

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155789	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2015
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NAME OF PROVIDER OR SUPPLIER RIDGEWOOD HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 181 CAMPUS DR LAWRENCEBURG, IN 47025
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaints IN00185807, IN00186254, IN00187413, and IN00187417.</p> <p>This visit resulted in a Partially Extended Survey-Substandard Quality of Care-Immediate Jeopardy.</p> <p>Complaint IN00185807 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00186254 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00187413 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00187417 - Substantiated. Federal/State deficiencies related to the allegations are cited at F225 and F226.</p> <p>Survey dates: November 19, 20 and 23, 2015</p> <p>Partially Extended Survey dates: November 24 and 25, 2015</p> <p>Facility number: 012523</p>	F 0000	<p>The submission of this Plan of Correction does not indicate an admission by Ridgewood Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Ridgewood Health Campus. This facility recognized it's obligation to provide legally and medially necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities (for Title 18/19 programs).</p>	

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

TITLE

(X6) DATE

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

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F 0225 SS=J Bldg. 00	<p>Provider number: 155789 AIM number: 201027870</p> <p>Census bed type: SNF: 40 SNF/NF: 28 Residential: 50 Total: 118</p> <p>Census payor type: Medicare: 27 Medicaid: 27 Other: 14 Total: 68</p> <p>Sample: 6</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed by 34849 on December 03, 2015.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning</p>			

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	<p>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 observation, interview and record review, the facility failed to ensure that nursing staff immediately reported and investigated suspected physical abuse for one resident who reported an allegation of physical abuse in a sample</p>	F 0225	Resident # 1 was discharged to Dearborn County Hospital on 11/21/15 at 10:50 pm and is no longer in the facility. Hospital records were reviewed and there was no documented evidence of injuries or trauma to the Resident #1's head. No documented cause	12/20/2015

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	<p>of six residents. (Resident E). This deficient practice resulted in an Immediate Jeopardy. The Immediate Jeopardy began on 11/20/2015 between 8:30 a.m. and 10:00 a.m. when a staff nurse was notified by Resident E's spouse of an alleged incident of physical abuse. The Executive Director and Regional Nurse Consultant were notified of the Immediate Jeopardy on 11/24/2015 at 5:45 p.m. The Immediate Jeopardy was removed on 11/25/2015 at 4:37 p.m., but noncompliance remained at the lower scope and severity of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy.</p> <p>Findings include: Resident E's clinical record was reviewed on 11/19/2015 at 1:20 p.m. Diagnoses included, but were not limited to, fall at home (11/3/2015) with left hip fracture and diabetes. He was admitted to the facility for rehabilitation following left total hip arthroplasty [THA], or hip replacement, on 11/6/2015. Occupational Therapy (OT) Plan of Care, dated 11/13/2015, indicated, "Reason for referral: This 66 year old male underwent</p>		<p>was identified for the diagnosis of the the subdural hemorrhage. On 11/23/15 Social Services initiated resident interviews with all residents who are interview able. The residents were asked "Do you feel safe here", "Has any staff member ever hit you?," "Has any staff member ever verbally or physically abused you?" Of the residents interviewed all stated they felt safe and that no staff member had ever hit them or verbally abused them. The resident interviews were completed 11/24/15 @ 10:15pm. Interviews with all facility nursing staff were initiated immediately by the Administrator, including those who fit the description given by the wife and daughter by Resident E of a "stocky, short blonde haired person" . In addition all other facility employees were interviewed and all interviewed staff members denied ever hitting a resident or being aware of any resident being hit by any staff, family member or visitor. All non interview able residents were identified on 11/24/15 and received a head to toe skin assessment conducted by the licensed nurses. These assessments on the non interview able residents were documented and completed 11/24/15 by 10:30 pm. The head to toe skin assessments revealed no unusual findings or signs that would indicate suspicion of abuse. Lpn # 2 was re-educated on the Abuse Policy and Procedure with an</p>		

