

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/07/2012
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NAME OF PROVIDER OR SUPPLIER CAMBRIDGE MANOR NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260
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F0000	<p>This visit was for the Investigation of Complaints IN00107297 and IN00107575. This visit resulted in a partially extended survey-immediate jeopardy.</p> <p>Complaint IN00107297 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00107575 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Unrelated deficiencies cited.</p> <p>Survey dates: May 1, 2, 3, 4, 2012 Extended survey dates: May 5, 6, 7, 2012</p> <p>Facility number: 000195 Provider number: 155298 AIM number: 100267690</p> <p>Survey team: Charles Stevenson RN</p> <p>Census bed type: SNF/ NF: 84 Total: 84</p> <p>Census payor type: Medicare: 13</p>	F0000	<p>This serves as the allegation of compliance for Cambridge Manor Nursing and Rehabilitation Center. Cambridge Manor Nursing and Rehabilitation Center asserts that all corrections described on this Plan of Correction have been implemented. In regards to the specific deficiencies, we have outlined our corrective actions and continued interventions to ensure compliance with regulations and our plan of actions.</p> <p>The staff of Cambridge Manor Nursing and Rehabilitation Center is committed to delivering high quality healthcare to its residents to obtain their highest level of physical, mental and psychosocial functioning. We respectfully submit that Cambridge Manor Nursing and Rehabilitation Center is in substantial compliance as set forth below, and we are confident that we will be found in substantial compliance with regulations upon re-survey. The statements made on the Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. Cambridge Manor Nursing and Rehabilitation Center has completed the following interventions as a result of the findings from survey exiting on 5/7/12.</p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></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>Medicaid: 60 Other: 11 Total: 84</p> <p>Sample: 3 Supplemental sample: 3</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 5/14/12 by Suzanne Williams, RN</p>			

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F0223 SS=K	<p>483.13(b), 483.13(b)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>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 interview and record review, the facility failed to protect 2 dependent residents from physical and psychosocial abuse (Transferring residents against their will, using unsafe and physically inappropriate transfer methods, cursing and arguing with another staff member in front of residents) by facility staff (LPN #1) for 2 residents of 2 (Residents E and F) reviewed for staff abuse in a group of 22 residents residing in the halls 3 North and West covered by LPN #1 on 4/15/12 and 21 residents on hall 3 South covered by LPN #1 on 4/17/12, 4/18/12, and 4/19/12 and potentially affected by the deficient practice. The facility also failed to fully investigate, report, and provide protection for residents following an observed physical and verbal altercation between 2 staff members (LPN #1 and QMA#2) potentially affecting 18 residents within seeing and hearing distance of the altercation in a population of 84.</p>	F0223	<p>F223 Free from Abuse/Involuntary Seclusion. Resident's E and F remain at the facility. Both residents were examined by the ADON and no evidence of injury related to the incident was identified. Both residents are receiving at least weekly follow up by the Social Service staff to ensure there are no negative outcomes from the event. The facility initiated another investigation related to the events of 4/15/12. All staff present on that date and several residents were interviewed. LPN#1 was terminated on 4/19/12. On 5/4/12 all residents of the facility were interviewed by the Social Service staff to determine if any resident had concerns about the day of 4/15/12 or any other concern related to staff treatment. Results of the investigation were reported to the department. All facility staff was re-educated on the facility</p>	05/21/2012	

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	<p>The Immediate Jeopardy began on 4/15/2012 when LPN #1 transferred Residents E and F from bed to wheelchair despite their protests that they did not want to get up. LPN #1 cursed at and berated QMA #2 in front of the resident during the transfers. LPN #1 and QMA #2 were then involved in a physical and verbal altercation at the Third Floor Nurse's station in sight and hearing of 18 residents in the third floor dining room. The Administrator, Vice President of Clinical Services, Director of Nursing, and 2 Assistant Directors of Nursing were notified of the immediate jeopardy on 5/03/12 at 4:00 p.m. The Immediate Jeopardy was removed on 5/04/12, but noncompliance remained at a reduced scope and severity of pattern, no actual harm with potential for more than minimal harm that is not immediate jeopardy.</p> <p>Findings Include:</p> <p>1. An undated, untitled report received from the Administrator on 5/01/12 at 3:00 p.m. and indicated by him to be his account of events occurring on 4/15/12 included, but was not limited to:</p> <p>"4/15/2012-At 9:03 am I was awakened by a phone call. It was (QMA #2)...I listened to her concerns which began 'I'm</p>		<p>Abuse Prohibition and Response Policy. All staff was provided a copy of the policy as part of the re-education. This was completed on 5/3/12 and 5/4/12 by the DON, ADONs and the Corporate Nurse and continues. Any staff not available was not allowed to return to duty until the re-education was completed. The Corporate Nurse Consultant completed education of the facility management team on 5/4/12. Focus included timely assessing of the resident. reporting and completing a through investigation. All allegations will be reported per guidelines and investigated. The Corporate Nurse Consultant will provide this education at least annually. All new employees will be re-educated on the facility abuse policy as part of the new employee orientation by the HR representative. Education on the facility abuse policy has been added to the facility education calendar to be included at least twice a year and will be accomplished by the facility Administrator. A meeting of the Resident Council was held on 5/4/12 to review the Abuse Policy and reminding the residents to report any concern</p>				

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	<p>sorry to call you, but the on-call nurses (sic) phone went straight to VM (voice mail).' I told her no problem, tell me what is going on. She began a 13 minute description of what she was upset about, which included (LPN #1)... wanted to get residents up and they did not, and therefore she would not help him. She then told me she went to call the on-call nurse, she said he (LPN #1) followed her down the hall saying nasty things to her, and he grabbed the phone out of her hand and hung it up. I asked her to repeat herself, and she stated '(LPN #1) grabbed the phone from my hand and hung it up!' I told her that was not acceptable, that I would begin addressing it immediately, and that I needed her to write a statement for me of what occurred, and that I would call her back shortly and tell her what was being done...I sent (LPN #6, the on-call nurse) a text message stating we needed to get (LPN #1) out of the building immediately, as apparently he had a dust-up with (QMA #2). She replied she was going over to the facility to find out what was going on, and she would call and tell him (LPN #1) to leave, to which I replied: let me know what you find out. At 9:58 I received a 1 minute phone call from (LPN #6) stating (LPN #1) wanted to stay and do his med pass as he had pre-set some medications. I told her I would call him and get him out of there,</p>		<p>immediately. All residents/responsible parties will be provided a copy of the facility Abuse Policy at the time of admission by the Admission/Marketing Coordinator. The facility has created an audit tool that will be completed at least twice weekly and coordinated by the facility Admission/Marketing Coordinator. At least one resident and one staff member will be interviewed to ensure staff and residents understand the policy. Results of the audit tool will be reviewed weekly in the Daily QA meeting. Any additional action such as education will be completed immediately. The Corporate Nurse Consultant will review all allegations of abuse investigations to ensure the policy has been accomplished and the appropriate action has occurred. Completion Date: 5/21/12</p>	

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	<p>and to make sure to get written, signed, dated statements from everyone on the floor...At 10:20 AM, I phoned the facility and spoke with (LPN #3), as she had answered the phone, who told me (LPN #1) wanted to stay and do his med pass prior to leaving, to which I stated 'no, he needs to leave immediately, would you mind putting him on the phone for me?' To which she replied, 'sure!' I asked him to tell me what happened and write out a statement and sign and date it and leave it for (LPN #6). I told him that (LPN #6) was on her way there, and that if what he was telling me was true, that is (sic) was a minor argument, and it was blown out of proportion, that she would probably call him and return him to work that day. I told him to stop what he was doing immediately and give report to (LPN #3) the other nurse on duty at the time and go home. He agreed. The duration of the phone call was 6 minutes. He agreed and complied, but I never did received (sic) anything other than his verbal statement, as this was another piece of direction that (LPN #6) did not follow.</p> <p>(LPN #6) then called me at 12:20 pm...I asked her what she found out, and she told me that 'it sounded like (LPN #1) was a little out of control, you know how he gets..' (Which I don't but apparently he could be moody?) So I said, well, there's</p>			

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	<p>no way we can bring him back today then, as she was concerned about how to cover the hole (find staffing to cover for LPN #1). I asked 'did you get all the statements?' She told me 'yes', and they would be put under my door so I could get them first thing Monday morning. I also inquired as to whether any residents witnessed this, as that would make it a state reportable, and she told me 'no, no one was around'...As I had told (LPN #6) to get statements from everyone on the floor, the 3 statements I received in the morning (attached, one is now missing after (corporate Regional Nurse's) review showed nothing other than a verbal altercation, in which the phone was grabbed from one staff member..."</p> <p>A hand written statement headed "Incident Report" and dated 4/15/12 prepared and signed by QMA #2 indicated: "On the above stated day on Sunday morning about 8:45 am I was scheduled to work as a QMA on the medication cart. The aide scheduled to work on the North hall did not show up so I volunteered to go on the floor as an aide to do patient care, while (LPN #1) do (sic) the medication administration. The nurse on call was notified and I was asked to do patient care on the North hall which was very much OK with me. As I was passing</p>						

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	<p>the breakfast trays on the North hall, I heard (Resident E) yelling 'Stop it, I don't want to get out of bed.' Just then (LPN #1) called me into the resident's room, still pulling on him to get out of bed. (LPN #1) asked me to help him transfer resident to the wheelchair, against his will. The resident wanted just his cell phone, and (LPN #1) said we don't have time to be looking around, he was just going to transfer him, and he can roam around in his room looking for his cell phone. I reminded (LPN #1) that resident was a fall risk, but just then the cell phone was found on the couch in his room.</p> <p>Next, (LPN #1) went into (Resident F's) room to start pulling on (Resident F) to get her out of bed to eat her breakfast. I offered to feed her in bed, then get her dressed and up after breakfast, again the resident refused to get out of bed in her nightgown. (LPN #1) wouldn't listen to the resident but kept pulling and tugging at her. I reminded him that her mode of transfer is the stand up lift. He have already (sic) pulled her out of bed half way. To prevent her from hitting the floor, I had to help him lift her up into the chair, this time the resident was upset and refused to eat. Out of nowhere, during the ugly transfer of this resident, (LPN #1) started cursing me out using fowl (sic) language, just because I said I was going</p>			

