

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/16/2016
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NAME OF PROVIDER OR SUPPLIER CROWNPOINTE OF GREENFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 831 SWOPE STREET GREENFIELD, IN 46140
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R 0000 Bldg. 00	<p>This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00196544.</p> <p>Complaint IN00196544 - Substantiated. State deficiencies related to the allegations are cited at R0053 and R0090.</p> <p>Survey dates: May 13 and 16, 2016</p> <p>Facility number: 012798 Provider number: 012798 AIM number: N/A</p> <p>Residential census: 46</p> <p>Sample: 7 Supplemental sample: 2</p> <p>These State deficiencies are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed by 30576 on May 20, 2016</p>	R 0000		
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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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R 0053 Bldg. 00	<p>410 IAC 16.2-5-1.2(w) Residents' Rights - Deficiency (w) Residents have the right to be free from verbal abuse.</p> <p>Based on interview and record review the facility failed to prevent a CNA from verbally abusing a resident for 1 of 5 residents reviewed for allegations of abuse (Resident #D).</p> <p>Finding include:</p> <p>Review of the record of Resident #D on 5/13/16 at 10:00 a.m., indicated the resident's diagnoses included, but were not limited to, diabetes, hypertension and depression.</p> <p>The nursing note for Resident #D, dated 12/15/15 at 4:30 p.m., indicated "management had incident brought to attention, CNA was overheard speaking loudly to resident about going to bed."</p> <p>The incident report sent to the Indiana State Department of Health, dated 12/16/15, provided by the Administrator on 5/13/16 at 1:25 p.m., indicated on 12/13/15 at 11:10 p.m., CNA #1 was heard by another CNA speaking loudly in a scolding voice telling Resident #D to go to bed and she should have already been in bed because it was after 11:00</p>			R 0053	<p>This situation, including staff and residents was investigated at the time of incident reporting by the previous Administrator. The involved staff member was terminated on 12/17/2015 and staff were in-serviced on Abuse 12/17/15. In addition to any actions taken at the time of the incident: Abuse and when to notify the Administrator will now be given at the time of hire for new employees. The scheduled Abuse in-service for July has been moved forward to June, 2016. Postings have been placed and in-serviced for: Abuse Definition Types of Abuse with examples When to Notify the Administrator Monitoring of Abuse In-services for completion will be tracked by the Administrator at time of hire and annually thereafter. New hire check-list will be completed by the Business Office Manager and confirmed by the Administrator.</p>		06/10/2016

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	<p>p.m. CNA #1 was suspended for three days on 12/16/15 pending the outcome of the investigation. The incident report indicated the Administrator was notified of the incident on 12/15/15 and all staff were inserviced on preventing abuse and reminded that the Administrator must be informed immediately any time someone suspects that a resident had been talked to inappropriately.</p> <p>In a written statement, dated 12/15/15 at 4:45 p.m., CNA #2 indicated to the former Administrator that she did not know what to do and began crying. CNA #2 indicated she did not want to get anyone in trouble. CNA #2 indicated she was afraid to leave her shift at 11:00 p.m. because she was afraid that night shift staff would be mean to Resident #D. CNA #2 indicated on 12/13/15, CNA #1 was mad because Resident #D was not in bed when she came in on night shift. CNA #2 indicated Resident #D came into the communication room and CNA #1 "wagged her finger at" Resident #D and said "Oh no, you are not coming in here, you are going to your room and going to bed right now" CNA #1 said it in a "very loud, scolding tone of voice". Resident #D did not say anything, she turned around with her walker and went to her room as if she was afraid.</p>			

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	<p>In a written statement, dated 12/15/15 (no time), QMA #4 indicated to the former Administrator that "yes" he had heard staff talking to a resident in harsh manner and ordering them to their room. QMA #4 indicated staff had been worried the CNA #1 yelled at Resident #D to go to her room.</p> <p>In a written statement, dated 12/16/15 (no time), QMA #3 indicated to the former Administrator that CNA #1 was "very loud and scolding when she talked to" Resident #D. CNA #1 told the resident "she must go to her room and go to bed." QMA #3 indicated she was afraid to report it the Administrator, because of retaliation from CNA #1 and was not sure if it was considered abuse.</p> <p>The follow up incident report sent to the Indiana State Department of Health on 12/21/15, indicated after completing a full investigation of the allegations of verbal abuse, it was determined that the allegation was substantiated. CNA #1 was informed by the phone she was terminated.</p> <p>Interview with the Director of Health Services (DHS) on 5/13/16 at 11:45 a.m., indicated night shift staff heard CNA #1 in a loud voice telling Resident #D to go to bed. The DHS indicated staff felt it</p>			

