

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155775	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/13/2011
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NAME OF PROVIDER OR SUPPLIER CUMBERLAND POINTE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1051 CUMBERLAND AVE WEST LAFAYETTE, IN47906
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F0000	<p>This visit was for the Investigation of Complaint IN00099417.</p> <p>Complaint number IN00099417 - Substantiated, Federal/state deficiencies related to the allegation are cited at F-223,F-225 AND F-226.</p> <p>Survey date: November 13, 2011</p> <p>Facility number: 000547 Provider number: 155775 AIM Number: 100267440</p> <p>Survey team: DeAnn Mankell, R.N.</p> <p>Census bed type: SNF: 29 NF: 37 Residential: 53 Total: 119</p> <p>Census payor type: Medicare: 9 Medicaid: 20 Other: 90 TOTAL 119</p> <p>Sample: 3</p> <p>These deficiencies also reflect state</p>	F0000	<p>The submission of this POC does not indicate an admission by Cumberland Pointe Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Cumberland Pointe Health Campus. This facility recognized it's obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities (for Title 18/19 programs).To this end, this plan of correction shall serve as the credible allegations of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only.The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</p>	

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

TITLE

(X6) DATE

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

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F0223 SS=D	<p>findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 11/17/11 Cathy Emswiller RN</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 record review and interview, the facility failed to prevent physical and mental abuse related to staff pouring water into the lap of a resident to get him to change his clothes for 1 of 1 allegations of abuse reviewed (Resident A).</p> <p>Findings include:</p> <p>1. Resident A's clinical record was reviewed on 11/13/2011 at 3:30 P.M.</p> <p>Resident A's diagnoses included, but were not limited to, chronic obstructive pulmonary disease, gout, anxiety, hypertension, anemia, chronic renal failure, and osteoarthritis.</p>	F0223	CORRECTIVE ACTION CNA #1 and RN #1 were placed on suspension on 11-01-11 after the allegation was first reported to the Director of Health Services that same day. After completion of the investigation both CNA #1 and RN #1 were terminated from employment on 11-07-11. CNA #2 was in-serviced on 11-04-11 regarding the abuse policies and the need to immediately inform if any suspicion or allegation of abuse is noted. The CNA knew that RN #1 was aware and thought she was reporting the incident to the Director. She was educated regarding the need for her to ensure the Director was informed immediately by asking another nurse for assistance or contacting the Director	12/02/2011	

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	<p>An investigation of a allegation of abuse provided by the facility was reviewed. The fax/Incident report indicated the incident date was 10/31/2011. The brief description of the incident was "on 11/1/2011 the resident's niece called the DON and shared a concern. She stated that on 10/31/2011 she had been told by the nurse that a CNA had poured water into the lap of Resident A in an attempt to get him to change his clothes. The niece reported that this nurse, RN #1, told her that the reason this was done was so that the staff could check his pockets for 'pills.' The nurse stated to the niece that it had been reported to her that a CNA saw him take pills out of his pocket and put them in the opposite pocket so the nurse wanted to check to see if he did have pills in his pocket."</p> <p>Resident A's nurses notes indicated on 10/30/11 at 6:30 P.M., "CNA observed res take 2 white pills out of (R) (right) pants pocket & put them in (L) (left) pants pocket. Writer spoke with res. asking if he had pills in his pocket. He said 'No--- I have mints' asked res. if he minded if I checked. He reached into his pocket & took out a white pill. Became angry stating 'Someone's been coming into my room going thru my things - how else would they know about that aspirin....'"</p> <p>This note lacked any notation of water</p>		<p>herself. CNA #2 received a written disciplinary action on 11-10-11 for her failure to ensure the nurse or herself reported the allegation to the Executive Director or Director of Health Services. All employees are educated to the facility's policies and procedures regarding abuse and neglect and resident rights at the time of hire in New Employee Orientation. The facility policy requires screening of employees, training of employees, prevention steps and identification steps that include prompt and immediate reporting of all allegations of abuse. If an allegation is made the first priority is immediately provision of safety for residents and suspension of the suspected employee(s) pending outcome of investigation. An investigation is immediately initiated as well as prompt reporting to the family member, physician, Trilogy management and state agencies. All residents at the time of admission are informed of the facility's zero tolerance for abuse standard and how residents may report any concerns they experience while residing at the campus. The Director of Health Services did take appropriate action immediately when informed of the allegations by suspending RN #1 and CNA #1 and reporting the incident to appropriate individuals and agencies. IDENTIFY OTHER RESIDENTS All other HC</p>	

