STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/12/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROWNPOINTE OF CARMEL	11610 TECHNOLOGY DR CARMEL, IN 46032

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R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00182622. Complaint IN00182622 Substantiated. State deficiencies related to the allegations are cited at R0052, R0090, and R0144. Survey Date: November 12, 2015 Facility number: 012309 Provider number: 012309 AIM number: NA Census bed type: Residential: 36 Total: 36 Census payor type: Other: 36 Total: 36 Sample: 3 These State findings are cited in accordance with 410 IAC 16.2-5. Quality Review completed by 21662 on November 16, 2015.	R 0000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted as a requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find the enclosed plan of correction for the survey ending 11/12/15. Please also find enclosed sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Should additional information be necessary to confirm compliance, feel free to contact me. Respectfully, Dawn Wendell Administrator	

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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R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on record review and interview the facility failed to ensure a resident was not placed in involuntary seclusion, in that when a resident fell and continuously insisted on being sent to the local area hospital for evaluation, the facility staff ignored the resident request and placed the resident in her room and shut the door. This deficient practice effected 1 of 3 sampled resident's. (Resident "B"). Findings include: The record for Resident "B" was reviewed on 11-12-15 at 10:30 a.m. Diagnoses included, but were not limited to, hypertension, depression with anxiety attacks, tinnitus, atrial fibrillation, history of uterine cancer, and lung nodules. These diagnoses remained current at the time of the record review. A review of the Interdisciplinary Progress Notes, dated 04-16-15 at 8:00 p.m., and documented by QMA (Qualified	R 0052	The 2567 alleges the following: R 052 *This rule is not met as evidenced by: Based on record review and interview with the facility failed to ensure a resident was not placed involuntary seclusion, in that when a resident fell and continuously insisted on being sent to the local area hospital for evaluation, the facility staff ignored the resident in her room and shut the door. This deficient practice effected 1 of 3 sampled residents'. (Resident B)* The facility contends that said allegation was noted by the Administrator on April 20, 2015. The Administrator followed the abuse prohibition policy and immediately initiated an investigation and suspended the QMA, pending the investigation results. An incident report was called into the ISDH on 4/20/15 to report the allegation. The CNA who was initially made aware of the allegation was counseled/re-educated on the facility's abuse prohibition policy on 4/20/15, (attachment A). Interviews were conducted with	11/25/2015

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	Medication Aide #8), indicated the following: "I was standing at the med. [medication] cart coming out from a residents room when another resident informed me that [Resident "B"] was yelling help. I notified the CNA [Certified Nurse Aide #9] and we immediately went to her room. Notice <sic> she was on the floor yelling. Myself and the Aide assisted her up and into her recliner. Resident was yelling and very upset because I explained to her I was with another emergency and since she was checked out OK I would return to send her out. She wasn't understanding so I stepped out so she would calm down, next thing I know paramedics was at the door, sent out 911." During record review on 11-12-15 at 11:00 a.m., the Administrator provided documentation of an "Incident" which originally occurred on 04-16-15 at 8:00 p.m. A review of the handwritten statement, included in the "Incident" from CNA #9 and dated 04-30-15 indicated the following: "[Name of QMA #8] and I were on 100 hall when another resident came around saying [Resident "B"] was screaming for		resident B and her family. Resident B did not report or exhibit mental anguish initially or with follow up interviews. Interviews were conducted with other resident with no problems noted. The conclusion of the investigation noted that while the alleged statement made by the QMA could not be definitively substantiated,there was concern regarding the QMA's disregard to follow the request of the resident and her ability to recognize that this was an issue. While the allegation of willful abuse was not substantiated, the employee was terminated.A follow up incident report form was submitted to the ISDH on 4/21/15,(attachment B). As a preventative measure all staff were in-serviced on the abuse prohibition policy on April 23 & 24, 2015, (attachment C) specifically noting allegations must be reported to the Administrator immediately.Additionally, all staff are educated on the abuse prohibition policy upon hire and routinely thereafter. 1.Resident B was affected. The allegation was noted by the Administrator on April 20, 2015 and an investigation was immediately initiated. Resident B was not harmed and did not exhibit signs of mental anguish. The alleged QMA was immediately suspended and was terminated from employment with the facility upon conclusion of the	

