

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155799	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/31/2014
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NAME OF PROVIDER OR SUPPLIER MARION REHABILITATION AND ASSISTED LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 614 WEST 14TH STREET MARION, IN 46953
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F000000	<p>This visit was for the PSR (Post Survey Revisit) to the Investigation of complaint # IN00150283 completed on 6/20/14.</p> <p>This visit was in conjunction with complaint investigation #IN00153032.</p> <p>Complaint #IN00150283: Not Corrected.</p> <p>Survey dates: July 30 and 31, 2014</p> <p>Facility number: 012809 Provider number: 155799 AIM number: 2011365580</p> <p>Survey team: Jason Mench RN-TC Shelley Reed, RN Angela Selleck RN</p> <p>Census bed type: NF: 13 SNF/NF: 33 Residential: 34 Total: 80</p> <p>Census by payor type: Medicare: 19 Medicaid: 13 Other: 48 Total: 80</p>	F000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F000224 SS=D	<p>Sample: 8</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed by Debora Barth, RN.</p> <p>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATE</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to ensure mistreatment, verbal and emotional abuse did not occur for 2 of 2 residents who met the criteria for abuse. (Resident C and D)</p> <p>Findings include:</p> <p>1. During an interview with the Administrator (ADM) on 7/30/14 at 9:00 a.m., information was requested related to the last ISDH reportables since the plan of correction date of 7/16/14.</p>	F000224	<p>F224 – The facility will ensure mistreatment, verbal and emotional abuse does not occur.</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident D was re-interviewed by the Administrator. Resident indicated that she has no problem with current C.N.A.'s caring for her. She only felt that she was</p>	08/13/2014

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	<p>The ISDH reportables were provided by the ADM and reviewed on 7/30/14 at 11:30 a.m.</p> <p>The clinical record for Resident (D) was reviewed on 7/30/14 at 2:30 p.m. Diagnoses for the resident included, but were not limited to, Parkinson's disease, depressive disorder, insomnia, hypertension, esophageal reflux, generalized pain, urinary tract infection, fracture of carpal bones, and arthropathy.</p> <p>The most recent Minimum Data Set (MDS) assessment, dated 5/12/14, indicated Resident (D) was not cognitively impaired. Resident (D) received the following Activities of Daily Living (ADL) assistance; transfer - extensive, one person physical assist, dressing and bathing-limited to physical help in part of bathing activity with one person physical assist.</p> <p>A review of the July 2014 Flow Sheet for Resident (D), provided by the Nurse Consultant on 7/30/14 at 12:20 p.m., indicated on 7/28/14 day shift, Resident (D) had a bed bath. No shower or bed bath was provided by night shift on 7/27/14 or 7/28/14.</p> <p>During an interview with Resident (D) on 7/30/14 at 10:00 a.m. she indicated CNA</p>		<p>being rushed and she doesn't move as quickly as she used to.. As the resident's health also appeared to be failing, her condition was referred to the attending physician and he ordered a urinary analysis. The test results were positive and she was treated accordingly. The resident's bathing time was adjusted and the staff caring for her were instructed to allow time for the resident to make decisions.</p> <p>An investigation was completed relevant to Resident C. Resident C was interviewed and indicated that he had no problem with any caregivers. He felt that overall he is treated well.</p> <p>How were other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken</p> <p>Alert and oriented residents were interviewed during the survey and any issues were addressed.</p> <p>What measures will be put in place or what systemic changes will be made to</p>				

