

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155714	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/23/2014
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NAME OF PROVIDER OR SUPPLIER OAK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 200 W FOURTH ST OAKTOWN, IN 47561
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F000000	<p>This visit was for the Investigation of Complaint IN00149399 and Complaint IN00149463. This visit resulted in a partially extended survey - Immediate Jeopardy.</p> <p>Complaint IN00149399- Substantiated, no deficiencies related to the allegations are cited.</p> <p>Complaint IN00149463 - Substantiated, Federal/State deficiencies related to the allegations are cited at F223, F225, and F226.</p> <p>Survey dates: May 20 and 21, 2014</p> <p>Extended survey dates: May 22 and 23, 2014</p> <p>Facility number: 000517 Provider number: 155714 AIM number: 100266770</p> <p>Survey team: Anne Marie Crays RN</p> <p>Census bed type: SNF/NF: 26 Total: 26</p>	F000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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F000223 SS=J	<p>Census payor type: Medicare: 8 Medicaid: 13 Other: 5 Total: 26</p> <p>Sample: 5 Extended sample: 3</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on May 27, 2014 by Jodi Meyer, RN</p> <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 observation, interview, and record review, the facility failed to ensure a resident was free from sexual abuse, for 1 of 7 residents reviewed for abuse, in a sample of 8. (Resident D)</p> <p>This deficient practice resulted in Immediate Jeopardy. The Immediate Jeopardy was identified on 5/21/14 and</p>	F000223	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations.	05/23/2014

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	<p>began on 5/19/14. The Administrator was notified of the Immediate Jeopardy at 2:38 P.M. on 5/21/14. The Immediate Jeopardy was removed on 5/23/14, but the facility remained out of compliance at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy, because all staff had not been re-inserviced on the policy of abuse and where the posted numbers of administrative staff were located.</p> <p>Findings include:</p> <p>1. On 5/20/14 at 3:30 P.M., the clinical record of Resident D was reviewed. Diagnoses included, but were not limited to, mental retardation, dementia, and schizophrenia.</p> <p>An admission Minimum Data Set (MDS) assessment, dated 4/24/14, indicated the resident had no speech, was rarely/never understood, and rarely/never understands others. The MDS assessment indicated the resident was unable to perform a brief interview for mental status, and was severely impaired in cognitive skills for daily decision making. The resident was totally dependent on two+ staff for bed mobility, transfer, and personal hygiene.</p> <p>Nurse's Notes included the following</p>		<p>The facility request the plan of correctionbe considered our allegation of compliance May 23, 2014 to the state findings ofthe complaint survey conducted on May 20, 21, 22 and 23, 2014</p> <p>F – 223</p> <p>The corrective action takenfor those residents found to have been affected by the deficient practice is thatupon the administrator receivingnotification of the allegation of abuse, the alleged abuser was immediately removedfrom the facility and removed from the work schedule. The resident identified as resident D is receivingcare and services, free of any type of abuse and displays no signs and symptomsof distress.</p> <p><i>The corrective action taken for the other residentshaving the potential to be affected by the same deficient practice is that all residents have the potential to be affectedby this deficient practice. Upon the Administrator receiving notification ofthe allegation of abuse, the alleged abuser was removed from the facility</i></p>				

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	<p>notations:</p> <p>5/19/14 at 7:15 A.M.: "DON [Director of Nursing] called facility said she had talked [with] [physician name] on an allegation of sexual abuse and has an order to send resident to [hospital name] ER to have rape kit used...."</p> <p>5/19/14 at 8:00 A.M.: "[Ambulance service] here to take resident per stretcher to [hospital name] sent staff member [with] resident."</p> <p>5/19/14 at 8:45 A.M. "L.E. [late entry] for 5-19-14 @ 0555 [5:55 A.M.]. Rc'd [received] call @ home per [CNA # 1], who informed DON that night nurse [LPN # 1] was acting in an inappropriate manner in res. [resident] room this a.m...."</p> <p>5/19/14 at 3:00 P.M.: "Res. returned from [hospital] @ this x [time]...."</p> <p>On 5/20/14 at 12:40 P.M., the Administrator provided an "Indiana State Department of Health Incident Report Form," dated 5/19/14. The form included: "Incident Date: 5-19-14, Incident Time: 2:05 A.M., Resident Name: [Resident D]...Diagnosis: Mental Retardation, Dementia, Schizophrenia, Staff Involved: Staff Name [LPN # 1], Staff Name:</p>		<p>and removed from the work schedule. On 05-19-14 the social service director interviewed all interviewable residents related to any allegations of verbal, physical, emotional and sexual abuse.</p> <p>No allegations of any type of abuse were reported by these residents. In addition all non-interviewable female residents had physical assessments completed by the director of nursing along with the day shift charge nurse. Upon completion of these assessments there were no suspicious bruises or bruises of unknown origin.</p> <p>The measures that have been put into place to ensure that the deficient practice does not recur is that as a continuing facility practice, all prospective employees will have references checked, background checks completed and licensure/certification checks completed prior to employment. The facility has reviewed its policy and procedure on abuse and found it to meet all State and Federal guidelines. The facility has also posted the Administrator and other key administrative staffs' phone</p>				