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	help. [Name of QMA #8] and I went to see what was wrong with [Resident "B"] and found her in her doorway on the floor. She started to scream at us saying we should have gotten to her quicker. We got [Resident "B"] off the floor and into her chair where she was safe. [Name of QMA #8] checked her out and told [Resident "B"] she was fine and asked her how she fell. [Resident "B"] continued to scream at [name of QMA #8] saying she wanted to go to the hospital. [Name of QMA #8] told [Resident "B"] it wasn't necessary to go but [Resident "B"] continued to scream loudly. [Name of QMA #8] told her she would finish her med. [medication] pass then send her out because it wasn't an emergency. [Resident "B"] was screaming loudly enough to wake up other residents so [name of QMA #8] told her she was shutting her door. Something to that degree. I do not remember her exact words but it was harmless." A review of a "Report of Concern," dated 04-17-15, by the Director of Nurses indicated, "Resident asked to speak to me about a situation privately in her apt. [apartment]. She told me that she asked to go to he ER [Emergency Room] and [QMA employee #8] would not assist her in doing so. Witness, if any - [name of		investigation. 2.All residents have the potential to be affected. All staff were educated on the abuse prohibition policy on April 23 & 24, 2015, (attachment C). All staff will continue to be educated on the abuse prohibition policy upon hire and routinely thereafter. All staff will be in-serviced on resident rights on November 23, 2015, (attachment D). 3.As a measure of ongoing compliance the Activity Director or designee will complete at least 10 resident interviews on a monthly basis ongoing to ensure residents rights are being honored, (attachment E). Any problems noted will be reported to the Administrator and addressed immediately. Additionally the monthly resident council meeting will include information on resident rights ongoing. 4.As a measure of quality assurance the Administrator or designee will monitor and sign off on said interviews ongoing. Should a deficient practice be noted, immediate corrective action will be taken. The plan of correction will be revised accordingly, if warranted.	

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	CNA [Certified Nurse Aide] #9]. Witness' statement: [Name of QMA #8] told [name of Resident "B"] that she was going to close the door because [name of Resident "B"] was yelling and being disruptive." The facility provided information indicated, "Resident shows me the bruising on her leg. She states she fell, she thinks from her walker. 'The bruise didn't show up until later. I didn't break anything. They took six x-rays.' She said she couldn't get to the call cord. Resident said she was scared and wanted to go to the ER. She said she wanted to go to the ER and [name of QMA #8] didn't want her to. She [in regard to the resident] 'scooted across the floor' and called her [family member]. Her [family member] on the phone told [name of Resident "B"] she 'needed to stop getting so emotional.' [Name of Resident "B"] says 'whenever I fall I just fall apart.' [Name of QMA #8] stated to her she 'had things to do. I'm behind and I don't not have to stand around and have you yell at me like that.' [Name of Resident "B"] said [name of QMA #8] said, 'I'm going to lock you in your room and not tell people where you are.' [Name of Resident "B"] said the CNA [employee #9] was there as well. 'I'm half afraid of her,' meaning the [name			

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	of QMA #8]." "Discussion with the resident (family members) on the phone. She [family member] called CPC [Crown Pointe of Carmel] because [name of Resident "B"] called them yelling and screaming that she fell and wanted to go to the emergency room. [Family member] states [Resident "B"] gets very emotional when she wants to go to the emergency room and she was 'torn' about calling 911 because [Resident"B"] frequently calls 911 for issues that aren't an emergency; i.e. sore throat. [Family member] said she was calling to get [name of QMA #8] opinion. ... She stated [name of QMA #8] said, 'I have other things to do, I'm behind an I'm not going to stand around and let her yell at me like that.' [Name of QMA #8] said she didn't want to be screamed at, so she just left [Resident "B"] in her room. She was not 'hurt and we lifted her into her chair.' [Resident "B"] said she was 'scared of [name of QMA #8] and wanted to go spend the night with her. ... She stated [name of QMA #8] said she was going to lock her in the room all night. [Family member] said she spoke to the CNA [#9] that was present and asked if [Resident "B"] was told she would be locked in her room. CNA [#9] giggled and said 'no.'"			