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	<p>being poured onto the resident.</p> <p>The change of condition form dated 10/30/11 at 7 P.M., indicated "Observed res c (with) 2 white pills in pants pocket - retrieved p (after) asking him about it - had 500 mg. on 1 side & 1405 on the other - also turned in an aspirin - stated he had 20 ASA (aspirin) from (name)."</p> <p>The DHS (Director of Health Services) provided a 5 page copy of her investigation into the allegation of abuse which indicated the following:</p> <p>"At approximately 8:45 A.M. on Monday morning Nov 1, 2011 DHS received a phone call.... The caller was CNA #3, who is also an employee at our facility.... CNA #3 ... works night shift ... where Resident A resides.</p> <p>In the phone call CNA #3 reported that she was upset about the way RN #1 handled a situation.... She stated that on Sunday evening shift of 10/30/2011 she received a phone call from RN #1. CNA #3 stated that RN #1 told her.... a CNA had noticed Resident A take pills out of his pants pocket. CNA #3 said that the nurse told her that the CNA 'accidentally' poured water on his pants so that she could change his pants in order to look for the 'pills.' CNA #3 said that she asked RN</p>		<p>residents that were alert and oriented were interviewed and asked if they had any concerns with how staff treated them or their care. No other alert and oriented residents expressed any concerns. The family members of non-alert and non-oriented residents are being contacted to ensure they have no concerns with staff treatment or care of their family member.</p> <p>MEASURES/SYSTEMIC CHANGES An Abuse Prevention and Reporting In-service was initiated on 11-01-11 with multiple sessions scheduled on multiple dates. The in-service is for each department and shift in the facility. MONITORING CORRECTIVE ACTION Interviews by the nursing manager and/or manager on duty will be completed with all alert and oriented health care residents three times weekly for four weeks to ensure residents have no concerns with staff treatment or care. Interviews will then be completed once weekly for eight weeks. Any concerns expressed by residents will be reported to the Executive Director (or designee) and investigated immediately with results of the interviews reported to the QA Committee each month. Each month at Resident Council residents are educated regarding their rights including the right to be free from any mistreatment including abuse and</p>		

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	<p>#1, 'Why didn't you just ask him if you could see the pills? Did you just ask him if you could check his pockets?' and RN #1 said 'No.'" CNA #1 said 'He's a dignified person, and I suggest you just ask him.'</p> <p>CNA #3 stated to the DNS, 'This was so undignified and if it had been my dad...'</p> <p>CNA #3 said that the way RN #1 talked she had initiated the plan to pour water on the resident.</p> <p>Since CNA #3 works on the unit she relayed to the DHS that she had talked to another CNA that worked on the unit named CNA #2 and she asked her about the incident. CNA #3 said that CNA #2 made the statement that she had heard about the incident but was not involved in it...."</p> <p>The report continued with the a notation of "At 10:00 A.M. on Monday 10/31/2011 the DNS and the Interdisciplinary team read an Incident Report in the morning Clinical Meeting that documented that Resident A had been seen taking pills out of one pants pocket and placing them in the opposite pocket. There was no mention of the water spill in the report.</p> <p>On the morning of 11/1/2011 after the phone call from CNA #3 the DHS placed</p>		<p>neglect and are asked if they have any concerns. All allegations of abuse will be reported to the QA Committee monthly and the Committee will review each allegation to ensure facility policy and procedure was followed. Should negative trends be noted, the QA Committee will report those findings to the Trilogy Division Support for additional training or corrective action.</p>		

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	<p>both CNA #1 and RN #1 on probation....</p> <p>On 11/1/2011 at approximately 11:00 A.M., RN #1 was called to the DHS office. She was asked about the incident and gave a statement that she did agree with CNA #1 to pour water on Resident A in order to get him to change his pants so that she could check his pants for any pills he might be hoarding or hiding. RN #1 stated in writing that CNA #1 said, 'Well I'm always the bad guy so I'll spill water on his pants and maybe then he will let me change them.' RN #1 said that she did not stop CNA #1 from pouring the water on the resident. RN #1 stated that CNA #1 got 3 Styrofoam glasses of water, approached Resident A's table while he was eating supper and 'accidentally' spilled the water and told him she would take him to his room to change. Resident A refused to let her change him. RN #1 stated that this incident was witnessed by CNA #2....</p> <p>On 11/1/2011 at approximately 11:20 A.M. the DHS spoke to RN #2 who had worked on the evening shift on 10/30/2011. RN #2 said she was aware that he had water on his pants. RN #2 asked RN #1 what had happened and was told that she was trying to get him to change his pants. RN #2 said she did see that he had water on his pants but did not</p>				

