

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155387	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/16/2015
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NAME OF PROVIDER OR SUPPLIER  CAROLETON MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 2500 IOWA AVE CONNERSVILLE, IN 47331
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: November 9, 10, 12, 13, and 16, 2015</p> <p>Facility number: 000318 Provider number: 155387 AIM number: 100266550</p> <p>Census bed type: SNF/NF: 48 Total: 48</p> <p>Census payor type: Medicare: 3 Medicaid: 40 Other: 5 Total: 48</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 30576 on November 20, 2015.</p>	F 0000	<p>Preparation and submission of this plan of correction by <b>Caroleton Manor</b>, does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely pursuant to the requirements under state and federal laws.</p>	
F 0225	483.13(c)(1)(ii)-(iii), (c)(2) - (4)			

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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SS=D Bldg. 00	<p><b>INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</b></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,</p>	F 0225	<b>F 225</b> 1. The identified 2nd shift nurse and CNA was	12/09/2015	

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	<p>the facility failed to immediately report to the Administrator or Director of Nursing Services an injury of unknown origin and an allegation of abuse from a family member, and failed to timely investigate both of these incidents. This affected 1 of 3 residents who fit the criteria for abuse and injuries of unknown origin. (Resident #34)</p> <p>Findings include:</p> <p>During an observation, on 11/10/15 at 10:19 a.m., Resident #34 was observed with a darkened area on her left wrist, that was black/blue in color and measured approximately 5 centimeters (cm) by 5 cm.</p> <p>Resident #34's record was reviewed on 11/13/2015 at 9:18 a.m. Physician's orders, dated October 2015, indicated Resident #34 had diagnosis that included, but were not limited to, dementia without behavioral disturbance, low blood potassium levels, high blood pressure, chronic ischemic heart disease, angina pectoris, osteoarthritis, high blood fats, constipation, depression, urinary incontinence, Vitamin D deficiency, iron deficiency anemia secondary to blood loss, gastro esophageal reflux disease, chronic kidney disease, and feeding difficulties.</p>		<p>reeducated on 11/19/15 by the Director of Nursing related to Resident #34 to ensure Abuse/Neglect is immediately reported to the Administrator and the Director of Nursing and the follow up investigation is timely.</p> <p>2. The Social Worker will complete an audit of current residents by 12/6/15 to ensure allegations of abuse and neglect have been immediately reported to the Administrator or Director of Nursing and investigated timely.</p> <p>3. Facility staff was reeducated on 11/19/15 by the Director of Nursing and the Staff Development Coordinator related to the requirement of immediately reporting allegations of Abuse/Neglect to the Director of Nursing and the Administrator.</p> <p>4. The Director of Nursing will audit the current residents weekly for 4 weeks and monthly for 2 months to ensure allegations of Abuse/ Neglect continue to be immediately reported and investigated timely. The Administrator will submit a report to the Quality Assurance Committee monthly for 3 months. The Administrator will be responsible for monitoring and follow up. Completion date: 12/9/15</p>		

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	<p>A quarterly MDS dated 9/25/15, indicated Resident #34 was severely cognitively impaired, did not reject care, required extensive assist of one for bed mobility, transfers, dressing, personal hygiene, and toileting, totally dependent on one for bathing, assist of one for ambulation, used a walker or wheel chair, was frequently incontinent of bladder and always continent of bowel.</p> <p>A care plan, initiated 2/24/10, indicated: "Resident receives an anti-platelet medication with increased risk for bruising r/t (related to) chronic anemia &amp; hx (history of) low platelet count, thin fragile skin, transfers self without assist and leaves facility with family and resident bumps [upper] arms on objects per self. Goal &amp; Target Date: Resident will remain free from complication r/t anti-platelet therapy (ie: hematuria (blood in the urine), coffee ground emesis, bloody stools, bruising) over the next 92 days. (12-28-15) Resident will remain free from bruises to upper extremities by 12-28-15. Approaches: Monitor and report labs as ordered. Monitor, document and report complications r/t use of anti-coagulants. Take caution to not bump resident's limbs/body. Avoid use of hard bristled tooth brushes. Plavix (anti-platelet) 75 mg (milligrams) tab 1</p>			

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	<p>tab po (by mouth) qd (every day). Generic: clopidogrel. ASA 81 mg tab po qd. Generic: acetylsalicylic acid. Skin sleeves to upper extremities. F/U (follow up) with hematologist if family wants due to anemia. Pad over bed table. Encourage to wear long sleeve clothing. Use gentle-touch technique. Provide protective equipment to bedside table, overbed table &amp; [upper] siderails. Follow up [with] POA regarding resident's daughter removed provided protective equipment to bedside table, overbed table and upper side rails."</p> <p>Nurses notes, dated 9/25/15 at 2:00 a.m., indicated: "Res (resident) has 32X9 cm red &amp; purple /black bruise from elbow to knuckles on (L) arm swelling noted on top of wrist area. Res is moving &amp; bending wrist. [No]voiced c/o pain [no] s/s (signs or symptoms) of pain...."</p> <p>An "Initial Report of Incident", dated 9/25/15, indicated:...Brief description of incident: Nurse observed red and purple bruise to left arm 32 cm x 9 cm: Type of injury/injuries: Bruise. Immediate action taken: Nurse assessed. Family and MD notified. Local Police Department notified. Investigation: Initiated."</p> <p>An "Initial with follow-up" report, dated 9/29/15, indicated: "...Brief description</p>			

