

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155678	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/13/2012
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NAME OF PROVIDER OR SUPPLIER WATERFORD PLACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 800 ST JOSEPH DR KOKOMO, IN 46901
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F0000	<p>This visit was for the Investigation of Complaint IN00120755.</p> <p>Complaint: IN00120755 Substantiated. Federal/State deficiencies related to the allegation are cited at F224, F225, F226 and F493.</p> <p>Survey dates: December 12 & 13, 2012</p> <p>Facility Number: 002667 Provider Number: 155678 AIM Number: 200300090</p> <p>Survey Team: Mary Jane G. Fischer RN</p> <p>Census Bed Type: SNF: 50 SNF/NF: 46 Residential: 38 Total: 134</p> <p>Census Payor Type: Medicare: 41 Medicaid: 32</p>	F0000	<p>Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the Provider of the accuracy or validity of the findings as alleged or conclusion set forth in the statement of deficiencies. This Plan of Correction is prepared and/or executed solely because it is required by the provision of federal and state law. Please accept this Plan of Correction as Waterford Place Health Campus' Credible Allegation of Compliance. The facility respectfully requests desk review of this Plan of Correction submitted as Waterford Place Health Campus' Credible Allegation of Compliance in response to the deficiencies cited.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>Other: 61 Total: 134</p> <p>Sample: 4</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 12/17/12 Cathy Emswiller RN</p>				

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F0224 SS=D	<p>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATE</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 interview and record review the facility failed to fully implement the facility policy in regard to a complete investigation of abuse and misappropriation which included resident interview and the suspension of a staff member for 2 of 4 sampled resident's. [Residents "A" and "D"].</p> <p>Findings include:</p> <p>1. The record for Resident "A" was reviewed on 12-12-12 at 12:30 p.m. Diagnoses included but were not limited to hypertension, dementia, left above the knee amputation, muscle weakness and left above the knee amputation. These diagnoses remained current at the time of the record review.</p>	F0224	<p>1. Resident A and Resident D continue to reside at the facility with no negative outcomes. 2. Interviews and observations were completed to determine if any other residents were affected. Staff has been reinserviced on the facility's Fraud and Abuse Policy and Resident Rights. Staff has also been reinserviced on Elder Justice Act (EJA) reporting requirements. 3. Staff has been re-educated on the Campus Abuse policy and procedure for abuse investigations. All allegations of abuse will be investigated thoroughly and reported per the Indiana unusual occurrence guidelines to all appropriate entities. The Executive Director or Designee will review all allegations of abuse to ensure a complete and thorough investigation is completed. 4. The results of these reviews will be brought to the daily Stand-Up meeting for review. Any identified trends will be brought to QAA and reviewed monthly for three months and then quarterly. 5. January 11, 2013</p>	01/11/2013	

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	<p>Review of facility reportable incident's on 12-12-12 at 11:00 a.m., indicated the resident made an allegation of abuse by a therapy staff member. The reportable indicated the incident occurred in the therapy gym, when the resident alleged the therapy staff member [employee #7] placed thumb in the resident's rectum.</p> <p>Interview on 12-12-12 at 11:00 a.m., the Physical Therapist, employee #6 indicated that on 12-04-12 she and the therapy assistant [employee #7] had the resident at the parallel bars in an attempt to stand on the right leg, when the resident began to lose balance and employee #7 braced the resident across the buttocks with the his forearm. "[Name of resident] started to go down and he [in reference to employee #7] positioned his forearm across [resident] bottom. There was nothing, in fact [resident] had to go to the doctor's office later that day. The next day [12-05-12], [resident]</p>			
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	<p>told me what happened. I reported it to [name of employee #8 - the Therapy Director]."</p> <p>Interview on 12-12-12 at 11:15 a.m., therapy assistant employee #7 indicated "I was working on standing with [resident] and [name of employee #8]. We had [resident] at the parallel bars when [resident] started to buckle. I put my forearm under [resident] buttocks, to provide support and straighten [resident] upright. I didn't hear anything about an allegation until the next day [12-05-12]. Actually [resident] was still on my case load and when I came into the room the next morning, [resident] was stand - offish. I didn't know why. Later I found out what was said. It made me a little anxious." When interviewed if he had been suspended during the investigation, the employee indicated, "no."</p> <p>Interview on 12-12-12 at 11:30 a.m., the Social Service Director indicated the following:</p>						

