

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155295	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/14/2014
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NAME OF PROVIDER OR SUPPLIER CLINTON HOUSE HEALTH AND REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 809 W FREEMAN ST FRANKFORT, IN 46041
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit resulted in an extended survey - immediate jeopardy.</p> <p>Survey dates: March 5, 6, 7, 10, 11, 12, 13, and 14, 2014.</p> <p>Facility number: 000192 Provider number: 155295 AIM number: 100291120</p> <p>Survey team: Bobette Messman, RN-TC (March 5, 6, 7, 10, 11, 13, and 14, 2014) Rita Mullen, RN (March 5, 6, 7, 10, 11, 13, and 14, 2014) Holly Duckworth, RN (March 5, 6, 7, 10, 11, 13, and 14, 2014) Maria Pantaleo, RN</p> <p>Census bed type: SNF/NF: 76 Total: 76</p> <p>Census payor type: Medicare: 9 Medicaid: 48 Other: 19 Total: 76</p> <p>These deficiencies reflect State</p>	F000000	<p>This plan of correction is the facility's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. THE FACILITY DISPUTES THE VALIDITY OF THE FINDING OUTLINED IN F223, 225, 226 and 520. WE HAVE ISSUED A REQUEST FOR AN INFORMAL DESPUTE RESOLUTION HEARING.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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	findings cited in accordance with 410 IAC 16.2. Quality Review was completed by Tammy Alley RN on March 24, 2014.			
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F000157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview the facility failed to notify the physician of an initial weight loss of 37.5 pounds for 1 of 3 resident's reviewed for weight loss (Resident</p>	F000157	<p>F157 NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC.)</p> <ul style="list-style-type: none"> · Resident #47 no longer resides at this facility. · Any resident who is to be weighed on a daily, weekly, or 	04/07/2014			

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	<p>#47).</p> <p>Findings include:</p> <p>The clinical record of Resident #47 was reviewed on 3/10/14 at 9:00 a.m. Resident was admitted to the facility on 9/25/13, for Rehabilitation post stroke. Diagnoses included, but were not limited to, diabetes, high blood pressure, obesity, schizoaffective disorder, chronic obstructive pulmonary disease, stroke and diarrhea due to clostridium difficle.</p> <p>A Care Plan for Altered nutrition and hydration, dated 10/2/13, indicated "Notify MD [medical doctor] of significant weight change."</p> <p>The weight entered in the facility electronic record, dated 9/25/13, indicated Resident #47's weight was 273.5 pounds.</p> <p>A weekly weight entered in the electronic record, on 10/1/13 at 7:00 a.m., indicated her weight was 236 pounds. This was a 37.5 pound weight loss.</p> <p>A Dietary Screening and Assessment, dated 10/2/13, indicated the Resident's weight was 273.5 pounds on 9/25/13. The weight of</p>		<p>monthly basis has the potential to be effected by this alleged deficient practice. Those residents currently on a daily or weekly weight records have been reviewed and if any discrepancies were found the physician has been notified.</p> <ul style="list-style-type: none"> · Accunurse (computer system) will be observed daily Monday through Friday by the Director of Nursing or designee to ensure the weights have been entered into the computer and proper protocol has been followed if abnormal weights have been flagged. · Daily and weekly weights will be audited by the Director of Nursing or designee 3 times a week for 4 weeks, then 2 times a week for 4 weeks, then once a week for 4 weeks, and once a month thereafter. Non compliance will be addressed through re-education and progressive disciplinary actions as indicated. Results of audits will be reviewed monthly in QA&A for 6 months and quarterly with subsequent plan development and implementation as appropriate. 		

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	<p>236.4 pounds, on 10/1/13, was not acknowledged and the initial loss of 37.5 pounds was not addressed.</p> <p>During an interview with the Director of Nursing on 3/11/14 at 11:00 a.m., she indicated the physician was not notified of the initial 37.5 pound weight loss.</p> <p>During an interview with Director of Nursing on 3/13/14 at 10:30 a.m., she indicated the admission weight in the computer on 9/25/13 of 273.5 pounds was wrong, the resident's weight was 250 pounds on admission. The system did trigger an alert for weight loss on 10/1/13, when the resident's weight was found to be 236.4 pounds, a 13.5 pound weight loss and not a 37.5 pound weight loss.</p> <p>3.1-5(a)(2)</p>				

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F000159 SS=B	<p>483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS</p> <p>Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that</p>			
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	<p>receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>Based on record review and interview, the facility failed to ensure residents with personal funds accounts were able to access their account on weekends for 4 of 4 residents reviewed for access to personal funds accounts. (Residents #9, 28, 30, and 93)</p> <p>Findings include:</p> <p>On 3/6/14, at 10:59 a.m., during an interview, Resident #9 indicated during the weekends staff were not here in the office and you cannot get your money.</p> <p>On 3/6/14, at 9:43 a.m., during an interview, Resident #28 indicated, "There isn't staff here on the weekends to get money. If you want money for the weekend, you have to get it Friday before the office staff leaves."</p> <p>On 3/6/14, at 9:21 a.m., during an interview, Resident #30 indicated</p>	F000159	<p>F159 FACILITY MANAGEMENT OF PERSONAL FUNDS</p> <ul style="list-style-type: none"> · Resident # 9, #28, #30 and #93 were interviewed by the facility administrator regarding their input to a process that would benefit them and also comply by to the regulation of having access to their funds on seven days a week. · Any resident who has funds in the resident trust account has the potential to be effected by this alleged practice. All residents have been informed of their ability to receive funds on each day of the week. · Facility has a new policy that provides residents access to their funds seven days a week. The times for availability are posted publically in the facility and residents are notified at the time of admission. Each resident was re-educated on the procedure. · Availability of funds each day of the week will be audited by the Executive Director weekly times four weeks, twice monthly times 2 months and monthly times 3 months. Non-compliance will be addressed through re-education and 	04/07/2014
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	<p>there is no staff to get your money on the weekends.</p> <p>On 3/6/14, at 10:41 a.m., during an interview, Resident #93 indicated there is no one here on the weekends to get your money when you need it.</p> <p>On 3/7/14 at 3:30 p.m., during an interview with the Administrator and Payroll and Accounts Payables Manager, they indicated that they do not have staff available for residents to access their personal fund accounts on the weekend. The Administrator indicated he was aware residents had requested access to their accounts on weekends.</p> <p>3.1-6(f)(1)</p>		<p>progressive disciplinary actions as indicated. Results of all audits will be reviewed monthly in QA&A for 6 months and quarterly with subsequent plan development and implementation as appropriate.</p>	

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F000223 SS=K	<p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on record review, interview and observation the facility failed to ensure the safety of residents from a known verbally and physically aggressive resident (Resident #8). Resident # 8 had a history of being verbally and physically aggressive towards residents and staff. Residents # 72, # 91, # 93, #30, # 21, and # 33 indicated they were fearful of resident #8 or had witnessed aggressive behavior from Resident # 8. They indicated they felt concerns to administration were not addressed. This deficit practice had the potential to affect 58 of 76 residents residing in the facility.</p> <p>An Immediate Jeopardy was identified on 3/11/14 at 5 p.m. The Immediate Jeopardy began on 3/11/14 with the indication during Resident #72, #91, #93, #30, #21, and #33 interviews that they were fearful of or had witnessed Resident #8's aggressive behavior. The</p>	F000223	<p>THE FACILITY DISPUTES THE VALIDITY OF THE FINDING OUTLINED IN F223. WE HAVE ISSUED A REQUEST FOR AN INFORMAL DESPUTE RESOLUTION HEARING.F223 FREE FROM ABUSE/INVOLUNTARY SECLUSION · Residents #93, 72, 21, 91, 30, and 33 have been interviewed and each indicated they felt safe in this facility. Social service has followed up and offered psychological counseling. · Resident # 8 no longer resides in this facility. · Resident # 30 has had an assessment and x-rays to show there are no injuries from wheel chair "bumping" her hands. · 58 of 76 residents have the potential to be effected by this alleged deficient practice. · Each resident and or family member has been educated on their rights to be free of any type of abuse, given the definition of abuse, and types of abuse. They have also been educated on how and where to report abuse. Each resident or family member was left with a</p>	04/07/2014	

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	<p>Administrator was notified of the Immediate Jeopardy on 3/11/14 at 5 p.m.</p> <p>Findings include:</p> <p>During an interview on 3/6/2014 at 9:04 a.m., Resident #30 indicated Resident #8 often yelled at the staff members. Resident #30 also indicated Resident #8 ran his wheelchair into her hands. She was unable to recall the date of the incident and indicated she believed the act to be intentional. The resident indicated that her hands swelled and she was required to have x-rays. She indicated no injuries were noted at the time of the x-rays, but her hands hurt.</p> <p>On 3/6/2014 at 2:20 p.m., during an interview with Resident #91, he indicated he had issues with Resident #8. He indicated during dinner in the main dining room, he approached the table where Resident #8 was seated. Resident #8 asked him who he was and who told him he could eat at his table. Resident # 91 indicated Resident #8 then told him to go away, and he was cussing and swearing at him.</p> <p>During an interview with Resident</p>		<p>copy of the abuse and reporting system and voiced understanding. · Staff have been re-educated on the Behavior Monitoring System and Reporting abuse · Resident # 8 no longer resides in the facility. · Residents and or family member will be interviewed using the QIS interviewing form with any concerns being brought to the Administrator immediately, 5 residents a week for 4 weeks, then 5 residents a week every other week for 1 month, then 5 residents every month for 4 months. · Five random employees will be questioned on the contents of the abuse policy 5 times a week for one month, then 5 random employees every other week for one month, then 5 employees every month for 4 months. · Special Resident Council meeting was held March 13, 2014 with education provided about abuse and steps to report it. · All employees were re-educated on the Covenant Care Abuse and Prevention, Interventions, Investigation and Crime Reporting Policy. · Executive Director and Director of Nursing were re-educated on the Covenant Care Abuse and Prevention, Interventions, Investigation and Crime Reporting Policy. · Executive Director has sent a letter to all families and/ or responsible parties to review facility process reporting grievances and</p>				

