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		A. BUILDING 00 B. WING	08/08/2019

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00299555. Complaint IN00299555 - Substantiated. State deficiencies related to the allegations are cited at R 0052. Survey dates: August 7, and 8, 2019. Facility number: 013880 Residential Census: 81 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on August 16, 2019.	R 0000	8-28-19 The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. This provide respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests Desk review in lieu of a Post Survey Review.	
R 0052 Bldg. 00	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. Based on observation, interview, and record review, the facility failed to prevent a resident with a known history of aggression, (Resident R) from physically assaulting 4 residents, (Residents T, S, Q, and U), and the facility failed to prevent another resident from being physically abused by a staff member (Resident B) for 6 of 6 residents reviewed for abuse.	R 0052	With regards to finding R052 what corrective actions will be accomplished for those residents found to have been affected: No negative outcome identified for those residents affected. Upon notification Administrator followed all reporting and investigating policy and procedure. Incidents	09/20/2019

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

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	Findings include: 1. On 8/7/19 at 9:45 a.m., a list of residents who had been discharged in the last 90 days was provided by the Administrator (ADM). The list indicated Resident R had been discharged on 7/25/19 for, "...behavioral reasons..." On 8/7/19 at 1:00 p.m., Resident R's medical record was reviewed. A discharge summary from [name of hospital] Stress Center, dated 3/22/19, indicated, "...[Resident R] was admitted from [name of another assisted living facility], where he had been admitted for respite care while [family member] was in the hospital. He has been increasingly agitated and irritable. This finally escalated to the point where he became aggressive with another resident after wandering into her room... the patient had 1 prior admission for psychotic symptoms associated with dementia. He had been maintained on paliperidone [an antipsychotic medication] long acting injectable because of history of medication resistance..." A hospital summary report, dated 3/29/19, indicated, "... patient was noted to be significantly more confused yesterday. He was resistant to taking medications...." A hospital summary report, dated 3/31/19, indicated, "...he [Resident R] was noted to escalate some yesterday evening...." A Nurse Practitioner (NP) progress note, dated 5/1/19, indicated, "... seen today for an acute visit for increased agitation. He is noted to be having increased agitation throughout the day, becoming very agitated easily and not easily redirected...."		were reported to Indiana State Department of Health. All Resident's responsible representatives and Physicians notified. Resident R was discharged from community on 7/25/19. CNA 16 was immediately suspended on 6/27/19 and subsequently terminated. In-service, Serving People with Dementia completed on July 31st and August 1st ,2019 Staff in-service on Abuse, Neglect and Misappropriation of Property was held on July 1st, 2019 Regional Vice President of Operations, Executive Director, Wellness Director and Memory Care Activities Director attended BBET/Varietas Training on August 13th, 2019. Regional Vice President of Operations, Administrator, Executive Director, Wellness Director and Memory Care Coordinator are scheduled to attend Certified Dementia Practitioner training on August 29th, 2019. All staff will be in-serviced on Abuse Prevention, Reporting, Investigating and Resident Rights by September 20th, 2019.	

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	A psychiatric progress note from [name of inpatient senior psychiatric facility], dated 5/14/19, indicated, "...the patient has been being aggressive towards staff trying to hit them and went into another resident's room and pinned his arm behind his back. The other resident began to yell, and staff came in and broke the altercation up. Resident has been refusing all medications and had not been sleeping at night... the staff at [name of Assisted Living (AL) facility] could not calm the patient down or easily redirect him and resident was placed on one on one observation until the patient could be sent out. [Name of AL] has agreed to take the patient back upon his discharge from [name of Psychiatric facility]. Patient apparently was hospitalized for psychosis and aggression associated with dementia on 2 previous occasions...." State reportable incidents related to Resident R were reviewed. Incident #37 indicated, "...5/13/19: [Resident R] was observed by staff grabbing the right arm of [Resident T], in [Resident T]'s apartment. [Resident R] was pushing [Resident T]'s arm behind his back while yelling, 'he stole my money'...." Incident #46 indicated, "...7/7/19: [Resident S] came to the common area and began yelling and hitting the back of the couch saying, 'no one cares, no one listens to me...' When asked if someone touched her wrist she said yes. When approaching her room there was a male resident [Resident R] standing with a CNA in front of the apartment near [Resident S]'s apartment. [Resident S] stated, 'yea him' (indicated [Resident R])...writer understood [Resident S] to explain that someone came to the door, came in and she wanted them out. She touched her wrist with her other hand as if someone had held onto her wrist...."		***How will you identify other residents having the potential to be affected by the same finding and what corrective action will be taken:*** All memory care residents had the potential to be affected. No memory care resident was found to be adversely affected. ***What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:*** No resident will be admitted with recent aggressive behaviors or psychotic episodes. All staff will be in serviced on the Abuse prevention, Reporting, Investigating and Resident Rights on September 5th, 2019 by the Executive Director. The facility also conducts these in-services for all new employees on hire, annually, and as needed for ongoing training. The Administrator or Designee will randomly select 5 staff members each week to take a test regarding abuse and reporting for 8 weeks, then 1 X a month times 4 months, the 1 X a quarter. The results will be reviewed at the monthly QA meeting.	

