. He complained that his things had been taken, and no one would give them back. When he tried to get someone to talk to him about where his things were, they all ignored him, and he got angrier and started to throw the ice. LPN 8 came to him and slammed his arms in the ice chest. There were new bruises observed on both of his arms. The facility denied	F 0740	**Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during visit on -- -9/16/2021** **Please accept this plan of correction as the provider's credible allegation of compliance as of 10/19/2021** **The provider respectfully requests a desk review to be considered in establishing that the provider is in substantial compliance.** **F740 Behavioral Health**	10/19/2021

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	access to review the surveillance footage. The interviewee indicated they did not understand why management or social services weren't called to help if his room had really become a problem again, and why the staff had waited for both the Administrator and Director of Nursing (DON) to be out of the building before they decided to clean his room out. Resident B was autistic and had obsessive compulsive disorder which was exhibited in his behaviors of being very particular and sensitive about anything in his room and that sometimes even meant old food. Once before staff had cleaned out his room without his permission and he had "gone off" then too. The problem was discussed with Resident B and an intervention was implemented to help where he agreed to a "cleaning day." Together staff were able to go through his items and throw away old food and rotten items that may be unhealthy but kept all his unsoiled items and loose-leaf papers. They put items to keep in a big trash bag he was allowed to keep in his room. It helped him to just be able to see his belongings in the bag, and know it was all still there. During an interview on 9/16/21 at 11:30 a.m., LPN 7 indicated she had been one of the staff members who went into Resident B's room and removed his items. She indicated Resident B's room was "filthy" and what started the problem was when she went into his room to set down a tray of food. When she set the tray in his bedside table a lot of gnats began to fly around and she indicated it was, "gross." Resident B never let anyone in his room to help clean up, LPN 7 indicated she waited for him to leave his room. He would usually take walks around the building or go look at the menus. That day when he left to go look at the menus, she entered his room and began to bag up all his trash. Things she threw		**Services** **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice** · Resident B will maintain the highest practical physical, mental, and psychosocial well-being with staff ensuring resident-centered behavioral health interventions are in place and working. Staff will implement housekeeping interventions to ensure a clean and healthy environment for the resident and others while maintaining resident rights and preferences. The nursing department will consult with both clinical and mental health providers for resident B to develop a plan that resident B will be receptive to in terms of personal/environmental cleanliness. · Staff are to incorporate Behavioral intervention Management Daily Follow-Ups o A program to monitor the effectiveness of resident-specific behavioral interventions after they have been established. This will be completed daily, ensuring that proper intervention is in place and is effective. § If not, IDT will develop and reapproach with a different intervention.	

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	away were, old food items, old beverage cups, and loose trash papers. She knew it would make him upset, but she felt that it was a health hazard. He started to scream and yell and there was ice on the floor from the ice chest. LPN 7 indicated the Administrator and DON were not in the building at the time, so she had to call to report his behaviors to the DON immediately. On 9/16/21 at 11:43 a.m., Resident B was observed during an interview. Minimal personal items were observed throughout his room. There was a small cardboard box of miscellaneous items and a small blue plastic easter basket on top of his bedside tabletop. There were two individually wrapped oatmeal cream pies, a sealed can of cola, and a small Father's Day gift bag on top of his dresser. There was one large, translucent trash bag of miscellaneous paper items observed on the floor at the foot of his bed. The floor, windows, and walls were bare. Resident B indicated his room was bare because all of his personal items had been stolen and thrown away without his permission. He indicated, on 9/1/21, he left his room to go look at the menus and walk around a little. When he began to go back to his room, he saw two staff members as they left his room with a large bag of all his things. He tried to get back to his room, but LPN 8 stood in the middle of the hall to distract him and blocked his way. When he got back to his room, all of his things were gone, including the scrap menu papers he collected and used to write notes and song lyrics on. He became very angry and yelled to get his things back. No one would listen or try to help him. So, he went to the ice machine and began to throw ice and scream some more to get someone's attention. LPN 8 came to him at the ice chest and slammed the lid on his arms and pinned his arms		**2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** · Any resident residing in a facility with mental health needs has the potential to be affected o All residents will be reviewed for mental health diagnosis and needs and ensured is being followed by the appropriate clinician. o Any resident who has a mental health disorder will be reviewed to ensure a plan of care is in place. o Behavior events for the last 90 days will be reviewed to ensure appropriate follow-up per policy. · Check behavioral documentation and flow sheets (for trending purposes) every day during the clinical meeting. o If behavior is identified, IDT will identify the root cause and develop a resident-centered behavioral intervention § We will update the resident profile sheets; it will list resident-specific and resident-centered behavioral interventions. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** · All staff will be in-serviced	