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	<p>of incident: Nurse observed red and purple bruise to left arm 32 cm X 9 cm: Type of Injury/Injuries: Bruise Immediate Action Taken: Nurse assessed. Family and MD notified. Local Police Department notified. Investigation: Initiated. Follow up: The investigation and staff interviews revealed that the resident has poor safety awareness. Staff interviews reveal that while providing ADL care the staff reported observing bruising to the hand and wrist area. The resident was positioned on the left side and the resident prefers to lay on her left side. The bruising was assessed by the licensed nurse and follow up with the physician. X ray was ordered and the resident has not complained of pain or have had difficulty with range of motion. The resident has a history of bruising easily and currently being treated by a Hematology and Oncology specialist. The medical record reveal that the resident is on Aspirin therapy, Plavix and Priority. The medical record also reveal that the resident had positive fecal occult blood on 09/18/15 and family declined Nephrology and GI consultant follow up and the physician is aware. The resident's bed and room was reevaluated for safety. The soft noodles to the bed rail was in place and the fall mat was also in place to the bedside for prevention.</p>			

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	<p>Intervention: The physician assessed the resident and the bruising to the left arm. The x-ray revealed degenerative changes and no fracture. Resident's grips remain equal and non-tender. The pain assessment was updated. The bed safety inspection revealed space between the bed rail and the bed. The left bed rail was removed and the bed was removed away from the wall with protective strips applied to the wall for prevention. Additional padding was provided to the right side rail for prevention and spacing between the bed and the rail was checked. Bed and room safety audits were completed on the current residents. Staff was reeducated on positioning, safety awareness, transfers or repositioning and abuse and neglect. The resident's care plan and care giver guide was updated. The staff was also reminded to make sure that the geri sleeves or the resident has long sleeves in place as the resident will allow for prevention. Social service interviewed the residents related to abuse and neglect and no concerns were reported. As a result of the investigation, the facility feels that the bruise is related to the resident putting hand between the rail and the bed, the resident acute disease processes, Aspiring and Plavix therapy, the resident's poor safety awareness and the resident history of bruising easily.</p>			

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	<p>The allegation of abuse is unsubstantiated."</p> <p>During an interview, on 11/13/2015 at 4:58 p.m., LPN #2 said she looked at the bruise and forgot to pass it on; that CNA #1 had "reported it to her around 8:00 p.m. She walks a little bit but not very far, she is declining. Resident #34 refuses to let staff assist her with a lot of things, she refuses care, staff has to go ahead and just do it, cleaning and cutting her nails is one of those areas, refusing meds, doesn't like to eat or drink as much, her daughter brought her in a piece of fish and she threw it on the floor. didn't see a raised area just the bruise the night it was reported".</p> <p>During an interview, on 11/16/2015 at 2:18 p.m., the Administrator indicated they found the bruise on second shift, LPN #3 said the CNA did inform her of the bruise, and she got busy and didn't report it or start the investigation. The second shift CNAs went home and they did the initial interviews at 2:00 a.m., when the third shift found the bruising. They called the physician that morning at 5:00 a.m. At 5:30 a.m., the ADoN (Assistant Director of Nursing) came in and starting getting more staff statements of anyone who worked on 9/25/15. At 8:00 a.m., the POA was notified, at 9:00</p>						

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	<p>a.m., the clinical team met and reviewed the incident. They discussed what they were going to do at that time, and they continued to gather the day shift interviews that worked on September 24, 25, and 26. They did inservices on abuse, neglect and transferring equipment, and that evening around supper they had gotten all the equipment and padded the wall; put all the interventions in place. At 8:00 p.m., the Interim DoN and the ADoN left the building. The Administrator came back in about 9:30 p.m., to inservice part of the 2nd shift. The 2nd shift CNA told her they reported it to her second shift nurse and the 2nd shift nurse was phoned and told the Administrator she got busy and forgot to pass it on or start the paperwork. The Administrator, ADoN, and Interim DoN had worked under the assumption it happened around the time it was found.</p> <p>An email confirmation of the initial reporting was sent 9/25/15 at 1:54 p.m., according to the administrator's e-mail confirmation and the reporting of the bruise was dated 9/29/15 at 4:44 p.m., and indicated it was the "follow up added".</p> <p>A "Resident Incident Interview" was completed on 9/25/15, for Resident #34 and indicated she did not know what</p>			