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	<p>#21, on 3/11/14 at 2:00 p.m., she indicated "Resident #8 does things and gets away with it. He cusses, pinches the aide's butts, is rude and threatens other residents. He runs into other resident with his wheelchair. His behaviors have not improved. Staff are afraid to report him he'll get them in trouble if they do.</p> <p>During an interview with LPN #1, on 3/11/14 at 3:25 p.m., she indicated Resident #8 will get them into trouble and he pats them on the butt and makes sexual remarks. She also indicated residents are afraid of him too.</p> <p>During an interview with Resident #93 on 3/11/14 at 3:29 p.m., the resident indicated Resident #8 often threatened other residents with physical harm. Resident #93 indicated she was standing near the entrance to the building on 3/11/14, and that Resident #8 approached her. She indicated Resident #8 had startled her and she told him she was startled. Resident #93 indicated Resident #8 then "... yelled a bad comment to [her] and left." Resident #93 indicated Resident #8 cursed at her in the past. Resident #93 indicated that she would not want to</p>		<p>allegations of abuse. · Non compliance will be addressed through re-education and progressive disciplinary actions as indicated. Results of audits will be reviewed monthly in QA&A for 6 months and quarterly with subsequent plan development and implementation as appropriate.</p> <p>F 223 (K): 42 C.F.R. §483.13(c) (1)(i) Free from Abuse / Involuntary Seclusion</p> <p><i>The Resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</i></p> <p>The statement of deficiency alleges the facility failed to ensure the safety of Residents from a known verbally and physically aggressive Resident [Resident 8]. F-223 non-compliance and imposed "Immediate Jeopardy" determination is supported by interviews with Resident's #72, #91, #93, #30, #21, and #33, who allegedly stated they were fearful of Resident #8, or had witnessed aggressive behavior from Resident #8".</p> <p><u>Facility Response to Interview Findings</u></p>				

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	<p>be alone with Resident #8, " ... because he has that big wheelchair and he has things he can pick up off of the floor. If he wanted to, he could hurt me." Resident #93 indicated she had not reported the behaviors of Resident #8 because she didn't " ...want any trouble. If he [Resident #8] found out, he would be really mad." Resident #93 also indicated she witnessed Resident #8 touch nursing staff inappropriately.</p> <p>During an interview with Certified Nursing Assistant # 1 (CNA), on 3/11/14 at 3:45 p.m., she indicated Resident #8 was verbally aggressive and threw things at staff members at times. She indicated Resident #8 threw a urinal across his room on 3/11/14 at approximately 3:15 p.m. The CNA indicated Resident #8 was sometimes verbally abusive towards staff and sometimes made physical threats towards other residents. The CNA also indicated Resident #8 repeatedly tried tickling her on the ribs. The CNA indicated she was a little afraid to be alone with Resident #8 if he was in a bad mood. She indicated administrative staff had attempted to talk with Resident #8 regarding his behaviors towards staff and other residents, but she did not believe the intervention was effective.</p>		<ul style="list-style-type: none"> · Resident #30 admits witnessing Resident #8 yelling at staff members; however she has not witnessed him yelling at facility Residents. She is not fearful of Resident 8 and she has never been threatened or felt threatened by him. She clearly does not like Resident 8 and has instigated multiple abuse incidents against him. · Resident #91 indicates Resident 8 began cussing and swearing at him after inquiring who he was, when Resident #91 responded by stating, "I can eat at this table". Nothing in the interview indicates Resident 91 was fearful of Resident 8, felt threatened, or was verbally threatened with bodily injury. They engaged in a mutually disrespectful interaction with one another. Resident 91s care plan indicates he was · Resident #21 was interviewed and offered her opinions of Resident 8s behavior; however, nothing outlined indicates Resident 21 was fearful of Resident 8. · Interview with LPN 1 indicates Resident 8 exhibited behavior towards staff, but does not mention specific behaviors directed at Residents. LPN 1 allegedly stated, "Residents are afraid of him too"; however, there is no indication as to which specific Residents were afraid or why. Since this individual is not listed on the confidential list of 				

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	<p>On 3/11/2014 at 3:45 p.m., during an interview with Resident #72, she indicated she recently complained to the Administrator regarding Resident #8 cursing and using f--- word in the main dining room during meals. Resident #72 sat at the far end of main dining room across the room from Resident #8. Resident #72 indicated she has seen Resident #8 with his fist raised at other residents and indicated she was fearful of this resident. Resident #72 indicated she had spoken to her son about Resident # 8's behavior and her fear. Resident # 72 indicated Resident # 8 could hurt her at any time with his wheelchair or coming into her room while sleeping, uninvited. Resident #72 indicated Administrator does nothing, so why say anything anymore.</p> <p>During an interview with Resident # 33, on 3/11/14 at 3:50 p.m., she indicated she was not afraid of Resident #8. " He comes in to get candy from me. I do want you to know, he's no angel."</p> <p>On 3/5/2014 at 4:50 p.m., while leaving the facility, Resident #8 was observed yelling loudly and cussing in main dining room. During interview at</p>		<p>names, we were unable to conduct our own internal interview to clarify information, evaluate accuracy, or determine if administrative follow-up was in order.</p> <ul style="list-style-type: none"> Resident #93 was interviewed and stated her opinion of Resident 8s behavior without any specific instances to support him "often threatening them". Resident #93 outlines an instance where Resident #8 allegedly yelled a bad comment to her and then proceeded to walk away after Resident #93 accused him of "startling her". Resident #93 indicates she would not want to be alone with Resident 8 and that he was big enough and strong enough that he could potentially hurt her. Resident 8 has never laid a hand on Resident 93 nor has he threatened her with bodily injury. CNA 1 confirms behavior directed towards staff and a statement that Resident 8 "sometimes made physical threats towards other Residents". The interview failed to determine if CNA 1 directly witnessed any specific events or if she reported them in accordance with Mandated Reporter requirements. Since this individual is not listed on the confidential list of names, we were unable to conduct our own internal interview to clarify information, evaluate accuracy, or determine if administrative 				

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	<p>this time with unnamed CNA regarding yelling behaviors, she indicated resident always does this and he will be asked to leave dining room if the yelling does not stop.</p> <p>The record for resident #8 was reviewed on 3/10/14 at 1:30 p.m. This resident was admitted to the facility on 9/9/10. Diagnosis include but were not limited to: paraplegia of lower extremities, altered Mental Status with behaviors, Diabetes Mellitus, and anxiety.</p> <p>Current physician orders indicated Medications including but not limited to: clonazepam (anti-anxiety) 0.5 mg (milligrams) every 6 hours for agitation, trazodone 50 mg daily for mood disorder, divalproex 500 mg daily for passive aggressive personality disorder, Klonopin 10.5 mg daily for anxiety disorder, and Depakote 500 mg daily for passive aggressive disorder.</p> <p>IDT (Interdisciplinary Team) assessment dated 3/5/14, care plan discussion identified behaviors of cursing at another resident, behaviors noted in care plan meetings.</p> <p>A 5/17/13 careplan indicated a problem of behaviors including</p>		<p>follow-up was in order.</p> <ul style="list-style-type: none"> Resident #72 allegedly stated to the surveyor that she was fearful of Resident 8; however, she's never experienced any physical or verbal acts of aggression directed at her. Resident #33 actually stated she was <u>NOT</u> afraid of Resident 8. There is nothing in this interview that suggests any verbal, physical, or witnessed acts of aggression. <p>An observation made by the surveyor indicates Resident 8 was observed yelling loudly and cussing in the main dining room on 3/5/14 at 4:50 p.m. This behavior was not directed at any Residents, nor did anyone in the area appear afraid. CNA 1 was interviewed and she confirmed her knowledge of Resident 8s behavior and required interventions to modify it in accordance with his care plan.</p> <p>Dementia and psychiatric conditions are indeed common ailments afflicting our Residents. Unfortunately, it is not uncommon for Residents in our setting to exhibit behaviors such as yelling, cursing, or acting inappropriately in public. These behaviors can be very offensive, undesirable, and challenging to remediate. For these reasons, facility staff is trained upon hire and no less often than annually on interventions to manage difficult and challenging behaviors.</p>		

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	<p>resident was yelling, cursing at other residents in the MDR, intervention included, but were not limited to, talk to resident as to why he is upset, staff to ask resident to remove himself from MDR if he continues to yell and curse.</p> <p>Nursing Notes indicated the following:</p> <p>12/3/2013 resident is impatient with staff and makes comments about staff weight, verbally abusive and uncooperative</p> <p>12/8/2013 verbally abusive to staff negative attitude/unpleasant mood, yelling out, aggressive to staff, inappropriate behavior</p> <p>12/14/13 verbally abusive, yelling out</p> <p>12/15/13 verbally abusive, fabricates stories, yelling at staff using inappropriate language, refusing treatments, inappropriate behavior, negative statements, anger toward staff</p> <p>12/19/13 resident is uncooperative with care and meds, needs much encouragement to be cooperative</p> <p>12/22/13 arguing with roommate, threatening to beat him up, then</p>		<p>Almost all of Resident 8s outbursts occurred in the dining room and under the direct supervision of staff that were trained to intervene and utilize behavior management techniques in accordance with his care plan.</p> <p>Resident 8 is wheelchair-bound due to muscular dystrophy/paraplegia. He has dementia, generalized anxiety, depression, and passive/aggressive personality disorder, He exhibits anti-social behavior and therefore is not well liked by others. In fact, several of the Residents interviewed [#30, #21, and #93] are friends of one another and share common feelings of discontent for Resident 8.</p> <p>Ironically, this incident outlined in the 2567 in regards to Resident 30 was actually <u>a physical abuse against Resident 8 himself</u>. Clinical record documentation clearly reflects Resident 8 bumped into Resident 30s hand with his wheelchair. This occurrence was directly witnessed by a staff member and not determined to be "intentional". As a result, Resident 30 proceeded to turn around and call Resident 8 names before she physically assaulted him by hitting him 3 times, clearly substantiating Resident 30 was not fearful of</p>		

