DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLETED	
		155357	B. WI	NG		02/23/	2018
			<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				I WALKER DR		
RAWLINS	S HOUSE HEALTH	& LIVING COMMUNITY			ETON, IN 46064		
(X4) ID	SUMMARY S	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 APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0000							
Bldg. 00	IN00246929, IN002 visit resulted in a Pa Survey-Substandard Jeopardy.	1 Quality of Care-Immediate	F 00	000	The plan of correction is to ser as Rawlins House credible allegation of compliance.	ve	
	are cited at F600, F6	encies related to the allegation 609 F610 and F726.			Submission of this plan of correction does not constitute admission by Rawlins House of management company that the	or its e	
	Complaint IN00246929 - Substantiated. Federal/State deficiencies related to the allegation are cited at F726.				allegations contained in the sureport is a true and accurate portrayal of the provision of nucare and other services in this		
	Complaint IN00248 Federal/State deficient are cited at F600, F6	encies related to the allegation			facility. Nor does this submissi constitute an agreement or admission of the survey allegations.	on	
	Unrelated deficience	ies are cited.					
	Survey dates: Febru	uary 19, 20, 21, 22 and 23 2018.					
	Facility number: 00	00248					
	Provider number: 1	55357					
	AIM number: 1002	91470					
	Census bed type: SNF/NF: 69 SNF: 17 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: NYLX11 Facility ID: 000248 If continuation sheet Page 1 of 35

PRINTED: 03/12/2018 FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155357			A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/23/2018	
	PROVIDER OR SUPPLIER S HOUSE HEALTH	& LIVING COMMUNITY		300 J H	ADDRESS, CITY, STATE, ZIP COD I WALKER DR ETON, IN 46064		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NTE.	(X5) COMPLETION DATE
F 0600 SS=K	accordance with 41 Quality Review cor 483.12(a)(1) Free from Abuse a	npleted on February 28, 2018.					
Bldg. 00	Exploitation The resident has to abuse, neglect, moreoperty, and explosubpart. This include freedom from corpinvoluntary seclus	ion and any physical or not required to treat the					
	or physical abuse involuntary seclus Based on interview failed to prevent ab 6 residents reviewed practice resulted in Broda chair as a reshours and Resident medication administ D and Resident J) T potential to affect 5	use verbal, mental, sexual, corporal punishment, or ion; and record review, the facility use by a staff member for 2 of d for abuse. This deficient Resident D being placed in a traint for approximately 4	F 00	600	F 600 We respectfully request a face to face IDR for this citation to present additional evidence for review.		03/19/2018
	LPN 7 placed Resic back as LPN 7 slep nurse also forcefull	lent D in a Broda chair, tilted it at the nurses' station. This y administered medication to a inistrator was notified of the			I. The corrective actions to be accomplished for thos residents found to have been affected by the		

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

immediate jeopardy on 2/21/18 at 1:20 p.m.

Event ID:

NYLX11

Facility ID: 000248

deficient practice.

If continuation sheet

Page 2 of 35

CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155357	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/23/2018	
	PROVIDER OR SUPPLIEI S HOUSE HEALTH	R LIVING COMMUNITY	STREE 300 J PENI			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	(X5) BE COMPLETION DATE	
	on 2/19/18 at 5:38 givere not limited to. Alzheimer's diseased dysphagia, and ane Resident D was adra A 14-day Minimun dated 1/30/18, indiccognitively impaire assistance with 2 periodic mobility, transfers, The resident used a device. A current health calindicated the reside behaviors. Intervet limited to, provide facility with the residence on 1/24/18 at 1:00 to have been exit see Review of the staff	mitted to the facility on 1/18/18. In Data Set (MDS) assessment, cated the resident was severely ed. He required extensive erson assistance for bed walking, dressing and hygiene. In wheelchair as his mobility are plan, dated 1/22/18, and exhibited wandering nations included, but were not a magazine or book, walk the edident or join an activity. In a.m., the resident was observed the exhibited wandering on the North Hall. It schedule for 1/30/18, LPN 7 In North Hall from 2:00 p.m. until		Resident D no longer resin the facility. LPN 7 employment has beterminated. Resident J has received psychosocial follow up reto being tearful following medication administration LPN 7. CNA 10 employment has terminated. LPN 3 was in-serviced or abuse and reporting, but since resigned and is no longer working in the facilic CNA 2, CNA 9, CNA 8, at laundry Aide 16 were in-serviced on abuse and reporting.	lated n from been n has lity.	
	Review of an India reportable, dated 1/Resident D was pla position. A staff m resident would not 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 ident other residents that may potentially be affected be the deficient practice. Other residents residing at	,	

Rawlins House have the potential

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	00	COMPL	ETED
		155357	B. W	ING		02/23/	2018
			1	STDEET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	L			I WALKER DR		
RAWI IN	S HOUSE HEALTH	& LIVING COMMUNITY			ETON, IN 46064		
	C NOOGE HEALTH	C LIVING CONNICION I		LLINDL			
(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	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
		ty investigation indicated the			to be affected by the alleged		
	following:				deficient practice.		
	A	0/1/10 1 CNA 10 :- 1:1					
		2/1/18, by CNA 10, indicated					
	1	N 7 to get a Broda chair (a			To identify conserve with the		
	I -	rheels) from another hall. She resident needed an order and			To identify concerns with abus	o€,	
		doesn't matter, he won't stay			restraint usage or medication administration, other residents		
		t to find a Broda chair on			with a BIMS of 8 or greater ha		
		en she returned, LPN 7 had			been interviewed using an Ab		
		e. CNA 10 indicated she did			questionnaire. Families of		
	1	D into the Broda chair			non-interviewable residents ha	ave	
		want LPN 7 to transfer him			been interviewed using an Ab		
	herself.				questionnaire. Staff members		
					work at the facility have been		
	A statement provide	ed by CNA 8, dated 2/1/18,			interviewed by corporate staff		
	indicated when she	arrived, she noticed Resident			regarding abuse. Any new		
		chair. She indicated she			allegations of abuse were repo	orted	
		and covered him up			to the Administrator and the IS	SDH	
	· ·	statement indicated LPN 7			immediately.		
	_	ou're going to want to keep					
		r nurse directed CNA 8 to					
		and move him into his],, , , ,		
	wheelchair.				A trend analysis was performe		
	A statement less CNI	A O dated 2/1/19 in direct d			and no other staff members w	ere	
	1	A 9, dated 2/1/18, indicated			identified to have ongoing	of	
		cility at 6:00 a.m. She			concerns or an accumulation	UI	
		D had a gown on the floor s seated in a Broda chair and it			abuse allegations.		
		ck. She asked LPN 7 why					
		he Broda chair and LPN 7					
		much last night." She			All residents at Rawlins House	۵.	
		unit came to the North Hall			assessed on 2/21/18 to ensure		
	unit looking for the				the facility is restraint free.	~	
	in the				and receiving to recording free.		
	A statement by LPN	V 4, indicated when he arrived					
	1	sident D "lying back in the					
		PN 7 what he was doing there.			III. The facility will put into	,	
		couldn't do anything with him,			· ·		
		keep him off the floor." LPN			place the following system		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155357	B. W	ING		02/23/	2018
				CTREET	ADDRESS SITY STATE TIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
		LOUINIANO COMMANDANTA			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
	4 stated to LPN 7 tl	hat she could not really just put			deficient practice does no	t	
	him there and LPN	7 stated "well I did."			recur.		
					1.000		
	During review of th	ne video surveillance of January					
	31, 2018 starting at	2:06 a.m., along with the					
	Administrator, Dire	ector of Nursing and Corporate			Staff were educated on pro	ner	
	Nurse, Resided D was seen seated in his				use of restraints and examp	· .	
	wheelchair at the nurses' station while LPN 7 was				1	JIES	
	sleeping at the nurses station. At 2:08 a.m., CNA				of inappropriate use of		
	10 brought a Broda chair to the North Hall and				restraints resulting in abuse	;.	
	LPN 7 was waking up and stretching. At 2:32 a.m.,						
	Resident D was moved from his wheelchair into						
	the Broda chair by CNA 10 and LPN 7. CNA 10				Staff are being advected		
		chair completely back and			Staff are being educated		
	1 ~	him. Resident D continued to			regarding appropriate		
	_	out the morning, continued to			behavioral interventions and	a	
		nd attempted to remove his			fall interventions.		
	l -	., CNA 10 removed Resident D's					
		tilted back in the Broda chair.					
		ent D appeared to only have					
		id no other clothing item			All 3rd party vendors with direct		
		dent D remained at the nurses'			patient care access that visit t		
		m., CNA 10 and CNA 8 removed			property of Rawlins House wil		
		e view of the video and he			receive education related to		
		n. wearing a shirt and jeans. At D was transferred from the			identifying abuse with detailed		
	Broda Chair to his				examples of what constitutes		
	Broug Chair to his	wneerdian.			abuse, including restraints, pri		
	An employee comp	nunication form, dated 2/2/18,			third party services being prov	iueu	
		as terminated for "Failure to			to Rawlins House residents.		
		ety, sleeping on clock on unit."					
	chaute restuent said	by, steeping on clock on unit.					
					Licensed nurses that work at		
	Confidential intervi	iews for staff were completed.			Rawlins House will receive		
		tes withheld to maintain			education immediately and pri	or to	
	anonymity.	William to mantain			working any shifts related to	0, 10	
	anonymity.				proper administration of		
	Employee 1 indicat	eed LPN 7 was the worst nurse			medication including the resid	ent's	
		and rude to the residents and			right to refuse as well as	0.11.0	
		refuse for LPN 7 to give them			documentation of medication		
	I		1		I accommendation of modification		

