STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155206	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNSBURG HEALTH CARE CENTER	1010 HORNADAY RD BROWNSBURG, IN 46112

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F000000	This visit was for the Investigation of Complaint IN00137429. Complaint IN00137429-Substantiated. Federal deficiencies related to the allegations are cited at F223, F225, and F226. Survey dates: October 8 and 9, 2013 Facility number: 000113 Provider number: 155206 AIM number: 100287670 Survey team: Teresa Buske RN-TC Mary Weyls RN Karen Hartman RN Census bed type: SNF 2 SNF/NF 89 Total: 91 Census payor type: Medicare 10 Medicaid 53 Other 28 Total: 91 This deficiencies reflect state findings cited in accordance with 410 IAC 16.2.	F000000	Submission of this plan of correction shall not constitute or be construed as an admission by Brownsburg Healthcare that the allegations contained in the survey report are accurate or reflect the provision of nursing care and services to the residents of Brownsburg Healthcare. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Desk Review in lieu of a Post Survey Revisit on or after November 8, 2013.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

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	Quality review completed on 10/17/2013 by Brenda Marshall Nunan, RN.			

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F000223 SS=D	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on interview and record review, the facility failed to ensure all residents were free from abuse for 3 of 3 residents reviewed for allegations of staff to resident abuse [Resident A, Resident B, and Resident C]. Findings include: Facility abuse investigations were reviewed on 10/9/13 at 11:30 a.m. An investigation report dated 6/4/13 indicated an allegation of CNA #5 yelling at Resident C in the hallway with witnesses on 6/3/13 at 2 p.m. The investigation report indicated CNA #6, CNA #7 and LPN #8 witnessed CNA #5 arguing repeatedly with Resident C. The investigation report indicated housekeeping staff #9 overheard CNA #5 loudly repeat "report me" in an angry tone to Resident C. The report also indicated CNA #6 heard CNA #5 in a loud mean voice state to Resident C "there's the nurse go ahead and	F000223	It is the facility policy to ensure that all residents are free from all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property and that all allegations are reported immediately to the facility Administrator and other officials in accordance with state laws. All residents have the potential to be affected. Resident C and CNA#5 were overheard with loud voices and it was reported by housekeeping. LPN was present and did not think was verbal abuse. More information was reported the next day to the Administrator by other staff who had overheard the loud voices, and the CNA was immediately suspended pending investigation. Appropriate authorities were notified. Resident B reported to CNA #12 that CNA# 10 was verbally aggressive to her and slamming the door to the bathroom. CNA#12 notified LPN#11who was on her dinner break . LPN spoke with resident,	11/08/2013

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	report me" repeatedly. CNA #7 according to the investigation report observed CNA #5 loudly and repeatedly told Resident C to "go ahead and report me." Documentation indicated LPN #8 heard Resident C state to CNA #5 "I'm gonna report you to state," and CNA #5 respond to Resident C in a raised tone, "go ahead and report me." The report indicated the investigation was initiated, and CNA #5 was suspended pending investigation. The report indicated CNA #5 was terminated on 6/6/13 due to the CNA had yelled and screamed at Resident C, and that Resident C and witnesses viewed this as verbal abuse. Upon interview of the Director of Nursing (DON) on 10/9/13 at 12:45 p.m., the DON stated she remembered on 6/3/13 that the housekeeping supervisor had called her and asked if she was aware of incident with CNA #5 and Resident C. The DON indicated she contacted LPN #8 who was working, and that LPN #8 told her "nothing was going on only a CNA was upset." The DON indicated the administrator became aware of the allegation on 6/4/13 and an investigation was started on 6/4/13.		went and got CNA#10 from her dinner break and suspended her. She was at the nurses station and had no further resident contact. Administrator was immediately notified and appropriate authorities were notified. Resident A was told by CNA#1 that she was not giving him a d--- shower. This was overheard by LPN#2 and CNA#3. LPN notified DON and CNA was suspended pending investigation. Administrator was immediately notified and appropriate authorities were notified. All CNA's were suspended pending investigation and were terminated per facility policy. Any concerns about abuse are taken seriously and immediately investigated with resident safety being the first concern. Nursing and facility staff have been inserviced on abuse and the policy for reporting abuse. Inservicing is done quarterly and upon employment. A specific emphasis was put on verbal abuse and that there is zero tolerance for any type of abuse. The Administrator and DNS will monitor every allegation of abuse that is made.	