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	<p>became verbally abusive toward CNAs, continues to propel throughout unit with w/c ignoring everyone, negative statements, anger towards others, inappropriate behavior</p> <p>12/24/13 resident rude and demanding, acts as though staff is "STUPID"</p> <p>12/26/13 therapy staff note resident is uncooperative with staff</p> <p>12/28/2013 resident refuses meds, inappropriate with staff, rude to CNA and housekeeping</p> <p>12/29/13 resident continues to be rude to staff demanding, says inappropriate things to staff</p> <p>1/12/2014 verbally abusive to staff, yelling constantly at CNAs and ordering them around, throwing book and lotion into the hallway, when staff reminded resident he could hit or harm another resident with this behavior resident stated "I don't care"</p> <p>2/2/2014 yelling at staff and peers, becoming angry, threatening staff saying, "I'll hurt you", rolling through hallways yelling at staff</p>		<p>Resident 8.</p> <p>In addition to the above instance, Resident 30 has engaged in previous physical and verbal abuse occurrences against Resident 8, emphasizing the fact she has no fear of him. The facility reported an event on 8/1/11 where Resident 30 physically struck Resident 8 with her fist. On 8/28/13, the facility reported an event where Resident 30 slapped Resident 8 with her hand. On 3/11/14, the facility reported an incident were Resident 30 was over-heard verbally abusing and antagonizing Resident 8 by calling him a "child molester".</p> <p>Although the 2567 outlines multiple interview references, there was only <u>ONE</u> Resident [#72] who stated she was fearful of Resident 8, although the entire context of that interview was not disclosed. The truth of the matter is that none of the individuals cited in the 2567 have exhibited any signs of fear. They continue to dine in the dining room every day for all three meals. They all eat, sleep, socialize, and function normally without any difficulties whatsoever.</p> <p>Fear is a completely normal emotional response and it is not uncommon to fear things or other people. Extreme fear can manifest itself with physical symptoms, such as headaches, chronic pain, muscle tension,</p>		

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	<p>3/8/2014 resident angry refused treatment, resident drove to dining room, when staff tried to redirect resident threatened multiple staff members, on multiple occasions, resident stated "If you do not stop bothering me, someone is going to get hurt, and that is a promise"</p> <p>3/9/2014 in dining room, new resident entered room and resident was upset and told her she was not welcome to eat cake there with them in dining room, during the shift, resident made numerous rude comments to staff and other residents, resident threatened staff on multiple occasions, resident uncooperative with treatments and resistant to redirection</p> <p>On 3/11/2014 at 2:10 p.m., during record review of incident reports provided by the Administrator regarding resident # 8, no report from Resident #72 or Resident # 91 was found.</p> <p>Social services notes for resident #8 indicated:</p> <p>7/31/2013 resident notified of new roommate/behavior poor began yelling at social service person</p>		<p>stomach problems, nausea, diarrhea, heart palpitations, shaking, sweating, hot flashes, dizziness, or numbness. Psychological Symptoms associated with extreme fear includes persistent, irrational thoughts, fear of passing out, or fear of losing control in public. Anxiety and fear may also cause irritability, inability to concentrate or relax excessive worrying, nervousness, and heightened self-consciousness. There is no evidence to support that any of the Residents outlined in the statement of deficiency have experienced any degree of physical or psychological harm as the result of Resident 8s behavior. Resident 8 has exhibited patterns of yelling, throwing objects, and using foul-language. A vast majority [almost all] of this behavior had been directed at staff. Very rarely has Resident 8 actually threatened bodily injury to another. From admission in 2010, there are occasional instances where Resident 8 would act out towards other Residents when he felt threatened, disrespected, or provoked. It is a fact that Resident 8 has never once initiated any acts of physical violence against another Resident. At times, Resident 8 expresses his unhappiness and feelings of discontent by raising his voice and using</p>		

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	<p>8/14/13 behaviors 8/13 and 8/14 discussed with resident not acceptable to yell and curse, threaten staff. Resident became defensive and yelled. DON aware of behaviors</p> <p>8/22/13 resident behaviors present 8/22/13 discussed behaviors with resident not acceptable to be using curse words in dining room, resident became defensive and yelled "keep out of my business" attempted to redirect resident, DON aware</p> <p>8/23/13 discussed behaviors with resident "These aids are d--m slow" indicated resident has issues with evening staff, attempted to redirect resident, DON aware</p> <p>8/26/13 behavior on 8/25 discussed the report he "accidentally" hit a resident hand, resident stated "he is going to hit resident," educated resident on consequences of hitting other residents nurse reported altercation to DON, DON to report to state</p> <p>8/27/13 behavior on 8/27 discussed with resident yelling at staff, DON aware of behavior</p> <p>8/29/13 incident happened on 8/23/13 discussed with resident</p>		<p>foul-language. While this is certainly undesirable, distasteful, and offensive to some, this is not necessary indicative of abuse in every instance.</p> <p>The 2567 cites 14 references to behavioral instances in nurse's notes. Only three of them involved other Residents, while the rest were documented instances of uncooperativeness, non-compliance, or verbal outbursts directed at staff. The 3 instances involving Residents are summarized as:</p> <ul style="list-style-type: none"> ·A verbal dispute with his roommate ·An instance where he was upset and was noted to be "yelling at staff and peers" ·An instance where he made a rude comment to another Resident by stating to her she was not welcomed to have cake <p>There are 22 references cited in the 2567 outlining Social Services Progress note entries. These entries confirm frequent attempts to discuss, coach, and counsel Resident 8 on his behavior, most of which are also documented to be directed at staff. Each of these sessions occurred in private office areas and out of direct view or earshot of others [Attachment 1].</p> <p>Various other professionals also followed Resident 8 closely, including his personal physician,</p>	

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	<p>situation yelling at resident in hallway, felt he was ignored by resident, stated he did not hit resident but the wall, DON and Administrator notified and report to state</p> <p>8/30/13 resident discussed going to (name of another nursing facility) resident denied request could not meet his needs, IDT discussed with resident verbal aggression and outburst does effect the other residents well being, Resident got upset and wheeled away from care plan meeting</p> <p>8/30/13 discussed with resident situation he was yelling at another resident, resident denied, DON aware</p> <p>9/4/13 resident was defensive during discussion on behavior, DON aware</p> <p>9/10/13 discussed behavior yelling and threatening staff on 9/8 explained to resident threatening to hit staff is unacceptable, resident denied, DON aware, attempt to redirect resident</p> <p>9/30/13 discussed with resident not appropriate to curse at residents, DON aware</p> <p>10/2/13 discussed with resident</p>		<p>psychiatrist, Vericare Social Workers [LSW], and the State Ombudsman. None of these individuals ever once raised concerns over Resident 8 being a danger to others.</p> <p>Resident 8 was frequently assessed [2-3 times/month for the past year] by Vericare Psychiatry Services. None of the notes documented indicate concerns over Resident 8 being any type of danger to others. Notes outline a Resident who is extremely sensitive and actively participating in improving negative personality traits and incidental behavioral short-comings.</p> <p>The initial assessment recorded on 5/9/13 summarizes his verbal abuse behavior as "low risk" and states, "patient has history of being verbally abusive and occasionally threatening verbally. While his behavior can be quite bothersome to some, patient is confined to a wheelchair and has not acted out on verbal threats. Tends to back down when confronted" [Attachment 2].</p> <p><u>Vericare Visit Notes</u> [Attachment 3]. 5/23/13, 6/13/13, 6/20/13, 6/27/13, 7/11/13, 7/18/13, 8/1/13, 9/12/13, 10/4/13, 10/11/13, 10/18/13, 10/25/13, 11/1/13, 11/8/13, 11/27/13, 12/4/13, 12/11/13, 12/18/13, 12/25/13,</p>		

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	<p>calling nurse a b--ch not appropriate behavior resident denied, resident yelling at social service person and wheeled off refusing to listen</p> <p>11/5/13 discussed with resident behavior 11/3 yelling with staff, tried to discuss with resident that cursing at staff is inappropriate</p> <p>11/18/13 discussed 11/17 situation, resident reminded that cursing and threatening staff is not ok, resident became defensive and started yelling tried to redirect resident but he wheeled off in wheelchair, attempted to redirect resident, DON aware</p> <p>12/30/2013 discussed behaviors for 12/28 and 12/29, resident yelling and making inappropriate comments, resident defensive, denied behavior "didn't do anything ...I am out of here!" attempted to explain yelling at staff and making inappropriate comments are not acceptable, resident wheeled off and refused to listen to anyone, DON aware</p> <p>1/30/14 resident was verbally aggressive towards staff on 1/28, met with resident to explain that cursing hurts people's feelings</p> <p>2/18/14 late entry for 2/4/14, resident</p>		<p>1/1/14, 1/8/14, 1/15/14, 1/29/14, 2/5/14, 2/12/14, 2/19/14, and 3/8/14.</p> <p>Resident 8s psychiatrist, Dr. David Spangler documented 4/3/14 that despite Resident 8s personality disorder, on-going manipulation, and attention-seeking behaviors, he remains a low risk for physical aggression. He also confirms Resident 8 had a history of responding positively to limit setting and re-direction [Attachment 4].</p> <p>Randall Pickering, LCSW followed Resident 8 for multiple therapy sessions. Summary outlines, "Mr. Stevens seemed to have a positive rapport with this writer. We spent quite a bit of time addressing his relationships with peers and staff. He was always looking for small ways to help out the staff, and on a number of occasions fellow residents also. We also discussed his responses to peers when verbally provoked, and he tried to avoid these individuals as much as possible. Given his Dx. of Borderline Personality and other mental/physical impairments, it is unfortunate, but not completely surprising, that he would verbally retaliate against his provocateurs in an angry manner. At no time did I witness any overt attempts to harm himself or any other person"</p>				

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	<p>was threatening staff and upset with another resident, advised if he continues to curse and yell in dining room he will be asked to leave, attempted to tell resident yelling and cursing is inappropriate resident wheeled away from social service person talking to him</p> <p>2/18/14 late entry for 2/6/14 resident was verbally inappropriate towards staff during care. CNA told resident it was inappropriate to talk that way to others, resident got angry, upset and started yelling, social service person met with resident to discuss inappropriate behavior, resident rode off in wheelchair</p> <p>3/3/13 resident was cursing and calling a resident names, incident with boxes and wheel chairs occurred, cursing and yelling occurred, resident was educated on dangers of wheelchair operation</p> <p>3/5/14 discussed with ombudsman resident and staffing concerns with resident</p> <p>During an interview with the DON on 3/10/14 at 2:00 p.m., she indicated the behaviors of Resident #8 are addressed in the care plan and was reviewed and revised in 3/14. She</p>		<p>[Attachment 5].</p> <p>Resident 8s attending physician, Dr. Eaton has summarized Resident 8s behavior and treatment by outlining, "His "aggression" is truly passive in nature, refuses meds, labs, showers, etc. Most of the time he is pleasant and helpful. He does however lack patience and gets short in his verbal responses, using foul language to illicit reactions from others. This reportedly intimidates other Residents. In David's defense, I have also heard that at times other Residents provoke him with name calling" [Attachment 6].</p> <p>The State Ombudsman, Andrea Smothers is very familiar with Resident 8 and followed his behaviors closely. Attached is a letter summarizing her professional opinion [Attachment 7]. Her letter supports ongoing facility efforts and successes in managing Resident 8s behaviors. "I never found or witnessed Mr. Steven's to make verbal statements that were not provoked or that he perceived as provoking. Mr. Steven's was often the recipient of statements made by other residents that were derogatory and also mean spirited. In response to that he has at times had verbal outbursts as a "knee jerk" reaction to those statements. Clinton House had</p>		