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	<p>"Shortly after lunch [12-05-12], [name of licensed nurse employee #10] told me [resident] was crying and upset. She [in reference to the license nurse] told me the therapist put his thumb up [resident] butt. I told the Administrator and then I went to the room and [resident] was in bed asleep - and I woke [resident] up. Visually I didn't see [resident] had been crying, no anxiety and no depression. I didn't ask any leading question. [Resident] indicated had been with 2 therapists and indicated 'they treated me very well.' I reported to the Executive Director. My understanding is that it happened the day before [12-04-12]."</p> <p>Further interview on 12-12-12 at 1:05 p.m., the Social Service Director indicated she had "not interviewed any other residents" during the investigative process to ensure the safety of the resident's.</p> <p>Interview on 12-12-12 at 11:40 a.m., the Therapy Director</p>			

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	<p>indicated he had been told about the allegation "mid-morning [12-05-12]" and "I switched therapist immediately. I interviewed my staff and they didn't know anything about it. [Name of Resident] didn't want to work with [name of employee #7]."</p> <p>Interview on 12-12-12 at 12:03 p.m., the Unit Manager licensed nurse employee #3 indicated, [Name of licensed nurse employee # 10] told me that [resident] was very upset and crying and said the therapist stuck his thumb up her butt. I notified Social Services to go talk to [resident]. I notified the Director of Health Services and the Executive Director. When I saw [resident] was calm and watching TV. I didn't interview [resident] because when I worked at the Sheriff's office I was told you could put thoughts in peoples head so that's why I told someone else."</p> <p>Interview on 12-12-12 at 12:30 p.m. Certified Nurses Aide,</p>						

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	<p>employee #9 indicated, "I took [resident] back to room after lunch and started to do incontinent care and change [resident]. That's when I was told by the resident that 'a man put his thumb down there.' When I asked 'where down there ?' [resident] said 'my bottom.' [Resident] got to crying and I told the nurse."</p> <p>Further interview on 12-13-12 at 10:30 a.m., the Therapy Director indicated employee #7 had not been suspended during the investigation. "I pulled him off the floor and had him work in the therapy gym under my supervision until the investigation was completed. It was done in about 45 minutes to 1 hour." When further interviewed for clarification, the Therapy Director repeated the investigation was completed in about "45 minutes to 1 hour."</p> <p>Further interview on 12-12-12 at 1:05 p.m., the Social Service Director indicated she had "not</p>			

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	<p>interviewed any other residents" during the investigative process to ensure the safety of the resident's.</p> <p>2. The facility provided documentation on 12-12-12 at 10:30 a.m., of a reportable incident and suspected misappropriation of medication which involved Resident "D."</p> <p>The record for Resident "D" was reviewed on 12-13-12 at 10:45 a.m. Diagnoses included but were not limited to chronic pain, cerebral vascular accident, myalgia and hemiplegia. These diagnoses remained current at the time of the record review.</p> <p>The facility documentation indicated on "08-03-12 between 4:00 a.m. and 2:00 p.m., there was "possible diversion of 5 Fentanyl [a narcotic pain medication] patch."</p> <p>The record indicated "it was identified during the 2:00 p.m. shift change medication count that</p>						

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	<p>a package of Fentanyl patches belonging to [name of Resident "D"] was tampered with. Although the perforated flap used to open the box was intact, evening shift nurse observed that the edge of the box appeared tampered with. Day shift QMA as well as the Unit Manager were present at the medication cart during this time and observed the tampered box as well. The nurse opened the box from the tampered side and discovered that the medication patches were missing. A close inspection of the box revealed that the side of the box had been open and re-glued with an adhesive glue."</p> <p>The documentation lacked information the local police department had been notified of the possible drug diversion.</p> <p>3. Review of the facility policy on 12-12-12 at 10:30 a.m., and titled "Abuse and Neglect Procedure Guidelines," and dated as revised 09-16-2011, indicated the</p>						

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	<p>following:</p> <p>"Purpose [bold type]: Trilogy Health Services (THS) has developed and implemented processes which strive to ensure the prevention and report of suspected or alleged resident abuse and neglect."</p> <p>"Procedure [bold type]: 1. THS has implemented processes in an effort to provide a comfortable and safe environment. 2. The Executive Director and Director of Health Services are responsible for the implementation and ongoing monitoring of abuse standards and procedures."</p> <p>"Definitions [bold type]: c. Physical abuse - includes hitting, slapping, pinching, spitting, holding or handling roughly, etc. Staff to resident abuse with or without injury." k. Misappropriation of Property - includes but is not limited to the deliberate misplacement,</p>						