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	<p>happened, said no one was rough with her or abused her, was not fearful of anyone, said she felt safe here.</p> <p>An "Incident Witness Account" dated 9/25/15 indicated an interview by CNA #7. "...While doing 2 a.m. bedcheck I noticed area on residents left arm when changing her. At 10 p.m. bedcheck resident was found clean &amp; dry. At 12 a.m. bedcheck resident was still found clean &amp; dry. At 2 a.m. bedcheck resident was found incontinent. I uncovered resident and found area on Resident's left arm. I went and got my 3rd shift nurse and reported it. She then asked the 2nd shift nurse if she was aware of it from her shift and that 2nd shift nurse stated that she was told about it on her shift by her 2nd shift CNA and had not went down to check it."</p> <p>2. Social Service Progress notes dated 11/6/15 at 5:05 p.m., indicated: "POC (plan of care) meeting today [with] [2 family members]...Family requests she be moved 11/7/15 to arm (room) [number] d/t [Family Member #1] stating her room mate or staff are constantly "Beating [Resident #34] up". When asked to clarify she stated she believes [Resident #34] has been "intentionally hurt". "[Family Member #2] disagreed &amp; stated he under [no] circumstances believes</p>			

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	<p>anyone has ever intentionally hurt [Resident #34]. [Family Member #1] angry when this [Social worker] stated that if [Family Member #1] truly believed [Resident #34] was being abused then it should be reported to state &amp; this [Social Worker] can make referral for transfer to alternate ECF (Extended Care Facility) or return home [with] services. [Family Member #2] declined offer &amp; again stated he has [no] doubt his mom is safe here &amp; he has [no] intention of her leaving as this is now her home...."</p> <p>During an interview, on 11/16/2015 at 9:14 a.m., the Administrator indicated the Social Services Director had taken notes about the allegation when it was made at 5:00 p.m., on a Friday, at the care plan meeting. The family member had said "I know [Resident #34] is being abused", and the Administrator didn't get notified until the 7th, and it didn't get sent into the state until the 8th. She said she was told about it on Saturday, and the care plan meeting was on Friday.</p> <p>During an interview, on 11/16/2015 at 2:33 p.m., the Administrator indicated they had the care plan meeting on 11/6/15, and the Power of Attorney disputed everything the family member said. At that time, the interdisciplinary team staff didn't think it was a reportable</p>			

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	<p>because the Power of Attorney disputed everything. The allegation of abuse wasn't reported at that time; they reported it to her the next day. She indicated she first reported this incident on 8:45 a.m., on 11/8/15.</p> <p>During an interview, on 11/16/2015 at 2:43 p.m., the Administrator indicated: at the end of the month she sends in all the reports to each agency, the police, ombudsman, all the other agencies, unless it is abuse and they have to suspend a staff or something like that, they would call in that case.</p> <p>A policy and procedure for "Reporting of Alleged Abuse to Facility Management" was provided by the Administrator on 11/13/15 at 4:20 p.m. The policy included, but was not limited to, "Policy Statement: It is the responsibility of our employees, facility consultants, Attending Physicians, family members, visitors, vendors, or others to promptly report any incident or suspected incident of neglect or resident abuse, including injuries of unknown source, and theft or misappropriation of resident property to facility management...g. "Injury of unknown source" is defined as an injury that meets both of the following conditions: (1) The source of the injury was not observed by any person or the</p>			

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	<p>source of the injury could not be explained by the resident; and (2) The injury is suspicious because of : (a) the extent of the injury...4. Employees, facility consultants and/or Attending Physicians must immediately report any suspected abuse or incidents of abuse to the Director of Nursing Services. In the absence of the Director of Nursing Services such reports may be made to the Nurse Supervisor on duty...9. The Administrator or Director of Nursing Services must be immediately notified of suspected abuse or incidents of abuse. If such incidents occur or are discovered after hours, the Administrator and/or Director of Nursing Services must be called at home or must be paged and informed of such incident...Reporting Abuse to State Agencies and Other Entities: Policy Statement: All suspected violations and all substantiated incidents of abuse will be immediately reported to appropriate state agencies and other entities or individuals as may be required by law...1. Should a suspected violation or substantiated incident of neglect, injuries of an unknown source, or abuse...be reported, the facility Administrator, or his/her designee, will promptly notify the following persons or agencies (verbally and written of such incident: a. The State licensing/certification agency responsible</p>			

