

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155785	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/02/2014
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NAME OF PROVIDER OR SUPPLIER WEST RIVER HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 714 S EICKHOFF RD EVANSVILLE, IN 47712
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F000000	<p>This visit was for the Post Survey Revisit (PSR) to the Investigation of Complaint IN00147386, completed on 4/17/14.</p> <p>This visit was in conjunction with the PSR to the Recertification and State Licensure Survey and State Residential Survey, completed on 6/4/14.</p> <p>Complaint IN00147386 - Not Corrected</p> <p>Survey date: July 2, 2014</p> <p>Facility Number: 012448 Provider Number: 155785 AIM Number: 201039500</p> <p>Survey Team: Anna Villain, RN TC Diane Hancock, RN Diana Perry, RN Denise Schwandner, RN</p> <p>Census bed type: SNF: 46 SNF/NF: 14 Residential: 69 Total: 129</p> <p>Census payor type:</p>	F000000	<p>Preparation or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged, or conclusions set forth on the statement of deficiencies.</p> <p>This plan of correction is prepared and executed solely because it is required by Federal and State law.</p> <p>This plan of correction is submitted in order to respond to the allegations of noncompliance cited during a recertification/licensure survey review concluding on July 2, 2014</p> <p>Please accept this plan of correction as the provider's credible aggregation of compliance effective on or before July 9, 2014.</p>	

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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F000223 SS=D	<p>Medicare: 15 Medicaid: 9 Other: 105 Total: 129</p> <p>Sample: 3</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on July 3, 2014 by Jodi Meyer, RN</p> <p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on observation, record review and interview, the facility failed to ensure 1 of 2 residents reviewed for allegations of abuse, in a total sample of 3, was free from physical abuse, in that a CNA was rough, shoved the resident, placed the resident in a head lock and covered the resident's face during care, resulting in</p>	F000223	Resident C's allegation of abuse was reported to the Executive Director approximately 8:45am on 6-20-2014 by resident's husband. Campus notified the Vanderburgh County Sheriff's office to report abuse. ISDH and APS notified of abuse allegation. MD notified of abuse allegation and examined resident. Employee in question was not working on that date.	07/09/2014

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	<p>small bruises and the potential for psychosocial harm related to abuse. (Resident C)</p> <p>Finding includes:</p> <p>The Administrator was interviewed on 7/2/14 at 8:40 a.m. regarding an allegation of staff abuse of Resident C. She indicated the resident's family member had placed a hidden video camera in Resident C's room. The family member approached her on 6/20/14 at 8:45 a.m. and asked if she could watch a video with him. She described what she saw on the video, which the husband indicated was motion activated and covered time on 6/19/14 from 5:00 a.m. to 9:30 a.m. CNA #1 brought Resident C's breakfast tray to the room and placed it on the overbed table. She assisted the resident to sit up in bed and pushed down on her legs to straighten them for the overbed table. The CNA then took a bite of the resident's breakfast herself, then left the room without assisting the resident.</p> <p>The CNA returned to the room later, removed the breakfast tray, placed the resident's clothing protector up over her face, and proceeded to remove the resident's incontinence brief. She turned her from side to side, removed the brief,</p>		<p>Vanderburgh County Sheriff's office has opened a case # 14-63342 on 6-20-2014 11:42am. The employee arrived at the campus to obtain her paycheck and was arrested by the Sheriff's office. Employee was terminated.</p> <p>Head to toe skin assessments were completed on residents the CRCA in question provided care to in the prior 2 weeks to assess for any suspicious injury or injuries of unknown origin. (No new injuries identified)</p> <p>Residents were interviewed to determine if any were affected by the alleged deficient practice and through systematic changes stated below the campus will ensure residents are free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. There were no negative findings from resident interviews. Staff training on abuse prevention as well as the caring for the aggressive resident, caregiver stress and burnout. Systemic change is Campus will complete a quarterly in service concerning abuse and neglect procedural guidelines. ED or her designee will administer a post test to 2 random campus staff to verify their understanding of abuse prevention procedure 5 times a week x one month 3 times a week x one month then weekly thereafter with results forwarded to the QA committee monthly for the following 12</p>				

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	<p>and provided no incontinence care/cleansing of the resident. The clothing protector remained in place over the resident's face and head. The resident swatted at the CNA. At one point, the resident was over on her side and holding tightly to the siderail. The CNA put the sheet up over the resident and the resident batted at the sheet until her hands were bound up in the sheet. The resident kicked at the CNA.</p> <p>The CNA assisted the resident to sit on the side of the bed and then put a sweater over the resident's head and onto her torso, pinning her arms to her side. At that time, she took both of her hands and shoved the resident roughly so she fell back onto the bed. She then sat her back up, put her in a head lock type hold, and finished dressing her. She then transferred her to the wheelchair roughly, "like a sack of potatoes."</p> <p>The Administrator informed the family member she would be calling law enforcement. She notified the local sheriff department. The CNA was not scheduled to work on 6/20/14, but came to the facility to get her check while the sheriff's deputy was investigating. They detained her at that time. She was later charged with Battery-Disabled by a Caregiver - D Felony.</p>		months.	

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	<p>The State Agency and Adult Protective Services were also notified.</p> <p>CNA #1's personnel file was reviewed on 7/2/14 at 9:25 a.m. The CNA was hired at the facility on 5/7/13. References were checked prior to employment. A criminal history check had been completed. The state CNA registry had been consulted. The CNA had been trained regarding resident rights and abuse prior to and upon hire. She had also been trained on the aging process. All staff had also been reinserviced following a previous complaint survey dated 4/17/14. Four other staff files were reviewed that were hired since 6/14/14. All had pre-employment screening and training completed.</p> <p>The abuse investigation was reviewed on 7/2/14 at 10:00 a.m. The investigation included interviews of all alert and oriented residents regarding rough, abusive care. They also interviewed all staff who had worked with the CNA. The CNA had no history of allegations, nor did they find any complaints about her during the investigation. A head-to-toe assessment was done of the resident. The resident had small bruises on her right wrist. Head-to-toe assessments were done on all residents</p>			

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	<p>this CNA cared for in the previous two weeks. The facility did additional inservices on Caregiver Stress on 6/24/14 and Aggressive Residents/Stress/ and Abuse on 6/25/14. The resident was observed frequently for several days after the incident and showed no signs of remembering the incident or any psychological harm.</p> <p>The resident was observed on 7/2/14 at 2:00 p.m. She was being assisted in the bathroom by two CNAs. She smiled as they were caring for her. The resident's family member was interviewed at that time. He indicated he was very pleased with the care of the resident. He indicated it was a problem with one staff person and they assured by their actions she would never work with residents again.</p> <p>The Abuse Prohibition Protocol was completed. CNA #2, CNA #3, Activity Assistant 1, CNA #4, CNA #5, LPN charge nurse #1, RN charge nurse #1, and the Activity Director were questioned regarding care of aggressive residents, reporting allegations of abuse or observations of abuse, monitoring staff for inappropriate interactions with residents, and monitoring staff to ensure residents are not neglected. All were aware of appropriate responses to</p>			

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	<p>aggressive residents and all were aware of reporting any issues immediately to the Administrator.</p> <p>This Federal Tag relates to Complaint IN00147386.</p> <p>3.1-27(a)(1)</p>			