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

Event ID:

NYLX11 Facility ID: 000248

If continuation sheet Page 5 of 35

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPLI	
		155357	B. W	ING		02/23/	2018
	ROVIDER OR SUPPLIER	& LIVING COMMUNITY		300 J F	ADDRESS, CITY, STATE, ZIP COD I WALKER DR .ETON, IN 46064		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DECLIDED IN AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TC	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		imployee 1 indicated he/she			administration at time of		
		ievance forms, as did therapy.			administration, according to		
	Employee 1 indicated that did not seem to work, so they just started calling the Administrator				professional nursing practice		
		calling the Administrator			standards and CarDon policie	S.	
	directly.						
	Employee 2 indicated LPN 7 left Resident D naked and they had it on camera. He/She stated it was						
					Licensed nurses that work at		
	-	hift nurse The Administrator			Rawlins House will complete a	a	
		rsing (DON) were aware of the			skills validation of medication		
	concerns with LPN	7. He/She thought the nurses'			pass.		
	were passing along	the information, but felt it					
		dministrator and Director of					
	Nursing (DON).						
					Newly hired licensed nurses w		
		ed LPN 7 did not treat residents			complete a medication pass s		
		not giving the residents their d the residents would have to			validation prior to working on t	ine	
	_	For it. He/She thought			floor and their skills and compliance with CarDon polic	ios	
		ware that LPN 7 was abusive.			and professional standards wi		
	-	ed staff often refused to work			monitored through observation		
	with LPN 7.				ensure competence.		
					·		
	Employee 4 indicate	ed he/she often heard					
	-	7 not giving residents their					
	pain medication.				Human Resources director,		
	E 1 6:1: /	14 1:41 11			Director of Nursing and		
		ed the complaints had been			Administrator educated regard		
		ime and the complaints went aff thought nothing was being			accurate documentation of rea		
	done.	an thought houning was being			for termination for employees.		
	40110.						
	Employee 6 indicate	ed he/she heard a lot of					
		PN 7 withholding pain			Administrator and staff educat	ted	
		should have been gone a long			on grievance process includin	g	
	_	neard LPN 7 say "if they are			follow up on grievances voice	-	
		joke with me, I am not giving			residents regarding medicatio	n	
	them their pain med	licine."			administration or potential		
					medication errors.		
	Employee 7 indicate	ed staff often filled out					

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

Event ID:

