

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155214	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/14/2014
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NAME OF PROVIDER OR SUPPLIER ST ANTHONY HOME - CROWN POINT	STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307
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F000000	<p>This visit was for the Investigation of Complaint IN00148938.</p> <p>Complaint IN00148938- Substantiated. Federal/State deficiencies related to the allegations are cited at F223 and F226.</p> <p>Survey dates: May 13 and 14, 2014</p> <p>Facility number: 000120 Provider number: 155214 AIM number: 100274780</p> <p>Survey team: Regina Sanders, RN</p> <p>Census bed type: SNF: 36 SNF/NF: 136 NCC: 7 Total: 179</p> <p>Census Payor type: Medicare: 42 Medicaid: 96 Other: 41 Total: 179</p> <p>Sample: 4</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F000000	<p>St. Anthony Home ("the provider") submits this Plan of Correction ("POC") in accordance with specific regulatory requirements. It shall not be construed as an admission of any alleged deficiency cited. The Provider submits this POC with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings of this survey if at any time the Provider determines that the disputed findings: (1) are relied upon to adversely influence or serve as a basis, in any way, for the selection and / or imposition of future remedies, or for any increase in future remedies, whether such remedies are imposed by the Centers for Medicare and Medicaid Services ("CMS"), the state of Indiana or any other entity; or (2) to serve, in any way, to facilitate or promote action by any third party against the Provider. Any changes to Provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on that basis.</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>Quality review completed on May 16, 2014 by Randy Fry 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 record review and interview, the facility failed to ensure a resident was free from abuse from a staff member, for 1 of 2 residents reviewed for abuse in a sample of 4. (Resident #E and Terminated CNA #2)</p> <p>Findings include:</p> <p>During the initial tour on 05/13/14 at 9:25 a.m., Unit Manager (UM) #1 indicated a visitor had witnessed Terminated CNA #2 hit resident #E. UM #1 indicated she was not in the facility at</p>	F000223	1.1 Resident E was assessed by the Charge Nurse to ensure no negative outcome to resident related to allegation of abuse; physician and family notified of same on date of allegation. This facility took immediate and appropriate action and reported this incident to the Indiana State Department of Health and the Crown Point Police Department on 4/24/14. The identified associate was immediately placed on administrative leave. A thorough internal investigation was completed with appropriate action taken.	06/01/2014

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	<p>the time. She indicated Terminated CNA #2 was escorted out of the building, and the Administrator was notified immediately.</p> <p>An undated, Indiana State Department of Health Incident Report Form, received from the Director of Nursing on 05/13/14 at 10 a.m., indicated on 04/02/14 at 7:50 p.m., a family member of another resident had alleged Terminated CNA #2 was seen striking Resident #E on the head. The family member had reported the incident to the front desk receptionist by phone and to the Unit Nurse. The Unit Nurse contacted the Nursing Supervisor, who then obtained a statement and notified the facility Administrator and the Director of Nursing. Terminated Employee #2 was immediately relieved of her duty and sent home. The resident was assessed for injury and was found to have no injuries.</p> <p>The Investigation on the Incident Report Form indicated Terminated CNA #2 admitted to striking the resident as a reflex action due to Resident #E had hit and kicked her repeatedly. Terminated CNA #2 indicated she didn't realize she had struck the resident until after it had already happened.</p> <p>The Incident Report Form indicated</p>		<p>1.2 All residents could potentially be affected by any abusive individual: staff, family, or visitor. That is why this facility screens potential employees as required by regulation and facility policy; and provides significant education to all employees on abuse prevention, recognition and reporting procedures from the time of new hire orientation through any future separation date.</p> <p>The Director of Staff Development / designee will comprehensively inservice staff on the types of abuse, as well as the abuse policy and procedure, with emphasis on how to report and how to recognize burnout in yourself and other associates.</p> <p>1.3 The Social Services Director / designee will conduct twenty (20) random staff interviews on all shifts weekly for two (2) months; then twice monthly for an additional four (4) months, and then quarterly for an additional six (6) months for understanding of how to report and how to recognize burnout in yourself and other associates. Reinforcement of understanding will be immediately provided and documented to those who are unclear or unsure.</p> <p>1.4 The Social Services Director / designee will report random staff interview findings to the Quality Assurance (QA) Committee</p>		

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	<p>Terminated CNA #2 had been released from employment from the facility.</p> <p>Resident #E's record was reviewed on 05/14/14 at 9:40 a.m. The resident's diagnoses included, but were not limited to, dementia with delusions and behavioral disturbances. The resident resided on an Alzheimer's/Dementia Care Unit. The Admission Minimum Data Set Assessment, dated 03/19/14, indicated the resident's cognition was severely impaired, had delusions, had physical, verbal and inappropriate behaviors four-six days, and required extensive assistance with activities of daily living.</p> <p>A facility policy, dated 01/2000, titled, "Abuse and Neglect", indicated, "The safety and welfare of the residents entrusted to the care of Franciscan Communities shall be maintained at all times..."</p> <p>This Federal Tag relates to complaint IN00148938.</p> <p>3.1-27(a)(1)</p>		<p>monthly for six (6) months and then quarterly until twelve (12) months have passed. The QA Committee will monitor data presented for any trends, and determine if further monitoring / action is necessary for continued compliance.</p> <p>1.5 Correction date: 6/1/14.</p>		

