| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155383 | A. BUILDING 00<br>B. WING | 11/12/2015 |

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| F 0000<br><br>Bldg. 00 | This visit was for the Investigation of Complaint IN00185787.<br><br>Complaint IN00185787 - Substantiated. Federal/State deficiencies related to the allegations are cited at F 223, F 225, and F 226.<br><br>Survey dates: November 10, 12, 2015<br><br>Facility number: 000393<br>Provider number: 155383<br>AIM number: 100289340<br><br>Census bed type:<br>SNF/NF: 81<br>Total: 81<br><br>Census payor type:<br>Medicare: 4<br>Medicaid: 55<br>Other: 22<br>Total: 81<br><br>Sample: 3<br><br>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed 11/13/15 by | F 0000 | The creation and submission of this Plan ofCorrection does not constitute an admission by this provider of any conclusionset forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan ofCorrection be considered the Letter of Credible Allegation and requests a DeskReview or Post Survey Review on or after 12/8/15. | |

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

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| | 29479. | | | |
| F 0223 SS=D Bldg. 00 | 483.13(b), 483.13(c)(1)(i)<br>FREE FROM ABUSE/INVOLUNTARY SECLUSION<br>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.<br><br>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.<br>Based on record review and interview, the facility failed to ensure staff did not abuse residents by tying the wheels together on a resident's wheelchair and making derogatory remarks to a resident for 2 of 3 residents reviewed for abuse allegations (Residents B and C).<br><br>Findings include:<br><br>The facility Reportable Incidents were reviewed on 11/10/15 at 11:15 a.m. An incident, dated 11/1/15, indicated the facility investigated an allegation of abuse concerning Resident B's wheelchair (w/c) wheels being tied together. The facility's investigation concluded the incident did occur.<br><br>1. The record for Resident B was reviewed on 11/10/15 at 10:30 a.m. His diagnoses included, but were not limited to, dementia with delusions, anxiety, and | F 0223 | **What corrective action(s) willbe accomplished for those residents found to have been affected by the deficientpractice?** Nurseand CNA involved in incidents terminated. **How will other residents havingthe potential to be affected by the same deficient practice be identified andwhat corrective action will be taken?** Allresidents have the potential to be affected by this alleged deficient practice. All staff inserviced on abuse, neglect and Elder Justice on11/3/2015. **What measures will be put intoplace or what systemic changes you will make to ensure that the deficientpractice does not recur** Staffinserviced on abuse, neglect and Elder Justice on 11/3/2015. All newstaff will be inserviced on abuse, neglect and Elder Justice in generalorientation by 12/8/15. **How the corrective action(s)will be monitored to** | 12/08/2015 |

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| | insomnia. A Quarterly Minimum Data Set Assessment, dated 10/28/15, indicated Resident B was severely cognitively impaired, and was actively involved in propelling his w/c.<br><br>During an interview with Housekeeper #3 on 11/12/15 at 11:30 a.m., she indicated on 10/29/15 about 4:00 a.m., she was delivering laundry to the East Hall and noted Resident B in front of the linen room door in his wheel chair (w/c) asking for help. Housekeeper #3 indicated as she approached Resident B it looked like his blanket had fallen off his shoulders and was preventing the wheels of his w/c from moving. She indicated as she reached the chair she realized the wheels had been tied together to prevent the resident from moving around in his w/c. She indicated she untied him and took him to his room, and she told LPN #1 what she found and what she did. Housekeeper #3 indicated the nurse said "ok". Housekeeper #3 indicated as she was walking through the lobby, the nurse and CNA were giggling.<br><br>During an interview with Resident C on 11/12/15 at 12:00 p.m., she indicated she once saw Resident B with his w/c wheels tied together.<br><br>2. An incident, dated 10/22/15, indicated | | **ensure the deficient practice will not recur, i.e., whatquality assurance program will be put into place** To ensure compliance, theED/Designee is responsible for completing the Abuse Prohibition andInvestigation tool, which includes for all allegations of abuse for allresidents, interview with staff, interview with resident, interview with any witnesses, including family/visitors, and notificationfamily/responsible party, weekly for 4 weeks and monthly for 6 months. Theresults of these audits will be reviewed by the CQI committee overseen by theED. If threshold of 95% is not achieved an action plan will be developedto ensure compliance. | |

