

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/27/2015
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NAME OF PROVIDER OR SUPPLIER PRAIRIE LAKES HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060
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F000000	<p>This visit was for the Investigation of Complaint IN00162988.</p> <p>Complaint: IN00162988 - Substantiated. Federal/State deficiencies related to the allegations are cited at F225 and F323.</p> <p>Survey dates: January 26 & 27, 2015</p> <p>Facility Number: 012305 Provider Number: 155779 AIM Number: 200987990</p> <p>Survey Team: Mary Jane G. Fischer RN TC</p> <p>Census Bed Type: SNF: 47 SNF/NF: 10 Residential: 41 Total: 98</p> <p>Census Payor Type: Medicare: 19 Medicaid: 10 Other: 28 Total: 57</p> <p>Sample: 4 Supplemental Sample: 2</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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F000225 SS=E	<p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review was completed by Tammy Alley RN on February 2, 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 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>A. Based on observation, record review and interview the facility failed to ensure allegations of abuse/neglect were thoroughly investigated, in that when a resident indicated nursing staff members were attempting to coerce her into doing something she did not want to do, and they displayed disrespectful actions towards her. The facility failed to follow their policy in regard to the investigation of alleged abuse. (Resident "B").</p> <p>B. When the facility staff members were alerted that two resident's rings were missing, the facility failed to notify the State Agency and the Local Police Department of the allegation of misappropriation of resident property. (Residents "E" and "F").</p> <p>C. In addition, facility staff members were unaware of the specifics related to the Elder Justice Act and reporting responsibilities for 1 of 1 Abuse and Elder Justice Act programs reviewed.</p> <p>This deficient practice affected 1 of 3</p>	F000225	<p>F225</p> <p>Responses to the cited findings do not constitute an admission or agreement by Prairie Lakes of the truth of the alleged or conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with federal and/or state law.</p> <p><i>In response to the cited findings R/T to F225, the following actions will be taken:</i></p> <p>A) With respect to these findings,</p>	02/26/2015

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	<p>sampled residents and 2 of 2 supplemental sample residents reviewed for abuse and misappropriation of property in a sample of 6. (Resident's "B," "E" and "F").</p> <p>Findings include:</p> <p>A1. The record for Resident "B" was reviewed on 01-26-15 at 11:45 a.m. Diagnoses included, but were not limited to, debility, gastroesophageal reflux disease, hypertension, history of fall and degenerative joint disease. These diagnoses remained current at the time of the record review.</p> <p>During a review of facility documentation, dated 01-22-15, Resident "B" indicated that 2 CNA's (Certified Nurses Aides) came into her room and said they were taking her to the bathroom. Resident "B" indicated to the staff members she didn't want to go and they (the staff members) "swung her legs around and made her go to the bathroom. Resident said she was so mad she called one of them a b----. Teachable moment with CNA."</p> <p>During interview on 01-26-15 at 2:30 p.m., the resident indicated, "They insisted I go to the bathroom and I told them I just needed my diaper changed.</p>		<p>All 57 of the 57 residents in the skilled nursing unit in the Health Care Center had the potential to be affected by this alleged deficient practice.</p> <p>B) With respect to how the facility will identify residents with the potential for the identified concern and take corrective action: <i>Nursing Leadership/Social Services will monitor daily during hourly rounding to identify any potential concerns.</i></p> <p>C) With respect to what systematic measures have been put into place to address the stated concern: <i>DHS and/or designee with the assistance</i></p>	

