STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155283	A. BUILDING _____ B. WING _____	**08/24/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WINTERSONG VILLAGE	**1005 SOUTH EDGEWOOD DRIVE KNOX, IN 46534**

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 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure an allegation of verbal abuse was reported and investigated for 1 of 3 residents reviewed for abuse. (Resident C) Finding includes: Record review for Resident C was completed on 8/24/20 at 10:33 a.m. [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) assessment, dated 5/19/20, indicated the resident was cognitively intact. The resident required a limited assistance of 1 person for bed mobility, transfers, toilet use, and personal hygiene. A Behavior Note written by LPN 1, dated 6/26/20 at 1:12 a.m., indicated at 10:40 p.m. Resident C was given [MEDICATION NAME] (nonsteroidal anti-[MEDICAL CONDITION] drug) for complaints of a headache. At 11:00 p.m. the resident requested Tylenol and was told she could not have it only 20 minutes after taking the [MEDICATION NAME]. At 11:20 p.m. the resident called 911 to report the nurse was yelling and cursing at her. The CNA in the hall heard the conversation and indicated she had not heard any yelling or cursing. At 11:50 p.m. the resident refused her scheduled [MEDICATION NAME] (pain medication) and was given Tylenol with the rest of her scheduled medications. At 12:45 a.m. the police were at the facility to discuss the concerns with the resident. A Police Report, dated 6/26/20 at 1:27 a.m., indicated Officer 1 and Officer 2 responded to the facility from a call from Resident C. Upon arrival to the facility Officer 1 spoke with Resident C. The resident stated that while she had been a resident at the facility the nurses were verbally abusive and did not provide her with the care she needed. They would not provide her medications in a timely manner and when she yelled for help they did not respond to her for long periods of time. The nurse the resident referred to was LPN 1, who was the nurse working the night shift the night of the call. The resident further indicated she had expressed her concerns to the head nurse and the nursing home administration. The Officers notified Adult Protective Services. The resident's record lacked any documentation to indicate follow up was completed with the resident related to her calling 911 or her allegations of verbal abuse. Interview with Officer 1 on 8/24/20 at 11:50 a.m., indicated the resident had called the police to make a report. When they arrived to the facility, Officer 1 spoke to the resident and Officer 2 spoke with LPN 1. She indicated the resident had stated the nurse was verbally abusive to her, would not give her her pain medication, and that she had slid off her chair and was yelling for hours before someone came to help her. Officer 1 could not remember if she had told the nurse that the resident stated she had been verbally abused. She further indicated she had called and filed a report with the Adult Protective Service (APS) agency after they left the facility. Interview with Officer 2 on 8/24/20 at 1:00 p.m., indicated when they arrived to the facility he had spoken to LPN 1 and his partner had spoken to the resident. LPN 1 had stated, She is crazy, I always give her her medication. He further indicated he could not remember if he or his partner had told the nurse the resident had stated she was verbally abused. Interview with the Director of Nursing on 8/24/20 at 1:25 p.m., indicated she had looked through progress notes for the months of July and August and could not find any information related to the resident calling the police. She would have to look in to it some more. Interview with Resident C on 8/24/20 at 1:33 p.m., indicated she could not remember why she had called the police, but LPN 1 was always verbally abusive to her. She told the nurse she was in pain and the nurse told her I don't believe you and always spoke nasty to her. She indicated no staff had come to talk to her after she called the police. She had told the head nurse and the Administrator on multiple occasions the nurse was verbally abusive to her and did not give her her medications. Interview with the Administrator on 8/24/20 at 2:46 p.m., indicated he was told the next day after the resident had called 911. The nurse indicated the resident had called 911 because she did not get her medication. The nurse said this was untrue and she did give the resident her medication. He did not follow up with any questions to the resident on the reasoning why she had called 911. He was unaware she had accused the nurse of yelling and cursing at her. The nurse should have called him immediately when the resident had called 911 and stated the nurse was yelling and cursing at her. A policy titled, Abuse & Neglect Policy and received as current from the facility on 8/24/20, indicated, .Reporting/Response The facility will ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility This Federal Tag relates to Complaint IN 961. 3.1-28(c)

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.