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| | the facility investigated an allegation of abuse concerning a nurse making derogatory remarks to Resident C.<br><br>The record for Resident C was reviewed on 11/10/15 at 2:05 p.m. Her diagnoses included, but were not limited to, anxiety, and bipolar disorder.<br><br>A Quarterly Minimum Data Set Assessment, dated 9/9/15, indicated Resident C was cognitively intact.<br><br>During an interview with Resident C on 11/12/15 at 12:00 p.m., she indicated one night she had asked to go to the bathroom and LPN #1 had told her "she wasn't the only one on the unit who needed help." Resident C indicated she had started crying, and LPN #1 told her to "stop whining and crying like a baby, that she wasn't the only one who had a hard life." Resident C indicated this had hurt her feelings. She also indicated another night she had gone to the lounge to color at the table there and LPN #1 had told her she couldn't because she couldn't have the lights on. When Resident C asked why the light couldn't be on, she indicated LPN #1 had told her "because it was the rules." When asked if it was a facility rule, Resident C was told it was her (LPN #1's) rule, and she was told to go back to her room. | | | |

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During an interview with Resident D on 11/12/15 at 10:05 p.m., she indicated she had heard something out of LPN #1's mouth she never thought she would hear a nurse say. She indicated LPN #1 had said to Resident C that "if she didn't stop it, she wasn't going to get any more help tonight." Resident D's Quarterly Minimum Data Set Assessment, dated 9/30/15, indicated she was cognitively intact.

A current facility policy, dated 2/2010 and last revised in 7/2015, titled "Abuse Prohibition, and Investigation" was provided by the DNS (Director of Nursing Services) on 11/10/15 at 10:00 a.m. The policy indicated: "Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain, or mental anguish....Willful - the individual's action was deliberate [not inadvertent or accidental]...Physical Abuse...improper use of restraints....Verbal Abuse...scolding and/or speaking to them in harsh voice tones."

A current facility policy, dated 6/2013 and last revised 2/2013, titled "Restrictive Devices" was provided by the HFA (Health Facility Administrator)

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| | on 11/10/15 at 11:10 a.m. The policy indicated: "It is the policy of [name of corporation] to prohibit the use of restrictive devices...for the purpose of discipline or convenience....Definition: A physical restraint is defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body...."<br><br>This federal tag relates to Complaint IN00185787.<br><br>3.1-27(a) | | | |
| F 0225 SS=D Bldg. 00 | 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS<br>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.<br><br>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source | | | |

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| | and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).<br><br>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.<br><br>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification 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 staff immediately reported awareness of an allegation of abuse to the administrator for 1 of 3 residents reviewed for abuse allegations (Resident B).<br><br>Findings include:<br><br>The facility Reportable Incidents were reviewed on 11/10/15 at 11:15 a.m. An incident, dated 11/1/15, indicated the facility investigated an allegation of abuse concerning Resident B's wheelchair (w/c) wheels being tied together. The facility's investigation | F 0225 | **What corrective action(s) willbe accomplished for those residents found to have been affected by thedeficient practice?** Nurse and CNA terminated. Housekeeper suspended and educated onreporting abuse immediately to Executive Director. **How will other residents havingthe potential to be affected by the same deficient practice be identified andwhat corrective action will be taken?** All residents have the potential to be affected bythe alleged deficient practice. All staff inserviced on reportingabuse and neglect on 11/3/2015. **What measures will be put intoplace or what** | 12/08/2015 |

