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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 04/30/2024 |
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| NAME OF PROVIDER OR SUPPLIER SWEET GALILEE AT THE WIGWAM | STREET ADDRESS, CITY, STATE, ZIP CODE 1315 JOHN STREET ANDERSON, IN 46016 |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| R 0000 Bldg. 00 | <p>This visit was for the Investigation of Complaints IN00432313, IN00432974, and IN00432987.</p> <p>Complaint IN00432313 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00432974 - State deficiencies related to the allegations are cited at R0052 and R0090.</p> <p>Complaint IN00432987 - No deficiencies related to the allegations are cited.</p> <p>Survey dates: April 29 & 30, 2024</p> <p>Facility number: 014706</p> <p>Residential Census: 85</p> <p>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed May 9, 2024.</p> | R 0000 | | |
| R 0052 Bldg. 00 | <p>410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion.</p> <p>Based on record review and interview, the facility failed to ensure Resident E was free from resident-to-resident abuse perpetrated by Resident C, failed to ensure Resident C was effectively monitored to prevent further events of</p> | R 0052 | <p>It is the intent of Sweet Galilee that all residents are free from abuse as required by 410 IAC 16.2-5-1.2(v)(1-6)</p> <p>1 Resident C was evicted</p> | 05/31/2024 |

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
| Joan Cook | Executive Director | 05/23/2024 |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| | <p>resident-to-resident abuse, and failed to ensure allegations of abuse were thoroughly investigated and Resident C was effectively supervised to prevent further events of abuse.</p> <p>Findings include:</p> <p>A facility reportable, dated 4/19/24 at 3:57 p.m., indicated Resident C spit on Resident E during a verbal disagreement in a common area. Resident E was sent to the emergency room for evaluation and the police department was notified. Resident E indicated he wished to press charges against Resident C. The police officers directed Resident C to remain in his apartment and to have no contact with Resident E. Resident E was placed on a 72 hour observation upon his return from the emergency room and Resident C was placed on every 15 minute checks for 48 hours.</p> <p>Resident C's clinical record was reviewed on 4/29/24 at 11:00 a.m. Diagnoses included depression and post-traumatic stress disorder.</p> <p>A SLUMS (St. Louis University Mental Status) Examination (a test to evaluate cognitive impairment) was performed on 1/17/24 and indicated the resident had moderate cognitive impairment.</p> <p>A service plan evaluation, completed on 1/22/24, indicated the resident was able to complete his activities of daily living independently, make his own decisions, and had no mobility deficits.</p> <p>A progress note, dated 3/16/24 at 11:09 p.m., indicated Resident C was intoxicated and had argued with multiple people. The police were called by another resident due to Resident C's aggressive behavior towards other residents.</p> | | <p>from the facility and no longer resides at Sweet Galilee.</p> <p>2 The deficiency had the potential to affect all residents. Resident H & J not longer feel threatened by Resident C.</p> <p>3 The facility has increased supervision in the evening and night, hiring receptionists to cover these shifts for security and additional oversight, The Ombudsman is scheduled to come to the facility to inservice Staff and Residents on Abuse and Reporting. Staff inserved by ED/designee on 5/16/24 and ongoing, that all incidents including threats will be reported to the Executive Director via the department supervisor, the grievance forms, or directly to the administrator. Executive Director to educate resident during Town Hall meeting in June.</p> <p>4 The Administrator/designee will audit daily for 30 days for allegations of Abuse, then continue weekly for 8 weeks. Random Audits to follow for 6 months.</p> <p>The findings will be reported to the Quality Assurance Committee. QAPI committee will review audit for a minimum of 6 months.</p> <p>5 Compliance date May 31, 2024</p> | |

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| | <p>A progress note, dated 3/18/24 at 3:11 p.m., entered by the DON, indicated, "Writer made aware of multiple concerns over the weekend regarding resident being intoxicated in public space inside building. Other residents report confrontational and aggressive behaviors, threatening statements including stating he was going to 'get his gun and shoot the next person who came to his room', and raising voice to others and so loudly in his room that residents outside room could hear. (Police) called on 3/16/24 by fellow residents r/t [related to] aggressive behaviors in common area. Resident left building before (Police) arrived. (Police) called again on 3/17/24 by staff r/t [related to] report of [resident] threatening with gun. Resident in room at time of (Police) arrival on 3/17/24. (Police) spoke with resident who denied allegations. Writer up to speak with resident about concerns. Resident out of room at this time Will address alleged behaviors with resident when he returns. ED [Executive Director] aware."</p> <p>A progress note, dated 4/19/24 at 10:30 a.m., entered by the DON, indicated, "Writer made aware by staff and other residents upon arrival this morning that resident [Resident C] was intoxicated in common area, and creating a disturbance. Other residents and staff reported resident [Resident C] and foul, aggressive language to receptionist, staff and residents in dining area. Resident was no longer in area when writer arrived. Writer went to speak with resident, however was told resident had left building at this time. ED notified. Staff instructed to notify writer or ED upon resident return to community."</p> <p>A progress note, dated 4/19/24 at 11:00 a.m., entered by the DON, indicated Resident E had</p> | | | |

