

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155762	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/11/2016
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NAME OF PROVIDER OR SUPPLIER FOREST PARK HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2401 S L ST RICHMOND, IN 47374
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00211164.</p> <p>Complaint IN00211164 - Substantiated. Federal/state deficiencies related to the allegations are cited at F223 and F226.</p> <p>Unrelated deficiency is cited.</p> <p>Survey dates: October 7 and 11, 2016</p> <p>Facility number: 011387 Provider number: 155762 AIM number: 200853180</p> <p>Census bed type: SNF: 23 SNF/NF: 43 Residential: 19 Total: 85</p> <p>Census payor type: Medicare: 17 Medicaid: 28 Other: 21 Total: 66</p> <p>Sample: 3</p> <p>These deficiencies reflects State findings cited in accordance with 410 IAC</p>	F 0000	<p>Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during a Complaint (IN00211164) Survey on October 11, 2016.</p> <p>Please accept this plan of correction as the provider's credible allegation of compliance.</p> <p>The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</p>	

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.

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F 0223 SS=D Bldg. 00	<p>16.2-3.1.</p> <p>Quality review completed by 30576 on October 13, 2016</p> <p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>Based on interview and record review, the facility failed to ensure verbal abuse did not occur for 2 of 3 residents, in a sample of 3, reviewed for abuse. (Resident #B and #C)</p> <p>Findings include:</p> <p>On 10-7-16 at 11:00 a.m., the Executive Director provided a copy of an ISDH (Indiana State Department of Health) document for reporting incidents, dated 9-26-16. This document indicated on 9-26-16, the facility discovered RN #1 had posted inappropriate comments on social media, involving Resident #B and/or Resident #C. A follow-up to this,</p>	F 0223	<p>F 223</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #85 - An investigation for the allegation of verbal abuse / social medial violation was investigated and reported to the ISDH by the Executive Director. Resident #B & C were unaware of the social media posting that referenced their room number. After the conclusion of the investigation, RN #1 employment was terminated.</p> <p>Identification of other</p>	11/04/2016			

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	<p>dated 9-30-16, clarified, "Employee [name of RN #1] made inappropriate statement on [name of a social media program] that she was on verge of smothering resident in [specified room number of Resident #B and Resident #C] in comment section of a post on her wall...Interview with [name of RN #1], admitted to posting state [name for a social media program], no excuses for her actions..." This document specified resident names, only a room number, was used in the posting on social media. Associated notes attributed to the facility's investigation of the incident indicated RN #1 was working at the facility and was at one of the nurse's stations when she posted the comments regarding Resident #B and/or Resident #C.</p> <p>On 10-7-16 at 11:00 a.m., the Executive Director provided a copy, also known as a screen shot, of the social media posting. This posting was attributed to RN #1 on 9-23-16 at 11:08 p.m. It demonstrated the following information, "Working my 6 the [sic] out of 7 with 2 of those over 12 hours...and I am on the verge of smothering the resident in [room number listed]..."</p> <p>In an interview with the Director of Health Services (DHS) on 10-7-16 at</p>		<p>residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected by the same alleged deficient practice.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: The campus staff will be re-educated on the following guidelines: 1). Abuse and Neglect 2). Cell Phones, Cameras & Other Electronic Devices 3). Bill of Resident Rights</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and / or observations for 5 staff members will be conducted by the DHS or designee 2 times per week times 4 weeks, then monthly times 5 months to ensure compliance: Interview of staff regarding any reported or observed allegations of abuse / neglect via social media, related to the residents at Forest Park Health Campus.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then</p>				

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	<p>2:14 p.m., she reported, "I was the one who saw the post the nurse put on [name for a social media program] on that Monday morning 9-26-16. She had posted it late on Friday evening, 9-23-16. When I interviewed her, she told me she had posted the comments and had no excuse for posting it."</p> <p>In an interview with CNA #2 on 10-11-16 at 5:35 a.m., she voiced she was aware RN #1 had recently posted something about one of the residents on social media site. "I can't remember exactly what it said, but it mentioned a room number. So, if you know much about any building, you could pretty easy find the room and who lives there. Just because somebody deletes something off of [name of a social media program], doesn't mean the other people who saw it deleted it, too. From what I know, it's really hard to get rid of something once it's posted." She clarified she was shown this posting by another person on or after 9-27-16.</p> <p>In an interview with CNA #3 on 10-11-16 at 6:05 a.m., she relayed she had not actually seen the social media posting from RN #1, but had heard about it from other persons. "I heard that it was something to the effect of everything was okay, but she was ready to strangle the</p>		randomly thereafter for further recommendation.				