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	Incident #47: "...7/8/19: while staff was redirecting [Resident R], he became agitated and struck [Resident S] in stomach area...." Incident #53: "...7/24/19: Resident R grabbed [Resident Q] by the arm, shoved her to the floor and grabbed [Resident U] by the arm...." Resident R's nursing progress notes were reviewed: On 4/26/19 at 4:39 a.m., "...hallucination noted during this shift. Resident R wandered in the hallway and going to others' rooms. He hits the writer in the hand and the aide in the toes when we were trying to calm him down and redirect him back to room. The aide alerts the writer when he was disturbing her and wanted to force the nursing office open to hit her. He said that he would fire us. We redirected x 7 but refused to yield...." On 5/10/19 at 12:29 p.m., "...Resident R upset this morning just before lunch about 11 am. Charge nurse attempted to redirect and talk with resident to calm him down. Was unsuccessful. Attempted to give prn liquid haldol [an antipsychotic medication], resident would not take. He then went to other residents' empty room and blocked the door and would not let staff in...." On 5/10/19 at 8:03 p.m., "...Resident R continues ATB tx [antibiotic treatment]. Writer attempts to administer medications times three this evening with no success, resident aggressively refusing medications." On 5/12/19 at 5:25 a.m., "...[Resident R] aggressively pacing unit, attempting to intrusively wonder into other residents' apartments. Upon attempts to redirect resident, he becomes aggressive with staff, attempts to become		***How the corrective actions will be monitored to ensure the finding will not recur:*** Administrator, Wellness Director and Community Relations Director will meet after each pre-admission assessment is completed to ensure resident is appropriate for Memory Care. All admissions and denials will be reviewed in monthly QA Meeting to ensure compliance All staff will be in serviced on the Abuse prevention, Reporting, Investigating and the Resident Rights on September 5th, 2019 by the Executive Director. The facility also conducts these in-services for all new employees on hire, annually, and as needed for ongoing training. The Administrator or Designee will randomly select 5 staff members each week to take a test regarding abuse and reporting for 8 weeks, then 1 X a month times 4 months, the 1 X a quarter. The results will be reviewed at the monthly QA meeting. ***By what date the systemic changes will be completed:*** September 20th, 2019	

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	combative, cursing at staff. Writer redirects resident back to his apartment, where he states he doesn't want to stay in there because it's too cold. Writer goes to adjust heat setting, resident threatens to assault writer. Writer explains to resident, just trying to turn heat on since he stated it was too cold, resident curses at writer to get the expletive out of apartment, threatens once again to assault writer...." On 5/13/19 at 5:16 a.m., "...Upon coming on shift, informed of incident between [Resident R] and another resident, and that [Resident R] will subsequently be sent [out] for evaluation on Monday d/t [due to] behavioral disturbances. Staff member sits outside of resident's room throughout night to ensure safety of [Resident R] as well as other residents on unit. Writer did not attempt to assess resident throughout night, as he is restful, do not want to disturb so as to risk provoking further behavioral disturbances. Will continue to monitor...." On 6/5/19 at 11:12 a.m., "...[Resident R] was very anxious and pacing the halls this am between 7 and 8 am. One on one sitter was with him but totally able to redirect. Writer assisted with redirection. Resident did eventually sit down and eat breakfast. Then after, he escalated again with pacing and wanting to fix things. Hard to redirect...." On 6/23/19 at 1:50 a.m., "...[Resident R] slides past evening shift staff exiting memory care unit through main elevator door. Writer steps in to assist, advising staff to go ahead down elevator while resident is distracted... After approximately five minutes of speaking to resident in calm tone of voice attempting to redirect out of door way, writer begins to pull door shut... Resident begins			

