STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SWEET GALILEE AT THE WIGWAM	1315 JOHN STREET ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00450055. Complaint IN00450055 - State deficiencies related to the allegations are cited at R0053 and R0216. Survey dates: January 13 & 14, 2025 Facility number: 014706 Residential Census: 98 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed January 23, 2025.	R 0000		
R 0053 Bldg. 00	410 IAC 16.2-5-1.2(w) Residents' Rights - Deficiency Based on record review and interview, the facility failed to protect a resident's right to be free of verbal abuse from another resident for 1 of 6 residents reviewed for verbal abuse. (Residents C and B) Findings include: Review of a Facility Reported Incident, dated 12/27/24, indicated Resident B and Resident C had an argument on 12/26/24, and facility staff attempted to diffuse the situation. During the incident, Resident B appeared to have been drinking and was not controllable. Resident B had placed her hands in Resident C's face and Resident C pushed her hands away, causing Resident C to stumble backwards.	R 0053	The deficiency has the potential to affect all Residents. Resident C no longer feels threatened by Resident B as evidenced by Resident interviews. The Executive Director will inservice all staff on the community's Abuse Policy. The Executive Director will review all abuse investigations to ensure compliance with the regulation weekly for the next 4 weeks then monthly for the next 3 months. The findings will be reported to the QAPI committee for the next 6 months. Negative variances will be corrected at the time of finding and	03/07/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Verna Banks	Executive Director	02/06/2025

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	During an interview on 1/13/25 at 10:46 am, Resident B indicated she had not fallen down during the incident, which occurred outside the dining room. She was seated at a table and she felt like Resident C and his tablemates were staring at her. She asked them what they were looking at, got up, and went over to where they were seated. They all began to argue, but she had not "laid hands" on Resident C. Resident C shoved her hands and she stumbled backwards. A kitchen-worker had called the police, and the police instructed her to stay away from the other resident. During an interview on 1/13/25 at 10:59 a.m., Resident C indicated the incident occurred outside of the dining room when Resident B "went off." He had no idea what started the argument. She just began to yell and curse at him and waved her hands in front of his face. He pushed her hands away from him and she stumbled backwards, but had not fallen. She was very intoxicated. He indicated he avoided and ignored her, especially when she had been drinking. Resident B's clinical record was reviewed on 1/13/25 at 10:15 a.m. Diagnoses included hypertension and depression. A Level of Care document, dated 1/8/25, indicated she was independent with all activities of daily living (ADLs) and was oriented to person, place, and time. Resident C's clinical record was reviewed on 1/13/25 at 12:06 p.m. Diagnoses included epilepsy, diabetes mellitus type II, angina, and atherosclerosis of the aorta. A Level of Care document, dated 9/11/24, indicated the resident		will be reported to the community's QAPI committee. The Executive Director is responsible for maintaining compliance with the regulation.	

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	understood information conveyed without difficulty, communicated information and was understood, and was oriented to person, place and time. A written clinical note for Resident B, completed by the Administrator on 12/24/24, un-timed, indicated the resident was witnessed being inappropriate, yelling and screaming during the evening. Staff requested she quiet down and she continue to do so for a half an hour before leaving to her apartment. She had appeared drunk. A written clinical note for Resident B, completed by the Administrator on 12/28/24, un-timed, indicated the resident had been in the lobby, yelling and talking loudly. Staff had reported that she became angry and asking if they were "going to put her out." Staff calmly encouraged her to go to her apartment and requested she stay there, and if she was unable to calm down and not disrupt the community. She quieted down, but had to be reminded a few other times. A written clinical note for Resident B, completed by the Administrator on 1/6/25 at 10:30 p.m., indicated Resident B was reported to be drunk and was cussing, calling out to another resident. She was asked to keep her voice down. She went upstairs and came back again, cussing and yelling. She finally returned to her apartment. A clinical record note for Resident B, entered by the Administrator on 1/7/25 at 5:46 p.m., indicated Resident B was presented with another written notice of violating her lease due to drinking and having multiple behaviors on 12/23/24, 12/24/24, 12/26/24, 12/28/24, and 1/6/25. She was behaving inappropriately toward other residents within the community, including yelling, screaming and			

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	insulting other residents in the dining room. A written statement from CNA 2, dated 12/26/24 at 6:10 p.m. and provided by the Administrator, indicated during dinner time or shortly after, the CNA was in the laundry room on the first floor and heard a "bunch of fuss." She went out and witnessed Resident B and Resident C arguing real bad, with raised voices. She got in between them and asked them to stop and go to their rooms. Resident B continued and was putting her hands up around Resident C's face. Resident C pushed her hands away and she stumbled backwards. A written statement from an interview with Resident C on 12/27/24, provided by the Administrator, indicated Resident C pushed Resident B, but hadn't intended to do so. He just wanted her to move. Resident C was drinking and she was mean when she was drinking. Resident B had called him names. During an interview on 1/13/25 at 2:20 p.m., Resident D indicated he witnessed the incident on 12/26/24. Resident B and Resident C were fussing at each other. Resident B had gone over to where Resident C was sitting with another resident. Resident D believed Resident B leaned down to speak with Resident C's tablemate. Resident D felt Resident B got too close to Resident C, with all the fussing going on, and he pushed her hands/arms away. Resident B stumbled backwards, but did not fall. Resident B became verbally aggressive when she was drinking and it appeared she had been drinking at the time of the altercation. During an interview on 1/14/25 at 10:06 a.m., Resident F indicated she was in the lobby when she heard Resident B yelling, screaming, cussing			