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	<p>person in a certain room number. No names were mentioned."</p> <p>On 10-7-16 at 1:30 p.m., the Executive Director provided a copy of a policy entitled, "Abuse and Neglect Procedural Guidelines." This policy's dated of revision was listed as 2-25-16 and was indicated to be the current policy utilized by the facility. It's purpose was listed as, "[Name of the Corporation] has developed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect...Definitions: ABUSE means the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain or mental anguish (known and/or alleged)...This presumes the instances of abuse of all residents, even those in a coma, cause physical harm, or pain and mental anguish. VERBAL ABUSE - may include oral, written or gestured language that includes disparaging and derogatory terms to the resident/patient or within hearing distance, to describe residents, regardless of their age, ability to comprehend or disability..."</p> <p>On 10-7-16 at 2:25 p.m., the Executive Director provided a copy of a policy entitled, "Cell Phones, Cameras & Other Electronic Devices," with a revision</p>			

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	<p>dated listed as 8-30-16 and was indicated to be the current policy utilized by the facility. This policy stated, "Resident privacy, confidentiality and well-being are of utmost importance to the Company. In an effort to protect the rights of our residents, the Company prohibits the use of personal cell phones, cameras and other electronic devices by covered individuals while working in the health campus environment. This policy defines the use of cell phone, cameras and other electronic devices by covered individuals while working in the health campus environment in order to protect resident privacy and confidentiality. Covered individuals are prohibited from taking keeping and/or distributing photographs or recordings through multimedia messages or on social media networks that may violate a resident's right to privacy and confidentiality...Use of person cell phones, cameras and other electronic devices is strictly prohibited while working in the health campus environment...Covered individuals must report any violation or suspected violation of this policy...The health campus will respond to all alleged violations of this policy, including any mental abuse, provide protections for any resident involved in the allegations, conduct a thorough investigation, implement corrective actions to prevent</p>			

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F 0226 SS=D Bldg. 00	<p>further abuse, and report the findings to registries, state licensing authorities and other agencies as required..."</p> <p>On 10-7-16 at 2:25 p.m., the Executive Director provided a copy of a policy entitled, "Bill of Resident Rights," with a revision date of 10-2004 and was indicated to be the current policy utilized by the facility. This policy stipulated, "...Abuse: You have the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment and involuntary seclusion..."</p> <p>This Federal tag relates to Complaint IN00211164.</p> <p>3.1-27(b)</p> <p>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 ensure policies related to verbal abuse and those associated with the staff's utilization of social media were implemented for 2 of 3 residents, in a sample of 3, reviewed for</p>	F 0226	<p>F 226</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #85 - An</p>	11/04/2016

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	<p>abuse. (Resident #B and #C)</p> <p>Findings include:</p> <p>On 10-7-16 at 11:00 a.m., the Executive Director provided a copy of an ISDH (Indiana State Department of Health) document for reporting incidents, dated 9-26-16. This document indicated on 9-26-16, the facility discovered RN #1 had posted inappropriate comments on social media, involving Resident #B and/or Resident #C. A follow-up to this, dated 9-30-16, clarified, "Employee [name of RN #1] made inappropriate statement on [name of a social media program] that she was on verge of smothering resident in [specified room number of Resident #B and Resident #C] in comment section of a post on her wall...Interview with [name of RN #1], admitted to posting state [name for a social media program], no excuses for her actions..." This document specified resident names, only a room number, was used in the posting on social media. Associated notes attributed to the facility's investigation of the incident indicated RN #1 was working at the facility and was at one of the nurse's stations when she posted the comments regarding Resident #B and/or Resident #C.</p>		<p>investigation for the allegation of verbal abuse / social medial violation was investigated and reported to the ISDH by the Executive Director. Resident #B & C were unaware of the social media posting that referenced their room number. After the conclusion of the investigation, RN #1 employment was terminated.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected by the same alleged deficient practice.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: The campus staff will be re-educated on the following guidelines: 1). Abuse and Neglect 2). Cell Phones, Cameras & Other Electronic Devices 3). Bill of Resident Rights</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and / or observations for 5 staff members will be conducted by the DHS or designee 2 times per week times 4 weeks, then monthly times 5 months to ensure</p>				