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	[CNA # 1], Brief Description of Incident: "6am - I received a call from [CNA # 1] (Night Shift CNA) stating that he took a smoke break at 2 am on Monday 19th and got back at 2:05 am. He then reported to [Resident D's] room. The door was shut and he proceeded to knock twice and enter the room to see if [LPN # 1] (Night Shift LPN) needed assistance. When he entered the room the privacy curtain was pulled to block the foot of the bed but the blinds were open and [CNA # 1] reported to have witnessed [LPN # 1] pull his pants up really fast through the reflection of the glass window. [CNA # 1] continued around the privacy curtain and found [LPN # 1] positioning a pillow under [Resident D]. When he stood up his shirt was tucked in the front of his pants. [Resident D] was positioned on her left side facing the wall with her night gown half on ([Resident D] is known for coming out of her clothes). Her bottom was uncovered or exposed facing [LPN # 1]. [CNA # 1] asked [LPN # 1] what he was doing. [LPN # 1] said he was cleaning her peg tube. [LPN # 1] then went to the bathroom to wash hands while [CNA # 1] covered up [Resident D] and lowered her bed. They then exited the room. [LPN # 1] became shaky and started following [CNA # 1] around consistently asking him what he was doing. [CNA # 1] attempted to call the		numbers throughout the facility for easy access for employees to immediately report all allegations of abuse. The facility has conducted a mandatory in-service for all employees on the facility abuse policy. The Elder Justice Act and the posting of the Administrator and other Administrative staffs' phone numbers for the employees' convenience immediately reporting all allegations of abuse. All staff was directed that any and all suspicious acts and/or allegations of abuse are to be immediately reported to the Administrator. <i>The corrective action taken to monitor to assure compliance is that a Quality Assurance tool has been developed and implemented to monitor the compliance of the facility abuse reporting system to ensure that all employees have the knowledge and are reporting any and all allegations of abuse immediately to the Administrator. This tool will be completed by the Administrator and/or his designee weekly for four weeks, then monthly for three</i>		

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	<p>Administrator and DNS [Director of Nursing Services] but felt intimidated by [LPN # 1's] size. [CNA # 1] reported that he in-turn started following [LPN # 1] around to keep an eye on him. [CNA # 1] left the facility once day shift reported to duty around 6 a.m. This is when [CNA # 1] called the Administrator and the Director of Nursing to report what he allegedly saw...."</p> <p>On 5/20/14 at 12:45 P.M., CNA # 1 was interviewed. CNA # 1 indicated he was working the night shift with LPN # 1. CNA # 1 indicated there was usually 1 nurse and 1 CNA who worked night shift. He indicated he had stepped outside for a smoke break, and came back in at approximately 2:05 A.M. He indicated he saw Resident D's door shut, and so he knocked and then walked in. He indicated the privacy curtain was pulled, but he could see the reflection in the window of LPN # 1 pulling his pants up "real quick." He indicated LPN # 1 had pulled up his pants so quickly that his shirt was still tucked part way in his pants. CNA # 1 indicated the resident was lying on her side, with her bare bottom exposed and her gown up around her neck. He indicated this was not unusual, as the resident did not sleep with a brief on, and she frequently tried to remove her gowns. He indicated he asked</p>		<p>months and then quarterly for three quarters. This tool will include the monitoring of allshifts. The outcomes will be reviewedthrough the facility Quality Assurance Program. Additional action will be taken by the Quality Assurance Committee ifwarranted.</p>				