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	<p>L [left] THA replacement on 11/6 [2015] following a fall on 11/3 [2015]. The patient reports complaints of weakness and decreased functional abilities of ADLs [activities of daily living] and functional mobility...Prior Residence and Living Arrangements: ...Independent with ADLs and ambulation...Discharge Plans: Discharge home and independent.... Initial Assessment: Functional Deficits: Cognition: Prior Level: Independent (no problems). Current Level: Indendent (no problems)...Underlying impairments: Cognition, Orientation: [oriented to] person, facility, nursing/family, and time (x4)...." The document indicated Resident E required "maximum assistance (76-99%)" for ADL self care, upper and lower body dressing. The resident required "moderate assistance (26-75%)" for ADL self care, bathing and toileting. The resident required "minimal assistance (1-25%)" for functional transfers.</p> <p>Nursing Admission Assessment and Data Collection, dated 11/12/2015, indicated Resident E was "alert and oriented." The resident required the assist of one for</p>		<p>emphasis of reporting timely on 11/24/15 by the Social Service Director . Re-education was initiated immediately on the Abuse Policy and Procedure on 11/23/15 for all facility employees, by the Administrator and Corporate Clinical Support Nurse. Although education was provided regarding the entire abuse policy an emphasis was placed on reporting all allegations of any suspected abuse timely. The education is continuing with oncoming employees prior to working their scheduled shift. The re-education will continue until all employees have been re-educated. The Administrator, Director of Nursing will be responsible for providing or arranging re-education for any employee who is not readily available prior to their return to work. A list of employees is being maintained by the Administrator of employees requiring in servicing. The list is referenced prior to every shift change to assure the re-education is provided prior to their return to work. A post test is being given to verify understanding of the abuse policy and reporting requirements at the conclusion of the training and will continue until all facility staff have completed and passed the test. An Emergent QA&A meeting was held with Administrator, Medical Director, Corporate Clinical Support Nurse, Assistant Director of Nursing, Social Service Director, Medical</p>	

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	<p>transfers and ADLs (activities of daily living).</p> <p>Social Service Progress Notes, dated 11/15/2015, indicated, "Res [resident] is...A&O [alert and oriented]...."</p> <p>Resident E was interviewed on 11/20/2015 at 11:31 a.m. He was alert and oriented to person, place and time. The resident complained of pain and nausea.</p> <p>Nurse's Notes, dated 11/21/2015 at 10:50 p.m., indicated, "[Ambulance service] arrived to transport resident to [Emergency Department]...for eval [evaluation] + [and] tx [treatment] per family request."</p> <p>Resident E's Hospital Neurosurgery History and Physical Notes, dated 11/22/2015 at 8:06 p.m. indicated, "History of Present Illness: ...He was noted to have altered mental status and was brought to [hospital]...MRI performed...showed SDH [subdural hematoma].... Per patient, he was discussing his blood pressure/insulin regimen with staff...and then 'saw a bright green light' and woke up with a headache. Per family, his altered mental status is very uncharacteristic of him as</p>		<p>Records Nurse, Staffing Nurse, Legacy Neighborhood Director, and MDS Coordinator on 11/24/15 at approximately 6:30 pm. to discuss and review abuse reporting and following the abuse policy by the facility staff and plans for correction. Re-education on the Abuse Policy and reporting requirements will be conducted quarterly by the Administrator and Director of Nursing with all facility employees x 1 year to assure ongoing compliance. Passing of the Post Test will be included to verify ongoing understanding of the Abuse Policy and Procedure and reporting. An additional post test on the abuse policy and procedure has been added to the onboarding process as of 12/8/15.</p> <p>Random interviews will be conducted throughout all shifts with the facility staff, by Administrator, DHS, ADHS, charge nurses and facility department leaders, to ensure there have not been any incidents noted on their shifts that have not been reported per the Abuse reporting policy. If an incident occurred during their shift investigation will include timely reporting to the administrator and or Director of Nursing , resident assessment completed, and assurance of safety of the resident. Random interviews will be conducted with facility staff on various shifts 5 times per week for 3 months, then 3 times per week for</p>		