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	<p>exploitation, or wrongful, temporary or permanent use of a resident's belongings or funds."</p> <p>"Protection [bold type]: - Upon identification of suspected abuse or neglect, immediately provide for the safety of the resident and the person reporting to maintain anonymity as reasonable and necessary. This may include, but is not limited to the following: Moving the resident to another room, Provided 1:1 monitoring, as appropriate, suspend suspected employee(s) pending outcome of investigation"</p> <p>"Reporting [bold type]: - The Elder Justice Act requires that if the event that caused the suspected abuse/neglect resulted in serious bodily injury, the Executive Director or designee is required to report the suspicion to the police department immediately but not later than 2 hours. If the event does not result in bodily injury, it must be reported no later than 24 hours."</p>						

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	<p>4. Interview on 12-12-12 at 2:30 p.m., during the Exit Conference the Executive Director indicated he had not notified the local police department of the allegation of abuse or misappropriation. "He [in reference to the Chief of Police] and I don't want to put words in his mouth, but he only wanted to be notified of a serious crime due to the multiple issues the police department deal with on a regular basis."</p> <p>This Federal tag relates to Complaint IN00120755.</p> <p>3.1-28(a)</p>			

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F0225 SS=D	<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>Based on interview and record</p>	F0225	1. Resident A and Resident D	01/11/2013	

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	<p>review the facility failed to sufficiently implement the facility policy in regard to the investigation of an allegation of abuse in which a resident identified a staff member of inappropriate touching and misappropriation for 2 of 4 sampled resident's. [Residents "A" and "D"].</p> <p>Findings include:</p> <p>1. The record for Resident "A" was reviewed on 12-12-12 at 12:30 p.m. Diagnoses included but were not limited to hypertension, dementia, left above the knee amputation, muscle weakness and left above the knee amputation. These diagnoses remained current at the time of the record review.</p> <p>Review of facility reportable incident's on 12-12-12 at 11:00 a.m., indicated the resident made an allegation of abuse by a therapy staff member. The reportable indicated the incident occurred in the therapy gym, when the resident</p>		<p>continue to reside at the facility with no negative outcomes. 2. Interviews and observations were completed to determine if any other residents were affected. Staff has been reinserviced on the facility's Fraud and Abuse Policy and Resident Rights. Staff has also been reinserviced on Elder Justice Act (EJA) reporting requirements. 3. Staff has been re-educated on the Campus Abuse policy and procedure for abuse investigations. All allegations of abuse will be investigated thoroughly and reported per the Indiana unusual occurrence guidelines to all appropriate entities. The Executive Director or Designee will review all allegations of abuse to ensure a complete and thorough investigation is completed. 4. The results of these reviews will be brought to the daily Stand-Up meeting for review. Any identified trends will be brought to QAA and reviewed monthly for three months and then quarterly. 5. January 11, 2013</p>		

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	<p>alleged the therapy staff member [employee #7] placed thumb in the resident's rectum.</p> <p>Interview on 12-12-12 at 11:00 a.m., the Physical Therapist, employee #6 indicated that on 12-04-12 she and the therapy assistant [employee #7] had the resident at the parallel bars in an attempt to stand on the right leg, when the resident began to lose balance and employee #7 braced the resident across the buttocks with the his forearm. "[Name of resident] started to go down and he [in reference to employee #7] positioned his forearm across [resident] bottom. There was nothing, in fact [resident] had to go to the doctor's office later that day. The next day [12-05-12], [resident] told me what happened. I reported it to [name of employee #8 - the Therapy Director]."</p> <p>Interview on 12-12-12 at 11:15 a.m., therapy assistant employee #7 indicated "I was working on</p>						

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	<p>standing with [resident] and [name of employee #8]. We had [resident] at the parallel bars when [resident] started to buckle. I put my forearm under [resident] buttocks, to provide support and straighten [resident] upright. I didn't hear anything about an allegation until the next day [12-05-12]. Actually [resident] was still on my case load and when I came into the room the next morning, [resident] was stand - offish. I didn't know why. Later I found out what was said. It made me a little anxious." When interviewed if he had been suspended during the investigation, the employee indicated, "no."</p> <p>Interview on 12-12-12 at 11:30 a.m., the Social Service Director indicated the following: "Shortly after lunch [12-05-12], [name of licensed nurse employee #10] told me [resident] was crying and upset. She [in reference to the license nurse] told me the therapist put his thumb up [resident] butt. I told the Administrator and then I</p>			