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	<p>One of them said I, 'was going to go to the bathroom.' I told her again I just needed my diaper changed. That's when she put her finger in my face and I told her not to be putting a finger in my face and I called her a b----. One of them has taken care of me since then but the other one hasn't taken care of me. I was scared when it happened."</p> <p>During an interview on 01-27-15 at 10:30 a.m., the Social Service Assistant indicated, "On Thursday [01-22-15] I received a report she [Resident "B"] had an incident with 2 aids on Wednesday evening. The 2 aides came into her room. She [Resident "B"] had soiled herself and they made her go to the bathroom and she didn't want to go. She said they were loud and singing and pointed a finger at her. I wrote a statement and turned it in to [Name of Assistant Director of Nurses]."</p> <p>A review of the handwritten statement by the Social Service Assistant indicated, "Resident states during previous evening two aides entered room, singing and talking very loudly. Resident states she soiled herself. The two aides then 'made' resident get up to toilet. The resident states one staff member pointed at her, but was unable to recall what was said. Resident states one staff member had</p>		<p><i>of Social Services will in-service All Staff on the Elder Justice Act, Abuse policy, reporting and investigations.</i></p> <p><i>The policy is clearly available to any staff member at any time. In addition to these in-services, the Nursing Leadership team is reviewing the nursing Hot Topics books daily to further determine any issues that require reporting to the Indiana State Department of Health. Facility staff will have a refresher of this policy every All-Staff meeting for the next six months.</i></p> <p>D) With respect to how the plan of corrective measures will be monitored:</p> <p><i>The Interdisciplinary</i></p>	

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	<p>long curls and the other had hair about an inch long. Resident states she feels safe at this time, but was 'angry.'"</p> <p>During an interview on 01-27-15 at 11:15 a.m., the Physical Therapist indicated he went to the resident's room on Thursday morning (01-22-15) and she (Resident "B") told me she had a complaint. She said that last night the aide was unprofessional in taking care of her and the aide pointed a finger at her. She was very upset. I went and got the nurse and she told the nurse what happened. I was told that nursing would be taking care of it.</p> <p>The Resident Concern form, completed by the licensed nurse, dated 01-22-15, indicated the resident was "Angry." "Resolution steps I took: listened, apologized and said Thank you and meant it !" The form indicated CNA #13 had a "face to face" meeting on 01-23-15 and was given a "teachable moment."</p> <p>A review of the staffing as worked schedule Employee #12 was allowed to work the evening shift on 01-23-15.</p> <p>During an interview on 01-27-15 at 9:40 a.m. Employee #12 confirmed she worked with resident's after the incident on 01-21-15.</p>		<p><i>Department Team will audit the</i></p> <p><i>Hot Topic Books and Concern</i></p> <p><i>Forms Monday thru Friday</i></p> <p><i>during the morning meeting to</i></p> <p><i>identify alleged abusive or possible</i></p> <p><i>misappropriation. Weekend</i></p> <p><i>Managers have been</i></p> <p><i>trained and are required to call</i></p> <p><i>the Executive Director immediately</i></p> <p><i>if</i></p> <p><i>abuse is alleged. All managers</i></p> <p><i>including charge nurses are aware</i></p> <p><i>that anyone alleged to have been</i></p> <p><i>involved in any type of abuse is to</i></p> <p><i>be</i></p> <p><i>suspended and removed from the</i></p> <p><i>campus immediately pending an</i></p> <p><i>investigation. These audits will be</i></p> <p><i>completed based upon the level</i></p> <p><i>of compliance with a goal of 100%.</i></p> <p><i>These audits will continue for 90</i></p> <p><i>days and will be included in Quality</i></p>		

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	<p>During an interview on 01-26-15 the Director of Nurses indicated Employee #12 had not been counseled, but did work with resident's following the incident with Resident "B."</p> <p>During an interview on 01-27-15 at 3:00 p.m., the Executive Director indicated this allegation of abuse had not been reported to the State Agency.</p> <p>B1. During an interview on 01-27-15 at 12:00 p.m., the Point of Contact person for the facility Abuse Prohibition Program, indicated she was unaware of the staff members pointing a finger at Resident "B."</p> <p>However when interviewed if there were any other areas of concern under investigation, Employee #5 indicated she had received a report of two residents who had "rings missing." The resident families (Residents "E" and "F") were aware and a meeting was being conducted with the family for Resident "E," "today at 2:00 p.m. They said it was a very unique and contemporary wedding band and they would bring in the Insurance papers." Employee #5 also indicated the state agency or local law enforcement had not been notified due to "we're waiting for the family to bring in</p>		<p><i>Assurance Meeting to determine whether</i></p> <p><i>these is a need to continue beyond the initial 90 days.</i></p> <p>E) Date of compliance with proposed actions: 2/26/2015</p>	