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	<p>LPN # 1, "What are you doing?" and LPN # 1 responded that he was fixing the resident's peg tube. He indicated LPN # 1 "got real shaky." CNA # 1 indicated he called the Administrator and the DON when he got off work at 6:00 A.M.</p> <p>On 5/21/14 at 9:45 A.M., hospital RN # 2 was interviewed. She indicated she was the "SANE" [Sexual Assault Nurse Examiner] who examined Resident D on 5/19/14. She indicated she performed several swabs of the resident's genital area, which were pink-tinged, and which would "indicate possible blood." RN # 2 indicated her exam revealed 2 lacerations in the "vaginal vault." RN # 2 indicated there was no other reason besides penetration that would have caused those lacerations.</p> <p>An Emergency Department record was reviewed at that time. The record, dated 5/19/14 at 9:00 A.M., indicated, "Neglect/Abuse...Exam of the perineum between anus and vagina reveals noted small amount of bright red blood. Superficial vaginal tear approximately 0.5 cm [centimeters] affected area is located at approximately 4 O'clock. Second superficial vaginal tear approximately 0.5 cm noted at 9 O'clock...Scant amount of blood noted in vaginal vault...."</p>			

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	<p>On 5/21/14 at 11:30 A.M., the DON was interviewed. She indicated she received a call on 5/19/14 from CNA # 1 at approximately 6:00 A.M. She indicated CNA # 1 informed her that he had something to tell her; that he had gone out for a smoke break, and when he came back in, he saw Resident D's door closed. He informed the DON he knocked, then pushed the door open, and saw a reflection in the mirror of [LPN # 1] pulling up his pants real fast. He indicated he thought LPN # 1 "was doing something to [Resident D]." The DON indicated she asked CNA # 1 when this happened, and he at first responded around 3:00 A.M, but then changed the time to 2:00 A.M.</p> <p>On 5/21/14 at 12:10 P.M., CNA # 2 was interviewed. He indicated he started work at 5:00 A.M. on 5/19/14. He indicated CNA # 1 "looked really upset." He indicated he finally asked CNA # 1 what was wrong, and CNA # 1 told him he had gone out for a smoke break, and when he came back in at approximately 2:00 A.M., he saw Resident D's door closed. He indicated he went inside and saw a reflection in the window of LPN # 1 pulling up his pants really fast. CNA # 1 told him that LPN # 1 got "overly nervous" and red-faced. CNA # 2</p>			

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	<p>indicated CNA # 1 was "visibly shaken and scared." CNA # 2 indicated he told CNA # 1 that he needed to call the DON "right now." CNA # 2 indicated he thought LPN # 1 "was acting strange, almost babbling," and talking to himself. CNA # 2 indicated CNA # 1 left the facility at that time, and called the Administrator and DON.</p> <p>2. On 5/20/14 at 12:15 P.M., the Administrator provided the current facility policy on "Resident Abuse Policy and Procedure," undated. The policy included: "...Purpose: To ensure that all employees, residents, family members, consultants, physicians, and visitors are aware that mistreatment, neglect, and abuse of residents...is strictly forbidden by this facility. Definitions: 1. Abuse: The willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish...3. Sexual Abuse: Includes, but is not limited to sexual harassment, sexual coercion or sexual assault...."</p> <p>An Immediate Jeopardy was identified on 5/21/14. The Immediate Jeopardy began on 5/19/14 when staff who witnessed alleged sexual abuse did not immediately notify the Administrator. The Administrator was notified at 2:38 P.M.</p>			

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	<p>on 5/21/14 of the Immediate Jeopardy related to failure to immediately notify the Administrator of the alleged abuse, which allowed the alleged staff member to continue to work in the facility for approximately 4 additional hours. The Immediate Jeopardy was removed on 5/23/14 when through observations, interviews, and record reviews, it was determined the facility had implemented the plan of action to remove the Immediate Jeopardy and that the steps taken removed the immediacy of the problem. The facility suspended LPN # 1, reinserviced staff on the abuse policy, and posted the Administrator's phone number, along with other administrative staff, in different locations throughout the facility. Staff verbalized knowledge of the abuse prohibition policy, including immediately notifying the Administrator of suspected abuse. Even though the facility's corrective actions removed the Immediate Jeopardy, the facility remained out of compliance at a reduced scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy.</p> <p>This Federal tag relates to Complaint IN00149463.</p> <p>3.1-27(a)(1)</p>						

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F000225 SS=L	<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>			