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	<p>he is usually fully oriented with exception of immediate post-op period following hip replacement."</p> <p>On 11/23/2015 at 12:15 p.m., Resident E's room was observed to be empty. LPN # 3 indicated the resident was discharged from the facility and admitted to the hospital.</p> <p>The Director of Health Services (DHS) was interviewed on 11/23/2015 at 12:45 p.m. She indicated Resident E was discharged from the facility and admitted to the hospital with encephalopathy (degeneration in brain function). The DHS indicated the family notified her earlier that morning that the resident had a subdural hematoma. The DHS did not report any allegations of abuse related to Resident E.</p> <p>Resident E's daughter was interviewed on 11/23/2015 at 2:36 p.m. She indicated she visited the resident at the facility on the evening on 11/21/2015. She indicated, "He was admitted [to the hospital] with a subdural hematoma... [Resident E] said [in the hospital], 'A nurse came in [at the facility] and was going to give me a cup full of medicine...she had something green in</p>		<p>two months, then weekly for one month, then quarterly x 6 months. . Audits will randomly include weekend shifts by the on-call nurse. In addition, a minimum of 10 residents will be interviewed by Social Services weekly x 4 weeks, then quarterly x 6 months , until substantial compliance is achieved based on QA recommendations and the reported findings from the random interviews of the staff and residents. The interviews will also be reviewed and discussed in the Clinical Care Meeting. In addition, every 6 months for 1 year, Abuse education will be provided by the Ombudsman or a guest speaker for the facility staff to provide additional education for the facility staff. The area Ombudsman has agreed and is scheduled to provide inservicing at the campus on Abuse Policy and Procedure according to the Federal Regulatory Guidelines on January the 21st 2016 at 1 pm and 4 pm. The Ombudsman will also provide an additional inservice 6 months later to the campus.</p> <p>Interviews are continuing as scheduled with the staff and residents and there have been no occurrences of unidentified allegations of abuse at this time.</p>		

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	<p>her hand and hit me in the head. I remember the pain being so bad I seen [sic] a light. I think she wants to do me in...He [Resident E] was worried they were mad after my mom [Resident B's wife] had talked to [State Surveyor the day before]. He said it [staff who struck him] was the heavy set one with blonde hair...He couldn't give specifics on time...." Resident E's daughter indicated she notified the Director of Health Services (DHS) of the allegations earlier that morning.</p> <p>On 11/23/2015 at 3:30 p.m., the Executive Director (ED) and Regional Nurse Consultant (RNC) indicated the daughter of Resident E was at the facility earlier in the day and reported that Resident E alleged that a staff member "hit him over the head." The ED indicated she then reported the incident to the State agency and they were in the process of investigating the allegation. The ED indicated there were three staff members who fit the description Resident E provided in the allegation.</p> <p>RN # 5 was interviewed on 11/23/2015 at 3:42 p.m. She indicated she worked on 11/22/2015 from 2:00 p.m. to 10:00 p.m.</p>			

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	<p>RN # 5 indicated the resident complained of a headache and was "nauseated...restless...talking out of his head...not acting right." RN # 5 indicated Resident E was transferred to the Emergency Department for evaluation and treatment at the family's request. On 11/23/2015 at 5:05 p.m., the ED and RNC indicated they had not suspended any staff members pending completion of the investigation, but were collecting statements from all staff who worked on or around the date of the alleged incident prior to them returning to work. On 11/24/2015 at 2:02 p.m. the ED indicated she interviewed LPN # 3 earlier in the day, who indicated Resident E's wife reported to [LPN # 3] on 11/20/2015 that Resident B reported a staff member hit him in the head. The ED indicated LPN # 3 reported to her that she "checked him over and he was fine...She didn't think anyone would do that." The ED further indicated she interviewed Certified Nursing Assistant (CNA) # 6, who worked the night shift on 11/21/2015, earlier in the day. The ED indicated CNA # 6 reported to her that Resident B's wife came in to the facility</p>			

