STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		r í				X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 00			COMPLETED	
		155357	B. W	ING		02/23/	/2018	
	ROVIDER OR SUPPLIER	& LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP COD 300 J H WALKER DR PENDLETON, IN 46064					
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	DDOVIDED & BLANCE CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG				TAG	DEFICIENCY)		DATE	
F 0000								
Bldg. 00	IN00246929, IN002 visit resulted in a Pa	ne Investigation of Complaints 248080 and IN00250160. This artially Extended I Quality of Care-Immediate	F 00	000	The plan of correction is to set as Rawlins House credible allegation of compliance.	rve		
	Federal/State deficie are cited at F600, F6 Complaint IN00246 Federal/State deficie are cited at F726. Complaint IN00248 Federal/State deficie are cited at F600, F6 Unrelated deficienc	1929 - Substantiated. 1929 - Substantiated. 19080 - Substantiated. 19080 - Substantiated. 1909 F610 and F726. 1909 F610 and F726. 1909 are cited. 1909 P610 and 23 2018. 1909 P610 P610 P610 P610 P610 P610 P610 P610			Submission of this plan of correction does not constitute admission by Rawlins House of management company that the allegations contained in the sureport is a true and accurate portrayal of the provision of nucare and other services in this facility. Nor does this submiss constitute an agreement or admission of the survey allegations.	or its e urvey ursing		
	Total: 86 Census payor type: Medicare: 20 Medicaid: 51 Other: 15 Total: 86							

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.

Event ID: NYLX11 Facility ID: 000248 If continuation sheet Page 1 of 35

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155357		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE A. BUILDING 00 COMPLETED B. WING 02/23/2018			ETED		
	PROVIDER OR SUPPLIER	& LIVING COMMUNITY	•	300 J H	ADDRESS, CITY, STATE, ZIP COD WALKER DR ETON, IN 46064		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TION SHOULD BE THE APPROPRIATE	
-	These deficiencies r accordance with 410	eflects State findings cited in					DATE
F 0600 SS=K Bldg. 00	Free from Abuse and Neglect		F 00	600	F 600		03/19/2018
	6 residents reviewed practice resulted in Broda chair as a resident and Resident medication administ D and Resident J) T potential to affect 56	ase by a staff member for 2 of all for abuse. This deficient Resident D being placed in a traint for approximately 4 J being tearful after tration with LPN 7. (Resident his deficient practice had the foresidents who lived on the too resided in the facility.			We respectfully request a face to face IDR for this citation to present additional evidence for review.		
	LPN 7 placed Resid back as LPN 7 slept nurse also forcefully resident. The Admi	ardy began on 1/31/18 when ent D in a Broda chair, tilted it at the nurses' station. This administered medication to a nistrator was notified of the on 2/21/18 at 1:20 p.m.			I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NYLX11 Facility ID: 000248

If continuation sheet Page 2 of 35

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155357	A. BUILDING 00 COMPLETED B. WING 02/23/2018			COMPLETED 02/23/2018	
		100001	D. W	_		0212312010	
NAME OF F	ROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD		
RAWLIN	S HOUSE HEALTH	& LIVING COMMUNITY	PENDLETON, IN 46064				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	,	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG	Findings include: 1. The clinical record on 2/19/18 at 5:38 gwere not limited to, Alzheimer's disease dysphagia, and aner Resident D was admanated 1/30/18, indicognitively impaire assistance with 2 permobility, transfers, The resident used a device. A current health carindicated the reside	ord for Resident D was reviewed o.m. Diagnoses included, but dementia with behaviors, a, chronic kidney disease, mia. Initted to the facility on 1/18/18. In Data Set (MDS) assessment, atted the resident was severely d. He required extensive erson assistance for bed walking, dressing and hygiene. wheelchair as his mobility The plan, dated 1/22/18, and exhibited wandering titions included, but were not		TAG	Resident D no longer resident in the facility. LPN 7 employment has been terminated. Resident J has received psychosocial follow up related to being tearful following medication administration for LPN 7. CNA 10 employment has been terminated. LPN 3 was in-serviced on abuse and reporting, but has since resigned and is no	ted rom een	
	On 1/24/18 at 1:00 to have been exit se	a magazine or book, walk the ident or join an activity. a.m., the resident was observed eking on the North Hall. schedule for 1/30/18, LPN 7 North Hall from 2:00 p.m. until 8.			longer working in the facility CNA 2, CNA 9, CNA 8, and laundry Aide 16 were in-serviced on abuse and reporting.		
	reportable, dated 1/z Resident D was place position. A staff me resident would not le The incident was in	na State Department of Health 31/18 at 8:40 a.m., indicated ced in a "geri chair in a reclined ember was concerned the be able to get up on his own." Inmediately reported to the N 7 was suspended pending an			II. The facility will identify other residents that may potentially be affected by the deficient practice. Other residents residing at Rawlins House have the poter		

PRINTED: 03/12/2018 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039	
STATEME	ENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	N OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155357	B. WING		02/23/2018	
	PROVIDER OR SUPPLIED	R & LIVING COMMUNITY	300 J	T ADDRESS, CITY, STATE, ZIP COD I H WALKER DR DLETON, IN 46064		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		
TAG	,	R LSC IDENTIFYING INFORMATION	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
1110		ity investigation indicated the	1110	to be affected by the alleged	DITTE	
	following:	ney mivestigation maneuted the		deficient practice.		
	100000000000000000000000000000000000000			denoism praedes.		
	A statement, dated	2/1/18, by CNA 10, indicated				
	she was told by LP	N 7 to get a Broda chair (a				
	reclining chair on v	wheels) from another hall. She		To identify concerns with abu	se,	
	asked the nurse if a	resident needed an order and		restraint usage or medication		
	the nurse stated "It	doesn't matter, he won't stay		administration, other residents	s	
	still." CNA 10 wer	nt to find a Broda chair on		with a BIMS of 8 or greater ha	ave	
		nen she returned, LPN 7 had		been interviewed using an Ab	use	
		ne. CNA 10 indicated she did		questionnaire. Families of		
	help move Resident D into the Broda chair because she did not want LPN 7 to transfer him herself.			non-interviewable residents h	ave	
				been interviewed using an Ab		
				questionnaire. Staff members		
				work at the facility have been		
	_	ed by CNA 8, dated 2/1/18,		interviewed by corporate staff		
		arrived, she noticed Resident		regarding abuse. Any new		
		a chair. She indicated she		allegations of abuse were rep		
		and covered him up		to the Administrator and the IS	SDH	
		statement indicated LPN 7		immediately.		
		You're going to want to keep				
		er nurse directed CNA 8 to				
		and move him into his				
	wheelchair.			A trend analysis was performe		
				and no other staff members w	/ere	
		A 9, dated 2/1/18, indicated		identified to have ongoing		
		acility at 6:00 a.m. She		concerns or an accumulation	ot	
		D had a gown on the floor		abuse allegations.		
		s seated in a Broda chair and it				
		ck. She asked LPN 7 why				
		the Broda chair and LPN 7				
		much last night." She		All residents at Rawlins House		
		unit came to the North Hall		assessed on 2/21/18 to ensur	e	
	unit looking for the	e Broua chair.		the facility is restraint free.		
	A statement by I Di	N 4 indicated when he arrived				
	A statement by LPN 4, indicated when he arrived to work, he saw Resident D "lying back in the broda" and asked LPN 7 what he was doing there.					
		couldn't do anything with him,		III. The facility will put into		
	Li i , indicated i	TO WILLIAM WILLIAM WILLIAM,	ı	place the following eyeter	nic I	

