

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155388	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/29/2013
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NAME OF PROVIDER OR SUPPLIER CORE OF BEDFORD INC	STREET ADDRESS, CITY, STATE, ZIP CODE 514 E 16TH ST BEDFORD, IN 47421
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F0000	<p>This visit was for a Recertification and State Licensure Survey. This visit resulted in an extended survey-substandard quality of care.</p> <p>Survey date: January 22, 2013 Extended survey dates: January 23, 24, 25, 28, and 29, 2013</p> <p>Facility number: 000370 Provider number: 155388 Aim number: 100290790</p> <p>Survey team: Donna M. Smith, RN-TC Susie Worsham, RN Cheryl Mabry, RN Bobbette Messman, RN Diana McDonald, RN Julie Baumgartner, RN (January 24, 25, 28, and 29, 2013)</p> <p>Census bed type: SNF/NF: 30 Total: 30</p> <p>Census payor type: Medicare: 3 Medicaid: 26 Other: 1 Total: 30</p> <p>These deficiencies reflect state</p>	F0000		

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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	findings cited in accordance with 410 IAC 16.2. Quality Review completed on February 05, 2013; by Kimberly Perigo, RN.				

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F0156 SS=C	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</p>						

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	<p>A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the</p>			

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	<p>individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>A. Based on observations and interviews, the facility failed to ensure posted information for reasonable suspicion of crime, state advocacy groups, State Ombudsman, to file a complaint, and Medicare/Medicaid information were prominently displayed for 2 of 2 days observed. (1/22/13 and 1/28/13)</p> <p>B. Based on interviews and record review, the facility failed to ensure residents would be informed of liability and/or appeal rights for medicare beneficiary residents for 3 of 3 residents reviewed. (Residents 22, 25, and 13)</p> <p>Findings include:</p> <p>A. On 1/22/13 at 9:30 a.m., upon entry to the facility, the</p>	F0156	<p>Policy: It is the policy of this facility to prominently display all required information in the facility. Affected Residents: 30 of 30 Systemic Changes: Facility has re-hung all postings that had been taken down during remodeling. The facility has also added the posters for Elder Justice Act and Reporting Suspicion of Crime. These posters are displayed by the employee time clock. See Attachments: 1A and 1B. Quality Assurance: Maintenance will check monthly to make sure all postings have not been removed ongoing (see attachment 13a). B. It is the policy of this facility to ensure all residents are informed of liability and /or appeal rights for medicare beneficiary residents. Affected Residents: (Residents 22,25 and 13) Systemic Changes: The facility will use a new form called.</p>	02/13/2013			

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	<p>Ombudsman/agency lists were posted in the hallway to the dining room at standing eye level or above only. No other information was presently located. Also, no information for reasonable suspicion of a crime was located at the employee's time clock or other area.</p> <p>On 1/28/13 at 2:30 p.m., the information for Medicare and Medicare information was found in front of the Administrator's office on a window sill, but was located behind a large table with a tall vase with a chair on both sides of the table. The framed information had become visible due to one of the chairs had been moved and was no longer in front of the framed sign. The reasonable suspicion of crime information for the staff was also not found.</p> <p>On 1/23/13 at 11:00 a.m., during an interview the Administrator indicated the CMS (CENTERS for MEDICARE & MEDICAID) memorandum with the "SUBJECT: Reporting Reasonable Suspicion of a Crime in a Long-Term Facility (LTC): Section 1150B of the Social Security Act" as his policy and procedure for reporting reasonable suspicion of crime.</p>		(Notice Of Medicare Provider Non-Coverage)See Attachments (2A and 2B)Quality Assurance: MDS Coordinator will notify family/ responsible party by phone within 2 days prior to notice of Medicare Non-Coverage. Facilities new form requires signature and return to facility. These forms will kept in resident financial file upon receipt of signature.	

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	<p>On 1/28/13 at 2:20 p.m., during an interview the Administrator indicated he was not aware he was suppose to have information for reasonable suspicion of a crime posted for the staff. He also indicated the wall containing the Ombudsman/agency lists should be lowered for better visibility by residents. In addition, the wall had been painted, and the signs were never returned to the wall.</p> <p>B. On 01/28/13 at 2:15 p.m., the Administrator indicated Resident #22 and #25, who resided in the facility, were still on Medicare with over 30 days left. Resident #13 had expired prior to his Medicare end date. Also, he indicated he presently did not and had not had any residents since June, 2012. He indicated he had no information and/or knowledge of her procedure related to the "NOTICE OF MEDICARE PROVIDER NON-COVERAGE" Presently, he indicated the Social Service Designee would send out the "NOTICE OF MEDICARE PROVIDER NON-COVERAGE" letter to the family and understood the letter should be sent to allow 2 days notice. He indicated he did not know how far ahead the letters were sent related to the 2 days notice, due to no information was documented and no</p>						

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	<p>copy of the letter was requested back. He also indicated he did not include information related to the cost if the resident were to change to other pay options.</p> <p>On 01/29/13 at 9:35 a.m., during an interview the Social Service Designee indicated she would mail out the "NOTICE OF MEDICARE PROVIDER NON-COVERAGE" letter but did not request a return of the notice letter to verify the letter was received or document the time the letter was sent.</p> <p>3.1-4(f)(3) 3.1-4(i) 3.1-4(l)(1)</p>				

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F0159 SS=E	<p>483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS</p> <p>Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that</p>			

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	<p>receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>Based on record review and interviews the facility failed to ensure personal funds were available for weekends and failed to informed how personal funds could be obtained on weekends for 9 of 11 residents reviewed for personal funds in a sample of 21 interviewable residents. Resident #24, #32, #22, #29, #19, #9, #8, #18, and #3)</p> <p>Findings include:</p> <p>During an interview with the Administrator on 1-28-13 at 1:30 p.m., he indicated he does not have banking hours posted nor does he have instructions on how to get money on the weekends or nights if a resident wanted or needed money. The Administrator indicated, "everyone knows they can call him and he will come in, I just live 3 minutes from here." The Administrator provided a list of people he would ask every Friday if they would like funds for over the weekend</p>	F0159	<p>Policy: It is the policy of this facility to have personal funds available for residents on weekends and holidays. Affected Residents.#24,#32,#22,#29#19,#9,#8,#18 and #3 Systemic Changes: Facility has placed a cash box at nurses station for residents to sign out money on weekends. Posters have been placed in the facility to inform residents of the funds availability on weekends and holidays. See attachment: 3A Quality Assurance: Facility has implemented posters and announced during the Resident Council Meeting held on 02/13/2013 availability of resident money on the weekends and holidays. The procedure to get money on weekends and holidays will be announced monthly at resident council meeting routinely.</p>	02/28/2013

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	<p>and the list included Resident #9, Resident # 18, Resident #22, Resident #34, Resident #5, Resident #13. The Administrator indicated the residents call him themselves when they would like their funds over the weekend or evenings.</p> <p>On 1/22/13 at 3:49 p.m., during an interview Resident #8 indicated no one was here on the weekends if he wanted money.</p> <p>On 1/22/12 at 2:45 p.m., during an interview Resident #19 indicated she was not able to get money on the weekend.</p> <p>On 1/22/13 at 3:49 p.m., during an interview Resident #24 indicated he could not get money on the weekends or when he wanted it if the Administrator had left.</p> <p>On 1/23/13 at 8:58 a.m., during an interview Resident #9 indicated she could not get money on the weekends.</p> <p>On 1/23/13 at 9:02 a.m., during an interview Resident #22 indicated he could not get money on the weekends.</p> <p>On 1/23/13 at 9:54 a.m., during an</p>						

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	<p>interview Resident #32 indicated she could not get money on the weekends and only when the Administrator was in the facility.</p> <p>On 1/23/13 at 10:18 a.m., during an interview Resident #3 indicated she could not get money on the weekends.</p> <p>On 1/23/13 at 11:25 a.m., during an interview Resident #29 indicated he could not get money on the weekends.</p> <p>On 1/23/13 (no time indicated), during an interview Resident #18 indicated he could not get money on the weekend.</p> <p>3.1-6(f)(1)</p>				

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F0164 SS=E	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>Based on observation and interview the facility failed to provide privacy curtains in 2 of 4 shared hallway bathrooms. This deficiency had the potential to affect 30 of 30 residents residing in the facility. (Southeast bathroom and northeast bathroom)</p>	F0164	<p>It is the policy of this facility to provide privacy curtains in all 4 bathrooms. Affected Residents: 30 of 30 Systemic Changes: Facility will purchase and place shower curtains that are the appropriate length providing adequate privacy of the residents. Quality Assurance: Maintenance will monitor shower curtains to</p>	02/28/2013	

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	<p>Findings include:</p> <p>On 1/28/12 at 10:30 a.m., the environmental tour was conducted with Maintenance employee #18.</p> <p>The northeast bathroom was observed with no privacy curtain around the toilet or tub/shower area. Maintenance employee #18 indicated if the door was opened during care, one could see into the shower or if a resident was on the toilet.</p> <p>The southeast bathroom was observed with the bathtub privacy curtain leaving a 10 inch opening at the end of the tub by the bathroom entry/exit door. Maintenance employee #18 indicated one could see the resident in the bathtub area if the door was opened during care. He also indicated all residents could use either bathrooms.</p> <p>3.1-3(o)</p>		<p>make sure they are in place and provide adequate privacy. Privacy curtain checks will be documented on the the Monthly Maintenance Checklist on an ongoing basis (see attachment 13a).</p>	