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	<p>#2 has been "rough talking" and rushing her in care. Resident (D) indicated it was an ongoing concern. Resident (D) stated "I almost hate to get up in the mornings." Resident (D) indicated she had spoken to the Social Service Director related to the concern and that the Social Service Director had written down the concern.</p> <p>During an interview with the ADM and Social Service Director on 7/30/14 at 11:34 a.m., the ADM indicated he had not heard of the concern related to Resident (D) and CNA #2. He indicated if it was just a case of rushing care, he would not report it because it would be more of a customer service issue, but would be looked into and investigated.</p> <p>The Social Service Director indicated Resident (D) was upset with CNA #2 and the CNA rushed her. The Social Service Director indicated Resident (D) feels CNA #2 has higher expectations with ADL care than what the resident's Parkinson's disease can handle at times. Resident (D) wanted a shower but instead was given a bed bath. The Social Service Director indicated she reported Resident (D)'s concern to the nurses and not to the ADM.</p> <p>During an interview with RN #1 on 7/30/14 at 12:34 p.m., she indicated she</p>		<p>ensure that the deficient practice does not recur</p> <p>Facility staff were in-serviced on abuse and guidelines. All abuse situations are to be reported to the Administrator immediately.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur</p> <p>Administrator or designee will interview five alert and oriented residents per week for five weeks. Then three alert and oriented residents per week for the next three weeks. Then one resident per week for one month. New grievances/complaints will be reviewed each morning at the morning meeting, five days per week, and progress toward resolution discussed. Results of all grievance/complaints tracking and trending will be provided monthly to the Quality Assurance Committee for review and follow-up and quarterly there-after..</p> <p>By what date the systemic changes will be completed</p> <p>The systemic changes will be completed by August 13, 2014</p>				

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	<p>had not received any grievances or paperwork related to a concern between Resident (D) and CNA#2.</p> <p>During an interview with Resident (D) and her daughter on 7/30/14 at 12:43 p.m., Resident (D) indicated CNA #2 had told her "Either you have to take a shower now or wait." Resident (D) indicated she told the Social Service Director, CNA #2 was "rough talking" and rushing her to either do it now or not and that she had seen her do care herself before and she could do her own care. Resident (D) stated "When CNA #2 talked to me and rushed me, I felt that I fell through the cracks. I got to the point I didn't want to get up, because I was hoping she (CNA #2) wasn't there. She talks to me like a prison warden."</p> <p>Resident (D)'s daughter indicated her mother was afraid of retaliation, but felt enough people are now aware of this concern to solve it.</p> <p>During an interview with the Social Service Director on 7/30/14 at 4:49 p.m., she indicated she was unable to find grievance documentation related to Resident (D)'s concern. The Social Service Director indicated the grievance had to be written Sunday night 7/27/14 into Monday morning 7/28/14. She</p>			

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	<p>stated "The grievance was slid under my office door before I arrived to work Monday morning."</p> <p>The Social Service Director indicated she had spoken to Resident (D) twice on 7/28/14. The Social Service Director indicated in total she spoke with Resident (D) for approximately five minutes because the resident would not open up much. She indicated Resident (D)'s eye contact the morning of 7/28/14 would waiver, her eyes and head would drop down and she would look away from her. She indicated Resident (D) did finally tell her that she was upset.</p> <p>The Social Service Director indicated the grievance stated CNA#2 had upset Resident (D) and CNA#2 had told the resident she had other things to do and the resident did not receive a shower.</p> <p>The Social Service Director indicated she only took the grievance of the concern to the clinical morning meeting on Monday 7/28/14 and not to the ADM because she felt it was only a nursing issue.</p> <p>The Social Service Director indicated Resident (D) was very alert and capable.</p> <p>A request to review the grievance</p>						

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	<p>documentation of the concern between Resident (D) and CNA #2 was requested on 7/30/14 at 11:34 a.m. and again on 7/30/14 at 1:18 p.m. The Social Service Director indicated she did not know who the nurse was that the grievance was given to and staff were being called to find it.</p> <p>During an interview with the Director of Nursing (D.o.N.) on 7/30/14 at 4:05 p.m., she indicated she was still unsure who the Social Service Director gave the grievance form to with the concern on it.</p> <p>During an interview with RN #1 on 7/31/14 at 11:40 a.m., she stated "I did not know there was an issue with CNA #2 and Resident (D). RN #1 indicated any concerns with a nursing staff member and a resident should be brought to her attention.</p> <p>No further documentation was provided at exit on 7/31/14. 2. During an interview with the Social Service Director (SSD) on 7/30/14 at 5:15 p.m., she indicated there had been a concern with Resident C's condom catheter. She indicated during care, 2 CNA's began to "giggle" when the resident developed an erection. She indicated a therapy staff walked in the room while the 2 CNA's were commenting on the the catheter.</p>						

