STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15A011	A. BUILDING _____ B. WING _____	**07/08/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ESPECIALLY KIDZ HEALTH & REHAB	**2325 S MILLER ST SHELBYVILLE, IN 46176**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0600 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure physical contact by a staff member towards a resident didn't occur by placing their arm towards a resident's chest to force medication to be administered orally and failure to ensure resident to resident physical abuse did not occur for 3 of 4 residents reviewed for abuse. (Resident B, D, and E) Findings include: A. The clinical record for Resident B was reviewed on 7/7/20 at 2:30 p.m. [DIAGNOSES REDACTED]. Her most recent Minimum Data Set assessment, dated 3/14/20, noted severe cognitive impairment, dependent for staff assistance with activities of daily living, and non-ambulatory. A care plan titled Non-Adherence, revised 7/2/20, indicated the following, .The resident is non-adherent with: medication/moves head side to side .Interventions .6. Respect resident's right to refuse .Hold chin to stabilize when giving meds (medications) An anonymous statement, dated 7/6/20, indicated the following, (name of Licensed Practical Nurse 4) put her hands around (name of Resident B's) neck and left red marks and told her she was going to take her medicine .Nurse (name of Licensed Practical Nurse 5) found the red marks on (name of Resident B) An interview conducted with Licensed Practical Nurse (LPN) 5, on 7/7/20 at 2:45 p.m., indicated Certified Nursing Assistant (CNA) 8 came to her, on 7/2/20 after 7:00 p.m., and told her she heard, from another staff member, that LPN 4 choked Resident B. LPN 5 notified the Director of Nursing (DON) and assessed Resident B's neck and chest. She noted Resident B's chest was red and she believed it was due to Resident B's shirt being wet from a beverage and causing the redness. An interview conducted with the DON, on 7/7/20 at 2:55 p.m., indicated an incident was reported to LPN 5 that LPN 4 choked a resident. She asked CNA 8 and CNA 8 demonstrated how LPN 4 was pushing Resident B back with her hand on her chest area to give her medications. She reported the incident to the Executive Director (ED) and had the CNA, CNA 10, that initially witnessed the incident fill out a Report of Concern. DON indicated she doesn't believe it was reported to the Indiana State Department of Health (ISDH). An interview conducted with the ED, on 7/7/20 at 3:11 p.m., indicated the incident was documented as a Report of Concern about the technique of medication administration for Resident B, not abuse. That was why it wasn't reported to ISDH. An interview conducted with LPN 4, on 7/7/20 at 3:34 p.m., indicated she put Resident B's medications in a 60 milliliter syringe. Resident B was strapped in her chair and leaning forward. She placed her right forearm across Resident B's chest to hold her back against the chair and tilted her head back so the medications would go down and she wouldn't aspirate. She utilized her right hand to tilt Resident B's head back and chin to get the syringe in. During this situation LPN 4 was calling for staff assistance but no one ever came to assist. LPN 5 came back to the unit, on 7/2/20 around 7:30 p.m., but she never spoke with LPN 4. LPN 4 indicated she wasn't aware of any issues. No one from the facility asked her about the incident until today, 7/7/20. She was notified, 7/7/20, by the facility staff to come in and fill out a statement related to the incident on 7/2/20. A REPORT OF CONCERN form, dated 7/2/20, indicated the following, .Witness Statement .I was going to tell (name of LPN 4) I was going to lunch, she was in with (name of Resident B). She had said before I walked in put your head down . That's when I walked in and (name of LPN 4) had her hand on (name of Resident B's) throat forcing her head back to give her her meds (medications). I then walked in and she asked me to go get a towel because (name of Resident B) spit her meds (medications) at her. I then immediately go to (name of CNA 8) .