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	<p>indicated behaviors had improved with the intervention of an Ipad. Behavior was not recent, and has had no problems lately.</p> <p>During an interview with the Social Services Director on 3/11/14 at 2:13 p.m., she indicated Resident #8 was encouraged to go to staff to express his feelings. When she gets behavior reports, she would go to Resident #8 to get both sides of the story, many times there are different sides of the story, he demonstrated defensive behavior. His behavior was discussed at morning meetings but not in recent past. Behaviors have improved, he is deeply involved in learning his Ipad. When he does act out, resident is asked to leave the area. Ombudsman has been helpful in directing activities for the resident and visits resident frequently.</p> <p>On 3/11/14 at 3 p.m., the administrator indicated he had no reportable occurrences related to the residents verbal or physical abusive behaviors.</p> <p>The Abuse and Crime Reporting Policies and Procedures, revised September 2011 was provided by the Adminsitrator on 3/5/14 and indicated: "...the policy of the facility</p>		<p>multiple interventions in place to try and minimize interaction between individuals that provoked Mr. Steven's and also assess and act appropriately when there was an altercation".</p> <p>While we immediately placed Resident 8 on 1:1 supervision to abate the immediate jeopardy, we have had Resident 8 on this same level of supervision in the past, which resulted in him becoming more agitated. The 2567 is misleading and implies the facility passively ignored or even allowed Resident 8s behaviors. The facility indeed took diligent measures to both monitor and manage Resident 8s personality, characteristics, and behaviors. Over time, these interventions included psychotropic medication management, behavior management, psychiatric services, social services, 1:1 supervision, behavioral contracts, etc. Interviews with facility staff substantiate staff awareness of Resident 8s behavior and the fact it responded easily to re-direction. Notes from professionals clearly outline continuous progress.</p> <p>Resident 8 exhibited patterns of behavior that could be easily modified and re-directed by staff accordingly. He was not random with his behavior and any interactions involving other</p>		

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	<p>is that every resident has the right to be free from verbal, sexual, physical, and mental abuse; neglect, corporal punishment, and involuntary seclusion...</p> <p>It is the responsibility of employees to promptly report to the facility administrator, local ombudsman (or local law enforcement agency) and to the State Licensing and Certification immediately or as soon as practically possible within 24 hours of detection, any incident of suspected or alleged neglect or resident abuse from other residents, staff, family or visitors; including injuries of unknown source and theft or misappropriation of resident property. Reports shall be thoroughly investigated in a timely manner...</p> <p>Purpose To protect the physical and emotional well-being and personal possessions of every resident...</p> <p>Definitions Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting harm, pain or mental anguish...Mental abuse includes but is not limited to humiliation, harassment, threats of punishment, or deprivation...Resident to Resident abuse mean the willful</p>		<p>Residents were often "provoked" or "antagonized" by the other party. Resident 8 has not caused serious harm, injury, or impairment to anyone. The facility did not allow Resident 8s behaviors to go unnoticed or unaddressed. Diligent measures were taken to address Resident 8s behaviors and manage them effectively enough to prevent instances of physical altercation.</p> <p>The facility contends Resident 8s behavior is no different than any other challenging dementia or psychiatric Resident in long-term care. He does not exhibit predatory patterns or tendencies to seek out conflicts with others. Resident 8 has lacked willful intent in regards to the incidents involving other Residents. His behavior was inadvertent, as opposed to intentional; unplanned as opposed to deliberate, and compelled as opposed to voluntary. Various long-term care professionals evaluated Resident 8 on a regular basis and these individuals have substantiated no past concerns of him posing an eminent threat to the safety of others. Our facility defined and implemented quality assessment, monitoring, and managing of Resident 8s dementia and psychiatric related behaviors. There is absolutely no evidence to support physical or psychological harm to any Resident. In light of this, F-223</p>		

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	<p>infliction of injury, unreasonable confinement, intimidation or punishment with resulting harm, pain or mental anguish by one resident towards another...Verbal abuse is defined as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability...</p> <p>4. Prevention The facility shall identify, analyze, and assess the following situations to minimize the likelihood of abuse, neglect, and/or missappropriation of resident property:...</p> <p>5. Identification The facility will monitor the adequacy of assessment, care planning, and monitoring of residents with needs or behaviors that may likely lead to conflict, altercation, abuse or neglect, such as: Physically aggressive or self injurious behaviors *verbally abusive behavior towards others *socially inappropriate or disruptive behaviors.</p> <p>6. Investigation Injuries of unknknown source, suspected or alleged abuse, neglect, involuntary seclusion, and</p>		(K) should be dismissed or reduced		

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	<p>misappropriation of resident property or found, will be investigated with results reported in accordance with facility police, federal and state regulation's...</p> <p>7. Protection To protect residents and employees from harm or regulation during investigations, the facility shall, take promptly measures to remove any resident from immediate harm or danger. The facility shall take reasonable measure to separate residents involved in alleged or witnessed Resident to Resident abuse...</p> <p>6 (sic). Reporting Additionally, the facility requires that employees immediately report the facts of known or suspected instances of abuse and all allegations of abuse and suspicions of crime immediately to the facility Administrator (either directly or anonymously) so that facility's responsibility to protect residents and promptly investigate occurrences can be met. Failure to report in the required time frames may result in disciplinary action, including termination. The facility Administrator, or designee, will immediately, or as</p>			
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	<p>soon as practically possible with 24 hours of receiving an allegation or forming a suspicion, report the instance of abuse, neglect, or misappropriation of resident property to the local ombudsman or local law enforcement agency and to the Department of Health Services (or appropriate State Agency) as required by law. The facility Administrator, or designee, shall report the findings of the internal investigation to officials in accordance with state law, including to the state survey and certification agency, within five working days of the incident...."</p> <p>The immediate jeopardy that began on 3/11/14 at 5 p.m., was removed on 3/12/14, when the facility placed Resident #8 on 1:1 care supervision by nursing staff, completed interviews of alert and oriented residents, and began all staff inserviceing on the facility abuse policy. The noncompliance remained at the lower scope and severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy because of the need for ongoing staff training, resident education and family education on the abuse policy and procedure.</p>			

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F000225 SS=K	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interviews, record review</p>	F000225	THE FACILITY DISPUTES THE	04/07/2014			

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	<p>and observation the facility failed to investigate alleged verbal abuse and prevent further potential abuse from a known verbally and physically aggressive resident (Resident #8). Resident # 8 had a history of being verbally and physically aggressive towards residents and staff. Residents # 72, # 91, # 93, #30, # 21, and # 33 indicated they were fearful of resident #8 or had witnessed aggressive behavior from Resident # 8. They indicated they felt concerns to administration were not addressed. This deficient practice had the potential to affect 58 of 76 residents residing in the facility.</p> <p>An Immediate Jeopardy was identified on 3/11/14 at 5 p.m. The Immediate Jeopardy began on 3/11/14 with the indication during Resident #72, #91, #93, #30, #21, and #33 interviews that they were fearful of or had witnessed Resident #8's aggressive behavior. The Administrator was notified of the Immediate Jeopardy on 3/11/14 at 5 p.m.</p> <p>Findings include:</p> <p>During an interview on 3/6/2014 at 9:04 a.m., Resident #30 indicated</p>		<p>VALIDITY OF THE FINDING OUTLINED IN F225. WE HAVE ISSUED A REQUEST FOR AN INFORMAL DESPUTE RESOLUTION HEARING.F225 INVESTIGATE/REPORT ALLIGATIONS/INDIVIDUALS · Residents #93, 72, 21, 91, 30, and 33 have been interviewed and each indicated they felt safe in this facility. Social service has followed up and offered psychological counseling. · Resident # 8 no longer resides in this facility. · Resident # 30 has had an assessment and x-rays to show there are no injuries from wheel chair "bumping" her hands. · 58 of 76 residents have the potential to be effected by this alleged deficient practice. · Each resident and or family member has been educated on their rights to be free of any type of abuse, given the definition of abuse, and types of abuse. They have also been educated on how and where to report abuse. Each resident or family member was left with a copy of the abuse and reporting system and voiced understanding. · Staff have been re-educated on the Behavior Monitoring System and Reporting abuse · Resident # 8 no longer resides in the facility. · Residents and or family member will be interviewed using the QIS interviewing form with any concerns being brought to the Administrator immediately, 5 residents a week for 4 weeks,</p>				

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	<p>Resident #8 often yelled at the staff members. Resident #30 also indicated Resident #8 ran his wheelchair into her hands. She was unable to recall the date of the incident and indicated she believed the act to be intentional. The resident indicated her hands swelled and she was required to have x-rays. She indicated no injuries were noted at the time of the x-rays, but her hands hurt.</p> <p>On 3/6/2014 at 2:20 p.m., during an interview with Resident #91, he indicated he had issues with Resident #8. He indicated during dinner in the main dining room, he approached the table where Resident #8 was seated. Resident #8 asked him who he was and who told him he could eat at his table. Resident # 91 indicated Resident #8 then told him to go away, and he was cussing and swearing at him.</p> <p>During an interview with Resident #21, on 3/11/14 at 2:00 p.m., she indicated "Resident #8 does things and gets away with it. He cusses, pinches the aide's butts, is rude and threatens other residents. He runs</p>		<p>then 5 residents a week every other week for 1 month, then 5 residents every month for 4 months. · Five random employees will be questioned on the contents of the abuse policy 5 times a week for one month, then 5 random employees every other week for one month, then 5 employees every month for 4 months. · Special Resident Council meeting was held March 13, 2014 with education provided about abuse and steps to report it. · All employees were re-educated on the Covenant Care Abuse and Prevention, Interventions, Investigation and Crime Reporting Policy. · Executive Director and Director of Nursing were re-educated on the Covenant Care Abuse and Prevention, Interventions, Investigation and Crime Reporting Policy. · Executive Director has sent a letter to all families and/ or responsible parties to review facility process reporting grievances and allegations of abuse. · Non compliance will be addressed through re-education and progressive disciplinary actions as indicated. Results of audits will be reviewed monthly in QA&A for 6 months and quarterly with subsequent plan development and implementation as appropriate.</p> <p>F 225 (K): 42 C.F.R. §483.13(c)(1)(ii), (c)(2) – (4) Investigate/Report</p>		

