

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155158	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/18/2023
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF THE WILLOWS	STREET ADDRESS, CITY, STATE, ZIP COD 1000 ELIZABETH DR VALPARAISO, IN 46383
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00408213.</p> <p>This visit was in conjunction with the Post Survey Revisit (PSR) to the Investigation of Complaint IN00406256 completed on April 21, 2023.</p> <p>Complaint IN00408213 - Federal/state deficiencies related to the allegations are cited at F609.</p> <p>Complaint IN00406256 - Corrected</p> <p>Survey dates: May 18, 2023</p> <p>Facility number: 000078 Provider number: 155158 AIM number: 100289310</p> <p>Census Bed Type: SNF/NF: 63 Total: 63</p> <p>Census Payor Type: Medicare: 14 Medicaid: 41 Other: 8 Total: 63</p> <p>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on 5/19/23.</p>	F 0000	<p>This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Life Care Center of the Willows agrees with the allegations and citations listed. Life Care Center of the Willows maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review.</p>	
F 0609 SS=D Bldg. 00	<p>483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment,</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tami	Adams	05/26/2023

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>the facility must:</p> <p>§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.</p> <p>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and interview, the facility failed to ensure an allegation of verbal abuse was immediately reported to the Administrator and reported timely to the State Survey Agency for 1 of 3 allegations of verbal and physical abuse reviewed. (Resident B)</p> <p>Finding includes:</p> <p>Resident B's record was reviewed on 5/18/23 at 2:02 p.m. Diagnoses included, but were not limited</p>	F 0609	<p><i>What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:</i></p> <p>1. Resident B: Was monitored by SSD for any psychosocial distress x 72 hours. No negative outcomes.</p> <p><i>How other residents having the</i></p>	05/19/2023
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	<p>to, cerebral palsy, intellectual disabilities, and cognitive communication deficit.</p> <p>The Quarterly Minimum Data Set (MDS) assessment, dated 3/16/23, indicated the resident was cognitively intact for daily decision making. He was totally dependent on staff for bed mobility, transfer, dressing, and toilet use.</p> <p>A "Concern & Comment Form," provided by the Administrator on 5/18/23 at 3:00 p.m., indicated CNA 1 reported the concern on the form on 5/13/23. The brief description of the concern indicated Resident B had told CNA 1 about a concern with CNA 2 on night shift. When the resident asked for water, the CNA 2 told him to get up and get it yourself. When he said he couldn't, the resident said "she started laughing and left him without water the whole night."</p> <p>The Incident Report to IDOH was completed on 5/16/23 at 2:01 p.m.</p> <p>A Psychosocial Note, dated 5/16/23 at 3:48 p.m., indicated the writer received the Concern and Comment Form from the Director of Nursing (DON), which was written out by a CNA. The form was found in a paperwork pile on a grievance card. The card stated that the resident reported to her regarding a verbalization that the resident had received from another employee whom was providing care to him. The resident was interviewed and indicated "the CNA told me to get up and get my own cup of water when I asked for one." The resident was able to identify the employee. The Administrator and DON were aware.</p> <p>Interview with the Administrator on 5/18/23 at 3:09 p.m., indicated she reported the incident as soon</p>		<p><i>potential to be affected by the same deficient practice will be identified and what corrective action will be taken:</i></p> <p>1. Abuse audit completed by SSD with all alert and oriented residents. No further concerns identified.</p> <p><i>What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:</i></p> <p>1. All staff educated on abuse and neglect reporting procedure on 5/19/23. 2. All newly hired staff will receive same educated prior to working.</p> <p><i>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:</i></p> <p>1. ED/Designee to audit all grievances 5x/week x 6 months. ED/Designee will interview 3 residents weekly and 3 staff members weekly x 6 months to ensure compliance r/t allegations of abuse related too proper and timely reporting. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews</p>	

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

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FORM APPROVED

OMB NO. 0938-039

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	<p>as she received it. The staff member had put the Concern & Comment Form under the Director of Nursing's door and did not alert the Administrator at the time of the event. The staff should be aware that they needed to contact the Administrator or supervising staff member immediately to get the information to her in a timely manner.</p> <p>This Federal tag relates to Complaint IN00408213.</p> <p>3.1-28(c)</p>		<p>will be increased as needed, if compliance is below 100%. The Administrator at Life Care Center of the Willows is responsible in ensuring compliance in this Plan of Correction</p>		