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	<p>at approximately 3:00 a.m. [11/22/2015] following Resident B's discharge [the evening of 11/21/2015] to remove his personal items from his room and reported to CNA # 6 that her husband reported to her that "someone or something green hit him in the head." The CNA indicated to the ED that the only green object in the resident's room was a green water pitcher. The ED and RNC indicated no staff had been suspended and the investigation was "in progress."</p> <p>A typed statement, dated 11/23/2015, was provided by the ED on 11/24/2015 at 2:02 p.m. The document indicated, "11/23/15. At approximately 9:00 a.m. [Resident E's wife and daughter] came in to talk to [DHS]. Family stated that [Resident E] had a subdural hematoma....Daughter stated that [Resident E] has made the same accusation two times at the hospital about something green hitting him in the head after he received his medicine. Daughter stated the description of the staff member was a Short Blond Stalky [sic] girl on nights [shift]...."</p> <p>A typed statement, dated 11/24/2015,</p>			

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	<p>was provided by the ED on 11/24/2015 at 2:02 p.m. The document indicated, "...12:50 p.m. Writer [ED] spoke with [CNA # 6] on phone, whom [sic] worked Friday [11/20/2015] and Saturday [11/21/2015]...[CNA # 6] stated that when the wife came back in around 3 a.m. and told [CNA # 6] that [Resident E] stated at the hospital that someone or something hit him in the head that was green. [CNA # 6] went into the room and the only thing that was green was his water picture [sic] that he had been drinking out of. It was still full of water." A typed statement, dated 11/24/2015, was provided by the Executive Director (ED) on 11/24/2015 at 2:02 p.m. The document indicated, " Writer [ED] interviewed [LPN # 2] at 1:15 p.m. regarding working last Friday [11/20/2015] with [Resident E][LPN # 2/Unit Manager] stated the wife [of Resident E] stated that [Resident E] was making a comment about a man hitting him in the head with something green. [LPN # 2] questioned wife if [Resident E] was confused and wife told her he did not seem to be. Wife asked [LPN # 2] if she thought anyone would hit him. [LPN</p>			

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	<p>#2] stated no to the wife and stated that nothing had been reported "</p> <p>A typed statement, dated 11/24/2015, was provided by the ED on 11/24/2015 at 4:35 p.m. The document indicated, "11/24/15 - SW [Social Work] called [LPN # 3] into the office.... [LPN # 3] recounted an interaction between a res [Resident E's] wife and her. [LPN # 3] stated she spoke to wife last week poss [possibly] Friday. Wife approached her and said 'he (res) said he remembers someone hitting him last night in the head w/ [with] something green.' Res wife asked, 'Do you think someone would do that?' [LPN # 3] replied No, of course not...."</p> <p>LPN # 3 was interviewed on 11/24/2015 at 5:07 p.m. She indicated she was the "charge nurse" on Tanner (200) hall. She indicated, "I'm pretty sure it [wife reporting incident to her] was Friday [11/20/2015]...I don't know exactly. It was definitely between eight thirty and ten a.m. I was in the middle of med [medication] pass. [Resident E's wife] approached me and said somebody hit him over the head with something green...a green object...something like</p>			
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	<p>that...he mentioned sometime in the night...he could have been dreaming...some man may have hit him with a green object." LPN # 3 indicated she asked Resident E's wife if he was hurt and his wife indicated, "He doesn't have any marks on him." LPN # 3 indicated, "I went back to my med pass and forgot it...I didn't [assess him]. I know I should have."</p> <p>CNA # 8 was interviewed on 11/24/2015 at 9:55 p.m. The CNA indicated, "I don't know [regarding time frame for reporting abuse]. I know they [named ED and DHS] usually leave after dinner, so probably before dinner."</p> <p>CNA # 6 was interviewed on 11/24/2015 at 9:59 p.m. The CNA indicated she worked night shift on 11/21/2015. Resident E's wife came back after he was discharged to collect his belongings. The CNA indicated, "That was the time she kept saying something hit his head.... No I didn't [report] because he was already sent out and he was kind of not making sense." CNA # 6 indicated Resident E's change in mental status was "sudden" and he was normally "with it."</p> <p>The current Abuse and Neglect</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155789	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2015
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NAME OF PROVIDER OR SUPPLIER RIDGEWOOD HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 181 CAMPUS DR LAWRENCEBURG, IN 47025
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	<p>Procedural Guidelines Policy and Procedure was provided by the Executive Director on 11/20/2015 at 2:00 p.m. The procedure indicated, "...3. Definitions: ...c. Physical Abuse - includes hitting, slapping, pinching, spitting, holding or handling roughly, etc ...ii. Staff to resident abuse with or without injury...e. Protection: ...i. Upon identification of suspected abuse or neglect, immediately provide for the safety of the resident...iv. Suspend suspected employee(s) pending outcome of investigation..."</p> <p>The current Accident and Incident Reporting Guidelines Policy and Procedure, provided by the ED on 11/24/2015 at 2:02 p.m., indicated, " Procedure: 1. All ...allegations of abuse ...shall be reported to the department supervisor as soon as it is discovered or when information of occurrence is learned...3. The assigned nurse or nursing supervisor shall complete an assessment and provide medical interventions as warranted. 4. Reporting of...abuse to state and federal agencies shall be in compliance in accordance with agency guidelines...6. The assigned nurse or nursing supervisor shall: a. Examine all</p>			