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	Upon interview of LPN #8 on 10/9/13 at 1 p.m., the LPN indicated she heard yelling in the 700 hallway on 6/3/13 in the afternoon. The LPN stated she heard Resident C repeatedly yell at CNA #5 "I'm reporting you." The LPN indicated she observed Resident C to stick her tongue out at the CNA, and to "blow" raspberries at her. LPN #8 indicated she heard CNA #5 say "report me," but not repeatedly. The LPN stated CNA #5's tone was naturally "loud," and that she did not feel the incident was abusive. However, LPN #8 stated the other witnesses thought the incident was "rough." Upon interview of CNA #6 on 10/9/13 at 1:05 p.m., the CNA indicated CNA #5 yelled "go ahead turn me in, I'm gonna turn you in" at Resident C repeatedly on 6/3/13. The CNA indicated that she didn't report the incident due to LPN #8 witnessed the incident, and LPN #8 would have been the supervisor she would have reported the abuse. Upon interview of CNA #7 on 10/9/13 at 1:20 p.m., the CNA indicated she heard CNA #5 loudly and repeatedly yell "go ahead report me, I want you to report me" at Resident C on 6/3/13.			

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	The CNA indicated LPN #8 was with her, and she assumed LPN #8 took care of the incident. CNA #7 stated she witnessed CNA #5 to go outside after the incident, and that CNA #5 completed her shift. Upon interview of LPN #8 on 10/8/13 at 3:20 p.m., LPN #8 indicated Resident C was alert and oriented. 2. Facility abuse investigations were reviewed on 10/9/13 at 11:30 a.m. An investigation report dated 6/21/13 indicated an allegation of CNA #10 being verbally aggressive with Resident B, as well as slamming doors, not answering call light, and refusing to provide care on 6/20/13. The investigation report indicated CNA #12 reported to LPN #11 that there was a complaint against CNA #10 from Resident B on 6/20/13 during evening shift. Documentation was noted of CNA #10 slamming Resident B's bathroom door when the resident asked for assistance moving equipment from her bed to the floor. The investigative report also indicated Resident B felt verbal aggression from CNA #10 when the CNA responded to her call light and stated "why did you call me when an aide was in here." The investigation report indicated CNA #10 was suspended			

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	when the allegation was made to LPN #11 on 6/20/13, and CNA #10 was terminated on 6/21/13 due to general conduct-verbal aggressive, defective work, excess break time, and leaving workplace without permission. The investigation indicated the Director of Nursing and the Administrator were immediately notified of the allegation. Upon interview of the LPN #11 on 10/9/13 at 1:45 p.m., the LPN indicated she was on supper break when CNA #12 informed her of the allegation. LPN #11 stated she immediately returned from supper break, and she went and interviewed Resident B. The LPN indicated Resident B stated CNA #10 was verbally aggressive with her when she answered her call light, and that CNA #10 intimidated Resident B when the doors were slammed. The LPN stated after she interviewed the resident, she immediately contacted the Director of Nursing (DON). The LPN indicated she then had CNA #10 clock out and leave the facility. Upon review of the closed clinical record of Resident B on 10/9/13 at 1:20 p.m., a nursing note dated 6/14/13 indicated the resident was alert and oriented to person, place, and time, and without focal deficits.			