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F0224 SS=E	<p>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATION</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interviews and record reviews, the facility failed to ensure residents were free from mental and/or verbal abuse for 3 of 7 residents interviewed for abuse/mistreatment in a sample of 9 resident interviewed related to abuse/mistreatment. (Resident #'s 19, 31, and 33)</p> <p>Findings include:</p> <p>1. The "CORE ABUSE POLICY" was provided by the Director of Nursing (DON) on 1/22/13 at 5:15 p.m. This current policy indicated the following:</p> <p>"POLICY IT IS POLICY OF CORE NURSING AND REHAB TO ACTIVELY SEEK TO IDENTIFY THE SIGNS AND SYMPTOMS OF ABUSE AND NEGLECT AND TO REPORT PROMPTLY AND ALLEGATIONS OF ABUSE AND NEGLECT TO THE STATE OF INDIANA.</p>	F0224	<p>Policy: It is the policy of this facility to implement policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Affected Residents:(Residents #'s 19, 31,and 33) Systemic Changes: Facility will no longer try to determine alleged abuse and instead, will treat all complaints as Alleged Abuse and will report and investigate according to Core of Bedford Abuse Policy and Procedure and state guidelines Quality Assurance: Facility will continue to in-service all staff on Abuse Policy and Procedure. All staff will be in-serviced upon hire of the facility Abuse Policy. Abuse training will be incorporated into all monthly staff in-services ongoing. The Director of Nursing or her designee will review all incidents on a daily basis ongoing.</p>	02/28/2013	

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	<p>PURPOSE TO ENSURE THAT EACH RESIDENT IS FREE OF PHYSICAL, MENTAL, VERBAL, AND SEXUAL ABUSE, CORPORAL PUNISHMENT, MENTAL AND PHYSICAL NEGLECT AND INVOLUNTARY SECULSION (sic).</p> <p>ABUSE IS WILLFUL INFLICTION OF INJURY, UNREASONABLE CONFINEMENT, INTIMINDATION (sic) OR PUNISHMENT (sic) WITH RESULTING PHYSICAL HARM, PAIN OR MENTAL ANGUISH, OR CARETAKER, OF GOODS OR SERVICES THAT ARE NECESSARY TO ATTAIN OR MAINTAIN PHYSICAL, MENTAL AND PSYCHOSOCIAL WELL BEING. THIS PRESUMES THAT INSTANCES OF ABUSE OF ALL RESIDENTS, EVEN THOSE IN A COMA, CAUSE PHYSICAL HARM, PAIN OR MENTAL ANGUISH.</p> <p>DEFINITION ...VERBAL ABUSE:REFERS TO ANY USE OF ORAL, WRITTEN OR GESTURED LANGUAGE THAT INCLUDES DESPARAGING (sic) AND DEROGATORY TERMS TO RESIDENTS OR THEIR FAMILIES OR WITHIN HEARING DISTANCES.</p>				

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	<p>...MENTAL ABUSE: INCLUDES BUT IS NOT LIMITED TO: HUMULATION (sic), HARASSMENT, THREATS OF PUNISHMENT (sic) OR DEPRIVATION.</p> <p>...THIS FACILITY RECONIZES (sic) THAT ABUSE MAY INCLUDE: ...FINANCIAL OR MATERIAL EXPLOITATION VIOLATION OF PERSONAL RIGHTS ...EMOTIONAL ABUSE...</p> <p>PROCEDURE WHEN OBSERVING ALLEGED ABUSE</p> <ol style="list-style-type: none"> 1. INTERVENE-STOP ABUSE IMMEDIATELY 2. MAKE SURE RESIDENT IS OUT OF HARMS WAY 3. REPORT THE ALLEGED ABUSE TO THE UNIT SUPERVISOR IMMEDIATELY AND NOTIFY ADMINISTRATOR AND DON 4. WHOEVER ALLEGED ABUSER IS MUST BE SENT HOME IMMEDIATELY. IF ALLEGED ABUSER IS THE NURSE MUST NOTIFY DON OR ADMINISTRATOR IMMEDIATELY. 5. INVESTIGATION MUST START IMMEDIATELY-STATEMENTS FROM ALL INVOLVED INFORMATION MUST BE SPECIFIC WITH DATE, TIME, LOCATION, WHO WAS INVOLVED AND WHAT 			

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	<p>ALLEGED ABUSE IS-(NO HEAR SAY OR HE SAID, SHE SAID.)...."</p> <p>2. On 1/22/13 at 2:32 p.m., during an interview Resident #19 indicated that she feared the "Boss" and LPN # 9, who is the Social Service Designee/MDS (Minimum Data Set). Presently, Resident #19 indicated they didn't respect or treat her as a person, but would not offer further information, and her face was observed with a grimacing expression.</p> <p>On 1/22/13 at 2:48 p.m., during a second interview Resident #19 indicated she felt fearful. With a grimacing facial expression again observed, she indicated she did not know how to express why she was afraid.</p> <p>On 1/22/13 at 4:15 p.m., during an interview Resident #31 indicated she was concerned about resident #19 due to how CNA #2 treated her on 12/31/12. She indicated she had been awakened by CNA #2 yelling at Resident #19, and when Resident #31 had asked what was going on, she indicated CNA #2 was rude to her. She also indicated Resident #19 was made to go to bed against her</p>			

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	<p>will and was not taken to the bathroom by CNA #2. She indicated Resident #19 was pretty upset and would not get out of bed the next day. In addition, Resident #31 indicated CNA #3 told her CNA #2 was stressed due to she had been working for 25 hours and was going to her other job.</p> <p>On 1/24/13 at 12:15 p.m., during an interview Resident #19 indicated she was also upset because she was afraid of the "Boss" and his wife (LPN #9). She also indicated LPN #9 had made her take 2 big white pills and 2 green/blue pills. She had wanted to know what was the purpose of the pills, but indicated LPN #9 would not let her see or explain the reason for the pills to her. She indicated LPN #9 made her take the pills.</p> <p>On 1/25/13 at 10:12 a.m., during an interview CNA #17 indicated while out with Resident #31 during the smoking time on New Year's Eve, Resident #31 indicated she had an awful night last night due to she was awoken by CNA #2 yelling at resident #19. CNA #17 indicated Resident #19 refused to get out of bed on 1/1/13 for breakfast and lunch and indicated Resident #19 was very withdrawn this same day. CNA #17 indicated she had fed her</p>						

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	<p>lunch in bed because she had refused to get up.</p> <p>On 1/25/13 at 3:19 p.m., during an interview with the Director of Nursing (DON), Resident #19 indicated she was still afraid of LPN #9 and the "Boss" because they would put her out of facility.</p> <p>Resident #19 also indicated LPN #9 made her take pills when she didn't want them. The DON asked the resident if the method of her pill administration by a spoon was the concern due to she usually was given her pills in applesauce, but Resident #19 indicated the method of administration was not the problem because she felt she received the wrong pills. At this same time during an interview, the DON indicated to Resident #19 since it had been several weeks ago when LPN #9 took over passing medications due to RN #12 had become ill, she was unable to determine what pills were given.</p> <p>Resident #19's record was reviewed on 1/25/13 at 10:30 a.m. The diagnoses included, but were not limited to, CVA (cerebral vascular accident) with right hemiparesis. The quarterly MDS (Minimum Data Set)</p>			

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	<p>assessment, dated 10/10/12, indicated the BIMS (Basic Interview Mental Status) score was 5 with a score of 8 to 15 as interviewable. The resident was able to answer the screening questions clearly prior to her resident interview on 1/22/13 at 2:45 p.m.</p> <p>Resident #19 and #31 indicated alleged verbal abuse due to the yelling and rudeness towards the residents as indicated. Resident #19 also indicated alleged mental abuse in the form of being fearful of being "put out of the facility" with the reporting of an incident related to her medications.</p> <p>3. On 1/22/12 at 2:33 p.m., during an interview Resident #33 indicated CNA #4 had "griped" about how many times he had gone to the bathroom, and this had happened about 4 or 5 days ago. He indicated she had said he had gone 3 times already, and he indicated he had only gone to the bathroom once. He also indicated she no longer took care of him now.</p> <p>On 1/22/13 at 5:35 p.m., during an interview the DON indicated Resident #33 did go to the bathroom frequently and every 30 minutes was normal for him. At that same time the DON provided a</p>						

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	<p>"BEHAVIOR/INCIDENT ALERT REPORT" form. The description of the behavior indicated the resident had been requesting to go to the bathroom every 30 minutes and was very irritable calling CNA #4 a b---h. Immediate interventions indicated the resident was given 1 to 1 and placed on 15 minute checks with a urinalysis to be obtained. Also, CNA #4 would not be taking care of the resident for awhile.</p> <p>On 1/25/13 at 8:40 a.m., the Administrator provided a report indicating on 1/22/13 at 7:00 p.m. during an interview conducted by the DON and Administrator, Resident #33 indicated CNA #4 had "talked hateful, and got mad cause she had to take me to the bathroom." The resident indicated he had "felt like he had been abused."</p> <p>Resident #33's record was reviewed on 1/25/13 at 4:00 p.m. The diagnoses included, but were not limited to, Parkinson's disease, bladder cancer, depression, anxiety disorder, and dementia. The quarterly MDS assessment, dated 10/11/12, indicated Resident #33's BIMS (Basic Interview Mental Status) score was 11 with a score of 8 to 15 as interviewable. The resident was indicated as frequently incontinent of bowel and bladder and required extensive</p>			