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| | concluded the incident did occur.<br><br>The incident, dated 11/1/15, indicated the actual incident occurred on 10/29/15 at 4:30 a.m. The report indicated Housekeeper #3 had found Resident B with the wheels of his wheel chair tied together, she had untied him and reported to the nurse on duty. The facility's investigation indicated the nurse (LPN #1) and CNA #2 had been suspended during the investigation. Housekeeper #3 had been suspended during the investigation for not reporting the incident to the administrator immediately.<br><br>During an interview on 11/12/15 at 10:15 a.m., the Administrator indicated she had asked Housekeeper #3 why she had not reported the incident to her (Administrator). The Administrator indicated Housekeeper #3 had thought it was enough that she had told the nurse on duty (LPN #1).<br><br>A current facility policy, dated 2/2010 and last revised 7/2015, titled "Abuse Prohibition, Reporting, And Investigating" was provided by the DNS (Director of Nursing Services) on 11/10/15 at 10:00 a.m. The policy indicated: "Policy/Procedure:...3. Employees whether direct care, contract | | **systemic changes you will make to ensure that the deficientpractice does not recur?** All staff inserviced on reporting abuse and neglecton 11/3/2015. All newstaff will be inserviced on reporting abuse and neglect in general orientationby 12/8/15. **How the corrective action(s)will be monitored to ensure the deficient practice will not recur, i.e., whatquality assurance program will be put into place** To ensure compliance, theED/Designee is responsible for completing the Abuse Prohibition andInvestigation tool, which includes for all allegations of abuse for allresidents, interview with staff, interview with resident, interview with any witnesses, including family/visitors, and notificationfamily/responsible party, weekly for 4 weeks and monthly for 6 months. Theresults of these audits will be reviewed by the CQI committee overseen by theED. If threshold of 95% is not achieved an action plan will be developedto ensure compliance. | |

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| | staff, ancillary departments, volunteers, or consultants receive instruction/training on abuse during orientation and periodically during ongoing inservice education. The training will include: a. What constitutes abuse b. To whom to report abuse...4. Residents and their families are educated as to whom and how to report allegations, incidents, and/or complaints without fear of retribution....5. All abuse allegations must be reported to the Executive Director immediately..."<br><br>This federal tag relates to Complaint IN00185787.<br><br>3.1-28(c) | | | |
| F 0226 SS=D Bldg. 00 | 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES<br>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.<br>Based on record review and interview, the facility failed to implement its policies and procedures for preventing abuse and immediately reporting an allegation of abuse of residents for 2 of 3 residents reviewed for allegations of abuse.(Residents B and C). | F 0226 | **What corrective action(s) willbe accomplished for those residents found to have been affected by thedeficient practice?** Nurse and CNA terminated. Housekeeper suspended and educated onreporting abuse immediately to | 12/08/2015 |

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| | Findings include:<br><br>The facility Reportable Incidents were reviewed on 11/10/15 at 11:15 a.m. An incident, dated 11/1/15, indicated the facility investigated an allegation of abuse concerning Resident B's wheelchair (w/c) wheels being tied together. The facility's investigation concluded the incident did occur.<br><br>1. The record for Resident B was reviewed on 11/10/15 at 10:30 a.m. His diagnoses included, but were not limited to, dementia with delusions, anxiety, and insomnia. A Quarterly Minimum Data Set Assessment, dated 10/28/15, indicated Resident B was severely cognitively impaired, and was actively involved in propelling his w/c.<br><br>During an interview with Housekeeper #3 on 11/12/15 at 11:30 a.m., she indicated on 10/29/15 about 4:00 a.m., she was delivering laundry to the East Hall and noted Resident B in front of the linen room door in his wheel chair (w/c) asking for help. Housekeeper #3 indicated as she approached Resident B it looked like his blanket had fallen off his shoulders and was preventing the wheels of his w/c from moving. She indicated as she reached the chair she realized the | | Executive Director. **How will other residents havingthe potential to be affected by the same deficient practice be identified andwhat corrective action will be taken?** Allresidents have the potential to be affected by this alleged deficientpractice. All staff inserviced on reportingabuse and neglect on 11/3/2015. **What measures will be put intoplace or what systemic changes you will make to ensure that the deficientpractice does not recur** All staff inserviced on reportingabuse and neglect on 11/3/2015. All newstaff will be inserviced on reporting abuse and neglect in general orientationby 12/8/15. **How the corrective action(s)will be monitored to ensure the deficient practice will not recur, i.e., whatquality assurance program will be put into place** To ensure compliance, theED/Designee is responsible for completing the Abuse Prohibition andInvestigation tool, which includes for all allegations of abuse for allresidents, interview with staff, interview with resident, interview with any witnesses, including family/visitors, and notificationfamily/responsible party, weekly for 4 weeks and monthly for 6 months. Theresults of these audits will be reviewed by the CQI committee overseen by theED. If threshold of 95% is | |

