STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155803	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON POINTE HEALTH AND REHAB	3800 ELI PLACE NEWBURGH, IN 47630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN0074906. Complaint IN00174906 - Substantiated, Federal/State deficiencies related to the allegations are cited at F225 and F226. Survey dates: June 8 and 9, 2015 Facility number: 012966 Provider number: 155803 AIM number: 201110390 Census bed type: SNF: 34 SNF/NF: 58 Residential: 46 Total: 138 Census payor type: Medicare: 17 Medicaid: 45 Other: 30 Total: 92 Sample: 5 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	

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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F 0225 SS=D Bldg. 00	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			

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	verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to immediately report an allegation of abuse to the Administrator, and failed to immediately report the allegation to the Indiana State Department of Health (ISDH), for 1 of 3 residents reviewed for abuse allegations, in a sample of 5. Resident A Findings include: The clinical record of Resident A was reviewed on 6/8/15 at 4:25 P.M. An admission Minimum Data Set (MDS) assessment, dated 6/4/15, indicated the resident scored an 11 out of 15 for cognition. A score of 15 indicated no memory impairment. On 6/8/15 at 5:00 P.M., the Administrator provided an "Indiana State Department of Health Incident Report Form," and witness statements. The form included: "Initial Report Date: 6-3-15...Incident Date: 6/1/15 or 6/2/15 Time of incident: approx. unknown [sic], Residents involved: [Resident A]...Staff Involved: Undetermined at this time. Brief Description of Incident: Resident's granddaughter indicated that her grandmother was treated with 'extreme	F 0225	**1) Immediate actions taken for those residents identified:** Investigation was initiated and submitted to ISDH on 6/3/15, interviews conducted, preventative measures implemented and Resident A follow up completed per protocol. **2) How the facility identified other residents:** All residents residing in the facility have the potential to be affected. **3) Measures put into place/ System changes:** Resident interviews were completed without findings. Facility staff were inserviced on the facility abuse policy and reporting of allegations of abuse immediately to the administrator. Audits will be conducted to ensure that allegations of abuse are reported to the administrator immediately and submitted to ISDH per regulation. The Administrator is responsible for oversight. **4) How the corrective actions will be monitored:** The results of these audits will be reviewed weekly times 4, monthly x 2 then quarterly x 1. Further monitoring will be determined by Quality Assurance.	07/09/2015

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	disrespect' by a female nursing assistant who assisted her to bathroom Sunday or Monday night. Resident described the staff member as a 'larger black lady.'...." A statement, signed by Resident A's family member, indicated, "6/1/2015 in room [number] [Resident A] was treated with extreme disrespect. [Resident A] went to the restroom and once back in her chair said 'I think I need to go again.' Whoever was in her room put her hand on her [Resident A's] head and told her 'You need to think real hard before I take you again.' This same person was in the room the night before and was making gesture about her in the hall to the other CNA's [sic]..." The statement had the notation: "Received morning of 6-3-15" and was signed by the Director of Nursing (DON). A statement, dated "6-2-15 (Tuesday) 8 pm. Pt [patient] gave generic description of a large female CNA that was African American. Stated it was the same CNA 2 nights in a row. Granddaughter [name] reported this to me." The statement indicated, "Received morning of 6-3-15" and was signed by the DON. A statement, dated 6/4/15 and signed by CNA # 1, indicated, "I worked Monday night on [number] hall and [Resident A]			

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	in room [number] ranged [sic]. I answered the light to help her...she began to complain about having a bad day. She told me that a 'fat black girl' yelled at her and she told the girl to leave her room and called her a 'little b---h.' [Resident A] said the girl came back in and she told her to leave the room and cursed her again...That morning...she thanked me, gave me a hug and asked me if I was working tonight. I told her 'no I'll be back later on' and she said 'don't leave me.'...A notation, dated 6/4/15 and signed by the Administrator, indicated, "HFA [Health Facility Administrator] & DON clarified abuse protocol & expectations, should residents report anything questionable that employee is responsible for notifying HFA directly...." A statement, written by LPN # 1 and undated, indicated, "...The pts [patients] granddaughter came straight to me at the med cart and stated that she had spoken to her grandmother and she felt like someone had been rude to her...She stated that she felt that someone had been rude to her Gma [sic] the night before by saying she needed to think about something. I asked her if she had the persons [sic] name or description. She said they were black, but she didn't know much else...stated that her Gma had just said it happened two nights in a row			