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F 0226 SS=J	<p>accident, incident or abused victims. b. Notify the attending physician or medical director of the occurrence...7. Investigative action shall be initiated by the attending nurse and/or nursing supervisor...."</p> <p>The Immediate Jeopardy that began on November 20, 2015 was removed on November 25, 2015 when through observation, interview and record review, the facility began inservicing staff and completing head-to-toe assessments on all non-interviewable residents in the facility. Even though the facility's corrective action removed the Immediate Jeopardy, the facility remained out of compliance at a reduced scope and severity level of no actual harm with potential for more than minimal harm that is not Immediate Jeopardy because of on-going monitoring and assessment, and because not all staff had been inserviced.</p> <p>This Federal tag relates to complaint IN00187417.</p> <p>3.1-28(c) 3.1-28(d)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT,</p>			

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Bldg. 00	<p>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 observation, interview and record review, the facility failed to ensure written policies and procedures prohibiting the mistreatment, neglect and abuse of residents were implemented after an alleged incident of physical abuse was reported to staff for 1 of 6 residents reviewed for abuse. (Resident E)</p> <p>This deficient practice resulted in an Immediate Jeopardy. The Immediate Jeopardy began on 11/20/2015 between 8:30 a.m. and 10:00 a.m. when a staff nurse was notified by Resident E's spouse of an alleged incident of physical abuse. The Executive Director and Regional Nurse Consultant were notified of the Immediate Jeopardy on 11/24/2015 at 5:45 p.m. The Immediate Jeopardy was removed on 11/25/2015 at 4:37 p.m., but noncompliance remained at the lower scope and severity of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy.</p> <p>Findings include:</p>	F 0226	<p>Resident # 1 was discharged to Dearborn County Hospital on 11/21/15 at 10:50 pm and is no longer in the facility. Hospital records were reviewed and there was no documented evidence of injuries or trauma to the Resident #1's head. No documented cause was identified for the diagnosis of the the subdural hemorrhage. On 11/23/15 Social Services initiated resident interviews with all residents who are interview able. The residents were asked "Do you feel safe here", "Has any staff member ever hit you?," "Has any staff member ever verbally or physically abused you?" Of the residents interviewed all stated they felt safe and that no staff member had ever hit them or verbally abused them. The resident interviews were completed 11/24/15 @ 10:15pm. Interviews with all facility nursing staff were initiated immediately by the Administrator, including those who fit the description given by the wife and daughter by Resident E of a "stocky, short blonde haired person" . In addition all other facility employees were interviewed and all interviewed staff members denied ever hitting a resident or being</p>	12/20/2015