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F 0226 SS=D Bldg. 00	<p>for surveying/licensing the facility. b. The local/State Ombudsman...2. Verbal/written notices to agencies will be made within twenty-four (24) hours of the occurrence of such incident...4. The Administrator or his/her designee, will provide the appropriate agencies or individuals listed above with a written report of the findings of the investigation within five (5) working days of the occurrence of the incident..."</p> <p>3.1-28(c) 3.1-28(d) 3.1-28(e)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review, the facility failed to follow their policy and procedure related to immediately reporting to the Administrator or Director of Nursing Services an injury of unknown origin and an allegation of abuse from a family member, and failed to follow their policy to start a timely investigation of both of these incidents.</p>	F 0226	<p><b>F 226</b></p> <p>1. The identified 2nd shift nurse and CNA was reeducated on 11/19/15 by the Director of Nursing related to the requirements of following the Abuse/ Neglect policy including immediately reporting to the Administrator and the Director of Nursing suspected abuse or injuries of unknown origin.</p>	12/09/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155387	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  11/16/2015
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NAME OF PROVIDER OR SUPPLIER  CAROLETON MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 2500 IOWA AVE CONNERSVILLE, IN 47331
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	<p>This affected 1 of 3 residents who fit the criteria for abuse and injuries of unknown origin. (Resident #34)</p> <p>Findings include:</p> <p>During an observation, on 11/10/15 at 10:19 a.m., Resident #34 was observed with a darkened area on her left wrist, that was black/blue in color and measured approximately 5 centimeters (cm) by 5 cm.</p> <p>Resident #34's record was reviewed on 11/13/2015 at 9:18 a.m. Physician's orders, dated October 2015, indicated Resident #34 had diagnosis that included, but were not limited to, dementia without behavioral disturbance, low blood potassium levels, high blood pressure, chronic ischemic heart disease, angina pectoris, osteoarthritis, high blood fats, constipation, depression, urinary incontinence, Vitamin D deficiency, iron deficiency anemia secondary to blood loss, gastro esophageal reflux disease, chronic kidney disease, and feeding difficulties.</p> <p>Nurses notes, dated 9/25/15 at 2:00 a.m., indicated: "Res (resident) has 32X9 cm red &amp; purple /black bruise from elbow to knuckles on (L) arm swelling noted on top of wrist area. Res is moving &amp;</p>		<p>2. Social Services will complete an audit by 12/6/15 of current residents to ensure the abuse/neglect policy related to immediately reporting and timely investigation is followed as required.</p> <p>3. Staff was reeducated on 11/19/15 by the Director of Nursing and the Staff Development Coordinator related to the requirements of following the Abuse/ Neglect policy including immediately reporting to the Administrator and the Director of Nursing suspected abuse or injuries of unknown origin.</p> <p>4. The Director of Nursing will audit the current residents' medical records weekly for 4 weeks and monthly for 2 months to ensure the abuse/neglect policy continues to be followed as required including immediate reporting and timely investigation of Abuse/Neglect. The Administrator will submit a report to the Quality Assurance Committee monthly for 3 months. The Administrator will be responsible for monitoring and follow up.</p> <p>Completion date: 12/9/15</p>	

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	<p>bending wrist. [No]voiced c/o pain [no] s/s (signs or symptoms) of pain...."</p> <p>An "Initial Report of Incident", dated 9/25/15, indicated:...Brief description of incident: Nurse observed red and purple bruise to left arm 32 cm x 9 cm: Type of injury/injuries: Bruise. Immediate action taken: Nurse assessed. Family and MD notified. Local Police Department notified. Investigation: Initiated."</p> <p>An "Initial with follow-up" report, dated 9/29/15, indicated: "...Brief description of incident: Nurse observed red and purple bruise to left arm 32 cm X 9 cm: Type of Injury/Injuries: Bruise Immediate Action Taken: Nurse assessed. Family and MD notified. Local Police Department notified. Investigation: Initiated. Follow up: The investigation and staff interviews revealed that the resident has poor safety awareness. Staff interviews reveal that while providing ADL care the staff reported observing bruising to the hand and wrist area. The resident was positioned on the left side and the resident prefers to lay on her left side. The bruising was assessed by the licensed nurse and follow up with the physician. X ray was ordered and the resident has not complained of pain or have had difficulty with range of motion. The</p>			

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	<p>resident has a history of bruising easily and currently being treated by a Hematology and Oncology specialist. The medical record reveal that the resident is on Aspirin therapy, Plavix and Priority. The medical record also reveal that the resident had positive fecal occult blood on 09/18/15 and family declined Nephrology and GI consultant follow up and the physician is aware. The resident's bed and room was reevaluated for safety. The soft noodles to the bed rail was in place and the fall mat was also in place to the bedside for prevention. Intervention: The physician assessed the resident and the bruising to the left arm. The x-ray revealed degenerative changes and no fracture. Resident's grips remain equal and non-tender. The pain assessment was updated. The bed safety inspection revealed space between the bed rail and the bed. The left bed rail was removed and the bed was removed away from the wall with protective strips applied to the wall for prevention. Additional padding was provided to the right side rail for prevention and spacing between the bed and the rail was checked. Bed and room safety audits were completed on the current residents. Staff was reeducated on positioning, safety awareness, transfers or repositioning and abuse and neglect. The resident's care plan and care giver guide</p>			

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	<p>was updated. The staff was also reminded to make sure that the geri sleeves or the resident has long sleeves in place as the resident will allow for prevention. Social service interviewed the residents related to abuse and neglect and no concerns were reported. As a result of the investigation, the facility feels that the bruise is related to the resident putting hand between the rail and the bed, the resident acute disease processes, Aspiring and Plavix therapy, the resident's poor safety awareness and the resident history of bruising easily. The allegation of abuse is unsubstantiated."</p> <p>During an interview, on 11/13/2015 at 4:58 p.m., LPN #2 said she looked at the bruise and forgot to pass it on; that CNA #1 had reported it to her around 8:00 p.m. "She walks a little bit but not very far, she is declining. Resident #34 refuses to let staff assist her with a lot of things, she refuses care, staff has to go ahead and just do it, cleaning and cutting her nails is one of those areas, refusing meds, doesn't like to eat or drink as much, her daughter brought her in a piece of fish and she threw it on the floor. didn't see a raised area just the bruise the night it was reported."</p> <p>During an interview, on 11/16/2015 at</p>			