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	<p>She indicated she and several other staff members thought the two CNA's should have been walked out of the building and the information was given to the Administrator.</p> <p>Resident C's clinical record was reviewed on 7/30/14 at 10:30 a.m. Diagnoses included, but not limited to, pneumonia, respiratory failure, tracheostomy and depression. A review of Resident C's Minimum Data Set assessment (MDS) indicated the resident was cognitively intact.</p> <p>During an interview with Physical Therapy Assistant (PTA) #5 on 7/31/14 at 9:30 a.m., he indicated PTA #4 had spoken with him on 7/25/14 about 2 CNA's making comments about Resident C's condom catheter during care of the resident. He indicated he reported this information to nursing staff on 7/28/14.</p> <p>During an interview with CNA #7 on 7/31/14 at 10:10 a.m., she indicated she was taking care of Resident C and he developed an erection. CNA #7 indicated she was in the room with CNA#8 and CNA#9. She indicated Resident C did get an erection during care and they did giggle when it happened. CNA #7 indicated she was informed they were not allowed back in Resident C's room.</p>						

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	<p>During a phone interview with PTA #4 on 7/31/14 at 11:00 a.m., she indicated on 7/25/14 she went to Resident C's room to provide therapy and two CNA's were in his room providing care. She indicated the 2 CNA's providing care giggled at the name of the catheter and then giggled again when the resident got an erection during care. PTA #4 indicated she did feel uncomfortable about this situation and went back to her department and asked multiple coworkers who she should report this to and was never told who to report it to.</p> <p>During an interview with LPN #10 on 7/31/14 at 11:05 a.m., she indicated she had been told about the comments made about Resident C's condom catheter and the Social Service Director told her that CNA #7 and CNA #8 were not allowed in Resident C's room.</p> <p>During an interview with RN #1 on 7/31/14 at 11:30 a.m., she indicated she received a call at home on 7/28/14 from LPN #3. LPN #3 informed her on 7/25/14 at around 11:00 a.m., 2 CNA's were "poking fun" at Resident C's condom catheter and at his erection during care. LPN #3 informed RN #1, a therapist had witnessed this incident and told PTA #5 on 7/25/14. PTA #5 told an unknown</p>			

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	<p>nursing staff member on 7/28/14, three days later. RN #1 indicated on 7/29/14, it was her understanding both CNA's had been re-assigned and a grievance was made and given to management. She indicated the Administrator said it was not sexual abuse or misconduct.</p> <p>During an interview with the Director of Nursing (DoN) and Corporate Nurse on 7/31/14 at 1:00 p.m., the DoN indicated the Administrator had told her he investigated the incident related to the condom catheter and it was not abuse or misconduct and the incident was not reported.</p> <p>No further information on the investigation of this incident was provided.</p> <p>A policy, "ABUSE PREVENTION, INTERVENTION, INVESTIGATION & CRIME REPORTING POLICY", dated September of 2011, provided by the Corporate Nurse on 7/31/14 at 1:30 a.m., indicated:</p> <p>"...POLICY</p> <p>It is policy that every resident has the right to be free from verbal, sexual, physical and mental abuse; neglect, corporal punishment and involuntary</p>						