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	<p>the Insurance papers." During interview Employee #5 indicated she found out about it last week, "I think it happened on 01-21-15 or 01-22-15."</p> <p>A review of the investigation included the statements of only 3 staff members who were involved with the residents. The resident's resided on different units.</p> <p>During an interview on 01-27-15 at 1:00 p.m., the Executive Director said he had not notified the Local Area Police department or the State Agency. "I encourage the families to contact the police department themselves."</p> <p>C1. During staff interviews regarding the Elder Justice Act, covered individuals and obligations to report the following responses were given.</p> <p>C2. 01-27-15 at 9:45 a.m. - Employee #12 "The Elder Justice Act was put in place to protect the resident from abuse and care and covered individuals is anyone over a certain age - an Elder. It's to protect and make sure the residents are safe." This staff member was unaware of the reporting responsibilities including protecting and non retaliation of the person who reported the incident.</p> <p>01-27-15 at 10:30 a.m., - Employee #5</p>			

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	<p>"The Elder Justice Act is a protection act generally for the Elderly. Covered individuals is anyone is the facility - the residents. This staff member was unaware of the reporting responsibilities including protecting and non retaliation of the person who reported the incident.</p> <p>01-27-15 at 11:15 a.m., - Employee #6 "The Elder Justice Act is about resident's, families, visitors, spouses and family members." This staff member was unaware of the reporting responsibilities including protecting and non retaliation of the person who reported the incident.</p> <p>01-27-15 at 11:15 a.m., - Employee #7 was unaware of the reporting responsibilities including protecting and non retaliation of the person who reported the incident.</p> <p>C3. A review of the Trilogy Health Services - "Abuse and Neglect Procedural Guidelines," on 01-26-15 at 10:20 a.m. and dated 11-2010, indicated the following:</p> <p>"Purpose: Trilogy Health Services, has developed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect."</p>			

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	<p>"Procedure: ...2. The Executive Director and Director of Health Services are responsible for the implementation and ongoing monitoring of abuse standards and procedures.</p> <p>3. Definitions: a. Abuse means the willful (bold type and underscored) means the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain or mental anguish (known or alleged)...</p> <p>d. Identification:... ii. Any person with knowledge or suspicion of suspected violations shall report immediately, without fear of reprisal. 1. Abuse, Neglect and Misappropriation of resident property is a crime and may result in the loss of professional license or nursing assistant certification... vii. The Executive Director is responsible for: 1. Notification to the State Department of Health (per State Guidelines) and other agencies, which include the Ombudsman, Adult Protective Services and/or local law enforcement agencies, as indicated...</p> <p>e. Protection: i. Upon identification of suspected abuse or neglect, immediately provide for the safety of the resident and the person reporting to maintain anonymity as reasonable and necessary.</p>			

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	<p>This may include, but is not limited to the following: ii. Moving the resident to another room, iii. Providing 1:1 monitoring, as appropriate, iv. Suspend suspected employee(s) pending outcome of investigation...</p> <p>g. Reporting: i. Any staff member, resident, visitor or responsible party may report known or suspected abuse, neglect, or misappropriation to local or state agencies. ii. Immediately and not more than 24 hours complete an initial report to applicable state agencies."</p> <p>C4. A review of the "Employee Standards and Code of Ethical Conduct," on 01-27-15 at 10:00 a.m., section "Elder Justice Act," dated as "revised June 2013," indicated the following:</p> <p>"Notification of Duty to Report - All employees are required to report any reasonable suspicion of a crime against any individual, who is a Resident of, or receiving care from a Trilogy facility..."</p> <p>During observation on 01-27-15 at 10:30 a.m., the facility signage, located in the main hallway, clearly indicated, "Federal Law requires that you report your suspicions directly to both Law Enforcement and State Survey Agencies. If the crime does not appear to cause</p>			

