

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155209	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/18/2014
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NAME OF PROVIDER OR SUPPLIER WATERS OF CLIFTY FALLS THE	STREET ADDRESS, CITY, STATE, ZIP CODE 950 CROSS AVE MADISON, IN 47250
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F000000	<p>This visit was for the Investigation of Complaints IN00156156 and IN00154894.</p> <p>Complaint IN00156156 - Substantiated. Federal/state deficiencies related to the allegations are cited at F223.</p> <p>Complaint IN00154894 - Unsubstantiated due to lack of evidence.</p> <p>Survey dates: September 17 and 18, 2014</p> <p>Facility number: 000116 Provider number: 155209 AIM number: 100266330</p> <p>Survey team: Jennifer Carr, RN - TC</p> <p>Census bed type: SNF/NF: 88 Total: 88</p> <p>Census payor type: Medicare: 14 Medicaid: 60 Private: 5 Other: 9 Total: 88</p> <p>Sample: 9</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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F000223 SS=B	<p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed on September 26, 2014, by Brenda Meredith, R.N.</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.</p> <p>Based on observation, interview and record review, the facility failed to ensure that 3 of 88 residents were free from physical abuse (Residents J, K, and M).</p> <p>Findings include:</p>	F000223	Preparation and/or execution of the plan of correction in general, or this corrective action in particular does not constitute an admission agreement by the facility of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction and specific corrective actions are prepared	10/01/2014

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	<p>The Administrator provided a copy of the Abuse Prevention Program on 9/17/2014 at 11:50 a.m. and indicated, "We had an allegation [yesterday]...I'm in the middle of inservicing the whole staff."</p> <p>Initial investigative documentation was provided by the Administrator, on 9/17/2014 at 1:45 p.m. The Initial Report to Indiana State Department of Health indicated, "Incident Date: 9/16/2014. Incident Time: 10:15 a.m. Residents Involved: ...[J...M...K]....Staff Name: [CNA #1]. Brief Description of Incident: CNA allegedly rough with residents while changing their clothes. Type of Injury/Injuries: discolorations identified on both wrists of Resident [J]. Immediate Action Taken: CNA suspended immediately. Head to toe assessments completed on both residents. Investigation initiated...."</p> <p>An Employee Action Form, dated 9/16/2014 at 10:15 a.m., indicated that CNA #1 was "...suspended for allegation of being rough w/ [with] residents during care."</p> <p>Alleged Abuse Incident/Injuries Observed at Time of Incident forms were completed within one hour on all 3 residents, and provided by the Administrator on 9/18/2014 at 4:47 p.m.</p>		<p>and/or executed in compliance with state and federal laws. Facility respectfully requests a desk review for F223B F223B It is the intent of this facility to ensure residents are free of physical abuse. 1. Resident J, K and M were assessed for harm and provided emotional support by the facility as listed in the report we completed to ISDH on 9-19-14. 2. Completion of 100% audit on all alert and oriented residents for abuse concerns as per the reportable on 9-16-14 concluded no other residents identified. 3. All staff were re-educated on the abuse policy and procedure as per the reportable stated on 9-16-14. Additional inservices are being provided for dementia training by Lacy, Beyl, and Company in October. Education on prevention of abuse will be done upon hire, every 6 months and prn including the Hand in Hand dementia training program. 4. Social Services will provide services to the residents and consultant prn. Resident's council will be advised of the policy and procedure for abuse in October's meeting and annually thereafter and prn to include ombudsman invitation. Administrator will be having listening sessions for all staff each month alternating shifts to allow employees time to express concerns. Employee Retention and Recruitment Committee</p>		

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	<p>Documentation indicated that Resident K, who was severely cognitively impaired, could not describe the incident. No injuries were noted. Resident J, who was severely cognitively impaired, could not describe the incident. No injuries were noted. Resident M, who was cognitively intact, "agreed that CNA was rough with her." No injuries were noted.</p> <p>Investigative documentation signed by the Administrator indicated, "Called police @ [at] 2:45 p.m. on 9/16/14 regarding allegation of abuse this a.m. After discussing incident with police dept [department], they told administrator to make sure we reported to the state and the state would call us if anything else needed to be done."</p> <p>In a written statement, dated 9/16/2014, the Administrator indicated, "[I] talked with [Resident M]...regarding allegation of abuse...[Resident M] said [CNA #1] was rough w/ [with] her and she was already hurting. She didn't seem like she was happy with her even before the incident. Resident was informed that she [CNA #1]...was not in the building anymore."</p> <p>Written statements, dated 9/16/2014, by CNA #2, who witnessed and reported the abuse, indicated, "This morning when I</p>		<p>consisting of direct care employees and 1 department manager started in September for more involvement in employee morale and retention ideas. Staff will be encouraged to report all allegations immediately. Administrator will report any allegation immediately to all appropriate agencies per protocol. SS/Designee will interview 2 residents per week for 1 month and then 1 resident a week for 2 months for any indications of abuse. All Reportables will be reviewed in the monthly QA meeting with review for determination of ongoing actions/monitoring. 5. The date of compliance is 10/1/2014.</p>				

