

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155813	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/22/2014
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NAME OF PROVIDER OR SUPPLIER VILLAGES AT HISTORIC SILVERCREST THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1809 OLD VINCENNES ROAD NEW ALBANY, IN 47150
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F000000	<p>This visit was for the Investigation of Complaint IN00154433</p> <p>Complaint IN00154433 - Substantiated. Federal/State deficiencies related to the allegations are cited at F225 and F226.</p> <p>Survey dates: August 21, 2014 and August 22, 2014</p> <p>Facility number: 012619 Provider number: 155813 AIM number: N/A</p> <p>Survey team: Jennifer Carr, RN</p> <p>Census bed type: SNF: 42 SNF/NF: 1 Residential: 16 Total: 59</p> <p>Census payor type: Medicare: 34 Medicaid: 0 Other: 25 Total: 59</p> <p>Sample: 4</p> <p>These deficiencies also reflect State</p>	F000000		

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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F000225 SS=D	<p>findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed on August 27, 2014, by Brenda Meredith, R.N.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 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>			

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	<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 review, the facility failed to ensure that all allegations of abuse were reported to officials in accordance with State law and provide evidence that all alleged violations were thoroughly investigated while preventing further potential abuse while the investigation was in progress for 1 of 4 residents reviewed for abuse. This involved an allegation abuse related to staff rough handling a resident. (Resident A)</p> <p>Findings include:</p> <p>During an interview with the Executive Director (ED) on 8/21/2014 at 11:02 a.m., she indicated that she was the point of contact person for abuse. Regarding which injuries of unknown origin should be investigated as alleged occurrences of abuse, the ED indicated, "I'd say it</p>	F000225	<p>1. The resident was already assessed and interviewed with no signs of abuse identified. 2. The Director of Social Services will interview alert and oriented residents residing on the same unit as the identified resident to ensure no concerns. 3. The Executive Director and Director of Health Services have been re-inserviced on the company guidelines for abuse to include reporting and investigating to ensure a clear understanding. A systemic change is the Department Managers will review the campus Abuse policy each month at their monthly departmental meetings to ensure staff reporting of allegations have been addressed and/or reported. 4. Home Office Support will review the facility accident/incident log to ensure investigation and reporting requirements have been initiated</p>	09/21/2014

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	<p>depends on where it is...I'd talk to staff...if it was suspicious in nature.... We would try to determine what the situation is...is there willful intent, what were the circumstances? It's so broad...if we have to have a thorough investigation that goes on for days...but if it's something I can just investigate quickly, then it may not meet the requirements [for reporting]."</p> <p>A copy of the current Abuse and Neglect Procedural Guidelines, provided by the ED on 8/21/2014 at 11:05 a.m., was reviewed on 8/21/2014 at 3:26 p.m. The procedure indicated, "The Executive Director and Director of Health Services are responsible for the implementation and ongoing monitoring of abuse standards and procedures....PHYSICAL ABUSE - includes...handling roughly....staff to resident abuse with or without injury....Any person with knowledge or suspicion of suspected violations shall report immediately, without fear of reprisal....IMMEDIATELY notify the Executive Director....Complete an Accident and Incident Report. Refer to the Accident and Incident Program regarding investigative procedures. The Executive Director is responsible for: Notification to the State Department of Health (per state guidelines) and other agencies....Upon identification of</p>		<p>per policy. This will occur once per week for 4 weeks, every other week for 4 weeks, then weekly for 4 additional weeks until 100% compliance has been achieved for 3 consecutive months. In addition, the Director of Social Services will conduct a new monthly audit that includes interviewing randomly selected residents each month to ensure there are no allegations of abuse that have not been addressed and/or reported. These audits will be reviewed by the QA Committee and implement action plans if they determine necessary to ensure substantial compliance reached.</p>	

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	<p>suspected abuse or neglect, immediately...suspend suspected employee(s) pending outcome of investigation....The Executive Director is accountable for investigating and reporting....Immediately and not more than 24 hours complete an initial report to applicable state agencies....A written report of the investigative outcome...will be submitted to the applicable State Agencies within five days."</p> <p>During an interview with the Assistant Director of Health Services (ADHS) on 8/22/2014 at 10:50 a.m., she indicated there was a recent incident with a CNA reporting that another CNA was "rough" with a resident, stating, "[CNA #1] got pulled to a different floor...she was aggravated about it. When I talked to her [CNA #1] about it, she told me that she did not feel like she was rough at all. It was like she was hurried. There was no intent. She was told she needed to slow down, change her mood, and calm down...." We talked to him [Resident A]. I guess during peri-care [incontinence care] it hurt when she was cleaning him. He's not able to verbalize a whole lot. I don't think he felt like it was intentional. I got a phone call at home from [RN #3], the nurse on the floor, and she said another CNA [CNA #2] reported it to her. [CNA #2] said she [CNA #1] had an</p>			