so I put him there to keep him off the floor." LPN

NYLX11

place the following systemic

changes to ensure that the

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155357	B. WI	NG		02/23/	2018
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	R			WALKER DR		
RAWLINS	S HOUSE HEALTH	& LIVING COMMUNITY			ETON, IN 46064		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID PROVIDER'S PLAN OF CORRECTION		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		nat she could not really just put			deficient practice does no	t	
	him there and LPN	7 stated "well I did."			recur.		
	31, 2018 starting at Administrator, Dire Nurse, Resided D w wheelchair at the nusleeping at the nurse 10 brought a Broda LPN 7 was waking Resident D was morthe Broda chair by 0 reclined the Broda of	the video surveillance of January 2:06 a.m., along with the sector of Nursing and Corporate was seen seated in his surses' station while LPN 7 was es station. At 2:08 a.m., CNA chair to the North Hall and up and stretching. At 2:32 a.m., ved from his wheelchair into CNA 10 and LPN 7. CNA 10 chair completely back and him. Resident D continued to			Staff were educated on propuse of restraints and example of inappropriate use of restraints resulting in abuse Staff are being educated regarding appropriate	oles	
	be restless throughout kick off his sheet are gown. At 4:46 a.m. brief while he was that 5:05 a.m., Reside	out the morning, continued to and attempted to remove his ., CNA 10 removed Resident D's cilted back in the Broda chair. ent D appeared to only have			behavioral interventions and fall interventions.		
	covered him. Resident Station. At 5:55 a.m. Resident D from the returned at 6:03 a.m. 6:05 a.m., Resident Broda Chair to his v. An employee commindicated LPN 7 was	nunication form, dated 2/2/18, as terminated for "Failure to			All 3rd party vendors with direct patient care access that visit the property of Rawlins House will receive education related to identifying abuse with detailed examples of what constitutes abuse, including restraints, printing party services being provito Rawlins House residents.	ne or to	
	Confidential intervi Exact times and dat anonymity. Employee 1 indicate ever by being mean	ews for staff were completed. es withheld to maintain ed LPN 7 was the worst nurse and rude to the residents and refuse for LPN 7 to give them			Licensed nurses that work at Rawlins House will receive education immediately and price working any shifts related to proper administration of medication including the resideright to refuse as well as documentation of medication		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: NYLX11 Facility ID: 000248

If continuation sheet Page 5 of 35

PRINTED: 03/12/2018 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. Bl	(X2) MULTIPLE CONSTRUCTION A. BUILDING O D. WING			(X3) DATE SURVEY COMPLETED	
		155357	B. WING			02/23	/2018	
	PROVIDER OR SUPPLIER	& LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP COD 300 J H WALKER DR PENDLETON, IN 46064					
(X4) ID PREFIX TAG	summary: (EACH DEFICIEN REGULATORY OR their medication. E wrote up several gri Employee 1 indicate so they just started of directly. Employee 2 indicate and they had it on c reported by a day sl and Director of Nur concerns with LPN were passing along stopped with the Ac Nursing (DON). Employee 3 indicate in a "good way" by pain medication and repeatedly ask her f	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION mployee 1 indicated he/she evance forms, as did therapy. ed that did not seem to work, calling the Administrator ed LPN 7 left Resident D naked amera. He/She stated it was nift nurse The Administrator sing (DON) were aware of the 7. He/She thought the nurses' the information, but felt it dministrator and Director of ed LPN 7 did not treat residents not giving the residents their d the residents would have to for it. He/She thought ware that LPN 7 was abusive.		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) administration at time of administration, according to professional nursing practice standards and CarDon policie Licensed nurses that work at Rawlins House will complete skills validation of medication pass. Newly hired licensed nurses we complete a medication pass so validation prior to working on floor and their skills and compliance with CarDon policie and professional standards we	es. a will skills the	(X5) COMPLETION DATE	
	Employee 3 indicate with LPN 7.	ed staff often refused to work			monitored through observatio ensure competence.			
	complaints of LPN pain medication. Employee 5 indicat going on for some t	ed he/she often heard 7 not giving residents their ed the complaints had been the complaints went the complaints went the complaints was being			Human Resources director, Director of Nursing and Administrator educated regard accurate documentation of refor termination for employees	ason		
	complaints about LI medication. LPN 7 time ago. He/She h	ed he/she heard a lot of PN 7 withholding pain should have been gone a long eard LPN 7 say "if they are oke with me, I am not giving licine."			Administrator and staff educa on grievance process includin follow up on grievances voice residents regarding medicatio administration or potential	ng d by		

FORM CMS-2567(02-99) Previous Versions Obsolete

Employee 7 indicated staff often filled out

Event ID:

NYLX11

Facility ID: 000248

medication errors.

If continuation sheet Page 6 of 35

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X3) DATE SURVEY		
AND PLAN	N OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED		
		155357	B. WING		02/23/2018
	PROVIDER OR SUPPLIER	≀ & LIVING COMMUNITY	300 J	r address, city, state, zip cod H WALKER DR DLETON, IN 46064	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	-	d to his/her knowledge, the			
	Administrator had i	not spoken to any of them.			
				Grievances voiced by a resident,	
	Employee 8 indicated when staff mentioned anything to the Administrator, he told them to go to nursing.			family member or staff memb	l l
				will be immediately reported t	l l
				administrator who will delega appropriate steps and determ	l l
	Employee 9 indicated when he/she arrived to work			the concern constitutes a	IIIC II
		ent D's genitals were visible and		reportable or a grievance.	
	the chair was tipped	•			
		a.m., the Administrator			
	indicated for the last couple of months, things			The grievance process direct	ing
	were not working well with LPN 7. He indicated			staff to contact the administra	tor
	-	administering medications		directly for each and every	
	timely.			grievance/concern has been	_
	During an interview	v on 2/20/18 at 9:46 a.m., the		posted at each nurse's station outside the social services of	
	-	ly in 2017, LPN 7 was not		and in the break room.	ice,
		day shift and she moved her to		and in the break room.	
		I bring her in and talk to her,			
	but felt she was not	_			
				All staff members that we	ork
		7 a.m., LPN 9 indicated when he		at Rawlins House will red	ceive
		esident D only had a T-shirt on		education immediately a	
		ere was a sheet on the floor.		prior to working any shift	
		ent D was reclined in the chair. Ides to take him to his room,		related to directly and	
		ut him in his wheelchair.		immediately reporting	
	cican min up and p	at mm m ms wheelellan.		· · · · ·	.
	During an interview	v on 2/21/18 at 9:48 a.m., the		allegations of abuse to the	
	_	N 7 told CNA 10 to go and get a		Administrator, after ensu	· 1
		10 did help transfer Resident D		resident safety, with deta	
		r. LPN 7 did not provide a		examples of what consti	
		nd although the DON had		abuse. Staff members w	ill be
		urveillance, she was unable to		educated to follow the al	oove
		esident D was placed in the		protocol, without fear of	
	Broda chair.			retaliation, even if the ab	user
	During a telephone	interview on 2/22/18 at 11:49		is a superior or manager	
	I During a telebrione	IIILCI VICW OII 2/22/10 at 11.49		1	- I