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	in the ice chest. LPN 8 kept saying, "go ahead, pull your arms out," with a smile on his face. Resident B could not get his arms out, so he began to yell for help. Resident B indicated he was told there was video surveillance, but he was not allowed to see it. Resident B pulled the sleeves on his shirt up to his elbows and revealed bruises on his forearms. There was a half-dollar sized bruise, purple in color, on the bottom of his right forearm. There was a linear bruise, approximately the length of an ink pen, dark purple in color, on his right upper forearm just below his wrist. Resident B indicated, over 200 pages of his scrap menu papers had been taken. They were important to him because he kept things like notes he thought of, and song lyrics on them. He liked the menus, because they already had the dates on them and he could remember what he ate, and what he wrote. Resident B indicated this was not the first time something like this had happened. Once before, staff had thrown away a lot of his personal things against his wishes, and he was promised it would never happen again and another "nice" staff person helped him get some of his papers back and cleaned up his room. He pointed to the bag of paper at the foot of his bed and indicated, "I was told I can keep my stuff like this." Resident B indicated he did not want to leave his room anymore because he was afraid it would happen again. During an interview with the DON and Administrator, on 9/16/21 at 11:54 a.m., the DON indicated on the day of the incident with Resident B and the ice machine, the DON and ADM were not in the facility at that time so Unit Manager (UM) 9 called her to report the incident. The DON reported the incident to the health department because Resident B alleged		on; o Resident-specific behavioral interventions o Appropriate behavior response o Resident rights o Resident preferences *In-services to have a Date of Completion by 10/19/2021. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place** · To ensure compliance, Social Service or designee is responsible for the completion of the Behavior Management CQI tool weekly for 4 weeks, monthly for 2 months, and then quarterly for 6 months. · The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. **Date of completion: 10/19/2021**	

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	LPN 8 hurt him. The Administrator indicated he followed up with Resident B the next day and Resident B indicated the last time something similar happened where his personal items had been thrown away without his permission. He got upset and displayed the same behaviors, until he got his stuff back. The DON indicated staff should have resident's permission before they entered a resident's room. When the video surveillance of the incident was the reviewed, the Administrator indicated Resident B and LPN 8 were both at the ice machine. Resident B's arms were in the ice chest as the resident was leaning against the lid. At one point the resident backed away, LPN 8 raised the lid so Resident B could remove his arms. The Administrator indicated he stopped watching the footage at that time. The Administrator indicated a grievance was filed and had been "resolved." During an interview on 9/16/21 at 12:09 p.m., the DON indicated staff members who had worked with Resident B were aware of how "particular" he was about his things and staff should not do anything that caused harm or fear for a resident. Staff should act as the resident's advocate. During an interview, on 9/16/21 at 12:10 p.m., DON indicated staff were in-serviced to read resident profiles so they could honor resident preferences, staff should honor resident preferences. During an interview on 9/16/21 at 12:20 p.m., UM 9 indicated she had worked with Resident B for a while and knew him well. He was very "peculiar and particular" about his things. She would call him a "hoarder" because anything that was brought into the room, he would want to			

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	keep. He did not like to socialize very much, but he would often come out of his room to take walks, go look at the menus, or activity board. Resident B was most attached to his loose papers, particularly the menu tickets that came with the meal trays. He used them to write notes on. On the day of the incident, UM 9 witnessed Resident B as he became very angry that his things had been thrown away. He screamed and yelled and went to the ice chest and threw ice everywhere. It took several staff to redirect him and calm him down. UM 9 had never seen him act like that before but had hear that something similar had happened once before. During an interview on 9/16/21 at 2:39 p.m., LPN 10 indicated she was not here the day of the incident but hear about it when she returned to work. She was not surprised he had behaved that, way because everyone knew how particular he was about his room and his things. He always got "really upset" when people touched his things. He used to come out of his room a couple times a day to walk up to the nurse's station and look at the menus, or activity board and walk to halls to look out the windows. He had not been doing that as much this past week or so, but LPN 10 indicated she thought that was because of the recent quarantine. During an interview on 9/16/21 at 2:41 p.m., Certified Nursing Assistant (CNA) 11 indicated she was a new CNA and had only worked with Resident B for about a week. In that short time, she indicated she already knew to be very careful about touching his things, and she always made sure that if she needed to move anything when she provided care, that she would ask him before touching or moving the item. He would either move it himself or tell her it was ok to move it			

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and where to put it. As long as staff approached him and asked or explained what needed to be done, he was usually really good about doing it and never refused care from her.