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	<p>witness the water being poured on the resident. RN #2 said she told RN #1 that pouring water on his clothes was not the best way to handle the problem. RN #2 told the DHS that she did not think the way it was handled was appropriate and that it should not have been handled in the dining room...."</p> <p>On 11/1/2011 at 2:30 P.M. the DHS called CNA #2 to come to the office and give an account of the story regarding Resident A.... CNA #2 stated that she was in the Dining Room at the ... table (where residents are assisted to eat) during the supper meal on 10/30/2011. She stated she heard a conversation between RN #1 and CNA #1. CNA #2 stated that she heard CNA #2 tell RN #1 that Resident A had taken a pill out of his pocket. CNA #2 said that RN #1 was asking CNA #1 for suggestions as to how they might be able to check his pockets without getting him upset. CNA #2 stated that RN #1 and CNA #1 talked about pouring water into his lap so that CNA #1 could go change his pants and then they could check to see what kind of pill he had in this pocket. CNA #2 felt like it was clear from the conversation she heard that both RN #1 and CNA #1 planned to deliberately pour water onto the resident and it was not an 'accident....'</p>			

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	<p>On 11/2/2011 at approximately 3:30 P.M. CNA #1 came to the DHS office and met with DHS and ADHS. CNA #1 brought a typed statement of the incident in question. CNA #1 said that during the evening meal on 10/30/2011 at approximately 5:45 P.M. she witnessed Resident A pull medication out of his pocket. CNA #1 stated that she had been passing meal trays and drinks in the dining room and she carried too many glasses at one time and the glasses were slippery and she wasn't very graceful. She stated that she was attempting to carry more that she should have and when she arrived at Resident A's table the glass slid out of her hand spilling water on the resident.... She stated later in the meal RN #1 came to the ... table where she was assisting (residents to eat) and expressed concern that she needed a way to search Resident A's pockets. CNA #1 said that RN #1 asked her if she had any ideas and CNA #1 said she told RN #1 that she had previously spilled water on his pants.... CNA #1 stated to the DHS that the spilled water had nothing to do with the 'pill' in his pocket. She stated that the two incidents had nothing to do with each other....</p> <p>On 11/3/2100 DHS spoke to CNA #2 at about 3:45 P.M. in the DHS office. DHS asked CNA #2 at this time to write her</p>			

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	<p>own statement of this incident. CNA #2 wrote a statement said that both CNA #1 and RN #1 had talked together and thought that getting Resident A to change his pants was the best solution. They talked together about the idea to pour water on his pants and this was done deliberately to get him to change his pants so that the pills could be checked. CNA #2 wrote that she knew this to be factual because she heard RN #1 ask CNA #1 to pour the water on his pants....DHS asked CNA #2 if she believed that CNA #1 poured the water on the resident deliberately and CNA #2 said 'Yes.'</p> <p>Summary: There were other more appropriate and respectful alternatives available to the CNA and the nurse in attempting to protect the safety of the resident related to the medication they thought he had in his pocket. This was a poor judgement decision by both and therefore both employees are being terminated from employment."</p> <p>CNA #1 and RN #1 were both terminated on 11/7/11 after being placed on suspension on 11/1/11. CNA #2 had been given a written reprimand on 11/10/11 for not reporting the incident immediately to her supervisor.</p>				

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	<p>CNA #2 was interviewed on 11/13/11 at 5:40 P.M., she indicated RN #1 was her supervisor and she had told CNA #2 that she had reported the incident to the DNS, but she had not done this.</p> <p>Review of Abuse and Neglect Procedural Guidelines dated 11/201 and revised 9/16/2011 and provided by the Administrator on 11/13/2011 at 4:30 P.M. indicated "(Name) has developed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect....Physical Abuse - includes hitting, slapping, pinching, spitting, holding or handling roughly, etc. It also included controlling behavior through corporal punishment.... Mental/Emotional Abuse-includes, but is not limited to, humiliation, harassment, and threats of punishment or deprivation...."</p> <p>This federal tag refers to complaint IN00099417.</p> <p>3.1-27(a)(1) 3.1-27(a)(3) 3.1-27(b)</p>				

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F0225 SS=D	<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 record review and interview, the facility failed to ensure physical and mental abuse related to staff pouring water into the lap of a resident to get him</p>	F0225	CORRECTIVE ACTION CNA #1 and RN #1 were placed on suspension on 11-01-11 after the allegation was first reported to the Director of Health Services that	12/02/2011