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	3. During review of information titled "Addendum to Unusual Occurrence of September 27, 2013" received from the DNS (Director of Nursing Services) on 10/9/13 at 12:45 PM, the following was noted: "RE: [Resident A]" "[Resident A] was yelled at by CNA [Certified Nurses Aide] [#1] on 9/27/13. It was overheard by two nuring (sic) staff: LPN [Licensed Practical Nurse] [#2] and CNA [#3] that she yelled at him, 'No, I'm not giving you a d--- shower.' DNS [Director of Nursing Service] spoke with resident who endorsed what was said and then stated it wasn't her fault she has a really hard life. He stated it made him feel bad for both himself and her that she yelled and cursed. CNA suspended on 9/27/13 at 9:55 am pending investigation. DNS spoke with all involved and CNA was terminated on 9/27/13 at 1:10 p.m. by phone by DNS and LPN [#4], MDS [minimum data set]. When DNS spoke with [CNA #1] prior to suspension she stated she knew she was in the DNS office because: 'I told [Resident A] I wasn't giving him a d--- shower.' During interview of LPN #2 on 10/9/13 at 12:55 PM, the LPN indicated on 9/27/13, she was in the			

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	hallway and was in the process of a medications pass when she overheard CNA #1 indicate to Resident A "No, I'm not giving you a d--- shower." The LPN indicated she went to Resident A's room and ask the CNA to leave Resident A's room and after speaking with the resident went out to the hallway and told CNA #1 that her behavior was inappropriate and "you can't talk to residents that way." Upon review of the facility's current policy and procedure titled "Resident Neglect, Abuse, and Misappropriation Policy" [no date] on 10/9/13 at 9:45 a.m., documentation was noted of "...STANDARD Residents will be free from misappropriation of resident property, and verbal, sexual, physical, and mental abuse, corporal punishment and involuntary seclusion...Definitions...verbal abuse: Defined as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples would include, but are not limited to: threats of harm; saying things to frighten a resident..."			

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	This Federal tag relates to Complaint IN00137429. 3.1-27(b)			

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F000225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must 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 and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record	F000225	It is the facility policy to report	11/08/2013

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	review, the facility failed to ensure 1) residents were protected during investigation of all allegations of abuse and 2) all allegations were reported immediately to the Administrator and/or State officials for 3 of 3 allegations of staff to resident abuse. [Resident A, Resident B, and Resident C]. Findings include: Facility abuse investigations were reviewed on 10/9/13 at 11:30 a.m. An investigation report dated 6/4/13 indicated an allegation of CNA #5 yelling at Resident C in the hallway with witnesses on 6/3/13 at 2 p.m. The investigation report indicated CNA #6, CNA #7 and LPN #8 witnessed CNA #5 arguing repeatedly with Resident C. The investigation report indicated housekeeping staff #9 overheard CNA #5 loudly repeat "report me" in an angry tone to Resident C. The report also indicated CNA #6 heard CNA #5 in a loud mean voice state to Resident C "there's the nurse go ahead and report me" repeatedly. CNA #7 according to the investigation report observed CNA #5 loudly and repeatedly told Resident C to "go ahead and report me." Documentation indicated LPN #8		all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property immediately to the Administrator and all other officials in accordance with state law. All residents have the potential to be affected. Resident C and CNA#5 were overheard with loud voices and it was reported by housekeeping. LPN was present and did not think was verbal abuse. More information was reported the next day to the Administrator by other staff who had overheard the loud voices, and the CNA was immediately suspended pending investigation. Appropriate authorities were notified. Resident B reported to CNA#12 that CNA#10 was verbally aggressive to her and slamming the door to the bathroom. CNA#12 notified LPN#11 who was on her dinner break. LPN spoke with resident and then got CNA#10 from her dinner break and suspended her. She was at the nurses station and had no further resident contact. Administrator was immediately notified and appropriate authorities were notified. Resident A was told by CNA#1 that she was not giving him a d___ shower. This was overheard by LPN#2 and CNA#3. LPN notified DNS and CNA was immediately suspended. Administrator was notified immediately and authorities were notified. All	