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	<p>2:18 p.m., the Administrator indicated they found the bruise on second shift, LPN #3 said the CNA did inform her of the bruise, and she got busy and didn't report it or start the investigation. The second shift CNAs went home and they did the initial interviews at 2:00 a.m., when the third shift found the bruising. They called the physician that morning at 5:00 a.m. At 5:30 a.m., the ADoN (Assistant Director of Nursing) came in and starting getting more staff statements of anyone who worked on 9/25/15. At 8:00 a.m., the POA was notified, at 9:00 a.m., the clinical team met and reviewed the incident. They discussed what they were going to do at that time, and they continued to gather the day shift interviews that worked on September 24, 25, and 26. They did inservices on abuse, neglect and transferring equipment, and that evening around supper they had gotten all the equipment and padded the wall; put all the interventions in place. At 8:00 p.m., the Interim DoN and the ADoN left the building. The Administrator came back in about 9:30 p.m., to inservice part of the 2nd shift. The 2nd shift CNA told her they reported it to her second shift nurse and the 2nd shift nurse was phoned and told the Administrator she got busy and forgot to pass it on or start the paperwork. The Administrator, ADoN, and Interim DoN</p>			

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	<p>had worked under the assumption it happened around the time it was found.</p> <p>An email confirmation of the initial reporting was sent 9/25/15 at 1:54 p.m., according to the administrator's e-mail confirmation and the reporting of the bruise was dated 9/29/15 at 4:44 p.m., and indicated it was the "follow up added".</p> <p>A "Resident Incident Interview" was completed on 9/25/15, for Resident #34 and indicated she did not know what happened, said no one was rough with her or abused her, was not fearful of anyone, said she felt safe here.</p> <p>An "Incident Witness Account" dated 9/25/15 indicated an interview by CNA #7"...While doing 2 a.m. bedcheck I noticed area on residents left arm when changing her. At 10 p.m. bedcheck resident was found clean &amp; dry. At 12 a.m. bedcheck resident was still found clean &amp; dry. At 2 a.m. bedcheck resident was found incontinent. I uncovered resident and found area on Resident's left arm. I went and got my 3rd shift nurse and reported it. She then asked the 2nd shift nurse if she was aware of it from her shift and that 2nd shift nurse stated that she was told about it on her shift by her 2nd shift CNA and had not went down to</p>			

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	<p>check it."</p> <p>2. Social Service Progress notes dated 11/6/15 at 5:05 p.m., indicated: "POC (plan of care) meeting today [with] [2 family members]...Family requests she be moved 11/7/15 to arm (room) [number] d/t [Family Member #1] stating her room mate or staff are constantly "Beating [Resident #34] up". When asked to clarify she stated she believes [Resident #34] has been "intentionally hurt". "[Family Member #2] disagreed &amp; stated he under [no] circumstances believes anyone has ever intentionally hurt [Resident #34]. [Family Member #1] angry when this [Social worker] stated that if [Family Member #1] truly believed [Resident #34] was being abused then it should be reported to state &amp; this [Social Worker] can make referral for transfer to alternate ECF (Extended Care Facility) or return home [with] services. [Family Member #2] declined offer &amp; again stated he has [no] doubt his mom is safe here &amp; he has [no] intention of her leaving as this is now her home...."</p> <p>During an interview, on 11/16/2015 at 9:14 a.m., the Administrator indicated the Social Services Director had taken notes about the allegation when it was made at 5:00 p.m. on a Friday, at the care plan meeting. The family member had said "I</p>			

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	<p>know [Resident #34] is being abused", and the Administrator didn't get notified until the 7th, and it didn't get sent into the state until the 8th. She said she was told about it on Saturday, and the care plan meeting was on Friday.</p> <p>During an interview, on 11/16/2015 at 2:33 p.m., the Administrator indicated they had the care plan meeting on 11/6/15, and the Power of Attorney disputed everything the family member said. At that time, the interdisciplinary team staff didn't think it was a reportable because the Power of Attorney disputed everything. The allegation of abuse wasn't reported at that time; they reported it to her the next day. She indicated she first reported this incident on 8:45 a.m., on 11/8/15.</p> <p>During an interview, on 11/16/2015 at 2:43 p.m., the Administrator indicated: at the end of the month she sends in all the reports to each agency, the police, ombudsman, all the other agencies, unless it is abuse and they have to suspend a staff or something like that, they would call in that case.</p> <p>A policy and procedure for "Reporting of Alleged Abuse to Facility Management" was provided by the Administrator on 11/13/15 at 4:20 p.m. The policy</p>						