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	<p>Resident E's daughter was interviewed on 11/23/2015 at 2:36 p.m. She indicated she visited the resident in the evening on 11/21/2015. She indicated, "He was admitted [to the hospital] with a subdural hematoma...[Resident E] said [in the hospital], 'A nurse came in [at the facility] and was going to give me a cup full of medicine...she had something green in her hand and hit me in the head. I remember the pain being so bad I seen [sic] a light. I think she wants to do me in...He [Resident E] was worried they were mad after my mom [Resident E's wife] had talked to [State Surveyor the day before].' He said it [staff who struck him] was the heavy set one with blonde hair...He couldn't give specifics on time...." Resident E's daughter indicated she notified the Director of Health Services (DHS) of the allegations earlier in that morning.</p> <p>On 11/23/2015 at 3:30 p.m., the Executive Director (ED) and Regional Nurse Consultant (RNC) indicated the daughter of Resident E was at the facility earlier in the day and reported that Resident E alleged that a staff member "hit him over the head." The ED</p>		<p>aware of any resident being hit by any staff, family member or visitor. All non interview able residents were identified on 11/24/15 and received a head to toe skin assessment conducted by the licensed nurses. These assessments on the non interview able residents were documented and completed 11/24/15 by 10:30 pm. The head to toe skin assessments revealed no unusual findings or signs that would indicate suspicion of abuse.</p> <p>Lpn # 2 was re-educated on the Abuse Policy and Procedure with an emphasis of reporting timely on 11/24/15 by the Social Service Director . Re-education was initiated immediately on the Abuse Policy and Procedure on 11/23/15 for all facility employees, by the Administrator and Corporate Clinical Support Nurse. Although education was provided regarding the entire abuse policy an emphasis was placed on reporting all allegations of any suspected abuse timely. The education is continuing with oncoming employees prior to working their scheduled shift. The re-education will continue until all employees have been re-educated. The Administrator, Director of Nursing will be responsible for providing or arranging re-education for any employee who is not readily available prior to their return to work. A list of employees is being</p>				

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	<p>indicated at that time, she reported the incident to the State agency and they were in the process of investigating the allegation. The ED indicated there were three staff members who fit the description Resident E provided in the allegation.</p> <p>RN # 5 was interviewed on 11/23/2015 at 3:42 p.m. She indicated she worked on 11/22/2015 from 2:00 p.m. to 10:00 p.m. RN # 5 indicated the resident complained of a headache and was "nauseated...restless...talking out of his head...not acting right." RN # 5 indicated Resident E was transferred to the Emergency Department for evaluation and treatment at the family's request.</p> <p>On 11/23/2015 at 5:05 p.m., the ED and RNC indicated they had not suspended any staff members pending completion of the investigation, but were collecting statements from all staff who worked on or around the date of the alleged incident prior to them returning to work.</p> <p>On 11/24/2015 at 2:02 p.m. the ED indicated she interviewed LPN # 3 earlier in the day, who indicated Resident E's wife reported to [LPN # 3] on 11/20/2015 that Resident E reported a staff member</p>		<p>maintained by the Administrator of employees requiring in servicing. The list is referenced prior to every shift change to assure the re-education is provided prior to their return to work.</p> <p>A post test is being given to verify understanding of the abuse policy and reporting requirements at the conclusion of the training and will continue until all facility staff have completed and passed the test. The ED and RNC was re educated by the Divisional Vice President on following the process in the Abuse Policy and Procedure.</p> <p>An Emergent QA&A meeting was held with Administrator, Medical Director, Corporate Clinical Support Nurse, Assistant Director of Nursing, Social Service Director, Medical Records Nurse, Staffing Nurse, Legacy Neighborhood Director, and MDS Coordinator on 11/24/15 at approximately 6:30 pm. to discuss and review abuse reporting and following the abuse policy by the facility staff and plans for correction. Re-education on the Abuse Policy and reporting requirements will be conducted quarterly by the Administrator and Director of Nursing with all facility employees x 1 year to assure ongoing compliance. Passing of the Post Test will be included to verify ongoing understanding of the Abuse Policy and Procedure and reporting. An additional post test on the abuse policy and procedure has been</p>		