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	kicking writer, twisting writer's arm while gnashing teeth and cursing at writer. Writer politely and calmly asks resident to stop kicking and squeezing wrist. Resident continues cursing at writer. Writer attempts to redirect resident to apartment. Resident still holding on to writer's left arm, twisting and squeezing. Writer unable to obtain keys from pocket to unlock resident's door d/t resident kicking, twisting and squeezing left wrist. At this time writer calls [Memory Care Director] to inform that resident needs a sitter or some type of one on one supervision...." On7/23/19 at 9:12 p.m., "...[Resident R] was observed at 6pm grabbing [Resident Q] and slamming her on the ground in the living room on the Memory Care unit. Writer and staff redirected resident at this time. Resident voiced 'She got smart with me'. Resident was unable to be redirected by staff, staff assisted the other residents to safety. Resident calmed down after 20 minutes and began to sit in the living room with his eyes closed...." During an interview on 8/8/19 at 10:28 a.m., Licensed Practical Nurse (LPN) 18, and Qualified Medication Aid (QMA) 19 indicated, Resident R was a ticking time bomb. For the most part he would sleep during the day, but had significant Sundowning (increased confusion and restlessness in patients with delirium or some form of dementia in the evening) syndrome. If he ever said, "no" or refused to do something, it would be best to just leave him alone, because he would trigger quickly. No meant no, and he did not take redirection well at all. During an interview on 8/8/19 at 11:50 a.m., with the Vice President of Clinical Operations (VPCO), Executive Director (ED), and Wellness Director			

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	(WD) present, the ED indicated Resident R was discharged because of his aggression and behaviors. He was initially admitted to the facility with a known history of behaviors, but at the time the IDT (interdisciplinary team) had determined the facility would be able to provide appropriate, structured dementia care for the resident in their Memory Care Unit. However, it became evident that the space (the entire Memory Care unit, 3rd floor) was too big for him, and he seemed to trigger around busier times of the evening, that, in combination with Sundowning symptoms, was too much for him. The facility was in constant contact with his family members, who came to sit with him one on one, and staff were almost constantly with him one on one, but he still managed to have behaviors towards other residents. 2. On 8/7/19 at 10:00 a.m., State reportable Incident #44 was reviewed and indicated, "...6/28/19 Visitor and Memory Care Activity Director (MCAD) reported to Executive Director (ED) that a CNA (certified Nursing Assistant) 16 had been inappropriate with Resident [B] when moving her to the activity area for activity. Visitor and MCAD reported that CNA 16 attempted to assist resident up from dining room chair, witness reported CNA 16 grasped [Resident B] by the arm and assisted her in getting up, [Resident B] appeared agitated and did not want to get up. [Resident B] walked around dining room and went back to dining room chair. CNA 16 approached resident again and grasped [Resident B] by the wrist and back of pants, lifted [Resident B] out of dining room chair. Resident stood up from dining room chair and dining room chair fell to floor. CNA 16 then continued to grasp [Resident B] by the wrist and escorted to the activity area for activity...."			