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	<p>to feed (another resident) whose food was now getting cold in the food cart (I had to warm it up before feeding it to him).</p> <p>I could not take all the cursing and rudeness from (LPN #1) anymore and I did not want to go against the ethics of my job, I reported to the other nurse, who then permitted me to make a call to the on call nurse. While I was on the phone, (LPN #1) rushed towards me, grabbed my hand with the phone, cut it off, raised the receiver up, like he was going to hit me, with it, then slammed it down. He was yelling at the same time and all I could do was trying to talk back for him to stop. The other nurse rushed in to intervene and was telling him to stop. I was too surprised at what happened."</p> <p>A hand written statement dated 4/15/12 prepared by LPN #3 indicated: "I was in the dining room supervising when (QMA #2) came to me and said I need to go home (symbol for "and") started crying. I calmed her down and asked why. She said (LPN #1) was calling her names and can not deal with that. I told her I had no authority to let her go home and to call the on call nurse. She picked up the phone and called and as she was talking to on call person I saw (LPN #1) charging toward the NS (nurse's station) and grabbed the phone from</p>				

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	<p>(QMA #2). He said 'You do not make the call I do.' At that point (QMA #2) tried to get the phone and they both started going back and forth. I stood between them and told (LPN #1) to stop because the Residents were present. He went to say, she needs to be looking for another job, she is lazy. I moved (QMA #2) away and later notified on call nurse."</p> <p>LPN #3 was interviewed on 5/03/12 at 11:00 a.m. She indicated that her written statement above was an accurate representation of the events of 4/15/12, and that no administrative or management person had interviewed her or asked for any information related to those events.</p> <p>QMA #2 was interviewed on 5/03/12 at 3:00 p.m. She indicated she was working on the 3rd Floor North hall, when she heard Resident E yelling about not wanting to get out of bed. She was called to the room by LPN #1. She indicated LPN #1 "dragged this man half out of bed." She indicated she told LPN #1 "This man does not get out of bed this way" and the resident was continuing to protest. After Resident F was up, she returned to the hall and continued to pass breakfast trays. She then heard LPN #1 in Resident F's room and went to assist. She indicated Resident F was care planned to use a mechanical lift, and LPN #1 was pulling</p>			

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	<p>on her arms, had her "half out of bed on one butt." She indicated Resident F continued to protest the entire time, and that she had to grab the resident to prevent her from falling during the transfer. She indicated LPN #1's behavior was "erratic" and that he had called her a whore in front of the resident. She indicated that while she was calling the on call nurse LPN #1 "charged" her and grabbed the phone away from her and slammed it down. She indicated this occurred at the nurse's station in front of residents.</p> <p>On 5/04/12 at 9:30 a.m. the 3rd floor ADON provided a list of 18 residents who typically eat in the 3rd floor dining room and would likely have been in the dining room on 4/15/12 at the time of the altercation between LPN #1 and QMA#2.</p> <p>2. The record of Resident E was reviewed on 5/04/12 at 2:00 p.m.</p> <p>Diagnoses included, but were not limited to, end stage renal disease, hypertension, diabetes mellitus, urinary tract infection, anemia, and dementia.</p> <p>An Annual Minimum Data Set (M.D.S.) assessment dated 2/09/12, indicated Resident E was mildly cognitively impaired, had no communication deficits,</p>				

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	<p>was generally understood and could understand when communicating, and had no significant mood or behavioral issues. He was dependent on staff for all activities of daily living. It indicated it was "very important" for Resident E to manage his own daily preferences.</p> <p>A "Social Services Discharge Note" dated 4/6/12 indicated "No impaired decision making noted this observation period."</p> <p>A care plan for resident E dated 3/08/12 indicated "Requires assist (symbol for "with") ADL's (activities of daily living) Needs ext (extensive) assist for bed mobility-transfers."</p> <p>A Fall Risk Assessment completed 12/05/11 indicated a score of 20, with 10 or greater being high risk for falls.</p> <p>3. The record of Resident F was reviewed on 5/04/12 at 3:00 p.m.</p> <p>Diagnoses included, but were not limited to, congestive heart failure, anemia, hypertension, rheumatoid arthritis, and osteoporosis.</p> <p>A Quarterly Minimum Data Set (M.D.S.) assessment dated 3/15/12 indicated Resident F was mildly cognitively impaired, had no communication deficits</p>			

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	<p>or behaviors, and required staff assistance for all activities of daily living, including maximum assistance of 2 staff for transfers.</p> <p>A care plan for Resident F, originated 7/22/11 and updated 3/2012, indicated "At risk for fractures R/T (related to) Osteoporosis...Encourage use of assistive devices...Special care with positioning, transferring and ROM (range of motion)."</p> <p>Nurse's notes for Resident F indicated:</p> <p>4/05/12 6:36 a.m. "Resident is alert to person, place, time, and date...max (maximum) assist of (symbol for 2) staff for transfers with mechanical lift..."</p> <p>4/13/12 4:03 a.m. "...max assist of (symbol for 1) for care and (symbol for 2) staff for transfers (symbol for "with") mechanical lift..."</p> <p>Resident F was interviewed on 5/03/12 at 2:10 p.m. She indicated she remembered LPN #1, and the incident of 4/15/12. Concerning LPN #1, she stated "he was always making me do things I didn't want to." She indicated that on 4/15/12 he "pulled on my arms to make me get up and I didn't want to." She indicated she had heard LPN #1 no longer worked at the facility and stated "Good. You need to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/07/2012
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NAME OF PROVIDER OR SUPPLIER CAMBRIDGE MANOR NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260
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	<p>treat people like you want to be treated. He didn't."</p> <p>4. During an interview on 5/02/12 at 2:30 p.m. with the Administrator, Vice President of Clinical Services, Director of Nursing, second and third floor Assistant Directors of Nursing, and Director of Social Services present, the Administrator indicated that following the allegation of resident abuse by staff on 4/15/12, no resident interviews had been conducted, no staff interviews were conducted, no attempts were made to identify any residents who may have been affected by the incidents, no resident assessments had been done, and that the allegations of abuse had not been reported to the State Agency.</p> <p>During the above interview, the Administrator indicated that following his consideration of the events of 4/15/12, that LPN #1 would be allowed to return to work on his next regularly scheduled day, 4/17/12. Review of time card records indicated LPN #1 worked on 4/17/12, 4/18/12, and 4/19/12 on the 3rd floor South hall, which housed 21 residents. Facility documents indicated, on 4/15/12, LPN #1 worked on the 3rd floor North and West halls, where a combined 22 residents resided.</p>			

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	<p>The personnel record of LPN #1 was reviewed on 5/03/12 at 9:00 a.m. "Disciplinary actions" for LPN #1 included, but were not limited to:</p> <p>4/15/11: "Disruptive or distractive behavior in the workplace. Family stated (LPN #1) and (QMA #2) were arguing over getting resident up to get weight and family felt this was unprofessional." Disposition: Suspension.</p> <p>6/21/11: "Making snide remarks in hallway within hearing range of multiple staff (symbol for "and") res. (residents)." Disposition: Written warning.</p> <p>6/30/11: "Reviewing previous professional performance from 2/11-6/30/11 concerning: 1. Conduct towards staff. 2. Inappropriate conversations in work setting. 3. Disruptive or distractive behaviors." Disposition: Second written warning.</p> <p>7/05/11: Discrepancies in narcotic pain documentation. Disposition: "Final written warning any further discrepancies in documentation, count, or conflicting info (information) from resident will result in termination."</p> <p>10/20/11: "Complaints regarding documentation of patient pain and pain</p>						

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NAME OF PROVIDER OR SUPPLIER CAMBRIDGE MANOR NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260
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	<p>med (medication) administration.</p> <p>Disposition: "Written warning added to previous discipline...Further problems regarding resident pain documentation, and narc (narcotic) count will result in termination."</p> <p>4/16/12: "Conduct unbecoming of a nurse. (LPN #1) arguing (symbol for "with") staff, cursing, (symbol for "and") trying to take phone away from staff." Disposition: Final written warning.</p> <p>An "Employee Disciplinary Action Form" dated 4/19/12, indicated LPN #1 was terminated for refusing to take a drug test. The form indicated "He refused to submit to drug testing saying it would be positive."</p> <p>During an interview on 5/06/12 at 1:15 p.m., the Vice President of Clinical Services indicated that following a series of telephone interviews with staff, she had determined that on 4/15/12 QMA #2 and LPN #3 had prepared voluntary statements concerning the alleged abuse of residents by LPN #1 and subsequent events. She indicated those statements had been given to LPN #6, the on call nurse and Assistant Director of Nursing. She indicated LPN #6 put those statements in a desk drawer without reading them. They remained in the desk</p>			

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	<p>drawer until the afternoon of 4/17/12 when the Administrator requested any documentation she had, and she provided the reports to him.</p> <p>5. An undated facility document titled "Abuse Protection and Response Policy," provided by the Administrator on 5/03/12 and indicated to be a current facility policy, indicated:</p> <p>"1. Policy: Abuse, as hereafter defined, will not be tolerated by anyone, including staff, patients, consultants and volunteers, family members or legal guardians, friends or any other individual (sic) Cambridge Manor Nursing and Rehabilitation Center. The center's administrator is responsible for assuring that patient safety, including freedom from risk of abuse, holds the highest priority.</p> <p>VI. Identification Issues: Any resident event that is reported to any staff by Resident, family member, other staff or any other person will be considered possible abuse if it meets any of the following criteria:</p> <p>A. Any indication of possible willful infliction of injury to include unexplained bruising.</p>						

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NAME OF PROVIDER OR SUPPLIER CAMBRIDGE MANOR NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260
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	<p>E. Any complaint of the use of oral, written, or gestured language that willfully includes disparaging or derogatory terms to Resident or families or within their hearing distance.</p> <p>2. Procedure: Staff observing or hearing about such events will report event immediately, either verbally or in writing, to their immediate supervisor, and the Administrator. The Supervisor will initiate action coordinating with the administrator if he/she is not on site.</p> <p>VII. Investigative Issues:</p> <p>1. Policy: Any staff having either direct or indirect knowledge of any event that might constitute abuse must report the event immediately.</p> <p>2. Procedure: Any staff having any knowledge of any of the above circumstances is required to ensure the incident is reported to the Administrator immediately.</p> <p>3. Policy: All events reported, as possible abuse will be investigated to determine whether abuse did or did not take place.</p> <p>4. Procedure: Supervisory staff will initiate investigative action.</p>			

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NAME OF PROVIDER OR SUPPLIER CAMBRIDGE MANOR NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260		
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	<p>VIII. Protective Issues:</p> <p>1. Policy: Residents will be protected from harm during an investigation.</p> <p>2. Procedure:</p> <p>A. Any individual found to be in danger of injury would be removed from the source of the suspected abusive behavior.</p> <p>B. Medical and emotional support will be made immediately available to any individual suffering suspected abuse.</p> <p>3. Policy: Staff person or persons suspected of abuse will be suspended immediately pending results of the investigation. Pay status during suspension is at the discretion of the Administrator.</p> <p>IX. Reporting and Response Issues:</p> <p>1. Policy: All reports of abuse or alleged abuse or neglect will be immediately assessed to determine the direction of the investigation.</p> <p>2. Procedure: Any allegation of abuse will be reported immediately to the supervisor and administrator. Any investigation that substantiates abuse or neglect findings will be reported immediately to the</p>				