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F000323 SS=D	<p>serious bodily injury you must report it within 24 hours after forming the suspicion. How do I report ? Individuals reporting suspicion of a crime must call, fax or email both local law enforcement and the state survey agency."</p> <p>This Federal tag relates to Complaint IN00162988.</p> <p>3.1-28(c)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review the faciity failed to ensure the correct positioning and transfer of dependents resident, in that when residents were dependent upon the nursing staff for transfer and positioning, the nursing staff incorrectly positioned a resident which resulted in the resident falling from the bed and onto the floor, and the incorrect transfer of a dependent resident from the wheelchair to bed and bed to wheelchair. This deficient practice affected 2 of 4 resident's reviewed for falls in a sample of 4. (Resident's "A" and "C").</p>	F000323	<p><u>F323</u></p> <p>Responses to the cited findings do not constitute an admission or agreement by the facility of the truth of the alleged or conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with</p>	02/26/2015

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	<p>Findings include:</p> <p>1. The record for Resident "A" was reviewed on 01-26-15 at 12:20 p.m. Diagnoses included, but were not limited to, hypertension, seizures, end stage dementia, left proximal femur fracture and chronic obstructive pulmonary disease. These diagnoses remained current at the time of the record review.</p> <p>A review of the resident's Minimum Data Set (MDS) assessment, dated 12-08-14, indicated the resident had cognitive impairment, rarely understood or understands, was totally dependent for bed mobility/transfers and required the assistance of 2 staff members.</p> <p>The resident's current plan of care, originally dated 06-12-14, indicated "I rely on the staff here at Prarie <sic> Lakes for all of my care. Due to my advanced dementia I am unable to participate or even speak. I require assistance of two people for my ADL's [Activities of Daily Living], and since I am completely dependant for transfer so please us the Maxi Move to transfer me."</p> <p>A review of the record indicated the resident was found on the floor on 01-08-15 at 12:15 p.m. The fall was</p>		<p>federal and/or state law.</p> <p><i>In response to the cited findings R/T to F323, the following Actions will be taken:</i></p> <p>A) With respect to these findings:</p> <p><i>Resident A & C assured to be transferred according to campus policy and procedures and Care Plan. All 57 of the 57 residents in the skilled nursing unit in the Health Care Center had the potential to be affected by this alleged deficient practice.</i></p> <p>B) With respect to how to facility will</p> <p>identify residents with the potential for the identified concern and take corrective action: <i>Nursing</i></p>		

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NAME OF PROVIDER OR SUPPLIER PRAIRIE LAKES HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060
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	<p>categorized as "unwitnessed." The Fall Circumstance Report, dated 01-08-15, indicated the resident required assist to transfer and had a "recent fall because of improper positioning in bed. Intervention indicated "staff education."</p> <p>A review of the facility reportable document indicated the resident was "found on the floor sitting upright position beside the bed with legs curled toward body. No S/Sx [sign or symptom] injury."</p> <p>During an interview on 01-27-15 at 2:15 p.m., Employee # 10 indicated she provided staff education to the CNA's (Certified Nurses Aides) who were responsible for the transfer and positioning of the resident in bed. "They didn't position her correctly and had her too close to the side of the bed and she fell out."</p> <p>2. The record for Resident "C" was reviewed on 01-26-15 at 2:40 p.m. Diagnoses included, but were not limited to, Alzheimer's dementia, history of fractured femur, history of right wrist fracture, osteoarthritis, history of falls, and difficulty in walking. These diagnoses remained current at the time of the record review.</p>		<p>Leadership</p> <p>will monitor during hourly rounding</p> <p>to observe for any concerns</p> <p>C) With respect to what systematic measures have been put into place to address the stated concern:</p> <p>DHS and/or designee will in-service all nursing staff on transfers,proper positioning, proper use of gait belts per campus policy and procedures.</p> <p>D) With respect to how the plan of corrective measures will be monitored:</p> <p>DHS and/or designee will observe transfers and proper use of gait belts 2 times per week for 3 month with the results of the audit</p>	