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	<p>seclusion....</p> <p>"...It is the responsibility of employees to immediately report to the facility administrator, local ombudsman (or local law enforcement agency), and to State Licensing and Certification immediately or as soon as practically possible within 24 hours of detection, any incident of suspected or alleged neglect or resident abuse from other residents, staff, family, or visitors...</p> <p>"...Identification</p> <p>Residents, families and staff shall be informed that they may report any concerns, incidents, or grievances without fear of reprisal or retribution. All persons making such reports are to be provided a non-threatening environment, and anonymity (if desired) to express identified concerns, with feed-back regarding the concerns expressed...</p> <p>"...Reporting</p> <p>Additionally, the facility requires that employees immediately report the facts of known or suspected instances of abuse and all allegations of abuse and suspicions of crime immediately to the facility Administrator (either directly or anonymously) so that facility's</p>						

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F000225 SS=D	<p>responsibility to protect residents and promptly investigate occurrences may be met. Failure to report in the required time frames may result in disciplinary action, including termination.</p> <p>The facility Administrator, or designee, will immediately, or as soon as practically possible within 24 hours of receiving an allegation or forming a suspicion, report the instance of abuse, neglect, or misappropriation of resident property to the local ombudsman or local law enforcement agency and to the Department of Health Services (or appropriate state agency) as required by law..."</p> <p>This federal tag relates to Complaint IN00150283.</p> <p>3.1-28(a)</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report</p>						

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	<p>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 record review and interview, the facility failed to ensure mistreatment, was reported immediately to the Administrator and to the state agency for 2 of 2 residents who met the criteria for abuse. (Resident C and D)</p> <p>Findings include:</p>	F000225	<p>F225 – Facility will ensure mistreatment is reported immediately to the Administrator and to the state agency for resident incidents that met the criteria for abuse'</p> <p>What corrective action will be</p>	08/13/2014

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	<p>During an interview with Resident (D) on 7/30/14 at 10:00 a.m., she indicated CNA #2 has been "rough talking" and rushing her in care. Resident (D) indicated it was an ongoing concern. Resident (D) stated "I almost hate to get up in the mornings." Resident (D) indicated she had spoken to the Social Service Director related to the concern and that the Social Service Director had written down the concern.</p> <p>During an interview with the ADM and Social Service Director on 7/30/14 at 11:34 a.m., the ADM indicated he had not heard of the concern related to Resident (D) and CNA #2. He indicated if it was just a case of rushing care, he would not report it because it would be more of a customer service issue, but would be looked into and investigated.</p> <p>The Social Service Director indicated Resident (D) was upset with CNA #2 and the CNA rushed her. The Social Service Director indicated Resident (D) felt CNA#2 had higher expectations with Activities of Daily Living (ADL) care than what the resident's Parkinson's disease could handle at times. Resident (D) wanted a shower but instead was given a bed bath. The Social Service Director indicated she reported Resident (D)'s concern to the nurses and not to the ADM.</p>		<p>accomplished for those residents found to have been affected by the deficient practice?</p> <p>Alert and oriented residents were interviewed during the survey and any issues were addressed.</p> <p>What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur</p> <p>Facility staff were in-serviced on abuse and guidelines. All abuse situations are to be reported to the Administrator immediately.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur</p> <p>Administrator or designee will interview five alert and oriented residents per week for five weeks. Then three alert and oriented residents per week for the next three weeks. Then one resident per week for one month. New grievances/complaints will be reviewed each morning at the morning meeting, five days per week, and progress toward resolution discussed. Results of all grievance/complaints tracking and trending will be provided</p>				

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	<p>During an interview with RN #1 on 7/30/14 at 12:34 p.m., she indicated she had not received any grievances or paperwork related to a concern between Resident (D) and CNA#2.</p> <p>During an interview with the Social Service Director on 7/30/14 at 4:49 p.m., she indicated she was unable to find grievance documentation related to Resident (D)'s concern.</p> <p>The Social Service Director indicated she only took the grievance of the concern to the clinical morning meeting on Monday 7/28/14 and not to the ADM because she felt it was only a nursing issue.</p> <p>During an interview with the Director of Nursing (D.o.N.) on 7/30/14 at 4:05 p.m., she indicated she was still unsure who the Social Service Director gave the grievance form with the concern on it to.</p> <p>During an interview with RN #1 on 7/31/14 at 11:40 a.m., she stated "I did not know there was an issue with CNA #2 and Resident (D). RN #1 indicated any concerns with a nursing staff member and a resident should be brought to her attention.</p> <p>No further documentation was provided</p>		<p>monthly to the Quality Assurance Committee for review and follow-up and quarterly there-after..</p> <p>By what date the systemic changes will be completed</p> <p>The systemic changes will be completed by August 13, 2014</p>				