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	On 8/7/19 at 11:35 a.m., Resident B was observed in the Memory Care Unit activity area. She was observed to be actively engaged in the exercise activity. At the end of the activity, Resident B did not require staff assistance as she independently stood from the couch, walked into the dining room area, and sat at a dining room chair for lunch. During an interview on 8/8/19 at 10:58 a.m., the MCAD indicated, she witnessed CNA 16 being rough with Resident B. She knew something was wrong with the way CNA 16 treated Resident B, because Resident B was very upset, which was unusual for her. Resident B was very independent, calm, quiet and cooperative, there was no reason for CNA 16 to have been rough with her. Resident B did not do anything wrong, and should not have been grabbed like that. The MCAD indicated she and other visitors witnessed CNA 16 grasping Resident B's wrist too tightly, and used the back of her pants to pull Resident B up from the dining room chair and push her onto the couch in the activity area. On 8/8/19 at 11:00 a.m., Resident B's medical record was reviewed. A nursing progress note dated 6/27/19 at 6:46 p.m., indicated, "...a visitor reported to ED that she witnessed, what she felt, was not the appropriate way for the CNA to interact with this resident. Investigation initiated immediately...." On 8/8/19 at 11:15 a.m., the Administrator (ADM) provided a copy of the facilities investigation. The MCAD's witness statement indicated, "...I heard a bunch of fussing and as I turned around, [CNA 16], one of the Memory Care CNA's, pushed [Resident B] down in her seat. I quickly ran up to [Resident B] to comfort her... [Resident B] was very upset at how she was being treated...."			

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	During an interview on 8/8/19 at 11:50 a.m., with the Vice President of Clinical Operations (VPCO), Executive Director (ED), and Wellness Director (WD) present, the ED indicated, CNA 16 was no longer employed by the facility because she was witnessed to have been rough with Resident B. The incident had been reported immediately per facility policy, and CNA 16 was immediately suspended for an investigation, but never returned to give her statement. The VPCO and ED indicated, Resident B was very cooperative and independent with her care, which included transfers and ambulation, so there was absolutely no reason for CNA 16 to have grabbed the Resident's wrist, or back of her pants. On 8/8/19 at 12:00 p.m., a current copy of current facility policy was provided by the ADM. The policy was titled, "Resident Neglect, Abuse and Misappropriated of Property," dated 6/2014, and indicated, "...Residents will be free from misappropriation of resident property, and verbal, sexual, physical and mental abuse, corporal punishment and involuntary seclusion...." This state residential finding relates to Complaint IN0029555.			
R 0116 Bldg. 00	410 IAC 16.2-5-1.4(a) Personnel - Noncompliance (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3.	R 0116	**R116**	09/20/2019

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	Based on record review, and interview, the facility failed to use the Indiana State Police Repository, to obtain criminal history reports, for 8 of 10 employees, randomly reviewed. Findings include: On 8/8/19 at 11:15 a.m., employee files were reviewed for 10 randomly selected, current employees. Criminal history/ background checks were conducted through (Name of Contracted Provider), a service that did not conduct a background check through the Indiana State Police Repository, for criminal history/ background checks. The following employees with criminal history/background checks through (Name of Contracted Provider) were identified: a. The Executive Director was hired 11/28/16. b. The Wellness Director was hired 4/8/19. c. The Administrator was hired 10/26/13. d. Certified Nursing Assistant (CNA) 9 was hired 4/18/19. e. Licensed Practical Nurse (LPN) 10 was hired 6/27/19. f. The Receptionist was hired 11/15/17. g. Qualified Medication Aid (QMA) 12 was hired 6/6/19. h. Certified Nursing Assistant (CNA) 14 was hired 7/24/17. On 8/8/19 at 1:45 p.m., during an interview, the Executive Director indicated, the facility's Corporate Office had recently identified a problem with the company they had been using for background checks. They did not believe the Indiana State Police Repository was included in the criminal history/ background search they received, for perspective employees. They did not have a copy of the contract with (Name of contracted company), for review. They had		With regards to finding R116 Traditions at North Willow will: ***What corrective actions will be accomplished for those residents found to have been affected by the finding:*** No resident was adversely affected. ***How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will take place:*** All residents had the potential to be affected. No residents were found to be adversely affected. All current employees will have current limited criminal background check per IN.Gov-8-22-19, 9-20-19 ***What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur:*** All new hires will have IN.Gov criminal background check ran prior to hire-8/22/19 Facility will only utilize IN.Gov for criminal background checks and will obtain finger prints as per IN.Gov protocol-9/20/19 (to allow 15 days for fingerprints to come back) ***How will the corrective actions***	