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLI	ETED
		155357	B. WING 02/23/2018			2018	
				GED FEE	A DODDEGG CHEV CHARE HID COD		
NAME OF 1	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
D 414/1 IN	0.1101105.115.1.71				WALKER DR		
RAWLIN	S HOUSE HEALTF	I & LIVING COMMUNITY		PENDL	ETON, IN 46064		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	_{тс}	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	a.m., LPN 3 indicar	ted she did remember the night					
	when Resident D w	vas in the Broda chair. She was					
	told her image was	seen on the video moving					
	Resident D to the s	ide so she could weigh another					
	resident. She indic	ated she was unfamiliar with					
	the resident and if l	ne was usually in a Broda chair.					
	She did not report t	he incident to the					
	Administrator.				IV The facility will monit	or	
					the corrective action by		
	Review of LPN 7's	employee record, indicated she			implementing the following	.	
	signed an acknowle	edgement of policies on				9	
	12/7/16. The polic	ies included, but were not			measures.		
	limited to, abuse pr	revention, code of conduct, and					
	reporting a reasonable suspicion of a crime against a resident.						
					The Director of Nursing, or	. ,	
	LPN 7 also signed	a general orientation checklist			designee, will audit new restra		
	on 12/7/16, indicat	ing she had received sufficient			for appropriate usage daily for		
	education and train	ing for abuse, neglect and			days, then weekly for 90 days		
	resident rights.				then monthly for 9 months.		
		signed an affirmation statement					
	indicating she agree	ed to abide by the code of			The Director of Nursing or		
	conduct.				The Director of Nursing, or	_	
					designee, will audit medication		
		4 p.m., the Corporate			pass with 5 nurses weekly for days, then 5 nurses monthly for		
		cated CNA 10 had been			90 days then one 1 nurse mor		
	· ·	for her contributions to the			for 9 months.	iuiiy	
	abusive conduct				ioi a monuia.		
		interview on 2/22/18 at 3:22					
	_	ted it was the CNA who			The Administrator or design	₁₆₆	
		esident D in the Broda chair.			will interview a minimum of		
		d to management before that			residents with a BIMS of 8		
	Resident D needed one on one observation						
	because he would often wander into other				greater, 5 family members		
	resident rooms. LPN 7 indicated she would often				representatives of residents	•	
	put her head down because she had a headache.				who have cognitive		
		e would occasionally document			impairment, and 5 staff		
	that she had admin	istered medication on her shift,			members using an Abuse		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. Bl	UILDING	00	COMPL	ETED
		155357	B. W	ING		02/23/	2018
		l .	1	CTDEET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	₹			I WALKER DR		
ΒΔ\Λ/Ι ΙΝΙ	S HOUSE HEALTH	& LIVING COMMUNITY			ETON, IN 46064		
IVAVVLIIV	- TOUGE HEALTH	a Livino Commoni i		LLINDL	1 014, 114 70007		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
		s busy, the day shift nurse			questionnaire to ensure		
	would then give the medication. She gave no				residents are free from abu		
	-	hy as the nurse in charge, she			This will be completed weel	-	
		ent D to be placed in the Broda			for 9 weeks and monthly for	r 9	
	chair.				months for a total of 12		
	2 The eliminal reservices	and for Decident Luces reviewed			months of monitoring.		
		ord for Resident J was reviewed a.m. Diagnoses included, but					
		bacterial pneumonia,					
		weakness, hypertension and					
	peripheral vascular disease. During an interview on 2/21/18 at 10:54 a.m., Resident J indicated she received two doses of				Any allegations of abuse wi		
					be reported immediately an		
					investigated. Results of the		
					interviews and audits will be	е	
		e night. She indicated she was			reported to the QA committ	ee	
		but stated the nurse brought			monthly and ongoing		
		f crushed medications and			frequency will be adjusted a	as	
	told her to take it.	The nurse was forceful and the			need if compliance is below	,	
		and very scared. The			100%.		
	medicine cup had h	er blood pressure medications					
	in it. She told CNA	6 about the incident.					
		imum Data Set (MDS)					
		/19/18, indicated Resident J					
	was cognitively into	act.					
	During an interview	v on 2/19/18 at 9:26 p.m., CNA 6			V. Date of Compliance		
		to work at 10:00 p.m. on			03/19/18.		
		xed until 6:00 a.m. on 1/31/18.					
		e saw LPN 7 coming out of					
		When she made her way back					
		n, she was crying and said the			Facility Administrator will be	,	
		e her medications again. The			responsible for ensuring		
		ld the nurse she had already			compliance by the date liste	_{ed.}	
	taken them. The resident was afraid and did not want her to leave her.				i compilation by the date list		
	want her to leave no	51.					
	CNA 6 indicated she notified the charge nurse, LPN 5, that Resident J stated she had taken her						
		LPN 5 told her to report it.					
			1		l		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NYLX11 Facility ID: 000248

If continuation sheet Page 9 of 35

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155357		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 02/23/2018			
	ROVIDER OR SUPPLIER	& LIVING COMMUNITY	300 J F	ADDRESS, CITY, STATE, ZIP COD I WALKER DR LETON, IN 46064	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	a.m., LPN 5 indicated Resident J supposed She did not go and at the unit manger than the unit manger that the unit manger than the unit manger that the unit manger that the unit	Sa.m., Unit Manager 4, DON, Corporate Nurse were corporate Nurse indicated she day by the therapist that the eto Resident J was heard exceived two doses of her immediately assessed Resident A 6, who indicated she did not next door roommate about 1. p.m., the DON indicated she 5. LPN 5 went to the Northing and CNA 6 told her that int J two doses of medicine. Her and was unaware the interest of the DON indicated LPN 5 Unit Manager 4 at home. She sident J and the resident was scared or tearful, but did stuck it in my mouth." 1. Dolicy, dated October 2014 and 6, titled "Abuse Policy," ON on 2/20/18 at 8:50 a.m., ving: provide each resident with an free from verbal, sexual, all abuse, corporal punishment, lusion"			
	AND SYMPTOMS	OF ABUSE			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NYLX11 Facility ID: 000248

If continuation sheet

Page 10 of 35

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155357		(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/23/2018	
	PROVIDER OR SUPPLIER IS HOUSE HEALTH & LIVING COMMUNITY	300 J H	ADDRESS, CITY, STATE, ZIP COD I WALKER DR ETON, IN 46064		
(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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
	Policy Statement Our facility will not condone any form of resident abuse or neglect. To aid in abuse prevention, all personnel are to report any signs and symptoms of abuse/neglect to their supervisor immediately who will report to the Administrator or authorized designee immediately. VII. REPORTING ABUSE TO: A. Administrator				
	Policy Statement It is the responsibility of our employeesto immediately report any incident or suspected incident of neglect or abuseto the Administrator or Designee if the Administrator is unavailablea. Abuse is defined as the willful infliction of injury; unreasonable confinement; intimidation; punishment with resulting physical harm; pain or mental anguish; or deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-beinge. Involuntary seclusion is defined as separation of a resident from other residents or from his or her room"				
	A current undated facility policy, titled "Use of Restraints," provided by the DON on 2/22/18 at 12:16 p.m., indicated the following: "Restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the prevention of falls. 3. Examples of devicesgeri-chairs"				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NYLX11 Facility ID: 000248

If continuation sheet Page 11 of 35

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155357		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 02/23/2018			
	ROVIDER OR SUPPLIER S HOUSE HEALTH	& LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP COD 300 J H WALKER DR PENDLETON, IN 46064				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL 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	
F 0609 SS=K Bldg. 00	An undated, facility Med Pass Clinical Sprovided by the DO indicated the follow "29. Medication or minutes before or at otherwise directed by the Immediate Jeograms removed on 2/2 staff confirmed the staff on abuse, restraprocess. The noncolower scope and sew with potential for mot immediate jeograms and not been inserved. This Federal tag relations in the facility must: 3.1-27(a)(1) 483.12(c)(1)(4) Reporting of Alleg §483.12(c) In respanse, neglect, exthe facility must: §483.12(c)(1) Ensity injuries of unknown misappropriation or reported immediate hours after the allegation do not in allegation do not	policy, titled "Licensed Nurse skills Validation," which was N on 2/21/18 at 4:10 p.m., ing: was given within the 60 fter the time designated unless by the physician" pardy (IJ) that began on 1/31/18 the physician of the property level of no actual harm ore than minimal harm that is arry because all employees ited. attes to Complaint IN00250160. The ded Violations of the physician of the					
	result in serious be	odily injury, to the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NYLX11 Facility ID: 000248

If continuation sheet Page 12 of 35

03/12/2018 PRINTED: FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 02/23/2018 155357 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 300 J H WALKER DR **RAWLINS HOUSE HEALTH & LIVING COMMUNITY** PENDLETON, IN 46064 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and interview, the facility F 0609 F 609 03/19/2018 failed to ensure that staff members who had knowledge of an incident of physical abuse and a resident who was tearful after medication We respectfully request a face administration on the evening shift, immediately to face IDR for this citation to reported those concerns to the facility present additional evidence for Administrator for 2 of 6 residents reviewed for review. abuse (Resident D and Resident J). This deficient practice had the potential to affect 56 residents who lived on the North Hall of 86 who resided in the facility. I. The corrective actions to be accomplished for those The immediate jeopardy began on 1/31/18 when residents found to have LPN 7 placed Resident D in a Broda chair, as a restraint and a resident was forcibly given been affected by the medication and staff did not immediately report deficient practice. their observations to the Administrator. The Administrator was notified of the immediate jeopardy on 2/21/18 at 1:20 p.m. Allegations for Resident D and Findings include: Resident J have been reported to the ISDH. 1. The clinical record for D was reviewed on 2/19/18 at 5:38 p.m. Diagnoses included, but were CNA 2, CNA 9, CNA 8, and not limited to, dementia with behaviors, laundry Aide 16 were