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	<p>at exit on 7/31/14. 2. During an interview with the Social Service Director (SSD) on 7/30/14 at 5:15 p.m., she indicated there had been a concern with Resident C's condom catheter. She indicated during care, 2 CNA's began to "giggle" when the resident developed an erection. She indicated a therapy staff walked in while the 2 CNA's were commenting on the catheter and did not report the incident. She indicated she and several other staff members thought the two CNA's should have been walked out of the building and the information was given to the Administrator.</p> <p>Resident C's clinical record was reviewed on 7/30/14 at 10:30 a.m. Diagnoses included, but not limited to, pneumonia, respiratory failure, tracheostomy and depression. A review of Resident C's Minimum Data Set assessment (MDS) indicated the Resident was cognitively intact.</p> <p>During an interview with Physical Therapy Assistant (PTA) #5 on 7/31/14 at 9:30 a.m., he indicated PTA #4 had spoken with him on 7/25/14 about 2 CNA's making comments about Resident C's condom catheter during care of the resident. He indicated he reported this information to nursing staff on 7/28/14. This was three days after the incident had</p>						

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	<p>occurred.</p> <p>During an interview with CNA #7 on 7/31/14 at 10:10 a.m., she indicated she was taking care of Resident C and he developed an erection. CNA #7 indicated she was in the room with CNA#8 and CNA#9. She indicated Resident C did get an erection during care and they did giggle when it happened. CNA #7 indicated she was informed they were not allowed back in Resident C's room.</p> <p>During a phone interview with PTA #4 on 7/31/14 at 11:00 a.m., she indicated on 7/25/14 she went to Resident C's room to provide therapy and two CNA's were in his room providing care. She indicated the 2 CNA's providing care giggled at the name of the catheter and then giggled again when the Resident got an erection during care. PTA #4 indicated she did feel uncomfortable about this situation and went back to her department and asked multiple coworkers who she should report this to and was never told who to report it to.</p> <p>During an interview with LPN #10 on 7/31/14 at 11:05 a.m., she indicated she had been told about the comments made about Resident C's condom catheter and the Social Service Director told her that CNA #7 and CNA #8 were not allowed</p>						

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	<p>in Resident C's room.</p> <p>During an interview with RN #1 on 7/31/14 at 11:30 a.m., she indicated she received a call at home on 7/28/14 from LPN #3. LPN #3 informed her on 7/25/14 at around 11:00 a.m., 2 CNA's were "poking fun" at Resident C's condom catheter and at his erection during care. LPN #3 informed RN #1 a therapist had witnessed this incident and told PTA #5 on 7/25/14. PTA #5 told an unknown nursing staff member on 7/28/14, three days later. RN #1 indicated on 7/29/14, it was her understanding both CNA's had been re-assigned and a grievance was made and given to management. She indicated the Administrator said it was not sexual abuse or misconduct.</p> <p>During an interview with the Director of Nursing (DoN) and Corporate Nurse on 7/31/14 at 1:00 p.m., the DoN indicated the Administrator had told her he investigated the incident related to the condom catheter and it was not abuse or misconduct and the incident was not reported.</p> <p>No further information on the investigation of this incident was provided.</p> <p>A policy, "ABUSE PREVENTION,</p>						