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NAME OF PROVIDER OR SUPPLIER CAMBRIDGE MANOR NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260
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	<p>Administrator or his/her designate representative and to other officials in accordance with State Law within 24 hours of the event.</p> <p>A. State survey and Certification agency.</p> <p>B. All other State required agencies.</p> <p>4. Procedures: An accurate summary reporting of all investigation conducted by the center will be maintained as a working document of the Quality Assessment/Quality Improvement Committee.</p> <p>All reports of abuse or alleged abuse have to be reported to ISDH within 24 hours of the incident. Any pertinent information will be submitted to ISDH within 5 days of the incident. This could include further information obtained as a result of investigation and or information obtained during the interview process."</p> <p>The Immediate Jeopardy that began on 4/15/2012 was removed on 5/04/12 based on the termination of LPN #1, observation and review of the facility's plan of abatement, including interviews with all residents to determine any other concerns about staff treatment, and reeducation of all staff members on resident care and abuse protocols, but noncompliance</p>			

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NAME OF PROVIDER OR SUPPLIER CAMBRIDGE MANOR NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260
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	<p>remained at a reduced scope and severity of pattern, no actual harm with potential for more than minimal harm that is not immediate jeopardy, while the facility completed interviewing and assessing residents, educating staff, and doing staff compliance post testing.</p> <p>3.1-27(a)(1) 3.1-27(b)</p>			

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NAME OF PROVIDER OR SUPPLIER CAMBRIDGE MANOR NURSING & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260			
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F0225 SS=K	<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 review, the facility failed to ensure allegations of</p>	F0225	F225: Investigate and Report Allegations/Individuals. Residents E and F remain at the	05/21/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/07/2012	
NAME OF PROVIDER OR SUPPLIER CAMBRIDGE MANOR NURSING & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260			
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	<p>verbal and physical abuse against 2 dependent residents (transferring residents against their will, using unsafe and physically inappropriate transfer methods, cursing and arguing with another staff member in front of residents) by facility staff (LPN #1), potentially affecting 43 residents on the 3rd floor, and an allegation of an observed physical and verbal altercation between 2 staff members (LPN #1 and QMA#2), potentially affecting 18 residents within seeing and hearing distance of the altercation in a population of 84, were thoroughly investigated, reported to State Agency as required by law, and that resident safety was assured.</p> <p>The Immediate Jeopardy began on 4/15/2012 when LPN #1 transferred Residents E and F from bed to wheelchair despite their protests that they did not want to get up. LPN #1 cursed at and berated QMA #2 in front of the resident during the transfers. LPN #1 and QMA #2 were then involved in a physical and verbal altercation at the Third Floor Nurse's station in sight and hearing of 18 residents in the third floor dining room. The Administrator, Vice President of Clinical Services, Director of Nursing, and 2 Assistant Directors of Nursing were notified of the immediate jeopardy on 5/03/12 at 4:00 p.m. The Immediate</p>		<p>facility. Both residents were examined by the ADON and no evidence of injury related to the incident was identified. Both residents are receiving at least weekly follow up by the Social Service staff to ensure there are no negative outcomes from the event. The facility initiated another investigation related to the events of 4/15/12. All staff present on that date and several residents were interviewed. LPN#1 was terminated on 4/19/12. On 5/4/12 all residents of the facility were interviewed by the Social Service staff to determine if any resident had concerns about the day of 4/15/12 or any other concern related staff treatment. Results of the investigation were reported to the department. All facility staff was re-educated on the facility Abuse Prohibition and Response Policy. All staff was provided a copy of the policy as part of the re-education. This was completed on 5/3/12 and 5/4/12 by the DON, ADONs and the Corporate Nurse and continues. Any staff not available was not allowed to return to duty until the re-education was completed. The Corporate Nurse Consultant completed</p>				

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	<p>Jeopardy was removed on 5/04/12, but noncompliance remained at a reduced scope and severity of pattern, no actual harm with potential for more than minimal harm that is not immediate jeopardy.</p> <p>Findings Include:</p> <p>1. An undated, untitled report received from the Administrator on 5/01/12 at 3:00 p.m. and indicated by him to be his account of events occurring on 4/15/12 included, but was not limited to:</p> <p>"4/15/2012-At 9:03 am I was awakened by a phone call. It was (QMA #2)...I listened to her concerns which began 'I'm sorry to call you, but the on-call nurses (sic) phone went straight to VM (voice mail).' I told her no problem, tell me what is going on. She began a 13 minute description of what she was upset about, which included (LPN #1)... wanted to get residents up and they did not, and therefore she would not help him. She then told me she went to call the on-call nurse, she said he (LPN #1) followed her down the hall saying nasty things to her, and he grabbed the phone out of her hand and hung it up. I asked her to repeat herself, and she stated '(LPN #1) grabbed the phone from my hand and hung it up!' I told her that was not acceptable, that I</p>		<p>education of the facility management team on 5/4/12. Focus included timely assessing of the resident. reporting and completing a through investigation. All allegations will be reported per guidelines and investigated. The Corporate Nurse Consultant will provide this education at least annually. All new employees will be re-educated on the facility abuse policy as part of the new employee orientation by the HR representative. Education on the facility abuse policy has been added to the facility education calendar to be included at least twice a year and will be accomplished by the facility Administrator. A meeting of the Resident Council was held on 5/4/12 to review the Abuse Policy and reminding the residents to report any concern immediately. All residents/responsible parties will be provided a copy of the facility Abuse Policy at the time of admission by the Admission/Marketing Coordinator. The facility has created an audit tool that will be completed at least that will be completed at least twice weekly and coordinated by the facility Admission/Marketing Coordinator. At least one</p>		

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NAME OF PROVIDER OR SUPPLIER CAMBRIDGE MANOR NURSING & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260			
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	would begin addressing it immediately, and that I needed her to write a statement for me of what occurred, and that I would call her back shortly and tell her what was being done...I sent (LPN #6, the on-call nurse) a text message stating we needed to get (LPN #1) out of the building immediately, as apparently he had a dust-up with (QMA #2). She replied she was going over to the facility to find out what was going on, and she would call and tell him (LPN #1) to leave, to which I replied: let me know what you find out. At 9:58 I received a 1 minute phone call from (LPN #6) stating (LPN #1) wanted to stay and do his med pass as he had pre-set some medications. I told her I would call him and get him out of there, and to make sure to get written, signed, dated statements from everyone on the floor...At 10:20 AM, I phoned the facility and spoke with (LPN #3), as she had answered the phone, who told me (LPN #1) wanted to stay and do his med pass prior to leaving, to which I stated 'no, he needs to leave immediately, would you mind putting him on the phone for me?' To which she replied, 'sure!' I asked him to tell me what happened and write out a statement and sign and date it and leave it for (LPN #6). I told him that (LPN #6) was on her way there, and that if what he was telling me was true, that is (sic) was a minor argument, and it was blown out of		resident and one staff member will be interviewed to ensure staff and residents understand the policy. Results of the audit tool will be reviewed weekly in the Daily QA meeting. Any additional action such as education will be completed immediately. The Corporate Nurse Consultant will review all allegations of abuse investigations to ensure the policy has been accomplished and the appropriate action has occurred. Completion Date: 5/21/12				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/07/2012
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NAME OF PROVIDER OR SUPPLIER CAMBRIDGE MANOR NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260
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	<p>proportion, that she would probably call him and return him to work that day. I told him to stop what he was doing immediately and give report to (LPN #3) the other nurse on duty at the time and go home. He agreed. The duration of the phone call was 6 minutes. He agreed and complied, but I never did received (sic) anything other than his verbal statement, as this was another piece of direction that (LPN #6) did not follow.</p> <p>(LPN #6) then called me at 12:20 pm...I asked her what she found out, and she told me that 'it sounded like (LPN #1) was a little out of control, you know how he gets..' (Which I don't but apparently he could be moody?) So I said, well, there's no way we can bring him back today then, as she was concerned about how to cover the hole (find staffing to cover for LPN #1). I asked 'did you get all the statements?' She told me 'yes', and they would be put under my door so I could get them first thing Monday morning. I also inquired as to whether any residents witnessed this, as that would make it a state reportable, and she told me 'no, no one was around'...As I had told (LPN #6) to get statements from everyone on the floor, the 3 statements I received in the morning (attached, one is now missing after (corporate Regional Nurse's) review showed nothing other than a verbal</p>			

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	<p>altercation, in which the phone was grabbed from one staff member..."</p> <p>A hand written statement headed "Incident Report" and dated 4/15/12 prepared and signed by QMA #2 indicated:</p> <p>"On the above stated day on Sunday morning about 8:45 am I was scheduled to work as a QMA on the medication cart. The aide scheduled to work on the North hall did not show up so I volunteered to go on the floor as an aide to do patient care, while (LPN #1) do (sic) the medication administration. The nurse on call was notified and I was asked to do patient care on the North hall which was very much OK with me. As I was passing the breakfast trays on the North hall, I heard (Resident E) yelling 'Stop it, I don't want to get out of bed.' Just then (LPN #1) called me into the resident's room, still pulling on him to get out of bed. (LPN #1) asked me to help him transfer resident to the wheelchair, against his will. The resident wanted just his cell phone, and (LPN #1) said we don't have time to be looking around, he was just going to transfer him, and he can roam around in his room looking for his cell phone. I reminded (LPN #1) that resident was a fall risk, but just then the cell phone was found on the couch in his room.</p>			

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NAME OF PROVIDER OR SUPPLIER CAMBRIDGE MANOR NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260
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	<p>Next, (LPN #1) went into (Resident F's) room to start pulling on (Resident F) to get her out of bed to eat her breakfast. I offered to feed her in bed, then get her dressed and up after breakfast, again the resident refused to get out of bed in her nightgown. (LPN #1) wouldn't listen to the resident but kept pulling and tugging at her. I reminded him that her mode of transfer is the stand up lift. He have already (sic) pulled her out of bed half way. To prevent her from hitting the floor, I had to help him lift her up into the chair, this time the resident was upset and refused to eat. Out of nowhere, during the ugly transfer of this resident, (LPN #1) started cursing me out using fowl (sic) language, just because I said I was going to feed (another resident) whose food was now getting cold in the food cart (I had to warm it up before feeding it to him).</p> <p>I could not take all the cursing and rudeness from (LPN #1) anymore and I did not want to go against the ethics of my job, I reported to the other nurse, who then permitted me to make a call to the on call nurse. While I was on the phone, (LPN #1) rushed towards me, grabbed my hand with the phone, cut it off, raised the receiver up, like he was going to hit me, with it, then slammed it down. He was yelling at the same time and all I could do was trying to talk back for him to stop.</p>			