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	<p>into other residents with his wheelchair. His behaviors have not improved. Staff are afraid to report him he'll get them in trouble if they do."</p> <p>During an interview with LPN #1, on 3/11/14 at 3:25 p.m., she indicated Resident #8 will get them into trouble and he pats them on the butt and makes sexual remarks. She also indicated residents are afraid of him too.</p> <p>During an interview with Resident #93 on 3/11/14 at 3:29 p.m., the resident indicated Resident #8 often threatened other residents with physical harm. Resident #93 indicated she was standing near the entrance to the building on 3/11/14, and that Resident #8 approached her. She indicated Resident #8 had startled her and she told him she was startled. Resident #93 indicated Resident #8 then "... yelled a bad comment to [her] and left." Resident #93 indicated Resident #8 cursed at her in the past. Resident #93 indicated she would not want to be alone with Resident #8, "... because he has that big wheelchair and he has things he can pick up off of the floor. If he wanted to, he could hurt me." Resident #93 indicated she</p>		<p>Allegations/Individuals <i>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).</i></p> <p>The findings outlined in the 2567 are misleading and inaccurate. The incident involving Resident 30 was <u>indeed investigated and reported to ISDH.</u></p> <p>Documentation clearly reflects Resident 8 bumped into Resident 30s hand with his wheelchair. As a result, Resident 30 proceeded to turn around and call Resident 8 names and physically assaulted him. Resident 30 is clearly not fearful of Resident 8. The incident was ultimately determined to be an accidental/unintentional event that led to a physical altercation where Resident 30 herself was the aggressor against Resident 8. The incident was witnessed by staff, so Resident 30s personal accounting was ultimately discredited. Her x-rays were indeed negative for evidence of fracture or soft tissue swelling [Attachment 8]. It is unclear whether her reported injury</p>		

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	<p>had not reported the behaviors of Resident #8 because she didn't "...want any trouble. If he [Resident #8] found out, he would be really mad." Resident #93 also indicated she witnessed Resident #8 touch nursing staff inappropriately.</p> <p>During an interview with Certified Nursing Assistant # 1 (CNA), on 3/11/14 at 3:45 p.m., she indicated Resident #8 was verbally aggressive and threw things at staff members at times. She indicated Resident #8 threw a urinal across his room on 3/11/14 at approximately 3:15 p.m. The CNA indicated Resident #8 was sometimes verbally abusive towards staff and sometimes made physical threats towards other residents. The CNA also indicated Resident #8 repeatedly tried tickling her on the ribs. The CNA indicated she was a little afraid to be alone with Resident #8 if he was in a bad mood. She indicated administrative staff had attempted to talk with Resident #8 regarding his behaviors towards staff and other residents, but she did not believe the intervention was effective.</p> <p>On 3/11/2014 at 3:45 p.m., during an interview with Resident #72, she indicated she recently complained to the Administrator regarding Resident</p>		<p>resulted from the unintentional wheelchair bump or was self-sustained from the 3 times she physically struck Resident 8. Clinton House was not cited with a deficiency over this occurrence. Resident 91 had an interaction with Resident 8 where his displeasure with the communication ended up with him "cussing and swearing". It is not a crime for an adult to use foul language, and Resident 91 never stated he felt threatened, fearful, or intimidated by their mutually disrespectful interaction with one another. He did not allege abuse or that he felt abused.</p> <p>The interview with Resident #21 does not outline any specific allegations. Behaviors of "cussing and pinching the aide's butts" are not reportable under state law. There is evidence behaviors of this nature were reported to Social Services are care planned accordingly. There are no specific findings regarding "being rude and threatening other residents", so it is unclear whether or not this reference is linked to an event that was indeed investigated and reported as required. The instance outlined of Resident 8 running into other residents with his wheelchair occurred once, and that particular event involved Resident 30 and was indeed investigated and reported.</p> <p>Interview with LVN 1 outlines</p>		

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	<p>#8 cursing and using f--- word in the main dining room during meals. Resident #72 sat at the far end of main dining room across the room from Resident #8. Resident #72 indicated she has seen Resident #8 with his fist raised at other residents and indicated she was fearful of this resident. Resident #72 indicated she had spoken to her son about Resident # 8's behavior and her fear. Resident # 72 indicated Resident # 8 could hurt her at any time with his wheelchair or coming into her room while sleeping, uninvited. Resident #72 indicated Administrator does nothing, so why say anything anymore.</p> <p>During an interview with Resident # 33, on 3/11/14 at 3:50 p.m., she indicated she was not afraid of Resident #8. " He comes in to get candy from me. I do want you to know, he's no angel."</p> <p>The record for resident #8 was reviewed on 3/10/14 at 1:30 p.m. This resident was admitted to the facility on 9/9/10. Diagnosis include but were not limited to: paraplegia of lower extremities, altered Mental Status with behaviors, Diabetes Mellitus, and anxiety.</p>		<p>behaviors directed towards staff which is not reportable under state law. The additional remark alleging, "other Residents are afraid of him too" does not outline any specific events, so it is unclear who this represents or whether or not this reference is linked to an event that was indeed investigated and reported as required.</p> <p>The interview with CNA#1 fails to identify any specific instances or events that went unreported or weren't investigated. Behaviors directed towards staff are not reportable, and there is no evidence CNA 1 actually witnessed or was aware of an allegation involving any specific Resident, events, or occurrences. The interview with Resident #72 indicates she complained to the Administrator regarding Resident 8 cursing and using the f---word in the main dining room during meals. She did not indicate the behavior was directed at a specific Resident, nor did she indicate she was intimidated or felt threatened by that specific instance, rendering it as not a reportable event. This behavior was indeed addressed by Social Services and care planned accordingly.</p> <p>Although Resident 8 told the surveyor she saw Resident 8 with his fist raised at 'other Residents', there is no indication when this occurred, against whom, or if she had reported that specific</p>		

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	<p>Current physician orders indicated Medications including but not limited to: clonazepam (anti-anxiety) 0.5 mg (milligrams) every 6 hours for agitation, trazodone 50 mg daily for mood disorder, divalproex 500 mg daily for passive aggressive personality disorder, Klonopin 10.5 mg daily for anxiety disorder, and Depakote 500 mg daily for passive aggressive disorder.</p> <p>IDT (Interdisciplinary Team) assessment dated 3/5/14, care plan discussion identified behaviors of cursing at another resident, behaviors noted in care plan meetings.</p> <p>A 5/17/13 care plan indicated a problem of behaviors including resident was yelling, cursing at other residents in the MDR, intervention included, but were not limited to, talk to resident as to why he is upset, staff to ask resident to remove himself from MDR if he continues to yell and curse.</p> <p>Nursing Notes indicated the following: 12/22/13 arguing with roommate, threatening to beat him up, then became verbally abusive toward CNAs, continues to propel throughout</p>		<p>instance to Administration. It is also unclear as to whether or not this alleged occurrence was linked to a previous event that had been investigated and reported. Administration must have knowledge of a specific event, specific allegation, or have reasonable suspicion that abuse has occurred in order to issue a report.</p> <p>Interview with Resident 33 confirms she was not afraid of Resident 8 and nothing outlined suggests the occurrence of any events whatsoever that would have warranted an investigation and reporting obligations. There is absolutely no evidence provided or specific occurrences outlined to suggest facility administration failed to investigate and/or report occurrences in accordance with facility policies and state law. F-225 (K) should not have been cited and Clinton House is requesting deficiency dismissal or consideration of reduction.</p>		

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	<p>unit with w/c ignoring everyone, negative statements, anger towards others, inappropriate behavior</p> <p>1/12/2014 verbally abusive to staff, yelling constantly at CNAs and ordering them around, throwing book and lotion into the hallway, when staff reminded resident he could hit or harm another resident with this behavior resident stated "I don't care"</p> <p>3/9/2014 in dining room, new resident entered room and resident was upset and told her she was not welcome to eat cake there with them in dining room, during the shift, resident made numerous rude comments to staff and other residents, resident threatened staff on multiple occasions, resident uncooperative with treatments and resistant to redirection</p> <p>On 3/11/2014 at 2:10 p.m., during review of incident reports provided by the Administrator regarding resident # 8, no report from Resident #72's concerns regarding Resident # 8 were provided. At this time, the Administrator indicated he was unaware of the above 12/22/13 event of Resident # 8 threatening to beat up his roommate.</p>				

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	<p>Social services notes for resident #8 indicated:</p> <p>8/22/13 resident behaviors present 8/22/13 discussed behaviors with resident not acceptable to be using curse words in dining room, resident became defensive and yelled "keep out of my business" attempted to redirect resident, DON aware</p> <p>8/26/13 behavior on 8/25 discussed the report he "accidentally" hit a resident hand, resident stated "he is going to hit resident," educated resident on consequences of hitting other residents nurse reported altercation to DON, DON to report to state</p> <p>8/29/13 incident happened on 8/23/13 discussed with resident situation yelling at resident in hallway, felt he was ignored by resident, stated he did not hit resident but the wall, DON and Administrator notified and report to state</p> <p>8/30/13 discussed with resident situation he was yelling at another resident, resident denied, DON aware</p> <p>9/30/13 discussed with resident not appropriate to curse at residents,</p>			
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	<p>DON aware</p> <p>12/30/2013 discussed behaviors for 12/28 and 12/29, resident yelling and making inappropriate comments, resident defensive, denied behavior "didn't do anything ...I am out of here!" attempted to explain yelling at staff and making inappropriate comments are not acceptable, resident wheeled off and refused to listen to anyone, DON aware</p> <p>2/18/14 late entry for 2/4/14, resident was threatening staff and upset with another resident, advised if he continues to curse and yell in dining room he will be asked to leave, attempted to tell resident yelling and cursing is inappropriate resident wheeled away from social service person talking to him</p> <p>3/3/13 resident was cursing and calling a resident names, incident with boxes and wheel chairs occurred, cursing and yelling occurred, resident was educated on dangers of wheelchair operation</p> <p>During an interview with the DON on 3/10/14 at 2:00 p.m., she indicated the behaviors of Resident #8 are addressed in the care plan and was reviewed and revised in 3/14. She</p>			
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	<p>indicated behaviors had improved with the intervention of an Ipad. Behavior was not recent, and has had no problems lately.</p> <p>During an interview with the Social Services Director on 3/11/14 at 2:13 p.m., she indicated Resident #8 was encouraged to go to staff to express his feelings. When she gets behavior reports, she would go to Resident #8 to get both sides of the story, many times there are different sides of the story, he demonstrated defensive behavior. His behavior was discussed at morning meetings but not in recent past. Behaviors have improved, he is deeply involved in learning his Ipad. When he does act out, resident is asked to leave the area. Ombudsman has been helpful in directing activities for the resident and visits resident frequently.</p> <p>The Abuse and Crime Reporting Policies and Procedures, revised September 2011 was provided by the Administrator on 3/5/14 and indicated: "...the policy of the facility is that every resident has the right to be free from verbal, sexual, physical, and mental abuse; neglect, corporal punishment, and involuntary seclusion..."</p>			
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	<p>It is the responsibility of employees to promptly report to the facility administrator, local ombudsman (or local law enforcement agency) and to the State Licensing and Certification immediately or as soon as practically possible within 24 hours of detection, any incident of suspected or alleged neglect or resident abuse from other residents, staff, family or visitors; including injuries of unknown source and theft or misappropriation of resident property. Reports shall be thoroughly investigated in a timely manner...</p> <p>Purpose To protect the physical and emotional well-being and personal possessions of every resident...</p> <p>Definitions Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting harm, pain or mental anguish...Mental abuse includes but is not limited to humiliation, harassment, threats of punishment, or deprivation...Resident to Resident abuse means the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting harm, pain or mental anguish by one resident towards another ...Verbal abuse is defined as the use of oral, written, or</p>				