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	<p>INTERVENTION, INVESTIGATION & CRIME REPORTING POLICY", dated September of 2011, provided by the Corporate Nurse on 7/31/14 at 1:30 a.m., indicated;</p> <p>"...POLICY</p> <p>It is policy that every resident has the right to be free from verbal, sexual, physical and mental abuse; neglect, corporal punishment and involuntary seclusion."</p> <p>"...It is the responsibility of employees to immediately report to the facility administrator, local ombudsman (or local law enforcement agency), and to State Licensing and Certification immediately or as soon as practically possible within 24 hours of detection, any incident of suspected or alleged neglect or resident abuse from other residents, staff, family, or visitors..."</p> <p>"...Identification</p> <p>Residents, families and staff shall be informed that they may report any concerns, incidents, or grievances without fear of reprisal or retribution. All persons making such reports are to be provided a non-threatening environment, and anonymity (if desired) to express</p>			

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	<p>identified concerns, with feed-back regarding the concerns expressed..."</p> <p>"...Reporting</p> <p>Additionally, the facility requires that employees immediately report the facts of known or suspected instances of abuse and all allegations of abuse and suspicions of crime immediately to the facility Administrator (either directly or anonymously) so that facility's responsibility to protect residents and promptly investigate occurrences may be met. Failure to report in the required time frames may result in disciplinary action, including termination.</p> <p>The facility Administrator, or designee, will immediately, or as soon as practically possible within 24 hours of receiving an allegation or forming a suspicion, report the instance of abuse, neglect, or misappropriation of resident property to the local ombudsman or local law enforcement agency and to the Department of Health Services (or appropriate state agency) as required by law..."</p> <p>This federal tag relates to Complaint IN00150283.</p> <p>3.1-28(c)</p>						

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F000226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to ensure the policy and procedure for concern/grievance, resident's rights, abuse prevention, intervention, investigation and crime reporting for mistreatment, verbal and emotional abuse was followed for 2 of 2 residents who met the criteria for abuse. (Resident C and D)</p> <p>Findings include:</p> <p>1. During an interview with Resident (D) on 7/30/14 at 10:00 a.m. she indicated CNA #2 has been "rough talking" and rushing her in care. Resident (D) indicated it was an ongoing concern. Resident (D) stated "I almost hate to get up in the mornings." Resident (D) indicated she had spoke to the Social Service Director related to the concern and that the Social Service Director had written down the concern.</p> <p>During an interview with the ADM and</p>	F000226	<p>F226 – Facility will ensure the policy and procedure for concern/grievance, resident’s rights, abuse prevention, intervention, investigation and crime reporting for mistreatment, verbal and emotional abuse are followed for all residents who meet the criteria for abuse.</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Alert and oriented residents were interviewed during the survey and any issues were addressed. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur Facility staff were in-serviced on abuse and guidelines. All abuse situations are to be reported to the Administrator immediately. How the corrective action will be monitored to ensure the deficient practice will not recur Administrator or designee will interview five alert and oriented residents per week for five</p>	08/13/2014			

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	<p>Social Service Director on 7/30/14 at 11:34 a.m., the ADM indicated he had not heard of the concern related to Resident (D) and CNA #2. He indicated if it was just a case of rushing care, he would not report it because it would be more of a customer service issue, but would be looked into and investigated.</p> <p>The Social Service Director indicated Resident (D) was upset with CNA #2 and the CNA rushed her. The Social Service Director indicated Resident (D) felt CNA#2 had higher expectations with Activities of Daily Living (ADL) care than what the resident's Parkinson's disease could handle at times. Resident (D) wanted a shower but instead was given a bed bath. The Social Service Director indicated she reported Resident (D)'s concern to the nurses and not to the ADM.</p> <p>During an interview with RN #1 on 7/30/14 at 12:34 p.m., she indicated she had not received any grievances or paperwork related to a concern between Resident (D) and CNA#2.</p> <p>During an interview with the Social Service Director on 7/30/14 at 4:49 p.m., she indicated she was unable to find grievance documentation related to Resident (D)'s concern. The Social</p>		<p>weeks. Then three alert and oriented residents per week for the next three weeks. Then one resident per week for one month. New grievances/complaints will be reviewed each morning at the morning meeting, five days per week, and progress toward resolution discussed. Results of all grievance/complaints tracking and trending will be provided monthly to the Quality Assurance Committee for review and follow-up and quarterly there-after.. By what date the systemic changes will be completed The systemic changes will be completed by August 13, 2014</p>		