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	Additional documentation indicated, "<sic> Phone call the CNA [#9] by DON [Director of Nurses] and administrator on the phone. [Name of CNA #9] asked if [name of QMA #8] told resident that she was going to lock her in her room and not tell anyone where she was. CNA states no, that resident was told they were closing the door." The packet of investigational information related to the incident indicated, "Employee [name of QMA #8] says she was giving meds [medications] on a different hallway (100) resident <sic> comes to QMA and states [Resident "B"] (300 hall) has fallen and is 'yelling for help.' Employee [QMA #8] and CNA [#9] lift resident to her chair. [Name of QMA #8] states resident is pointing to CNA stating she needs help. She is 'yelling' I want to go to the emergency room. 'There is no calming her down' I [QMA #8] keep telling her she needs to calm down. We can only do one thing at a time. The way she was acting really yelling I [QMA #8] left her. She [QMA #8] was asked if she left the resident alone while she was yelling she said yes. I asked why the CNA didn't stay with her, she [QMA] could not comment why.'" The documentation indicated the Administrator was unaware of the			

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	incident until 04-20-15 when the Administrator "noted a concern from [Name of Resident "B"]. A review of the Concern form indicated, "[Name of Resident "B"] had spoken to the Director of Nursing regarding her desire to go to the ER [Emergency Room] after she had fallen over the weekend. [Name of Resident "B"] didn't feel the QMA [Qualified Medication Aide-- employee # 8] on the floor had listened to her request. As a follow-up the administrator spoke with [name of Resident "B"]. Through further interview, [Resident "B"] stated the QMA had refused her initial request to go to the ER. [Name of Resident "B"] went on to state the QMA said, 'I'm going to close the door, lock you in our room and non one will find you.' Immediate Action Taken: On 04-20-15 per facility policy DON [Director of Nurses] phoned QMA employee #8 alerting her she was suspended pending investigation. An investigation was initiated immediately." "CNA [Certified Nurse Aide employee #9] was present during the aforementioned incident. While having the same description of the event surrounding the resident fall, [name of CNA #9] denies that [name of QMA #8] stated, 'I'm going to close the door, lock			

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	you in your room and no one will find you.' However, subsequent interviews with [family member of the resident] and other employees, reflected that [name of QMA #8] showed a pattern of the QMA not addressing the need of the resident and/or resident request." During an interview on 11-12-15 at 12:40 p.m., the Director of Nurses indicated the staff member called her at home and indicated [name of Resident "B"] was "really upset. I was told she had fallen and wanted to go to t the hospital - that is not unusual and she [in regard to Resident "B"] sometimes calls on her own. I didn't know the part about shutting the door on her, she was upset and she wanted to go to the hospital and asked what should be done. The next morning the [family member] called me and told me what the resident had told her. The family member indicated [name of QMA #8] was rude to her and said she 'didn't have time for this.' [Name of CNA #9] knew about the statement [closing the door on Resident "B"] but she is quiet and wants to do her work and not get involved. I first heard about the verbage from [name of family member] and I immediately called the Administrator. I started the investigation. It was during the investigation what we found out what [name of CNA #9] knew what had			

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	happened. We terminated [name of QMA #8]." When interviewed if CNA #9 was suspended or terminated, the Director of Nurses indicated "no because she wasn't in the direct line of what was going on." A review of the Employee time cards on 11-12-15 at 1:00 p.m., and verified by the Business office manager, indicated QMA #8 worked the following dates and times: Thursday 04-16-16 1:55 p.m., until 11:02 p.m. Friday - employee did not work Saturday 04-18-15 6:00 p.m., until 7:00 a.m., on 04-19-15 Sunday 04-19-15 6:19 p.m., until 6:21 a.m., on 04-20-15 A review of the Employee time cards on 11-12-15 at 1:00 p.m., and verified by the Business office manager, indicated CNA #9 worked the following dates and times: Thursday 04-16-16 1:56 p.m., until 9:11 p.m. Friday - employee did not work Saturday 04-18-15 1:27 p.m., until 8:59 p.m. Sunday 04-19-15 1:47 p.m., until 10:00 p.m. The Business Office Manager indicated CNA #9 remained employed by the facility.			