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	heard Resident C state to CNA #5 "I'm gonna report you to state," and CNA #5 respond to Resident C in a raised tone, "go ahead and report me." The report indicated the investigation was initiated, and CNA #5 was suspended pending investigation. The report indicated CNA #5 was terminated on 6/6/13 due to the CNA had yelled and screamed at Resident C, and that Resident C and witnesses viewed this as verbal abuse. Upon interview of the Director of Nursing (DON) on 10/9/13 at 12:45 p.m., the DON stated she remembered on 6/3/13 that the housekeeping supervisor had called her and asked if she was aware of incident with CNA #5 and Resident C. The DON indicated she contacted LPN #8 who was working, and that LPN #8 told her "nothing was going on only a CNA was upset." The DON indicated the Administrator became aware of the allegation on 6/4/13 and an investigation was started on 6/4/13. Upon interview of CNA #6 on 10/9/13 at 1:05 p.m., the CNA indicated CNA #5 yelled "go ahead turn me in, I'm gonna turn you in" at Resident C repeatedly on 6/3/13. The CNA		CNA's were suspended pending investigation and were terminated per facility policy. Any concerns about abuse are taken seriously and immediately investigated with resident safety being the first concern. Nursing and facility staff have been inserviced on abuse and timely reporting of abuse with an emphasis put on immediately reporting to the Administrator and authorities. Abuse inservicing is done upon employment and quarterly. The Administrator and DNS will monitor every allegation of abuse that is made.	

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	indicated that she didn't report the incident due to LPN #8 witnessed the incident, and LPN #8 would have been the supervisor she would have reported the abuse. Upon interview of CNA #7 on 10/9/13 at 1:20 p.m., the CNA indicated she heard CNA #5 loudly and repeatedly yell "go ahead report me, I want you to report me" at Resident C on 6/3/13. The CNA indicated LPN #8 was with her, and she assumed LPN #8 took care of the incident. CNA #7 stated she witnessed CNA #5 to go outside after the incident, and that CNA #5 completed her shift. Upon interview of LPN #8 on 10/8/13 at 3:20 p.m., LPN #8 indicated Resident C was alert and oriented. Upon review of CNA #5's time sheet on 10/9/13 at 2:05 p.m., documentation indicated CNA #5 completed shift on 6/3/13, and returned to work on 6/4/13 at 6:55 a.m. CNA #5 worked for 2.5 hours on 6/4/13. Upon interview of the Director of Nursing and Administrator on 10/9/13 at 2:30 p.m., both indicated CNA #5 completed entire shift on 6/3/13 and returned to work on 6/4/13 for day			

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	shift. The Administrator indicated CNA #5 was suspended on 6/4/13 at 9:23 a.m. The Administrator indicated she was not notified of the allegation on 6/3/13 until 6/4/13. The Administrator also indicated ISDH was initially notified of the allegation on 6/4/13 at 1:44 p.m. 2. Facility abuse investigations were reviewed on 10/9/13 at 11:30 a.m. An investigation report dated 6/21/13 indicated an allegation of CNA #10 being verbally aggressive with Resident B, as well as slamming doors, not answering call light, and refusing to provide care on 6/20/13. The investigation report indicated CNA #12 reported to LPN #11 that there was a complaint against CNA #10 from Resident B on 6/20/13 during evening shift. Documentation was noted of CNA #10 slamming Resident B's bathroom door when the resident asked for assistance moving equipment from her bed to the floor. The investigative report also indicated Resident B felt verbal aggression from CNA #10 when the CNA responded to her call light and stated "why did you call me when an aide was in here." The investigation report indicated CNA #10 was suspended when the allegation was made to LPN #11 on 6/20/13, and CNA #10 was			

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	terminated on 6/21/13 due to general conduct-verbal aggressive, defective work, excess break time, and leaving workplace without permission. The investigation indicated the Director of Nursing and the Administrator were immediately notified of the allegation. Upon interview of the LPN #11 on 10/9/13 at 1:45 p.m., the LPN indicated she was on supper break when CNA #12 informed her of the allegation. LPN #11 stated she immediately returned from supper break, and she went and interviewed Resident B. The LPN indicated Resident B stated CNA #10 was verbally aggressive with her when she answered her call light, and that CNA #10 intimidated Resident B when the doors were slammed. The LPN stated after she interviewed the resident, she immediately contacted the Director of Nursing (DON). The LPN indicated she then had CNA #10 clock out and leave the facility. The LPN indicated she became aware of the allegation sometime after 7 p.m. Upon review of the closed clinical record of Resident B on 10/9/13 at 1:20 p.m., a nursing note dated 6/14/13 indicated the resident was alert and oriented to person, place, and time, and without focal deficits.			