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	<p>assistance of 1 person for toileting and personal hygiene.</p> <p>The care plan notes, dated 1/17/13, indicated Resident #33 required a toileting schedule to support reduction of incontinent episodes and to allow for plenty of time in bathroom.</p> <p>Resident #33 indicated alleged verbal abuse related to the CNA's response with his request to go to the bathroom.</p> <p>3.1-27(b)</p>			

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F0225 SS=F	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>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.</p> <p>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).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>A. Based on record reviews and</p>	F0225	It is the policy of this facility to	02/28/2013			

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	<p>interviews the facility failed to ensure allegations of abuse/mistreatment and missing money/personal belongings were identified and thoroughly investigated for 3 of 7 residents interviewed in a sample of 9 interviewable residents related to abuse/mistreatment (Resident #'s 19, 31, and 33).</p> <p>B. Based on record reviews and interviews the facility failed to investigate allegation of missing money/personal property for 4 of 4 residents interviewed in a sample of 8 interviewable residents with reported missing money/personal property (Resident #'s 6, 9, 19, and 33).</p> <p>This deficiency had the potential to affect 30 of 30 residents residing in the facility.</p> <p>Findings include:</p> <p>1. The "CORE ABUSE POLICY" was provided by the Director of Nursing (DON) on 1/22/13 at 5:15 p.m. This current policy indicated the following:</p> <p>"POLICY IT IS POLICY OF CORE NURSING AND REHAB TO ACTIVELY SEEK TO IDENTIFY THE SIGNS AND SYMPTOMS OF ABUSE AND</p>		<p>ensure all allegations of abuse/mistreatment and missing money/personal belongings are identified and thoroughly investigated. Affected Residents: Potential to affect 30 of 30 residents. Systemic Changes: Facility has implemented new policy and procedures for resident money and personal property. Included in this policy it directs family members to check in to the facility belongings that will be included in the resident inventory (see attachment 12a and 12b) The facility is mailing out letters to all families to notify them of the money and personal property facility policy (See attachment: 5A) Residents that refuse to allow facility to keep money secured will sign a waiver explaining the facility can not be responsible for lost of misplaced money. (See attachment: 5B) Quality Assurance: The facility will investigate and report all incidents of lost money and personal property to ISDH. Staff inservicing on a monthly basis on abuse. This will improve the facility ability to identify alleged abuse and staffs ability to report to administrator.</p>				

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	<p>NEGLECT AND TO REPORT PROMPTLY AND ALLEGATIONS OF ABUSE AND NEGLECT TO THE STATE OF INDIANA.</p> <p>PURPOSE TO ENSURE THAT EACH RESIDENT IS FREE OF PHYSICAL, MENTAL, VERBAL, AND SEXUAL ABUSE, CORPORAL PUNISHMENT, MENTAL AND PHYSICAL NEGLECT AND INVOLUNTARY SECULSION (sic).</p> <p>ABUSE IS WILLFUL INFLECTION OF INJURY, UNREASONABLE CONFINEMENT, INTIMINDATION (sic) OR PUSHIMENT (sic) WITH RESULTING PHYSICAL HARM, PAIN OR MENTAL ANGUISH, OR CARETAKER, OF GOODS OR SERVICES THAT ARE NECESSARY TO ATTAIN OR MAINTAIN PHYSICAL, MENTAL AND PSYCHOSOCIAL WELL BEING. THIS PRESUMES THAT INSTANCES OF ABUSE OF ALL RESIDENTS, EVEN THOSE IN A COMA, CAUSE PHYSICAL HARM, PAIN OR MENTAL ANGUISH.</p> <p>DEFINITION ...VERBAL ABUSE:REFERS TO ANY USE OF ORAL, WRITTEN OR GESTURED LANGUAGE THAT</p>				

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	<p>INCLUDES DESPARAGING (sic) AND DEROGATORY TERMS TO RESIDENTS OR THEIR FAMILIES OR WITHIN HEARING DISTANCES.</p> <p>...MENTAL ABUSE: INCLUDES BUT IS NOT LIMITED TO :HUMULIATION (sic), HARASSMENT, THREATS OF PUNSHIMENT (sic) OR DEPRIVATION.</p> <p>...MISAPPROPRIATION OF PROPERTY: DEFINED AS THE PATTERNED (sic) OR DELIBERATE MISPLACEMENT, EXPLOITATION OR WRONGFUL TEMPORARY OR PERMANENT USE OF A RESIDENT'S BELONGINGS OR MONEY WITH THE RESIDENT'S CONSENT.</p> <p>THIS FACILITY RECONIZES (sic) THAT ABUSE MAY INCLUDE: ...FINANCIAL OR MATERIAL EXPLOITATION VIOLATION OF PERSONAL RIGHTS ...EMOTIONAL ABUSE...</p> <p>PROCEDURE WHEN OBSERVING ALLEGED ABUSE 1. INTERVENE-STOP ABUSE IMMEDIATELY 2. MAKE SURE RESIDENT IS OUT OF HARMS WAY 3. REPORT THE ALLEGED ABUSE</p>			

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	<p>TO THE UNIT SUPERVISOR IMMEDIATELY AND NOTIFY ADMINISTRATOR AND DON</p> <p>4. WHOEVER ALLEGED ABUSER IS MUST BE SENT HOME IMMEDIATELY. IF ALLEGED ABUSER IS THE NURSE MUST NOTIFY DON OR ADMINISTRATOR IMMEDIATELY.</p> <p>5. INVESTIGATION MUST START IMMEDIATELY-STATEMENTS FROM ALL INVOLVED INFORMATION MUST BE SPECIFIC WITH DATE, TIME, LOCATION, WHO WAS INVOLVED AND WHAT ALLEGED ABUSE IS-(NO HEAR SAY OR HE SAID, SHE SAID.)</p> <p>PROCEDURE FOR FACILITY ADMINISTRATION: THE FACILITY MUST: ...2. REPORT BY TELEPHONE ANY ALLEGED ABUSE TO THE STATE OF INDIANA WITHIN 24 HOURS 3. INVESTIGATE THE ALLEGATION 4. WITHIN 5 WORKING DAYS,REPORT THE FINDINGS OF THE INVESTIGATION IN WRITING.</p> <p>PROCEDURE FOR PREVENTION 1. INSERVICES 2. MONITORING QUALITY ASSURANCE 3. MONITORING INCIDENT AND ACCIDENT REPORTS</p>						

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	<p>4. DEAL ONE ON ONE WITH STAFF DISPLAYING SIGNS AND SYMPTOMS OF IMPATIENCE, HURRIEDNESS, ECT."</p> <p>A. 2. On 1/22/13 at 2:32 p.m., during an interview Resident #19 indicated that she feared the "Boss" and LPN # 9, who is the Social Service Designee/MDS (Minimum Data Set). Presently, Resident #19 indicated they didn't respect or treat her as a person, but would not offer further information, and her face was observed with a grimacing expression.</p> <p>On 1/22/13 at 2:48 p.m., during a second interview Resident #19 indicated she felt fearful. With a grimacing facial expression again observed, she indicated she did not know how to express why she was afraid.</p> <p>On 1/22/13 at 4:15 p.m., during an interview Resident #31 indicated she was concerned about resident #19 due to how CNA #2 treated her on 12/31/12. She indicated she had been awakened by CNA #2 yelling at Resident #19, and when Resident #31 had asked what was going on,</p>			

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NAME OF PROVIDER OR SUPPLIER CORE OF BEDFORD INC	STREET ADDRESS, CITY, STATE, ZIP CODE 514 E 16TH ST BEDFORD, IN 47421
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	<p>she indicated CNA #2 was rude to her. She also indicated Resident #19 was made to go to bed against her will and was not taken to the bathroom by CNA #2. She indicated Resident #19 was pretty upset and would not get out of bed the next day. In addition, Resident #31 indicated CNA #3 told her CNA #2 was stressed due to she had been working for 25 hours and was going to her other job.</p> <p>On 1/22/13 at 5:25 p.m., during an interview the Director of Nursing (DON) indicated she did not consider Resident #19's incident as verbal abuse as the resident reported to her the next day she was having no problems, but she had inserviced the staff related to this incident. This was not reported to the Indiana Department of Health as indicated by the facility's abuse policy and procedure.</p> <p>On 1/24/13 at 12:15 p.m., during an interview Resident #19 indicated she was upset because she was afraid of the "Boss" and his wife (LPN #9). She also indicated LPN #9 had made her take 2 big white pills and 2 green/blue pills. She had wanted to know what was the purpose of the pills, but indicated LPN #9 would not</p>			

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	<p>let her see or explain the reason for the pills to her. She indicated LPN #9 made her take the pills.</p> <p>On 1/25/13 at 10:12 a.m., during an interview CNA #17 indicated while out with Resident #31 during the smoking time on New Year's Eve, Resident #31 indicated she had an awful night last night due to she was awoken by CNA #2 yelling at resident #19. CNA #17 indicated Resident #19 refused to get out of bed on 1/1/13 for breakfast and lunch and indicated Resident #19 was very withdrawn this same day. CNA #17 indicated she had fed her lunch in bed because she had refused to get up.</p> <p>On 1/25/13 at 3:19 p.m., during an interview with the Director of Nursing (DON), Resident #19 indicated she was still afraid of LPN #9 and the "Boss" because they would put her out of facility.</p> <p>Resident #19 also indicated LPN #9 made her take pills when she didn't want them. The DON asked the resident if the method of her pill administration by a spoon was the concern due to she usually was given her pills in applesauce, but Resident #19 indicated the method of administration was not the problem</p>			