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	where the CNA was rude and that it was a very large black women [sic]...She said now her Gma was saying that someone placed a hand on her head while she was in her chair and told her to think about things. I told her to put that in her statement...I told her as soon as I got her grievance I would call the DON...I called DON and went over situation in detail and told her that granddaughter had put her cell and work number on statement...I told her I was sure they would get back with her first thing in the morning...." The statement indicated, "Rc'd 6/5/15." On 6/8/15 at 8:00 P.M., CNA # 1 was interviewed. She indicated she worked the 6:00 P.M. to 6:00 A.M. shift on Monday 6/1/15. CNA # 1 indicated, "I got report, and then took [Resident A] to the bathroom. I asked her how her day was, and she said she had a bad day. She said she called another worker a b---h 2 times." She indicated that Resident A was mad at the CNA who took her to the bathroom, and felt like she was yelled at. CNA # 1 indicated the staff member that the resident was complaining about was CNA # 2, whose "voice carried when she talked." CNA # 1 indicated that she reported to her nurse that Resident A was complaining of her neck pain, but did not mention the complaints regarding CNA # 2. She indicated she was inserviced			

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	regarding immediately reporting any allegation of abuse, because the resident "could have been reaching out to her." On 6/8/15 at 8:25 P.M., LPN # 1 was interviewed. LPN # 1 indicated she was working the evening of 6/2/15. She indicated a family member of Resident A informed her that "someone has been rude to my grandmother." LPN # 1 indicated the family member told her that a staff member had told Resident A to "think about something." The family member told LPN # 1 that someone "put a hand on her head and told her to think about it." LPN # 1 indicated she was going to have the family member fill out a grievance form. LPN # 1 indicated she asked what the staff member looked like, and the resident described the perpetrator as a "very large black woman." LPN # 1 indicated no staff member was working who looked like that. LPN # 1 indicated she immediately called the DON, and put the family member's phone numbers on the statement. She indicated the DON told her to write out a statement, and "slide it under her door." On 6/9/15 at 10:55 A.M., during an interview with the Administrator, she indicated she had not been notified of the alleged abuse on 6/1/5 or 6/2/15. She indicated staff had been re-inserviced on			

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	the abuse policy and procedure. On 6/8/15 at 4:40 P.M., the Administrator provided the current facility policy on "Abuse, Neglect, and Misappropriation of Resident Property," dated 4/2012. The policy included: "This facility's policy is that the resident has the right to be free from verbal, sexual, physical and mental abuse...This policy's purpose is to ensure that resident rights are protected by providing a method for investigation and reporting of allegations...The facility will ensure that all allegations of mistreatment, neglect or abuse...are reported immediately to the Administrator of the facility and to other officials in accordance with state law...The Administrator and/or other officials shall notify in accordance with State guidelines...If residents sustains injury by an employee or employee is a suspected perpetrator: i. Remove the employee from resident care areas immediately. ii. Staff is to notify immediate supervisor and he or she must conduct interview with employee and resident...iv. [sic] Administrator must be notified immediately of situation, and he/she must conduct an investigation immediately...." This Federal tag relates to Complaint IN00174906.			

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	3.1-28(c)			
F 0226 SS=D Bldg. 00	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 staff implemented the facility's abuse policy, by failing to immediately report an allegation of abuse to the Administrator, and failing to immediately report the allegation to the Indiana State Department of Health (ISDH), for 1 of 3 residents reviewed for abuse allegations, in a sample of 5. Resident A Findings include: The clinical record of Resident A was reviewed on 6/8/15 at 4:25 P.M. An admission Minimum Data Set (MDS) assessment, dated 6/4/15, indicated the resident scored an 11 out of 15 for cognition. A score of 15 indicated no memory impairment. On 6/8/15 at 5:00 P.M., the	F 0226	**1) Immediate actions taken for those residents identified:** Investigation was initiated and submitted to ISDH on 6/3/15, interviews conducted, preventative measures implemented and Resident A follow up completed per protocol. **2) How the facility identified other residents:** All residents residing in the facility have the potential to be affected. **3) Measures put into place/ System changes:** Resident interviews were completed without findings. Facility staff were inserviced on the facility abuse policy and reporting of allegations of abuse immediately to the administrator. Audits will be conducted to ensure that allegations of abuse are reported to the administrator immediately and submitted to ISDH per regulation. The Administrator is responsible for oversight. **4) How the corrective actions will be monitored:** The results of	07/09/2015

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	Administrator provided an "Indiana State Department of Health Incident Report Form," and witness statements. The form included: "Initial Report Date: 6-3-15...Incident Date: 6/1/15 or 6/2/15 Time of incident: approx. unknown [sic], Residents involved: [Resident A]...Staff Involved: Undetermined at this time. Brief Description of Incident: Resident's granddaughter indicated that her grandmother was treated with 'extreme disrespect' by a female nursing assistant who assisted her to bathroom Sunday or Monday night. Resident described the staff member as a 'larger black lady.'...." A statement, signed by Resident A's family member, indicated, "6/1/2015 in room [number] [Resident A] was treated with extreme disrespect. [Resident A] went to the restroom and once back in her chair said 'I think I need to go again.' Whoever was in her room put her hand on her [Resident A's] head and told her 'You need to think real hard before I take you again.' This same person was in the room the night before and was making gesture about her in the hall to the other CNA's [sic]..." The statement had the notation: "Received morning of 6-3-15" and was signed by the Director of Nursing (DON). A statement, dated "6-2-15 (Tuesday) 8		these audits will be reviewed weekly times 4, monthly x 2 then quarterly x 1. Further monitoring will be determined by Quality Assurance.	