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NAME OF PROVIDER OR SUPPLIER CAMBRIDGE MANOR NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260
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	<p>The other nurse rushed in to intervene and was telling him to stop. I was too surprised at what happened."</p> <p>A hand written statement dated 4/15/12 prepared by LPN #3 indicated: "I was in the dining room supervising when (QMA #2) came to me and said I need to go home (symbol for "and") started crying. I calmed her down and asked why. She said (LPN #1) was calling her names and can not deal with that. I told her I had no authority to let her go home and to call the on call nurse. She picked up the phone and called and as she was talking to on call person I saw (LPN #1) charging toward the NS (nurse's station) and grabbed the phone from (QMA #2). He said 'You do not make the call I do.' At that point (QMA #2) tried to get the phone and they both started going back and forth. I stood between them and told (LPN #1) to stop because the Residents were present. He went to say, she needs to be looking for another job, she is lazy. I moved (QMA #2) away and later notified on call nurse."</p> <p>LPN #3 was interviewed on 5/03/12 at 11:00 a.m. She indicated that her written statement above was an accurate representation of the events of 4/15/12, and that no administrative or management person had interviewed her or asked for</p>			

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	<p>any information related to those events.</p> <p>QMA #2 was interviewed on 5/03/12 at 3:00 p.m. She indicated she was working on the 3rd Floor North hall, when she heard Resident E yelling about not wanting to get out of bed. She was called to the room by LPN #1. She indicated LPN #1 "dragged this man half out of bed." She indicated she told LPN #1 "This man does not get out of bed this way" and the resident was continuing to protest. After Resident F was up, she returned to the hall and continued to pass breakfast trays. She then heard LPN #1 in Resident F's room and went to assist. She indicated Resident F was care planned to use a mechanical lift, and LPN #1 was pulling on her arms, had her "half out of bed on one butt." She indicated Resident F continued to protest the entire time, and that she had to grab the resident to prevent her from falling during the transfer. She indicated LPN #1's behavior was "erratic" and that he had called her a whore in front of the resident. She indicated that while she was calling the on call nurse LPN #1 "charged" her and grabbed the phone away from her and slammed it down. She indicated this occurred at the nurse's station in front of residents.</p> <p>On 5/04/12 at 9:30 a.m. the 3rd floor</p>			

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	<p>ADON provided a list of 18 residents who typically eat in the 3rd floor dining room and would likely have been in the dining room on 4/15/12 at the time of the altercation between LPN #1 and QMA#2.</p> <p>2. The record of Resident E was reviewed on 5/04/12 at 2:00 p.m.</p> <p>Diagnoses included, but were not limited to, end stage renal disease, hypertension, diabetes mellitus, urinary tract infection, anemia, and dementia.</p> <p>An Annual Minimum Data Set (M.D.S.) assessment dated 2/09/12, indicated Resident E was mildly cognitively impaired, had no communication deficits, was generally understood and could understand when communicating, and had no significant mood or behavioral issues. He was dependent on staff for all activities of daily living. It indicated it was "very important" for Resident E to manage his own daily preferences.</p> <p>A "Social Services Discharge Note" dated 4/6/12 indicated "No impaired decision making noted this observation period."</p> <p>A care plan for resident E dated 3/08/12 indicated "Requires assist (symbol for "with") ADL's (activities of daily living) Needs ext (extensive) assist for bed</p>			

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NAME OF PROVIDER OR SUPPLIER CAMBRIDGE MANOR NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260
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	<p>mobility-transfers."</p> <p>A Fall Risk Assessment completed 12/05/11 indicated a score of 20, with 10 or greater being high risk for falls.</p> <p>3. The record of Resident F was reviewed on 5/04/12 at 3:00 p.m.</p> <p>Diagnoses included, but were not limited to, congestive heart failure, anemia, hypertension, rheumatoid arthritis, and osteoporosis.</p> <p>A Quarterly Minimum Data Set (M.D.S.) assessment dated 3/15/12 indicated Resident F was mildly cognitively impaired, had no communication deficits or behaviors, and required staff assistance for all activities of daily living, including maximum assistance of 2 staff for transfers.</p> <p>A care plan for Resident F, originated 7/22/11 and updated 3/2012, indicated "At risk for fractures R/T (related to) Osteoporosis...Encourage use of assistive devices...Special care with positioning, transferring and ROM (range of motion)."</p> <p>Nurse's notes for Resident F indicated:</p> <p>4/05/12 6:36 a.m. "Resident is alert to person, place, time, and date...max</p>			

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NAME OF PROVIDER OR SUPPLIER CAMBRIDGE MANOR NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260
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	<p>(maximum) assist of (symbol for 2) staff for transfers with mechanical lift..."</p> <p>4/13/12 4:03 a.m. "...max assist of (symbol for 1) for care and (symbol for 2) staff for transfers (symbol for "with") mechanical lift..."</p> <p>Resident F was interviewed on 5/03/12 at 2:10 p.m. She indicated she remembered LPN #1, and the incident of 4/15/12. Concerning LPN #1, she stated "he was always making me do things I didn't want to." She indicated that on 4/15/12 he "pulled on my arms to make me get up and I didn't want to." She indicated she had heard LPN #1 no longer worked at the facility and stated "Good. You need to treat people like you want to be treated. He didn't."</p> <p>4. During an interview on 5/02/12 at 2:30 p.m. with the Administrator, Vice President of Clinical Services, Director of Nursing, second and third floor Assistant Directors of Nursing, and Director of Social Services present, the Administrator indicated that following the allegation of resident abuse by staff on 4/15/12, no resident interviews had been conducted, no staff interviews were conducted, no attempts were made to identify any residents who may have been affected by the incidents, no resident assessments had</p>			

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NAME OF PROVIDER OR SUPPLIER CAMBRIDGE MANOR NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260
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	<p>been done, and that the allegations of abuse had not been reported to the State Agency.</p> <p>During the above interview, the Administrator indicated that following his consideration of the events of 4/15/12, that LPN #1 would be allowed to return to work on his next regularly scheduled day, 4/17/12. Review of time card records indicated LPN #1 worked on 4/17/12, 4/18/12, and 4/19/12 on the 3rd floor South hall, which housed 21 residents. Facility documents indicated, on 4/15/12, LPN #1 worked on the 3rd floor North and West halls, where a combined 22 residents resided.</p> <p>The personnel record of LPN #1 was reviewed on 5/03/12 at 9:00 a.m. "Disciplinary actions" for LPN #1 included, but were not limited to:</p> <p>4/15/11: "Disruptive or distractive behavior in the workplace. Family stated (LPN #1) and (QMA #2) were arguing over getting resident up to get weight and family felt this was unprofessional." Disposition: Suspension.</p> <p>6/21/11: "Making snide remarks in hallway within hearing range of multiple staff (symbol for "and") res. (residents)." Disposition: Written warning.</p>			

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	<p>6/30/11: "Reviewing previous professional performance from 2/11-6/30/11 concerning: 1. Conduct towards staff. 2. Inappropriate conversations in work setting. 3. Disruptive or distractive behaviors." Disposition: Second written warning.</p> <p>7/05/11: Discrepancies in narcotic pain documentation. Disposition: "Final written warning any further discrepancies in documentation, count, or conflicting info (information) from resident will result in termination."</p> <p>10/20/11: "Complaints regarding documentation of patient pain and pain med (medication) administration. Disposition: "Written warning added to previous discipline...Further problems regarding resident pain documentation, and narc (narcotic) count will result in termination."</p> <p>4/16/12: "Conduct unbecoming of a nurse. (LPN #1) arguing (symbol for "with") staff, cursing, (symbol for "and") trying to take phone away from staff." Disposition: Final written warning.</p> <p>An "Employee Disciplinary Action Form" dated 4/19/12, indicated LPN #1 was terminated for refusing to take a drug test.</p>			

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NAME OF PROVIDER OR SUPPLIER CAMBRIDGE MANOR NURSING & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>The form indicated "He refused to submit to drug testing saying it would be positive."</p> <p>During an interview on 5/06/12 at 1:15 p.m., the Vice President of Clinical Services indicated that following a series of telephone interviews with staff, she had determined that on 4/15/12 QMA #2 and LPN #3 had prepared voluntary statements concerning the alleged abuse of residents by LPN #1 and subsequent events. She indicated those statements had been given to LPN #6, the on call nurse and Assistant Director of Nursing. She indicated LPN #6 put those statements in a desk drawer without reading them. They remained in the desk drawer until the afternoon of 4/17/12 when the Administrator requested any documentation she had, and she provided the reports to him. These statements are included in their entirety above.</p> <p>The Immediate Jeopardy that began on 4/15/2012 was removed on 5/04/12 based on the termination of LPN #1, observation and review of the facility's plan of abatement, including interviews with all residents to determine any other concerns about staff treatment, and reeducation of all staff members on resident care and abuse protocols, but noncompliance remained at a reduced scope and severity</p>						

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NAME OF PROVIDER OR SUPPLIER CAMBRIDGE MANOR NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260
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	<p>of pattern, no actual harm with potential for more than minimal harm that is not immediate jeopardy, while the facility completed interviewing and assessing residents, educating staff, and doing staff compliance post testing.</p> <p>3.1-28(c) 3.1-28(d) 3.1-28(e)</p>			

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--	---	--	---

NAME OF PROVIDER OR SUPPLIER CAMBRIDGE MANOR NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260
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F0226 SS=K	<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 implement their abuse prevention policy to ensure allegations of verbal and physical abuse against 2 dependent residents (transferring residents against their will, using unsafe and physically inappropriate transfer methods, cursing and arguing with another staff member in front of residents) by facility staff (LPN #1), potentially affecting 43 residents on the 3rd floor, and an allegation of an observed physical and verbal altercation between 2 staff members (LPN #1 and QMA#2), potentially affecting 18 residents within seeing and hearing distance of the altercation in a population of 84, were thoroughly investigated, reported to State Agency as required by law, and that resident safety was assured.</p> <p>The Immediate Jeopardy began on 4/15/2012 when LPN #1 transferred Residents E and F from bed to wheelchair despite their protests that they did not want to get up. LPN #1 cursed at and berated QMA #2 in front of the resident</p>	F0226	<p>F226 Develop/Implement Abuse/Neglect, ETC Policies Resident's E and F remain at the facility. Both residents were examined by the ADON and no evidence of injury related to the incident was identified. Both residents are receiving at least weekly follow up by the Social Service staff to ensure there are no negative outcomes from the event. The facility initiated another investigation related to the events of 4/15/12. All staff present on that date and several residents were interviewed. LPN#1 was terminated on 4/19/12. On 5/4/12 all residents of the facility were interviewed by the Social Service staff to determine if any resident had concerns about the day of 4/15/12 or any other concern related staff treatment. Results of the investigation were reported to the department. All facility staff was re-educated on the facility Abuse Prohibition and Response Policy. All staff was provided a copy of the policy as part of the</p>	05/21/2012