On 9/16/21 at 11:50 a.m., the DON provided copies of the reportable Incident #342 and corresponding investigation. The investigation included but was not limited: the reportable incident #342, witness statements, a skin assessment for Resident B.

A skin assessment, dated 9/1/21, completed by UM 9 indicated bruises to both his forearms. A bruise on his right forearm which measured 5 cm (centimeters) wide by 1 cm long. A bruise on his left forearm which measured 6 cm wide by 1 cm long. A third area was circled on his left forearm and indicated, "bruising, blood drawn."

Witness statements included, but were not limited to the following:
a. LPN 7 undated statement: "...related to the incident with [Resident B] noted the day in question as the staff nurse for the day... noted during med pass that res [resident] had a foul odor present, flying nets [gnats] mold and mildew on several of the items, multiple areas with large amount of ants, a rotten egg noted with Easter decorations that was half eaten and the presence of a maggot crawling on a piece of the content in question. I removed the items at this time because I thought it was a health hazard."
b. Social Service Director, Statement, dated 9/1/21: "...[Resident B] was standing by the ice machine yelling and screaming "someone stole from me!" I began to walk with him to calm him down, he yelled and screamed, "I want it back..." I observed [Resident B] picking up his phone and dialing 911..." Statement 2 dated 9/1/21: "...After

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EMT [Emergency Medical Transport] and Police left the building I visited [Resident B] in his room...[Resident B] stated he walked down the hall to look at the dinner menu and the clock. [Resident B] was headed back towards his room and saw a staff wearing red leaving his room carrying something yellow in her hand... it looked like a trash can... [Resident B] noticed his property was removed... then stated he came out of his room and walked down the hall towards the ice machine... placed his hand in the machine. He stated, "I was upset." [Resident B] reported that a man in blue shut the door while his arm was in the machine. [Resident B] pulled his left sleeve up and pointed to a bruise that he received while arm was in the machine..."
c. UM 9 Statement dated 9/2/21: "...resident starts screaming and stated, if he didn't get his property back, he would hurt us... went around at 8:10 to do a skin and pain assessment and noted 2 bruises on L [left] FA [forearms] and RFA [right forearm] asked resident how he got them and resident states when I was in ice machine earlier, door kept falling on my arms..."

On 9/16/21 at 3:00 p.m., a record review was completed for Resident B. Resident B had diagnoses which included but were not limited to obsessive-compulsive personality disorder (OCD), Autistic disorder and muscle weakness.

Resident B had comprehensive care plans which included, but were not limited to:
a. A care plan, initiated 9/28/2020, indicated Resident B was intellectually disabled due to his diagnoses of depressive disorder, Autism and OCD. Interventions for this plan of care included, but were not limited to a behavioral-based treatment plan, crisis intervention and training in ADLs (activities of

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	daily living) b. A care plan, initiated 1/20/2021, indicated Resident B preferred to keep items such as "meal tray cards" papers, paper plates, napkins etc. in excess. These items become very important to him as personal items and he will become fixated and distressed if they are moved or displaced. Interventions for the plan of care included but were not limited to: Staff should avoid removing or replacing his personal items. Intervention #1 Staff should educate resident on sanitation procedures. Intervention #2 Staff should reapproach at a later time. Intervention #4 Staff should allow resident to assist with gathering personal property... c. A care plan, initiated 1/29/2021, indicated Resident B had behaviors of aggression/agitation, screaming and yelling and using profanity towards staff and personal distress when personal items are moved or he is encouraged to clean his room... Interventions for this plan of care included but were not limited to: Intervention #1 staff should approach resident in a friendly and calm manner, then ask him for help to complete a task. On 4/1/21 at 3:50 p.m., the SSD completed a quarterly MDS (minimum data set) interview. The note indicated, "...writer engaged resident in discussion regarding his medical conditions and continuing to refuse care from staff. Resident discussed his past family history and stated things were taken from him..." A Monthly Behavior Symptom Summary Form, dated 6/26/21, indicated, April monthly behaviors summary, no behaviors were coded, "No changes at this time." A Monthly Behavior Symptom Summary Form			

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dated 6/27/21 indicated, May monthly behaviors summary, no behaviors were coded, "No changes at this time. Continue to follow appropriate interventions."