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	Upon review of CNA #10's time sheet on 10/9/13 at 2:15 p.m., documentation indicated CNA #10 was clocked out from work at 9:32 p.m. on 6/20/13. Upon interview of the Administrator on 10/9/13 at 2:30 p.m., the Administrator indicated ISDH was notified of the allegation from 6/20/13 on 6/21/13 at 11:41 a.m. This notification was the initial notification to ISDH with follow-up. 3. During review of information titled "Addendum to Unusual Occurrence of September 27, 2013" received from the DNS (Director of Nursing Services) on 10/9/13 at 12:45 p.m., the following was noted: "RE: [Resident A]" "[Resident A] was yelled at by CNA [Certified Nurses Aide] [#1] on 9/27/13. It was overheard by two nuring (sic) staff: LPN [Licensed Practical Nurse] [#2] and CNA [#3] that she yelled at him, 'No, I'm not giving you a d--- shower.' DNS [Director of Nursing Service] spoke with resident who endorsed what was said and then stated it wasn't her fault she has a really hard life. He stated it made him feel bad for both himself and her that she			

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	yelled and cursed. CNA suspended on 9/27/13 at 9:55 am pending investigation. DNS spoke with all involved and CNA was terminated on 9/27/13 at 1:10 p.m. by phone by DNS and LPN [#4], MDS [minimum data set]. When DNS spoke with [CNA #1] prior to suspension she stated she knew she was in the DNS office because: [sic] 'I told [Resident A] "wasn't giving him a d--- shower.' During interview of LPN #2 on 10/9/13 at 12:55 p.m., the LPN indicated on 9/27/13, she was in the hallway and was in the process of a medications pass when she overheard CNA #1 indicate to Resident A "No, I'm not giving you a d--- shower." The LPN indicated she went to Resident A's room and ask the CNA to leave Resident A's room and after speaking with the resident went out to the hallway and told CNA #1 that her behavior was inappropriate and "you can't talk to residents that way." The LPN then indicated she left the area to report the behavior to the DNS. The LPN then indicated she went to Resident D's room where CNA #1 was starting to assist the resident with a bath. The LPN indicated she told the CNA she needed to leave the building.			

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	This Federal tag relates to Complaint IN00137429. 3.1-28(c)			

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F000226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to implement its policies and procedures to 1) protect residents during investigation of all allegations and 2) immediately report all allegations to the Administrator and/or State officials for 3 of 3 allegations of staff to resident abuse. [Resident A, Resident B, and Resident C] Findings include: Facility abuse investigations were reviewed on 10/9/13 at 11:30 a.m. An investigation report dated 6/4/13 indicated an allegation of CNA #5 yelling at Resident C in the hallway with witnesses on 6/3/13 at 2 p.m. The investigation report indicated CNA #6, CNA #7 and LPN #8 witnessed CNA #5 arguing repeatedly with Resident C. The investigation report indicated housekeeping staff #9 overheard CNA #5 loudly repeat "report me" in an angry tone to Resident C. The report also indicated CNA #6 heard CNA #5 in a loud	F000226	It is the facility policy that residents are protected during all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property at the time of the allegation and during the ensuing investigation. All residents have the potential to be affected. Resident C and CNA#5 were overheard with loud voices and it was reported by housekeeping. LPN was present and did not think was verbal abuse. More information was reported to to the Administrator the next day by staff who had overheard the loud voices and the CNA was immediately suspended pending investigation. Appropriate authorities were notified. Resident B reported to CNA#12 that CNA#10 was verbally aggressive to her and slamming the door to the bathroom. CNA#12 notified LPN#11 who was on her dinner break. LPN spoke with the resident, then got CNA#10 from her dinner break and suspended her. CNA was at the nurses station and had no further resident contact. Administrator	11/08/2013