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	<p>Service Director indicated the grievance had to be written Sunday night 7/27/14 into Monday morning 7/28/14. She stated</p> <p>"The grievance was slid under my office door before I arrived to work Monday morning."</p> <p>The Social Service Director indicated she only took the grievance of the concern to the clinical morning meeting on Monday 7/28/14 and not to the ADM because she felt it was only a nursing issue.</p> <p>During an interview with the Director of Nursing (D.o.N.) on 7/30/14 at 4:05 p.m., she indicated she was still unsure who the Social Service Director gave the grievance form with the concern on it to.</p> <p>During an interview with RN #1 on 7/31/14 at 11:40 a.m., she stated "I did not know there was an issue with CNA #2 and Resident (D). RN #1 indicated any concerns with a nursing staff member and a resident should be brought to her attention.</p> <p>No further documentation was provided at exit on 7/31/14. 2. During an interview with the Social Service Director (SSD) on 7/30/14 at 5:15 p.m., she indicated a concern with Resident C's condom catheter. She indicated during</p>			

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	<p>care, 2 CNA's began to "giggle" when the resident developed an erection. She indicated a therapy staff walked in while the 2 CNA's were commenting on the the catheter and did not report the incident. She indicated she and several other staff members thought the two CNA's should have been walked out of the building and the information was given to the Administrator.</p> <p>Resident C's clinical record was reviewed on 7/30/14 at 10:30 a.m. Diagnoses included, but not limited to, pneumonia, respiratory failure, tracheostomy and depression. A review of Resident C's Minimum Data Set assessment (MDS) indicated the Resident was cognitively intact.</p> <p>During an interview with Physical Therapy Assistant (PTA) #5 on 7/31/14 at 9:30 a.m., he indicated PTA #4 had spoken with him on 7/25/14 about 2 CNA's making comments about Resident C's condom catheter during care of the Resident. He indicated he reported this information to nursing staff on 7/28/14.</p> <p>During an interview with CNA #7 on 7/31/14 at 10:10 a.m., she indicated she was taking care of Resident C and he developed an erection. CNA #7 indicated she was in the room with CNA#8 and</p>				

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	<p>CNA#9. She indicated Resident C did get an erection during care and they did giggle when it happened. CNA #7 indicated she was informed they were not allowed back in Resident C's room.</p> <p>During a phone interview with PTA #4 on 7/31/14 at 11:00 a.m., she indicated on 7/25/14 she went to Resident C's room to provide therapy and two CNA's were in his room providing care. She indicated the 2 CNA's providing care giggled at the name of the catheter and then giggled again when the Resident got an erection during care. PTA #4 indicated she did feel uncomfortable about this situation and went back to her department and asked multiple coworkers who she should report this to and was never told who to report it to.</p> <p>During an interview with LPN #10 on 7/31/14 at 11:05 a.m., she indicated she had been told about the comments made about Resident C's condom catheter and the Social Service Director told her that CNA #7 and CNA #8 were not allowed in Resident C's room.</p> <p>During an interview with RN #1 on 7/31/14 at 11:30 a.m., she indicated she received a call at home on 7/28/14 from LPN #3. LPN #3 informed her on 7/25/14 at around 11:00 a.m., 2 CNA's were</p>				