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	<p>because she felt she received the wrong pills. At this same time during an interview, the DON indicated to Resident #19 since it had been several weeks ago when LPN #9 took over passing medications due to RN #12 had become ill, she was unable to determine what pills were given.</p> <p>On 1/25/13 at 4:50 p.m., during an interview LPN #1 indicated she felt Resident #19 was sad on New Year's Day, and she told her the next time someone upsets her to be sure and tell her.</p> <p>On 1/22/13 at 5:35 p.m., the DON provided her investigation related to Resident #19's incident on 12/31/12 and 1/1/13. This investigation indicated the following:</p> <p>On 1/1/13 at 12:30 a.m., a report was received from LPN #1 overhearing CNA #2 "speaking inappropriately" to Resident #19 on the previous night shift. Resident #19 indicated she felt the aide "was communication in an inappropriate way that should be handled." Resident #19's roommate, who is Resident #21, indicated she was awoken by yelling. Resident #21 indicated she heard CNA #2 tell Resident #19 "I don't have time for</p>			

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	<p>this..." Resident #21 indicated when she asked what was going on, "she was rude even to me" and felt CNA #2 "was being unnecessarily (sic) loud and obnoxious." CNA #3 came in the room later and indicated to Resident #21 CNA #2 was "just too stressed from working two jobs."</p> <p>On 1/4/13 (no time indicated) - another meeting was indicated with the residents (Resident #19 and #21) and the Administrator and DON "to discuss concern brought to our attention from 1/1/13 3 am." Resident #19 indicated the CNA involved should not loose her job as a result of the "alleged incident on 1/1/13 3 am." Resident #21 indicated she heard loud voices and had a concern regarding Resident #19. All three staff members involved would have 1:1 training regarding communication and resident rights with the DON.</p> <p>On 1/23/13 at 4:30 p.m., CNA #2's time card was provided by the Administrator. At this same time during an interview, the Administrator indicated CNA #2 worked her scheduled shift 12/31/12 at 5:00 p.m. to 1/1/13 at 5:00 a.m. The CNA was not sent immediately home pending the completion of the investigation per facility's abuse policy and procedure.</p>						

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	<p>Resident #19's record was reviewed on 1/25/13 at 10:30 a.m. The diagnoses included, but were not limited to, CVA (cerebral vascular accident) with right hemiparesis. The quarterly MDS (Minimum Data Set) assessment, dated 10/10/12, indicated the BIMS (Basic Interview Mental Status) score was 5 with a score of 8 to 15 as interviewable.</p> <p>Resident #31's record was reviewed on 1/25/13 at 1:00 p.m. The quarterly MDS assessment, dated 12/27/12, indicated the BIMS score was 14 with a score of 8 to 15 as interviewable.</p> <p>Resident #19 and #31 indicated allegations of verbal abuse due to the yelling and rudeness towards them as indicated. Resident #19 also indicated alleged mental abuse in the form of being fearful of being "put out of the facility" with the reporting of an incident related to her medications.</p> <p>A. 3. On 1/22/12 at 2:33 p.m., during an interview Resident #33 indicated CNA #4 had "griped" about how many times he had gone to the bathroom and happened about 4 or 5 days ago. He indicated she had said he had gone 3 times already, and he indicated he had only gone to the</p>						

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	<p>bathroom once. He also indicated she no longer took care of him now.</p> <p>On 1/22/13 at 5:35 p.m., during an interview the DON indicated Resident #33 did go to the bathroom frequently and every 30 minutes was normal for him. At this same time the DON provided a "BEHAVIOR/INCIDENT ALERT REPORT" form. The description of the behavior indicated the resident had been requesting to go to the bathroom every 30 minutes and was very irritable calling the CNA a b---h. Immediate interventions indicated the resident was given 1 to 1 and placed on 15 minute checks with a urinalysis to be obtained. Also, the CNA would not be taking care of the resident for awhile.</p> <p>On 1/25/13 at 8:40 a.m., the Administrator provided a report indicating on 1/22/13 at 7:00 p.m. during an interview conducted by the DON and Administrator, Resident #33 indicated CNA #4 had "talked hateful, and got mad cause she had to take me to the bathroom." The resident indicated he had "felt like he had been abused."</p> <p>On 1/23/12 at 4:30 p.m., during an interview the Administrator indicated CNA #4 had worked from 6:00 a.m. to</p>						

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	<p>8:00 a.m. this morning. At this same time during an interview, the DON indicated she had not called the CNA to inform her she was suspended due to it was 10 to 11 p.m. last night and CNA #4 was not scheduled to work. The DON indicated CNA #4 had switched days with another CNA which resulted in her at work this a.m. but was sent home as soon as the facility realized she was working due to the pending investigation.</p> <p>CNA #4 worked 2 hours on 1/24/13 although the investigation had not been completed per facility's abuse policy and procedure. Also, Resident #33's allegation of verbal abuse was not identified and/or thoroughly investigated.</p> <p>Resident #33's record was reviewed on 1/25/13 at 4:00 p.m. The diagnoses included, but were not limited to, Parkinson's disease, bladder cancer, depression, anxiety disorder, and dementia. The quarterly MDS assessment, dated 10/11/12, indicated Resident #33's BIMS (Basic Interview Mental Status) score was 11 with a score of 8 to 15 as interviewable. The resident was indicated as frequently incontinent of bowel and bladder and required extensive assistance of 1 person for</p>				

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	<p>toileting and personal hygiene.</p> <p>B. 4. On 1/22/13 at 2:37 p.m., during an interview Resident #33 indicated about 3 weeks ago he reported he was missing \$46.00 and was still missing this money from his Bible.</p> <p>On 1/22/13 at 2:53 p.m., during an interview Resident #19 indicated she had been missing tapes from months ago and sunglasses from weeks ago. She indicated she had reported the missing items to a male employee but could not remember the name. She indicated the personal property was still missing.</p> <p>On 1/22/13 at 3:55 p.m., during an interview Resident #6 indicated he had lost \$3.00 and then, \$6.00 for a total of \$9.00. He indicated he had reported the money lost, and the money was replaced at the last Resident Council meeting.</p> <p>On 1/23/13 at 9:10 a.m., during an interview Resident #9 indicated she had lost \$9.00 and then \$8.50 one month ago and had reported the lost money to the staff.</p> <p>The Resident Council minutes, dated 1/9/13, indicated Resident #9's money of \$9.00 was replaced and</p>						

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	<p>Resident #33's amount of \$46.00 was again reported in this meeting.</p> <p>On 1/23/13 at 9:10 a.m., during an interview the Administrator indicated when he had reported money missing, he would just replace it. He indicated he did not investigate or report the missing money per facility's policy and procedure.</p> <p>3.1-28(c) 3.1-28(d)</p>				

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F0226 SS=F	<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 record reviews and interviews the facility failed to follow their abuse policy related to investigating, reporting, and suspension of involved employees during the investigation period for 5 of 9 interviewed residents in a sample of 21 interviewable residents interviewed (Resident #'s 6, 9, 19, 31, and 33). This deficiency had the potential to affect 30 of 30 residents residing in the facility.</p> <p>Findings include:</p> <p>1. The "CORE ABUSE POLICY" was provided by the Director of Nursing (DON) on 1/22/13 at 5:15 p.m. This current policy indicated the following:</p> <p>"POLICY IT IS POLICY OF CORE NURSING AND REHAB TO ACTIVELY SEEK TO IDENTIFY THE SIGNS AND SYMPTOMS OF ABUSE AND NEGLECT AND TO REPORT PROMPTLY AND ALLEGATIONS OF ABUSE AND NEGLECT TO THE</p>	F0226	<p>It is the Policy of this facility to implement policies and procedures that prohibit mistreatment, neglect, and abuse of residents, and missappropriation of resident property. Affected Residents: (Resident #6, 9, 19, 31, and 33) Potential 30 of 30 residents Systemic Changes: The facility will no longer try to determine alleged abuse. The facility is going to treat all complaints as alleged abuse and will report and investigate according to Core of Bedford Abuse Policy and Procedure and state guidelines. Quality Assurance: Facility will continue to in-service all staff on the Abuse Policy and Procedure. The Director of Nursing or designee will review all incident reports and behavioral alert reports on a daily basis ongoing. All staff will be in-serviced upon hire, and on a monthly basis. This will be ongoing.</p>	02/28/2013	