A Monthly Behavior Symptom Summary Form dated 6/30/21 indicated, June monthly behaviors summary, no behaviors were coded, "no changes at this time. Continue to follow appropriate interventions."

A Monthly Behavior Symptom Summary Form dated 7/29/21 indicated, July monthly behaviors summary, no behaviors were coded, "no changes at this time. Continue to follow appropriate interventions."

Resident B's nursing progress notes from 4/1/21 through current were reviewed.

On 6/2/21 at 2:10 p.m. a progress note indicated, the resident had rotten boiled eggs from Easter. When Housekeeping attempted to remove the eggs, he became upset and refused to allow the eggs to be removed. There were no follow up progress notes, behavioral notes, or documentation of additional attempted approaches, care plan interventions, or resident educations.

On 6/14/21 at 4:22 p.m., the SSD entered a note which indicated, the SSD and ED (Executive Director) visited Resident B's room and discussed proper sanitation and cleaning of the room for infection control purposes. Resident B has continued to refuse showers and throwing away of trash. ED provided resident with a tote and encouraged resident to discard of expired food. Staff planned to allow the resident time to properly clean his room and re-approach.

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	Resident B had two assessments titled, "Preferences for Customary Routine and Activities," one dated 7/6/21 and the second dated 9/14/21. Both assessments indicated Resident B felt it was "very important" to be able to take care of his personal belongings. On 8/9/21 at 10:17 a.m., a progress note indicated, staff attempted to assist Resident B to clean his room, but the resident refused. Items that needed to be thrown away included but were not limited to a PB&J (peanut butter and jelly) sandwich dated 6/26/21. There were no follow up progress notes, behavioral notes, or documentation of additional attempted approaches, care plan interventions, or resident educations. On 8/15/21 at 10:02 a.m., a progress note indicated, the PB&J sandwich was still in Resident B's room. Staff offered to assist him to clean his room, but he refused. There were no follow up progress notes, behavioral notes, or documentation of additional attempted approaches, care plan interventions, or resident educations. On 8/25/21 at 8:17 p.m., a progress note indicated, Resident B refused to have his room cleaned of old trash menus, cups, popcorn bags, and empty food containers but there were still no follow up progress notes, behavioral notes, or documentation of additional attempted approaches, care plan interventions, or resident educations. On 9/1/21 at 2:11 p.m., the SSD visited the resident due to complaints about him throwing water on the floor. The SSD asked him if he had			

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	155383	A. BUILDING 00 B. WING	09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON HEALTHCARE CENTER	8201 W WASHINGTON ST INDIANAPOLIS, IN 46231

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thrown water on the floor and Resident B denied it. Housekeeping had been in his room several times to mop up the water. Resident B appeared agitated and refused to further engage in conversation.

On 9/1/21 at 2:16 p.m., a progress note, written by LPN 7, indicated Resident B was noted to have behaviors, and was educated about throwing water and food on the floor that it could be a hazard for him as well as the staff, but the resident responded, "I don't care all of you can die."

On 9/16/21 at 2:40 p.m., the DON provided copies of current facility policies.

The first policy was titled, "Abuse Prohibition, Reporting, and Investigation," revised 2/2020. The policy indicated, "...It is the policy of [name of management company] to provide each resident with an environment that is free from abuse, neglect, misappropriation of resident property and exploitation... misappropriation of resident funds or property- deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's property or money without the resident's consent...."

A second policy, titled, "Behavior Management Policy," revised 5/2019. the policy indicated, " ...It is the policy of [name of management company] to provide behavior interventions for residents with problematic or distressing behaviors. Interventions provided are both individualized and non-pharmacological and part of a supportive physical and psychosocial environment that is directed toward preventing, relieving and/or accommodating a resident's

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	distressed behavior... Care plans should be initiated for any behavioral issues that affects, or has the potential to affect the resident or other residents... When a behavior occurs, the staff communicated to the nurse what behavior occurred. The nurse records the behavior on the monitoring form, if the residents is being monitored for the behavior, including what interventions were attempted during the episode and whether or not they were effective...." A third policy, titled, "Resident Rights," 3/2017 indicated, "You have the right to a dignified existence, self-determination... you have a right to be informed, and participate in your treatment. that includes the right to... participate in the development and implementation of your person-centered plan of care...you have the right to make choices about aspects of your life in the facility that are significant to you..." This Federal tag relates to Complaints IN00362249 and IN00362608. 3.1-37(a)			