(Name of CNA 8) found a red mark on her throat This form was signed by CNA 10. There was no written statement by CNA 8 about the concern involving Resident B and LPN 4. A written statement, undated, was completed by LPN 5. The statement indicated the following, .On 07-02-20 approx. (approximately) 8p (8:00 p.m.), (name of CNA 8) came to Vent 1 (Vent Unit 1), state another CNA, (name of CNA 10) reported her (sic) that (name of LPN 4) choked resident (name of Resident B) while giving her medications .I then completed an assessment (symbol for with) DON on phone .Resident had a red rash like area around the neck area of her shirt. Shirt was sticky & (and) hard A form titled Ongoing Assessment of Non-Pressure Related Skin Condition, dated 7/2/20, noted Resident B to have a rash around the collar area. The area was documented as resolved, on 7/3/20. There was no indication of the incident being reported to the ISDH Survey Report System. B. The clinical record of Resident D was reviewed on 7-7-20 at 2:32 p.m. Her [DIAGNOSES REDACTED]. Her most recent Minimum Data Set assessment, dated 6-5-20, indicated Resident D is moderately cognitively intact, has physical behaviors toward others and other unspecified behaviors not directed toward others. She is non-ambulatory and is dependent for bed mobility and transfers and requires extensive assistance with locomotion. In review of the nursing progress notes, an entry dated 5-7-20 at 7:15 p.m., indicated, Resident D sustained 7.5 (cm/centimeter) x (by) 7.5 cm red area on R (right) arm from being hit and pinched by another resident .(CNA) saw another resident 'raise her arm like she's going to hit (name of Resident D) .(PCA) (personal care attendant) ran to end of hall and found other resident hitting (name of Resident D). (Name of Resident D) crying and states, 'I told her to go away and she wouldn't .she hit and pinched me.' A physical assessment was conducted, followed by notifications to the family, attending physician and Assistant Director of Nursing. A skin assessment sheet, dated 5-7-20 at 7:10 p.m., indicated Resident D had a new reddened area to the back of her right forearm, measured at 7.5 cm by 7.5 cm. The following day, 5-8-20, this area was identified as resolved. A form entitled, Possible or Potential Mental Anguish Assessment, dated 5-8-20, for a resident incident, indicated Resident D was not observed by staff to display any signs or symptoms of mental anguish and the resident did not indicate any signs or symptoms of mental anguish. No further documentation was located in the clinical record regarding this incident. The next note located in the nursing progress note was dated 5-19-20. In an interview with the Executive Director on 7-7-20 at 3:40 p.m., she indicated the facility did not file a reportable incident for the 5-7-20 incident of Resident E hitting Resident D. We separated them and there really was nothing else. We let the doctor and family know. I remember discussing it the next morning in the morning meeting. Just didn't think about filing one (ISDH reportable). I don't know if there was any other investigation done. C. The clinical record of Resident E was reviewed on 7-8-20 at 8:50 a.m. Her [DIAGNOSES REDACTED]. Her most recent Minimum Data Set assessment, dated 4-7-20, indicated her speech is unclear and displays moderate hearing loss. She has difficulty understanding and being understood and is cognitively impaired. It indicated staff identified behaviors of being short-tempered and has other behaviors not directed at others. She is dependent for bed mobility and transfers, is non-ambulatory and requires extensive assistance with locomotion. Review of Resident E's nursing progress notes, an entry dated 5-7-20 at 7:10 p.m., indicated Resident E, hit another resident and pinched her on the R (right) arm. It indicated the family and Assistant Director of Nursing were notified of the incident. The next nursing progress note, dated 5-8-20, did not reference any follow-up to this incident. No further nursing progress notes after that date referenced this incident. A form entitled, Mood and Behavior Communication Memo, was initiated on 5-7-20. This form indicated on 5-7-20 at 6:50 p.m., an incident of physical aggression occurred when Resident E went to (name of Resident D) who was watching TV @ (at) end of hall and proceeded to hit her and pinch her on the R (right) arm. (Both residents) separated and 15 min (minute) checks started. An accompanying document was included of the 15 minute checks to document Resident E's location

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