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	<p>to change his clothes was reported to the Administrator immediately for 1 of 1 allegations of abuse reviewed (Resident A).</p> <p>Findings include:</p> <p>1. Resident A's clinical record was reviewed on 11/13/2011 at 3:30 P.M.</p> <p>Resident A's diagnoses included, but were not limited to, chronic obstructive pulmonary disease, gout, anxiety, hypertension, anemia, chronic renal failure, and osteoarthritis.</p> <p>An investigation of a allegation of abuse provided by the facility was reviewed. The fax/Incident report indicated the incident date was 10/31/2011. The brief description of the incident was "on 11/1/2011 the resident's niece called the DON and shared a concern. She stated that on 10/31/2011 she had been told by the nurse that a CNA had poured water into the lap of Resident A in an attempt to get him to change his clothes. The niece reported that this nurse, RN #1, told her that the reason this was done was so that the staff could check his pockets for 'pills.' The nurse stated to the niece that it had been reported to her that a CNA saw him take pills out of his pocket and put them in the opposite pocket so the nurse wanted</p>		<p>same day. After completion of the investigation both CNA #1 and RN #1 were terminated from employment on 11-07-11. CNA #2 was in-serviced on 11-04-11 regarding the abuse policies and the need to immediately inform if any suspicion or allegation of abuse is noted. The CNA knew that RN #1 was aware and thought she was reporting the incident to the Director. She was educated regarding the need for her to ensure the Director was informed immediately by asking another nurse for assistance or contacting the Director herself. CNA #2 received a written disciplinary action on 11-10-11 for her failure to ensure the nurse or herself reported the allegation to the Executive Director or Director of Health Services. All employees are educated to the facility's policies and procedures regarding abuse and neglect and resident rights at the time of hire in New Employee Orientation. The facility policy requires screening of employees, training of employees, prevention steps and identification steps that include prompt and immediate reporting of all allegations of abuse. If an allegation is made the first priority is immediately provision of safety for residents and suspension of the suspected employee(s) pending outcome of investigation. An investigation is immediately initiated as well as prompt reporting to the family</p>		

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	<p>to check to see if he did have pills in his pocket."</p> <p>Resident A's nurses notes indicated on 10/30/11 at 6:30 P.M., "CNA observed res take 2 white pills out of (R) (right) pants pocket & put them in (L) (left) pants pocket. Writer spoke with res. asking if he had pills in his pocket. He said 'No--- I have mints' asked res. if he minded if I checked. He reached into his pocket & took out a white pill. Became angry stating 'Someone's been coming into my room going thru my things - how else would they know about that aspirin....'"</p> <p>This note lacked any notation of water being poured onto the resident.</p> <p>The change of condition form dated 10/30/11 at 7 P.M., indicated "Observed res c (with) 2 white pills in pants pocket - retrieved p (after) asking him about it - had 500 mg. on 1 side & 1405 on the other - also turned in an aspirin - stated he had 20 ASA (aspirin) from (name)."</p> <p>The DHS (Director of Health Services) provided a 5 page copy of her investigation into the allegation of abuse which indicated the following:</p> <p>"At approximately 8:45 A.M. on Monday morning Nov 1, 2011 DHS received a phone call.... The caller was CNA #3,</p>		<p>member, physician, Trilogly management and state agencies. All residents at the time of admission are informed of the facility's zero tolerance for abuse standard and how residents may report any concerns they experience while residing at the campus. The Director of Health Services did take appropriate action immediately when informed of the allegations by suspending RN #1 and CNA #1 and reporting the incident to appropriate individuals and agencies. IDENTIFY OTHER RESIDENTS All other HC residents that were alert and oriented were interviewed and asked if they had any concerns with how staff treated them or their care. No other alert and oriented residents expressed any concerns. The family members of non-alert and non-oriented residents are being contacted to ensure they have no concerns with staff treatment or care of their family member.</p> <p>MEASURES/SYSTEMIC CHANGES An Abuse Prevention and Reporting In-service was initiated on 11-01-11 with multiple sessions scheduled on multiple dates. The in-service is for each department and shift in the facility. MONITORING CORRECTIVE ACTION Interviews by the nursing manager and/or manager on duty will be completed with all alert and oriented health care</p>		

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	<p>who is also an employee at our facility.... CNA #3 ... works night shift ... where Resident A resides.</p> <p>In the phone call CNA #3 reported that she was upset about the way RN #1 handled a situation.... She stated that on Sunday evening shift of 10/30/2011 she received a phone call from RN #1. CNA #3 stated that RN #1 told her.... a CNA had noticed Resident A take pills out of his pants pocket. CNA #3 said that the nurse told her that the CNA 'accidentally' poured water on his pants so that she could change his pants in order to look for the 'pills.' CNA #3 said that she asked RN #1, 'Why didn't you just ask him if you could see the pills? Did you just ask him if you could check his pockets?' and RN #1 said 'No.'" CNA #1 said 'He's a dignified person, and I suggest you just ask him.'</p> <p>CNA #3 stated to the DNS, 'This was so undignified and if it had been my dad...'</p> <p>CNA #3 said that the way RN #1 talked she had initiated the plan to pour water on the resident.</p> <p>Since CNA #3 works on the unit she relayed to the DHS that she had talked to another CNA that worked on the unit named CNA #2 and she asked her about the incident. CNA #3 said that CNA #2</p>		<p>residents three times weekly for four weeks to ensure residents have no concerns with staff treatment or care. Interviews will then be completed once weekly for eight weeks. Any concerns expressed by residents will be reported to the Executive Director (or designee) and investigated immediately with results of the interviews reported to the QA Committee each month. Each month at Resident Council residents are educated regarding their rights including the right to be free from any mistreatment including abuse and neglect and are asked if they have any concerns. All allegations of abuse will be reported to the QA Committee monthly and the Committee will review each allegation to ensure facility policy and procedure was followed. Should negative trends be noted, the QA Committee will report those findings to the Trilogy Division Support for additional training or corrective action.</p>		