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	<p>attitude and when she was cleaning him [Resident A]...the resident said 'Ow!' Then I called [Executive Director] and she said she would take care of it. I don't know what happened after that....[RN #3] examined [Resident A]...there was no redness or visible bruising. [CNA #1] said she was cleaning him and lifted up on his testicles and he said 'Ouch!'...."</p> <p>CNA #2 was interviewed on 8/22/2014 at 11:05 a.m. Recounting the morning of 7/18/2014, she indicated, "I had asked [CNA #1] to help me. She was in a really bad mood. The nurses on the other side [unit] said she was slamming doors [on her way to unit where incident allegedly occurred]...."</p> <p>Resident A's clinical record was reviewed on 8/21/2014 at 11:40 a.m. Diagnoses included, but were not limited to, closed fracture of right hip, stress fracture of right shaft of femur (thigh bone), muscle weakness, and aphasia (difficulty expressing oneself) secondary to history of CVA (stroke). Minimum Data Set (MDS) assessment, dated 7/18/2014, indicated a Brief Interview for Mental Status (BIMS) score of 10 of 15; indicating he was moderately cognitively intact.</p> <p>A 7/18/2014 at 6:30 a.m. Pain</p>			

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	<p>Circumstance, Assessment, Data Collection and Intervention form indicated, "Location of pain: Scrotum. New onset: [check mark]. R/T [related to]: Handling during BM [bowel movement] change. Type: Acute...Intensity of the worst pain....: Moderate pain (4-5)...."</p> <p>A 7/10/2014 at 6:30 a.m. Nursing Note indicated, "Pt [patient] complaint, see Incident Report and pain circumstance form. Called [ADHS] to convey information and spoke with [ED] as well. Pt assessed...no further complaints."</p> <p>Resident A's wife was interviewed on 8/22/2014 at 11:50 a.m. She indicated, "They told me they had an incident with a night shift employee who was rough with him but they had talked to her and taken care of it. She [facility staff who relayed the information] said 'she was kind of rough with him'....No, I don't think he was hurt. I don't know what they were doing....He has difficulty talking."</p> <p>Resident A was interviewed on 8/22/2014 at 12:26 p.m. and provided only "yes" and "no" answers to questions. He indicated that he did not recall the alleged incident and was not currently having any pain.</p>			

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	<p>CNA #1 was interviewed on 8/22/2014 at 2:05 p.m., indicating that she was "frustrated" with her change in assignment that day, but denied being rough, using profanity, or slamming doors. She indicated she was assisting CNA #2 with providing peri-care to Resident A and lifted his testicles to ensure they were clean.</p> <p>The ED was interviewed on 8/22/2014 at 3:08 p.m. and indicated, "At no time was it told to me that the patient [Resident A] complained of pain. I was told that the CNAs were arguing...."</p> <p>The ED provided a copy of a typed statement, dated 7/18/2014 and signed by her. The statement included, but was not limited to, "...a CNA was complaining of another CNA being upset about her assignment. I then called the nurse in charge, [RN #3]. [RN #3] explained that [CNA #2] reported to her that [CNA #1] was mad that she was assigned to 2nd floor...reported that [CNA #1] was very rushed and abrupt when she was providing care to [Resident A]. [RN #3] confirmed that [CNA #1] was not intentionally hurting the resident....she was able to calm her down and confirmed she could provide care appropriately."</p> <p>The DHS (Director of Nursing Services)</p>			

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F000226 SS=D	<p>was interviewed on 8/22/2014 at 3:50 p.m. and indicated, "When I returned on Monday [7/21/2014], I was told by [ADHS] there was a CNA who was upset because she was pulled from one hall to another...she was cursing in the hall and slammed a door. She was in a resident's room with another CNA who said she seemed angry and there was a confrontation between the two CNAs in front of the resident...."</p> <p>This Federal tag relates to Complaint IN00154433.</p> <p>3.1-28(c) 3.1-28(d) 3.1-28(e)</p> <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 interview and record review, the facility failed to follow it's policy and</p>	F000226	1. The resident was already assessed and interviewed with no signs of abuse identified. 2. The	09/21/2014