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	mean voice state to Resident C "there's the nurse go ahead and report me" repeatedly. CNA #7 according to the investigation report observed CNA #5 loudly and repeatedly told Resident C to "go ahead and report me." Documentation indicated LPN #8 heard Resident C state to CNA #5 "I'm gonna report you to state," and CNA #5 respond to Resident C in a raised tone, "go ahead and report me." The report indicated the investigation was initiated, and CNA #5 was suspended pending investigation. The report indicated CNA #5 was terminated on 6/6/13 due to the CNA had yelled and screamed at Resident C, and that Resident C and witnesses viewed this as verbal abuse. Upon interview of the Director of Nursing (DON) on 10/9/13 at 12:45 p.m., the DON stated she remembered on 6/3/13 that the housekeeping supervisor had called her and asked if she was aware of incident with CNA #5 and Resident C. The DON indicated she contacted LPN #8 who was working, and that LPN #8 told her "nothing was going on only a CNA was upset." The DON indicated the Administrator became aware of the allegation on 6/4/13 and		was immediately notified and appropriate authorities were notified. Resident A was told by CNA#1 that she was not giving him a d--- shower. This was overheard by LPN#2 and CNA#3. LPN notified DNA and CNA was immediately suspended pending investigation. Administrator was immediately notified and appropriate authorities were notified. All CNA's were suspended pending investigation and terminated per facility policy. All concerns about abuse are taken seriously and immediately investigated with resident safety being the first concern. All staff have been inserviced on abuse and the policy for reporting immediately and ensuring that the resident is immediately protected and removed from any situation that could cause harm. A special emphasis was put on immediately removing the staff alledged to have committed abuse from the resident and from the facility. Inservicing on abuse is done upon employment and quarterly. The Administrator and DNS will monitor every allegation of abuse that is made.	

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	an investigation was started on 6/4/13. Upon interview of CNA #6 on 10/9/13 at 1:05 p.m., the CNA indicated CNA #5 yelled "go ahead turn me in, I'm gonna turn you in" at Resident C repeatedly on 6/3/13. The CNA indicated that she didn't report the incident due to LPN #8 witnessed the incident, and LPN #8 would have been the supervisor she would have reported the abuse. Upon interview of CNA #7 on 10/9/13 at 1:20 p.m., the CNA indicated she heard CNA #5 loudly and repeatedly yell "go ahead report me, I want you to report me" at Resident C on 6/3/13. The CNA indicated LPN #8 was with her, and she assumed LPN #8 took care of the incident. CNA #7 stated she witnessed CNA #5 to go outside after the incident, and that CNA #5 completed her shift. Upon interview of LPN #8 on 10/8/13 at 3:20 p.m., LPN #8 indicated Resident C was alert and oriented. Upon review of CNA #5's time sheet on 10/9/13 at 2:05 p.m., documentation indicated CNA #5 completed shift on 6/3/13, and returned to work on 6/4/13 at 6:55			

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	a.m. CNA #5 worked for 2.5 hours on 6/4/13. Upon interview of the Director of Nursing and Administrator on 10/9/13 at 2:30 p.m., both indicated CNA #5 completed entire shift on 6/3/13 and returned to work on 6/4/13 for day shift. The Administrator indicated CNA #5 was suspended on 6/4/13 at 9:23 a.m. The Administrator indicated she was not notified of the allegation on 6/3/13 until 6/4/13. The Administrator also indicated ISDH was initially notified of the allegation on 6/4/13 at 1:44 p.m. 2. Facility abuse investigations were reviewed on 10/9/13 at 11:30 a.m. An investigation report dated 6/21/13 indicated an allegation of CNA #10 being verbally aggressive with Resident B, as well as slamming doors, not answering call light, and refusing to provide care on 6/20/13. The investigation report indicated CNA #12 reported to LPN #11 that there was a complaint against CNA #10 from Resident B on 6/20/13 during evening shift. Documentation was noted of CNA #10 slamming Resident B's bathroom door when the resident asked for assistance moving equipment from her bed to the floor. The investigative report also indicated			