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NYLX11

Facility ID: 000248

If continuation sheet

Page 13 of 35

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155357	B. W	ING		02/23/2018	
NAME OF I	PROVIDER OR SUPPLIE	D	-	STREET A	ADDRESS, CITY, STATE, ZIP COD	•	_
NAME OF I	PROVIDER OR SUPPLIE.	ĸ			H WALKER DR		
RAWLIN	S HOUSE HEALTH	1 & LIVING COMMUNITY		PENDL	ETON, IN 46064		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	,	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	IATE CONTENTION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
		e, chronic kidney disease,			in-serviced on abuse and		
	dysphagia, and ane	emia.			reporting.		
	Pagidant Dayag ad	mitted to the facility on 1/18/18.					
		n Data Set (MDS) assessment,			CNA 10 employment has t	peen	
	dated 1/30/18, indicated Resident D was severely				terminated.		
	cognitively impaired. Resident D required						
	extensive assistance with 2 person assistance for						
		fers, walking, dressing and					
	hygiene. Resident	D used a wheelchair as his					
	mobility device.				II. The facility will identif	5 .,	
					_	ıy	
	A current health care plan, dated 1/22/18,				other residents that may	_	
	indicated Resident D exhibited wandering				potentially be affected by		
		ntions included, but were not			the deficient practice.		
	_	a magazine or book, walk the					
	facility with the res	sident or join an activity.					
	Review of the staff	schedule for 1/30/18, LPN 7			Other residents with a BIMS	of 8	
		e North Hall from 2:00 p.m. until			or greater have been intervie		
	6:00 a.m. on 1/31/1	-			using an Abuse questionnaire	•	
					Families of non-interviewable		
	During review of the	he video surveillance of January			residents have been interview	wed	
	31, 2018 starting at	t 2:06 a.m., along with the			using an Abuse questionnaire	e.	
		ector of Nursing and Corporate			Staff members who work at the	he	
	Nurse, the following	ng was noted:			facility have been interviewed	-	
					corporate staff regarding abu	•	
		2 was seen walking around			Any new allegations of abuse		
		resident sat in a Broda chair			reported to the Administrator	and	
	(reclining chair on	wheels).			the ISDH immediately.		
	At 3.51 am Laun	dry Aid 10 was seen in the					
	1	ndry carts near Resident D while					
		e Broda chair, leaned back. No					
	other staff person v	, and the second					
		-			III. The facility will put int	o	
	At 4:44 a.m., LPN	3 was seen bringing another			place the following syste		
	resident in a Broda	chair to be weighed. She			changes to ensure that the		
		out of the way, then pushed			deficient practice does no		
	the other resident to	o be weighed and then left.			dencient practice does no	υ ι	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPL	ETED
		155357	B. W	ING		02/23/	′2018
				_	_		
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
					I WALKER DR		
RAWLIN	S HOUSE HEALTH	& LIVING COMMUNITY		PENDL	ETON, IN 46064		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
					recur.		
	At 5:29 a.m., CNA	8 walked by Resident D, picked			1.000		
		is on the floor and tossed it					
	back over the reside						
					All staff as such and that	ماسا	
	At 5:30 a.m., CNA	11 walked past Resident D to			All staff members that work		
	place her items at the	-			at Rawlins House receive		
					education immediately ar	nd	
	Review of an India	na State Department of Health			prior to working any shifts	3	
	reportable, dated 1/31/18 at 8:40 a.m., indicated				related to directly and		
	Resident D was placed in a "geri chair in a reclined				immediately reporting		
	position. A staff member was concerned the					_	
	resident would not be able to get up on his own."				allegations of abuse to the		
					Administrator, after ensuring		
	The report indicated	d the incident was immediately			resident safety, with detailed		
	reported to the Adn	ninistrator. LPN 7 was			examples of what constit	utes	
	suspended pending	an investigation. Although			abuse. Staff members wi		
	this incident started	at 2:06 am, no one reported it			educated to follow the ab		
	to the Administrato	r until the LPN 4 arrived to				ove	
	work on day shift.				protocol, without fear of		
					retaliation, even if the ab	user	
	Review of the facili	ity investigation, a statement,			is a superior or manager.	i	
	dated 2/1/18, by CN	NA 10, indicated she was told					
	by LPN 7 to get a E	Broda chair from another hall.					
	She asked the nurse	e if a resident needed an order					
	and the nurse stated	l "It doesn't matter, he won't			3rd party vendors with direct		
	stay still." CNA 10	went to find a Broda chair on			patient care access that visit t	he	
	another hall and wh	en she returned, LPN 7 had			property of Rawlins House wil		
	already retrieved or	ne. CNA 10 indicated she did			receive education related to	•	
	help remove Reside	ent D into the Broda chair			directly and immediately report	tina	
	because she did not	want LPN 7 to transfer him			allegations of abuse to the	9	
	herself.				Administrator with detailed		
					examples of what constitutes		
	A statement provide	ed by CNA 8, dated 2/1/18,			abuse and how to report abus	е	
	indicated when she arrived, she noticed Resident				prior to third party services be		
	D seated in a Broda chair. She indicated she				provided to Rawlins House	9	
	picked up his gown and covered him up				residents.		
		statement indicated LPN 7					
	continued to say "Y	ou're going to want to keep					
	1	er nurse directed CNA 8 to					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NYLX11 Facility ID: 000248

If continuation sheet Page 15 of 35

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í		ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLETED
		155357	B. W	'ING		02/23/2018
NAME OF I	DROWNER OR GURNI IEE			STREET A	ADDRESS, CITY, STATE, ZIP COD	
NAME OF I	PROVIDER OR SUPPLIEF	C.		300 J F	I WALKER DR	
	S HOUSE HEALTH	& LIVING COMMUNITY		PENDL	ETON, IN 46064	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION
TAG		D and move him into his		TAG	The Administrator and DON	DATE
	wheelchair.	and move min into ms			received Corporate Directed	
	wheelenan.				training on CarDon's abuse	
	A statement by CN.	A 9, dated 2/1/18, indicated			reporting policy. The Administ	rator
she arrived at the facility at 6:00 a.m. She					has since resigned and is no	
	indicated Resident	D had a gown on the floor			longer employed at the facility	. An
	beside him. He was	s seated in a Broda chair and it			interim administrator with	
		ck. She asked LPN 7 why			considerable experience in lor	ng
		he Broda chair and LPN 7			term care is filling the role of the	he
		much last night." She			Administrator until a new	
	indicated the other unit came to the North Hall				Administrator is hired. Any nev	
unit looking for the Broda chair.				Administrator will receive thore	_	
					training by CarDon corporate	staff
	A statement by LPN 4, indicated when he arrived to work, he saw Resident D "lying back in the				on CarDon's abuse reporting	
		PN 7 what he was doing there.			policy.	
		couldn't do anything with him,				
		keep him off the floor." LPN				
	_	nat she could not really just put			Administrator and staff educat	had
		7 stated "well I did."			on grievance process includin	
					follow up on grievances voice	
	An employee comn	nunication form, dated 2/2/18,			residents regarding medication	-
	indicated LPN 7 wa	s terminated for "Failure to		administration or potential		
	ensure resident safe	ty, sleeping on clock on unit."			medication errors.	
	On 2/20/18 at 10:22	7 a.m., LPN 9 indicated when he				
		sident D only had a T-shirt on				
		heet was on the floor. He			Grievances voiced by a reside	ent
		D was reclined in the chair. He			family member or staff member	
		to take him to his room, clean			will be immediately reported to	
	him up and put him				administrator who will delegate	
	' '				appropriate steps and determi	
	During an interview	on 2/21/18 at 9:48 a.m., the			the concern constitutes a	
	DON indicated LPN	N 7 told CNA 10 to go and get a			reportable or a grievance.	
	Broda chair. CNA	10 did help transfer Resident D				
		r. LPN 7 did not provide a				
		nd although the DON had				
		rveillance, she was unable to			The grievance process direction	•
	_	sident D was placed in the			staff to contact the administrat	tor
	Broda chair.				directly for each and every	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NYLX11 Facility ID: 000248