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	<p>gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability...</p> <p>4. Prevention The facility shall identify, analyze, and assess the following situations to minimize the likelihood of abuse, neglect, and/or misappropriation of resident property:...</p> <p>5. Identification The facility will monitor the adequacy of assessment, care planning, and monitoring of residents with needs or behaviors that may likely lead to conflict, altercation, abuse or neglect, such as: Physically aggressive or self injurious behaviors *verbally abusive behavior towards others *socially inappropriate or disruptive behaviors.</p> <p>6. Investigation Injuries of unknown source, suspected or alleged abuse, neglect, involuntary seclusion, and misappropriation of resident property or found, will be investigated with results reported in accordance with facility police, federal and state regulation's...</p>				

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	<p>7. Protection To protect residents and employees from harm or regulation during investigations, the facility shall, take promptly measures to remove any resident from immediate harm or danger. The facility shall take reasonable measure to separate residents involved in alleged or witnessed Resident to Resident abuse...</p> <p>The immediate jeopardy that began on 3/11/14 was removed on 3/12/14 at when the facility placed Resident #8 on 1:1 care supervision by nursing staff, completed interviews of alert and oriented residents, and began all staff inservice on the facility abuse policy. The noncompliance remained at the lower scope and severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy because of the need for ongoing staff training, resident education and family education on the abuse policy and procedure.</p> <p>3.1-28(d)</p>			
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F000226 SS=K	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview, record review the facility failed to follow their abuse prevention policy and procedure to prevent verbal abuse of residents from a known verbally and physically aggressive resident (Resident #8). Resident # 8 had a history of being verbally and physically aggressive towards residents and staff.</p> <p>Residents # 72, # 91, # 93, #30, # 21, and # 33 indicated they were fearful of resident #8 or had witnessed aggressive behavior from Resident # 8. They indicated they felt concerns to administration were not addressed. This deficient practice had the potential to affect 58 of 76 residents residing in the facility.</p> <p>An Immediate Jeopardy was identified on 3/11/14 at 5 p.m. The Immediate Jeopardy began on 3/11/14 with the indication during Resident #72, #91, #93, #30, #21, and #33 interviews that they were fearful of or had witnessed Resident #8's aggressive behavior. The Administrator was notified of the</p>	F000226	<p>THE FACILITY DISPUTES THE VALIDITY OF THE FINDING OUTLINED IN F226. WE HAVE ISSUED A REQUEST FOR AN INFORMAL DESPUTE RESOLUTION HEARING.226 DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES · Residents #93, 72, 21, 91, 30, and 33 have been interviewed and each indicated they felt safe in this facility. Social service has followed up and offered psychological counseling.</p> <p>· Resident # 8 no longer resides in this facility. · Resident # 30 has had an assessment and x-rays to show there are no injuries from wheel chair "bumping" her hands. · 58 of 76 residents have the potential to be effected by this alleged deficient practice. · Each resident and or family member has been educated on their rights to be free of any type of abuse, given the definition of abuse, and types of abuse. They have also been educated on how and where to report abuse. Each resident or family member was left with a copy of the abuse and reporting system and voiced understanding. · Staff have been</p>	04/07/2014			

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	<p>Immediate Jeopardy on 3/11/14 at 5 p.m.</p> <p>Findings include:</p> <p>During an interview on 3/6/2014 at 9:04 a.m., Resident #30 indicated Resident #8 often yelled at the staff members. Resident #30 also indicated Resident #8 ran his wheelchair into her hands. She was unable to recall the date of the incident and indicated that she believed the act to be intentional. The resident indicated her hands swelled and she was required to have x-rays. She indicated no injuries were noted at the time of the x-rays, but her hands hurt.</p> <p>On 3/6/2014 at 2:20 p.m., during an interview with Resident #91, he indicated he had issues with Resident #8. He indicated during dinner in the main dining room, he approached the table where Resident #8 was seated. Resident #8 asked him who he was and who told him he could eat at his table. Resident # 91 indicated Resident #8 then told him to go away, and he was cussing and swearing at him.</p>		<p>re-educated on the Behavior Monitoring System and Reporting abuse · Resident # 8 no longer resides in the facility. · Residents and or family member will be interviewed using the QIS interviewing form with any concerns being brought to the Administrator immediately, 5 residents a week for 4 weeks, then 5 residents a week every other week for 1 month, then 5 residents every month for 4 months. · Five random employees will be questioned on the contents of the abuse policy 5 times a week for one month, then 5 random employees every other week for one month, then 5 employees every month for 4 months. · Special Resident Council meeting was held March 13, 2014 with education provided about abuse and steps to report it. · All employees were re-educated on the Covenant Care Abuse and Prevention, Interventions, Investigation and Crime Reporting Policy. · Executive Director and Director of Nursing were re-educated on the Covenant Care Abuse and Prevention, Interventions, Investigation and Crime Reporting Policy. · Executive Director has sent a letter to all families and/ or responsible parties to review facility process reporting grievances and allegations of abuse. · Non compliance will be addressed through re-education and</p>		

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	<p>During an interview with Resident #21, on 3/11/14 at 2:00 p.m., she indicated "Resident #8 does things and gets away with it. He cusses, pinches the aide's butts, is rude and threatens other residents. He runs into other resident with his wheelchair. His behaviors have not improved. Staff are afraid to report him he'll get them in trouble if they do. "</p> <p>During an interview with LPN #1, on 3/11/14 at 3:25 p.m., she indicated Resident #8 will get them into trouble and he pats them on the butt and makes sexual remarks. She also indicated residents are afraid of him too.</p> <p>During an interview with Resident #93 on 3/11/14 at 3:29 p.m., the resident indicated Resident #8 often threatened other residents with physical harm. Resident #93 indicated she was standing near the entrance to the building on 3/11/14, and Resident #8 approached her. She indicated Resident #8 had startled her and she told him she was startled. Resident #93 indicated Resident #8 then " ... yelled a bad comment to [her] and left." Resident #93 indicated Resident #8 cursed at</p>		<p>progressive disciplinary actions as indicated. Results of audits will be reviewed monthly in QA&A for 6 months and quarterly with subsequent plan development and implementation as appropriate.</p> <p>F 226 (K): 42 C.F.R. §483.13(C) Develop/Implement Abuse/Neglect, Etc. Policies</p> <p><i>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of property.</i></p> <p>The facility has indeed developed and implemented abuse policies and procedures. The facility has a Resident with problematic behavior that is easily modifiable and responsive to re-direction. This Resident has not physically harmed anyone and has only encountered a few Resident-to-Resident incidents that were clearly provoked or antagonized by the other party. The specific instances outlined are individually addressed under informal dispute details outlined under F-225 (K). There is absolutely no evidence to support that any of these instances resulted in any degree of physical harm, pain, or mental anguish to Residents.</p> <p>Clinton House does not have a pattern of failing to identify, investigate, or report abuse in accordance with facility policies</p>		

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	<p>her in the past. Resident #93 indicated she would not want to be alone with Resident #8, " ... because he has that big wheelchair and he has things he can pick up off of the floor. If he wanted to, he could hurt me." Resident #93 indicated she had not reported the behaviors of Resident #8 because she didn ' t " ...want any trouble. If he [Resident #8] found out, he would be really mad." Resident #93 also indicated she witnessed Resident #8 touch nursing staff inappropriately.</p> <p>During an interview with Certified Nursing Assistant # 1 (CNA), on 3/11/14 at 3:45 p.m., she indicated Resident #8 was verbally aggressive and threw things at staff members at times. She indicated Resident #8 threw a urinal across his room on 3/11/14 at approximately 3:15 p.m. The CNA indicated Resident #8 was sometimes verbally abusive towards staff and sometimes made physical threats towards other residents. The CNA also indicated Resident #8 repeatedly tried tickling her on the ribs. The CNA indicated she was a little afraid to be alone with Resident #8 if he was in a bad mood. She indicated administrative staff had attempted to talk with Resident #8 regarding his behaviors towards staff</p>		<p>and state laws. Since our previous annual survey 2-6-13, the facility identified and self-reported 10 different instances of alleged or suspected abuse.</p> <p>March 2013 – 1 Resident-to-Resident altercation June 2013 – 2 Resident-to-Resident altercations August 2013 – 2 Resident-to-Resident altercations October 2013 – 1 Resident-to-Resident altercation and 1 Staff-to-Resident allegation of abuse November 2013 - 1 Resident-to-Resident altercation February 2014 - 1 Resident-to-Resident altercation and 1 Staff-to-Resident allegation of abuse</p> <p>None of the reported instances above resulted in deficiencies substantiating concerns over facility practices in developing and implementing abuse policies and procedures. The facility has clearly complied with F-226 regulation. We are therefore requesting deficiency dismissal or consideration of reduction.</p>				