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	<p>hit him in the head. The ED indicated LPN # 3 reported to her that she "checked him over and he was fine...She didn't think anyone would do that." The ED further indicated she interviewed Certified Nursing Assistant (CNA) # 6, who worked the night shift on 11/21/2015, earlier in the day. The ED indicated CNA # 6 reported to her that Resident E's wife came in to the facility at approximately 3:00 a.m. [11/22/2015] following Resident E's discharge [the evening of 11/21/2015] to remove his personal items from his room and reported to CNA # 6 that her husband reported to her that "someone or something green hit him in the head." The CNA indicated to the ED that the only green object in the resident's room was a green water pitcher. The ED and RNC indicated no staff had been suspended and the investigation was "in progress."</p> <p>A typed statement, dated 11/23/2015, was provided by the ED on 11/24/2015 at 2:02 p.m. The document indicated, "11/23/15. At approximately 9:00 a.m. [Resident E's wife and daughter] came in to talk to [DHS]. Family stated that</p>		<p>added to the onboarding process as of 12/8/15.</p> <p>Random interviews will be conducted throughout all shifts with the facility staff, by Administrator, DHS, ADHS, charge nurses and facility department leaders, to ensure there have not been any incidents noted on their shifts that have not been reported per the Abuse reporting policy. If an incident occurred during their shift investigation will include timely reporting to the administrator and or Director of Nursing , resident assessment completed, and assurance of safety of the resident.</p> <p>Random interviews will be conducted with facility staff on various shifts 5 times per week for 3 months, then 3 times per week for two months, then weekly for one month, then quarterly x 6 months. . Audits will randomly include weekend shifts by the on-call nurse. In addition, a minimum of 10 residents will be interviewed by Social Services weekly x 4 weeks, then quarterly x 6 months , until substantial compliance is achieved based on QA recommendations and the reported findings from the random interviews of the staff and residents. The interviews will also be reviewed and discussed in the Clinical Care Meeting. In addition, every 6 months for 1 year, Abuse education will be provided by the Ombudsman or a guest speaker for the facility staff to provide</p>				

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	<p>[Resident E] had a subdural hematoma....Daughter stated that [Resident E] has made the same accusation two times at the hospital about something green hitting him in the head after he received his medicine. Daughter stated the description of the staff member was a Short Blond Stalky [sic] girl on nights [shift]...."</p> <p>A typed statement, dated 11/24/2015, was provided by the ED on 11/24/2015 at 2:02 p.m. The document indicated, "...12:50 p.m. Writer [ED] spoke with [CNA # 6] on phone, whom [sic] worked Friday [11/20/2015] and Saturday [11/21/2015]...[CNA # 6] stated that when the wife came back in around 3 a.m. and told [CNA # 6] that [Resident E] stated at the hospital that someone or something hit him in the head that was green. [CNA # 6] went into the room and the only thing that was green was his water picture [sic] that he had been drinking out of. It was still full of water."</p> <p>A typed statement, dated 11/24/2015, was provided by the Executive Director (ED) on 11/24/2015 at 2:02 p.m. The document indicated, "Writer [ED] interviewed [LPN # 2] at 1:15 p.m.</p>		<p>additional education for the facility staff. The area Ombudsman has agreed and is scheduled to provide inservicing at the campus on Abuse Policy and Procedure according to the Federal Regulatory Guidelines on January the 21st 2016 at 1 pm and 4 pm. The Ombudsman will also provide an additional inservice 6 months later to the campus. Interviews are continuing as scheduled with the staff and residents and there have been no occurrences of unidentified allegations of abuse at this time.</p>		