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F000226 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 record review and interview, the facility failed to ensure the facility's abuse policy was followed, related to not immediately reporting an allegation of abuse to the Administrator of the facility, for 1 of 2 residents reviewed for abuse allegations in a total sample of 4. (Resident #B, RN #3, Evening Supervisor #4)</p> <p>Findings include:</p> <p>Resident #B's record was reviewed on 05/13/14 at 11:10 a.m. The resident's diagnoses included, but were not limited to, right knee tendon rupture and diabetes mellitus. The resident was admitted into the facility on 05/05/14 and discharged from the facility on 05/06/14.</p> <p>A Nurse Practitioner's Progress Note, dated 05/05/14, indicated the resident was alert and oriented to person, place, and time.</p> <p>Review of an Investigative and Reporting Form, dated 05/07/14, on</p>	F000226	<p>1.1 This resident no longer resides in the facility.</p> <p>1.2 Any resident making an allegation of abuse could potentially be affected by staff failing to recognize that it was an allegation or failing to immediately report according to facility policy. The House Supervisor was inservice on abuse policy and procedure with emphasis on recognizing what may be an allegation of a more subtle nature than a direct accusation and immediate notification when an allegation of abuse occurs.</p> <p>1.3 The Director of Staff Development / designee will comprehensively inservice staff on the abuse policy and procedure with emphasis on immediate notification when an allegation of abuse occurs. The Social Services Director / designee will conduct twenty (20) random staff interviews on all shifts weekly for two (2) months; then twice monthly for an additional four (4) months, and then quarterly for an additional six (6) months for understanding of alleged abuse procedures and</p>	06/01/2014	

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	<p>05/13/14 at 10 a.m., indicated the Director of Nursing (DoN) and the Administrator spoke with Resident #B's family on the telephone. The form indicated the daughter alleged on 05/05/14 on the evening shift, RN #3, "wagged her finger" in the resident's face and said, "Tell your family to stop telling us what to do." "Your family won't accept you so you are stuck with us." The Investigation indicated the resident denied the allegation had occurred. The Investigative and Reporting Form further indicated other staff members and alert and oriented residents were interviewed and there were no concerns voiced in regards to RN #3 or other staff members.</p> <p>During an interview on 05/13/14 at 10:38 a.m., the DoN indicated on 05/05/14, Evening Supervisor #4 had sent her an e-mail informing her Resident #B's family was upset. She indicated she had not been aware of the allegation about RN #3 wagging her finger in the resident's face until the telephone conference call with the resident's daughter and the Administrator. She indicated once she had been made aware of the allegation, the incident was investigated and reported to the Indiana State Department of Health.</p> <p>During an interview on 05/13/14 at 2:40</p>		<p>ensuring timely notification.</p> <p>1.4 The Social Services Director / designee will report audit findings to the Quality Assurance (QA) Committee monthly for six (6) months and then quarterly until twelve (12) months have passed. The QA Committee will monitor data presented for any trends, and determine if further monitoring / action is necessary for continued compliance.</p> <p>1.5 Correction date: 6/1/14.</p>				

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	<p>p.m., Evening Supervisor #4 indicated she had been contacted by the RN #5 due to the resident needed a bedside commode, and the staff could not find one. She indicated the resident's daughter had been upset about several things. She indicated RN #5 entered the resident's room to give him his medications and the daughter was upset with her so she had asked RN #3 to take over. Evening Supervisor #4 indicated she had entered the room after RN #3 had administered the resident's medications and the resident's daughter had said RN #3 had waved her finger in the resident's face and informed the resident to tell his family to , "stop telling us how to do our job." Evening Supervisor #4 indicated it could have been considered abuse, but she had not looked at it as abuse because from the time RN #3 had entered the room and she had entered the room, there had not been enough time for this to happen. She indicated she had asked RN #3 and RN #3 had indicated she did not say this to the resident. Evening Supervisor #4 indicated she had notified the DoN.</p> <p>During an interview on 05/13/14 at 3:10 p.m., the DoN indicated Evening Supervisor #4 had sent her a message. She indicated the message did not state the allegation of RN #3 placing her finger</p>			

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	<p>in the resident's face and telling him to tell his family to stop telling the staff how to do their job. She indicated the message indicated there was a problem with the resident's family. She indicated the Social Service Director had spoken with the resident on 05/06/14 and the resident indicated this did not occur. She indicated had she had been told about the finger in the face, she would have asked for more information from the resident's daughter.</p> <p>A facility policy, dated 01/2000, titled, "Abuse and Neglect", and received from the DoN as current, indicated, "...All associates and volunteers are required to report allegations of abuse/neglect immediately to their supervisors, who in turn shall immediately notify the Executive Director/Administrator..."</p> <p>This Federal Tag relates to complaint IN00148938.</p> <p>3.1-28(a)</p>						