NYLX11 Facility ID: 000248

If continuation sheet Page 6 of 35

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	
		155357	B. W	ING		02/23	/2018
	PROVIDER OR SUPPLIE	R I & LIVING COMMUNITY	•	300 J F	ADDRESS, CITY, STATE, ZIP COD I WALKER DR .ETON, 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	ATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NIE.	DATE
	1 -	d to his/her knowledge, the not spoken to any of them.					
	anything to the Adito nursing. Employee 9 indicates	ted when staff mentioned ministrator, he told them to go ted when he/she arrived to work ent D's genitals were visible and d back.			Grievances voiced by a reside family member or staff member will be immediately reported to administrator who will delegat appropriate steps and determ the concern constitutes a reportable or a grievance.	er o the e the	
	indicated for the lawere not working we she had a problem timely. During an interview DON indicated ear getting the flow of	a.m., the Administrator st couple of months, things well with LPN 7. He indicated administering medications w on 2/20/18 at 9:46 a.m., the ly in 2017, LPN 7 was not day shift and she moved her to d bring her in and talk to her, t "teachable."			The grievance process directi staff to contact the administra directly for each and every grievance/concern has been posted at each nurse's statior outside the social services off and in the break room.	tor	
	arrived to work, Re and no brief and th He indicated Resid He instructed the a clean him up and p During an interview DON indicated LP Broda chair. CNA into the Broda chai written statement a viewed the video so	7 a.m., LPN 9 indicated when he esident D only had a T-shirt on ere was a sheet on the floor. ent D was reclined in the chair. ides to take him to his room, ut him in his wheelchair. W on 2/21/18 at 9:48 a.m., the N 7 told CNA 10 to go and get a 10 did help transfer Resident D r. LPN 7 did not provide a nd although the DON had urveillance, she was unable to esident D was placed in the			All staff members that we at Rawlins House will receducation immediately apprior to working any shift related to directly and immediately reporting allegations of abuse to the Administrator, after ensuresident safety, with detal examples of what constitute abuse. Staff members will educated to follow the abuse of the safety of the safet	ceive and s ane aring ailed autes aill be bove	
	During a telephone	interview on 2/22/18 at 11:49			retaliation, even if the ab is a superior or manager		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155357		A. BUII	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 02/23/2018	
		STREET ADDRESS, CITY, STATE, ZIP COD 300 J H WALKER DR PENDLETON, IN 46064					
(EACH DEFICIEN REGULATORY OF	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
when Resident D w told her image was Resident D to the si resident. She indicathe resident and if h She did not report to Administrator. Review of LPN 7's signed an acknowled 12/7/16. The policilimited to, abuse proporting a reasonal against a resident. LPN 7 also signed a on 12/7/16, indication.	ras in the Broda chair. She was seen on the video moving ide so she could weigh another ated she was unfamiliar with he was usually in a Broda chair. The incident to the employee record, indicated she edgement of policies on the included, but were not evention, code of conduct, and ble suspicion of a crime			the corrective action by implementing the followin measures. The Director of Nursing, or designee, will audit new restra	g nints 30		
indicating she agree conduct. On 2/22/18 at 12:24 Administrator indicterminated that day abusive conduct During a telephone p.m., LPN 7 indicates suggested to put Resident D needed because he would or resident rooms. LP put her head down to the conduct the conduct that the co	at p.m., the Corporate rated CNA 10 had been for her contributions to the resident D in the Broda chair. It to management before that one on one observation often wander into other N 7 indicated she would often because she had a headache.			pass with 5 nurses weekly for days, then 5 nurses monthly for 90 days then one 1 nurse more for 9 months. The Administrator or design will interview a minimum of residents with a BIMS of 8 of greater, 5 family members of representatives of residents who have cognitive	30 or nthly nee 5 or		
F	ROVIDER OR SUPPLIEF B HOUSE HEALTH SUMMARY (EACH DEFICIEN REGULATORY OF a.m., LPN 3 indicated when Resident D we told her image was Resident. She indicated the resident and if he she did not report the Administrator. Review of LPN 7's signed an acknowled 12/7/16. The policic limited to, abuse proporting a reasonal against a resident. LPN 7 also signed an acknowled 12/7/16, indicated education and train resident rights. On 12/7/16, LPN 7 indicating she agreed conduct. On 2/22/18 at 12:24 Administrator indicated that day abusive conduct During a telephone p.m., LPN 7 indicated that day abusive conduct During a telephone p.m., LPN 7 indicated that day abusive conduct During a telephone p.m., LPN 7 indicated she would do resident rooms. LP put her head down LPN 7 indicated she would consider the put her head down LPN 7 indicated she	ROVIDER OR SUPPLIER B HOUSE HEALTH & LIVING COMMUNITY SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION a.m., LPN 3 indicated she did remember the night when Resident D was in the Broda chair. She was told her image was seen on the video moving Resident D to the side so she could weigh another resident. She indicated she was unfamiliar with the resident and if he was usually in a Broda chair. She did not report the incident to the Administrator. Review of LPN 7's employee record, indicated she signed an acknowledgement of policies on 12/7/16. The policies included, but were not limited to, abuse prevention, code of conduct, and reporting a reasonable suspicion of a crime against a resident. LPN 7 also signed a general orientation checklist on 12/7/16, indicating she had received sufficient education and training for abuse, neglect and resident rights. On 12/7/16, LPN 7 signed an affirmation statement indicating she agreed to abide by the code of conduct. On 2/22/18 at 12:24 p.m., the Corporate Administrator indicated CNA 10 had been terminated that day for her contributions to the	A BUIL 155357 ROVIDER OR SUPPLIER B HOUSE HEALTH & LIVING COMMUNITY SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION a.m., LPN 3 indicated she did remember the night when Resident D was in the Broda chair. She was told her image was seen on the video moving Resident D to the side so she could weigh another resident. She indicated she was unfamiliar with the resident and if he was usually in a Broda chair. She did not report the incident to the Administrator. 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LPN 7 indicated she would often put her head down because she had a headache. LPN 7 indicated she would occasionally document	ROVIDER OR SUPPLIER B HOUSE HEALTH & LIVING COMMUNITY SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION a.m., LPN 3 indicated she did remember the night when Resident D was in the Broda chair. She was told her image was seen on the video moving Resident D to the side so she could weigh another resident. She indicated she was unfamiliar with the resident and if he was usually in a Broda chair. She did not report the incident to the Administrator. Review of LPN 7's employee record, indicated she signed an acknowledgement of policies on 12/7/16. The policies included, but were not limited to, abuse prevention, code of conduct, and reporting a reasonable suspicion of a crime against a resident. LPN 7 also signed a general orientation checklist on 12/7/16, indicating she had received sufficient education and training for abuse, neglect and resident rights. On 12/7/16, LPN 7 signed an affirmation statement indicating she agreed to abide by the code of conduct. On 2/22/18 at 12:24 p.m., the Corporate Administrator indicated CNA 10 had been terminated that day for her contributions to the abusive conduct During a telephone interview on 2/22/18 at 3:22 p.m., LPN 7 indicated it was the CNA who suggested to put Resident D in the Broda chair. She had complained to management before that Resident D needed one on one observation because he would often wander into other resident rooms. LPN 7 indicated she would often put her head down because she had a headache. 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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155357		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 02/23/2018	
	PROVIDER OR SUPPLIER	& LIVING COMMUNITY	300 J	ADDRESS, CITY, STATE, ZIP COD H WALKER DR LETON, IN 46064	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION busy, the day shift nurse	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) questionnaire to ensure	(X5) COMPLETION DATE
	would then give the explanation as to who would allow Reside chair. 2. The clinical recoon 2/20/18 at 9:26 a were not limited to, dysphagia, muscle where the peripheral vascular. During an interview Resident J indicated her medications one unsure of the date, there a second dose of told her to take it. The resident was tearful medicine cup had here in it. She told CNA	medication. She gave no my as the nurse in charge, she and D to be placed in the Broda and for Resident J was reviewed and. Diagnoses included, but bacterial pneumonia, weakness, hypertension and disease. Ton 2/21/18 at 10:54 a.m., a she received two doses of enight. She indicated she was but stated the nurse brought of crushed medications and the nurse was forceful and the and very scared. The er blood pressure medications 6 about the incident.		residents are free from about This will be completed week for 9 weeks and monthly formonths for a total of 12 months of monitoring. Any allegations of abuse were be reported immediately as investigated. Results of the interviews and audits will be reported to the QA commit monthly and ongoing frequency will be adjusted need if compliance is below 100%.	ekly or 9 vill nd e ne tee tee
	assessment, dated 1 was cognitively inta During an interview indicated she came 1/30/2018 and work During her shift, she Resident J's room to Resident J's room nurse made her taker resident said she tol taken them. The rewant her to leave he CNA 6 indicated sh LPN 5, that Resider	on 2/19/18 at 9:26 p.m., CNA 6 to work at 10:00 p.m. on ed until 6:00 a.m. on 1/31/18. e saw LPN 7 coming out of When she made her way back a, she was crying and said the her medications again. The d the nurse she had already sident was afraid and did not		V. Date of Compliance 03/19/18. Facility Administrator will be responsible for ensuring compliance by the date list	

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

Event ID:

NYLX11 Facility ID: 000248

If continuation sheet

Page 9 of 35

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00		
		155357	B. W.	_		02/23/	2018
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COD		
RAWI INI	S HOUSE HEALTH	& LIVING COMMUNITY			WALKER DR ETON, IN 46064		
	T		ı	<u> </u>			(V.C.)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		LISC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
IAU	During a telephone a.m., LPN 5 indicat Resident J supposed She did not go and a the unit manger that On 2/21/18 at 11:13 Administrator and Conterviewed. The Cowas told during the next door roommate saying Resident J remedication. They is J and spoke to CNA say anything to the Resident J. On 2/21/18 at 12:31 had spoken to LPN Hall to get somethin LPN 7 gave Resident She did not assess is resident was tearful stated she did call U had interviewed Redenied saying she we state the nurse "just A current facility per revised August 2011 provided by the DO indicated the follow "It is the policyto environment that is physical, and mental and involuntary sec	interview on 2/20/18 at 11:41 ed CNA 6 did tell her that fly took her medication twice. assess the resident, but called t evening at home. B a.m., Unit Manager 4, DON, Corporate Nurse were forporate Nurse indicated she day by the therapist that the e to Resident J was heard exceived two doses of her mmediately assessed Resident a 6, who indicated she did not next door roommate about p.m., the DON indicated she 5. LPN 5 went to the North and CNA 6 told her that ant J two doses of medicine. Her and was unaware the 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." Dolicy, dated October 2014 and 6, titled "Abuse Policy," DN on 2/20/18 at 8:50 a.m., wing: provide each resident with an free from verbal, sexual, all abuse, corporal punishment, flusion"		IAU			DATE

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

Event ID:

NYLX11 Facility ID: 000248

If continuation sheet Page 10 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 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 PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG 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 employees...to immediately report any incident or suspected incident of neglect or abuse...to the Administrator or Designee if the Administrator is unavailable. .a. 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-being. ...e. 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 devices...geri-chairs...."