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	<p>In an interview with the Director of Health Services (DHS) on 10-7-16 at 2:14 p.m., she reported, "I was the one who saw the post the nurse put on [name for a social media program] on that Monday morning 9-26-16. She had posted it late on Friday evening, 9-23-16. When I interviewed her, she told me she had posted the comments and had no excuse for posting it."</p> <p>On 10-7-16 at 1:30 p.m., the Executive Director provided a copy of a policy entitled, "Abuse and Neglect Procedural Guidelines." This policy's dated of revision was listed as 2-25-16 and was indicated to be the current policy utilized by the facility. It's purpose was listed as, "[Name of the Corporation] has developed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect...Definitions: ABUSE means the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain or mental anguish (known and/or alleged)...This presumes the instances of abuse of all residents, even those in a coma, cause physical harm, or pain and mental anguish. VERBAL ABUSE - may include oral, written or gestured language that includes disparaging and derogatory terms to the resident/patient or</p>		<p>compliance: Interview of staff regarding any reported or observed allegations of abuse / neglect via social media, related to the residents at Forest Park Health Campus.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>	

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	<p>within hearing distance, to describe residents, regardless of their age, ability to comprehend or disability..."</p> <p>On 10-7-16 at 2:25 p.m., the Executive Director provided a copy of a policy entitled, "Cell Phones, Cameras & Other Electronic Devices," with a revision dated listed as 8-30-16 and was indicated to be the current policy utilized by the facility. This policy stated, "Resident privacy, confidentiality and well-being are of utmost importance to the Company. In an effort to protect the rights of our residents, the Company prohibits the use of personal cell phones, cameras and other electronic devices by covered individuals while working in the health campus environment. This policy defines the use of cell phone, cameras and other electronic devices by covered individuals while working in the health campus environment in order to protect resident privacy and confidentiality. Covered individuals are prohibited from taking keeping and/or distributing photographs or recordings through multimedia messages or on social media networks that may violate a resident's right to privacy and confidentiality...Use of person cell phones, cameras and other electronic devices is strictly prohibited while working in the health campus environment...Covered individuals must</p>			

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F 0309 SS=D Bldg. 00	<p>report any violation or suspected violation of this policy...The health campus will respond to all alleged violations of this policy, including any mental abuse, provide protections for any resident involved in the allegations, conduct a thorough investigation, implement corrective actions to prevent further abuse, and report the findings to registries, state licensing authorities and other agencies as required..."</p> <p>On 10-7-16 at 2:25 p.m., the Executive Director provided a copy of a policy entitled, "Bill of Resident Rights," with a revision date of 10-2004 and was indicated to be the current policy utilized by the facility. This policy stipulated, "...Abuse: You have the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment and involuntary seclusion..."</p> <p>This Federal tag relates to Complaint IN00211164.</p> <p>3.1-28(a)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and</p>			