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	recently completed, and submitted, an application, for background checks through the Indiana Government website to correct the problem. On 8/8/19 at 1:45 p.m., the Executive Director provided a copy of the application, titled "IN.GOV Account Agreement, National American Industry Classification System (NAICS) Organizational Information (required for Individuals and Businesses)." This documented indicated the application had been mailed on 7/23/19.		***be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place:*** Business office manager will obtain criminal checks on pre-hires. Administrator or designee(s) will review and monitor criminal checks. The results will be reviewed at monthly QA meeting. ***What date will the systemic changes be completed:*** 9-20-19	
R 0304 Bldg. 00	410 IAC 16.2-5-6(e) Pharmaceutical Services - Deficiency (e) Medicine or treatment cabinets or rooms shall be appropriately locked at all times except when authorized personnel are present. All Schedule II drugs administered by the facility shall be kept in individual containers under double lock and stored in a substantially constructed box, cabinet, or mobile drug storage unit. Based on observation, interview, and record review, the facility failed to identify a Memory Care Resident was keeping over the counter medications at bedside, for self administration (Resident 70), for 1 of 5 residents observed during a medication administration observation. Findings include: On 8/8/19 at 8:50 a.m., during a medication	R 0304	**R304** With regards to finding R304 Traditions at North Willow will: ***What corrective actions will be accomplished for those residents found to have been affected by the finding:*** No resident was adversely affected. All medications were removed from bedside of resident	09/01/2019

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	administration observation, on the Memory Care Unit, with Licensed Practical Nurse (LPN) 17, morning scheduled medications were administered to Resident 70, in her room. The residents nightstand, beside the bed had an open access in the front. A bottle of Maalox (antacid) tablets and an open box of Pepcid (antacid) was visible lying on the top of a semi transparent plastic grocery bag, in the nightstand. Other medications could be seen through the bag. LPN 17 placed the plastic grocery bag on Resident 70's bed, and opened it. The bag contained 5 boxes of Pepcid , a box with a bottle of liquid ear wax remover, A box of Gaviscon (antacid), and a box of Equate (generic brand) antacid tablets. When questioned by LPN 17, Resident 70 became argumentative, saying these were her things, and no one had the right to mess with her things. The nurse left the room, and left the medications on the bed. During an interview, LPN 17 indicated she had not seen the bag or medications before. The resident should not have medication in her room, or at bedside. She needed to call the resident's son to ask if he had brought the medication to the resident, and let him know she should not have medications in her room. The nursing staff should have administered her medications. The medication observation ended at 10:00 a.m., the medications had not been removed from Resident 70's room or reported to anyone else during the medication administration observation. On 8/8/19 at 10:30 a.m., a review of Resident 70's medical record indicated the primary diagnosis		70 and POA was notified. Medications were placed on medication cart for nursing administration. -Completed 8/8/19 ***How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will take place*:** All memory care residents had the potential to be affected. No memory care residents were found to be affected. All apartments on memory care checked to ensure there are no other bedside medication present. -Completed 8/8/19 ***What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur:*** All nursing staff will receive in-service on bedside medication policy.-9/5/19 Reminder posted on Memory Care and in break room. 8/9/19 Letters will be sent to memory care Residents' POA's reminding them of the importance of giving all medications to nursing staff for proper storage-8-30-19 ***How will the corrective actions be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place:***	

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	08/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	was dementia. There were no doctor's orders for medications at the bedside, or medication self-administration. Resident 70 resided on the secured Memory Care Unit. On 8/8/19 at 12:05 p.m.,during an interview, the Wellness Director indicated residents on the Memory Care Unit were not qualified to self-administer medications. Resident 70 should not have had any medications in her room. Resident 70 was not alert and oriented (self, time, place, and situation). She had placed a call to Resident 70's son. She believed he had provided the medications. He had not yet returned the call. On 8/8/19 at 11:15 a.m., the Wellness Director provided a current policy, dated 6/14, titled "Self Administration of Medication." This policy indicated "...residents who have the cognitive and physical ability to take their own medications are encouraged to do so. A resident who takes his or her own medications medications must be evaluated by his or her physician to be certain it is a acceptable and safe arrangement...a resident who is capable of self-administering his or her own medication must be...oriented to person, place, and time...storage of self-administered medications will comply with state and federal regulations...."		Administrator or designee(s) will check all memory care apartments for bedside medications every Monday for one month, then twice monthly for two months, then monthly for seven months.-8/26/19-8/26/20 ***What date will the systemic changes be completed:*** 9/1/19	