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	<p>and other residents, but she did not believe the intervention was effective.</p> <p>On 3/11/2014 at 3:45 p.m., during an interview with Resident #72, she indicated she recently complained to the Administrator regarding Resident #8 cursing and using f--- word in the main dining room during meals. Resident #72 sat at the far end of main dining room across the room from Resident #8. Resident #72 indicated she has seen Resident #8 with his fist raised at other residents and indicated she was fearful of this resident. Resident #72 indicated she had spoken to her son about Resident # 8's behavior and her fear. Resident # 72 indicated Resident # 8 could hurt her at any time with his wheelchair or coming into her room while sleeping, uninvited. Resident #72 indicated Administrator does nothing, so why say anything anymore.</p> <p>During an interview with Resident # 33, on 3/11/14 at 3:50 p.m., she indicated she was not afraid of Resident #8. " He comes in to get candy from me. I do want you to know, he's no angel."</p> <p>The record for resident #8 was reviewed on 3/10/14 at 1:30 p.m.</p>			
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	<p>This resident was admitted to the facility on 9/9/10. Diagnoses include but were not limited to: paraplegia of lower extremities altered Mental Status with behaviors, Diabetes Mellitus, and anxiety.</p> <p>Current physician orders indicated Medications including but not limited to: clonazepam (anti-anxiety) 0.5 mg (milligrams) every 6 hours for agitation, trazodone 50 mg daily for mood disorder, divalproex 500 mg daily for passive aggressive personality disorder, Klonopin 10.5 mg daily for anxiety disorder, and Depakote 500 mg daily for passive aggressive disorder.</p> <p>IDT (Interdisciplinary Team) assessment dated 3/5/14, care plan discussion identified behaviors of cursing at another resident, behaviors noted in care plan meetings.</p> <p>A 5/17/13 care plan indicated a problem of behaviors including resident was yelling, cursing at other residents in the MDR, intervention included, but were not limited to, talk to resident as to why he is upset, staff to ask resident to remove himself from MDR if he continues to yell and curse.</p>			
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	<p>Nursing Notes indicated the following:</p> <p>12/22/13 arguing with roommate, threatening to beat him up, then became verbally abusive toward CNAs, continues to propel throughout unit with w/c ignoring everyone, negative statements, anger towards others, inappropriate behavior</p> <p>1/12/2014 verbally abusive to staff, yelling constantly at CNAs and ordering them around, throwing book and lotion into the hallway, when staff reminded resident he could hit or harm another resident with this behavior resident stated "I don't care"</p> <p>2/2/2014 yelling at staff and peers, becoming angry, threatening staff saying, "I'll hurt you", rolling through hallways yelling at staff</p> <p>3/8/2014 resident angry refused treatment, resident drove to dining room, when staff tried to redirect resident threatened multiple staff members, on multiple occasions, resident stated "If you do not stop bothering me, someone is going to get hurt, and that is a promise"</p> <p>3/9/2014 in dining room, new resident</p>				

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	<p>entered room and resident was upset and told her she was not welcome to eat cake there with them in dining room, during the shift, resident made numerous rude comments to staff and other residents, resident threatened staff on multiple occasions, resident uncooperative with treatments and resistant to redirection</p> <p>Social services notes for resident #8 indicated:</p> <p>8/22/13 resident behaviors present 8/22/13 discussed behaviors with resident not acceptable to be using curse words in dining room, resident became defensive and yelled "keep out of my business" attempted to redirect resident, DON aware 8/26/13 behavior on 8/25 discussed the report he " accidentally" hit a resident hand, resident stated "he is going to hit resident," educated resident on consequences of hitting other residents nurse reported altercation to DON, DON to report to state 8/29/13 incident happened on 8/23/13 discussed with resident situation yelling at resident in hallway,</p>			
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	<p>felt he was ignored by resident, stated he did not hit resident but the wall, DON and Administrator notified and report to state</p> <p>8/30/13 resident discussed going to (name of another nursing facility) resident denied request could not meet his needs, IDT discussed with resident verbal aggression and outburst does effect the other residents well being, Resident got upset and wheeled away from care plan meeting</p> <p>8/30/13 discussed with resident situation he was yelling at another resident, resident denied, DON aware</p> <p>9/30/13 discussed with resident not appropriate to curse at residents, DON aware</p> <p>12/30/2013 discussed behaviors for 12/28 and 12/29, resident yelling and making inappropriate comments, resident defensive, denied behavior "didn't do anything ...I am out of here!" attempted to explain yelling at staff and making inappropriate comments are not acceptable, resident wheeled off and refused to listen to anyone, DON aware</p> <p>2/18/14 late entry for 2/4/14, resident</p>			
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	<p>was threatening staff and upset with another resident, advised if he continues to curse and yell in dining room he will be asked to leave, attempted to tell resident yelling and cursing is inappropriate resident wheeled away from social service person talking to him</p> <p>3/3/13 resident was cursing and calling resident names, incident with boxes and wheel chairs occurred, cursing and yelling occurred, resident was educated on dangers of wheelchair operation</p> <p>During an interview with the DON on 3/10/14 at 2:00 p.m., she indicated the behaviors of Resident #8 are addressed in the care plan and was reviewed and revised in 3/14. She indicated behaviors had improved with the intervention of an Ipad. Behavior was not recent, and has had no problems lately.</p> <p>During an interview with the Social Services Director on 3/11/14 at 2:13 p.m., she indicated Resident #8 was encouraged to go to staff to express his feelings. When she gets behavior reports, she would go to Resident #8 to get both sides of the story, many times there are different sides of the story, he demonstrated defensive</p>			
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	<p>behavior. His behavior was discussed at morning meetings but not in recent past. Behaviors have improved, he is deeply involved in learning his Ipad. When he does act out, resident was asked to leave the area. Ombudsman has been helpful in directing activities for the resident and visits resident frequently.</p> <p>On 3/11/2014 at 2:10 p.m., during review of incident reports provided by the Administrator regarding resident # 8, no report from Resident #72 was identified. He indicated he no state reportable incidents for Resident # 8 and he provided 3 resident concern worksheets, but these were related to Resident # 8's motorized wheelchair.</p> <p>The Abuse and Crime Reporting Policies and Procedures, revised September 2011 was provided by the Administrator on 3/5/14 and indicated: "...the policy of the facility is that every resident has the right to be free from verbal, sexual, physical, and mental abuse; neglect, corporal punishment, and involuntary seclusion...</p> <p>It is the responsibility of employees to promptly report to the facility administrator, local ombudsman (or local law enforcement agency) and to</p>			
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	<p>the State Licensing and Certification immediately or as soon as practically possible within 24 hours of detection, any incident of suspected or alleged neglect or resident abuse from other residents,staff,family or visitors; including injuries of unknown source and theft or misappropriation of resident property. Reports shall be thoroughly investigated in a timely manner...</p> <p>5. Identification The facility will monitor the adequacy of assessment, care planning, and monitoring of residents with needs or behaviors that may likely lead to conflict, altercation, abuse or neglect, such as: Physically aggressive or self injurious behaviors *verbally abusive behavior towards others *socially inappropriate or disruptive behaviors.</p> <p>6. Investigation Injuries of unknown source, suspected or alleged abuse, neglect, involuntary seclusion, and misappropriation of resident property or found, will be investigated with results reported in accordance with facility police, federal and state regulation's...</p> <p>7. Protection To protect residents and employees</p>			
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	<p>from harm or regulation during investigations, the facility shall, take promptly measures to remove any resident from immediate harm or danger. The facility shall take reasonable measure to separate residents involved in alleged or witnessed Resident to Resident abuse...</p> <p>6 (sic). Reporting Additionally, the facility requires that employees immediately report the facts of known or suspected instances of abuse and all allegations of abuse and suspicions of crime immediately to the facility Administrator (either directly or anonymously) so that facility's responsibility to protect residents and promptly investigate occurrences can be met. Failure to report in the required time frames may result in disciplinary action, including termination.</p> <p>The facility Administrator, or designee, will immediately, or as soon as practically possible with 24 hours of receiving an allegation or forming a suspicion, report the instance of abuse, neglect, or misappropriation of resident property to the local ombudsman or local law enforcement agency and to the Department of Health Services (or</p>			
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	<p>appropriate State Agency) as required by law. The facility Administrator, or designee, shall report the findings of the internal investigation to officials in accordance with state law, including to the state survey and certification agency, within five working days of the incident...."</p> <p>The immediate jeopardy that began on 3/11/14 at was removed on 3/12/14 when the facility placed Resident#8 on 1:1 care supervision by nursing staff, completed interviews of alert and oriented residents, and began all staff inservicing on the facility abuse policy. The noncompliance remained at the lower scope and severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy because of ongoing staff training, resident education and family education on the abuse policy and procedure.</p> <p>3.1-28(a)</p>				

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F000325 SS=D	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on interview and record review, the facility failed to promptly address an initial recorded weight loss of 37.5 pounds for 1 of 3 residents reviewed for weight loss (Resident #47).</p> <p>Findings include:</p> <p>The clinical record of Resident #47 was reviewed on 3/10/14 at 9:00 a.m. Resident was admitted to the facility on 9/25/13, for rehabilitation post stroke.</p> <p>Diagnoses included, but were not limited to, diabetes, high blood pressure, obesity, schizoaffective disorder, chronic obstructive pulmonary disease and stroke.</p> <p>The weight entered in the facility electronic record, dated 9/25/13, indicated Resident #47's weight was 273.5 pounds.</p>	F000325	<p>F325 MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <ul style="list-style-type: none"> · Resident # 47 no longer resides in the facility · Any resident who is to be weighed on a daily, weekly, or monthly basis has the potential to be effected by this alleged deficient practice. Those residents currently on a daily or weekly weight records have been reviewed and if any discrepancies were found the physician has been notified. · Accunurse (computer system) will be observed daily Monday through Friday by the Director of Nursing or designee to ensure the weights have been entered into the computer and proper protocol has been followed if abnormal weights have been flagged. · Daily and weekly weights will be audited by the Director of Nursing or designee 3 times a week for 4 weeks, then 2 times a week for 4 weeks, then once a week for 4 weeks, and once a month 	04/07/2014
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	<p>A weekly weight entered in the electronic record on 10/1/13 at 7:00 a.m., indicated her weight was 236 pounds. This was a 37.5 pound weight loss.</p> <p>A Dietary Screening and Assessment, dated 10/2/13, indicated the Resident's weight was 273.5 pounds on 9/25/13. The weight of 236 pounds, on 10/1/13, was not acknowledged and the loss of 37.5 pounds was not address.</p> <p>An Interdisciplinary Assessment and Progress note, dated 10/2/13, indicated Resident #47 thought the food was good and her weight was 273.5 pounds. The weight of 236.4 pounds on 10/1/13, and a weigh loss of 37.5 pounds was not addressed.</p> <p>Resident #47 was admitted to the hospital on 10/7/13. Her weight when readmitted to the facility on 10/9/13, was electronically recorded as 263.8 pounds.</p> <p>An Interdisciplinary Assessment and Progress note, dated 10/11/13, did not address Resident #47's weight loss.</p> <p>During an interview with the Director</p>		<p>thereafter. Non compliance will be addressed through re-education and progressive disciplinary actions as indicated. Results of audits will be reviewed monthly in QA&A for 6 months and quarterly with subsequent plan development and implementation as appropriate.</p>		