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	<p>during the transfers. LPN #1 and QMA #2 were then involved in a physical and verbal altercation at the Third Floor Nurse's station in sight and hearing of 18 residents in the third floor dining room. The Administrator, Vice President of Clinical Services, Director of Nursing, and 2 Assistant Directors of Nursing were notified of the immediate jeopardy on 5/03/12 at 4:00 p.m. The Immediate Jeopardy was removed on 5/04/12, but noncompliance remained at a reduced scope and severity of pattern, no actual harm with potential for more than minimal harm that is not immediate jeopardy.</p> <p>Findings Include:</p> <p>1. An undated, untitled report received from the Administrator on 5/01/12 at 3:00 p.m. and indicated by him to be his account of events occurring on 4/15/12 included, but was not limited to:</p> <p>"4/15/2012-At 9:03 am I was awakened by a phone call. It was (QMA #2)...I listened to her concerns which began 'I'm sorry to call you, but the on-call nurses (sic) phone went straight to VM (voice mail).' I told her no problem, tell me what is going on. She began a 13 minute description of what she was upset about, which included (LPN #1)... wanted to get</p>		<p>re-education. This was completed on 5/3/12 and 5/4/12 by the DON, ADONs and the Corporate Nurse and continues. Any staff not available was not allowed to return to duty until the re-education was completed. The Corporate Nurse Consultant completed education of the facility management team on 5/4/12. Focus included timely assessing of the resident. reporting and completing a through investigation. All allegations will be reported per guidelines and investigated. The Corporate Nurse Consultant will provide this education at least annually. All new employees will be re-educated on the facility abuse policy as part of the new employee orientation by the HR representative. Education on the facility abuse policy has been added to the facility education calendar to be included at least twice a year and will be accomplished by the facility Administrator. A meeting of the Resident Council was held on 5/4/12 to review the Abuse Policy and reminding the residents to report any concern immediately. All residents/responsible parties will be provided a copy of the</p>		

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NAME OF PROVIDER OR SUPPLIER CAMBRIDGE MANOR NURSING & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260			
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	<p>residents up and they did not, and therefore she would not help him. She then told me she went to call the on-call nurse, she said he (LPN #1) followed her down the hall saying nasty things to her, and he grabbed the phone out of her hand and hung it up. I asked her to repeat herself, and she stated '(LPN #1) grabbed the phone from my hand and hung it up!' I told her that was not acceptable, that I would begin addressing it immediately, and that I needed her to write a statement for me of what occurred, and that I would call her back shortly and tell her what was being done...I sent (LPN #6, the on-call nurse) a text message stating we needed to get (LPN #1) out of the building immediately, as apparently he had a dust-up with (QMA #2). She replied she was going over to the facility to find out what was going on, and she would call and tell him (LPN #1) to leave, to which I replied: let me know what you find out. At 9:58 I received a 1 minute phone call from (LPN #6) stating (LPN #1) wanted to stay and do his med pass as he had pre-set some medications. I told her I would call him and get him out of there, and to make sure to get written, signed, dated statements from everyone on the floor...At 10:20 AM, I phoned the facility and spoke with (LPN #3), as she had answered the phone, who told me (LPN #1) wanted to stay and do his med pass</p>		<p>facility Abuse Policy at the time of admission by the Admission/Marketing Coordinator. The facility has created an audit tool that will be completed at least that will be completed at least twice weekly and coordinated by the facility Admission/Marketing Coordinator. At least one resident and one staff member will be interviewed to ensure staff and residents understand the policy. Results of the audit tool will be reviewed weekly in the Daily QA meeting. Any additional action such as education will be completed immediately. The Corporate Nurse Consultant will review all allegations of abuse investigations to ensure the policy has been accomplished and the appropriate action has occurred. Completion Date: 5/21/12</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/07/2012
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	<p>prior to leaving, to which I stated 'no, he needs to leave immediately, would you mind putting him on the phone for me?' To which she replied, 'sure!' I asked him to tell me what happened and write out a statement and sign and date it and leave it for (LPN #6). I told him that (LPN #6) was on her way there, and that if what he was telling me was true, that is (sic) was a minor argument, and it was blown out of proportion, that she would probably call him and return him to work that day. I told him to stop what he was doing immediately and give report to (LPN #3) the other nurse on duty at the time and go home. He agreed. The duration of the phone call was 6 minutes. He agreed and complied, but I never did received (sic) anything other than his verbal statement, as this was another piece of direction that (LPN #6) did not follow.</p> <p>(LPN #6) then called me at 12:20 pm...I asked her what she found out, and she told me that 'it sounded like (LPN #1) was a little out of control, you know how he gets..' (Which I don't but apparently he could be moody?) So I said, well, there's no way we can bring him back today then, as she was concerned about how to cover the hole (find staffing to cover for LPN #1). I asked 'did you get all the statements?' She told me 'yes', and they would be put under my door so I could</p>			

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	<p>get them first thing Monday morning. I also inquired as to whether any residents witnessed this, as that would make it a state reportable, and she told me 'no, no one was around'...As I had told (LPN #6) to get statements from everyone on the floor, the 3 statements I received in the morning (attached, one is now missing after (corporate Regional Nurse's) review showed nothing other than a verbal altercation, in which the phone was grabbed from one staff member..."</p> <p>A hand written statement headed "Incident Report" and dated 4/15/12 prepared and signed by QMA #2 indicated: "On the above stated day on Sunday morning about 8:45 am I was scheduled to work as a QMA on the medication cart. The aide scheduled to work on the North hall did not show up so I volunteered to go on the floor as an aide to do patient care, while (LPN #1) do (sic) the medication administration. The nurse on call was notified and I was asked to do patient care on the North hall which was very much OK with me. As I was passing the breakfast trays on the North hall, I heard (Resident E) yelling 'Stop it, I don't want to get out of bed.' Just then (LPN #1) called me into the resident's room, still pulling on him to get out of bed. (LPN #1) asked me to help him transfer</p>			
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	<p>resident to the wheelchair, against his will. The resident wanted just his cell phone, and (LPN #1) said we don't have time to be looking around, he was just going to transfer him, and he can roam around in his room looking for his cell phone. I reminded (LPN #1) that resident was a fall risk, but just then the cell phone was found on the couch in his room.</p> <p>Next, (LPN #1) went into (Resident F's) room to start pulling on (Resident F) to get her out of bed to eat her breakfast. I offered to feed her in bed, then get her dressed and up after breakfast, again the resident refused to get out of bed in her nightgown. (LPN #1) wouldn't listen to the resident but kept pulling and tugging at her. I reminded him that her mode of transfer is the stand up lift. He have already (sic) pulled her out of bed half way. To prevent her from hitting the floor, I had to help him lift her up into the chair, this time the resident was upset and refused to eat. Out of nowhere, during the ugly transfer of this resident, (LPN #1) started cursing me out using fowl (sic) language, just because I said I was going to feed (another resident) whose food was now getting cold in the food cart (I had to warm it up before feeding it to him).</p> <p>I could not take all the cursing and rudeness from (LPN #1) anymore and I</p>			

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	<p>did not want to go against the ethics of my job, I reported to the other nurse, who then permitted me to make a call to the on call nurse. While I was on the phone, (LPN #1) rushed towards me, grabbed my hand with the phone, cut it off, raised the receiver up, like he was going to hit me, with it, then slammed it down. He was yelling at the same time and all I could do was trying to talk back for him to stop. The other nurse rushed in to intervene and was telling him to stop. I was too surprised at what happened."</p> <p>A hand written statement dated 4/15/12 prepared by LPN #3 indicated: "I was in the dining room supervising when (QMA #2) came to me and said I need to go home (symbol for "and") started crying. I calmed her down and asked why. She said (LPN #1) was calling her names and can not deal with that. I told her I had no authority to let her go home and to call the on call nurse. She picked up the phone and called and as she was talking to on call person I saw (LPN #1) charging toward the NS (nurse's station) and grabbed the phone from (QMA #2). He said 'You do not make the call I do.' At that point (QMA #2) tried to get the phone and they both started going back and forth. I stood between them and told (LPN #1) to stop because the Residents were present. He went to say,</p>			

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	<p>she needs to be looking for another job, she is lazy. I moved (QMA #2) away and later notified on call nurse."</p> <p>LPN #3 was interviewed on 5/03/12 at 11:00 a.m. She indicated that her written statement above was an accurate representation of the events of 4/15/12, and that no administrative or management person had interviewed her or asked for any information related to those events.</p> <p>QMA #2 was interviewed on 5/03/12 at 3:00 p.m. She indicated she was working on the 3rd Floor North hall, when she heard Resident E yelling about not wanting to get out of bed. She was called to the room by LPN #1. She indicated LPN #1 "dragged this man half out of bed." She indicated she told LPN #1 "This man does not get out of bed this way" and the resident was continuing to protest. After Resident F was up, she returned to the hall and continued to pass breakfast trays. She then heard LPN #1 in Resident F's room and went to assist. She indicated Resident F was care planned to use a mechanical lift, and LPN #1 was pulling on her arms, had her "half out of bed on one butt." She indicated Resident F continued to protest the entire time, and that she had to grab the resident to prevent her from falling during the transfer. She indicated LPN #1's behavior</p>			

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	<p>was "erratic" and that he had called her a whore in front of the resident. She indicated that while she was calling the on call nurse LPN #1 "charged" her and grabbed the phone away from her and slammed it down. She indicated this occurred at the nurse's station in front of residents.</p> <p>On 5/04/12 at 9:30 a.m. the 3rd floor ADON provided a list of 18 residents who typically eat in the 3rd floor dining room and would likely have been in the dining room on 4/15/12 at the time of the altercation between LPN #1 and QMA#2.</p> <p>2. The record of Resident E was reviewed on 5/04/12 at 2:00 p.m.</p> <p>Diagnoses included, but were not limited to, end stage renal disease, hypertension, diabetes mellitus, urinary tract infection, anemia, and dementia.</p> <p>An Annual Minimum Data Set (M.D.S.) assessment dated 2/09/12, indicated Resident E was mildly cognitively impaired, had no communication deficits, was generally understood and could understand when communicating, and had no significant mood or behavioral issues. He was dependent on staff for all activities of daily living. It indicated it was "very important" for Resident E to</p>			