If continuation sheet Page 16 of 35

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155357		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED			
		155357	B. W.	ING		02/23/	2018
	PROVIDER OR SUPPLIEI S HOUSE HEALTH	R I & LIVING COMMUNITY		300 J H	ADDRESS, CITY, STATE, ZIP COD I WALKER DR .ETON, IN 46064		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	AIL.	DATE
	8 indicated she que from when she saw report the incident surveillance video, at 5:28 a.m. tossing sat in the Broda characteristic buring a telephone a.m., LPN 3 indicated when Resident D with told her image was Resident D to the size if he was usually in not report the incided buring a telephone	v on 2/22/18 at 12:58 p.m., CNA stioned where the Broda came of Resident D. She did not to the Administrator. On the CNA 8 was seen on the video g a sheet over the resident as he air. interview on 2/22/18 at 11:49 ted she did remember the night was in the Broda chair. She was seen on the video moving ide so she could weigh another unfamiliar with the resident and a Broda chair or not. She did ent to the Administrator. interview on 2/22/18 at 3:22 ted it was the CNA who			grievance/concern has been posted at each nurse's station outside the social services of and in the break room. IV The facility will monit the corrective action by implementing the following measures. The Regional Director of Operations and Corporate Cli Specialist will oversee all allegations of abuse to ensure immediate reporting is occurr	tor ng inical	
	suggested to put Resident D needed because he would oresident rooms. Liput her head down She occasionally deadministered medication. She was busy, the deadministered medication. She why as the nurse in Resident D to be placed by the medication of the placed by the medication of the placed by the medication of the placed by	esident D in the Broda chair. In d to management before that one on one observation often wander into other PN 7 indicated she would often because she had a headache. In output that she had eation on her shift, but because lay shift nurse would then give the gave no explanation as to a charge, she would allow acced in the Broda chair. In ord for Resident J was reviewed a.m. Diagnoses included, but a bacterial pneumonia, weakness, hypertension and			by using a timeline for each occurrence daily and ongoing no current end date. A third party consulting firm, I Beyl, will review all allegation abuse to ensure immediate reporting is occurring by using timeline for each occurrence monthly ongoing with no currend date. The Administrator or designer interview any resident (or representative) who has allegabuse or been alleged to have	g with Lacy s of g a ent	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLETED
		155357	B. W	ING		02/23/2018
				STREET	ADDRESS, CITY, STATE, ZIP COD	
NAME OF F	PROVIDER OR SUPPLIEF	R			I WALKER DR	
RAWLIN	S HOUSE HEALTH	& LIVING COMMUNITY			ETON, IN 46064	
	Г				- ·, ··· · · · · · · · · · · · · · · · ·	<u> </u>
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		R LSC IDENTIFYING INFORMATION d she received two doses of	+	TAG	been abused to determine if the	DATE
		e night. She indicated she was				
		but stated the nurse brought			allegation was handled promp	ouy.
		of crushed medications and				
		The nurse was forceful, she				
		y scared. The medicine cup			The Administrator, or designe	e
		sure medications in it. She told			will interview 5 random staff	-,
	CNA 6 about the incident.				members on various shifts we	ekly
					for 12 weeks, then monthly for	
	An Admission Minimum Data Set (MDS)				months to ensure they are aw	
	assessment, dated 1/19/18, indicated Resident J				of and understand the proced	ure
	was cognitively intact.				for reporting abuse.	
	_	v on 2/19/18 at 9:26 p.m., CNA 6				
		to work at 10:00 p.m. on				
		ked until 1/31/18 at 6:00 a.m.			Results of these audits and	
		e saw LPN 7 coming out of			interviews will be reported to t	he
		When she made her way back			QA committee monthly and	
		n, she was crying and said the			ongoing frequency will be adju	
		e her medications again. The			as needed if compliance is be	low
		ld the nurse she had already			100%.	
		sident was afraid and did not				
	want her to leave he	er.				
	CNA 6 indicated ab	ne notified the charge nurse,				
		nt J stated she had taken her				
	· ·	LPN 5 told her to report it.			V. Dien of Commontion	
	incarcation twice.	221. C told her to report it.			V. Plan of Correction	
	During a telephone	interview on 2/20/18 at 11:41			completion date 03/19/18.	
		ted CNA 6 did tell her that				
		dly took her medication twice.				
		assess the resident, but called			, ,	.
	the unit manger tha				Facility Administrator will	be
					responsible for ensuring	
		3 a.m., Unit Manager 4, DON,			compliance.	
		Corporate Nurse were				
		Corporate Nurse indicated she				
		day by the therapist that the				
		e to Resident J was heard				
	saying Resident J re	eceived two doses of her				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155357		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/23/2018		
	PROVIDER OR SUPPLIEF	& LIVING COMMUNITY	300 J F	ADDRESS, CITY, STATE, ZIP COD I WALKER DR LETON, IN 46064	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION
	assessed Resident J	dicated they immediately and spoke to CNA 6, who ot say anything to the next ut Resident J.			
	had spoken to LPN Hall to get somethin LPN 7 gave Reside She did not assess I resident was tearful stated she did call U had interviewed Re	p.m., the DON indicated she 5. LPN 5 went to the North ng and CNA 6 told her that nt J two doses of medicine. her and was unaware the . The DON indicated LPN 5 Unit Manager 4 at home. She sident J. The resident denied ed or tearful, but did state the in my mouth."			
	revised August 201 provided by the DC indicated the follow "It is the policyto environment that is	provide each resident with an free from verbal, sexual, il abuse, corporal punishment,			
	AND SYMPTOMS Policy Statement Our facility will not abuse or neglect. T personnel are to rep of abuse/neglect to	t condone any form of resident o aid in abuse prevention, all ort any signs and symptoms their supervisor immediately the Administrator or authorized			
	VII. REPORTIN A. Administrator Policy Statement				
	It is the responsibili	ty of our employeesto			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NYLX11

Facility ID: 000248

If continuation sheet

Page 19 of 35

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155357		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU A. BUILDING 00 COMPLE B. WING 02/23/2				
	PROVIDER OR SUPPLIER S HOUSE HEALTH	& LIVING COMMUNITY	300 J	ADDRESS, CITY, STATE, ZIP CO H WALKER DR LETON, IN 46064	DD -	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION
TAG	immediately report incident of neglect or Designee if the Aa. Abuse is define injury; unreasonable punishment with resmental anguish; or of including a caretake necessary to attain of and psychosocial we. Involuntary sees separation of a reside from his or her room. The Immediate Jeogwas removed on 2/2 staff confirmed the staff on abuse, restraprocess. The noncolower scope and sew with potential for more immediate jeoga had not been inservited.	clusion is defined as lent from other residents or n" pardy (IJ) that began on 1/31/18 the second of the secon	TAG	DEFICIENCY		DATE
F 0610 SS=K Bldg. 00	§483.12(c) In resp	nt/Correct Alleged Violation conse to allegations of eploitation, or mistreatment,				
		e evidence that all alleged oughly investigated.				
	. , , ,	vent further potential abuse, on, or mistreatment while s in progress.				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NYLX11 Facility ID: 000248

If continuation sheet

Page 20 of 35

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155357	B. W	NG		02/23/	2018
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				I WALKER DR		
RAWI INS	S HOUSE HEALTH	& LIVING COMMUNITY			ETON, IN 46064		
					1		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE		DATE
	\$402.42(a)(4) Dam	out the recycline of all					
		ort the results of all					
	-	ne administrator or his or					
		oresentative and to other ance with State law,					
		ate Survey Agency, within					
	_	the incident, and if the					
		s verified appropriate					
	corrective action n						
		and record review, the facility	F 00	510	F 610		03/19/2018
		investigate allegations of					00,00,00
	abuse by a staff men	mber (Resident D). This			We respectfully request a fa	ace	
	deficient practice allowed Resident D to remain				to face IDR for this citation		
	restrained and uncovered for approximately 4				present additional evidence		
		nt practice had the potential to			review.		
		who lived on the North Hall of					
	86 who resided in the	ne facility.					
	TEN : 1: / :	1 1 1/21/10 1			I. The corrective actions t	0	
		ardy began on 1/31/18 when			be accomplished for those	9	
		tions of abuse and the facility			residents found to have		
		y investigate the allegations. was notified of the immediate			been affected by the		
	jeopardy on 2/21/18				deficient practice.		
	Jeopardy on 2/21/16	o at 1.20 p.m.			deficient practice.		
	Findings include:						
	i mamga meraue.						
	The clinical reco	ord for D was reviewed on			Resident D no longer resides i	in	
		. Diagnoses included, but were			the facility.	•••	
		entia with behaviors,					
	Alzheimer's disease	, chronic kidney disease,					
	dysphagia, and aner	nia.					
					II. The facility will identify	/	
		nitted to the facility on 1/18/18.			other residents that may	•	
		Data Set (MDS) assessment,			potentially be affected by		
	-	ated Resident D was severely			the deficient practice.		
cognitively impaired. Resident D required				lio delicient practice.			
		with 2 person assistance for					
		ers, walking, dressing and					
		O used a wheelchair as his			Residents residing at Rawlins		
	mobility device.				Tresidents residing at Irawiins		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NYLX11 Facility ID: 000248