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	<p>STATE OF INDIANA.</p> <p>PURPOSE TO ENSURE THAT EACH RESIDENT IS FREE OF PHYSICAL, MENTAL, VERBAL, AND SEXUAL ABUSE, CORPORAL PUNISHMENT, MENTAL AND PHYSICAL NEGLECT AND INVOLUNTARY SECULSION (sic).</p> <p>ABUSE IS WILLFUL INFLICTION OF INJURY, UNREASONABLE CONFINEMENT, INTIMINDATION (sic) OR PUSHIMENT (sic) WITH RESULTING PHYSICAL HARM, PAIN OR MENTAL ANGUISH, OR CARETAKER, OF GOODS OR SERVICES THAT ARE NECESSARY TO ATTAIN OR MAINTAIN PHYSICAL, MENTAL AND PSYCHOSOCIAL WELL BEING. THIS PRESUMES THAT INSTANCES OF ABUSE OF ALL RESIDENTS, EVEN THOSE IN A COMA, CAUSE PHYSICAL HARM, PAIN OR MENTAL ANGUISH.</p> <p>DEFINITION ...VERBAL ABUSE:REFERS TO ANY USE OF ORAL, WRITTEN OR GESTURED LANGUAGE THAT INCLUDES DESPARAGING (sic) AND DEROGATORY TERMS TO RESIDENTS OR THEIR FAMILIES</p>			

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	<p>OR WITHIN HEARING DISTANCES.</p> <p>...MENTAL ABUSE: INCLUDES BUT IS NOT LIMITED TO :HUMULIATION (sic), HARASSMENT, THREATS OF PUNSHMENT (sic) OR DEPRIVATION.</p> <p>...MISAPPROPRIATION OF PROPERTY: DEFINED AS THE PATTERNED (sic) OR DELIBERATE MISPLACEMENT, EXPLOITATION OR WRONGFUL TEMPORARY OR PERMANENT USE OF A RESIDENT'S BELONGINGS OR MONEY WITH THE RESIDENT'S CONSENT.</p> <p>THIS FACILITY RECONIZES (sic) THAT ABUSE MAY INCLUDE: ...FINANCIAL OR MATERIAL EXPLOITATION VIOLATION OF PERSONAL RIGHTS ...EMOTIONAL ABUSE...</p> <p>PROCEDURE WHEN OBSERVING ALLEGED ABUSE 1. INTERVENE-STOP ABUSE IMMEDIATELY 2. MAKE SURE RESIDENT IS OUT OF HARMS WAY 3. REPORT THE ALLEGED ABUSE TO THE UNIT SUPERVISOR IMMEDIATELY AND NOTIFY ADMINISTRATOR AND DON</p>			

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	<p>4. WHOEVER ALLEGED ABUSER IS MUST BE SENT HOME IMMEDIATELY. IF ALLEGED ABUSER IS THE NURSE MUST NOTIFY DON OR ADMINISTRATOR IMMEDIATELY.</p> <p>5. INVESTIGATION MUST START IMMEDIATELY-STATEMENTS FROM ALL INVOLVED INFORMATION MUST BE SPECIFIC WITH DATE, TIME, LOCATION, WHO WAS INVOLVED AND WHAT ALLEGED ABUSE IS-(NO HEAR SAY OR HE SAID, SHE SAID.)</p> <p>PROCEDURE FOR FACILITY ADMINISTRATION: THE FACILITY MUST: ... 3. INVESTIGATE THE ALLEGATION 4. WITHIN 5 WORKING DAYS,REPORT THE FINDINGS OF THE INVESTIGATION IN WRITING.</p> <p>PROCEDURE FOR PREVENTION 1. INSERVICES 2. MONITORING QUALITY ASSURANCE 3. MONITORING INCIDENT AND ACCIDENT REPORTS 4. DEAL ONE ON ONE WITH STAFF DISPLAYING SIGNS AND SYMPTOMS OF IMPATIENCE,HURRIEDNESS, ECT.</p>				

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	<p>Resident #19 was pretty upset and would not get out of bed the next day. In addition, Resident #31 indicated CNA #3 told her CNA #2 was stressed due to she had been working for 25 hours and was going to her other job.</p> <p>On 1/22/13 at 5:25 p.m., during an interview the Director of Nursing (DON) indicated she did not consider Resident #19's incident as verbal abuse as the resident reported to her the next day she was having no problems, but she had inserviced the staff related to this incident. This was not reported to the Indiana Department of Health per the facility's policy and procedure.</p> <p>On 1/24/13 at 12:15 p.m., during an interview Resident #19 indicated she was upset because she was afraid of the "Boss" and his wife (LPN #9). She also indicated LPN #9 had made her take 2 big white pills and 2 green/blue pills. She had wanted to know what was the purpose of the pills, but indicated LPN #9 would not let her see or explain the reason for the pills to her. She indicated LPN #9 made her take the pills.</p> <p>On 1/25/13 at 10:12 a.m., during an interview CNA #17 indicated while out</p>			

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	<p>with Resident #31 during the smoking time on New Year's Eve, Resident #31 indicated she had an awful night last night due to she was awoken by CNA #2 yelling at resident #19. CNA #17 indicated Resident #19 refused to get out of bed on 1/1/13 for breakfast and lunch and indicated Resident #19 was very withdrawn this same day. CNA #17 indicated she had fed her lunch in bed because she had refused to get up.</p> <p>On 1/25/13 at 3:19 p.m., during an interview with the Director of Nursing (DON), Resident #19 indicated she was still afraid of LPN #9 and the "Boss" because they would put her out of facility.</p> <p>Resident #19 also indicated LPN #9 made her take pills when she didn't want them. The DON asked the resident if the method of her pill administration by a spoon was the concern due to she usually was given her pills in applesauce, but Resident #19 indicated the method of administration was not the problem because she felt she received the wrong pills. At this same time during an interview, the DON indicated to Resident #19 since it had been several weeks ago when LPN #9 took over passing medications due to RN</p>			

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	<p>#12 had become ill, she was unable to determine what pills were given.</p> <p>On 1/25/13 at 4:50 p.m., during an interview LPN #1 indicated she felt Resident #19 was sad on New Year's Day, and she told her the next time someone upsets her to be sure and tell her.</p> <p>On 1/22/13 at 5:35 p.m., the DON provided her investigation related to Resident #19's incident on 12/31/12 and 1/1/13. This investigation indicated the following:</p> <p>On 1/1/13 at 12:30 a.m., a report was received from LPN #1 overhearing CNA #2 "speaking inappropriately" to Resident #19 on the previous night shift. Resident #19 indicated she felt the aide "was communication in an inappropriate way that should be handled." Resident #19's roommate, who is Resident #21, indicated she was awoken by yelling. Resident #21 indicated she heard CNA #2 tell Resident #19 "I don't have time for this..." Resident #21 indicated when she asked what was going on, "she was rude even to me" and felt CNA #2 "was being unnecessarily (sic) loud and obnoxious." CNA #3 came in the room later and indicated to</p>			

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	<p>Resident #21 CNA #2 was "just too stressed from working two jobs."</p> <p>On 1/4/13 (no time indicated) - another meeting was indicated with the residents (Resident #19 and #21) and the Administrator and DON "to discuss concern brought to our attention from 1/1/13 3 am." Resident #19 indicated the CNA involved should not loose her job as a result of the "alleged incident on 1/1/13 3 am." Resident #21 indicated she heard loud voices and had a concern regarding Resident #19. All three staff members involved would have 1:1 training regarding communication and resident rights with the DON.</p> <p>On 1/23/13 at 4:30 p.m., CNA #2's time card was provided by the Administrator. At this same time during an interview, the Administrator indicated CNA #2 worked her scheduled shift 12/31/12 at 5:00 p.m. to 1/1/13 at 5:00 a.m. CNA #2 was not immediately sent home related to the alleged verbal abuse per the facility's abuse policy and procedure.</p> <p>Resident #19 and #31 indicated allegations of verbal abuse due to the yelling and rudeness towards them as indicated. Resident #19 also indicated alleged mental abuse in the</p>				

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	<p>form of being fearful of being "put out of the facility" with the reporting of an incident related to her medications.</p> <p>Resident #19's record was reviewed on 1/25/13 at 10:30 a.m. The diagnoses included, but were not limited to, CVA (cerebral vascular accident) with right hemiparesis. The quarterly MDS (Minimum Data Set) assessment, dated 10/10/12, indicated the BIMS (Basic Interview Mental Status) score was 5 with a score of 8 to 15 as interviewable.</p> <p>Resident #31's record was reviewed on 1/25/13 at 1:00 p.m. The quarterly MDS assessment, dated 12/27/12, indicated the BIMS (Basic Interview Mental Status) score was 14 with a score of 8 to 15 as interviewable.</p> <p>3. On 1/22/12 at 2:33 p.m., during an interview Resident #33 indicated CNA #4 had "griped" about how many times he had gone to the bathroom and happened about 4 or 5 days ago. He indicated she had said he had gone 3 times already, and he indicated he had only gone to the bathroom once. He also indicated she no longer took care of him now.</p> <p>On 1/22/13 at 5:35 p.m., during an interview the DON indicated Resident</p>			

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	<p>#33 did go to the bathroom frequently and every 30 minutes was normal for him. At this same time the DON provided a "BEHAVIOR/INCIDENT ALERT REPORT" form. The description of the behavior indicated the resident had been requesting to go to the bathroom every 30 minutes and was very irritable calling the CNA a b---h. Immediate interventions indicated the resident was given 1 to 1 and placed on 15 minute checks with a urinalysis to be obtained. Also, the CNA would not be taking care of the resident for awhile.</p> <p>On 1/25/13 at 8:40 a.m., the Administrator provided a report indicating on 1/22/13 at 7:00 p.m. during an interview conducted by the DON and Administrator, Resident #33 indicated CNA #4 had "talked hateful, and got mad cause she had to take me to the bathroom." The resident indicated he had "felt like he had been abused."</p> <p>On 1/23/12 at 4:30 p.m., during an interview the Administrator indicated CNA #4 had worked from 6:00 a.m. to 8:00 a.m. this morning. At this same time during an interview, the DON indicated she had not called the CNA to inform her she was suspended due to it was 10 to 11 p.m. last night and</p>						