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	<p>and [CNA #1] went into [Resident M's] room to give A.M. care I witnessed [CNA #1] being rough with resident. I saw [CNA #1] put [Resident M's] shirt on forcefully and lifted her head roughly....[Resident M] c/o [complained] to [CNA #1] that she was being rough and said, 'Ow.' After...I was in the shower with one resident...[CNA #1] came in with [Resident J] to give her a shower. [CNA #1] approached [Resident J] with the wrong attitude and then [Resident J] began having some behaviors. [CNA #1] was roughly removing [Resident J's] dress during this....[CNA #1] an [sic] I was [sic] getting [Resident K] up...[CNA #1] was putting on her shirt on an [sic] [CNA #1] len [sic] her forward rough an [sic] [CNA #1] said I can't stand her today."</p> <p>Documentation by the Social Services Director, dated 9/17/14, indicated, "Statement from [CNA #1] regarding events on 9/16/2014...[CNA #1] states that all she remembers doing with [Resident M] is helping her eat and then helping her up with the help of other staff. [CNA #1] says she remembers nothing negative happening....[CNA #1] states that she did give [Resident J] a bath yesterday. [CNA #1] said [Resident #J] clearly did not want to take a bath and was kicking, pinching and had [CNA #1]</p>			
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	<p>by the throat....[CNA #1 said she...does not remember even doing any care with [Resident K]."</p> <p>The Administrator indicated on 9/18/2014 at 4:02 p.m., "[Residents M, J and K] were all handled roughly [by CNA #1]...[CNA #2] came into morning meeting crying [to report]. I suspended her [CNA #1] immediately. I looked at [Resident J] and she had discoloration of both wrists, but she's combative and just had labs drawn. She further indicated that the discoloration on Resident J's left wrist looked "older..green and purple...an odd shape....[Resident M] thought she was rough. The other two [residents] couldn't speak...aren't able to."</p> <p>Resident M's record was reviewed on 9/18/2014 at 4:29 p.m. Diagnoses included, but were not limited to, multiple sclerosis, rheumatoid arthritis, and anxiety. Her most recent Minimum Data Set (MDS) assessment, dated 8/18/2014, indicated a Brief Interview for Mental Status (BIMS) score of 8; indicating the resident was moderately cognitively impaired. She required total assist of 1-2 persons for all activities of daily living (ADLs).</p>			

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	<p>Resident M was interviewed on 9/18/2014 at 4:48 p.m. and observed to be sitting in her wheelchair with her head/neck bent toward her right side. She was alert and oriented to person, place and general time. She indicated, "I was in bed and she [CNA #1] was trying to get me up and was trying to put my top on and when she did so, she was tough on my neck...she yanked my shirt collar down and hurt my neck in a way that it was startling me....[CNA #1] seemed like she was in a hurry....[CNA #1 was] rough with my feet...mostly my right leg hurts, but they both do. She further indicated that her neck still hurt and that she does not normally have neck pain. She indicated that CNA #1 had previously been rough in providing care "on occasion."</p> <p>The Administrator indicated, on 9/18/2014 at 5:01 p.m., that the allegations of abuse regarding CNA #1 on 9/16/2014 were substantiated and further stated, "I let [CNA #1] go."</p> <p>Resident K was observed on 9/18/2014 at 5:40 p.m. She was non-verbal and could not be interviewed. No injuries were</p>			

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	<p>observed.</p> <p>CNA #2 was interviewed, on 9/19/2014 at 1:28 p.m., via phone and indicated, "All what I seen [sic] is what I got wrote [sic] down."</p> <p>The Abuse Prevention Policy and Procedure, provided by the Administrator on 9/17/2014 at 11:50 a.m., indicated, "Policy: It is the policy of this facility to prevent resident abuse, neglect, mistreatment and....This facility will not tolerate resident abuse by anyone, including staff members...."</p> <p>This Federal Tag relates to Complaint IN00156156.</p> <p>3.1-27(a)(1)</p>						