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	<p>procedure for abuse investigation, protection, and reporting for 1 of 4 residents reviewed for abuse. This involved an allegation abuse related to staff rough handling a resident. (Resident A)</p> <p>Findings include:</p> <p>During an interview with the Executive Director (ED) on 8/21/2014 at 11:02 a.m., she indicated that she was the point of contact person for abuse. Regarding which injuries of unknown origin should be investigated as alleged occurrences of abuse, the ED indicated, "I'd say it depends on where it is...I'd talk to staff...if it was suspicious in nature....We would try to determine what the situation is...is there willful intent, what were the circumstances? It's so broad...if we have to have a thorough investigation that goes on for days...but if it's something I can just investigate quickly, then it may not meet the requirements [for reporting]."</p> <p>A copy of the current Abuse and Neglect Procedural Guidelines, provided by the ED on 8/21/2014 at 11:05 a.m., was reviewed on 8/21/2014 at 3:26 p.m. The procedure indicated, "The Executive Director and Director of Health Services are responsible for the implementation and ongoing monitoring of abuse</p>		<p>Director of Social Services will interview alert and oriented residents residing on the same unit as the identified resident to ensure no concerns. 3. The Executive Director and Director of Health Services have been re-inserviced on the company guidelines for abuse to include reporting and investigating to ensure a clear understanding. A systemic change is the Department Managers will review the campus Abuse policy each month at their monthly departmental meetings to ensure staff reporting of allegations have been addressed and/or reported. 4. Home Office Support will review the facility accident/incident log to ensure investigation and reporting requirements have been initiated per policy. This will occur once per week for 4 weeks, every other week for 4 weeks, then weekly for 4 additional weeks until 100% compliance has been achieved for 3 consecutive months. In addition, the Director of Social Services will conduct a new monthly audit that includes interviewing randomly selected residents each month to ensure there are no allegations of abuse that have not been addressed and/or reported. These audits will be reviewed by the QA Committee and implement action plans if they determine necessary to ensure substantial compliance reached.</p>				

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	<p>standards and procedures....PHYSICAL ABUSE - includes...handling roughly....staff to resident abuse with or without injury....Any person with knowledge or suspicion of suspected violations shall report immediately, without fear of reprisal....IMMEDIATELY notify the Executive Director....Complete an Accident and Incident Report. Refer to the Accident and Incident Program regarding investigative procedures. The Executive Director is responsible for: Notification to the State Department of Health (per state guidelines) and other agencies....Upon identification of suspected abuse or neglect, immediately...suspend suspected employee(s) pending outcome of investigation....The Executive Director is accountable for investigating and reporting....Immediately and not more than 24 hours complete an initial report to applicable state agencies....A written report of the investigative outcome...will be submitted to the applicable State Agencies within five days."</p> <p>During an interview with the Assistant Director of Health Services (ADHS) on 8/22/2014 at 10:50 a.m., she indicated there was a recent incident (7/18/2014) with a CNA reporting that another CNA was "rough" with a resident, stating,</p>			

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	<p>"[CNA #1] got pulled to a different floor...she was aggravated about it. When I talked to her [CNA #1] about it, she told me that she did not feel like she was rough at all. It was like she was hurried. There was no intent. She was told she needed to slow down, change her mood, and calm down..." We talked to him [Resident A]. I guess during peri-care [incontinence care] it hurt when she was cleaning him. He's not able to verbalize a whole lot. I don't think he felt like it was intentional. I got a phone call at home from [RN #3], the nurse on the floor, and she said another CNA [CNA #2] reported it to her. [CNA #2] said she [CNA #1] had an attitude and when she was cleaning him [Resident A] and the resident said 'Ow!' Then I called [Executive Director] and she said she would take care of it. I don't know what happened after that...[RN #3] examined [Resident A]...there was no redness or visible bruising. [CNA #1] said she was cleaning him and lifted up on his testicles and he said 'Ouch!'...."</p> <p>CNA #2 was interviewed on 8/22/2014 at 11:05 a.m. Recounting the morning of 7/18/2014, she indicated, "I had asked [CNA #1] to help me. She was in a really bad mood. The nurses on the other side [unit] said she was slamming doors [on her way to unit where incident</p>			