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	<p>manage his own daily preferences.</p> <p>A "Social Services Discharge Note" dated 4/6/12 indicated "No impaired decision making noted this observation period."</p> <p>A care plan for resident E dated 3/08/12 indicated "Requires assist (symbol for "with") ADL's (activities of daily living) Needs ext (extensive) assist for bed mobility-transfers."</p> <p>A Fall Risk Assessment completed 12/05/11 indicated a score of 20, with 10 or greater being high risk for falls.</p> <p>3. The record of Resident F was reviewed on 5/04/12 at 3:00 p.m.</p> <p>Diagnoses included, but were not limited to, congestive heart failure, anemia, hypertension, rheumatoid arthritis, and osteoporosis.</p> <p>A Quarterly Minimum Data Set (M.D.S.) assessment dated 3/15/12 indicated Resident F was mildly cognitively impaired, had no communication deficits or behaviors, and required staff assistance for all activities of daily living, including maximum assistance of 2 staff for transfers.</p> <p>A care plan for Resident F, originated</p>				

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	<p>7/22/11 and updated 3/2012, indicated "At risk for fractures R/T (related to) Osteoporosis...Encourage use of assistive devices...Special care with positioning, transferring and ROM (range of motion)."</p> <p>Nurse's notes for Resident F indicated:</p> <p>4/05/12 6:36 a.m. "Resident is alert to person, place, time, and date...max (maximum) assist of (symbol for 2) staff for transfers with mechanical lift..."</p> <p>4/13/12 4:03 a.m. "...max assist of (symbol for 1) for care and (symbol for 2) staff for transfers (symbol for "with") mechanical lift..."</p> <p>Resident F was interviewed on 5/03/12 at 2:10 p.m. She indicated she remembered LPN #1, and the incident of 4/15/12. Concerning LPN #1, she stated "he was always making me do things I didn't want to." She indicated that on 4/15/12 he "pulled on my arms to make me get up and I didn't want to." She indicated she had heard LPN #1 no longer worked at the facility and stated "Good. You need to treat people like you want to be treated. He didn't."</p> <p>4. During an interview on 5/02/12 at 2:30 p.m. with the Administrator, Vice President of Clinical Services, Director of</p>			

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	<p>Nursing, second and third floor Assistant Directors of Nursing, and Director of Social Services present, the Administrator indicated that following the allegation of resident abuse by staff on 4/15/12, no resident interviews had been conducted, no staff interviews were conducted, no attempts were made to identify any residents who may have been affected by the incidents, no resident assessments had been done, and that the allegations of abuse had not been reported to the State Agency.</p> <p>During the above interview, the Administrator indicated that following his consideration of the events of 4/15/12, that LPN #1 would be allowed to return to work on his next regularly scheduled day, 4/17/12. Review of time card records indicated LPN #1 worked on 4/17/12, 4/18/12, and 4/19/12 on the 3rd floor South hall, which housed 21 residents. Facility documents indicated, on 4/15/12, LPN #1 worked on the 3rd floor North and West halls, where a combined 22 residents resided.</p> <p>The personnel record of LPN #1 was reviewed on 5/03/12 at 9:00 a.m. "Disciplinary actions" for LPN #1 included, but were not limited to:</p> <p>4/15/11: "Disruptive or distractive</p>			

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	<p>behavior in the workplace. Family stated (LPN #1) and (QMA #2) were arguing over getting resident up to get weight and family felt this was unprofessional." Disposition: Suspension.</p> <p>6/21/11: "Making snide remarks in hallway within hearing range of multiple staff (symbol for "and") res. (residents)." Disposition: Written warning.</p> <p>6/30/11: "Reviewing previous professional performance from 2/11-6/30/11 concerning: 1. Conduct towards staff. 2. Inappropriate conversations in work setting. 3. Disruptive or distractive behaviors." Disposition: Second written warning.</p> <p>7/05/11: Discrepancies in narcotic pain documentation. Disposition: "Final written warning any further discrepancies in documentation, count, or conflicting info (information) from resident will result in termination."</p> <p>10/20/11: "Complaints regarding documentation of patient pain and pain med (medication) administration. Disposition: "Written warning added to previous discipline...Further problems regarding resident pain documentation, and narc (narcotic) count will result in termination."</p>			

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	<p>4/16/12: "Conduct unbecoming of a nurse. (LPN #1) arguing (symbol for "with") staff, cursing, (symbol for "and") trying to take phone away from staff." Disposition: Final written warning.</p> <p>An "Employee Disciplinary Action Form" dated 4/19/12, indicated LPN #1 was terminated for refusing to take a drug test. The form indicated "He refused to submit to drug testing saying it would be positive."</p> <p>During an interview on 5/06/12 at 1:15 p.m., the Vice President of Clinical Services indicated that following a series of telephone interviews with staff, she had determined that on 4/15/12 QMA #2 and LPN #3 had prepared voluntary statements concerning the alleged abuse of residents by LPN #1 and subsequent events. She indicated those statements had been given to LPN #6, the on call nurse and Assistant Director of Nursing. She indicated LPN #6 put those statements in a desk drawer without reading them. They remained in the desk drawer until the afternoon of 4/17/12 when the Administrator requested any documentation she had, and she provided the reports to him.</p> <p>5. An undated facility document titled</p>			

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	<p>"Abuse Protection and Response Policy," provided by the Administrator on 5/03/12 and indicated to be a current facility policy, indicated:</p> <p>"1. Policy: Abuse, as hereafter defined, will not be tolerated by anyone, including staff, patients, consultants and volunteers, family members or legal guardians, friends or any other individual (sic) Cambridge Manor Nursing and Rehabilitation Center. The center's administrator is responsible for assuring that patient safety, including freedom from risk of abuse, holds the highest priority.</p> <p>VI. Identification Issues: Any resident event that is reported to any staff by Resident, family member, other staff or any other person will be considered possible abuse if it meets any of the following criteria:</p> <p>A. Any indication of possible willful infliction of injury to include unexplained bruising.</p> <p>E. Any complaint of the use of oral, written, or gestured language that willfully includes disparaging or derogatory terms to Resident or families or within their hearing distance.</p>			

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	<p>2. Procedure: Staff observing or hearing about such events will report event immediately, either verbally or in writing, to their immediate supervisor, and the Administrator. The Supervisor will initiate action coordinating with the administrator if he/she is not on site.</p> <p>VII. Investigative Issues:</p> <p>1. Policy: Any staff having either direct or indirect knowledge of any event that might constitute abuse must report the event immediately.</p> <p>2. Procedure: Any staff having any knowledge of any of the above circumstances is required to ensure the incident is reported to the Administrator immediately.</p> <p>3. Policy: All events reported, as possible abuse will be investigated to determine whether abuse did or did not take place.</p> <p>4. Procedure: Supervisory staff will initiate investigative action.</p> <p>VIII. Protective Issues:</p> <p>1. Policy: Residents will be protected from harm during an investigation.</p> <p>2. Procedure:</p>			

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NAME OF PROVIDER OR SUPPLIER CAMBRIDGE MANOR NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260
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	<p>A. Any individual found to be in danger of injury would be removed from the source of the suspected abusive behavior.</p> <p>B. Medical and emotional support will be made immediately available to any individual suffering suspected abuse.</p> <p>3. Policy: Staff person or persons suspected of abuse will be suspended immediately pending results of the investigation. Pay status during suspension is at the discretion of the Administrator.</p> <p>IX. Reporting and Response Issues:</p> <p>1. Policy: All reports of abuse or alleged abuse or neglect will be immediately assessed to determine the direction of the investigation.</p> <p>2. Procedure: Any allegation of abuse will be reported immediately to the supervisor and administrator. Any investigation that substantiates abuse or neglect findings will be reported immediately to the Administrator or his/her designate representative and to other officials in accordance with State Law within 24 hours of the event.</p> <p>A. State survey and Certification agency.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/07/2012	
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	<p>B. All other State required agencies.</p> <p>4. Procedures: An accurate summary reporting of all investigation conducted by the center will be maintained as a working document of the Quality Assessment/Quality Improvement Committee.</p> <p>All reports of abuse or alleged abuse have to be reported to ISDH within 24 hours of the incident. Any pertinent information will be submitted to ISDH within 5 days of the incident. This could include further information obtained as a result of investigation and or information obtained during the interview process."</p> <p>During an interview with the Vice President of Clinical services on 5/07/12 at 3:00 p.m. she indicated that the above referenced policy was the policy related to abuse issues in place at the facility and that it was the parent corporation's expectation that these policies and procedures would be followed by staff and management of the facility.</p> <p>The Immediate Jeopardy that began on 4/15/2012 was removed on 5/04/12 based on the termination of LPN #1, observation and review of the facility's plan of abatement, including interviews with all</p>						

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	<p>residents to determine any other concerns about staff treatment, and reeducation of all staff members on resident care and abuse protocols, but noncompliance remained at a reduced scope and severity of pattern, no actual harm with potential for more than minimal harm that is not immediate jeopardy, while the facility completed interviewing and assessing residents, educating staff, and doing staff compliance post testing.</p> <p>3.1-28(a) 3.1-28(c) 3.1-28(d) 3.1-28(e)</p>			

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F0490 SS=K	<p>483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING</p> <p>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>Based on interview and record review, the facility failed to ensure the facility was administered in a manner that enabled residents to attain and maintain the highest practicable physical, mental, and psychosocial well-being by not following State and Federal regulations and facility policy to ensure allegations of verbal and physical abuse against 2 dependent residents (transferring residents against their will, using unsafe and physically inappropriate transfer methods, cursing and arguing with another staff member in front of residents) by facility staff (LPN #1), potentially affecting 43 residents on the 3rd floor, and an allegation of an observed physical and verbal altercation between 2 staff members (LPN #1 and QMA#2), potentially affecting 18 residents within seeing and hearing distance of the altercation in a population of 84, were thoroughly investigated, reported to State Agency as required by law, and that resident safety was assured.</p> <p>The Immediate Jeopardy began on 4/15/2012 when LPN #1 transferred</p>	F0490	<p>F490 Effective Administration/Resident well being. Residents E and F remain at the facility. Both residents were examined by the ADON and no evidence of injury related to the incident were identified. Both residents are receiving at least weekly follow up by the Social Service staff to ensure there are no negative outcomes from the event. The facility initiated another investigation related to the events of 4/15/12. All staff present on that date and several residents were interviewed. LPN#1 was terminated on 4/19/12. On 5/4/12 all residents of the facility were interviewed by the Social Service staff to determine if any resident had concerns about the day of 4/15/12 or any other concern related staff treatment. Results of the investigation were reported to the department. The facility has a new Administrator. All facility staff was re-educated on the facility Abuse Prohibition and Response Policy. All staff was</p>	05/21/2012			