If continuation sheet Page 21 of 35

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER	l í	JILDING	00	COMPL	
	22 201442011011	155357	B. W			02/23	
		133337	D. W	_		02/20/	72010
NAME OF P	ROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP COD		
					I WALKER DR		
RAWLIN	S HOUSE HEALTH	I & LIVING COMMUNITY		PENDL	ETON, IN 46064		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					House have the potential to be		
		re plan, dated 1/22/18,			affected by the alleged deficie		
	indicated Resident D exhibited wandering				practice. The facility grievance		
		ntions included, but were not			logs and other reportables for		
	-	a magazine or book, walk the			past 30 days have been revie	wed	
	facility with the res	sident or join an activity.			and missing items added if		
					available.		
		schedule for 1/30/18, LPN 7					
	-	North Hall from 2:00 p.m. until					
	6:00 a.m. on 1/31/1	8.					
	Daniana af an India	or Chata Danamina and a fill a like					
		na State Department of Health //31/18 at 8:40 a.m., indicated					
	*	-			III. The facility will put into)	
	-	iced in a "geri chair in a reclined			place the following syster	nic	
	-	be able to get up on his own."			changes to ensure that th	е	
		ne incident was immediately			deficient practice does no		
	-	ninistrator. LPN 7 was			recur.		
	suspended pending				100011		
	suspended pending	an investigation.					
	Review of the facil	ity investigation, a statement,					
		NA 10, indicated she was told			The Administrator and DON		
		Broda chair (reclining chair on			received Corporate Directed		
		er hall. She asked the nurse if			training on CarDon's abuse po	olicy	
	· · ·	n order and the nurse stated			and the structural components	-	
	"It doesn't matter, h	ne won't stay still." CNA 10			a complete investigation. The		
		la chair on another hall and			Administrator and DON were		
	when she returned,	LPN 7 had already retrieved			provided with a copy of the		
		cated she did help remove			investigative checklist, which		
		Broda chair because she did			guides them to complete a full		
	not want LPN 7 to	transfer him herself.			investigation of abuse allegati		
					and were instructed how to		
	During review of the	ne video surveillance of January			complete the checklist with ea	ıch	
	31, 2018 starting at	2:06 a.m., along with the			and every abuse allegation.	For	
	Administrator, Dire	ector of Nursing and Corporate			each abuse allegation, the		
	Nurse, several staff	member were seen in the			Administrator will scan a copy	of	
	video during the tir	ne Resident D was in the Broda			the complete investigative file		
	chair. The following				including the completed check		
					to the Regional Director of		
	At 2:06 am Resid	led D was seen sitting in his	1		Operations Director of Clinica	al.	

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155357	B. WING		02/23/2018
		<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP COD	
NAME OF I	PROVIDER OR SUPPLIEF	₹		H WALKER DR	
RAWLIN	S HOUSE HEALTH	& LIVING COMMUNITY		LETON, IN 46064	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	DATE
	wheelchair at the m	urses' station.		Services, and the Clinical	
	A+ 2:00 a m CNA	10 brought a Broda chair to the		Specialist to ensure all necess	sary
	North Hall.	To blought a Bloua chair to the		components are present. No employee suspended for an	
	Troitii Tian.			allegation of abuse will be retu	ırned
	At 2:32 a.m., Resident D was moved from his			without prior approval from the	
	wheelchair into the Broda chair by CNA 10 and			Regional Director of Operation	
	LPN 7. CNA 10 reclines the Broda chair				
	completely back an	d placed a sheet over him.			
	At 3:05 a.m., CNA	2 was seen walking around			
	Resident D.	<u>8</u>			
				IV The facility will monit	or
	At 3:51 a.m., Laundry 16 was seen in the video			the corrective action by	•
	-	rts near Resident D while he		implementing the following	na l
		roda chair, leaned back. No		measures.	.9
	other staff person w	vas present.		moudanos:	
	At 4:44 a.m., LPN	3 was seen bringing another			
		chair to be weighed. She			
		out of the way, then pushed		A third party consulting firm, L	
	the other resident to	the scales to weigh and left.		Beyl, will review all allegations	
				abuse monthly ongoing with n	0
		10 removed Resident D's brief		current end date to ensure a	
	while he was tilted	back in the Broda chair.		thorough investigation is completed.	
	At 5:05 a.m., Resid	lent D appeared to only have			
		nd no other clothing item.			
	Resident D remaine	ed at the nurses' station.			
				The Regional Director of	-:
		8 walked by Resident D, picked		Operations and Corporate Cli Specialist will oversee all	ilicai
	_	as on the floor and tossed it		allegations of abuse daily or fo	or
	back over the reside	ent.		each occurrence ongoing,	
	At 5:30 am CNA	9 walked past Resident D to		including review of the investi-	gative
	place her items at the			file with no current end date to	
	r			ensure a thorough investigation	on is
	At 5:55 a.m., CNA 10 and CNA 8 removed			completed.	
		e view of the video and he			
	returned at 6:03 a.n	n, wearing a shirt and leans. At			

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLI	ETED
		155357	B. W.	ING		02/23/2	2018
NAME OF I			•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	C		300 J H	I WALKER DR		
RAWLIN	S HOUSE HEALTH	& LIVING COMMUNITY		PENDL	ETON, IN 46064		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		D was transferred from the		TAG			DATE
	Broda Chair to his wheelchair. An employee communication form, dated 2/2/18, indicated LPN 7 was terminated only for "Failure to ensure resident safety, sleeping on clock on				Pasults of these audits will	ha	
				Results of these audits will be reported to the QA committee			
					monthly and the need for		
					additional training or		
					monitoring will be adjusted	as I	
	unit."				needed if compliance is bel		
	.	0/00/10 + 10 40 + 1			100%.		
	_	on 2/22/18 at 10:40 a.m., the Director of Nursing were not					
		employees shown in the video.					
		re the statement provided by					
		licated she did not bring the					
	Broda chair to the u	unit, did not match the video					
		nt no statements were provided			V. Plan of Correction		
		3, Laundry Aid 10 related to the			completion date 03/19/18.		
	allegation.						
	On 2/22/18 at 12:24	p.m., the Corporate					
	Administrator indic	ated CNA 10 had been			Facility Administrator will be	•	
		r her contributions to the			responsible for ensuring		
	abusive conduct				compliance.		
	A current facility po	olicy, dated October 2014 and					
		6, titled "Abuse Policy,"					
		ON on 2/20/18 at 8:50 a.m.,					
	indicated the follow						
		provide each resident with an					
		free from verbal, sexual,					
	and involuntary sec	al abuse, corporal punishment,					
	and myolumary sec	IMDIOTI					
	V. ABUSE INVI	ESTIGATIONS					
	Policy Statement						
	_	ent abuse, neglect and injuries					
		rce shall be immediately and					
	thoroughly investig management.	ated by the facility					
		ent or suspected incident of					
		l notify the following persons					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NYLX11 Facility ID: 000248

If continuation sheet Page 24 of 35

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155357	B. WING	_	02/23/2018
			STREET	ADDRESS, CITY, STATE, ZIP COD	
NAME OF P	PROVIDER OR SUPPLIE	R	300 J	H WALKER DR	
RAWLIN	S HOUSE HEALTH	1 & LIVING COMMUNITY	PEND	LETON, IN 46064	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	``	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	_	n incident when applicable: sing/certification agency			
	7. Employees of this facility who have been accused of resident abuse will be suspended from duty"				
	was removed on 2/ staff confirmed the staff on abuse, rest process. The nonc lower scope and se with potential for re	opardy (IJ) that began on 1/31/18 /22/18 when interviews with a facility had begun inservicing raints and the reporting ompliance remained at the everity level of no actual harm more than minimal harm that is pardy because all employees viced.			
	This Federal tag re	lates to Complaint IN00250160.			
	3.1-28(d)				
F 0677 SS=D Bldg. 00	§483.24(a)(2) A r carry out activities necessary service nutrition, groomin hygiene; Based on, interview failed to ensure res staff for toileting, r 6 residents reviewe	ed for Dependent Residents resident who is unable to so of daily living receives the est o maintain good ag, and personal and oral w and record review, the facility sidents who were dependent on received those services for 2 of ed for Activities of Daily Living Resident D and Resident G).	F 0677	F 677 I. The corrective actions to the corr	
	2/19/18 at 5:38 p.n not limited to, dem	ord for D was reviewed on n. Diagnoses included, but were nentia with behaviors, e, chronic kidney disease,		be accomplished for those residents found to have been affected by the deficient practice.	e