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	<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 observation, interview, and record review, the facility failed to ensure the Administrator was immediately notified of alleged sexual abuse, for 1 of 7 residents reviewed for abuse, in a sample of 8. (Resident D) This deficient practice had the potential to affect 26 of 26 residents residing in the facility who were at risk being abused by the accused staff member (LPN # 1).</p> <p>This deficient practice resulted in Immediate Jeopardy. The Immediate Jeopardy was identified on 5/21/14 and began on 5/19/14. The Administrator was notified of the Immediate Jeopardy at 2:38 P.M. on 5/21/14. The Immediate Jeopardy was removed on 5/23/14, but the facility remained out of compliance at the lower scope and severity level of widespread, no actual harm with potential for more than minimal harm that is not immediate jeopardy, because all staff had not been re-inserviced on the policy of abuse and where the posted numbers of administrative staff were located.</p>	F000225	<p>By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request the plan of correction be considered our allegation of compliance May 23, 2014 to the state findings of the complaint survey conducted on May 20, 21, 22 and 23, 2014 F - 225</p> <p>The corrective action taken for those residents found to have been affected by the deficient practice is that upon the administrator receiving notification of the allegation of abuse, the alleged abuser was immediately removed from the facility and removed from the work schedule. The staff</p>	05/23/2014			

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	<p>Findings include:</p> <p>1. On 5/20/14 at 3:30 P.M., the clinical record of Resident D was reviewed. Diagnoses included, but were not limited to, mental retardation, dementia, and schizophrenia.</p> <p>An admission Minimum Data Set (MDS) assessment, dated 4/24/14, indicated the resident had no speech, was rarely/never understood, and rarely/never understands others. The MDS assessment indicated the resident was unable to perform a brief interview for mental status, and was severely impaired in cognitive skills for daily decision making. The resident was totally dependent on two+ staff for bed mobility, transfer, and personal hygiene.</p> <p>On 5/20/14 at 12:40 P.M., the Administrator provided an "Indiana State Department of Health Incident Report Form," dated 5/19/14. The form included: "Incident Date: 5-19-14, Incident Time: 2:05 A.M., Resident Name: [Resident D]...Diagnosis: Mental Retardation, Dementia, Schizophrenia, Staff Involved: Staff Name [LPN # 1], Staff Name: [CNA # 1], Brief Description of Incident: "6am - I received a call from [CNA # 1] (Night Shift CNA) stating that he took a smoke break at 2 am on Monday 19th</p>		<p>member who failed to immediately notify the Administrator of the allegation of abuse (CNA #1) received one on one re-education on the facility abuse policy and procedure by the Administrator on the day 05-19-14 that the allegation was reported.</p> <p><i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that all residents have the potential to be affected by the deficient practice. All interviewable residents were interviewed related to allegations of all types of abuse and no additional allegations were reported. All non-interviewable female residents were physically assessed for any suspicious bruises or bruises of unknown origin and none were found. The measures that have been put into place to ensure that the deficient practice does not recur is that The facility has reviewed it policy and procedure on abuse and found it to meet all State and Federal guidelines. The facility has also posted the Administrator</i></p>				

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	and got back at 2:05 am. He then reported to [Resident D's] room. The door was shut and he proceeded to knock twice and enter the room to see if [LPN # 1] (Night Shift LPN) needed assistance. When he entered the room the privacy curtain was pulled to block the foot of the bed but the blinds were open and [CNA # 1] reported to have witnessed [LPN # 1] pull his pants up really fast through the reflection of the glass window. [CNA # 1] continued around the privacy curtain and found [LPN # 1] positioning a pillow under [Resident D]. When he stood up his shirt was tucked in the front of his pants. [Resident D] was positioned on her left side facing the wall with her night gown half on ([Resident D] is known for coming out of her clothes). Her bottom was uncovered or exposed facing [LPN # 1]. [CNA # 1] asked [LPN # 1] what he was doing. [LPN # 1] said he was cleaning her peg tube. [LPN # 1] then went to the bathroom to wash hands while [CNA # 1] covered up [Resident D] and lowered her bed. They then exited the room. [LPN # 1] became shaky and started following [CNA # 1] around consistently asking him what he was doing. [CNA # 1] attempted to call the Administrator and DNS [Director of Nursing Services] but felt intimidated by [LPN # 1's] size. [CNA # 1] reported that he in-turn started following [LPN # 1]		and other key administrative staffs' phone numbers throughout the facility for easy access for employees to immediately report all allegations of abuse. The facility has conducted a mandatory in-service for all employees on the facility abuse policy. The Elder Justice Act and the posting of the Administrator and other Administrative staffs' phone numbers are posted for the employees' convenience in immediately reporting all allegations of abuse. All staff was directed that any and all suspicious acts and/or allegations of abuse are to be immediately reported to the Administrator. The facility annually conducts and will continue to conduct an all staff mandatory in-service on the facility abuse policy and procedure. In addition the facility will annually conduct an all staff mandatory in-service on the Elder Justice Act. <i>The corrective action taken to monitor to assure compliance is that a Quality Assurance tool has been developed and implemented to monitor the compliance of the facility abuse reporting system to</i>				