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F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) identified the checks were initiated 5-7-20 at 7:00 p.m., and continued through 5-8-20 at 7:00 p.m. On 7-8-20 at 11:00 a.m., the Director of Nursing indicated she was unable to locate any additional follow up information and/or documentation related to the incident. In an interview with the Executive Director (ED) on 7-7-20 at 3:40 p.m., she indicated the facility did not file a reportable incident for the 5-7-20 incident of Resident E hitting Resident D. We separated them and there really was nothing else. We let the doctor and family know. I remember discussing it the next morning in the morning meeting. Just didn't think about filing one (ISDH reportable). I don't know if there was any other investigation done. On 7-7-20 at 11:15 a.m., the ED provided a copy of a policy entitled, Abuse Prohibition, Reporting and Investigation. This policy was identified as the current policy utilized by the facility and had a revision date of 9-2017. This policy indicated, This facility shall prohibit and prevent abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. Abuse is the willful infliction of injury .with resulting physical harm, pain or mental anguish .Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Physical Abuse -- Includes hitting, slapping, pinching .Verbal Abuse -- Oral, written and/or gestured language that willfully includes disparaging and/or derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disabilities. Examples include, but are not limited to, threats of harm or saying things to frighten a resident . This Federal tag relates to Complaint IN 993. 3.1-27(a)(1) 3.1-27(b)
F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow their abuse policy in regards to reporting allegations of abuse and conducting a thorough investigation into allegations of abuse for 3 of 4 residents reviewed for abuse. (Resident B, D, and E) Findings include: A. The clinical record for Resident B was reviewed on 7/7/20 at 2:30 p.m. Her [DIAGNOSES REDACTED]. Her most recent Minimum Data Set assessment, dated 3/14/20, noted severe cognitive impairment, dependent for staff assistance with activities of daily living, and non-ambulatory. 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Examples include, but are not limited to, threats of harm or saying things to frighten a resident .IF Resident Abuse, Or Suspicion of Abuse, Is Reported: 1. The resident(s) involved in the incident shall be removed from the situation at once or facility personnel shall remain with the resident to ensure safety. 2. The individual who witnessed the incident or who was informed of the allegation shall immediately notify a charge nurse assigned to the unit on which the resident resides. If this is not feasible due to circumstances, the individual shall be responsible to notify any other nurse currently on duty. The nurse shall examine the resident(s) involved to determine whether physical injuries have occurred and their extent. This examination shall be documented in the resident's clinical record. 3. The charge nurse is responsible to notify the facility Administrator and Director of Nursing immediately and to ensure no tampering or destruction of evidence, if applicable. 4. Any facility personnel implicated in the alleged abuse shall be

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F 0607 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) immediately removed from the resident care and shall remain suspended until an investigation is completed. A thorough investigation shall be initiated. 5. Any resident implicated in the alleged abuse shall be placed under appropriate monitoring/supervision to prevent recurrence until investigation is completed and/or transferred for medical/psychiatric evaluation to be conducted relative to mood/behavior exhibited .6. The resident's attending physician shall be notified as soon as feasible and any orders shall be noted and initiated .8. The family of the resident(s) and/or resident representative shall be notified per policy .10. Residents shall be questioned about the nature of the incident and their statement placed in writing. 11. Investigation shall be conducted to assure other residents have not been affected by the incident or inappropriate behaviors and the results documented. 12. Statements shall be taken including, but not limited to, facts and observations by involved employee(s); facts and observations by witnessing employee(s); facts and observations by witnessing non-employee(s); facts and observations by any others who might have pertinent information; facts and observations by the licensed nurse or individual to whom the initial report was made. 13. Follow-up assessments shall be completed/documented during every shift until the resident(s) is stable and resident safety is maintained. 14. The Administrator, Director of Nursing, or designee, is responsible to notify the following agencies, as applicable: State Department of Health; Adult Protective Services; Ombudsman; Applicable Licensing Agency. 15. The Administrator is responsible to coordinate the investigation, assure an accurate and complete written record of the incident and investigation, and to file a follow-up report with the State Department of Health . This Federal tag relates to Complaint IN 993. 3.1-28(a) 3.1-28(c) 3.1-28(d) 3.1-28(e)