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155357		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	COM	(X3) DATE SURVEY COMPLETED 02/23/2018	
	ROVIDER OR SUPPLIEI S HOUSE HEALTH	R & LIVING COMMUNITY	300 J H	ADDRESS, CITY, STATE, ZIP CO I WALKER DR .ETON, IN 46064	OD a	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL DUSC INFORMATION	ID PREFIX	PROVIDERS PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP		(X5) COMPLETION
F 0609 SS=K Bldg. 00	An undated, facility Med Pass Clinical sprovided by the DC indicated the follow "29. Medication minutes before or a otherwise directed." The Immediate Jeo was removed on 2/2 staff confirmed the staff on abuse, restriction and see with potential for not immediate jeophad not been inserved. This Federal tag rel. 3.1-27(a)(1) 483.12(c)(1)(4) Reporting of Alleg §483.12(c) In restriction abuse, neglect, exthe facility must:	was given within the 60 fter the time designated unless by the physician" pardy (IJ) that began on 1/31/18 22/18 when interviews with facility had begun inservicing raints and the reporting compliance remained at the verity level of no actual harm more than minimal harm that is ardy because all employees riced. lates to Complaint IN00250160. ged Violations conse to allegations of exploitation, or mistreatment, sure that all alleged	TAG			DATE
	violations involvin exploitation or mis injuries of unknown misappropriation reported immedia hours after the all events that cause or result in serious than 24 hours if the	g abuse, neglect, streatment, including				
	violations involvin exploitation or mis injuries of unknow misappropriation reported immedia hours after the all events that cause or result in serious than 24 hours if the allegation do not in	g abuse, neglect, streatment, including on source and of resident property, are tely, but not later than 2 egation is made, if the the allegation involve abuse is bodily injury, or not later ne events that cause the				

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

Event ID:

NYLX11 Facility ID: 000248

If continuation sheet Page 12 of 35

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155357	B. W	ING		02/23	/2018
RAWLIN	PROVIDER OR SUPPLIEF	& LIVING COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP COD 300 J H WALKER DR PENDLETON, IN 46064			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
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	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 failed to ensure that staff members who had knowledge of an incident of physical abuse and a resident who was tearful after medication administration on the evening shift, immediately reported those concerns to the facility Administrator for 2 of 6 residents reviewed for 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.		F 0609		F 609 We respectfully request a face		03/19/2018
					to face IDR for this citation to present additional evidence for review.		
	The impression	andy began on 1/21/101			I. The corrective actions to be accomplished for those		
		pardy began on 1/31/18 when dent D in a Broda chair, as a			residents found to have	•	
		lent was forcibly given			been affected by the		
		f did not immediately report			deficient practice.		
		o the Administrator. The			-		
		notified of the immediate					
	jeopardy on 2/21/18	3 at 1:20 p.m.					
	Findings include:	al Car Danasa in a la			Allegations for Resident D a Resident J have been report to the ISDH.		
	1. The clinical record for D was reviewed on						
	_	Diagnoses included, but were entia with behaviors,			CNA 2, CNA 9, CNA 8, and laundry Aide 16 were		

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 Alzheimer's disease, chronic kidney disease, in-serviced on abuse and dysphagia, and anemia. reporting. Resident D was admitted to the facility on 1/18/18. CNA 10 employment has been A 14-day Minimum Data Set (MDS) assessment, terminated. dated 1/30/18, indicated Resident D was severely cognitively impaired. Resident D required extensive assistance with 2 person assistance for bed mobility, transfers, walking, dressing and hygiene. Resident D used a wheelchair as his mobility device. II. The facility will identify other residents that may A current health care plan, dated 1/22/18, potentially be affected by indicated Resident D exhibited wandering the deficient practice. behaviors. Interventions included, but were not limited to, provide a magazine or book, walk the facility with the resident or join an activity. Other residents with a BIMS of 8 Review of the staff schedule for 1/30/18, LPN 7 was assigned to the North Hall from 2:00 p.m. until or greater have been interviewed 6:00 a.m. on 1/31/18. using an Abuse questionnaire. Families of non-interviewable residents have been interviewed During review of the video surveillance of January 31, 2018 starting at 2:06 a.m., along with the using an Abuse questionnaire. Administrator, Director of Nursing and Corporate Staff members who work at the Nurse, the following was noted: facility have been interviewed by corporate staff regarding abuse. At 3:05 a.m., CNA 2 was seen walking around Any new allegations of abuse were reported to the Administrator and Resident D as the resident sat in a Broda chair (reclining chair on wheels). the ISDH immediately. At 3:51 a.m., Laundry Aid 10 was seen in the video with her laundry carts near Resident D while he was seated in the Broda chair, leaned back. No other staff person was present. III. The facility will put into At 4:44 a.m., LPN 3 was seen bringing another place the following systemic resident in a Broda chair to be weighed. She changes to ensure that the moved Resident D out of the way, then pushed deficient practice does not the other resident to be weighed and then left.

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

Event ID:

NYLX11

Facility ID: 000248

If continuation sheet

Page 14 of 35

NAME OF PROVIDER OR SUPPLIER RAWLINS HOUSE HEALTH & LIVING COMMUNITY STREET ADDRESS, CITY, STATE, ZIP COD 300 J H WALKER DR PENDLETON, IN 46064	
CROSS-REFERENCED TO THE APPROPRIATE	(X5) OMPLETION DATE
At 5:29 a.m., CNA 8 walked by Resident D, picked up his sheet that was on the floor and tossed it back over the resident. At 5:30 a.m., CNA 11 walked past Resident D to place her items at the nurses' station. Review of an Indiana State Department of Health reportable, dated 1/31/18 at 8:40 a.m., indicated Resident D was placed in a "geri chair in a reclined position. A staff member was concerned the resident would not be able to get up on his own." The report indicated the incident was immediately reported to the Administrator. LPN 7 was suspended pending an investigation. Although this incident started at 2:06 am, no one reported it to the Administrator until the LPN 4 arrived to work on day shift. Review of the facility investigation, a statement, dated 2/1/18, by CNA 10, indicated she was told by LPN 7 to get a Broda chair from another hall. She asked the nurse if a resident matter, he won't stay still. "CNA 10 went to find a Broda chair on another hall and when she returned, LPN 7 had already retrieved one. CNA 10 indicated she did help remove Resident D into the Broda chair because she did not want LPN 7 to transfer him herself. A statement provided by CNA 8, dated 2/1/18, indicated when she arrived, she noticed Resident D seated in a Broda chair is the indicated she picked up his gown and covered him up immediately. The statement indicated LPN 7 continued to say "Vortro going to want to keep	DATE

him there." Another nurse directed CNA 8 to

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			COMPLETED	
		155357	B. W	ING		02/23/	2018	
		<u>l</u>		STDEET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF I	PROVIDER OR SUPPLIE	₹			I WALKER DR			
ΒΔ\Λ/Ι ΙΝΙ	S HOUSE HEALTH	& LIVING COMMUNITY			ETON, IN 46064			
IVAVVLIIV	THE TILALIII	C LIVING COMMONITI		LINDL	1 014, 114 70004			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)	
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TAG	 	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
removed Resident D and move him into his				The Administrator and DON				
	wheelchair.				received Corporate Directed			
					training on CarDon's abuse			
		A 9, dated 2/1/18, indicated			reporting policy. The Administ	rator		
		icility at 6:00 a.m. She			has since resigned and is no	.		
		D had a gown on the floor			longer employed at the facility	. An		
		s seated in a Broda chair and it			interim administrator with			
	had been leaned back. She asked LPN 7 why Resident D was in the Broda chair and LPN 7				considerable experience in lor	•		
					term care is filling the role of the Administrator until a new	ile		
	stated "He was too much last night." She indicated the other unit came to the North Hall				Administrator until a new Administrator is hired. Any ne			
	unit looking for the Broda chair.				Administrator will receive thor			
	unit looking for the broda chair.				training by CarDon corporate	-		
	A statement by LPN 4, indicated when he arrived				on CarDon's abuse reporting	Stan		
		sident D "lying back in the			policy.			
		PN 7 what he was doing there.			policy:			
		couldn't do anything with him,						
		o keep him off the floor." LPN						
	-	nat she could not really just put			Administrator and staff educat	ted		
		7 stated "well I did."			on grievance process includin			
					follow up on grievances voice	-		
	An employee comm	nunication form, dated 2/2/18,			residents regarding medicatio	n .		
	indicated LPN 7 wa	as terminated for "Failure to			administration or potential			
	ensure resident safe	ety, sleeping on clock on unit."			medication errors.			
		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			
		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	in his wheelchair.			administrator who will delegat			
	Daning and intent	2/21/19 =4 0.49 = 41			appropriate steps and determine	ine it		
	_	v on 2/21/18 at 9:48 a.m., the			the concern constitutes a			
	DON indicated LPN 7 told CNA 10 to go and get a				reportable or a grievance.			
	Broda chair. CNA 10 did help transfer Resident D							
	into the Broda chair. LPN 7 did not provide a							
	written statement and although the DON had viewed the video surveillance, she was unable to				The grievance process direction	, l		
		esident D was placed in the			staff to contact the administration	-		
	Broda chair.	ostacii D was piaced iii tiic			directly for each and every	lOI		