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	<p>around to keep an eye on him. [CNA # 1] left the facility once day shift reported to duty around 6 a.m. This is when [CNA # 1] called the Administrator and the Director of Nursing to report what he allegedly saw. Administrator [name] and DNS [name] educated [CNA # 1] on the importance of reporting allegations of abuse or neglect immediately...."</p> <p>On 5/20/14 at 12:45 P.M., CNA # 1 was interviewed. CNA # 1 indicated he was working the night shift with LPN # 1. CNA # 1 indicated there was usually 1 nurse and 1 CNA who worked night shift. He indicated he had stepped outside for a smoke break, and came back in at approximately 2:05 A.M. He indicated he saw Resident D's door shut, and so he knocked and then walked in. He indicated the privacy curtain was pulled, but he could see the reflection in the window of LPN # 1 pulling his pants up "real quick." He indicated LPN # 1 had pulled up his pants so quickly that his shirt was still tucked part way in his pants. CNA # 1 indicated the resident was lying on her side, with her bare bottom exposed and her gown up around her neck. He indicated this was not unusual, as the resident did not sleep with a brief on, and she frequently tried to remove her gowns. He indicated he asked LPN # 1, "What are you doing?" and</p>		<p>ensure that all employees have the knowledge and are reporting any and all allegations of abuse immediately to the Administrator. This tool will be completed by the Administrator and/or his designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. This tool will include the monitoring of all shifts. The outcomes will be reviewed through the facility Quality Assurance Program. Additional action will be taken by the Quality Assurance Committee if warranted.</p>	

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	<p>LPN # 1 responded that he was fixing the resident's peg tube. He indicated LPN # 1 "got real shaky." CNA # 1 indicated he called the Administrator and the Director of Nursing (DON) when he got off work at 6:00 A.M. He indicated he knew he should have called the Administrator and the DON immediately, but that he had to find their numbers, and that LPN # 1 kept watching him.</p> <p>On 5/20/14 at 4:00 P.M., the Administrator was interviewed. He indicated he received a phone call at approximately 6:00 A.M. from CNA # 1. CNA # 1 informed him of what he witnessed at approximately 2:00 A.M. The Administrator indicated he immediately counseled CNA # 1 that he should have called him immediately.</p> <p>On 5/21/14 at 9:45 A.M., hospital RN # 2 was interviewed. She indicated she was the "SANE" [Sexual Assault Nurse Examiner] who examined Resident D on 5/19/14. She indicated she performed several swabs of the resident's genital area, which were pink-tinged, and which would "indicate possible blood." RN # 2 indicated her exam revealed 2 lacerations in the "vaginal vault." RN # 2 indicated there was no other reason besides penetration that would have caused those lacerations.</p>			

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	<p>An Emergency Department record was reviewed at that time. The record, dated 5/19/14 at 9:00 A.M., indicated, "Neglect/Abuse...Exam of the perineum between anus and vagina reveals noted small amount of bright red blood. Superficial vaginal tear approximately 0.5 cm [centimeters] affected area is located at approximately 4 O'clock. Second superficial vaginal tear approximately 0.5 cm noted at 9 O'clock...Scant amount of blood noted in vaginal vault...."</p> <p>On 5/21/14 at 11:30 A.M., the DON was interviewed. She indicated she received a call on 5/19/14 from CNA # 1 at approximately 6:00 A.M. She indicated CNA # 1 informed her that he had something to tell her; that he had gone out for a smoke break, and when he came back in, he saw Resident D's door closed. He informed the DON he knocked, then pushed the door open, and saw a reflection in the mirror of [LPN # 1] pulling up his pants real fast. He indicated he thought LPN # 1 "was doing something to [Resident D]." The DON indicated she asked CNA # 1 when this happened, and he at first responded around 3:00 A.M, but then changed the time to 2:00 A.M. She indicated she immediately asked the CNA if he had</p>			

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	<p>informed the Administrator, and he indicated he had not. The DON indicated she told CNA # 1 he needed to call the Administrator right then, and she also contacted the Administrator. The DON indicated she called the facility, and LPN # 1 was giving LPN # 2 an end-of-shift report. The DON indicated she told LPN # 1 he needed to leave the facility immediately.</p> <p>2. On 5/20/14 at 12:15 P.M., the Administrator provided the current facility policy on "Resident Abuse Policy and Procedure," undated. The policy included: "...Purpose: To ensure that all employees, residents, family members, consultants, physicians, and visitors are aware that mistreatment, neglect, and abuse of residents...is strictly forbidden by this facility. Definitions: 1. Abuse: The willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish...3. Sexual Abuse: Includes, but is not limited to sexual harassment, sexual coercion or sexual assault...Procedure of Investigation Allegiations [sic] of Abuse:...2. Staff members of this facility who have concerns regarding abuse, neglect...are to report their concerns immediately to the charge nurse. The charge nurse will immediately notify</p>			