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	<p>made the statement that she had heard about the incident but was not involved in it...."</p> <p>The report continued with the a notation of "At 10:00 A.M. on Monday 10/31/2011 the DNS and the Interdisciplinary team read an Incident Report in the morning Clinical Meeting that documented that Resident A had been seen taking pills out of one pants pocket and placing them in the opposite pocket. There was no mention of the water spill in the report.</p> <p>On the morning of 11/1/2011 after the phone call from CNA #3 the DHS placed both CNA #1 and RN #1 on probation....</p> <p>On 11/1/2011 at approximately 11:00 A.M., RN #1 was called to the DHS office. She was asked about the incident and gave a statement that she did agree with CNA #1 to pour water on Resident A in order to get him to change his pants so that she could check his pants for any pills he might be hoarding or hiding. RN #1 stated in writing that CNA #1 said, 'Well I'm always the bad guy so I'll spill water on his pants and maybe then he will let me change them.' RN #1 said that she did not stop CNA #1 from pouring the water on the resident. RN #1 stated that CNA #1 got 3 Styrofoam glasses of water, approached Resident A's table while he</p>			

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	<p>was eating supper and 'accidentally' spilled the water and told him she would take him to his room to change. Resident A refused to let her change him. RN #1 stated that this incident was witnessed by CNA #2....</p> <p>On 11/1/2011 at approximately 11:20 A.M. the DHS spoke to RN #2 who had worked on the evening shift on 10/30/2011. RN #2 said she was aware that he had water on his pants. RN #2 asked RN #1 what had happened and was told that she was trying to get him to change his pants. RN #2 said she did see that he had water on his pants but did not witness the water being poured on the resident. RN #2 said she told RN #1 that pouring water on his clothes was not the best way to handle the problem. RN #2 told the DHS that she did not think the way it was handled was appropriate and that it should not have been handled in the dining room...."</p> <p>On 11/1/2011 at 2:30 P.M. the DHS called CNA #2 to come to the office and give an account of the story regarding Resident A.... CNA #2 stated that she was in the Dining Room at the ... table (where residents are assisted to eat) during the supper meal on 10/30/2011. She stated she heard a conversation between RN #1 and CNA #1. CNA #2 stated that she</p>			

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	<p>heard CNA #2 tell RN #1 that Resident A had taken a pill out of his pocket. CNA #2 said that RN #1 was asking CNA #1 for suggestions as to how they might be able to check his pockets without getting him upset. CNA #2 stated that RN #1 and CNA #1 talked about pouring water into his lap so that CNA #1 could go change his pants and then they could check to see what kind of pill he had in this pocket. CNA #2 felt like it was clear from the conversation she heard that both RN #1 and CNA #1 planned to deliberately pour water onto the resident and it was not an 'accident...'</p> <p>On 11/2/2011 at approximately 3:30 P.M. CNA #1 came to the DHS office and met with DHS and ADHS. CNA #1 brought a typed statement of the incident in question. CNA #1 said that during the evening meal on 10/30/2011 at approximately 5:45 P.M. she witnessed Resident A pull medication out of his pocket. CNA #1 stated that she had been passing meal trays and drinks in the dining room and she carried too many glasses at one time and the glasses were slippery and she wasn't very graceful. She stated that she was attempting to carry more than she should have and when she arrived at Resident A's table the glass slid out of her hand spilling water on the resident.... She stated later in the meal RN</p>			