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	<p>went to the room and [resident] was in bed asleep - and I woke [resident] up. Visually I didn't see [resident] had been crying, no anxiety and no depression. I didn't ask any leading question. [Resident] indicated had been with 2 therapists and indicated 'they treated me very well.' I reported to the Executive Director. My understanding is that it happened the day before [12-04-12]."</p> <p>Further interview on 12-12-12 at 1:05 p.m., the Social Service Director indicated she had "not interviewed any other residents" during the investigative process to ensure the safety of the resident's.</p> <p>Interview on 12-12-12 at 11:40 a.m., the Therapy Director indicated he had been told about the allegation "mid-morning [12-05-12]" and "I switched therapist immediately. I interviewed my staff and they didn't know anything about it. [Name of Resident] didn't want to work with</p>						

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	<p>[name of employee #7]."</p> <p>Interview on 12-12-12 at 12:03 p.m., the Unit Manager licensed nurse employee #3 indicated, [Name of licensed nurse employee # 10] told me that [resident] was very upset and crying and said the therapist stuck his thumb up her butt. I notified Social Services to go talk to [resident]. I notified the Director of Health Services and the Executive Director. When I saw [resident] was calm and watching TV. I didn't interview [resident] because when I worked at the Sheriff's office I was told you could put thoughts in peoples head so that's why I told someone else."</p> <p>Interview on 12-12-12 at 12:30 p.m. Certified Nurses Aide, employee #9 indicated, "I took [resident] back to room after lunch and started to do incontinent care and change [resident]. That's when I was told by the resident that 'a man put his thumb down there.' When I asked 'where down there ?'</p>						

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	<p>[resident] said 'my bottom.' [Resident] got to crying and I told the nurse."</p> <p>Further interview on 12-13-12 at 10:30 a.m., the Therapy Director indicated employee #7 had not been suspended during the investigation. "I pulled him off the floor and had him work in the therapy gym under my supervision until the investigation was completed. It was done in about 45 minutes to 1 hour." When further interviewed for clarification, the Therapy Director repeated the investigation was completed in about "45 minutes to 1 hour."</p> <p>Further interview on 12-12-12 at 1:05 p.m., the Social Service Director indicated she had "not interviewed any other residents" during the investigative process to ensure the safety of the resident's.</p> <p>2. The facility provided documentation on 12-12-12 at 10:30 a.m., of a reportable incident</p>			

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	<p>and suspected misappropriation of medication which involved Resident "D."</p> <p>The record for Resident "D" was reviewed on 12-13-12 at 10:45 a.m. Diagnoses included but were not limited to chronic pain, cerebral vascular accident, myalgia and hemiplegia. These diagnoses remained current at the time of the record review.</p> <p>The facility documentation indicated on "08-03-12 between 4:00 a.m. and 2:00 p.m., there was "possible diversion of 5 Fentanyl [a narcotic pain medication] patch."</p> <p>The record indicated "it was identified during the 2:00 p.m. shift change medication count that a package of Fentanyl patches belonging to [name of Resident "D"] was tampered with. Although the perforated flap used to open the box was intact, evening shift nurse observed that the edge of the box appeared tampered with. Day shift</p>			

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	<p>QMA as well as the Unit Manager were present at the medication cart during this time and observed the tampered box as well. The nurse opened the box from the tampered side and discovered that the medication patches were missing. A close inspection of the box revealed that the side of the box had been open and re-glued with an adhesive glue."</p> <p>The documentation lacked information the local police department had been notified of the possible drug diversion.</p> <p>3. Review of the facility policy on 12-12-12 at 10:30 a.m., and titled "Abuse and Neglect Procedure Guidelines," and dated as revised 09-16-2011, indicated the following:</p> <p>"Purpose [bold type]: Trilogy Health Services (THS) has developed and implemented processes which strive to ensure the prevention and report of suspected</p>				

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	<p>or alleged resident abuse and neglect."</p> <p>"Procedure [bold type]: 1. THS has implemented processes in an effort to provide a comfortable and safe environment. 2. The Executive Director and Director of Health Services are responsible for the implementation and ongoing monitoring of abuse standards and procedures."</p> <p>"Definitions [bold type]: c. Physical abuse - includes hitting, slapping, pinching, spitting, holding or handling roughly, etc. Staff to resident abuse with or without injury." k. Misappropriation of Property - includes but is not limited to the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or funds."</p> <p>"Protection [bold type]: - Upon identification of suspected abuse or neglect, immediately provide for</p>			