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	<p>Administrator and Director of Nursing...7. If the alleged concern involves the charge nurse, the allegations will be immediately reported to the Administrator, Director of Nursing and/or Social Services...."</p> <p>An Immediate Jeopardy was identified on 5/21/14. The Immediate Jeopardy began on 5/19/14 when staff who witnessed alleged sexual abuse did not immediately notify the Administrator. The Administrator was notified at 2:38 P.M. on 5/21/14 of the Immediate Jeopardy related to failure to immediately notify the Administrator of the alleged abuse, which allowed the alleged staff member to continue to work in the facility for approximately 4 additional hours. The Immediate Jeopardy was removed on 5/23/14 when through observations, interviews, and record reviews, it was determined the facility had implemented the plan of action to remove the Immediate Jeopardy and that the steps taken removed the immediacy of the problem. The facility suspended LPN # 1, reinserviced staff on the abuse policy, and posted the Administrator's phone number, along with other administrative staff, in different locations throughout the facility. Staff verbalized knowledge of the abuse prohibition policy, including immediately notifying the Administrator</p>			

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F000226 SS=L	<p>of suspected abuse. Even though the facility's corrective actions removed the Immediate Jeopardy, the facility remained out of compliance at a reduced scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy.</p> <p>This Federal tag relates to Complaint IN00149463.</p> <p>3.1-28(c)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on observation, interview, and record review, the facility failed to implement their policy to ensure the Administrator was immediately notified of alleged sexual abuse, for 1 of 7</p>	F000226	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or	05/23/2014

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	<p>residents reviewed for abuse, in a sample of 8. (Resident D) This deficient practice had the potential to affect 26 of 26 residents residing in the facility who were at risk being abused by the accused staff member (LPN # 1).</p> <p>This deficient practice resulted in Immediate Jeopardy. The Immediate Jeopardy was identified on 5/21/14 and began on 5/19/14. The Administrator was notified of the Immediate Jeopardy at 2:38 P.M. on 5/21/14. The Immediate Jeopardy was removed on 5/23/14, but the facility remained out of compliance at the lower scope and severity level of widespread, no actual harm with potential for more than minimal harm that is not immediate jeopardy, because all staff had not been re-inserviced on the policy of abuse and where the posted numbers of administrative staff were located.</p> <p>Findings include:</p> <p>1. On 5/20/14 at 3:30 P.M., the clinical record of Resident D was reviewed. Diagnoses included, but were not limited to, mental retardation, dementia, and schizophrenia.</p> <p>An admission Minimum Data Set (MDS) assessment, dated 4/24/14, indicated the resident had no speech, was rarely/never</p>		<p>allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request the plan of correction be considered our allegation of compliance May 23, 2014 to the state findings of the complaint survey conducted on May 20, 21, 22 and 23, 2014 F – 226 The corrective action taken for those residents found to have been affected by the deficient practice is that upon the Administrator receiving notification of the allegation of abuse, the resident identified as resident D, received the necessary care and services to protect resident D from abuse. The Administrator immediately removed the alleged abuser from the facility and the workschedule. The Administrator immediately notified all appropriate agencies in accordance with facility policy and procedure as well as in accordance with State and Federal regulations. The Administrator also educated the identified staff member CNA #1 on the importance of immediately notifying the Administrator during the phone conversation when CNA #1 was reporting the allegation of abuse. <i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that all residents have the potential to be</i></p>				