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	<p>#1 came to the ... table where she was assisting (residents to eat) and expressed concern that she needed a way to search Resident A's pockets. CNA #1 said that RN #1 asked her if she had any ideas and CNA #1 said she told RN #1 that she had previously spilled water on his pants.... CNA #1 stated to the DHS that the spilled water had nothing to do with the 'pill' in his pocket. She stated that the two incidents had nothing to do with each other....</p> <p>On 11/3/2100 DHS spoke to CNA #2 at about 3:45 P.M. in the DHS office. DHS asked CNA #2 at this time to write her own statement of this incident. CNA #2 wrote a statement said that both CNA #1 and RN #1 had talked together and thought that getting Resident A to change his pants was the best solution. They talked together about the idea to pour water on his pants and this was done deliberately to get him to change his pants so that the pills could be checked. CNA #2 wrote that she knew this to be factual because she heard RN #1 ask CNA #1 to pour the water on his pants....DHS asked CNA #2 if she believed that CNA #1 poured the water on the resident deliberately and CNA #2 said 'Yes.'</p> <p>Summary: There were other more appropriate and</p>			

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	<p>respectful alternatives available to the CNA and the nurse in attempting to protect the safety of the resident related to the medication they thought he had in his pocket. This was a poor judgement decision by both and therefore both employees are being terminated from employment."</p> <p>CNA #1 and RN #1 were both terminated on 11/7/11 after being placed on suspension on 11/1/11. CNA #2 was given a written reprimand on 11/10/11 for not reporting the incident immediately to her supervisor.</p> <p>CNA #2 was interviewed on 11/13/11 at 5:40 P.M., she indicated RN #1 was her supervisor and she had told CNA #2 that she had reported the incident to the DNS, but she had not done this.</p> <p>Review of Abuse and Neglect Procedural Guidelines dated 11/201 and revised 9/16/2011 and provided by the Administrator on 11/13/2011 at 4:30 P.M. indicated "(Name) has developed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect.... Any person with knowledge or suspicion of suspected violations shall report immediately, without fear of reprisal."</p>				

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F0226 SS=D	<p>This federal tag refers to complaint IN00099417.</p> <p>3.1-28(c)</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. Based on record review and interview, the facility failed ensure an allegation of physical and mental abuse related to staff pouring water into the lap of a resident to get him to change his clothes was reported immediately to the administrator for 1 of 1 allegations of abuse reviewed (Resident A).</p> <p>Findings include:</p> <p>1. Resident A's clinical record was reviewed on 11/13/2011 at 3:30 P.M.</p> <p>Resident A's diagnoses included, but were not limited to, chronic obstructive pulmonary disease, gout, anxiety,</p>	F0226	CORRECTIVE ACTION CNA #1 and RN #1 were placed on suspension on 11-01-11 after the allegation was first reported to the Director of Health Services that same day. After completion of the investigation both CNA #1 and RN #1 were terminated from employment on 11-07-11. CNA #2 was in-serviced on 11-04-11 regarding the abuse policies and the need to immediately inform if any suspicion or allegation of abuse is noted. The CNA knew that RN #1 was aware and thought she was reporting the incident to the Director. She was educated regarding the need for her to ensure the Director was informed immediately by asking another nurse for assistance or contacting the Director	12/02/2011

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	<p>hypertension, anemia, chronic renal failure, and osteoarthritis.</p> <p>An investigation of a allegation of abuse provided by the facility was reviewed. The fax/Incident report indicated the incident date was 10/31/2011. The brief description of the incident was "on 11/1/2011 the resident's niece called the DON and shared a concern. She stated that on 10/31/2011 she had been told by the nurse that a CNA had poured water into the lap of Resident A in an attempt to get him to change his clothes. The niece reported that this nurse, RN #1, told her that the reason this was done was so that the staff could check his pockets for 'pills.' The nurse stated to the niece that it had been reported to her that a CNA saw him take pills out of his pocket and put them in the opposite pocket so the nurse wanted to check to see if he did have pills in his pocket."</p> <p>Resident A's nurses notes indicated on 10/30/11 at 6:30 P.M., "CNA observed res take 2 white pills out of (R) (right) pants pocket & put them in (L) (left) pants pocket. Writer spoke with res. asking if he had pills in his pocket. He said 'No--- I have mints' asked res. if he minded if I checked. He reached into his pocket & took out a white pill. Became angry stating 'Someone's been coming into my</p>		<p>herself. CNA #2 received a written disciplinary action on 11-10-11 for her failure to ensure the nurse or herself reported the allegation to the Executive Director or Director of Health Services. All employees are educated to the facility's policies and procedures regarding abuse and neglect and resident rights at the time of hire in New Employee Orientation. The facility policy requires screening of employees, training of employees, prevention steps and identification steps that include prompt and immediate reporting of all allegations of abuse. If an allegation is made the first priority is immediately provision of safety for residents and suspension of the suspected employee(s) pending outcome of investigation. An investigation is immediately initiated as well as prompt reporting to the family member, physician, Trilogy management and state agencies. All residents at the time of admission are informed of the facility's zero tolerance for abuse standard and how residents may report any concerns they experience while residing at the campus. The Director of Health Services did take appropriate action immediately when informed of the allegations by suspending RN #1 and CNA #1 and reporting the incident to appropriate individuals and agencies. IDENTIFY OTHER RESIDENTS All other HC</p>				