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	and name calling. Resident B could be very nasty and belligerent. On several occasions she had yelled and cussed at Resident F. On one occasion, Resident B was screaming at her and called her a white bi---. Resident F had observed the other resident verbally yell and scream at multiple residents and was frequently intoxicated. Mostly, people just tried to avoid Resident B when she was drinking. During an interview on 1/13/25 at 3:55 p.m., CNA 3 indicated she was unaware of any increased needs for Resident B or if she had any negative behaviors. During an interview on 1/13/25 at 4:06 p.m., LPN 4 indicated she was not aware of any specific residents who required monitoring of negative behaviors. During an interview on 1/13/25 at 1:54 p.m., the Administrator indicated the incident between Resident B and Resident C was reported to her timely. The police had been called and had not taken an official report or assigned a case number. They diffused the situation and told both parties to remain in their rooms for the night. A current facility policy, revised 12/2024, titled, "Resident's Personal Rights Policy and Procedure," provided by the Administrator on 1/13/25 at 10:00 a.m., included the following: "Each resident will have the right to: 1. Be free from mental, emotional, social and physical abuse...."			
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance Based on interview and record review, the facility failed to accurately complete a resident's needs	R 0216	The deficiency had the potential to affect all Residents.	03/07/2025

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	assessment to include negative behaviors which prevented the development of interventions to meet the resident's needs for 1 of 6 residents reviewed for assessment. (Resident B) Findings include: Resident B's clinical record was reviewed on 1/13/25 at 10:15 a.m. Diagnoses included hypertension and depression. The resident had admitted to the facility on 6/27/24. Her Level of Care assessment, dated 1/8/25, indicated she was independent with all activities of daily living (ADL's) and was oriented to person, place, and time. The Behavior section of the assessment indicated the resident's attitudes, habits and emotional states do not limit the individual's type of living arrangement and companions. A clinical record note, entered by the Administrator on 1/7/25 at 5:46 p.m., indicated Resident B was presented with another written notice of violating her lease due to drinking and having multiple behaviors on 12/23/24, 12/24/24, 12/26/24, 12/28/24, and 1/6/25. She was behaving inappropriately toward other residents within the community, including yelling, screaming and insulting other residents in the dining room. A written clinical note for Resident B, completed by the Administrator on 12/24/24 at an unspecified time indicated the resident was witnessed being inappropriate, yelling and screaming during the evening. Staff requested she quiet down and she continue to do so for a half an hour before leaving to her apartment. She had appeared drunk. A written clinical note for Resident B, completed by the Administrator on 12/28/24 at an		The DON/designee will assess and update Resident B's Level of Care Assessment. The DON/designee will audit the Level of Care Assessments for all current Residents to ensure accuracy. The DON/Designee will ensure the Level of Care Assessments are completed accurately every 6 months or as needed. The DON/Designee will in-service all nursing staff on all the necessary components of the resident evaluation and assessment process. Resident Level of Care Assessments will be audited monthly for the next 6 months. Any variances will be corrected at the time of identification and communicated to the community's QAPI committee. The Executive Director is responsible for the continued compliance of this regulation.	

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	unspecified time indicated the resident had been in the lobby, yelling and talking loudly. Staff had reported that she became angry and asking if they were "going to put her out." Staff calmly encourage her to go to her apartment and requested she stay there, if she was unable to calm down and not disrupt the community. She quieted down, but had to be reminded a few other times. A written clinical note for Resident B, completed by the Administrator on 1/6/25 at 10:30 p.m., indicated Resident B was reported to be drunk and was cussing, calling out to other residents. She was asked to keep her voice down. She went upstairs and came back again, cussing and yelling. She finally returned to her apartment. During an interview on 1/13/25 at 3:55 p.m., CNA 3 indicated she was unaware of any increased needs for Resident B or that she had behaviors. During an interview on 1/13/25 at 4:06 p.m., LPN 4 indicated she was not aware of any specific residents who required monitoring for negative behaviors. During an interview on 1/13/25 at 3:48 p.m., RN 5 indicated she had been completing the Level of Care (LOC) assessments for the facility during transition to a new Director of Nursing. When completing Resident B's LOC assessment, she asked the staff if the resident ever displayed behaviors and multiple other questions regarding Resident B's condition. The staff had indicated she had not had behaviors. She indicated she had not reviewed the resident's clinical record and had not seen the documentation of her history of behaviors. The LOC should have been coded differently to indicate this under the Behaviors			

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	section. The LOC enabled the staff to be aware of the resident's needs. During an interview on 1/13/25 at 3:18 p.m., the Administrator indicated Resident B's LOC assessment regarding resident behaviors was incorrectly entered on the assessment. There was no specific policy regarding LOC assessment.			