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	<p>understood, and rarely/never understands others. The MDS assessment indicated the resident was unable to perform a brief interview for mental status, and was severely impaired in cognitive skills for daily decision making. The resident was totally dependent on two+ staff for bed mobility, transfer, and personal hygiene.</p> <p>On 5/20/14 at 12:40 P.M., the Administrator provided an "Indiana State Department of Health Incident Report Form," dated 5/19/14. The form included: "Incident Date: 5-19-14, Incident Time: 2:05 A.M., Resident Name: [Resident D]...Diagnosis: Mental Retardation, Dementia, Schizophrenia, Staff Involved: Staff Name [LPN # 1], Staff Name: [CNA # 1], Brief Description of Incident: "6am - I received a call from [CNA # 1] (Night Shift CNA) stating that he took a smoke break at 2 am on Monday 19th and got back at 2:05 am. He then reported to [Resident D's] room. The door was shut and he proceeded to knock twice and enter the room to see if [LPN # 1] (Night Shift LPN) needed assistance. When he entered the room the privacy curtain was pulled to block the foot of the bed but the blinds were open and [CNA # 1] reported to have witnessed [LPN # 1] pull his pants up really fast through the reflection of the glass window. [CNA # 1] continued around the privacy curtain</p>		<p>affected bythis deficient practice. During thephone conversation with staff member identified as CNA #1, when CNA #1 wasinforming the Administrator of the allegation of abuse, the Administratorre-educated CNA #1 on the importance of immediately reporting any and allallegations of abuse to the Administrator. The measures that have beenput into place to ensure that the deficient practice does not recur is that Thefacility has reviewed it policy and procedure on abuse and found it to meet allState and Federal guidelines. Thefacility has also posted the Administrator and other key administrative staffs'phone numbers throughout the facility for easy access for employees toimmediately report all allegations of abuse. The facility has conducted a mandatory in-service for all employees onthe facility abuse policy. The ElderAbuse Act and the posting of the Administrator and other Administrative staffs'phone numbers are posted for the employees' convenience in immediatelyreporting all allegations of abuse. Allstaff was directed that any and all suspicious acts and/or allegations of abuseare to be immediately reported to the Administrator. The facility annually conducts and willcontinue to conduct an all staff mandatory in-service on the facility abusepolicy and procedure. In addition thefacility</p>				

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	<p>and found [LPN # 1] positioning a pillow under [Resident D]. When he stood up his shirt was tucked in the front of his pants. [Resident D] was positioned on her left side facing the wall with her night gown half on ([Resident D] is known for coming out of her clothes). Her bottom was uncovered or exposed facing [LPN # 1]. [CNA # 1] asked [LPN # 1] what he was doing. [LPN # 1] said he was cleaning her peg tube. [LPN # 1] then went to the bathroom to wash hands while [CNA # 1] covered up [Resident D] and lowered her bed. They then exited the room. [LPN # 1] became shaky and started following [CNA # 1] around consistently asking him what he was doing. [CNA # 1] attempted to call the Administrator and DNS [Director of Nursing Services] but felt intimidated by [LPN # 1's] size. [CNA # 1] reported that he in-turn started following [LPN # 1] around to keep an eye on him. [CNA # 1] left the facility once day shift reported to duty around 6 a.m. This is when [CNA # 1] called the Administrator and the Director of Nursing to report what he allegedly saw. Administrator [name] and DNS [name] educated [CNA # 1] on the importance of reporting allegations of abuse or neglect immediately...."</p> <p>On 5/20/14 at 12:45 P.M., CNA # 1 was interviewed. CNA # 1 indicated he was</p>		<p>will annually conduct an all staff mandatory in-service on the ElderJustice Act. The facility also is andwill continue to provide education to all residents/responsible parties onabuse and the Elder Justice Act. <i>The corrective action taken to monitor to assurecompliance is that a QualityAssurance tool has been developed and implemented to monitor the compliance ofthe facility abuse reporting system to ensure that all employees have theknowledge and are reporting any and all allegations of abuse immediately to theAdministrator. This tool will becompleted by the Administrator and/or his designee weekly for four weeks, thenmonthly for three months and then quarterly for three quarters. This tool will include the monitoring of allshifts. The outcomes will be reviewedthrough the facility Quality Assurance Program. Additional action will be taken by the Quality Assurance Committee ifwarranted.</i></p>	

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	<p>working the night shift with LPN # 1. CNA # 1 indicated there was usually 1 nurse and 1 CNA who worked night shift. He indicated he had stepped outside for a smoke break, and came back in at approximately 2:05 A.M. He indicated he saw Resident D's door shut, and so he knocked and then walked in. He indicated the privacy curtain was pulled, but he could see the reflection in the window of LPN # 1 pulling his pants up "real quick." He indicated LPN # 1 had pulled up his pants so quickly that his shirt was still tucked part way in his pants. CNA # 1 indicated the resident was lying on her side, with her bare bottom exposed and her gown up around her neck. He indicated this was not unusual, as the resident did not sleep with a brief on, and she frequently tried to remove her gowns. He indicated he asked LPN # 1, "What are you doing?" and LPN # 1 responded that he was fixing the resident's peg tube. He indicated LPN # 1 "got real shaky." CNA # 1 indicated he called the Administrator and the Director of Nursing (DON) when he got off work at 6:00 A.M. He indicated he knew he should have called the Administrator and the DON immediately, but that he had to find their numbers, and that LPN # 1 kept watching him.</p> <p>On 5/20/14 at 4:00 P.M., the</p>			