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	During an interview on 11-12-15 at 2:20 p.m., the Administrator indicated she was not aware of the extent of the incident which occurred on 04-16-15 until 04-20-15 and was unaware the staff members were allowed to continue to work, during an investigation. A review of the facility policy on 11-12-15 at 10:00 a.m., titled "Abuse Prohibition Reporting and Investigation," and dated 1/2015, indicated the following: "Policy: It is the policy of this facility allegations of abuse will be communicated to, and thoroughly investigated by, the correct authority. 1. This facility will not permit residents to be subjected to abuse by anyone, including employees, other residents, consultants, volunteers, staff or personnel of other agencies serving the resident, family members, legal guardians, sponsors, friends or other individuals." "Mental Abuse - A single traumatic episode toward a resident which includes, but is not limited to, humiliation, harassment and threats of punishment or deprivation requiring behavior intervention. ... Involuntary Seclusion - Separation of a resident from other			

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	residents or from her/his room or confinement to her/his room (with or without roommates) against the resident's will, or the will of the resident's legal representative." "If resident abuse, or suspicion of abuse, is reported: 1. The resident(s) involved in the incident will be removed from the situation at once or facility personnel will remain with the resident to ensure safety. 2. The individual who witnessed the incident or who was informed of the allegation shall immediately notify a charge nurse assigned to the unit on which the resident resides. If this is not feasible due to circumstances, the individual shall be responsible to notify any other nurse currently on duty. The nurse will examine the resident(s) involved to determine whether physical injuries have occurred and their extent. This examination shall be documented in the resident's clinical record. 3. The charge nurse is responsible to notify the facility Administrator and Director of Nursing immediately. 4. Any facility personnel implicated in the alleged abuse will be immediately removed from the resident's care and will remain suspended until an investigation is completed. A thorough investigation will be initiated. 5. Any resident implicated in the alleged abuse will be placed under appropriate			

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	monitoring/supervision to prevent recurrence until investigation is completed and/or transferred for medical/psychiatric evaluation to be conducted relative to mood/behavior exhibited. ... 13. Follow-up assessments will be completed/documented during every shift until the resident(s) is stable and resident's safety is maintained. 14. The Administrator, Director of Nursing, or designee, is responsible to notify the following agencies, as applicable: State Department of Health, Adult Protective Services, Ombudsman and Applicable Licensing Agency. 15. The Administrator is responsible to coordinate the investigation , assure an accurate and complete written record of the incident and investigation, and to file a follow-up report to the State Department of Health." "Protecting the Resident from Immediate Danger - If a resident's is in an abusive situation, the resident should be immediately separated from the harmful situation. You always want to ensure their safety. ... If it is a staff member that is suspected of abusing a resident, the staff member must be immediately suspended pending further investigation of the situation." "Reporting of Abuse - (bold type) Any			

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	abuse, suspicions of abuse, unusual observations and unusual circumstances should be reported to your supervisor immediately after removing the resident form the harmful/potential harmful situation. ... The Administrator/Designee is responsible for reporting any abuse or alleged abuse situations to the Indiana State Department of health, Ombudsman, and Adult Protective Services initially within 24 hours of occurrence and a follow-up report should be submitted within 5 business days of occurrence. This State finding relates to Complaint IN00182622.			
R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (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: (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: (A) epidemic outbreaks; (B)poisonings; (C) fires; or			

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	(D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (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. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (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. (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			
	Based on record review and interview the facility failed to implement their abuse policy and suspend alleged employees and failed to ensure the Indiana State Department of Health as well as other government agencies were notified for 1 of 1 incidents of alleged abuse. (Resident "B").	R 0090	The 2567 alleges the following: R 090 *This rule is not met as evidenced by: Based on record review and interview the facility failed to implement their abuse policy and suspend alleged employees and failed to ensure the Indiana State Department of Health as well as other government agencies were notified for 1 of 1 incidents of*	11/25/2015