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	<p>the safety of the resident and the person reporting to maintain anonymity as reasonable and necessary. This may include, but is not limited to the following: Moving the resident to another room, Provided 1:1 monitoring, as appropriate, suspend suspected employee(s) pending outcome of investigation"</p> <p>"Reporting [bold type]: - The Elder Justice Act requires that if the event that caused the suspected abuse/neglect resulted in serious bodily injury, the Executive Director or designee is required to report the suspicion to the police department immediately but not later than 2 hours. If the event does not result in bodily injury, it must be reported no later than 24 hours."</p> <p>4. Interview on 12-12-12 at 2:30 p.m., during the Exit Conference the Executive Director indicated he had not notified the local police department of the allegation of abuse or misappropriation. "He [in</p>			

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	<p>reference to the Chief of Police] and I don't want to put words in his mouth, but he only wanted to be notified of a serious crime due to the multiple issues the police department deal with on a regular basis."</p> <p>This Federal tag relates to Complaint IN00120755.</p> <p>3.1-28(a) 3.1-28(c) 3.1-28(d)</p>			

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F0226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</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 interview and record review the facility failed to fully implement the facility policy in regard to the investigation of abuse and misappropriation for 2 of 4 sampled resident's. [Residents "A" and "D"].</p> <p>Findings include:</p> <p>1. The record for Resident "A" was reviewed on 12-12-12 at 12:30 p.m. Diagnoses included but were not limited to hypertension, dementia, left above the knee amputation, muscle weakness and left above the knee amputation. These diagnoses remained current at the time of the record review.</p> <p>Review of facility reportable incident's on 12-12-12 at 11:00 a.m., indicated the resident made an allegation of abuse by a therapy</p>	F0226	<p>1. Resident A and Resident D continue to reside at the facility with no negative outcomes. 2. Interviews and observations were completed to determine if any other residents were affected. Staff has been reinserviced on the facility's Fraud and Abuse Policy and Resident Rights. Staff has also been reinserviced on Elder Justice Act (EJA) reporting requirements. 3. Staff has been re-educated on the Campus Abuse policy and procedure for abuse investigations. All allegations of abuse will be investigated thoroughly and reported per the Indiana unusual occurrence guidelines to all appropriate entities. The Executive Director or Designee will review all allegations of abuse to ensure a complete and thorough investigation is completed. 4. The results of these reviews will be brought to the daily Stand-Up meeting for review. Any identified trends will be brought to QAA and reviewed monthly for three months and then quarterly. 5. January 11, 2013</p>	01/11/2013	

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	<p>staff member. The reportable indicated the incident occurred in the therapy gym, when the resident alleged the therapy staff member [employee #7] placed thumb in the resident's rectum.</p> <p>Interview on 12-12-12 at 11:00 a.m., the Physical Therapist, employee #6 indicated that on 12-04-12 she and the therapy assistant [employee #7] had the resident at the parallel bars in an attempt to stand on the right leg, when the resident began to lose balance and employee #7 braced the resident across the buttocks with the his forearm. "[Name of resident] started to go down and he [in reference to employee #7] positioned his forearm across [resident] bottom. There was nothing, in fact [resident] had to go to the doctor's office later that day. The next day [12-05-12], [resident] told me what happened. I reported it to [name of employee #8 - the Therapy Director]."</p>						

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	<p>Interview on 12-12-12 at 11:15 a.m., therapy assistant employee #7 indicated "I was working on standing with [resident] and [name of employee #8]. We had [resident] at the parallel bars when [resident] started to buckle. I put my forearm under [resident] buttocks, to provide support and straighten [resident] upright. I didn't hear anything about an allegation until the next day [12-05-12]. Actually [resident] was still on my case load and when I came into the room the next morning, [resident] was stand-offish. I didn't know why. Later I found out what was said. It made me a little anxious." When interviewed if he had been suspended during the investigation, the employee indicated, "no."</p> <p>Interview on 12-12-12 at 11:30 a.m., the Social Service Director indicated the following: "Shortly after lunch [12-05-12], [name of licensed nurse employee #10] told me [resident] was crying and upset. She [in reference to the</p>						

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	<p>license nurse] told me the therapist put his thumb up [resident] butt. I told the Administrator and then I went to the room and [resident] was in bed asleep - and I woke [resident] up. Visually I didn't see [resident] had been crying, no anxiety and no depression. I didn't ask any leading question. [Resident] indicated had been with 2 therapists and indicated 'they treated me very well.' I reported to the Executive Director. My understanding is that it happened the day before [12-04-12]."</p> <p>Further interview on 12-12-12 at 1:05 p.m., the Social Service Director indicated she had "not interviewed any other residents" during the investigative process to ensure the safety of the resident's.</p> <p>Interview on 12-12-12 at 11:40 a.m., the Therapy Director indicated he had been told about the allegation "mid-morning [12-05-12]" and "I switched therapist immediately. I</p>			