STATEMENT 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	B. WING 02/23/2018			2018
				OTREET	ADDRESS CITY STATE ZIR COR		
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD I WALKER DR		
DAMI INI	S HOUSE HEALTH	8 LIVING COMMUNITY			ETON, IN 46064		
KAWLIN	O HOUSE REALTH	& LIVING COMMUNITY		PENUL	.E I ON, IN 40004		
(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 APPROPRI	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					grievance/concern has been		
	_	v on 2/22/18 at 12:58 p.m., CNA			posted at each nurse's station		
	8 indicated she questioned where the Broda came				outside the social services of	fice,	
	from when she saw Resident D. She did not				and in the break room.		
	_	to the Administrator. On the					
		CNA 8 was seen on the video					
	_	a sheet over the resident as he					
	sat in the Broda chair.				IV The facility will monit	tor	
					the corrective action by		
	During a telephone interview on 2/22/18 at 11:49				implementing the following	ng	
	a.m., LPN 3 indicated she did remember the night				measures.	•	
	when Resident D was in the Broda chair. She was						
	told her image was seen on the video moving						
		de so she could weigh another					
		infamiliar with the resident and			The Regional Director of		
		a Broda chair or not. She did			Operations and Corporate Cli	inical	
	not report the incide	ent to the Administrator.			Specialist will oversee all	iiiodi	
	B				allegations of abuse to ensure	e	
		interview on 2/22/18 at 3:22			immediate reporting is occurr		
	* .	ted it was the CNA who			by using a timeline for each	9	
		sident D in the Broda chair.			occurrence daily and ongoing	with	
	_	d to management before that one on one observation			no current end date.	,	
		often wander into other					
		N 7 indicated she would often					
		because she had a headache.					
	-	ocumented that she had			A third party consulting firm, I	_acy	
		eation on her shift, but because			Beyl, will review all allegation	-	
		ay shift nurse would then give			abuse to ensure immediate		
		e gave no explanation as to			reporting is occurring by using	g a	
		charge, she would allow			timeline for each occurrence		
		aced in the Broda chair.			monthly ongoing with no curre	ent	
	l control of pro	and Divan elimi.			end date.		
	2. The clinical reco	ord for Resident J was reviewed					
		a.m. Diagnoses included, but					
		bacterial pneumonia,					
	dysphagia, muscle weakness, hypertension and				The Administrator or designe	е	
	peripheral vascular				interview any resident (or		
	r				representative) who has alleg		
	During an interview	y on 2/21/18 at 10:54 a.m			abuse or been alleged to hav	е	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPLETED
		155357	B. W	/ING		02/23/2018
NAME OF I	DOMINED OD STIDDLIEE			STREET A	ADDRESS, CITY, STATE, ZIP COD	
	PROVIDER OR SUPPLIEF				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 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		LSC IDENTIFYING INFORMATION I she received two doses of		TAG	been abused to determine if the	
		e night. She indicated she was			allegation was handled promp	
	unsure of the date, but stated the nurse brought				anegation was narialed promp	ay.
		f crushed medications and				
		The nurse was forceful, she				
	was tearful and very	y scared. The medicine cup			The Administrator, or designe	e,
	had her blood press	ure medications in it. She told			will interview 5 random staff	
	CNA 6 about the in	cident.			members on various shifts we	-
	Am Adoption 3.51	Data Cat (MDC)			for 12 weeks, then monthly for	
		imum Data Set (MDS)			months to ensure they are aw	
	assessment, dated 1/19/18, indicated Resident J was cognitively intact.				of and understand the proced for reporting abuse.	ure
	was cognitively inte	ici.			lor reporting abuse.	
	During an interview on 2/19/18 at 9:26 p.m., CNA 6					
	indicated she came	to work at 10:00 p.m. on				
		ted 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
		d the nurse she had already sident was afraid and did not			100%.	
	want her to leave he					
	"and not to leave no					
	CNA 6 indicated sh	e notified the charge nurse,				
		nt J stated she had taken her				
	medication twice. 1	LPN 5 told her to report it.			V. Plan of Correction	
	Data and 1 1	:			completion date 03/19/18.	
		interview on 2/20/18 at 11:41				
	· ·	ed CNA 6 did tell her that ally took her medication twice.				
		assess the resident, but called				
	the unit manger tha				Facility Administrator will	be
	and manger tha	· w			responsible for ensuring	
		a.m., Unit Manager 4, DON,			compliance.	
	Administrator and Corporate Nurse were					
		orporate Nurse indicated she				
		day by the therapist that the				
		e to Resident J was heard				
	saying Resident J re	eceived two doses of her			1	

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

Event ID:

NYLX11 Facility ID: 000248

If continuation sheet Page 18 of 35

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		l í				X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING <u>00</u>			COMPLETED	
		155357	B. WI	ING		02/23	/2018	
NAME OF D	PROVIDER OR SUPPLIER	•	_	STREET A	DDRESS, CITY, STATE, ZIP COD	-		
					WALKER DR			
RAWLIN	S HOUSE HEALTH	& LIVING COMMUNITY		PENDLE	ETON, IN 46064			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	,	(EACH DEFICIENCY 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	
		dicated they immediately and spoke to CNA 6, who						
		ot say anything to the next						
	door roommate abo							
		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. ner and was unaware the						
		. The DON indicated LPN 5						
		Jnit Manager 4 at home. She						
	had interviewed Resident J. The resident denied							
	saying she was scared or tearful, but did state the nurse "just stuck it in my mouth."							
		olicy, dated October 2014 and						
	-	6, titled "Abuse Policy,"						
	indicated the follow	N on 2/20/18 at 8:50 a.m.,						
		provide each resident with an						
		free from verbal, sexual,						
		al abuse, corporal punishment,						
	and involuntary sec							
		IG & RECOGNIZING SIGNS						
	AND SYMPTOMS	OF ABUSE						
	Policy Statement	t condone any form of resident						
	_	o aid in abuse prevention, all						
	_	ort any signs and symptoms						
		their supervisor immediately						
		he Administrator or authorized						
	designee immediate	ely.						
	VII DEDODÆDI	C ADUCE TO.						
	VII. REPORTIN A. Administrator	O ABUSE IO:						
	A. Auministrator							
	Policy Statement							
	•	ty of our employeesto						
1			ı				I	

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

Event ID:

NYLX11

Facility ID: 000248

If continuation sheet

Page 19 of 35

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155357	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	COM	PLETED 23/2018	
	PROVIDER 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 COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
	incident of neglect or Designee if the Aa. Abuse is define injury; unreasonable punishment with resemental 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 Jeop was removed on 2/2 staff confirmed the staff on abuse, restrict process. The nonce lower scope and see with potential for more immediate jeops had not been inserved.	clusion is defined as dent from other residents or n" pardy (IJ) that began on 1/31/18 22/18 when interviews with facility had begun inservicing aints and the reporting empliance remained at the verity level of no actual harm fore than minimal harm that is ardy because all employees					
F 0610 SS=K Bldg. 00	§483.12(c) In resp	nt/Correct Alleged Violation conse to allegations of aploitation, or mistreatment,					
	violations are thor §483.12(c)(3) Pre	re evidence that all alleged oughly investigated.					
	neglect, exploitation is	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