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	Findings include: The record for Resident "B" was reviewed on 11-12-15 at 10:30 a.m. Diagnoses included, but were not limited to, hypertension, depression with anxiety attacks, tinnitus, atrial fibrillation, history of uterine cancer, and lung nodules. These diagnoses remained current at the time of the record review. During record review on 11-12-15 at 11:00 a.m., the Administrator provided documentation of an "Incident" which originally occurred on 04-16-15 at 8:00 p.m. "[Name of QMA #8] and I were on 100 hall when another resident came around saying [Resident "B"] was screaming for help. [Name of QMA #8] and I went to see what was wrong with [Resident "B"] and found her in her doorway on the floor. She started to scream at us saying we should have gotten to her quicker. We got [Resident "B"] off the floor and into her chair where she was safe. [Name of QMA #8] checked her out and told [Resident "B"] she was fine and asked her how she fell. [Resident "B"] continued to scream at [name of QMA #8] saying she wanted to go to the hospital. [Name of QMA #8] told [Resident "B"] it wasn't necessary to go but [Resident "B"] continued to scream		*alleged abuse. (Resident B)* The facility contends that said allegation was noted by the Administrator on April 20, 2015. The Administrator followed the abuse prohibition policy and immediately initiated an investigation and suspended the QMA, (attachment F) pending the investigation results. An incident report was called into the ISDH on 4/20/15 to report the allegation. The CNA who was initially made aware of the allegation was counseled/re-educated on the facility's abuse prohibition policy on 4/20/15, (attachment A). Interviews were conducted with resident B and her family. Resident B did not report or exhibit mental anguish initially or with follow up interviews. Interviews were conducted with other resident with no problems noted. The conclusion of the investigation noted that while the alleged statement made by the QMA could not be definitively substantiated,there was concern regarding the QMA's disregard to follow the request of the resident and her ability to recognize that this was an issue. While the allegation of willful abuse was not substantiated, the employee was terminated.A follow up incident report form was submitted to the ISDH on 4/21/15,(attachment B). As a preventative measure all staff were in-serviced on the abuse prohibition policy on April	

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	loudly. [Name of QMA #8] told her she would finish her med. [medication] pass then send her out because it wasn't an emergency. [Resident "B"] was screaming loudly enough to wake up other residents so [name of QMA #8] told her she was shutting her door. Something to that degree. I do not remember her exact words but it was harmless." A review of a "Report of Concern," dated 04-17-15, and signed by the Director of Nurses indicated, "Resident asked to speak to me about a situation privately in her apt. [apartment]. She told me that she asked to go to he ER [Emergency Room] and [name of QMA employee #8] would not assist her in doing so. Witness, if any - [name of CNA [Certified Nurse Aide #9]. Witness' statement: [Name of QMA #8] told [name of Resident "B"] that she was going to close the door because [name of Resident "B"] was yelling and being disruptive." Further review of the packet of information and documented by the Administrator on 04-20-15 indicated, "Resident shows me the bruising on her leg. She states she fell, she thinks over her walker. 'The bruise didn't show up until later. I didn't break anything. They		23 & 24, 2015, (attachment C) specifically noting allegations must be reported to the Administrator immediately.Additionally, all staff are educated on the abuse prohibition policy upon hire and routinely thereafter. 1.Resident B was affected. The allegation was noted by the Administrator on April 20, 2015 and an investigation was immediately initiated. Resident B was not harmed and did not exhibit signs of mental anguish. The alleged QMA was immediately suspended and was terminated from employment with the facility upon conclusion of the investigation. 2.All residents have the potential to be affected. All staff were educated on the abuse prohibition policy on April 23 & 24, 2015, (attachment C). All staff will continue to be educated on the abuse prohibition policy upon hire and routinely thereafter. All staff will be in-serviced on the facility's abuse prohibition policy on November 23, 2015, (attachment G). 3.As a measure of on-going compliance the Administrator or designee will review all allegations of abuse with the corporate nurse consultant when reported ongoing. The facility policy on abuse prohibition will be followed. 4.As a measure of quality assurance the nurse consultant	

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	took six x-rays.' She said she couldn't get to the call cord. Resident said she was scared and wanted to go to the ER. She said she wanted to go to the ER and [name of QMA #8] didn't want her to. She [in regard to the resident] 'scooted across the floor' and called her [family member].' Her [family member] on the phone told [name of Resident "B"] she 'needed to stop getting so emotional.' [Name of Resident "B"] says 'whenever I fall I just fall apart.' [Name of QMA #] stated to her she 'had things to do. I'm behind and I don't not have to stand around and have you yell at me like that.' [Name of Resident "B"] said [name of QMA #8] said, 'I'm going to lock you in your room and not tell people where you are.' [Name of Resident "B"] said the CNA [employee #9] was there as well. 'I'm half afraid of her,' meaning the QMA #8." "Discussion with the resident (family members) on the phone. She [family member] called CPC [Crown Pointe of Carmel] because [name of Resident "B"] called them yelling and screaming that she fell and wanted to go to the emergency room. [Family member] states [Resident "B"] gets very emotional when she wants to go to the emergency room and she was 'torn' about calling 911 because [Resident"B"] frequently calls		will review any allegations of abuse and investigations to ensure all allegations are addressed per the facility policy ongoing. Should a deficient practice be noted, immediate corrective action will be taken. The plan of correction will be revised accordingly, if warranted.	