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NYLX11 Facility ID: 000248

If continuation sheet Page 25 of 35

03/12/2018 PRINTED: FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 02/23/2018 155357 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 300 J H WALKER DR **RAWLINS HOUSE HEALTH & LIVING COMMUNITY** PENDLETON, IN 46064 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE dysphagia, and anemia. Resident D no longer Resident D was admitted to the facility on 1/18/18. resides at the facility. A 14-day Minimum Data Set (MDS) assessment, dated 1/30/18, indicated Resident D was severely Resident G is receiving cognitively impaired. Resident D required assistance with toileting. extensive assistance with two person assistance for bed mobility, transfers, walking, dressing and CNA 10 employment has hygiene. been terminated. A current health care plan, dated 1/28/18, indicated Resident D was unable to perform late LPN 7 employment has been loss Activities of Daily Living (ADL) related to terminated. weakness and debility. He required two person assistance with transfers and toileting. Interventions included, but were not limited to, provide incontinence care after being toileted. II. The facility will identify other residents that may During review of the video surveillance of January potentially be affected by 31, 2018 starting at 2:06 a.m., along with the Administrator, Director of Nursing (DON) and the deficient practice. Corporate Nurse, Resided D was seen sitting in a Broda chair (reclining wheel chair on wheels) from 2:06 a.m. through 6:05 a.m., Resident D was not toileted and a new brief was not placed on Other residents residing at Resident B. Rawlins House who are dependent on staff for toileting Review of Resident D's ADL charting, CNA 10 did have the potential to be not document any care provided after 1:03 a.m. on affected by the alleged 1/31/18 deficient practice, ADL scores, care plans and assignment 2. The clinical record for Resident G was reviewed sheets are being reviewed to on 2/20/18 at 8:40 a.m. Diagnoses included, but identify residents who are were not limited to, orthopedic aftercare, pain in dependent on staff for toileting right leg, pulmonary heart disease, anxiety and to ensure the staff are aware insomnia. An 14-day Minimum Data Set (MDS) of toileting needs and are assessment, dated 1/24/18, indicated Resident G providing the assistance was cognitively intact. needed. A current health care plan, dated 1/19/18,

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	î í	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155357	A. BU B. W	JILDING ING	00	COMPLETED 02/23/2018	
NAME OF PROVIDER OR SUPPLIER RAWLINS HOUSE HEALTH & LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP COD 300 J H WALKER DR PENDLETON, IN 46064				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	nn ou un nn ou on gonn norwou	(X5	5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLE	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATI	Е
	indicated Resident	G was unable to perform late					
	loss ADL's related t	to weakness and debility. She					
	required extensive a	assistance with one person			III. The facility will put into place the following systemic		
	assistance for toilet	ing.					
					changes to ensure that th		
		e plan, dated 1/14/18, indicated			deficient practice does no		
		all risk. Interventions included,			recur.		
	but were not limited to, assist with ADL's as needed to meet needs. During an interview on 2/19/18 at 6:25 p.m., Resident G indicated she had to wait 90 minutes one night for her call light to be answered and urinated in her brief about two or three weeks ago. One nurse, LPN 7, would not help answer call lights. The resident indicated she would occasionally take herself to the bathroom, but was				100411		
					Numerica staff will be advected		
					Nursing staff will be educated		
					providing assistance to reside		
					who are dependent on staff for toileting. Staff will be educated		
					regarding promptly responding		
					call lights. Newly hired staff	9 10	
	· ·	he did complain to the DON			members will be educated		
		rse was no longer employed at			regarding providing assistance	e to	
	the facility.	ise was no longer employed at			residents who are dependent		
	the facility.				staff for toileting as well as		
	A current facility no	olicy, dated January 1, 2018,			promptly responding to call lig	hts	
		S OF DAILY LIVING,"			and the staff member will be		
		ON on 2/23/18 at 2:24 p.m.,			randomly observed to ensure		
	indicated the follow	* .			competence.		
	"POLICY	-					
	The interdisciplinar	ry management team must take					
	reasonable steps to	ensure the accurate daily					
		ADLs by facility nursing staff.			IV The facility will monit	or	
	Due to the need for				the corrective action by		
		coding as it relates to care			implementing the followir	ıg	
	planning and reimbursement, adherence to this				measures.		
	policy is essential."						
	3.1-38(a)(2)(C)						
					The DON or designee will into	erview	
					5 cognitively intact residents		
					are dependent on staff for toil		
					to ensure call lights are being		

responded to and assistance is

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 03/12/2018 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155357	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/23/2018		
	PROVIDER OR SUPPLIEF	& LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP COD 300 J H WALKER DR PENDLETON, IN 46064				
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	BATE		
				being provided on various shift The DON or designee will obse 5 cognitively impaired resident who are dependent on staff for toileting to ensure toileting assistance is being provided of various shifts. This audit will of for 5 residents daily for 4 week then 5 residents weekly for 8 weeks, then 5 residents month for 9 months for a total of 12 months of monitoring.	erve s n ccur es,		
				Results of these observations interviews will be reported to the QA committee monthly and ongoing frequency will be adjuted as needed if compliance is belief 100%.	ne sted		
				V. Plan of Correction completion date 03/19/18.			
				Facility Administrator will responsible for ensuring compliance.	be		
F 0726 SS=D	483.35(a)(3)(4)(c) Competent Nursir						

FORM CMS-2567(02-99) Previous Versions Obsolete

§483.35 Nursing Services

Bldg. 00

Event ID:

NYLX11

Facility ID: 000248

Page 28 of 35 If continuation sheet

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING	COMPLETED			
		155357	B. WING		02/23/2018	
NAME OF F	PROVIDER OR SUPPLIEF	₹		T ADDRESS, CITY, STATE, ZIP COD		
RAWLINS HOUSE HEALTH & LIVING COMMUNITY				H WALKER DR DLETON, IN 46064		
	Г			T		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	COMPLETION DATE	
1710		nave sufficient nursing staff	1710		BATE	
		te competencies and skills				
	sets to provide nu	rsing and related services				
		safety and attain or				
	_	est practicable physical,				
		nosocial well-being of each				
	resident, as deteri	individual plans of care and				
	considering the nu					
		acility's resident population				
	in accordance witl	h the facility assessment				
	required at §483.70(e).					
	licensed nurses h	e facility must ensure that				
		d skill sets necessary to				
		needs, as identified				
	through resident a					
	described in the p	lan of care.				
		viding care includes but is				
		essing, evaluating, planning resident care plans and				
	responding to resi					
	3					
		ency of nurse aides.				
		ensure that nurse aides are				
		ite competency in skills and				
	1	sary to care for residents'				
	needs, as identified through resident assessments, and described in the plan of care. Based on record review and interview, the facility					
			F 0726	F726	03/19/2018	
	failed to follow physician orders for medication					
	administration for 2 of 6 residents reviewed for					
	physician's orders.	(Resident D, Resident G)				
	Findings include:			I. The corrective actions		
	r manigs include:			be accomplished for those	se	
	1. The clinical record for Resident D was reviewed			residents found to have		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NYLX11 Facility ID: 000248

If continuation sheet Page 29 of 35

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
155357		B. WING 02/23/2018			2018		
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER					I WALKER DR		
RAWLINS HOUSE HEALTH & LIVING COMMUNITY					ETON, IN 46064		
	Г		1				
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	TE.	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		o.m. Diagnoses included, but			been affected by the		
		dementia with behaviors,			deficient practice.		
	dysphagia, and anei	e, chronic kidney disease,					
	uyspnagia, and anei	illa.					
	Resident D was adr	nitted to the facility on 1/18/18.					
		n Data Set (MDS) assessment,			Resident D no longer resides	in	
	I -	cated Resident D was severely			the facility.		
	· ·	d. He required extensive			Desident Cie ve estate e v	ation .	
		person assistance for bed			Resident G is receiving medic	alion	
		walking, dressing and hygiene.			per MD order and received psychosocial support with no		
	The resident used a wheelchair as his mobility device.				negative outcomes.		
					negative outcomes.		
					LPN 7 employment has been		
		t D's physician orders,			terminated.		
	1 *	rector of Nursing on 2/23/18 at					
	_	l an order for levothryroxine			Med error report completed w	ith	
		75 mcg to be given one time			MD notification for Resident G		
	daily from 5:00 a.m	n. through 6:00 a.m.			Resident D. No negative		
	Duning resident a Cal	a video surveillens£ I			outcomes noted for Resident	D or	
	_	e video surveillance of January 2:06 a.m., along with the			Resident G.		
	_	ector of Nursing and Corporate					
		was seated at the nurses station					
	l '	until 5:55 a.m., when CNA 10					
		d Resident D from the view of					
		turned at 6:03 a.m. wearing a			l		
	shirt and jeans.	2			II. The facility will identify	у	
					other residents that may		
	Review of the Med	ication Administration Record,			potentially be affected by		
	LPN 7 charted she administered levothryroxine to				the deficient practice.		
	Resident D between 5:00 a.m. and 6:00 a.m. on						
	1/31/18. The video did not show LPN 7 administer						
	any medication to Resident D.2. The clinical record for Resident G was reviewed on 2/20/18 at 8:40 a.m. Diagnoses included, but						
					Other residents are residing a		
					Rawlins House have the poter	ntial	
					to be affected by the alleged		
	·	orthopedic aftercare, pain in			deficient practice. The medica		
		y heart disease, anxiety and			administration report for the la	ıst	
	insomnia. An 14-day Minimum Data Set (MDS)				30 days is being reviewed for		