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>		COMPLETED	
		155357	B. W	NG		02/23/2018	
				GTDFFT	ADDRESS SITE STATE SID COD		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
DAVA/LINI		O L IV/INIO COMMMUNITY/			I WALKER DR		
RAWLIN	S HOUSE HEALTH	& LIVING COMMUNITY		PENDL	ETON, IN 46064		
(X4) ID	SUMMARY S	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 APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	§483.12(c)(4) Repinvestigations to the designated reposition of the designated reposition of the State of the designated reposition of the State of	cort the results of all the administrator or his or coresentative and to other ance with State law, atte Survey Agency, within the incident, and if the coverified appropriate must be taken. and record review, the facility investigate allegations of mber (Resident D). This lowed Resident D to remain wered for approximately 4 attention to the North Hall of the facility. ardy began on 1/31/18 when tions of abuse and the facility investigate the allegations. Was notified of the immediate at 1:20 p.m.	F 00	TAG	F 610 We respectfully request a fato face IDR for this citation is present additional evidence review. I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice. Resident D no longer resides in the facility. II. The facility will identify other residents that may potentially be affected by	ace to for	
	extensive assistance bed mobility, transfe	d. Resident D required with 2 person assistance for ers, walking, dressing and D used a wheelchair as his			the deficient practice. Residents residing at Rawlins		

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

Event ID:

NYLX11 Facility ID: 000248

If continuation sheet Page 21 of 35

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155357		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 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	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
	indicated Resident behaviors. Interver limited to, provide facility with the res Review of the staff	re plan, dated 1/22/18, D exhibited wandering ntions included, but were not a magazine or book, walk the ident or join an activity. schedule for 1/30/18, LPN 7 North Hall from 2:00 p.m. until 8.		House have the potential to be affected by the alleged deficien practice. The facility grievance logs and other reportables for past 30 days have been review and missing items added if available.	nt : the	
	reportable, dated 1/ Resident D was pla position. A staff m resident would not The report stated th	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." e incident was immediately ninistrator. LPN 7 was an investigation.		III. The facility will put into place the following system changes to ensure that the deficient practice does not recur.	nic e	
	dated 2/1/18, by CN by LPN 7 to get a E wheels) from anoth a resident needed at "It doesn't matter, h went to find a Brod when she returned, one. CNA 10 indic Resident D into the not want LPN 7 to the During review of the 31, 2018 starting at Administrator, Dire Nurse, several staff	ity investigation, a statement, NA 10, indicated she was told Broda chair (reclining chair on er hall. She asked the nurse if in order and the nurse stated are won't stay still." CNA 10 a chair on another hall and LPN 7 had already retrieved ated she did help remove Broda chair because she did transfer him herself. The video surveillance of January 2:06 a.m., along with the actor of Nursing and Corporate frember were seen in the one Resident D was in the Broda and was observed:		The Administrator and DON received Corporate Directed training on CarDon's abuse po and the structural components a complete investigation. The Administrator and DON were provided with a copy of the investigative checklist, which guides them to complete a full investigation of abuse allegation and were instructed how to complete the checklist with each and every abuse allegation. Fe each abuse allegation, the Administrator will scan a copy the complete investigative file including the completed check to the Regional Director of	ons ch For	

At 2:06 a.m., Resided D was seen sitting in his

Operations, Director of Clinical

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. Bl	A. BUILDING 00 COMPLETE			ETED
		155357	B. W	ING		02/23/	/2018
		ı		STDEET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	₹			I WALKER DR		
ΕΔΙΛ/Ι ΙΝΙ	S HOUSE HEALTH	I & LIVING COMMUNITY			ETON, IN 46064		
IVAVVLIIV	- TOOGL HEALIH	TA LIVINO COMMONITI		LLINDL	L 1 O 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		
(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 APPROPRIAT		TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	wheelchair at the nu	urses' station.			Services, and the Clinical		
					Specialist to ensure all necess	sary	
		10 brought a Broda chair to the			components are present. No		
	North Hall.				employee suspended for an		
		10 11			allegation of abuse will be retu		
		lent D was moved from his			without prior approval from the		
		Broda chair by CNA 10 and			Regional Director of Operation	ns.	
	LPN 7. CNA 10 reclines the Broda chair						
	completely back an	d placed a sheet over him.					
	A+ 2:05 c CNIA	2 was seen walking around					
	Resident D.	2 was seen warking around					
	Resident D.				l		
	At 3:51 a.m., Laundry 16 was seen in the video				IV The facility will monite	or	
		rts near Resident D while he			the corrective action by		
		roda chair, leaned back. No			implementing the followin	g	
	other staff person w				measures.		
	other starr person w	vas present.					
	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	acy	
		the scales to weigh and left.			Beyl, will review all allegations	of	
					abuse monthly ongoing with n	0	
	At 4:46 a.m., CNA	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	ent D appeared to only have					
	socks on his feet an	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 Clir	nical	
	_	as on the floor and tossed it			Specialist will oversee all		
	back over the reside	ent.			allegations of abuse daily or fo	or	
					each occurrence ongoing,		
	At 5:30 a.m., CNA 9 walked past Resident D to				including review of the investig	_	
	place her items at the	he nurses' station.			file with no current end date to		
					ensure a thorough investigation	II IS	
		10 and CNA 8 removed			completed.		
		e view of the video and he					
	returned at 6:03 a.m	n. wearing a shirt and jeans. At					

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
	PROVIDER OR SUPPLIER S HOUSE HEALTH	& LIVING COMMUNITY	300 J F	ADDRESS, CITY, STATE, ZIP COD I WALKER DR ETON, 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	COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
1/10		D was transferred from the	IAU		DATE
	Broda Chair to his			Results of these audits will	ho
	Dioua Chan to fils	wneelellall.			
	An amplazza aamm	nunication form, dated 2/2/18,		reported to the QA committ	iee
		as terminated only for "Failure"		monthly and the need for	
		2		additional training or	
		afety, sleeping on clock on		monitoring will be adjusted	as
	unit."			needed if compliance is be	low
	D	2/22/19 - 4 10 40 41		100%.	
	_	v on 2/22/18 at 10:40 a.m., the			
	Administrator and Director of Nursing were not aware of the three employees shown in the video. They were not aware the statement provided by				
		licated she did not bring the			
		unit, did not match the video		V. Plan of Correction	
		at no statements were provided			
		3, Laundry Aid 10 related to the		completion date 03/19/18.	
	allegation.				
		4 p.m., the Corporate			
		cated CNA 10 had been		Facility Administrator will be	e
		or her contributions to the		responsible for ensuring	
	abusive conduct			compliance.	
		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,			
		al abuse, corporal punishment,			
	and involuntary sec	elusion"			
	V. ABUSE INVI	ESTIGATIONS			
	Policy Statement				
	-	ent abuse, neglect and injuries			
		rce shall be immediately and			
	thoroughly investigated by the facility				
	management.				
		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

	AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155357		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/23/2018		
	ROVIDER OR SUPPLIER S HOUSE HEALTH	& LIVING COMMUNITY	3	00 J H \	DDRESS, CITY, STATE, ZIP COD WALKER DR TON, IN 46064		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		O EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
F 0677	a. The State licensis7. Employees of the accused of resident duty" The Immediate Jeograms was removed on 2/2 staff confirmed the staff on abuse, restraprocess. The noncollower scope and sew with potential for more immediate jeograms and not been inserved. This Federal tag related 3.1-28(d)	incident when applicable: Ing/certification agency This facility who have been abuse will be suspended from a party (IJ) that began on 1/31/18 Incident when interviews with facility had begun inservicing and the reporting in mpliance remained at the rerity level of no actual harm fore than minimal harm that is and because all employees fixed. In the service of the servic					
F 0677 SS=D Bldg. 00	§483.24(a)(2) A recarry out activities necessary service nutrition, grooming hygiene; Based on, interview failed to ensure resistaff for toileting, received (ADL) assistance (Findings include: 1. The clinical reco 2/19/18 at 5:38 p.m. not limited to, deme	and record review, the facility dents who were dependent on ceived those services for 2 of d for Activities of Daily Living Resident D and Resident G).	F 0677		F 677 I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.		03/19/2018