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	911 for issues that aren't an emergency; i.e. sore throat. [Family member] said she was calling to get [name of QMA #8] opinion. [Family member] said she knows it's hard to get a word in edgewise as [Resident "B"] can yell, she has anxiety and can to to the 'whole spectrum of emotion during an episode.' She stated [QMA #8] said, 'I have other things to do, I'm behind and I'm not going to stand around and let her yell at me like that.' [Name of QMA #8] said she didn't want to be screamed at, so she just left [Resident "B"] in her room. She was not 'hurt and we lifted her into her chair.' [Resident "B"] said she was 'scared of [name of QMA #8] and wanted to go spend the night with her. [Family member] said she always does this when there is any conflict...resident or staff member. She stated [name of QMA #8] said she was going to lock her in the room all night. [Family member] said she spoke to the CNA [#9] that was present and asked if [Resident "B"] was told she would be locked in her room. CNA [#9] giggled and said 'no.'" "<sic> Phone call the CNA [#9] by DON [Director of Nurses] and administrator on the phone. [name of CNA #9] asked if [name of QMA #8] told resident that she was going to lock her in her room and not tell anyone where she was. CNA states			

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	no, that resident was told they were closing the door." The documentation indicated the Administrator was unaware of the incident until 04-20-15 when the Administrator "noted a concern from [Name of Resident "B"]. "[Name of Resident "B"] had spoken to the Director of Nursing regarding her desire to go to the ER [Emergency Room] after she had fallen over the weekend. [Name of Resident "B"] didn't feel the QMA [Qualified Medication Aide-- employee # 8] on the floor had listened to her request. As a follow-up the administrator spoke with [name of Resident "B"]. Through further interview, [Resident "B"] stated the QMA had refused her initial request to go to the ER. [Name of Resident "B"] went on to state the QMA said, 'I'm going to close the door, lock you in our room and no one will find you.' Immediate Action Taken: On 04-20-15 per facility policy DON [Director of Nurses] phoned QMA employee #8 alerting her she was suspended pending investigation. An investigation was initiated immediately." "CNA [Certified Nurse Aide employee #9] was present during the aforementioned incident. While having the same description of the event			

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	surrounding the resident fall, CNA [#9] denies that [name of QMA #8] stated 'I'm going to close the door, lock you in your room and no one will find you.' However, subsequent interviews with [family member of the resident] and other employees, reflected that [name of QMA #8] showed a pattern of the QMA not addressing the need of the resident and/or resident request." A review of the Employee time cards on 11-12-15 at 1:00 p.m., and verified by the Business office manager, indicated QMA #8 worked the following dates and times: Thursday 04-16-16 1:55 p.m., until 11:02 p.m. Friday - employee did not work Saturday 04-18-15 6:00 p.m., until 7:00 a.m., on 04-19-15 Sunday 04-19-15 6:19 p.m., until 6:21 a.m., on 04-20-15 A review of the Employee time cards on 11-12-15 at 1:00 p.m., and verified by the Business office manager, indicated CNA #9 worked the following dates and times: Thursday 04-16-16 1:56 p.m., until 9:11 p.m. Friday - employee did not work Saturday 04-18-15 1:27 p.m., until 8:59 p.m. Sunday 04-19-15 1:47 p.m., until 10:00 p.m.			

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	During an interview on 11-12-15 at 2:20 p.m., the Administrator indicated she was not aware of the extent of the incident which occurred on 04-16-15 until 04-20-15 when she read the resident concern report. She indicated CNA # 8 and QMA #9 were not reported to the Registry. A review of the facility policy on 11-12-15 at 10:00 a.m., titled "Abuse Prohibition Reporting and Investigation," and dated 1/2015, indicated the following: Policy: It is the policy of this facility allegations of abuse will be communicated to, and thoroughly investigated by, the correct authority. 1. This facility will not permit residents to be subjected to abuse by anyone, including employees, other residents, consultants, volunteers, staff or personnel of other agencies serving the resident, family members, legal guardians, sponsors, friends or other individuals. ... 3. This facility will report all report incidents, which includes allegations of abuse, immediately to the Long Term Care Division of the State Department of health. ... 8. The facility Administrator is designated as the individual responsible for coordinating all efforts in			