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	<p>room going thru my things - how else would they know about that aspirin...." This note lacked any notation of water being poured onto the resident.</p> <p>The change of condition form dated 10/30/11 at 7 P.M., indicated "Observed res c (with) 2 white pills in pants pocket - retrieved p (after) asking him about it - had 500 mg. on 1 side & 1405 on the other - also turned in an aspirin - stated he had 20 ASA (aspirin) from (name)."</p> <p>The DHS (Director of Health Services) provided a 5 page copy of her investigation into the allegation of abuse which indicated the following:</p> <p>"At approximately 8:45 A.M. on Monday morning Nov 1, 2011 DHS received a phone call.... The caller was CNA #3, who is also an employee at our facility.... CNA #3 ... works night shift ... where Resident A resides.</p> <p>In the phone call CNA #3 reported that she was upset about the way RN #1 handled a situation.... She stated that on Sunday evening shift of 10/30/2011 she received a phone call from RN #1. CNA #3 stated that RN #1 told her.... a CNA had noticed Resident A take pills out of his pants pocket. CNA #3 said that the nurse told her that the CNA 'accidentally'</p>		<p>residents that were alert and oriented were interviewed and asked if they had any concerns with how staff treated them or their care. No other alert and oriented residents expressed any concerns. The family members of non-alert and non-oriented residents are being contacted to ensure they have no concerns with staff treatment or care of their family member.</p> <p>MEASURES/SYSTEMIC CHANGES An Abuse Prevention and Reporting In-service was initiated on 11-01-11 with multiple sessions scheduled on multiple dates. The in-service is for each department and shift in the facility. MONITORING CORRECTIVE ACTION Interviews by the nursing manager and/or manager on duty will be completed with all alert and oriented health care residents three times weekly for four weeks to ensure residents have no concerns with staff treatment or care. Interviews will then be completed once weekly for eight weeks. Any concerns expressed by residents will be reported to the Executive Director (or designee) and investigated immediately with results of the interviews reported to the QA Committee each month. Each month at Resident Council residents are educated regarding their rights including the right to be free from any mistreatment including abuse and</p>		

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	<p>poured water on his pants so that she could change his pants in order to look for the 'pills.' CNA #3 said that she asked RN #1, 'Why didn't you just ask him if you could see the pills? Did you just ask him if you could check his pockets?' and RN #1 said 'No.'" CNA #1 said 'He's a dignified person, and I suggest you just ask him.'</p> <p>CNA #3 stated to the DNS, 'This was so undignified and if it had been my dad...' CNA #3 said that the way RN #1 talked she had initiated the plan to pour water on the resident.</p> <p>Since CNA #3 works on the unit she relayed to the DHS that she had talked to another CNA that worked on the unit named CNA #2 and she asked her about the incident. CNA #3 said that CNA #2 made the statement that she had heard about the incident but was not involved in it...."</p> <p>The report continued with the a notation of "At 10:00 A.M. on Monday 10/31/2011 the DNS and the Interdisciplinary team read an Incident Report in the morning Clinical Meeting that documented that Resident A had been seen taking pills out of one pants pocket and placing them in the opposite pocket. There was no mention of the water spill in the report.</p>		neglect and are asked if they have any concerns. All allegations of abuse will be reported to the QA Committee monthly and the Committee will review each allegation to ensure facility policy and procedure was followed. Should negative trends be noted, the QA Committee will report those findings to the Trilogy Division Support for additional training or corrective action.		