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| | wheels had been tied together to prevent the resident from moving around in his w/c. She indicated she untied him and took him to his room, and she told LPN #1 what she found and what she did. Housekeeper #3 indicated the nurse said "ok". Housekeeper #3 indicated as she was walking through the lobby, the nurse and CNA were giggling.<br><br>During an interview with Resident C on 11/12/15 at 12:00 p.m., she indicated she once saw Resident B with his w/c wheels tied together.<br><br>2. An incident, dated 10/22/15, indicated the facility investigated an allegation of abuse concerning a nurse making derogatory remarks to Resident C.<br><br>The record for Resident C was reviewed on 11/10/15 at 2:05 p.m. Her diagnoses included, but were not limited to, anxiety, and bipolar disorder.<br><br>A Quarterly Minimum Data Set Assessment, dated 9/9/15, indicated Resident C was cognitively intact.<br><br>During an interview with Resident C on 11/12/15 at 12:00 p.m., she indicated one night she had asked to go to the bathroom and LPN #1 had told her "she wasn't the only one on the unit who needed help." | | not achieved an action plan will be developedto ensure compliance. | |

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| | Resident C indicated she had started crying, and LPN #1 told her to "stop whining and crying like a baby, that she wasn't the only one who had a hard life." Resident C indicated this had hurt her feelings. She also indicated another night she had gone to the lounge to color at the table there and LPN #1 had told her she couldn't because she couldn't have the lights on. When Resident C asked why the light couldn't be on, she indicated LPN #1 had told her "because it was the rules." When asked if it was a facility rule, Resident C was told it was her (LPN #1's) rule, and she was told to go back to her room.<br><br>During an interview with Resident D on 11/12/15 at 10:05 p.m., she indicated she had heard something out of LPN #1's mouth she never thought she would hear a nurse say. She indicated LPN #1 had said to Resident C that "if she didn't stop it, she wasn't going to get any more help tonight." Resident D's Quarterly Minimum Data Set Assessment, dated 9/30/15, indicated she was cognitively intact.<br><br>A current facility policy, dated 2/2010 and last revised in 7/2015, titled "Abuse Prohibition, and Investigation" was provided by the DNS (Director of Nursing Services) on 11/10/15 at 10:00 | | | |

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| | a.m. The policy indicated: "Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain, or mental anguish....Willful - the individual's action was deliberate [not inadvertent or accidental]...Physical Abuse...improper use of restraints....Verbal Abuse...scolding and/or speaking to them in harsh voice tones."<br><br>A current facility policy, dated 6/2013 and last revised 2/2013, titled "Restrictive Devices" was provided by the HFA (Health Facility Administrator) on 11/10/15 at 11:10 a.m. The policy indicated: "It is the policy of [name of corporation] to prohibit the use of restrictive devices...for the purpose of discipline or convenience....Definition: A physical restraint is defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body...."<br><br>This federal tag relates to Complaint IN00185787.<br><br>3.1-28(a) | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155383 | A. BUILDING 00<br>B. WING | 11/12/2015 |

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

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