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	<p>of Nursing on 3/13/14 at 10:30 a.m., she indicated the resident's weight was 250 pounds on admission not 273.5 pounds. The system did trigger an alert for weight loss on 10/1/13, when the resident's weight was found to be 236.4 pounds. A 13.5 pound weight loss and not a 37.5 pound weight loss. She was not able to find the date physician was notified of the weight loss but the electronic data indicated the issue was resolved on 10/6/13. This was 5 days before the weight loss was addressed. The resident was started on a dietary supplement upon her return to the facility on 10/9/13.</p> <p>A policy and Procedure, dated 2006, received from the Director of Nursing, on 3/11/14, indicated the following:</p> <p>"...Notify the charge nurse or physician of all weight changes of five pounds (or 5%) or ;more in a 30-day period or ten percent in a 180-day or per state requirement...."</p> <p>An Interact, Change in Condition guide, dated 2003, and received from the Director of Nursing on 3/13/14 at 1:30 p.m., indicated for a weight loss of greater than 5% in 1 month "Notify the attending or on- call MD...no later than the next regular visit or phone or</p>				

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	fax communication." 3.1-46(a)(1)			
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F000465 SS=E	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview the facility failed to maintain residents rooms, (210, 212, 214,216, 409, 410, 412, 413, 416, 508, 512, 513, 515, 517, 519) and common areas, in a clean orderly state of good repair for 3 of 3 facility hallways.</p> <p>Findings include:</p> <p>During an environmental tour on 3/6/14 at 1:45 p.m., accompanied by the Maintenance Manager and the Housekeeping Manager, the following were observed:</p> <p>West wing:</p> <p>a) Activities room door was marred and chipped on the bottom one third of the door.</p> <p>b) The beauty shop door had a plastic guard on the bottom half of the door that was streaked and smeared with a white substance.</p> <p>c) Clean utility room door was chipped and marred on the lower half of the door.</p>	F000465	<p>F465 SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT</p> <ul style="list-style-type: none"> · All identified areas were corrected by the maintenance staff in order to meet the regulation of maintaining resident rooms and common areas in clean and orderly state of good repair. · Any resident who lives in the facility has the potential to be effected by this alleged practice. · The Executive Director and Maintenance Supervisor completed an audit of the resident care areas and common areas to identify areas that were not in good repair. Maintenance Supervisor will develop a monthly schedule of painting door frames twice a month and staining doors one time per month. Any chipped doors will be repaired during the door staining process. · An audit will be completed by the Housekeeping and Laundry Supervisor to identify areas of concern. Those will be relayed to the Maintenance Supervisor to repair with in that week. Audits will continue weekly times four weeks, twice monthly times 2 months and monthly times 3 months. Non-compliance will be addressed through re-education and 	04/07/2014
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	<p>d) laundry room door and door jam was marred and chipped</p> <p>e) room 508, entry door was chipped and marred, lower half of the door</p> <p>f) room 512, entry door was marred, lower half of the door</p> <p>g) room 513, entry door was marred, lower half of the door</p> <p>h) room 515, entry door was marred, lower half of the door</p> <p>i) room 517, entry door was marred, lower half of the door, bathroom door marred</p> <p>j) room 519, entry door was marred, lower half of the door</p> <p>Dementia Unit (700 hall)</p> <p>a) shower hallway entry door was marred and chipped</p> <p>Main Dining Room</p> <p>a) cabinets doors and Formica on the west wall were marred and chipped.</p> <p>East Wing</p>		<p>progressive disciplinary actions as indicated. Results of all audits will be reviewed monthly in QA&A for 6 months and quarterly with subsequent plan development and implementation as appropriate.</p>	

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	<p>a) laundry room door was chipped and marred</p> <p>b) Nursing Service door was chipped and marred</p> <p>c) hallway door of room 416 had large chip at the 2.5 foot level that had jagged edges, large marred areas on the lower half of the door.</p> <p>d) door to supply storage marred</p> <p>e) bathroom doors between 212/210 marred, entry door to room 212 marred</p> <p>f), bathroom door between 214/216, marred</p> <p>g) entry door room 409, marred</p> <p>h) bathroom door 410 marred</p> <p>i) entry door 412 marred</p> <p>j) entry door 413 marred</p> <p>During the environmental tour on with Maintenance Manager and Housekeeping Manager, they indicated rooms were totally cleaned and repainted at the time residents leave the facility and a new resident</p>			
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	<p>is being admitted. They indicated other rooms were done on a rotating basis.</p> <p>During an interview with the Executive Director (ED) on 3/14/14 at 9:30 a.m., he indicated he was not aware of the doors and the large chipped surfaces on the door of room 416. He was not aware of the coated plastic area on the beauty shop door.</p> <p>3.1-19(f)</p>			
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F000520 SS=F	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on interviews, observations, and record reviews, the facility failed to identify and implement a plan of action related to environmental issues and resident to resident ongoing abuse allegations. This deficit practice had the potential to impact 76 of 76 residents residing in the facility.</p> <p>Findings include:</p>	F000520	<p>THE FACILITY DISPUTES THE VALIDITY OF THE FINDING OUTLINED IN F520. WE HAVE ISSUED A REQUEST FOR AN INFORMAL DESPUTE RESOLUTION HEARING.F520 QAA COMMITTEE-MEMBERS/MEET QUARTERLY /PLANS · All residents who are affected will have the ability to provide input to the issues with in the facility by involvement in resident counsel and / or participation with the resident interviews conducted.</p>	04/07/2014	

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	<p>During a 3/14/14, 1:30 p.m., interview , the Administrator was queried regarding the Quality Assurance Committee (QAA), and the identified concerns of the survey team. The Administrator indicated the following:</p> <p>Care areas such as specific environmental issues and specific abuse allegations were not specifically reviewed by QAA on any schedule. A concern in those areas would be identified by the Interdisciplinary Team and brought to QAA as a concern.</p> <p>The Administrator indicated the QAA committee had not identified a concern on the internal environment and resident to resident abuse investigations, and they had not developed a plan of action in these areas.</p> <p>3.1-52(b)(2)</p>		<p>Those that are not interviewable, families were contacted from input. · All residents were affected. · The Executive Director will utilize the QIS interview form to interview each resident or family member. Once completed these forms will be processed utilizing key leadership team to develop Quality action teams to plan for problem resolution. The Executive Director will utilize the Resident Council to help brainstorm resolution to problems. All areas of concern will be taken through next QAA committee and placed on the agenda. · Interviews will be conducted monthly times 3, and quarterly there after. All interviews will be reviewed weekly in meeting with key leadership team and Quality Action Steps will begin at that meeting. Non-compliance will be addressed through re-education and progressive disciplinary actions as indicated. Results of all interviews will be reviewed monthly in Resident Counsel and in QA&A monthly with subsequent plan development and implementation as appropriate.</p> <p>F 520 (F): 42 C.F.R. § 483.75(o) (1)—QAA Committee-Members/Meet Quarterly/Plans</p> <p><i>A facility must maintain a quality assessment and assurance committee consisting of the director of</i></p>		

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			<p>nursing services; a physician designated by the facility; and at least w3 other members of the facility's staff.</p> <p>In order to comply with F 520, the facility must maintain a quality assessment and assurance committee consisting of specific members, meet at least quarterly, and make good faith efforts to identify and correct quality deficiencies. The 2567 alleges that this requirement was not met at Clinton House purely based on issues identified by the surveyors. The requirements of F-520 were clearly met. The regulation requires a facility to have a quarterly Quality Assurance meeting with the appropriate individuals in attendance, take minutes, and develop action plans based on identified areas of concern. There is no documented evidence, in the 2567 or elsewhere, to support that such a meeting was not occurring per regulation. The facility had not received any deficiencies on the 2013 survey in these two areas, so all QA monitoring was based on internally-identified processes and outcomes.</p> <p>It is not an appropriate application of F-520 regulation to determine non-compliance when surveyor-identified issues are not referenced in Quality Assessment and Assurance Committee minutes. The requirement is for the committee to make good-faith</p>	

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			<p>efforts and identify quality issues. Facilities are not expected to identify the exact same issues as the surveyors. The two specific examples provided are not "repeat issues" and were not previously cited by the department within the past year.</p> <p>Our facility has an ongoing quality assessment and assurance committee that includes all the designated members as required. This committee meets no less often than quarterly and takes good-faith measures to identify, remediate, and monitor actual or potential quality deviations. Our Executive Director contends the surveyors never asked for our Quality Assurance policy. We've attached a copy for your reference [Attachment #9].</p> <p>The facility had absolutely no Resident or family complaints on environmental issues or resident to resident ongoing abuse allegations to warrant Quality Assurance review. Additionally, the facility was actively in the midst of a preliminary investigation into the behavior management issues and had not yet reached the root-cause to be addressed by the committee. The issues specifically cited in F-223, 225, and 226; were more appropriately behavior management issues and the Executive Director did inform the</p>	

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			<p>team leader that the QQA Committee was actively working on Quality Improvement Action Plan in this area. These issues were newly identified during March, and therefore would have expectedly been addressed during the next scheduled quarterly meeting.</p> <p>Clinton House defined and implemented good faith quality assessment activities and took adequate measures to remediate self-identified issues. The 2567 does not indicate that the facility failed to have quarterly meetings, develop action plans, or communicate those plans to the staff. Accordingly, there was no deficient practice under F-520, and this deficiency should be dismissed.</p> <p>Thank you for your consideration of the information contained in this letter and its exhibits. We look forward to discussing these issues with you at a face-to-face meeting.</p>	