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	<p>"poking fun" at Resident C's condom catheter and at his erection during care. LPN #3 informed RN #1 a therapist had witnessed this incident and told PTA #5 on 7/25/14. PTA #5 told an unknown nursing staff member on 7/28/14. RN #1 indicated on Tuesday, it was her understanding both CNA's had been re-assigned and a grievance was made and given to management. She indicated the Administrator said it was not sexual abuse or misconduct.</p> <p>During an interview with the Director of Nursing (DoN) and Corporate Nurse on 7/31/14 at 1:00 p.m., the DoN indicated the Administrator had told her he investigated the incident related to the condom catheter and it was not abuse or misconduct and the incident was not reported.</p> <p>No further information on the investigation of this incident was provided.</p> <p>3. Review of undated "Marion Rehabilitation and Assisted Living Center Concern/Grievance Policy" provided by the ADM on 7//30/14 at 3:31 p.m. indicated the following:</p> <p>"Purpose: To ensure all residents have the right to voice a grievance without fear</p>						

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	<p>of reprisal and all grievances are addressed and resolved to the facility's ability in a timely fashion.</p> <p>Protocol:</p> <p>1. Any grievance or concern that cannot be immediately resolved will be documented on the Concern/Grievance form...</p> <p>...2. The Concern/Grievance forms will be kept in public location so they are easily accessible.</p> <p>...4. The Social Service Director will review the issue, keep a copy, and forward it to the appropriate department head for resolution.</p> <p>5. The receiving department manager will act immediately and begin interventions toward resolution..."</p> <p>Review of undated "Marion Rehabilitation and Assisted Living Center Resident Rights" provided by the ADM on 7/30/14 at 3:31 p.m. indicated the following:</p> <p>... a. Residents have the right to be treated with consideration, respect, and recognition of their dignity and</p>						

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(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>individuality.</p> <p>...o. Residents have the right to be free from verbal abuse.</p> <p>Review of the "Abuse Prevention, Intervention Investigation & Crime Reporting Policy" revised September 2011 was provided by the ADM on 7/30/14 at 3:31 p.m., indicated the following:</p> <p>"BASIC RESPONSIBILITY:</p> <p>Facility Administrator, or designee and All Facility Employees</p> <p>POLICY</p> <p>It is the policy that every resident has the right to be free from verbal, sexual, physical, and mental abuse, neglect, corporal punishment, and involuntary seclusion.</p> <p>Any form of mistreatment of residents, including but not limited to abuse, neglect, exploitation, involuntary seclusion, or misappropriation of property is strictly prohibited.</p> <p>It is the responsibility of employees to immediately report to the facility</p>						

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	<p>administrator...and to State Licensing and Certification immediately or as soon as practically possible within 24 hours of detection, any incident of suspected or alleged neglect or resident abuse from other residents, staff... Reports shall be investigated in a timely manner.</p> <p>The facility will comply with Section 1150B of the Social Security Act (the Act) as established by section 6703(b)(3) of the Patient Protection and Affordable Care Act in reference to reporting any reasonable suspicion of crimes committed against a resident of a long-term facility...</p> <p>...PURPOSE</p> <p>To protect the physical and emotional well-being and personal possessions of every resident...</p> <p>DEFINITIONS</p> <p>Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting harm, pain or mental anguish...</p> <p>...Verbal Abuse is defined as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their</p>			

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	<p>families, or within their hearing distance regardless of their age, ability to comprehend, or disability.</p> <p>...4. Prevention</p> <p>...Regular staff monitoring to determine whether inappropriate behaviors are occurring, such as use of derogatory language, rough handling of residents, inattention to residents while providing care, or failure to provide adequate assistance when needed...</p> <p>...6. Investigation</p> <p>Injuries of unknown source, suspected or alleged abuse, neglect... will be investigated with results reported in accordance with facility policies, federal and state regulations..."</p> <p>...6. Reporting</p> <p>...the facility requires that employees immediately report the facts of known or suspected instances of abuse and all allegations of abuse and suspicions of crime immediately to the facility Administrator (either directly or anonymously) so that facility's responsibility to protect residents and promptly investigate occurrences may be met..."</p>						

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R000000	This federal tag relates to Complaint IN00150283. 3.1-28(a)	R000000			