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	<p>On the morning of 11/1/2011 after the phone call from CNA #3 the DHS placed both CNA #1 and RN #1 on probation....</p> <p>On 11/1/2011 at approximately 11:00 A.M., RN #1 was called to the DHS office. She was asked about the incident and gave a statement that she did agree with CNA #1 to pour water on Resident A in order to get him to change his pants so that she could check his pants for any pills he might be hoarding or hiding. RN #1 stated in writing that CNA #1 said, 'Well I'm always the bad guy so I'll spill water on his pants and maybe then he will let me change them.' RN #1 said that she did not stop CNA #1 from pouring the water on the resident. RN #1 stated that CNA #1 got 3 Styrofoam glasses of water, approached Resident A's table while he was eating supper and 'accidentally' spilled the water and told him she would take him to his room to change. Resident A refused to let her change him. RN #1 stated that this incident was witnessed by CNA #2....</p> <p>On 11/1/2011 at approximately 11:20 A.M. the DHS spoke to RN #2 who had worked on the evening shift on 10/30/2011. RN #2 said she was aware that he had water on his pants. RN #2 asked RN #1 what had happened and was</p>			
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	<p>told that she was trying to get him to change his pants. RN #2 said she did see that he had water on his pants but did not witness the water being poured on the resident. RN #2 said she told RN #1 that pouring water on his clothes was not the best way to handle the problem. RN #2 told the DHS that she did not think the way it was handled was appropriate and that it should not have been handled in the dining room...."</p> <p>On 11/1/2011 at 2:30 P.M. the DHS called CNA #2 to come to the office and give an account of the story regarding Resident A.... CNA #2 stated that she was in the Dining Room at the ... table (where residents are assisted to eat) during the supper meal on 10/30/2011. She stated she heard a conversation between RN #1 and CNA #1. CNA #2 stated that she heard CNA #2 tell RN #1 that Resident A had taken a pill out of his pocket. CNA #2 said that RN #1 was asking CNA #1 for suggestions as to how they might be able to check his pockets without getting him upset. CNA #2 stated that RN #1 and CNA #1 talked about pouring water into his lap so that CNA #1 could go change his pants and then they could check to see what kind of pill he had in this pocket. CNA #2 felt like it was clear from the conversation she heard that both RN #1 and CNA #1 planned to deliberately pour</p>			

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NAME OF PROVIDER OR SUPPLIER CUMBERLAND POINTE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1051 CUMBERLAND AVE WEST LAFAYETTE, IN47906		
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	<p>water onto the resident and it was not an 'accident....'</p> <p>On 11/2/2011 at approximately 3:30 P.M. CNA #1 came to the DHS office and met with DHS and ADHS. CNA #1 brought a typed statement of the incident in question. CNA #1 said that during the evening meal on 10/30/2011 at approximately 5:45 P.M. she witnessed Resident A pull medication out of his pocket. CNA #1 stated that she had been passing meal trays and drinks in the dining room and she carried too many glasses at one time and the glasses were slippery and she wasn't very graceful. She stated that she was attempting to carry more that she should have and when she arrived at Resident A's table the glass slid out of her hand spilling water on the resident.... She stated later in the meal RN #1 came to the ... table where she was assisting (residents to eat) and expressed concern that she needed a way to search Resident A's pockets. CNA #1 said that RN #1 asked her if she had any ideas and CNA #1 said she told RN #1 that she had previously spilled water on his pants.... CNA #1 stated to the DHS that the spilled water had nothing to do with the 'pill' in his pocket. She stated that the two incidents had nothing to do with each other....</p>				

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	<p>On 11/3/2100 DHS spoke to CNA #2 at about 3:45 P.M. in the DHS office. DHS asked CNA #2 at this time to write her own statement of this incident. CNA #2 wrote a statement said that both CNA #1 and RN #1 had talked together and thought that getting Resident A to change his pants was the best solution. They talked together about the idea to pour water on his pants and this was done deliberately to get him to change his pants so that the pills could be checked. CNA #2 wrote that she knew this to be factual because she heard RN #1 ask CNA #1 to pour the water on his pants....DHS asked CNA #2 if she believed that CNA #1 poured the water on the resident deliberately and CNA #2 said 'Yes.'</p> <p>Summary: There were other more appropriate and respectful alternatives available to the CNA and the nurse in attempting to protect the safety of the resident related to the medication they thought he had in his pocket. This was a poor judgement decision by both and therefore both employees are being terminated from employment."</p> <p>CNA #1 and RN #1 were both terminated on 11/7/11 after being placed on suspension on 11/1/11. CNA #2 had been given a written reprimand on</p>			

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	<p>11/10/11 for not reporting the incident immediately to her supervisor.</p> <p>CNA #2 was interviewed on 11/13/11 at 5:40 P.M., she indicated RN #1 was her supervisor and she had told CNA #2 that she had reported the incident to the DNS, but she had not done this.</p> <p>During an interview with the DHS on 11/13/11 at 4:00 P.M., she indicated the incident had happened on 10/130/11, but she was not informed until 11/1/11. She was in charge of the building, at the time, as the Administrator was on vacation. She did call the Administrator, but she was the one who had done the investigation in the absence of the Administrator. CNA #2 had a written reprimand for not reporting immediately to the Administrator or to the DHS, since the Administrator was out of town. She reported the allegation to ISDH within 24 hours of learning of the allegation.</p> <p>Review of Abuse and Neglect Procedural Guidelines dated 11/201 and revised 9/16/2011 and provided by the Administrator on 11/13/2011 at 4:30 P.M. indicated "(Name) has developed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect....Immediately notify the</p>			

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	<p>Executive Director. If the Executive Director is absent they may appoint a designee...."</p> <p>This federal tag refers to complaint IN00099417.</p> <p>3.1-28(a)</p>				