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| | <p>come to the common area to notify staff that he had seen Resident C getting off an elevator and had been engaged with an altercation with Resident C. During a verbal exchange, Resident C had spit in Resident E's face. Staff confirmed that Resident C was in his room. Police were called and spoke to Resident C and instructed him to remain in his room for the remainder of the day. Police indicated they would be obtaining a warrant for Resident C's arrest.</p> <p>Review of the Police Report, dated 4/24/24, indicated that on 4/19/24, the video footage showed Resident C and Resident E having a verbal altercation outside of an elevator on the fourth floor at approximately 10:55 a.m. At one point, Resident C was observed making a motion with his head consistent of a forceful spit into the face of Resident E. Resident E was observed sitting down in his wheelchair and made a clear wiping motion to his face.</p> <p>During an interview on 4/29/24 at 11:14 a.m., the Administrator indicated Resident C had an active Hepatitis C infection and Resident E was sent to the emergency room following the incident to evaluate for exposure and any further injury.</p> <p>During an interview on 4/30/24 at 1:15 p.m., the DON indicated she had spoken to the Administrator regarding the multiple behaviors and incidents involving Resident C, and a need to remove the resident from the facility. The Administrator had indicated to her that he had verbally requested permission to complete an involuntary discharge from the facility, but had not received a response. She was not aware of any search of Resident C's room for a gun following his threats on 3/18/24 and she had no police report for the incident on 3/18/24. The</p> | | | |

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| | <p>DON indicated Resident C should not be interviewed during the survey activities, as it was not safe to do so.</p> <p>During an interview on 4/30/24 at 1:15 p.m., the Interim Administrator indicated she was unable to locate any documentation regarding a request to complete an involuntary discharge. She had no information of an investigation, reporting to the state agency, nor a police report for the 3/18/24 incident.</p> <p>During an interview on 4/30/24 at 2:03 p.m., Resident J indicated Resident C was constantly cussing at other residents and walked around like he was ready to fight. He consistently tossed the puzzles residents were working on to the floor, and was drunk a lot of times. Resident J had reported several incidents to Receptionist 3.</p> <p>During an interview on 4/30/24 at 2:03 p.m., Resident H indicated Resident C called her a "bitch" several times and had threatened to slit her throat during an incident in March. At that time, Resident C indicated to her and other residents that he had a gun in his apartment and was going to shoot them. She reported this incident in March to Receptionist 3. She heard Resident C threaten to slit another resident's throat if the resident ever called the police again. This occurred in March, but she was unable to identify a specific date.</p> <p>During a phone interview on 4/30/24 at 2:45 p.m., Receptionist 3 indicated she had not reported the incidents described to her to the Administrator or DON because she had not witnessed them with her own eyes. She had been educated regarding abuse and the need to report allegations to the Administrator, but she thought Resident C's</p> | | | |

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| R 0090 Bldg. 00 | <p>multiple behaviors had already been addressed.</p> <p>A current "Resident Lease Agreement," found on the table on 4/29/24 at 1:00 p.m., indicated the following: "...II. Terms and Obligations...C. Termination...2. Termination by Owner. It is the intention of the Owner to assist its residents in remaining in the Unit as long as it is safe for the residents to do so and they do not constitute a threat to themselves or others in the Premises...."</p> <p>This citation relates to Complaint IN00432974.</p> <p>410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B) poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal</p> | | | |