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	included, but was not limited to, "Policy Statement: It is the responsibility of our employees, facility consultants, Attending Physicians, family members, visitors, vendors, or others to promptly report any incident or suspected incident of neglect or resident abuse, including injuries of unknown source, and theft or misappropriation of resident property to facility management...g. "Injury of unknown source" is defined as an injury that meets both of the following conditions: (1) The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and (2) The injury is suspicious because of : (a) the extent of the injury...4. Employees, facility consultants and/or Attending Physicians must immediately report any suspected abuse or incidents of abuse to the Director of Nursing Services. In the absence of the Director of Nursing Services such reports may be made to the Nurse Supervisor on duty...9. The Administrator or Director of Nursing Services must be immediately notified of suspected abuse or incidents of abuse. If such incidents occur or are discovered after hours, the Administrator and/or Director of Nursing Services must be called at home or must be paged and informed of such incident...Reporting Abuse to State Agencies and Other			

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F 0252 SS=D Bldg. 00	<p>Entities: Policy Statement: All suspected violations and all substantiated incidents of abuse will be immediately reported to appropriate state agencies and other entities or individuals as may be required by law...1. Should a suspected violation or substantiated incident of neglect, injuries of an unknown source, or abuse...be reported, the facility Administrator, or his/her designee, will promptly notify the following persons or agencies (verbally and written of such incident: a. The State licensing/certification agency responsible for surveying/licensing the facility. b. The local/State Ombudsman...2. Verbal/written notices to agencies will be made within twenty-four (24) hours of the occurrence of such incident...4. The Administrator or his/her designee, will provide the appropriate agencies or individuals listed above with a written report of the findings of the investigation within five (5) working days of the occurrence of the incident..."</p> <p>3.1-28(c) 3.1-28(d) 3.1-28(e)</p> <p>483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean,</p>				

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	<p>comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. Based on observation and interview the facility failed to provide a resident with a safe, clean, comfortable and homelike environment for 1 of 30 residents observed for homelike environment. (Resident #29)</p> <p>Findings include:</p> <p>On 11/09/15 3:02 p.m., an interview with Resident #29 indicated he thinks staff should do spot checks in the bathrooms to check the toilets and the trash that has overflowed onto the floor at times.</p> <p>Observation of Resident #29's bathroom on 11/12/15 at 10:15 a.m., indicated bathroom was clean, no trash in trash can, the toilet and extender seat were clean.</p> <p>On 11/13/15 at 12:05 p.m., observation of Resident #29's bathroom indicated extender seat had smeared feces on the inside of the seat and no overflowing trash.</p> <p>Observation on 11/16/15 at 9:45 a.m., of Resident # 29's bathroom indicated extender seat had smeared feces on inside rim and on inside of the toilet, no trash</p>	F 0252	<p><b>F 252</b></p> <p>1. Resident #29's bathroom toilet and extender seat was cleaned on 11/17/15 by housekeeping staff.</p> <p>2. The Environmental Service Manager completed an audit on 11/17/15 of the current residents' bathrooms and extender seats to ensure that they care clean and order free.</p> <p>3.. Nursing and housekeeping staff was reeducated on 11/17/15 by the Staff Development Coordinator to ensure resident bathrooms and extender seats are clean and odor free.</p> <p>4. The Environmental Service Manager will audit residents' bathrooms and extender seats weekly for 4 weeks and monthly for 2 months to ensure bathrooms and extender seats continue to be clean as required. The Environmental Service Manager will submit a report to the Quality Assurance Committee monthly for 3 months. The Administrator will be responsible for monitoring and follow up.</p> <p>Completion Date: 12/9/15</p>	12/09/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155387	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/16/2015
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	<p>overflowing or on the floor.</p> <p>On 11/16/15 at 1:38 p.m., indicated observation of Resident #29's bathroom, the toilet and extender seat had a moderate amount of smeared feces on the inside rim of the toilet and extender seat, trash can was empty.</p> <p>Interview with Resident #29 on 11/16/15 at 1:41 p.m., indicated he can use the toilet without assistance and removes toilet extender before he uses toilet. Resident #29 indicated he gets rubber gloves or paper towels to remove the toilet extender because it is always dirty with bowel movement on it.</p> <p>On 11/16/15 1:47 p.m., interview with Housekeeping Supervisor indicated "I just sent someone to clean Resident #29's bathroom about 20 minutes ago." The Housekeeping Supervisor indicated the CNA's are suppose to tell us or clean it but this is not being done, the other three residents that uses this toilet needs assistance from the CNA's for toileting.</p> <p>Observation with the Housekeeping Supervisor on 11/16/15 at 1:50 p.m., of Resident #29's bathroom indicated moderate amount of feces around the inside rim of the toilet and extender seat.</p>			