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	pm. Pt [patient] gave generic description of a large female CNA that was African American. Stated it was the same CNA 2 nights in a row. Granddaughter [name] reported this to me." The statement indicated, "Received morning of 6-3-15" and was signed by the DON. A statement, dated 6/4/15 and signed by CNA # 1, indicated, "I worked Monday night on [number] hall and [Resident A] in room [number] ranged [sic]. I answered the light to help her...she began to complain about having a bad day. She told me that a 'fat black girl' yelled at her and she told the girl to leave her room and called her a 'little b---h.' [Resident A] said the girl came back in and she told her to leave the room and cursed her again...That morning...she thanked me, gave me a hug and asked me if I was working tonight. I told her 'no I'll be back later on' and she said 'don't leave me.'...A notation, dated 6/4/15 and signed by the Administrator, indicated, "HFA [Health Facility Administrator] & DON clarified abuse protocol & expectations, should residents report anything questionable that employee is responsible for notifying HFA directly...." A statement, written by LPN # 1 and undated, indicated, "...The pts [patients] granddaughter came straight to me at the			

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	med cart and stated that she had spoken to her grandmother and she felt like someone had been rude to her...She stated that she felt that someone had been rude to her Gma [sic] the night before by saying she needed to think about something. I asked her if she had the persons [sic] name or description. She said they were black, but she didn't know much else...stated that her Gma had just said it happened two nights in a row where the CNA was rude and that it was a very large black women [sic]...She said now her Gma was saying that someone placed a hand on her head while she was in her chair and told her to think about things. I told her to put that in her statement...I told her as soon as I got her grievance I would call the DON...I called DON and went over situation in detail and told her that granddaughter had put her cell and work number on statement...I told her I was sure they would get back with her first thing in the morning...." The statement indicated, "Rc'd 6/5/15." On 6/8/15 at 8:00 P.M., CNA # 1 was interviewed. She indicated she worked the 6:00 P.M. to 6:00 A.M. shift on Monday 6/1/15. CNA # 1 indicated, "I got report, and then took [Resident A] to the bathroom. I asked her how her day was, and she said she had a bad day. She said she called another worker a b---h 2			

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	times." She indicated that Resident A was mad at the CNA who took her to the bathroom, and felt like she was yelled at. CNA # 1 indicated the staff member that the resident was complaining about was CNA # 2, whose "voice carried when she talked." CNA # 1 indicated that she reported to her nurse that Resident A was complaining of her neck pain, but did not mention the complaints regarding CNA # 2. She indicated she was inserviced regarding immediately reporting any allegation of abuse, because the resident "could have been reaching out to her." On 6/8/15 at 8:25 P.M., LPN # 1 was interviewed. LPN # 1 indicated she was working the evening of 6/2/15. She indicated a family member of Resident A informed her that "someone has been rude to my grandmother." LPN # 1 indicated the family member told her that a staff member had told Resident A to "think about something." The family member told LPN # 1 that someone "put a hand on her head and told her to think about it." LPN # 1 indicated she was going to have the family member fill out a grievance form. LPN # 1 indicated she asked what the staff member looked like, and the resident described the perpetrator as a "very large black woman." LPN # 1 indicated no staff member was working who looked like that. LPN # 1 indicated			

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	she immediately called the DON, and put the family member's phone numbers on the statement. She indicated the DON told her to write out a statement, and "slide it under her door." On 6/9/15 at 10:55 A.M., during an interview with the Administrator, she indicated she had not been notified of the alleged abuse on 6/1/5 or 6/2/15. She indicated staff had been re-inserviced on the abuse policy and procedure. On 6/8/15 at 4:40 P.M., the Administrator provided the current facility policy on "Abuse, Neglect, and Misappropriation of Resident Property," dated 4/2012. The policy included: "This facility's policy is that the resident has the right to be free from verbal, sexual, physical and mental abuse...This policy's purpose is to ensure that resident rights are protected by providing a method for investigation and reporting of allegations...The facility will ensure that all allegations of mistreatment, neglect or abuse...are reported immediately to the Administrator of the facility and to other officials in accordance with state law...The Administrator and/or other officials shall notify in accordance with State guidelines...If residents sustains injury by an employee or employee is a suspected perpetrator: i. Remove the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155803	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/09/2015
NAME OF PROVIDER OR SUPPLIER HAMILTON POINTE HEALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 3800 ELI PLACE NEWBURGH, IN 47630	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	employee from resident care areas immediately. ii. Staff is to notify immediate supervisor and he or she must conduct interview with employee and resident...iv. [sic] Administrator must be notified immediately of situation, and he/she must conduct an investigation immediately...." This Federal tag relates to Complaint IN00174906. 3.1-28(a)			