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	<p>CNA #4 was not scheduled to work. The DON indicated CNA #4 had switched days with another CNA which resulted in her at work this a.m. but was sent home as soon as the facility realized she was working due to the pending investigation.</p> <p>CNA #4 worked 2 hours on 1/24/13 although the investigation had not been completed per facility's abuse policy and procedure. Also, Resident #33's allegation of verbal abuse was not identified and/or thoroughly investigated.</p> <p>Resident #33's record was reviewed on 1/25/13 at 4:00 p.m. The diagnoses included, but were not limited to, Parkinson's disease, bladder cancer, depression, anxiety disorder, and dementia. The quarterly MDS assessment, dated 10/11/12, indicated Resident #33's BIMS (Basic Interview Mental Status) score was 11 with a score of 8 to 15 as interviewable. The resident was indicated as frequently incontinent of bowel and bladder and required extensive assistance of 1 person for toileting and personal hygiene.</p> <p>4. On 1/22/13 at 2:37 p.m., during an interview Resident #33 indicated about 3 weeks ago he reported he</p>			

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	<p>was missing \$46.00 and was still missing this money from his Bible.</p> <p>On 1/22/13 at 2:53 p.m., during an interview Resident #19 indicated she had been missing tapes from months ago and sunglasses from weeks ago. She indicated she had reported the missing items to a male employee but could not remember the name. She indicated the personal property was still missing.</p> <p>On 1/22/13 at 3:55 p.m., during an interview Resident #6 indicated he had lost \$3.00 and then, \$6.00 for a total of \$9.00. He indicated he had reported the money lost, and the money was replaced at the last Resident Council meeting.</p> <p>On 1/23/13 at 9:10 a.m., during an interview Resident #9 indicated she had lost \$9.00 and then \$8.50 one month ago and had reported the lost money to the staff.</p> <p>The Resident Council minutes, dated 1/9/13, indicated Resident #9's money of \$9.00 was replaced and Resident #33's amount of \$46.00 was again reported in this meeting.</p> <p>On 1/23/13 at 9:10 a.m., during an interview the Administrator indicated</p>						

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	<p>when he had reported money missing, he would just replace it. He indicated he did not investigate or report the missing money per the facility's policy and procedure.</p> <p>3.1-28(a)</p>				

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F0280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on record review and interview the facility failed to ensure a family member was notified and/or made aware of the scheduled health care plan meeting to attend for 1 of 3 families interviewed. (Resident #4)</p> <p>Findings include:</p> <p>On 1/25/13 at 12:39 p.m., during an interview Resident #4's husband indicated he had never been informed when care planning meetings were scheduled.</p> <p>Resident #4's record was reviewed on</p>	F0280	<p>It is the policy of this facility to notify and record invitation of family members to each residents care plan conference. Systemic Changes: A Notice of Care Plan Conference letter (see attachment 7) will be sent or phone call made to the family member or responsible individual by the Social Service Director. The letter or phone call will provide the date and time for the Care Plan Conference. The Social Service Director will maintain an ongoing calendar of scheduled Care Plan Conference and identify if the family member or responsible party for the resident will be attending the conference. Mailing</p>	02/28/2013	

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	<p>1/24/13 at 4:20 p.m. The Social Service notes did not indicate any information related to the husband attending any care meetings. The "CARE CONFERENCE SUMMARY," dated 12/13/12, 9/13/12, 6/14/12, and 3/22/12, indicated Resident #4's responsible party was invited and did not attend on each of these specified dates.</p> <p>On 1/25/13 at 1:35 p.m., during a phone interview LPN #9, who was also the Social Service /MDS coordinator, indicated the care plan facesheet is where attendees for care conference are listed. She also indicated she only would invite family members, who were involved in care of the residents, via phone but did not have/keep a record of who, when, or where the care plan was scheduled.</p> <p>3.1-35(d)(2)(B)</p>		<p>the notification of the Care Plan Conference will be done Quarterly or with and significant change in residents condition and will be documented in the Social Service Notes of the resident's clinical record. Quality Assurance: The Director of Nursing will be responsible for monitoring the notification and documentation of scheduled Care Plan Conferences on a weekly basis ongoing.</p>		

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F0282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview the facility failed to ensure the health care plan interventions were followed related to nail care for 1 of 3 residents reviewed for Activities of Daily Living in a sample of 8 and to ensure the physician's orders for a laboratory test and bowel protocol were followed for 1 of 10 residents residents reviewed for unnecessary medications. (Resident #19)</p> <p>Findings include:</p> <p>1. On 1/22/13 at 11:43 a.m., Resident #19's fingernails were observed with a dark substance underneath her nails. On 1/28/13 at 11:09 a.m., Resident #19's fingernails were again observed with dark substance underneath her nails. At this same time during an interview, LPN #1 indicated Resident #19 will only let CNA #4 do her fingernails, but she was going to attempt to clean them today.</p> <p>On 1/25/13 at 10:35 a.m., Resident #19's care plan, originally dated</p>	F0282	<p>Policy: It is the policy of this facility to provide Care Plans that directs the care of the resident to ensure all health and well-being needs are met. Affected resident: #19 Systemic Changes: Nail Care is performed by direct care staff during showers. Shower reports (see attachment 4a) are completed by nurse aides at each shower. Nail care is documented at this time. In the event a resident refuses nail care the nurse aide will document the refusal on the shower report. The Shower report is reviewed by the charge nurse before the end of shift. Once the charge nurse observes the refusal he/she will meet with the resident to obtain information regarding the refusal and provide patient education accordingly. Documentation of the incident and the patient education and or interventions will be done at this this time by the charge nurse in the resident's record. Quality Assurance: Shower reports are forwarded to and reviewed by the Director of Nursing daily. The Director of Nursing coordinates with the Social Service Director a plan for interventions to resolve the refusal of care. The problem is</p>	02/28/2013	

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	<p>4/1/11 and updated 1/17/13, indicated the resident's nails should be cleaned and trimmed.</p> <p>2. Resident #19's record was reviewed on 1/25/13 at 10:45 a.m. The resident's diagnoses included, but were not limited to, diabetic mellitus and Cerebral Vascular Accident (CVA) with hemiplegia.</p> <p>The physician's order dated 4/12/12, was to obtain a Hemoglobin A1C (diabetic blood test) with the next laboratory day.</p> <p>The physician's order dated 11/26/12, indicated to follow the bowel protocol. This bowel protocol was if no BM (bowel movement) in 3 days, give 4 oz (ounce) of prune juice & Milk of Magnesium 30 ml (milliliter) po (by mouth) prn (as needed); if no results in 8 hours, give Docolax suppository rectally prn; if no results in 4 hours give soap suds enema, and if no results after enema, call Nurse Practitioner/Medical Doctor.</p> <p>The resident's bowel movement (BM) indicated no bowel movement from 11/27/12 through 11/29/12, 12/14/12 through 12/17/12, 12/23/12 through 12/26/12, 12/28/12 through 12/30/12, and 1/24/13 through 1/27/13. No</p>		<p>identified in the Care Plan with interventions to direct care and ensure the resident's needs are being met. Policy: It is the policy of this facility to ensure that laboratory services are provided by qualified persons in accordance with each resident's care plan. Affected resident #19 Systemic Changes: A policy and procedure was developed to outline the procedure for obtaining laboratory services on 2/14/13 (see attachment 4b). Nursing staff will be in-serviced regarding the policy and procedure. Quality Assurance: Upon admission and as needed the Medical director or Nurse Practitioner will review each resident's record of medications, previous labs (if provided), and health history. The Medical Director or Nurse Practitioner will provide orders for laboratory services upon admission as needed. Orders will be transcribed and services coordinated by the facility charge nurse. (see attachment 4c) The DON performs weekly audits of the Lab Monitoring Tool to ensure initiation and completion of lab services per doctors orders. Policy: It is the policy of this facility to ensure that each resident's doctor's orders for bowel protocol are followed. Affected resident #19 Systemic changes: A policy and procedure was developed for following the Bowel Protocol and</p>		

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	<p>information was indicated related to any medications/interventions were completed.</p> <p>On 1/29/13 at 10:00 a.m., during an interview RN #12 indicated the bowel protocol was if no bowel movement in 3 days, the resident was to be given Milk of Magnesium (laxative) with prune juice; then, if no bowel movement in 8 hours, Ducolax suppository (laxative) was to be given. She also indicated Resident #19 did have an order for Miralax (laxative) daily for constipation.</p> <p>3. On 1/29/13 at 9:36 a.m., during an interview the Director of Nursing indicated the facility followed the physician's orders for laboratory tests (labs). She also indicated the facility did not have a policy or procedure in obtaining labs.</p> <p>On 1/29/13 at 10:25 a.m., during an interview the Director of Nursing and LPN #9 indicated Resident #19's last Hgb A1C was last ordered on 4/12/12. No results were found with a HGB (Hemoglobin) laboratory result was indicated. The physician's progress notes dated April 10, 2012, indicated no results were found for the Hgb A1C.</p>		<p>bowel activity. (see attachment 4d) Quality Assurance: Staff performing personal care for the residents who are total care or assisted for toileting will document the bowel movements on the resident ADL record by the end of the aides shift. The aide will notify the charge nurse in the event of a bowel movement at the earliest possible opportunity or before the end of the shift. The charge nurse will document the bowel movement in the resident's medication record at the entry for the bowel protocol. The charge nurse will review the bowel management entries of the MAR each shift to identify the need for implementation of the bowel protocol per doctor's orders. The bowel protocol will be followed by each charge nurse per orders and results monitored and documented by the charge nurse. Director of Nursing will ensure bowel protocol procedures are followed up daily for one week, weekly for 4 weeks, then monthly for 3 months.</p>		