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	<p>interviewed my staff and they didn't know anything about it. [Name of Resident] didn't want to work with [name of employee #7]."</p> <p>Interview on 12-12-12 at 12:03 p.m., the Unit Manager licensed nurse employee #3 indicated, [Name of licensed nurse employee # 10] told me that [resident] was very upset and crying and said the therapist stuck his thumb up her butt. I notified Social Services to go talk to [resident]. I notified the Director of Health Services and the Executive Director. When I saw [resident] was calm and watching TV. I didn't interview [resident] because when I worked at the Sheriff's office I was told you could put thoughts in peoples head so that's why I told someone else."</p> <p>Interview on 12-12-12 at 12:30 p.m. Certified Nurses Aide, employee #9 indicated, "I took [resident] back to room after lunch and started to do incontinent care and change [resident]. That's when</p>			

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	<p>I was told by the resident that 'a man put his thumb down there.' When I asked 'where down there ?' [resident] said 'my bottom.' [Resident] got to crying and I told the nurse."</p> <p>Further interview on 12-13-12 at 10:30 a.m., the Therapy Director indicated employee #7 had not been suspended during the investigation. "I pulled him off the floor and had him work in the therapy gym under my supervision until the investigation was completed. It was done in about 45 minutes to 1 hour." When further interviewed for clarification, the Therapy Director repeated the investigation was completed in about "45 minutes to 1 hour."</p> <p>The resident's clinical record, dated 12-10-12 1920 [7:20 p.m.] late entry for 12-06-12 <sic>, "head to toe assessment complete. Excoriation noted to rectal area as previously noted on admission. No new areas noted at this time."</p>						

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	<p>Further review of the clinical record lacked additional information related to the resident after the allegation and investigation of abuse.</p> <p>2. The facility provided documentation on 12-12-12 at 10:30 a.m., of a reportable incident and suspected misappropriation of medication which involved Resident "D."</p> <p>The record for Resident "D" was reviewed on 12-13-12 at 10:45 a.m. Diagnoses included but were not limited to chronic pain, cerebral vascular accident, myalgia and hemiplegia. These diagnoses remained current at the time of the record review.</p> <p>The facility documentation indicated on "08-03-12 between 4:00 a.m. and 2:00 p.m., there was "possible diversion of 5 Fentanyl [a narcotic pain medication] patch."</p>			
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	<p>The record indicated "it was identified during the 2:00 p.m. shift change medication count that a package of Fentanyl patches belonging to [name of Resident "D"] was tampered with. Although the perforated flap used to open the box was intact, evening shift nurse observed that the edge of the box appeared tampered with. Day shift QMA as well as the Unit Manager were present at the medication cart during this time and observed the tampered box as well. The nurse opened the box from the tampered side and discovered that the medication patches were missing. A close inspection of the box revealed that the side of the box had been open and re-glued with an adhesive glue."</p> <p>The documentation lacked information the local police department had been notified of the possible drug diversion.</p> <p>3. Review of the facility policy on 12-12-12 at 10:30 a.m., and titled</p>			

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	<p>"Abuse and Neglect Procedure Guidelines," and dated as revised 09-16-2011, indicated the following:</p> <p>"Purpose [bold type]: Trilogy Health Services (THS) has developed and implemented processes which strive to ensure the prevention and report of suspected or alleged resident abuse and neglect."</p> <p>"Procedure [bold type]: 1. THS has implemented processes in an effort to provide a comfortable and safe environment. 2. The Executive Director and Director of Health Services are responsible for the implementation and ongoing monitoring of abuse standards and procedures."</p> <p>"Definitions [bold type]: c. Physical abuse - includes hitting, slapping, pinching, spitting, holding or handling roughly, etc. Staff to resident abuse with or without injury." k.</p>			

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	<p>Misappropriation of Property - includes but is not limited to the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or funds."</p> <p>"Protection [bold type]: - Upon identification of suspected abuse or neglect, immediately provide for the safety of the resident and the person reporting to maintain anonymity as reasonable and necessary. This may include, but is not limited to the following: Moving the resident to another room, Provided 1:1 monitoring, as appropriate, suspend suspected employee(s) pending outcome of investigation"</p> <p>"Reporting [bold type]: - The Elder Justice Act requires that if the event that caused the suspected abuse/neglect resulted in serious bodily injury, the Executive Director or designee is required to report the suspicion to the police department immediately but not</p>				