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	investigation of abuse allegations and for assuring that all policies and procedures are followed. 9. The Administrator shall initiate and direct the investigation immediately and the findings of the investigation must be compiled by the Administrator within 5 days of the initials notification of the incident. 10. All reports of abuse must be reported to the Administrator immediately and to the resident's representative (sponsor, legal representative) per policy. ... 14. The Administrator, Director of Nursing, or designee, is responsible to notify the following agencies, as applicable: State Department of Health, Adult Protective Services, Ombudsman and Applicable Licensing Agency. 15. The Administrator is responsible to coordinate the investigation , assure an accurate and complete written record of the incident and investigation, and to file a follow-up report to the State Department of Health." Review of facility policy on 11-12-15 at 10:00 a.m., titled "Abuse Educational Program," and undated indicated the following: "Protecting the Resident from Immediate Danger - If a resident's is in an abusive situation, the resident should be immediately separated from the harmful			

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	situation. You always want to ensure their safety. ... If it is a staff member that is suspected of abusing a resident, the staff member must be immediately suspended pending further investigation of the situation." "Reporting of Abuse - (bold type) Any abuse, suspicions of abuse, unusual observations and unusual circumstances should be reported to your supervisor immediately after removing the resident form the harmful/potential harmful situation. ... The Administrator/Designee is responsible for reporting any abuse or alleged abuse situations to the Indiana State Department of health, Ombudsman, and Adult Protective Services initially within 24 hours of occurrence and a follow-up report should be submitted within 5 business days of occurrence. This State finding relates to Complaint IN00182622.			
R 0144 Bldg. 00	410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. /Based on observation and interview the	R 0144	1. No residents were harmed. The previous water damage was	11/25/2015

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	facility failed to ensure the facility was in a state of good repair when the facility sustained extensive water damage from the air conditioning units. This deficient practice effected 1 of 1 resident room and 1 of 2 common areas observed. (Resident B, and 300 hall) Findings include: During the Initial Tour of the facility on 11-12-15 at 8:45 a.m., with Employee # 1 in attendance, an area in the ceiling, located on the 300 hall, appeared to have paint peeling and discoloration. When interviewed Employee #1 indicated she was unaware of what caused the discoloration in the ceiling. "The maintenance man is here and he will probably know." Employee #1 summoned the Maintenance Supervisor and when interviewed he indicated the facility had problems with the air conditioning units, which were located on "top of the building. The building is old and so is some of the equipment. The air conditioning condensation started leaking into the building. This is damage from the water that came down this hallway." During this observation, the area measured 1 foot in width by 1 1/2 feet in length. When interviewed if any resident's rooms		due to a leaking air conditioner which was replaced on October 21, 2015. Patchwork was in progress, but not completed as this was planned to be completed upon ensuring the leaks were resolved. The damaged drywall was removed and replaced. The discolored area in question was immediately removed and replaced. 2. All residents have the potential to be affected. All rooms are being audited for any housekeeping or maintenance concerns. Any concerns will be addressed immediately. All staff will be in-serviced on November 23, 2015 on the process for completing maintenance request forms. The maintenance request forms will be reviewed by the Administrator or designee and be completed by the maintenance Supervisor or designee. 3. As a measure of ongoing compliance the housekeeping staff will complete an audit to include 10 apartments weekly ongoing, (attachment H) to monitor for environmental concerns ongoing. Any findings will be reported to the Administrator immediately. 4. As a measure of quality assurance the Administrator or designee will review said audits monthly ongoing to ensure any concerns are addressed. Should a deficient practice be noted, immediate corrective action will be taken. The plan of correction will be revised accordingly, if warranted.	

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	were involved the Maintenance Supervisor indicated "no." During an observation on 11-12-15 at 10:00 a.m., and with permission of Resident "B", the resident's bathroom was observed with an area in the ceiling of the shower stall, which was circular and measured 1 1/2 feet in width by 1 1/2 feet in length. The center of this area was black and measured 1 foot width by 1 foot in length and the paint to the surrounding circular area was peeling. The adjacent area of the ceiling was discolored with gray and yellow. During interview on 11-12-15 at 10:15 a.m., Resident "B" indicated she was unsure what happened, but it had been there for awhile. The Maintenance Supervisor was informed of the area area and indicated he was unaware there had been water damage in the resident's room. This State finding relates to Complaint IN00182622.			