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	3.1-35(g)(2)			

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F0356 SS=C	<p>483.30(e) POSTED NURSE STAFFING INFORMATION</p> <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation and interviews the facility failed to ensure staffing was posted timely and accurately with total hours for 5 of 5 days observed. (1/22, 1/23, 1/24, 1/25 and 1/28/13)</p>	F0356	It is the policy of this facility to provide direct care staffing information on a daily basis to the public in a clear and easily accessible form. Systemic Changes: A policy was developed on 2/11/13 to ensure direct care	02/28/2013			

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	<p>Findings include:</p> <p>On 1/22/13 (Tuesday) at 9:30 a.m., upon entry into the facility, the last day on the staff posting was indicated as Sunday (1/20/13). Also, total hours for each licensed and unlicensed nursing staff was not available.</p> <p>On 1/23, 1/24, and 1/25/13; staff posting did not include the total hours work for the licensed and unlicensed nursing staff.</p> <p>On 1/28/12 at 8:55 a.m., the Director of Nursing indicated she did not include the total hours for each category of licensed and unlicensed nursing staff. She also indicated she would post the information for the weekend behind the present schedule for the night nurse to post. She indicated if an employee became ill or was sent home as on 1/23/13, she did not correct the posting schedule. She also indicated she was unaware of the time length she was to keep the posting information.</p> <p>3.1-13(a)</p>		<p>staff posting requirements are met (see attachment 8). Quality Assurance: The DON or designee in her absence will post the Direct Care Staffing Report (see attachment 9) on a daily basis and update information at the beginning of each shift. The report will be posted for accessibility to residents and public located outside the administrators office near the main entrance of the facility. The report will contain the following: Facility Name Current Date Total number of hours for Nursing Aides, Registered Nurses or LPN Resident Census</p>		

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F0371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observations, interview, and record review the facility failed to ensure a clean and sanitary kitchen related to handwashing, food storage, handwashing sink's water temperature and dishwasher's water temperatures for 2 of 2 days observed. This deficiency had the potential to affect 30 of 30 residents utilizing the kitchen services. (1/22/13 and 1/25/13)</p> <p>Findings include:</p> <p>1. On 1/22/13 at 9:45 a.m., the initial kitchen tour was completed with Cook #15. The following was observed:</p> <p>At the handwashing sink, Cook #15 indicated one has to wait for 10 minutes sometimes to get the water warm. The water temperature at this same time was checked by Cook #15 and was 70 degrees Fahrenheit.</p> <p>In the refrigerator a pound of butter was observed open in its package on</p>	F0371	<p>It is the policy of this facility to ensure a clean and sanitary kitchen related to handwashing, food storage, handwashing sink's water temperature and dishwasher temperature meet the requirements set by state guidelines. Affected Residents: Had the potential to affect 30 of 30 residents. Systemic Changes: A water heater was installed in the kitchen and the handwashing sink water temperature is above 100 and below 120 degrees Fahrenheit. A policy has been implemented for dating food items and procedure implemented on storage of open food items in refrigerator (See Attachment: 10A) Maintenance has addressed all dry storage area concerns. Maintenance will monitor the dry storage area on monthly inspections (see attachment 13A). A hand sanitizer policy has been implemented for dietary staff (see attachment 10B). The dishwasher is owned and maintained by Ecolab. Ecolab came to facility and adjusted temperature to meet requirements (see attachment 14A). The kitchen cooking</p>	02/28/2013			

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	<p>the top shelf of the refrigerator.</p> <p>In the freezer a bag containing 6 pieces of fish were being stored undated.</p> <p>One Teflon-like 8 inch skillet pan was observed with the bottom and sides all scratched up leaving grooves in areas of the pan.</p> <p>In the dry storage area, the ceiling was observed with peeling paint throughout, and a dinner plate size water spot observed in one of the corners over the storage of food. A black substance was observed in streaks down the wall behind stored dry goods. Also, a personal coat was observed hanging on back of door with a purse on the floor.</p> <p>On 1/22/13 at this same time during an interview Cook #15 indicated she did not know personal items could not be stored in the dry storage room. She indicated the facility had a locker room, but she preferred to keep the items close to her.</p> <p>2. On 1/25/13 at 10:45 a.m., in the kitchen the following was observed:</p> <p>After completing 1 pureed dish, Cook #15 was observed to rinse and load</p>		<p>equipment will be replaced by material other than teflon by the required completion date. Kitchen staff have been directed to place personal clothing in approved staff storage areas. QualityAssurance: Maintenance is checking water temperature daily and documenting (see attachment 15A). Dishwasher temperatures are being monitored daily and documented (see attachment 15B). The Dietary Manager also is doing Quality Assurance monitoring of the dishwasher temperatures and documenting (see attachment 15C). This QA process will be ongoing.</p>		

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	<p>the pureed equipment into the dishwasher. As she prepared to pureed the next dish of fish, Cook #15 was observed to use hand sanitizer and proceeded to pureed the fish. After completing the fish pureed, Cook #15 proceeded to rinse and load this pureed equipment and started the dishwasher. As she removed the first cleaned pureed equipment from the dishwasher rack, no handwashing was observed. Again, Cook #15 was observed to use hand sanitizer as she prepared the next pureed dish.</p> <p>At this same time the dishwasher temperatures were observed. In the first dishwashing cycle with the pureed equipment the washing temperature was 135 degrees Fahrenheit (F). As Cook #15 ran the dishwasher cycle again, she indicated the dishwasher had to be run several times to get the water temperature up. The dishwashing washing cycle was 149 degrees F.</p> <p>At this same time during an interview Dietary Manager #8 indicated she was unaware of the black substance in the dry storage area and indicated it could had happened during the last rain. She also indicated staff should store their personal items in the</p>			

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	<p>locker room.</p> <p>At this same time during an interview Dietary Aide #20 indicated she wasn't aware that she couldn't hang personal items behind the door in dry storage room where they were presently located.</p> <p>3. On 1/25/13 at 2:25 p.m., the dishwasher was again observed. As the dishwasher was operating, Dietary Manager #8 indicated the washing cycle temperature was 143 degrees F and the rinse cycle was 173 degrees F. The second dishwashing cycle was then completed with a washing temperature of 143 and a rinsing water temperature of 173 degrees Fahrenheit. At this same time during an interview Dietary Manager #8 and Dietary Aide #20 indicated the dishwashing machine label indicated the washing water temperature should be 150 to 160 and the rinsing water temperature should be 180.</p> <p>4. On 1/28/13 at 1:44 p.m., during an interview Dietary Manager #8 indicated staff should not be using hand sanitizer between dirty dishes and food as they should wash their hands. She indicated the hand sanitizer in the kitchen was to be</p>			

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	<p>used only with non food contact. Also, she indicated the kitchen served 30 residents in the facility.</p> <p>5. The "RETAIL FOOD ESTABLISHMENT SANITATION REQUIREMENTS TITLE 410 IAC 7-24" indicated the following:</p> <p>"HANDWASHING... ...by vigorously rubbing together the surfaces of their lathered hands and arms for at least twenty (20) seconds in water having a temperature of at least one hundred (100) degrees Fahrenheit...."</p> <p>3.1-21(i)(2)</p>			

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F0406 SS=D	<p>483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.</p> <p>Based on record review and interview the facility failed to ensure a yearly mental review was completed for 1 of 1 resident reviewed for PASARR (Preadmission Screening and Resident Review). (Resident #5)</p> <p>Findings include:</p> <p>Resident #5's record was reviewed on 1/25/13 at 10:36 a.m. The residents diagnoses included, but were not limited to, depression and seizure disorder related to epilepsy. The PASARR/MI (Preadmission Screening and Resident Review/Mental Illness) certification form, dated 3/22/2011, indicated the resident was mentally ill and was to receive a yearly resident review. No information was indicated for a yearly review in 2012.</p>	F0406	It is the policy of this facility to coordinate or provide specialized rehabilitative services in accordance with 483.75.Affected Resident: #5 The local Mental Health Agency was notified and Level II was completed on 02/05/2013.Systemic changes: Any new admission who requires a Level II will be screened at this time for yearly review. The Social Service Director will notify Local Mental Health Agency of the date due for the yearly review.Quality Assurance: Social Service will review all PASARR and keep log of all Yearly Reviews. This will be monitored with every new admission and ongoing.	02/28/2013			

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	<p>On 1/28/13 at 9:04 a.m., the Director of Nursing indicated she was not able to locate the yearly mental review and also indicated the yearly review for 2012 had not been completed.</p> <p>3.1-23(a)(1)</p>			

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F0441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review, and interview the facility failed to</p>	F0441	Policy: It is the policy of this facility to maintain an infection	02/22/2013			