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	<p>later than 2 hours. If the event does not result in bodily injury, it must be reported no later than 24 hours."</p> <p>4. Interview on 12-12-12 at 2:30 p.m., during the Exit Conference the Executive Director indicated he had not notified the local police department of the allegation of abuse or misappropriation. "He [in reference to the Chief of Police] and I don't want to put words in his mouth, but he only wanted to be notified of a serious crime due to the multiple issues the police department deal with on a regular basis."</p> <p>5. Review of the facility policy on 12-13-12 at 11:30 a.m., titled "Accident and Incident Reporting Guidelines," undated, indicated the following:</p> <p>"Purpose [bold type]: To ensure all accident, incident and allegations of abuse involving residents, visitors, or employees are investigated and reported to the</p>			

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	<p>facility administration."</p> <p>"Procedure [bold type]: Documentation in medical record completed, recorded on the 24 hour report. Follow up information - such as 72 hour assessment and charting"</p> <p>This Federal tag relates to Complaint IN00120755.</p> <p>3.1-28(a)</p>				

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F0493 SS=D	<p>483.75(d)(1)-(2) GOVERNING BODY-FACILITY POLICIES/APPOINT ADMN The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility</p> <p>Based on interview and record review the facility failed to fully implement the facility policy in regard to the reporting investigation of abuse and misappropriation as outlined in the Elder Justice Act for 2 of 4 sampled resident's reviewed for abuse and misappropriation. [Resident "A" and "D"].</p> <p>Findings include:</p> <p>1. The record for Resident "A" was reviewed on 12-12-12 at 12:30 p.m. Diagnoses included but were not limited to hypertension, dementia, left above the knee amputation, muscle weakness and left above the knee amputation. These diagnoses remained current at the time of the</p>	F0493	<p>1. Resident A and Resident D continue to reside at the facility with no negative outcomes. 2. Interviews and observations were completed to determine if any other residents were affected. Staff has been reinserviced on the facility's Fraud and Abuse Policy and Resident Rights. Staff has also been reinserviced on Elder Justice Act (EJA) reporting requirements. 3. Staff has been re-educated on the Campus Abuse policy and procedure for abuse investigations. All allegations of abuse will be investigated thoroughly and reported per the Indiana unusual occurrence guidelines to all appropriate entities. The Executive Director or Designee will review all allegations of abuse to ensure a complete and thorough investigation is completed. 4. The results of these reviews will be brought to the daily Stand-Up meeting for review. Any identified trends will be brought to QAA and reviewed</p>	01/11/2013			

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	<p>record review.</p> <p>Review of facility reportable incident's on 12-12-12 at 11:00 a.m., indicated the resident made an allegation of abuse by a therapy staff member. The reportable indicated the incident occurred in the therapy gym, when the resident alleged the therapy staff member [employee #7] placed thumb in the resident's rectum.</p> <p>Interview on 12-12-12 at 11:00 a.m., the Physical Therapist, employee #6 indicated that on 12-04-12 she and the therapy assistant [employee #7] had the resident at the parallel bars in an attempt to stand on the right leg, when the resident began to lose balance and employee #7 braced the resident across the buttocks with the his forearm. "[Name of resident] started to go down and he [in reference to employee #7] positioned his forearm across [resident] bottom. There was nothing, in fact [resident] had to go</p>		monthly for three months and then quarterly. 5. January 11, 2013		

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	<p>to the doctor's office later that day. The next day [12-05-12], [resident] told me what happened. I reported it to [name of employee #8 - the Therapy Director]."</p> <p>Interview on 12-12-12 at 11:15 a.m., therapy assistant employee #7 indicated "I was working on standing with [resident] and [name of employee #8]. We had [resident] at the parallel bars when [resident] started to buckle. I put my forearm under [resident] buttocks, to provide support and straighten [resident] upright. I didn't hear anything about an allegation until the next day [12-05-12]. Actually [resident] was still on my case load and when I came into the room the next morning, [resident] was stand-offish. I didn't know why. Later I found out what was said. It made me a little anxious." When interviewed if he had been suspended during the investigation, the employee indicated, "no."</p> <p>Interview on 12-12-12 at 11:30</p>			