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	Resident B felt verbal aggression from CNA #10 when the CNA responded to her call light and stated "why did you call me when an aide was in here." The investigation report indicated CNA #10 was suspended when the allegation was made to LPN #11 on 6/20/13, and CNA #10 was terminated on 6/21/13 due to general conduct-verbal aggressive, defective work, excess break time, and leaving workplace without permission. The investigation indicated the Director of Nursing and the Administrator were immediately notified of the allegation. Upon interview of the LPN #11 on 10/9/13 at 1:45 p.m., the LPN indicated she was on supper break when CNA #12 informed her of the allegation. LPN #11 stated she immediately returned from supper break, and she went and interviewed Resident B. The LPN indicated Resident B stated CNA #10 was verbally aggressive with her when she answered her call light, and that CNA #10 intimidated Resident B when the doors were slammed. The LPN stated after she interviewed the resident, she immediately contacted the Director of Nursing (DON). The LPN indicated she then had CNA #10 clock out and leave the facility. The LPN indicated she became aware of			

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	the allegation sometime after 7 p.m. Upon review of the closed clinical record of Resident B on 10/9/13 at 1:20 p.m., a nursing note dated 6/14/13 indicated the resident was alert and oriented to person, place, and time, and without focal deficits. Upon review of CNA #10's time sheet on 10/9/13 at 2:15 p.m., documentation indicated CNA #10 was clocked out from work at 9:32 p.m. on 6/20/13. Upon interview of the Administrator on 10/9/13 at 2:30 p.m., the Administrator indicated ISDH was notified of the allegation from 6/20/13 on 6/21/13 at 11:41 a.m. This notification was the initial notification to ISDH with follow-up. 3. During review of information titled "Addendum to Unusual Occurrence of September 27, 2013" received from the DNS (Director of Nursing Services) on 10/9/13 at 12:45 p.m., the following was noted: "RE: [Resident A]" "[Resident A] was yelled at by CNA [Certified Nurses Aide] [#1] on 9/27/13. It was overheard by two nuring (sic) staff: LPN [Licensed Practical Nurse] [#2]			

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	and CNA [#3] that she yelled at him, 'No, I'm not giving you a d--- shower.' DNS [Director of Nursing Service] spoke with resident who endorsed what was said and then stated it wasn't her fault she has a really hard life. He stated it made him feel bad for both himself and her that she yelled and cursed. CNA suspended on 9/27/13 at 9:55 am pending investigation. DNS spoke with all involved and CNA was terminated on 9/27/13 at 1:10 p.m. by phone by DNS and LPN [#4], MDS [minimum data set]. When DNS spoke with [CNA #1] prior to suspension she stated she knew she was in the DNS office because: [sic] 'I told [Resident A] "wasn't giving him a d--- shower.' During interview of LPN #2 on 10/9/13 at 12:55 p.m., the LPN indicated on 9/27/13, she was in the hallway and was in the process of a medications pass when she overheard CNA #1 indicate to Resident A "No, I'm not giving you a d--- shower." The LPN indicated she went to Resident A's room and ask the CNA to leave Resident A's room and after speaking with the resident went out to the hallway and told CNA #1 that her behavior was inappropriate and "you can't talk to residents that way." The LPN then			

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	indicated she left the area to report the behavior to the DNS. The LPN then indicated she went to Resident D's room where CNA #1 was starting to assist the resident with a bath. The LPN indicated she told the CNA she needed to leave the building. Upon review of the facility's current policy and procedure titled "Resident Neglect, Abuse, and Misappropriation Policy" [no date] on 10/9/13 at 9:45 a.m., documentation was noted of "...POLICY/PROCEDURE...5. Residents/families alleging abuse, neglect, or misappropriation of property are to be protected during the investigation. Included in the protective measures are: a. Suspension of the individual accused of the alleged neglect, abuse, misappropriation of resident property for duration of the investigation...6. All reported incidents of alleged abuse, neglect, or misappropriation of resident property are immediately investigated and reported per state and federal law (typically within 24 hours of witness/identification). All employees are responsible for reporting abuse to his/her supervisor. The supervisor is responsible for reporting to the Administrator, DON [Director of Nursing], and Social Service Director and beginning			

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	investigation...." This Federal tag relates to Complaint IN00137429. 3.1-28(a)			