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	<p>Administrator was interviewed. He indicated he received a phone call at approximately 6:00 A.M. from CNA # 1. CNA # 1 informed him of what he witnessed at approximately 2:00 A.M. The Administrator indicated he immediately counseled CNA # 1 that he should have called him immediately.</p> <p>On 5/21/14 at 9:45 A.M., hospital RN # 2 was interviewed. She indicated she was the "SANE" [Sexual Assault Nurse Examiner] who examined Resident D on 5/19/14. She indicated she performed several swabs of the resident's genital area, which were pink-tinged, and which would "indicate possible blood." RN # 2 indicated her exam revealed 2 lacerations in the "vaginal vault." RN # 2 indicated there was no other reason besides penetration that would have caused those lacerations.</p> <p>An Emergency Department record was reviewed at that time. The record, dated 5/19/14 at 9:00 A.M., indicated, "Neglect/Abuse...Exam of the perineum between anus and vagina reveals noted small amount of bright red blood. Superficial vaginal tear approximately 0.5 cm [centimeters] affected area is located at approximately 4 O'clock. Second superficial vaginal tear approximately 0.5 cm noted at 9</p>			

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NAME OF PROVIDER OR SUPPLIER OAK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 200 W FOURTH ST OAKTOWN, IN 47561
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	<p>O'clock...Scant amount of blood noted in vaginal vault...."</p> <p>On 5/21/14 at 11:30 A.M., the DON was interviewed. She indicated she received a call on 5/19/14 from CNA # 1 at approximately 6:00 A.M. She indicated CNA # 1 informed her that he had something to tell her; that he had gone out for a smoke break, and when he came back in, he saw Resident D's door closed. He informed the DON he knocked, then pushed the door open, and saw a reflection in the mirror of [LPN # 1] pulling up his pants real fast. He indicated he thought LPN # 1 "was doing something to [Resident D]." The DON indicated she asked CNA # 1 when this happened, and he at first responded around 3:00 A.M, but then changed the time to 2:00 A.M. She indicated she immediately asked the CNA if he had informed the Administrator, and he indicated he had not. The DON indicated she told CNA # 1 he needed to call the Administrator right then, and she also contacted the Administrator. The DON indicated she called the facility, and LPN # 1 was giving LPN # 2 an end-of-shift report. The DON indicated she told LPN # 1 he needed to leave the facility immediately.</p> <p>2. On 5/20/14 at 12:15 P.M., the</p>			

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	<p>Administrator provided the current facility policy on "Resident Abuse Policy and Procedure," undated. The policy included: "...Purpose: To ensure that all employees, residents, family members, consultants, physicians, and visitors are aware that mistreatment, neglect, and abuse of residents...is strictly forbidden by this facility. Definitions: 1. Abuse: The willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish...3. Sexual Abuse: Includes, but is not limited to sexual harassment, sexual coercion or sexual assault...Procedure of Investigation Allegiations [sic] of Abuse:...2. Staff members of this facility who have concerns regarding abuse, neglect...are to report their concerns immediately to the charge nurse. The charge nurse will immediately notify Administrator and Director of Nursing...7. If the alleged concern involves the charge nurse, the allegations will be immediately reported to the Administrator, Director of Nursing and/or Social Services...."</p> <p>An Immediate Jeopardy was identified on 5/21/14. The Immediate Jeopardy began on 5/19/14 when staff who witnessed alleged sexual abuse did not immediately notify the Administrator. The</p>				

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	<p>Administrator was notified at 2:38 P.M. on 5/21/14 of the Immediate Jeopardy related to failure to immediately notify the Administrator of the alleged abuse, which allowed the alleged staff member to continue to work in the facility for approximately 4 additional hours. The Immediate Jeopardy was removed on 5/23/14 when through observations, interviews, and record reviews, it was determined the facility had implemented the plan of action to remove the Immediate Jeopardy and that the steps taken removed the immediacy of the problem. The facility suspended LPN # 1, reinserviced staff on the abuse policy, and posted the Administrator's phone number, along with other administrative staff, in different locations throughout the facility. Staff verbalized knowledge of the abuse prohibition policy, including immediately notifying the Administrator of suspected abuse. Even though the facility's corrective actions removed the Immediate Jeopardy, the facility remained out of compliance at a reduced scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy.</p> <p>This Federal tag relates to Complaint IN00149463.</p>			

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