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	<p>was too demanding. DHS indicated the facility had interviewed CNA #1 and she admitted she told Resident #D to go to bed in a loud voice. The facility felt like it was abuse or on the verge of abuse so they terminated CNA #1.</p> <p>Interview with the DHS on 5/16/16 at 11:08 a.m., indicated the staff did not report the allegation of verbal abuse on 12/13/15 to the Administrator immediately. The DHS indicated she was unsure if any resident interviews were completed related to the abuse allegation. The DHS indicated she was unsure if the physician or the family of Resident #D were notified. The DHS indicated CNA #1 did not work at the facility after 12/13/15. The DHS indicated she was unsure if the Indiana State Department of Health was notified of the incident timely as the former Administrator had done the reporting.</p> <p>Interview with QMA #3 on 5/16/16 at 11:30 a.m., indicated it was obvious that CNA # would get annoyed and irritated if Resident #D was up during the night. QMA #3 indicated she could not remember exactly what CNA #1 said to the resident.</p> <p>The "ABUSE" policy provided by the Administrator on 5/13/16 at 1:25 p.m.,</p>			

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	<p>indicated "...Resident abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish." ...Verbal abuse was defined as the use of oral, written or gestured language that willfully included disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse included, but were not limited to, "...raising your voice to a resident in a scolding or abrupt manner" and saying things to frighten a resident. "...Should an occurrence of abusive behavior be reported or witness, the Administrator shall be notified immediately." "...Should the incident be deemed an unusual occurrence the state survey and certification agency shall be notified". Appropriate documentation shall be completed and initial notification of responsible party and physician made and documented. An investigation was to include, but were not limited to, "...identification and interview of other residents who might have been affected by the same practice."</p> <p>This Residential tag relates to Complaint IN00196544.</p>			

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R 0090 Bldg. 00	<p>410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency</p> <p>(g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following:</p> <p>(1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to:</p> <p>(A) epidemic outbreaks; (B) poisonings; (C) fires; or (D) major accidents.</p> <p>If the division cannot be reached, a call shall be made to the emergency telephone number published by the division.</p> <p>(2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative.</p> <p>(3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility.</p> <p>(4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the:</p> <p>(A) employee's full name; and</p>			
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	<p>(B) dates and hours worked during the past twelve (12) months.</p> <p>(5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability.</p> <p>(6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request</p> <p>Based on interview and record review the facility failed to report an allegation of verbal abuse within 24 hours to the State agency for 1 of 5 residents reviewed for abuse (Resident #D).</p> <p>Finding include:</p> <p>Review of the record of Resident #D on 5/13/16 at 10:00 a.m., indicated the resident's diagnoses included, but were not limited to, diabetes, hypertension and depression.</p> <p>The nursing note for Resident #D, dated 12/15/15 at 4:30 p.m., indicated "management had incident brought to attention, CNA was overheard speaking loudly to resident about going to bed."</p> <p>The incident report sent to the Indiana</p>	R 0090	All staff will be in-serviced on unusual occurrences and when to notify the Administrator. All new employees will be in-serviced on unusual occurrences and when to notify the Administrator. A list of when to notify the Administrator will be posted. Monitoring of In-services for completion is tracked by the Administrator. New hire check-list will be signed off by Administrator and Business Monitoring of Abuse In-services for completion will be tracked by the Administrator at time of hire and annually thereafter. New hire check-list will be completed by the Business Office Manager and confirmed by the	06/10/2016			

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	<p>State Department of Health, dated 12/16/15, provided by the Administrator on 5/13/16 at 1:25 p.m., indicated on 12/13/15 at 11:10 p.m., CNA #1 was observed by another CNA speaking loudly in a scolding voice telling Resident #D to go to bed and she should have already been in bed because it was after 11:00 p.m. CNA #1 was suspended for three days on 12/16/15 pending the outcome of the investigation. The incident report indicated the Administrator was notified of the incident on 12/15/15 and all staff were inserviced on preventing abuse and reminded that the Administrator must be informed immediately any time someone suspects that a resident had been talked to inappropriately.</p> <p>Interview with the Director of Health Services (DHS) on 5/16/16 at 11:08 a.m., indicated the staff did not report the allegation of verbal abuse on 12/13/15 to the Administrator immediately. The DHS indicated she was unsure if the Indiana State Department of Health was notified of the incident timely as the former Administrator had done the reporting.</p> <p>The "ABUSE" policy provided by the Administrator on 5/13/16 at 1:25 p.m., indicated "...Should an occurrence of abusive behavior be reported or witness,</p>		Administrator. Office Manager.				

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	<p>the Administrator shall be notified immediately." "...Should the incident be deemed an unusual occurrence the state survey and certification agency shall be notified".</p> <p>This Residential tag relates to Complaint IN00196544.</p>				