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	<p>services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on interview and record review, the facility failed to ensure call lights are answered in a timely manner to prevent resident from physical discomfort and mental anguish for 2 of 2 residents reviewed for timely response to call light activation. (Resident #B and Resident #C)</p> <p>Findings include:</p> <p>1. In an interview with Resident #B on 10-11-16 at 8:40 a.m., she relayed, " It can take as long as an hour to get somebody to actually respond to the call light. Sure, they may poke their head in and tell me they will be back to help me, but it may take up to an hour to actually get somebody to help me to the bathroom. And let me tell you, when you are needing to go, that seems like an eternity. It ' s very frustrating and uncomfortable. It ' s happened a bunch of times. I hate to say anything, but it ' s the truth. And I know it ' s hard on the staff when you have to deal with a [name of a type of a brand of mechanical] lift and everything that goes with that."</p> <p>In an interview on 10-11-16 at 8:40 a.m.,</p>	F 0309	<p>F 309</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #B & #C were observed to ensure call lights were answered in a timely manner.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: DHS or designee will observe call light response time on all neighborhoods, on all shifts to ensure the call lights are answered in a timely manner.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the nursing staff on the following guideline: Answering Call Lights</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 5 residents will be conducted by the DHS or designee 2 times per week times 4 weeks, then</p>	11/04/2016

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	<p>with a community member that visits with Resident #B's roommate, she shared, "I ' ve witnessed for myself that it can take the aides at least an hour to come and help get [name of Resident #B] to the bathroom, after she ' s put her[call] light on."</p> <p>In review of the clinical record for Resident #B on 10-7-16 at 1:55 p.m., it documented her diagnoses included, but were not limited to, obesity, polyosteoarthritis, fibromyalgia, diabetes and neuropathy. Her most recent Minimum Data Set (MDS) assessment, dated 9-9-16, indicated she is cognitively intact, requires extensive assistance of two or more persons for transfer, bed mobility and toileting, is nonambulatory, uses a wheelchair for mobility, is always incontinent of urine and is occasionally incontinent of stool. Her care plan specified the use of an mechanical lift with transfers.</p> <p>2. In an interview with a family member of Resident #C on 10-11-16 at 8:30 a.m., he shared Resident #C sometimes forgets to ask for help or to use the call light, related to toileting or other needs. However, on those occasions that she does utilize the call light, "it takes anywhere from 5 minutes to an hour for them to respond. When they don ' t come</p>		<p>monthly times 5 months to ensure compliance. Monitoring / auditing of this plan of correction will occur on all shifts: Observe call light response time to ensure call lights are answered timely.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155762	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/11/2016
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NAME OF PROVIDER OR SUPPLIER FOREST PARK HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2401 S L ST RICHMOND, IN 47374
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	<p>pretty quick and check on her, then she will start yelling out, " Nurse, Nurse. " I ' m sure that upsets some of the workers here. Part of the problem is she can ' t hear very good. And when she does put on the call light, she expects them to be here pretty quick."</p> <p>In an interview at the same time with another family member of Resident #C, she stipulated, "Plus there are times that someone will come and turn off the call] light; say they will be back to help her because they are working with someone else, but it may take a long time to get the help, like to go to the bathroom. I ' ve seen this happen more than once myself."</p> <p>A review of the clinical record of Resident #C on 10-7-16 at 1:12 p.m. revealed her diagnoses included, but were not limited to, Alzheimer's disease, stage 4 chronic kidney disease, atherosclerotic heart disease, congestive heart failure, chronic low back pain associated with spondylosis of the thoracic and lumbar spine. Her most recent Minimum Data Set assessment, dated 9-24-16, specified she is moderately cognitively impaired, requires extensive assistance of one person for transfers, bed mobility, ambulation in her room, dressing, bathing, hygiene and toileting, is occasionally incontinent of bowel and</p>			

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	<p>bladder.</p> <p>In an interview with the Executive Director on 10-11-16 at 12:20 p.m., he shared, "I think the call lights should be responded to within five minutes, unless there are extenuating circumstances, like some type of an emergency with another resident. Even then, this should be explained to the resident that the staff is currently busy with another situation and will be with them as soon as they can. All staff are responsible for answering call lights. If that person is not able to deal with the problem, they need to let the resident know and then get the right person to deal with the problem." In interview at the same time, the Director of Health Services and the Assistant Director of Health Services concurred with the Executive Director.</p> <p>3.1-37(a)</p>			