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	<p>allegedly occurred]...."</p> <p>Resident A's clinical record was reviewed on 8/21/2014 at 11:40 a.m. Diagnoses included, but were not limited to, closed fracture of right hip, stress fracture of right shaft of femur (thigh bone), muscle weakness, and aphasia (difficulty expressing oneself) secondary to history of CVA (stroke). Minimum Data Set (MDS) assessment, dated 7/18/2014, indicated a Brief Interview for Mental Status (BIMS) score of 10 of 15; indicating he was moderately cognitively intact.</p> <p>A 7/18/2014 at 6:30 a.m. Pain Circumstance, Assessment, Data Collection and Intervention form indicated, "Location of pain: Scrotum. New onset: [check mark]. R/T [related to]: Handling during BM [Bowel Movement] change. Type: Acute...Intensity of the worst pain....: Moderate pain (4-5)...."</p> <p>A 7/10/2014 at 6:30 a.m. Nursing Note indicated, "Pt [patient] complaint, see Incident Report and pain circumstance form. Called [ADHS] to convey information and spoke with [ED] as well. Pt assessed...no further complaints."</p> <p>Resident A's wife was interviewed on</p>			

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	<p>8/22/2014 at 11:50 a.m. She indicated, "They told me they had an incident with a night shift employee who was rough with him but they had talked to her and taken care of it. She [facility staff who relayed the information] said 'she was kind of rough with him'....No, I don't think he was hurt. I don't know what they were doing....He has difficulty talking."</p> <p>Resident A was interviewed on 8/22/2014 at 12:26 p.m. and provided only "yes" and "no" answers to questions. He indicated that he did not recall the alleged incident and was not currently having any pain.</p> <p>CNA #1 was interviewed on 8/22/2014 at 2:05 p.m., indicating that she was "frustrated" with her change in assignment that day, but denied being rough, using using profanity, or slamming doors. She indicated she was assisting CNA #2 with providing incontinence care to Resident A and lifted his testicles to ensure they were clean.</p> <p>The ED was interviewed on 8/22/2014 at 3:08 p.m. and indicated, "At no time was it told to me that the patient [Resident A] complained of pain. I was told that the CNAs were arguing...."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155813		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/22/2014	
NAME OF PROVIDER OR SUPPLIER VILLAGES AT HISTORIC SILVERCREST THE				STREET ADDRESS, CITY, STATE, ZIP CODE 1809 OLD VINCENNES ROAD NEW ALBANY, IN 47150			
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	<p>During the interview, the ED provided a copy of a typed statement, signed by her, dated 7/18/2014. The statement included, but was not limited to, "...a CNA was complaining of another CNA being upset about her assignment. I then called the nurse in charge, [RN #3]. [RN #3] explained that [CNA #2] reported to her that [CNA #1] was mad that she was assigned to 2nd floor....reported that [CNA #1] was very rushed and abrupt when she was providing care to [Resident A]. [RN #3] confirmed that [CNA #1] was not intentionally hurting the resident....she was able to calm her down and confirmed she could provide care appropriately." The ED indicated that an Accident and Incident form (referenced in Abuse and Neglect Procedural Guidelines) was not completed for Resident A and the incident which occurred on 7/18/2014.</p> <p>The DHS (Director of Nursing Services) was interviewed on 8/22/2014 at 3:50 p.m. and indicated, "When I returned on Monday [7/21/2014], I was told by [ADHS] there was a CNA who was upset because she was pulled from one hall to another...she was cursing in the hall and slammed a door. She was in a resident's room with another CNA who said she seemed angry and there was a confrontation between the two CNAs in</p>						

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	<p>front of the resident....One said the other seemed to be almost rough...was being very negative and had a poor attitude.</p> <p>A copy of Accident and Incident Reporting Guidelines (referenced in Abuse and Neglect Procedural Guidelines) and a blank Accident and Incident Form (referenced in Abuse and Neglect Procedural Guidelines) were provided by the DHS on 8/22/2014 at 4:15 p.m. and reviewed at that time. The Accident and Incident Reporting Guidelines indicated, "Procedure: 1. All accidents, incidents, and allegation of Abuse (see Abuse policy) including injuries of unknown source, shall be reported to the department supervisor as soon as it is discovered or when information of occurrence is learned. 2. An Accident and Incident Form shall be completed for known accidents, incidents and abuse allegations....5. Reporting of incident, accidents or abuse to state and federal agencies shall be in compliance in accordance with agency guidelines....10. The administrative staff shall complete the investigation, by completion of the...State Agency form as required."</p> <p>This Federal tag relates to Complaint IN00154433.</p> <p>3.1-28(a)</p>			

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