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

Event ID:

NYLX11 Facility ID: 000248

If continuation sheet Page 25 of 35

STATEMEN	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. W	ING		02/23/	2018
NAME OF I	PROVIDER OR SUPPLIEI	3	•		ADDRESS, CITY, STATE, ZIP COD		
RAWLIN	S HOUSE HEALTH	& LIVING COMMUNITY			I WALKER DR ETON, IN 46064		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	·ΤΕ	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION .	+	TAG	DEFICIENCY)		DATE
	dysphagia, and anemia.						
	Dagidant Dayas adı	mitted to the facility on 1/19/19			Resident D no longer		
		nitted to the facility on 1/18/18. n Data Set (MDS) assessment,			resides at the facility.		
		cated Resident D was severely					
	cognitively impaired. Resident D required				Resident G is receiving		
	extensive assistance with two person assistance				assistance with toileting.		
	for bed mobility, transfers, walking, dressing and						
	hygiene.				CNA 10 employment has	;	
					been terminated.		
	A current health ca	re plan, dated 1/28/18,					
	indicated Resident D was unable to perform late				LPN 7 employment has b	peen	
	loss Activities of Daily Living (ADL) related to				terminated.		
	weakness and debility. He required two person				terrimatea.		
	assistance with tran						
		ded, but were not limited to,					
	provide incontinent	ce care after being toileted.			II. The facility will identify	v	
	D : : 64				other residents that may	'	
	_	ne video surveillance of January			potentially be affected by		
	_	2:06 a.m., along with the					
		ector of Nursing (DON) and esided D was seen sitting in a			the deficient practice.		
		ing wheel chair on wheels) from					
	,	5:05 a.m., Resident D was not					
		brief was not placed on			Other residents residing at		
	Resident B.				Rawlins House who are		
					dependent on staff for toile	tina	
	Review of Residen	t D's ADL charting, CNA 10 did			have the potential to be	ıy	
	not document any o	eare provided after 1:03 a.m. on			affected by the alleged		
	1/31/18.				deficient practice, ADL sco	rec	
					care plans and assignment		
		ord for Resident G was reviewed			sheets are being reviewed		
		a.m. Diagnoses included, but			identify residents who are		
		, orthopedic aftercare, pain in			dependent on staff for toile	tina	
	0 0 1	y heart disease, anxiety and			to ensure the staff are awa		
		ay Minimum Data Set (MDS) /24/18, indicated Resident G			of toileting needs and are	J	
	was cognitively int				providing the assistance		
	was cognitively int	act.			needed.		
	A current health ca	re plan, dated 1/19/18			nogueu.		

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 DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE indicated Resident G was unable to perform late loss ADL's related to weakness and debility. She required extensive assistance with one person III. The facility will put into assistance for toileting. place the following systemic changes to ensure that the Another health care plan, dated 1/14/18, indicated deficient practice does not Resident D was a fall 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., Nursing staff will be educated on Resident G indicated she had to wait 90 minutes providing assistance to residents one night for her call light to be answered and who are dependent on staff for urinated in her brief about two or three weeks ago. toileting. Staff will be educated One nurse, LPN 7, would not help answer call regarding promptly responding to lights. The resident indicated she would call lights. Newly hired staff occasionally take herself to the bathroom, but was members will be educated not supposed to. She did complain to the DON regarding providing assistance to and was told the nurse was no longer employed at residents who are dependent on the facility. staff for toileting as well as promptly responding to call lights A current facility policy, dated January 1, 2018, and the staff member will be titled "ACTIVITIES OF DAILY LIVING...," randomly observed to ensure provided by the DON on 2/23/18 at 2:24 p.m., competence. indicated the following: "...POLICY The interdisciplinary management team must take reasonable steps to ensure the accurate daily IV The facility will monitor documentation of ADLs by facility nursing staff. Due to the need for accuracy in ADL the corrective action by documentation and coding as it relates to care implementing the following planning and reimbursement, adherence to this measures. policy is essential." 3.1-38(a)(2)(C)The DON or designee will interview 5 cognitively intact residents who are dependent on staff for toileting to ensure call lights are being responded to and assistance is

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155357	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/23/2018
	PROVIDER OR SUPPLIER S HOUSE HEALTH	& LIVING COMMUNITY	300 J I	ADDRESS, CITY, STATE, ZIP COD H WALKER DR LETON, IN 46064	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	ON (X5) BE COMPLETION DATE
				being provided on various some The DON or designee will of 5 cognitively impaired resid who are dependent on staff toileting to ensure toileting assistance is being provide various shifts. This audit wiften 5 residents daily for 4 withen 5 residents weekly for weeks, then 5 residents more for 9 months for a total of 1 months of monitoring.	observe lents f for d on II occur eeks, 8 onthly
				Results of these observation interviews will be reported to QA committee monthly and ongoing frequency will be a as needed if compliance is 100%.	to the adjusted
				V. Plan of Correction completion date 03/19/1	8.
				Facility Administrator v responsible for ensurir compliance.	
F 0726 SS=D Bldg. 00	483.35(a)(3)(4)(c) Competent Nursir §483.35 Nursing §	ng Staff			

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

Event ID:

NYLX11

Facility ID: 000248

If continuation sheet

Page 28 of 35

PRINTED: 03/12/2018

NATEMINI OF DEPKTINCES AND PLAN OF CORRECTION DESTRICATION NUMBER AND PLAN OF CORRECTION DESTRICATION NUMBER 155357 NAME OF PROVIDER OR SUPPLIER RAWLINS HOUSE HEALTH & LIVING COMMUNITY OVAID SUMMARY STATEMENT OF DESTCIENCE PREFIX TAG The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain assessments and individual plans of care and considering the number, aculty and diagnoses of the facility resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. \$483.35(a)(7) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary 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 failed to follow physician orders for medication administration for 2 of 6 residents reviewed for physician's orders. (Resident D, Resident C) I. The corrective actions to		T OF HEALTH AND HU R MEDICARE & MEDIC					ORM APPROVED OMB NO. 0938-039
RAWLINS HOUSE HEALTH & LIVING COMMUNITY PREFIX TAG The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility must ensure that licensed nurses have the specific competencies by assessment required at \$483.70(e). \$483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. \$483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. \$483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident acre plans and responding to resident from the plan of care. Based on record review and interview, the facility failed to follow physician orders for medication administration for 2 of 6 residents reviewed for physician's orders. (Resident D, Resident G)	STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BUILD		(X3) DA	TE SURVEY MPLETED
RECIL TORY OF USE DEPTITY NO INFORMATION TAG RECILATORY OR LISE DIENTIFY IND INFORMAT				30	00 J H WALKER DR	CIP COD	
with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary 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 failed to follow physician's orders. (Resident D, Resident G) F 0726 F726 F726 F726	PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PRE	FIX (EACH CORRECTIVE ACTI CROSS-REFERENCED TO	ON SHOULD BE THE APPROPRIATE	COMPLETION
physician's orders. (Resident D, Resident G)		The facility must with the appropria sets to provide not to assure resident maintain the high mental, and psycoresident, as deter assessments and considering their diagnoses of their accordance with required at §483. §483.35(a)(3) The licensed nurses through resident at through resident at through resident at described in the psychological systems of the second responding to residents and implementing responding to residents able to demonstrate through residents and implementing responding to residents and implementing resp	have sufficient nursing staff ate competencies and skills ursing and related services t safety and attain or est practicable physical, hosocial well-being of each mined by resident I individual plans of care and umber, acuity and facility's resident population that he facility assessment 70(e). The facility must ensure that have the specific diskill sets necessary to reeds, as identified assessments, and plan of care. Toviding care includes but is essing, evaluating, planning gresident care plans and hident's needs. The includes are attained as a second as				
					I. The corrective	actions to	