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	<p>Residents E and F from bed to wheelchair despite their protests that they did not want to get up. LPN #1 cursed at and berated QMA #2 in front of the resident during the transfers. LPN #1 and QMA #2 were then involved in a physical and verbal altercation at the Third Floor Nurse's station in sight and hearing of 18 residents in the third floor dining room. The Administrator, Vice President of Clinical Services, Director of Nursing, and 2 Assistant Directors of Nursing were notified of the immediate jeopardy on 5/03/12 at 4:00 p.m. The Immediate Jeopardy was removed on 5/04/12, but noncompliance remained at a reduced scope and severity of pattern, no actual harm with potential for more than minimal harm that is not immediate jeopardy.</p> <p>Findings Include:</p> <p>1. An undated, untitled report received from the Administrator on 5/01/12 at 3:00 p.m. and indicated by him to be his account of events occurring on 4/15/12 included, but was not limited to:</p> <p>"4/15/2012-At 9:03 am I was awakened by a phone call. It was (QMA #2)...I listened to her concerns which began 'I'm sorry to call you, but the on-call nurses (sic) phone went straight to VM (voice</p>		<p>provided a copy of the policy as part of the re-education. This was completed on 5/3/12 and 5/4/12 by the DON, ADONs and the Corporate Nurse and continues. Any staff not available was not allowed to return to duty until the re-education was completed. Education of the facility management team was completed on 5/4/12 by the corporate nurse consultant. Focus included timely assessing of the resident. reporting and completing a through investigation. All allegations will be reported per guidelines and investigated. The corporate nurse consultant will provide this education at least annually. On 5/15/12 the facility changed to the parent corporations Abuse Prohibition Policy. Education was completed on 5/14 and 5/15 for all facility on this policy by the Corporate Nurse Consultant. A copy of the policy was provided to all staff. A copy was provided to the Admission/Marketing Coordinator to provide to residents/responsible parties of all new admissions by the Admission/Marketing Coordinator. A copy was provided to the facility HR representative to provide to all new employees at the time of</p>				

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	mail).' I told her no problem, tell me what is going on. She began a 13 minute description of what she was upset about, which included (LPN #1)... wanted to get residents up and they did not, and therefore she would not help him. She then told me she went to call the on-call nurse, she said he (LPN #1) followed her down the hall saying nasty things to her, and he grabbed the phone out of her hand and hung it up. I asked her to repeat herself, and she stated '(LPN #1) grabbed the phone from my hand and hung it up!' I told her that was not acceptable, that I would begin addressing it immediately, and that I needed her to write a statement for me of what occurred, and that I would call her back shortly and tell her what was being done...I sent (LPN #6, the on-call nurse) a text message stating we needed to get (LPN #1) out of the building immediately, as apparently he had a dust-up with (QMA #2). She replied she was going over to the facility to find out what was going on, and she would call and tell him (LPN #1) to leave, to which I replied: let me know what you find out. At 9:58 I received a 1 minute phone call from (LPN #6) stating (LPN #1) wanted to stay and do his med pass as he had pre-set some medications. I told her I would call him and get him out of there, and to make sure to get written, signed, dated statements from everyone on the		new facility orientation. All new employees will be re-educated on the facility abuse policy as part of the new employee orientation. Education on the facility abuse policy has been added to the facility education calendar to be included at least twice a year and will be accomplished by the facility Administrator. A meeting of the Resident Council was held on 5/4/12 to review the Abuse Policy and reminding the residents to report any concern immediately. All residents and responsible parties will be provided a copy of the facility Abuse Policy at the time of admission. The facility has created an audit tool that will be completed at least that will be completed at least twice weekly and coordinated by the facility Admission/Marketing Coordinator. At least one resident and one staff member will be interviewed to ensure staff and residents understand the policy. Results of the audit tool will be reviewed weekly in the Daily QA meeting. Any additional action such as education will be completed immediately. The Corporate Nurse Consultant will review all allegations of abuse investigations to ensure the policy has been accomplished and the appropriate action has				

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	<p>floor...At 10:20 AM, I phoned the facility and spoke with (LPN #3), as she had answered the phone, who told me (LPN #1) wanted to stay and do his med pass prior to leaving, to which I stated 'no, he needs to leave immediately, would you mind putting him on the phone for me?' To which she replied, 'sure!' I asked him to tell me what happened and write out a statement and sign and date it and leave it for (LPN #6). I told him that (LPN #6) was on her way there, and that if what he was telling me was true, that is (sic) was a minor argument, and it was blown out of proportion, that she would probably call him and return him to work that day. I told him to stop what he was doing immediately and give report to (LPN #3) the other nurse on duty at the time and go home. He agreed. The duration of the phone call was 6 minutes. He agreed and complied, but I never did received (sic) anything other than his verbal statement, as this was another piece of direction that (LPN #6) did not follow.</p> <p>(LPN #6) then called me at 12:20 pm...I asked her what she found out, and she told me that 'it sounded like (LPN #1) was a little out of control, you know how he gets..' (Which I don't but apparently he could be moody?) So I said, well, there's no way we can bring him back today then, as she was concerned about how to cover</p>		<p>occurred. Completion Date: 5/21/12</p>	

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	<p>the hole (find staffing to cover for LPN #1). I asked 'did you get all the statements?' She told me 'yes', and they would be put under my door so I could get them first thing Monday morning. I also inquired as to whether any residents witnessed this, as that would make it a state reportable, and she told me 'no, no one was around'...As I had told (LPN #6) to get statements from everyone on the floor, the 3 statements I received in the morning (attached, one is now missing after (corporate Regional Nurse's) review showed nothing other than a verbal altercation, in which the phone was grabbed from one staff member..."</p> <p>A hand written statement headed "Incident Report" and dated 4/15/12 prepared and signed by QMA #2 indicated:</p> <p>"On the above stated day on Sunday morning about 8:45 am I was scheduled to work as a QMA on the medication cart. The aide scheduled to work on the North hall did not show up so I volunteered to go on the floor as an aide to do patient care, while (LPN #1) do (sic) the medication administration. The nurse on call was notified and I was asked to do patient care on the North hall which was very much OK with me. As I was passing the breakfast trays on the North hall, I heard (Resident E) yelling 'Stop it, I don't</p>			

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	<p>want to get out of bed.' Just then (LPN #1) called me into the resident's room, still pulling on him to get out of bed. (LPN #1) asked me to help him transfer resident to the wheelchair, against his will. The resident wanted just his cell phone, and (LPN #1) said we don't have time to be looking around, he was just going to transfer him, and he can roam around in his room looking for his cell phone. I reminded (LPN #1) that resident was a fall risk, but just then the cell phone was found on the couch in his room.</p> <p>Next, (LPN #1) went into (Resident F's) room to start pulling on (Resident F) to get her out of bed to eat her breakfast. I offered to feed her in bed, then get her dressed and up after breakfast, again the resident refused to get out of bed in her nightgown. (LPN #1) wouldn't listen to the resident but kept pulling and tugging at her. I reminded him that her mode of transfer is the stand up lift. He have already (sic) pulled her out of bed half way. To prevent her from hitting the floor, I had to help him lift her up into the chair, this time the resident was upset and refused to eat. Out of nowhere, during the ugly transfer of this resident, (LPN #1) started cursing me out using fowl (sic) language, just because I said I was going to feed (another resident) whose food was now getting cold in the food cart (I had to</p>			

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	<p>warm it up before feeding it to him).</p> <p>I could not take all the cursing and rudeness from (LPN #1) anymore and I did not want to go against the ethics of my job, I reported to the other nurse, who then permitted me to make a call to the on call nurse. While I was on the phone, (LPN #1) rushed towards me, grabbed my hand with the phone, cut it off, raised the receiver up, like he was going to hit me, with it, then slammed it down. He was yelling at the same time and all I could do was trying to talk back for him to stop. The other nurse rushed in to intervene and was telling him to stop. I was too surprised at what happened."</p> <p>A hand written statement dated 4/15/12 prepared by LPN #3 indicated: "I was in the dining room supervising when (QMA #2) came to me and said I need to go home (symbol for "and") started crying. I calmed her down and asked why. She said (LPN #1) was calling her names and can not deal with that. I told her I had no authority to let her go home and to call the on call nurse. She picked up the phone and called and as she was talking to on call person I saw (LPN #1) charging toward the NS (nurse's station) and grabbed the phone from (QMA #2). He said 'You do not make the call I do.' At that point (QMA #2) tried to</p>				

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	<p>get the phone and they both started going back and forth. I stood between them and told (LPN #1) to stop because the Residents were present. He went to say, she needs to be looking for another job, she is lazy. I moved (QMA #2) away and later notified on call nurse."</p> <p>LPN #3 was interviewed on 5/03/12 at 11:00 a.m. She indicated that her written statement above was an accurate representation of the events of 4/15/12, and that no administrative or management person had interviewed her or asked for any information related to those events.</p> <p>QMA #2 was interviewed on 5/03/12 at 3:00 p.m. She indicated she was working on the 3rd Floor North hall, when she heard Resident E yelling about not wanting to get out of bed. She was called to the room by LPN #1. She indicated LPN #1 "dragged this man half out of bed." She indicated she told LPN #1 "This man does not get out of bed this way" and the resident was continuing to protest. After Resident F was up, she returned to the hall and continued to pass breakfast trays. She then heard LPN #1 in Resident F's room and went to assist. She indicated Resident F was care planned to use a mechanical lift, and LPN #1 was pulling on her arms, had her "half out of bed on one butt." She indicated Resident F</p>			

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	<p>continued to protest the entire time, and that she had to grab the resident to prevent her from falling during the transfer. She indicated LPN #1's behavior was "erratic" and that he had called her a whore in front of the resident. She indicated that while she was calling the on call nurse LPN #1 "charged" her and grabbed the phone away from her and slammed it down. She indicated this occurred at the nurse's station in front of residents.</p> <p>On 5/04/12 at 9:30 a.m. the 3rd floor ADON provided a list of 18 residents who typically eat in the 3rd floor dining room and would likely have been in the dining room on 4/15/12 at the time of the altercation between LPN #1 and QMA#2.</p> <p>2. The record of Resident E was reviewed on 5/04/12 at 2:00 p.m.</p> <p>Diagnoses included, but were not limited to, end stage renal disease, hypertension, diabetes mellitus, urinary tract infection, anemia, and dementia.</p> <p>An Annual Minimum Data Set (M.D.S.) assessment dated 2/09/12, indicated Resident E was mildly cognitively impaired, had no communication deficits, was generally understood and could understand when communicating, and had</p>			