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| | <p>representative.</p> <p>(3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility.</p> <p>(4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the:</p> <p>(A) employee's full name; and</p> <p>(B) dates and hours worked during the past twelve (12) months.</p> <p>(5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability.</p> <p>(6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request</p> <p>Based on record review and interview, the facility failed to report resident to resident abuse the Indiana Department of Health. (Residents C)</p> <p>Findings include:</p> <p>Resident C's clinical record was reviewed on 4/29/24 at 11:00 a.m. Diagnoses included depression and post-traumatic stress disorder.</p> <p>A SLUMS (St. Louis University Mental Status) Examination (a test to evaluate cognitive impairment) was performed on 1/17/24 and the resident had moderate cognitive impairment.</p> <p>A service plan evaluation, completed on 1/22/24, indicated the resident was able to complete his</p> | R 0090 | It is the intent of Sweet Galilee to inform the division within twenty four hours of becoming aware of an unusual occurrence that directly threatens the welfare safety or health of a resident as required by 410 IAC 16.2-5-1.3(g) (1-6). 1, The administrator who failed to inform the division of occurrences that directly threatened the welfare safety or health of a resident is no longer with the organization. 2. All residents could have been affected by alleged deficient practice. 3. The Regional Operations | 05/31/2024 | | | |

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| | <p>activities of daily living independently, made his own decisions, and had no mobility deficits.</p> <p>A progress note, dated 3/16/24 at 11:09 p.m., indicated Resident C was intoxicated and had argued with multiple people. The police were called by another resident due to Resident C's aggressive behavior towards other residents.</p> <p>A progress note, dated 3/18/24 at 3:11 p.m., entered by the DON, indicated "Writer made aware of multiple concerns over the weekend regarding resident being intoxicated in public space inside building. Other residents report confrontational and aggressive behaviors, threatening statements including stating he was going to 'get his gun and shoot the next person who came to his room', and raising voice to others and so loudly in his room that residents outside room could hear. (Police) called on 3/16/24 by fellow residents r/t [related to] aggressive behaviors in common area. Resident left building before (Police) arrived. (Police) called again on 3/17/24 by staff r/t [related to] report of threatening with gun. Resident in room at time of (Police) arrival on 3/17/24. (Police) spoke with resident who denied allegations. Writer up to speak with resident about concerns. Resident out of room at this time Will address alleged behaviors with resident when he returns. ED [Executive Director] aware."</p> <p>During an interview on 4/30/24 at 1:15 p.m., the DON indicated she was not aware of any search of Resident C's room for a gun following his threats on 3/18/24 and she had no police report for the incident on 3/18/24. She was unsure if a report had been submitted to the state agency.</p> <p>During an interview on 4/30/24 at 1:15 p.m., the</p> | | <p>Director will in-serviced the current Executive Director and Director of Nursing concerning Abuse and reporting of all occurrences within 24 hours of being notified.</p> <p>4. The Executive Director will audit for abuse allegations daily for 30 days. The Executive Director will then audit every week for 8 weeks, continuing monthly for up to 6 months. QAPI will review audits and make recommendations as needed.</p> <p>5. Compliance date May 31, 2024</p> | |

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| | <p>Interim Administrator indicated she had no information of an investigation, reporting to the state agency or a police report for the 3/18/24 incident.</p> <p>During an interview on 4/30/24 at 2:03 p.m., Resident J indicated Resident C was constantly cussing at other residents and walks around like he was ready to fight. He frequently tossed the puzzles resident's were working on to the floor and was drunk a lot of times. He had reported several incidents to Receptionist 3.</p> <p>During an interview on 4/30/24 at 2:03 p.m., Resident H indicated Resident C called her a "bitch" several times and had threatened to slit her throat during an incident in March. Resident C had indicated to her and other residents that he had a gun in his apartment and was going to shoot them. Resident H reported this incident in March 2024 to Receptionist 3. Resident H heard Resident C threaten to slit another resident's throat if the resident ever called the police again. This occurred in March 2024, but the resident was unable to identify a specific date.</p> <p>During a phone interview on 4/30/24 at 2:45 p.m., Receptionist 3 indicated she had not reported the incidents described to her to the Administrator or DON because she had not witnessed them with her own eyes. She had been educated regarding abuse and a need to report allegations to the Administrator, but she thought Resident C's multiple behaviors had already been addressed.</p> <p>A current "Resident Lease Agreement," found on the table on 4/29/24 at 1:00 p.m. upon return from lunch, indicated the following: "...Attachment 11 Abuse and Neglect Prevention...Investigation...If a resident alleges or an investigation uncovers</p> | | | |

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

PRINTED: 05/24/2024
FORM APPROVED
OMB NO. 0938-039

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| | possible abuse, neglect, misappropriation of resident property, a crime or a death other than by disease processes as the result of actions by a staff member, visitor or another resident, the Administrator or designee shall contact local law enforcement authorities and adult protective services within 24-hours of the allegations. A preliminary report of the incident shall be faxed or sent by electronic mail, to the Indiana State Department of Health within 24-hours of occurrence...." This citation relates to Complaint IN00432974. | | | | | | |