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F 0311 SS=D Bldg. 00	<p>3.1-19(f)(5)</p> <p>483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.</p> <p>Based on observation, interview, and record review, the facility failed to provide a resident with active range of motion (AROM) and ambulation daily, according to her Restorative Program for 1 of 3 residents reviewed for Activities of Daily Living (ADL) of 14 who met the criteria for ADL. (Resident #3)</p> <p>Findings include:</p> <p>Resident #3's record was reviewed on 11/12/15 at 10:19 a.m. Her diagnoses documented on her November 2016 physician's recapitulation orders indicated but were not limited to, mild cognitive impairment and an artificial hip.</p> <p>Resident #3's annual Minimum Data Set (MDS) assessment dated 10/7/15, indicated she was understood and usually understood others. She was severely impaired in her cognitive daily decision making skills. She required extensive assistance of 2 plus persons for bed mobility. She required extensive</p>	F 0311	<p><b>F 311</b></p> <p>1. Resident #3 was screened by therapy on 12/4/15 and no decline in ambulation or range of motion was observed.</p> <p>Nursing staff was reeducated by the restorative Nurse Coordinator on 12/2/15 to ensure that Resident #3 is receiving active range of motion and ambulation daily as ordered.</p> <p>2. The Restorative Nursing Coordinator audited the current residents' restorative programs on 12/2/15 to ensure restorative services are being provided as ordered.</p> <p>3. The Nursing Staff will be reeducated by the Restorative Nursing Coordinator by 12/8/15 related to the requirements of providing Restorative Programs as ordered.</p> <p>4. The Restorative Nursing Coordinator will audit 10 current residents' restorative programs weekly for 4 weeks and monthly</p>	12/09/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155387	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/16/2015
NAME OF PROVIDER OR SUPPLIER  CAROLETON MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 IOWA AVE CONNERSVILLE, IN 47331		
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	<p>assistance of 1 person for transfer, and to walk in her room and corridor. She had no impairment in her range of motion. Her mobility devices included a wheelchair and walker.</p> <p>A Physical Therapist Progress and Discharge Summary for Resident #3 dated 10/16/15, indicated therapy recommended a Restorative Nursing Program for ambulation to decrease her risk of decline in functional status.</p> <p>A physician's order for Resident #3 dated 10/21/15, indicated her Restorative Program would include AROM to her bilateral lower extremities with 2 pound ankle weights for 20 repetitions daily and ambulation with a walker for 50 to 90 feet daily with extensive assistance of 1 person.</p> <p>A Plan of Care for Resident #3 initiated 10/21/15, indicated she required bilateral range of motion due to her potential for decline related to limited mobility and weakness. She required walking due to her potential for falls related to her limited ambulation ability.</p> <p>Resident #3's Restorative Nursing Care Flow Record for October 2015 indicated she was not provided AROM on 10/22/15, 10/23/15, 10/26/15, 10/27/15,</p>		<p>for 2 months to ensure restorative programs continue to be provided as ordered. The Director of Nursing will submit a report to the Quality Assurance Committee monthly for 3 months. The Director of Nursing will be responsible for monitoring and follow up.</p> <p>Completion Date: 12/9/15</p>		

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	<p>10/28/15, 10/29/15, and 10/31/15. The narrative notes indicated Restorative Staff were pulled to work the floor on 10/22/15 and 10/26/15. No explanation was documented for the other dates AROM was not provided. She was not provided ambulation on 10/22/15 and 10/23/15. No explanation was documented why ambulation was not provided.</p> <p>Resident #3's Restorative Nursing Care Flow Record for November 2015 indicated she was not provided AROM on 11/2/15, 11/3/15, 11/4/15, 11/6/15, 11/9/15, 11/11/15, and 11/12/15. The narrative notes indicated Restorative staff were pulled to work the floor on 11/12/15. No explanation was documented for the other dates AROM was not provided. She was not provided ambulation on 11/1/15 and 11/9/15. No explanation was documented why ambulation was not provided.</p> <p>On 11/16/15 at 9:54 a.m., Resident #3 was observed to be alert and was seated upright in her wheelchair in the hallway.</p> <p>An interview with Restorative Aide #4 on 11/16/15 at 10:13 a.m., indicated Resident #3 was on a AROM and ambulation Restorative Program. Resident #3 had walked with the</p>			

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	<p>assistance of a rolling walker and Restorative Aide #4 earlier that morning. Resident #3 was cooperative and participated in her AROM and ambulation Restorative Programs. Restorative Aide #4 was unsure why some of the documentation was left blank on the October and November 2015 Restorative Nursing Care Flow Records. Restorative Aide #4 indicated at times the Restorative Staff were pulled from Restorative to work as a CNA on the floor and could not complete resident's Restorative Programs.</p> <p>An interview with the MDS Coordinator on 11/16/15 at 10:58 a.m., indicated she was responsible for the residents Restorative Programs. She indicated there was only 1 Restorative Aide available daily and sometimes that Restorative Aide was pulled from Restorative to work the floor as a CNA. Resident's Restorative Programs did not get completed at times when the Restorative Aide had to work as a CNA.</p> <p>An interview with the Administrator on 11/16/15 at 2:45 p.m., indicated an issue was identified in a meeting in October 2015 that residents were not always receiving their Restorative Programs. She indicated the Restorative Staff had reported they were not always able to</p>			

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	<p>provide residents with their Restorative Programs because they had to work as a CNA, and residents had reported it as well. It would be included in the criteria for their November 2015 Quality Assurance meeting.</p> <p>The Restorative Nursing Program provided by the Administrator on 11/16/15 at 3:29 p.m., indicated the following: "... Range of Motion Program: To maintain or improve joint mobility to assist resident/patient in maintaining or achieving their most independent function. To promote management and prevention of contractures. Resident/patient requires restorative nursing care to: Prevent or reduce contractures and deformity. Preserve range of motion of residual limb to allow for use of prosthesis. Increase and/or maintain individually determined Range of Motion (ROM). Prevent further joint mobility limitation. Stimulate circulation and enhance muscle strengthening. Ambulatory Programs ("Positioning", "Bed Mobility", and "Mobility" Programs): To promote increased independence. To promote circulation, stimulation, and muscle strengthening. To reduce the potential for falls. To increase self-esteem...."</p> <p>3.1-38(a)(2)(B)</p>			