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	<p>regarding working last Friday [11/20/2015] with [Resident E][LPN # 2/Unit Manager] stated the wife [of Resident E] stated that [Resident E] was making a comment about a man hitting him in the head with something green. [LPN # 2] questioned wife if [Resident E] was confused and wife told her he did not seem to be. Wife asked [LPN # 2] if she thought anyone would hit him. [LPN #2] stated no to the wife and stated that nothing had been reported "</p> <p>A typed statement, dated 11/24/2015, was provided by the ED on 11/24/2015 at 4:35 p.m. The document indicated, "11/24/15 - SW [Social Work] called [LPN # 3] into the office.... [LPN # 3] recounted an interaction between a res [Resident E's] wife and her. [LPN # 3] stated she spoke to wife last week (poss [possibly] Friday. Wife approached her and said 'he (res) said he remembers someone hitting him last night in the head w/ [with] something green.' Res wife asked 'Do you think someone would do that?' [LPN # 3] replied No, of course not...."</p> <p>LPN # 3 was interviewed on 11/24/2015 at 5:07 p.m. She indicated she was the</p>			
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	<p>"charge nurse" on Tanner (200) hall. She indicated, "I'm pretty sure it [wife reporting incident to her] was Friday [11/20/2015]...I don't know exactly. It was definitely between eight thirty and ten a.m.. I was in the middle of med [medication] pass. [Resident E's wife] approached me and said somebody hit him over the head with something green...a green object...something like that...he mentioned sometime in the night...he could have been dreaming...some man may have hit him with a green object." LPN # 3 indicated she asked Resident B's wife if he was hurt and his wife indicated, "He doesn't have any marks on him." LPN # 3 indicated, "I went back to my med pass and forgot it...I didn't [assess him]. I know I should have."</p> <p>CNA # 8 was interviewed on 11/24/2015 at 9:55 p.m. The CNA indicated, "I don't know [regarding time frame for reporting abuse]. I know they [named ED and DHS] usually leave after dinner, so probably before dinner."</p> <p>CNA # 6 was interviewed on 11/24/2015 at 9:59 p.m. The CNA indicated she worked night shift on 11/21/2015.</p>			

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	<p>Resident E's wife came back after he was discharged to collect his belongings. The CNA indicated, "That was the time she kept saying something hit his head.... No I didn't [report] because he was already sent out and he was kind of not making sense." CNA # 6 indicated Resident E's change in mental status was "sudden" and he was normally "with it."</p> <p>The current Abuse and Neglect Procedural Guidelines Policy and Procedure was provided by the Executive Director on 11/20/2015 at 2:00 p.m. The procedure indicated, " ...3. Definitions: ...c. Physical Abuse - includes hitting, slapping, pinching, spitting, holding or handling roughly, etc ...ii. Staff to resident abuse with or without injury...e. Protection: ...i. Upon identification of suspected abuse or neglect, immediately provide for the safety of the resident...iv. Suspend suspected employee(s) pending outcome of investigation...."</p> <p>The current Accident and Incident Reporting Guidelines Policy and Procedure, provided by the ED on 11/24/2015 at 2:02 p.m., indicated, "Procedure: 1. All ...allegations of abuse ...shall be reported to the department</p>			

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	<p>supervisor as soon as it is discovered or when information of occurrence is learned...3. The assigned nurse or nursing supervisor shall complete an assessment and provide medical interventions as warranted. 4. Reporting of...abuse to state and federal agencies shall be in compliance in accordance with agency guidelines...6. The assigned nurse or nursing supervisor shall: a. Examine all accident, incident or abused victims. b. Notify the attending physician or medical director of the occurrence...7. Investigative action shall be initiated by the attending nurse and/or nursing supervisor...."</p> <p>The Immediate Jeopardy that began on November 20, 2015 was removed on November 25, 2015 when through observation, interview and record review, the facility began inservicing staff and completing head-to-toe assessments on all non-interviewable residents in the facility. Even though the facility's corrective action removed the Immediate Jeopardy, the facility remained out of compliance at a reduced scope and severity level of no actual harm with potential for more than minimal harm</p>			

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	that is not Immediate Jeopardy because of on-going monitoring and assessment, and because not all staff had been inserviced. This Federal tag relates to complaint IN00187417. 3.1-28(a)				