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	<p>a.m., the Social Service Director indicated the following: "Shortly after lunch [12-05-12], [name of licensed nurse employee #10] told me [resident] was crying and upset. She [in reference to the license nurse] told me the therapist put his thumb up [resident] butt. I told the Administrator and then I went to the room and [resident] was in bed asleep - and I woke [resident] up. Visually I didn't see [resident] had been crying, no anxiety and no depression. I didn't ask any leading question. [Resident] indicated had been with 2 therapists and indicated 'they treated me very well.' I reported to the Executive Director. My understanding is that it happened the day before [12-04-12]."</p> <p>Further interview on 12-12-12 at 1:05 p.m., the Social Service Director indicated she had "not interviewed any other residents" during the investigative process to ensure the safety of the resident's.</p>				

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	<p>Interview on 12-12-12 at 11:40 a.m., the Therapy Director indicated he had been told about the allegation "mid-morning [12-05-12]" and "I switched therapist immediately. I interviewed my staff and they didn't know anything about it. [Name of Resident] didn't want to work with [name of employee #7]."</p> <p>Interview on 12-12-12 at 12:03 p.m., the Unit Manager licensed nurse employee #3 indicated, [Name of licensed nurse employee # 10] told me that [resident] was very upset and crying and said the therapist stuck his thumb up her butt. I notified Social Services to go talk to [resident]. I notified the Director of Health Services and the Executive Director. When I saw [resident] was calm and watching TV I didn't interview [resident] because when I worked at the Sheriff's office I was told you could put thoughts in peoples head so that's why I told someone else."</p>						

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	<p>Interview on 12-12-12 at 12:30 p.m. Certified Nurses Aide, employee #9 indicated, "I took [resident] back to room after lunch and started to do incontinent care and change [resident]. That's when I was told by the resident that 'a man put his thumb down there.' When I asked 'where down there ?' [resident] said 'my bottom.' [Resident] got to crying and I told the nurse."</p> <p>Further interview on 12-13-12 at 10:30 a.m., the Therapy Director indicated employee #7 had not been suspended during the investigation. "I pulled him off the floor and had him work in the therapy gym under my supervision until the investigation was completed. It was done in about 45 minutes to 1 hour." When further interviewed for clarification, the Therapy Director repeated the investigation was completed in about "45 minutes to 1 hour."</p> <p>The documentation lacked</p>						

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	<p>additional information the local police department had been notified of a possible allegation of abuse.</p> <p>2. The facility provided documentation on 12-12-12 at 10:30 a.m., of a reportable incident and suspected misappropriation of medication which involved Resident "D."</p> <p>The record for Resident "D" was reviewed on 12-13-12 at 10:45 a.m. Diagnoses included but were not limited to chronic pain, cerebral vascular accident, myalgia and hemiplegia. These diagnoses remained current at the time of the record review.</p> <p>The facility documentation indicated on "08-03-12 between 4:00 a.m. and 2:00 p.m., there was "possible diversion of 5 Fentanyl [a narcotic pain medication] patch."</p> <p>The record indicated "it was identified during the 2:00 p.m. shift change medication count that</p>			

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	<p>a package of Fentanyl patches belonging to [name of Resident "D"] was tampered with. Although the perforated flap used to open the box was intact, evening shift nurse observed that the edge of the box appeared tampered with. Day shift QMA as well as the Unit Manager were present at the medication cart during this time and observed the tampered box as well. The nurse opened the box from the tampered side and discovered that the medication patches were missing. A close inspection of the box revealed that the side of the box had been open and re-glued with an adhesive glue."</p> <p>The documentation lacked information the local police department had been notified of the possible drug diversion.</p> <p>3. Review of the facility policy on 12-12-12 at 10:30 a.m., and titled "Abuse and Neglect Procedure Guidelines," and dated as revised 09-16-2011, indicated the</p>						

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	<p>following:</p> <p>"Purpose [bold type]: Trilogy Health Services (THS) has developed and implemented processes which strive to ensure the prevention and report of suspected or alleged resident abuse and neglect."</p> <p>"Reporting [bold type]: - The Elder Justice Act requires that if the event that caused the suspected abuse/neglect resulted in serious bodily injury, the Executive Director or designee is required to report the suspicion to the police department immediately but not later than 2 hours. If the event does not result in bodily injury, it must be reported no later than 24 hours."</p> <p>4. Interview on 12-12-12 at 2:30 p.m., during the Exit Conference the Executive Director indicated he had not notified the local police department of the allegation of abuse or misappropriation. "He [in reference to the Chief of Police]</p>						

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	<p>and I don't want to put words in his mouth, but he only wanted to be notified of a serious crime due to the multiple issues the police department deal with on a regular basis."</p> <p>This Federal tag relates to Complaint IN00120755.</p> <p>3.1-13(i)(4) 3.1-13(s)</p>				