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F 0312 SS=D Bldg. 00	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on record review, observation, and interview, the facility failed to ensure a resident, who was totally dependent on staff for personal hygiene, received necessary services to maintain good grooming in that her fingernails were soiled for 3 of 5 survey days. This affected 1 of 2 residents who fit the criteria for grooming. (Resident #34)</p> <p>Findings include:</p> <p>During an observation, on 11/10/2015 at 10:07 a.m., both of Resident #34's hands had a blackish substance under the fingernails.</p> <p>On 11/12/2015, at 10:01 a.m., Resident #34 was observed with CNA # 6. Resident #34's fingernails were long and had a dark substance under the nails.</p> <p>On 11/13/15, at 9:10 a.m., Resident #34 was observed sitting in her room. Her fingernails had a small amount of a dark</p>	F 0312	<p><b>F 312</b></p> <ol style="list-style-type: none"> <li>1. Resident #34 fingernails were cut and cleaned by Certified Nursing Assistant on 11/17/15.</li> <li>2. The Administrator on 11/17/15 completed an audit of the current residents' fingernail to ensure nail care is provided as required.</li> <li>3. The nursing staff was reeducated by the Staff Development Coordinator on 11/19/15 and 12/4/15 related to ensuring nail care is provided as required.</li> <li>4. The Director of Nursing will audit 5 current residents weekly for 4 weeks and monthly for 2 months to ensure that nail care continues to be provided as required. The Director of Nursing will submit a report to the Quality Assurance Committee monthly for 3 months. The Director of Nursing will be responsible for monitoring and follow up.</li> </ol>	12/09/2015

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	<p>substance under her nails.</p> <p>On 11/13/2015, at 4:25 p.m., Resident #34 was observed sitting in her room in a chair with both hands above her lap robe and her fingernails were unevenly trimmed with a dark substance under her fingernails.</p> <p>On 11/16/2015 at 11:47 a.m., Resident #34 was sitting in her wheelchair in the dining room feeding herself lunch. Her fingernails had a dark brown substance under the nails.</p> <p>Resident #34's record was reviewed on 11/13/2015 at 9:18 a.m. Physician's orders for October, 2013, indicated diagnoses that included, but were not limited to; dementia without behavioral disturbance, low blood potassium, high blood pressure, chronic ischemic heart disease, angina pectoris, osteoarthritis, high blood fats, constipation, depression, urinary incontinence, and feeding difficulties.</p> <p>A quarterly Minimum Data Set assessment (MDS), dated 9/25/15, indicated Resident #34 was severely cognitively impaired, did not reject care, required extensive assist of one for bed mobility, transfers, dressing, personal hygiene, and toileting, totally dependent</p>		Completion Date: 12/9/15				

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	<p>on one for bathing, assist of one for ambulation, was frequently incontinent of bladder and always continent of bowel.</p> <p>A care plan, with a problem onset dated 2/24/10, indicated: "Inability to perform ADL's (activities of daily living) independently R/T (related to) functional &amp; cognitive loss. Goal &amp; Target date: Resident will continue to participate with ADL's over the next 92 days. 12-28-15. Approaches: Provide all materials needed to complete ADLs (i.e. water,soap, clothing, hygiene products. Encourage completion of ADLs as much as possible. Maintain clean, well trimmed nails. Change and launder clothing daily. Maintain oral care bid (twice a day) - no natural teeth. Bath or shower twice weekly with shampoo...."</p> <p>During an interview, on 11/13/2015 at 4:40 p.m., CNA # 3 indicated Resident #34's baths are given on Wednesdays and Saturdays and she gets a complete bed bath every evening. She said it is the nurse's job to trim her fingernails and the CNAs let the nurse know when her nails need to be trimmed.</p> <p>During an interview, on 11/13/2015 at 4:58 p.m., LPN #2 indicated Resident #34 refuses to let staff assist her with a lot of things, she refuses care, staff has to</p>			

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	<p>go ahead and just do it, and cleaning and cutting her nails is one of those areas.</p> <p>A policy and procedure was request for personal hygiene related to fingernails and the following was provided by the Administrator on 11:16 a.m. at 12:48 p.m.: "Goals and Objectives: It is the policy of this facility to develop and maintain goals and objectives for the Nursing Service Department. Our department's goals and objectives are to:</p> <ol style="list-style-type: none"> <li>1. Provide each resident with nursing care.</li> <li>2. Develop and implement a course of action to take in providing nursing care.</li> <li>3. Ensure that each resident;s care is provided in a respectful and dignified manner.</li> <li>4. Provide a ready reference to established nursing policies and procedures to ensure that our goal of providing care is maintained...." <p>3.1-38(a)(3)(E)</p> </li></ol>			