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	<p>no significant mood or behavioral issues. He was dependent on staff for all activities of daily living. It indicated it was "very important" for Resident E to manage his own daily preferences.</p> <p>A "Social Services Discharge Note" dated 4/6/12 indicated "No impaired decision making noted this observation period."</p> <p>A care plan for resident E dated 3/08/12 indicated "Requires assist (symbol for "with") ADL's (activities of daily living) Needs ext (extensive) assist for bed mobility-transfers."</p> <p>A Fall Risk Assessment completed 12/05/11 indicated a score of 20, with 10 or greater being high risk for falls.</p> <p>3. The record of Resident F was reviewed on 5/04/12 at 3:00 p.m.</p> <p>Diagnoses included, but were not limited to, congestive heart failure, anemia, hypertension, rheumatoid arthritis, and osteoporosis.</p> <p>A Quarterly Minimum Data Set (M.D.S.) assessment dated 3/15/12 indicated Resident F was mildly cognitively impaired, had no communication deficits or behaviors, and required staff assistance for all activities of daily living, including</p>			

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	<p>maximum assistance of 2 staff for transfers.</p> <p>A care plan for Resident F, originated 7/22/11 and updated 3/2012, indicated "At risk for fractures R/T (related to) Osteoporosis...Encourage use of assistive devices...Special care with positioning, transferring and ROM (range of motion)."</p> <p>Nurse's notes for Resident F indicated:</p> <p>4/05/12 6:36 a.m. "Resident is alert to person, place, time, and date...max (maximum) assist of (symbol for 2) staff for transfers with mechanical lift..."</p> <p>4/13/12 4:03 a.m. "...max assist of (symbol for 1) for care and (symbol for 2) staff for transfers (symbol for "with") mechanical lift..."</p> <p>Resident F was interviewed on 5/03/12 at 2:10 p.m. She indicated she remembered LPN #1, and the incident of 4/15/12. Concerning LPN #1, she stated "he was always making me do things I didn't want to." She indicated that on 4/15/12 he "pulled on my arms to make me get up and I didn't want to." She indicated she had heard LPN #1 no longer worked at the facility and stated "Good. You need to treat people like you want to be treated. He didn't."</p>						

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	<p>4. During an interview on 5/02/12 at 2:30 p.m. with the Administrator, Vice President of Clinical Services, Director of Nursing, second and third floor Assistant Directors of Nursing, and Director of Social Services present, the Administrator indicated that following the allegation of resident abuse by staff on 4/15/12, no resident interviews had been conducted, no staff interviews were conducted, no attempts were made to identify any residents who may have been affected by the incidents, no resident assessments had been done, and that the allegations of abuse had not been reported to the State Agency.</p> <p>During the above interview, the Administrator indicated that following his consideration of the events of 4/15/12, that LPN #1 would be allowed to return to work on his next regularly scheduled day, 4/17/12. Review of time card records indicated LPN #1 worked on 4/17/12, 4/18/12, and 4/19/12 on the 3rd floor South hall, which housed 21 residents. Facility documents indicated, on 4/15/12, LPN #1 worked on the 3rd floor North and West halls, where a combined 22 residents resided.</p> <p>The personnel record of LPN #1 was reviewed on 5/03/12 at 9:00 a.m.</p>			
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	<p>"Disciplinary actions" for LPN #1 included, but were not limited to:</p> <p>4/15/11: "Disruptive or distracting behavior in the workplace. Family stated (LPN #1) and (QMA #2) were arguing over getting resident up to get weight and family felt this was unprofessional." Disposition: Suspension.</p> <p>6/21/11: "Making snide remarks in hallway within hearing range of multiple staff (symbol for "and") res. (residents)." Disposition: Written warning.</p> <p>6/30/11: "Reviewing previous professional performance from 2/11-6/30/11 concerning: 1. Conduct towards staff. 2. Inappropriate conversations in work setting. 3. Disruptive or distracting behaviors." Disposition: Second written warning.</p> <p>7/05/11: Discrepancies in narcotic pain documentation. Disposition: "Final written warning any further discrepancies in documentation, count, or conflicting info (information) from resident will result in termination."</p> <p>10/20/11: "Complaints regarding documentation of patient pain and pain med (medication) administration. Disposition: "Written warning added to</p>			

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	<p>previous discipline...Further problems regarding resident pain documentation, and narc (narcotic) count will result in termination."</p> <p>4/16/12: "Conduct unbecoming of a nurse. (LPN #1) arguing (symbol for "with") staff, cursing, (symbol for "and") trying to take phone away from staff." Disposition: Final written warning.</p> <p>An "Employee Disciplinary Action Form" dated 4/19/12, indicated LPN #1 was terminated for refusing to take a drug test. The form indicated "He refused to submit to drug testing saying it would be positive."</p> <p>During an interview on 5/06/12 at 1:15 p.m., the Vice President of Clinical Services indicated that following a series of telephone interviews with staff, she had determined that on 4/15/12 QMA #2 and LPN #3 had prepared voluntary statements concerning the alleged abuse of residents by LPN #1 and subsequent events. She indicated those statements had been given to LPN #6, the on call nurse and Assistant Director of Nursing. She indicated LPN #6 put those statements in a desk drawer without reading them. They remained in the desk drawer until the afternoon of 4/17/12 when the Administrator requested any</p>						

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	<p>documentation she had, and she provided the reports to him.</p> <p>5. An undated facility document titled "Abuse Protection and Response Policy," provided by the Administrator on 5/03/12 and indicated to be a current facility policy, indicated:</p> <p>"1. Policy: Abuse, as hereafter defined, will not be tolerated by anyone, including staff, patients, consultants and volunteers, family members or legal guardians, friends or any other individual (sic) Cambridge Manor Nursing and Rehabilitation Center. The center's administrator is responsible for assuring that patient safety, including freedom from risk of abuse, holds the highest priority.</p> <p>VI. Identification Issues: Any resident event that is reported to any staff by Resident, family member, other staff or any other person will be considered possible abuse if it meets any of the following criteria:</p> <p>A. Any indication of possible willful infliction of injury to include unexplained bruising.</p> <p>E. Any complaint of the use of oral, written, or gestured language that</p>			

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	<p>willfully includes disparaging or derogatory terms to Resident or families or within their hearing distance.</p> <p>2. Procedure: Staff observing or hearing about such events will report event immediately, either verbally or in writing, to their immediate supervisor, and the Administrator. The Supervisor will initiate action coordinating with the administrator if he/she is not on site.</p> <p>VII. Investigative Issues:</p> <p>1. Policy: Any staff having either direct or indirect knowledge of any event that might constitute abuse must report the event immediately.</p> <p>2. Procedure: Any staff having any knowledge of any of the above circumstances is required to ensure the incident is reported to the Administrator immediately.</p> <p>3. Policy: All events reported, as possible abuse will be investigated to determine whether abuse did or did not take place.</p> <p>4. Procedure: Supervisory staff will initiate investigative action.</p> <p>VIII. Protective Issues:</p>			

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	<p>1. Policy: Residents will be protected from harm during an investigation.</p> <p>2. Procedure:</p> <p>A. Any individual found to be in danger of injury would be removed from the source of the suspected abusive behavior.</p> <p>B. Medical and emotional support will be made immediately available to any individual suffering suspected abuse.</p> <p>3. Policy: Staff person or persons suspected of abuse will be suspended immediately pending results of the investigation. Pay status during suspension is at the discretion of the Administrator.</p> <p>IX. Reporting and Response Issues:</p> <p>1. Policy: All reports of abuse or alleged abuse or neglect will be immediately assessed to determine the direction of the investigation.</p> <p>2. Procedure: Any allegation of abuse will be reported immediately to the supervisor and administrator. Any investigation that substantiates abuse or neglect findings will be reported immediately to the Administrator or his/her designate representative and to other officials in</p>			

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	<p>accordance with State Law within 24 hours of the event.</p> <p>A. State survey and Certification agency.</p> <p>B. All other State required agencies.</p> <p>4. Procedures: An accurate summary reporting of all investigation conducted by the center will be maintained as a working document of the Quality Assessment/Quality Improvement Committee.</p> <p>All reports of abuse or alleged abuse have to be reported to ISDH within 24 hours of the incident. Any pertinent information will be submitted to ISDH within 5 days of the incident. This could include further information obtained as a result of investigation and or information obtained during the interview process."</p> <p>During an interview with the Vice President of Clinical services on 5/07/12 at 3:00 p.m. she indicated that the above referenced policy was the policy related to abuse issues in place at the facility and that it was the parent corporation's expectation that these policies and procedures would be followed by staff and management of the facility.</p> <p>An undated facility document received</p>			

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	<p>from the Vice President of Clinical Services on 5/07 12 at 3:50 p.m., and identified as the current job description for the facility's Administrator, included, but was not limited to:</p> <p>"Purpose of Your Job Position: The primary purpose of your job position is to direct the day-to-day functions of the facility in accordance with current federal, state, and local standards, guidelines, and regulations that govern long-term care facilities to ensure that the highest degree of quality care can be provided to our residents at all times.</p> <p>Administrative Functions:</p> <p>Plan, develop, organize, implement, evaluate, and direct the facility's programs and activities...</p> <p>Ensure that all employees, residents, visitors and the general public follow established policies and procedures...</p> <p>Assume the administrative authority, responsibility and accountability of directing the activities and programs of the facility...</p> <p>Counsel/discipline personnel as requested or as may be necessary...</p>			

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	<p>Terminate employment of personnel when necessary, documenting and coordination such actions with the Personnel Director...</p> <p>Ensure that all residents receive care in a manner and in an environment that maintains or enhances their quality of life without abridging the safety and rights of other residents..."</p> <p>The Immediate Jeopardy that began on 4/15/2012 was removed on 5/04/12 based on the termination of LPN #1, observation and review of the facility's plan of abatement, including interviews with all residents to determine any other concerns about staff treatment, and reeducation of all staff members on resident care and abuse protocols, but noncompliance remained at a reduced scope and severity of pattern, no actual harm with potential for more than minimal harm that is not immediate jeopardy, while the facility completed interviewing and assessing residents, educating staff, and doing staff compliance post testing.</p> <p>3.1-13(a) 3.1-13(g)(1) 3.1-13(q) 3.1-13(r)</p>				