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>		COMPL	ETED
		155357	B. W			02/23/2018	
						,	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD		
					I WALKER DR		
RAWLIN	S HOUSE HEALTH	& LIVING COMMUNITY		PENDL	ETON, IN 46064		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	ID PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP		ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG			DATE
	assessment, dated 1	/24/18, indicated Resident G			administration per MD order.	administration per MD order.	
	was cognitively inta	act.			Medication error reports will b	е	
					completed for any concerns n	oted.	
	During an interview	v on 2/19/18 at 6:25 p.m.,					
	Resident G indicate	ed LPN 7 gave her Ambien					
		on) at 4:00 p.m. She was					
		medication in the evening.			III. The facility will put into)	
	LPN 7 was always	gave medication way too early.			place the following syster	nic	
					changes to ensure that th		
	Confidential interviews for staff working 2/19/18 through 2/23/18 were completed.				deficient practice does no		
					recur.	,,	
					recui.		
	Employee 1 indicated LPN 7 was the worst nurse						
		and rude to the residents and					
	would refuse to give	e them their medication.			l		
					Licensed nurses and		
		ed LPN 7 would pre-pull			Qualified Medication Aid	S	
		n tell residents it was not their			will be educated on		
		dministrator and Director of			medication administration	n	
		re aware of the concerns with			per physicians order		
		ought the nurses' were passing				to.	
	-	on, but felt it stopped with the			including, but not limited		
	Administrator and I	Director of Nursing (DON).			documentation of medica	ation	
		11 701 7 11 1 1 1 1 1 1 1 1			administration at time of		
		ed LPN 7 did not treat residents			administration, administe	ering	
		not giving them their pain			medication within time fra	ame	
		hought management was aware			per physician order and		
		sive. He/She indicated staff				iot	
	often refused to wo	rk with LPN 7.			presetting medications.		
	Employee 4 indicat	ed he/she often heard					
	complaints of LPN 7 not giving residents their						
	pain medication.						
	Employee 6 indicated he/she heard a lot of complaints about LPN 7 withholding pain medication. LPN 7 should have been gone a long				N/ The feetility		
					IV The facility will monit	Or	
					the corrective action by		
		neard LPN 7 say "if they are			implementing the followir	ıg	
	_	joke with me, I am not giving			measures.		
	them their pain medicine."						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NYLX11 Facility ID: 000248

If continuation sheet Page 31 of 35

ľ		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 1	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00		(X3) DATE SURVEY COMPLETED	
155357			B. WING 02/23/2018				
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD I WALKER DR		
RAWLIN	S HOUSE HEALTH	I & LIVING COMMUNITY		PENDL	ETON, IN 46064		
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ATE	(X5) COMPLETION DATE
	During an interview questioned, the Ad Nursing were not a any medication fro a.m. During a telephone p.m., LPN 7 indicated that she administer she was busy throu nurse actually gave no other explanation administering any she left at 6:22 a.m. A current, undated, "Licensed Nurse M Validation," provided: "5. Bring medicates in the second process of the second process o	v on 2/22/18 at 10:40 a.m., when ministrator and Director of ware LPN 7 did not administer m 2:06 a.m. until she left at 6:22 interview on 2/22/18 at 3:22 ted she would sometimes chart ed the medication, but because gh the night, the day shift the medication. She provided on as to why she was not seen medication from 2:06 a.m. until on 1/31/18. If a cility policy, titled led Pass Clinical Skills led by the DON on 2/21/18 at d the following: tion cart to an area adjacent to was given within the 60 minutes time designated unless			The DON or designee will observed medication administration for residents on various shifts to ensure medications are being administered per physicians' order, at the correct time, medications are not pre-set, at the documentation of medications are not pre-set, at time of administration is occurring at time of administrations daily for weeks, then 5 residents week 8 weeks, then 5 residents more for 9 months for a total of 12 months of monitoring. Results of these audits will be reported to the QA committee monthly and ongoing frequent will be adjusted as need if compliance is below 100%.	and tion the or 4 sly for nthly	
					V. Plan of Correction completion date 03/19/18		
					Facility Administrator wil responsible for ensuring compliance.	l be	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155357 B. WING 02/23/2018 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 300 J H WALKER DR **RAWLINS HOUSE HEALTH & LIVING COMMUNITY** PENDLETON, IN 46064 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5)PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE F 9999 Bldg. 00 410 IAC 16.2-3.1-14 Personnel: F 9999 F9999 03/19/2018 (u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of I. The corrective actions to initial employment, or within thirty (30) days for be accomplished for those personnel assigned to the Alzheimer's and residents found to have dementia special care unit, and three (3) hours been affected by the annually thereafter to meet the needs or deficient practice. preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. Based on record review and interview, the facility LPN 7 employment has been failed to a ensure the required annual three hour terminated. dementia training was complete for 3 of 5 employee records reviewed. (LPN 7, CNA 8 and CNA 10 employment has been CNA 10) terminated. Findings include: CNA 8 has completed the required annual three hour Review of Employee records began on 2/20/18 at dementia training. 2:10 p.m. The following noncompliance was found: LPN 7 had a hire date of 12/7/16. Her employment II. The facility will identify record did not indicate completion of dementia other residents that may training for 2017. LPN 7 worked a total of 233 potentially be affected by hours in January. the deficient practice. CNA 8 had a hire date of 7/12/17. Her employment record did not indicate completion of dementia training for 2017. CNA 8 worked a total of 72 hours in January. Other residents residing at

Rawlins House with a

03/12/2018 PRINTED: FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/23/2018 155357 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 300 J H WALKER DR **RAWLINS HOUSE HEALTH & LIVING COMMUNITY** PENDLETON, IN 46064 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE CNA 10 had a hire date of 7/18/16. Her diagnosis of dementia have employment record did not indicate completion of the potential to be affected by dementia training for 2017. CNA 10 worked a total the alleged deficient practice. of 83 hours in January. Audit completed of all staff members to ensure annual On 2/22/18 at 12:31 p.m., the Director of Nursing three hour dementia training is indicated LPN 7 would normally work on the completed. North Hall or Center Hall. She would rarely work on the South Hall or Memory Unit. During an interview on 2/23/18 at 9:36 a.m., Human III. The facility will put into Resource 15 indicated staff get paid to do their place the following required in-services. The computer will flag when systematic changes to a task is due. She has a staff list and a list of tasks ensure that the deficient that were due. There is no good way to run a report, she just has to look at each employee. She practice does not recur. inherited a mess when she was hire in last May. Review of a policy, "ISDH Educational Requirements," provided by the Corporate Nurse Human resources director will on 2/23/18 at 2:34 p.m., indicated the following: provide list of staff members ...(u) In addition to the required due for with annual three hour inservice...dementia-specific training...and three dementia training due to the (3) hours annually thereafter to meet the needs or administrator. preferences, or both, of cognitively impaired residents...." Staff members will be educated regarding dementia training requirement and provided an opportunity to complete training. IV The facility will monitor the corrective action by implementing the following measures.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 03/12/2018
FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES				OM	IB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		1		ONSTRUCTION	(X3) DATE		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER			A. BUILDING <u>00</u>			COMPLETED	
155357			B. W	ING		02/23	/2018
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD		
					I WALKER DR		
RAWLIN	S HOUSE HEALT	H & LIVING COMMUNITY		PENDL	ETON, IN 46064		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					Administrator or designee v		
					audit the completion of annual		
					dementia training weekly for 12 weeks then monthly for 9 months.		
					Results of these audits will be		
					reported to the QA committee		
					monthly and ongoing frequency will be adjusted as need if compliance is below 100%.		
					V. Plan of Correction		
					completion date 03/19/18		
					Facility Administrator will	be	
					responsible for ensuring		
					compliance.		

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: NYLX11 Facility ID: 000248 If continuation sheet Page 35 of 35