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	<p>ensure infection control practices were followed related to handwashing and glove use while passing ice and transporting soiled linen barrels for 3 of 7 CNA's observed (CNA #'s 7 and 2 unidentified CNA's) and for 1 of 1 LPN observed during 1 of 2 dressing changes (LPN #1).</p> <p>Findings include:</p> <p>1) Observation of CNA #7 on 1-25-13 at 10:25 am and 1-28-13 at 10:45 am; while passing ice to residents in 5 double occupied rooms, no hand washing was observed between the handling of the mugs brought out of the residents rooms to the hall to fill with ice. CNA #7 did not ensure the scoop handle was kept out of the metal container that contained the ice or out of the ice itself. During the 1-28-13 observation, the ice container had water and ice in the bottom 2 inches of the container and the scoop was allowed to rest in the water. Employee #7 used her bare hands to reach into the water to retrieve the scoop and after filling the mug, dried her hands on her scrubs.</p> <p>2) Observed CNA #7 on 1-22-13 at 9:45 am; transporting urinals from resident rooms through the hall to the common bathrooms and after</p>		<p>control program that performs investigations, implements controls and prevents infections in the facility. Affected residents: Potential to affect 30 residents Systemic Changes: All staff will be in-serviced on standard precautions, hand washing while providing direct care, and use of personal protective equipment while performing direct care. A container for the Ice / Water Pass will be purchased to hold the ice scoop while performing this duty to maintain infection control. Quality Assurance: Infection control in-servicing is done upon hire and is part of the new employee file, and every 6 months routinely for all staff ongoing.</p>		

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	<p>emptying them, transporting them back to the resident rooms with the same gloves on. No hand washing was observed after returning the urinals to the resident rooms.</p> <p>3) Observation on 1-29-13 at 10:41 am; of CNA's pushing soiled linen containers in halls with gloved hands.</p> <p>4) Observed LPN #1 applying cream to residents legs. After removing gloves, LPN #1 washed her hands for 17 seconds. LPN #1 then picked up the closed jar of cream and washed it off and rewashed her hands for 4 seconds.</p> <p>5) On 1/22/13 at 2:48 p.m., when exiting Resident 19's room, CNA #7 was observed walking in resident's room with gloves on picking up a urinal and walking down hall with urinal uncovered to dump in bathroom; then with gloves still on walk into next resident room with out washing hands.</p> <p>During an interview that occurred at the exit conference on 1-29-13 at 5 p.m., the DON and Employee #9 and Employee #8 both indicated that glove use in the halls was not the facility policy or practice.</p> <p>Review of the facilities handwashing policy indicates that hand washing must</p>			

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	<p>occur in between resident contact and/or contact with bodily secretions. Hand washing, according to the policy, must be done for 20 seconds.</p> <p>3.1-18(l)</p>			

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F0456 SS=B	<p>483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION</p> <p>The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. Based on observation and interview the facility failed to ensure light fixtures were covered and/or in good repair in 1 of 4 closets observed (soiled utility room) and in 1 of 1 laundry room and in 1 of 1 kitchen.</p> <p>Findings include:</p> <p>On 1/28/13 at 10:30 a.m., the environmental tour was conducted. No light cover was observed in the soiled utility room. In the laundry room 4 of the 4 fluorescent lights were uncovered. At this same time during an interview, Maintenance employee #18 indicated the fluorescent lights should be covered.</p> <p>On 1/25/13 at 2:30 p.m., during a kitchen observation, the light fixtures above the stove/oven area had 2 of the 4 lights with a piece of the light fixture broken out on one end.</p> <p>3.1-19(bb)</p>	F0456	<p>It is the policy of this facility to ensure all light fixtures are covered and in good repair. Affected Residents: None Systemic Changes: Light fixtures have been added to the Monthly Maintenance checklist. (See Attachment: 13A) Quality Assurance: Facility has ordered light fixture covers for the kitchen area and has purchased fluorescent light bulb tubes for non-resident areas. Maintenance will monitor monthly and document findings and report to Administrator when light fixtures need replaced and repaired. Administrator will order parts to repair or replace light fixtures. The monitoring will continue on an ongoing basis.</p>	02/28/2013	

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F0458 SS=E	<p>483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms.</p> <p>Based on observation and interview the facility failed to provide at least 80 square feet of room space per resident room. This would affect 4 of 4 residents residing in 3 rooms. (Rooms 3, 6, and 8)</p> <p>Findings include:</p> <p>On 1/28/13 at 10:30 a.m., during the environmental tour the following multiple resident rooms failed to provide 80 square (sq) feet (ft) per resident.</p> <p>In Room 3 with 2 beds, the room measured 153.19 sq. ft. - 76.59 sq. ft. SNF/NF;</p> <p>In Room 6 with 2 beds, the room measured 157.98 sq. ft. - 76.99 sq. ft. SNF/NF;</p> <p>In Room 8 with 2 beds, the room measured 152.97 sq. ft. - 76.48 sq. ft. SNF/NF.</p> <p>At this same time during an interview, Maintenance employee #18 indicated</p>	F0458	<p>It is the policy of this facility to provide at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms, unless a state waiver is provided. Affected Residents: Rooms #3, #6 and #8 were found not to meet the requirements, however a waiver was in affect for the rooms. Systemic Changes: Letter to request for room waiver will be sent to ISDH.</p>	02/14/2013	

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	rooms 3, 6, and 8 were less than 80 sq. ft. per resident. 3.1-19(2)				

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F0518 SS=C	<p>483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS</p> <p>The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures.</p> <p>Based on observations and interviews the facility failed to ensure staff were knowledgeable related to the available electrical outlets with a power outage for 3 of 3 supervisory staff interviewed.</p> <p>(LPN #1 [charge nurse], Director of Nursing, Dietary Manager/Activities #8)</p> <p>Findings include:</p> <p>On 1/25/13 at 3:40 p.m., during an interview with LPN #1, floor charge nurse indicated she was not sure which electrical plugs could be used with a power outage.</p> <p>On 1/25/13 at 3:50 p.m., during an interview Dietary Manager/Activities #8 indicated the electrical plugs available for use if a power outage occurred was the plug in on the left as one walked into any of the rooms on the hall containing Room #'s 11 to 18.</p> <p>On 1/28/13 at 8:40 a.m., during an</p>	F0518	<p>It is the policy of this facility to provide training for all staff upon employment and periodic review of the facility emergency procedures. Systemic Changes: Training that identifies the emergency power outlets will be provided in each new employee's orientation by maintenance supervisor. A review of the emergency power access will be done yearly with all staff during Facility Safety Training. Quality Assurance: The facility maintains and emergency instruction manual accessible at all times at the nursing station. All staff will be inserviced on the location and content of the manual upon hire and annually.</p>	02/28/2013	

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	<p>interview the Director of Nursing indicated she was unsure which rooms had electrical outlets for use if a power outage would occur.</p> <p>On 1/28/13 at 8:55 am, during an interview the Director of Nursing indicated rooms 1 to 6 had the emergency power outlets, which was the opposite hall of Room #'s 11 to 18.</p> <p>On 1/29/13 at 2:50 p.m., the Administrator provided the emergency outlet information. This information indicated the emergency electrical power outlets were located in rooms 1 to 6 with 1 outlet per room available, nurse's station, medicine room, and outlets in the hallway with no specifications given.</p> <p>3.1-51(b)</p>			

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F0520 SS=F	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on record review and interview the facility failed to ensure the quality assessment and assurance committee identified quality deficiencies, developed and implemented plans of actions to correct deficiencies, and had a plan in place for on-going monitoring of corrective action. This deficient practice had the potential to affect all 30 resident residing in the facility.</p>	F0520	<p>Policy: It is the Policy of this facility to ensure the Quality Assessment and Assurance Committee identifies quality deficiencies, develops and implements plans of action to correct deficiencies. Affected Residents: Potential to affect all 30 residents. Systemic Change: Facility will conduct quarterly Quality Assurance Meetings and will identify quality deficiencies. The committee will develop and implement plans of action to correct deficiencies. Quality</p>	02/28/2013	

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	<p>Findings include:</p> <p>On 1/29/13 at 9:25 a.m., the ADM (Administrator) was interviewed regarding the facility's Quality Assessment and Assurance Program. (QAA). He indicated the facility did have a program with the committee consisting of the Administrator, the Director of Nursing (DON), Social Services, Activities, the Medical Director, Dietary/Activities, Therapy, and the Nurse Practitioner. He also indicated if an employee had a concern he had an open door policy and indicated they met quarterly.</p> <p>At that same time during an interview, the Administrator indicated the QAA agenda contained the last QA minutes, previous old business, and reviewed hospice, resident incidents, wound and skin issues, pharmacy reviews, MD (Medical Doctor) visits, Psych (Psychoactive) medications, GDR (Gradual Drug Reduction)'s, consultant reports, resident concerns, employee issues, staff reports and inservices. Also, the ADM indicated in the last QAA meeting in October of 2012 a resident's concern related to too much TV noise by his roommate was addressed, request for a bigger chart rack, and handwashing were discussed. Headphones were</p>		Assurance: Quality Assurance Meetings will be conducted quarterly (see attachment 6a).		

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	<p>purchased related to the loud TV.</p> <p>The Administrator indicated he did not have any minutes indicating that they had defined any concerns with missing money, abuse allegations, or any specific issues.</p> <p>3.1-52(b)(2)</p>				