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

Findings include:

1. The clinical record for Resident D was reviewed

Event ID:

NYLX11

Facility ID: 000248

be accomplished for those residents found to have

If continuation sheet

Page 29 of 35

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		155357	B. W	ING		02/23/	2018
		l .		CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	2			I WALKER DR		
D 4 / 4 / 1 / 1 / 1		S I IVING COMMINITY					
KAWLIN	3 HOUSE HEALTH	& 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	12	DATE
	on 2/19/18 at 5:38 p	p.m. Diagnoses included, but			been affected by the		
	were not limited to,	dementia with behaviors,			deficient practice.		
	Alzheimer's disease	e, chronic kidney disease,			donoione praotico.		
	dysphagia, and aner						
	Resident D was adr	nitted to the facility on 1/18/18.			Desident Dae langer resides	in	
	A 14-day Minimum	n Data Set (MDS) assessment,			Resident D no longer resides	111	
		cated Resident D was severely			the facility.		
		ed. He required extensive			Basidant Oil	_4:	
		person assistance for bed			Resident G is receiving medic	ation	
		walking, dressing and hygiene.			per MD order and received		
		wheelchair as his mobility			psychosocial support with no		
	device. Review of Resident D's physician orders,				negative outcomes.		
					LPN 7 employment has been		
		rector of Nursing on 2/23/18 at			terminated.		
		d an order for levothryroxine					
		75 mcg to be given one time			Med error report completed w		
		n. through 6:00 a.m.			MD notification for Resident G	and	
	daily from 5.00 a.ii	i. unough 6.00 a.m.			Resident D. No negative		
	During ravious of th	ne video surveillance of January			outcomes noted for Resident	D or	
	_	2:06 a.m., along with the			Resident G.		
		ector of Nursing and Corporate					
	-						
		was seated at the nurses station until 5:55 a.m., when CNA 10					
		and Resident D from the view of					
		turned at 6:03 a.m. wearing a			II. The facility will identify	v	
	shirt and jeans.				other residents that may	<i>'</i>	
	Davison aft. M. 1	igation Administration December			potentially be affected by		
		ication Administration Record,			1 -		
	LPN 7 charted she administered levothryroxine to Resident D between 5:00 a.m. and 6:00 a.m. on 1/31/18. The video did not show LPN 7 administer				the deficient practice.		
	any medication to F	Kesident D.					
		10 7 11 7			Other residents are residing a		
		ord for Resident G was reviewed			Rawlins House have the poter	ntial	
		a.m. Diagnoses included, but			to be affected by the alleged		
		orthopedic aftercare, pain in			deficient practice. The medica	ition	
		y heart disease, anxiety and			administration report for the la	st	
	insomnia. An 14-d	ay Minimum Data Set (MDS)			30 days is being reviewed for		
	I				1		

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	COMPL	ETED
		155357	B. W			02/23/	
NAME OF I	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
D 414/1 IN	0.1.01.105.115.41.71.1	A LINUNIA CONTRALIBUTY			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 APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	assessment, dated 1	/24/18, indicated Resident G			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		
		lews for staff working 2/19/18			deficient practice does no		
	through 2/23/18 we	re completed.			recur.	,,	
					recui.		
		ed 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	
		11.001.5.111			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					
		7 not giving residents their					
	pain medication.	/ not giving residents then					
	pain incurcation.						
	Employee 6 indicat	ed he/she heard a lot of			N/ The feetility		
		PN 7 withholding pain			IV The facility will monit	Or	
	_	should have been gone a long			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 med						

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

Event ID:

NYLX11 Facility ID: 000248

If continuation sheet Page 31 of 35

	OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155357	· /	JILDING NG	ONSTRUCTION 00	(X3) DATE (COMPL 02/23/	ETED
	PROVIDER OR SUPPLIE S HOUSE HEALTH	R I & LIVING COMMUNITY		300 J H	ADDRESS, CITY, STATE, ZIP COD I WALKER DR ETON, IN 46064		
(X4) ID PREFIX TAG	During an interview questioned, the Ad-	STATEMENT OF DEFICIENCIE SICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION 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		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) The DON or designee will obe medication administration for residents on various shifts to	serve	(X5) COMPLETION DATE
	p.m., LPN 7 indicathat she administer she was busy throut nurse actually gave no other explanation administering any she left at 6:22 a.m. A current, undated, "Licensed Nurse Market at 19 indicated of the control of	facility policy, titled led Pass Clinical Skills			ensure medications are being administered per physicians' order, at the correct time, medications are not pre-set, at the documentation of medication administration is occurring at time of administrations daily f weeks, then 5 residents week 8 weeks, then 5 residents motor 9 months for a total of 12 months of monitoring.	and tion the for 4 kly for	
	4:10 p.m., indicated "5. Bring medica resident room29. Medication v before or after the totherwise directed	ntion cart to an area adjacent to was given within the 60 minutes time designated unless			Results of these audits will be reported to the QA committee monthly and ongoing frequen will be adjusted as need if compliance is below 100%.	;	
					V. Plan of Correction completion date 03/19/18		
					Facility Administrator will responsible for ensuring compliance.		

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155357		ILDING NG	ONSTRUCTION 00	(X3) DATE S COMPLI 02/23/2	ETED
	PROVIDER OR SUPPLIEI S HOUSE HEALTH	RI & 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 ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION DATE
F 9999 Bldg. 00	subsection (I), staff residents shall have dementia-specific t initial employment personnel assigned dementia special ca annually thereafter preferences, or both residents and to gai standards of care for	the required inservice hours in a who have regular contact with a minimum of six (6) hours of raining within six (6) months of to the Alzheimer's and the unit, and three (3) hours to meet the needs or an of cognitively impaired on understanding of the current or residents with dementia.	F 99	999	I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.	e	03/19/2018
	failed to a ensure the dementia training wemployee records race CNA 10) Findings include: Review of Employed 2:10 p.m. The following found: LPN 7 had a hire definition of the desired found and the desired found and the desired found found and the desired found found for the desired fo	view and interview, the facility ne required annual three hour was complete for 3 of 5 eviewed. (LPN 7, CNA 8 and ee records began on 2/20/18 at owing noncompliance was attended of 12/7/16. Her employment			LPN 7 employment has been terminated. CNA 10 employment has been terminated. CNA 8 has completed the required annual three hour dementia training.	een	
	training for 2017. Inhours in January. CNA 8 had a hire direcord did not indicate.	LPN 7 worked a total of 233 late of 7/12/17. Her employment cate completion of dementia CNA 8 worked a total of 72			other residents that may potentially be affected by the deficient practice. Other residents residing at Rawlins House with a		

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.

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

Event ID:

NYLX11

Facility ID: 000248

If continuation sheet

Page 34 of 35

DEPARTMENT OF HEALTH AND HUMAN SERVICES	
CENTERS FOR MEDICARE & MEDICAID SERVICES	

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155357	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 02/23/2018
	ROVIDER OR SUPPLIEI S HOUSE HEALTH	R I & LIVING COMMUNITY	300 J H	ADDRESS, CITY, STATE, ZIP COD H WALKER DR LETON, IN 46064	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NOT MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OBE COMPLETION
				Administrator or designed audit the completion of a dementia training weekly weeks then monthly for months.	annual y for 12
				Results of these audits will reported to the QA commit monthly and ongoing freque will be adjusted as need if compliance is below 100%	itee uency
				V. Plan of Correction completion date 03/19/	18
				Facility Administrator 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