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	<p>A review of the resident's MDS indicated the resident had severe cognitive impairment and required extensive assistance and two staff members with transfer. The assessment further indicated the resident had range of motion limitations to both lower extremities.</p> <p>During an observation on 01-26-15 at 2:40 p.m., the resident was seated in a wheel chair in the common area of the Unit. CNA #14 approached the resident and then moved the resident from the common area to her room. CNA #14 indicated she was getting ready to "lay the resident down." CNA #14 summoned the help of CNA #15.</p> <p>During this observation CNA #15 placed the Gait Belt around the resident's waist. The CNA instructed the resident they were going to move her from the wheelchair to the bed. With a CNA on each side of the resident, both CNA's held onto the gait belt and then placed their arms under the resident's axila. In one movement the CNA's transferred the resident to the side of the bed and then moved the resident to a laying position by holding the resident around the shoulders and upper legs.</p> <p>The CNA's provided pericare to the</p>		<p><i>observations reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 3 months then randomly thereafter for further recommendation.</i></p> <p>E) Date of compliance with proposed actions: 2/26/2015</p>	

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	<p>resident and then instructed the resident they were going to move her from the bed back into the wheelchair. The Gait belt had been left on the resident, and in one movement the resident was positioned to a seated position on the side of the bed.</p> <p>The CNA's held onto the Gait belt, placed their arms under the resident's axila and attempted to position the resident back into the wheelchair. During this transfer, the resident's lower legs became twisted, and the CNA's struggled in their attempt stand and pivot the resident back into the wheelchair.</p> <p>During an interview on 01-27-15 at 11:15 a.m., the Occupational Therapist indicated the nursing staff should never position their arm under the resident's axila. "It can cause damage and when I see them do that I immediately stop them."</p> <p>3. A review of the facility policy on 01-27-15 at 1:00 p.m., titled "Transfer Activities," and dated 2006, indicated the following:</p> <p>"Purpose - To transfer the resident from bed to chair, toilet or tub safely."</p> <p>"Procedure - Transfer from Bed to Wheelchair... 4. Assist the resident to a</p>			

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	<p>sitting position on the side of the bed. 5. Apply transfer belt. 6. Lock wheel chair brakes, raise food <sic> rests and place wheel chair at an angle at the side of the bed nearest resident's unaffected side. 7. If resident is able to participate in transfer, have resident place strong leg and foot forward and weak foot back. 8. Spread your feet apart, flex your hips and knees... 9. Align your knees with the resident's knees. 10. Hold the transfer belt from underneath straighten your hips and legs slightly and lift the client to a standing position on a count of three. 11. Stabilize the resident's weak or paralyzed let <sic> with your knee. 12. Pivot on your foot farthest from the wheel chair and position the resident over the wheel chair seat ... 14. Lower the resident into the wheel chair by flexing your hips and knees. 15. Support may be provided by use of a transfer belt. Do not support the resident under the arms as this prevents the resident from using his/her unaffected extremity. Do not allow resident to put arms around your neck... 21. The procedure is reversed form transferring the resident from the wheelchair back to bed."</p> <p>This Federal tag relates to Complaint IN00162988.</p> <p>3.1-45(a)(2)</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/13/2015

FORM APPROVED

OMB NO. 0938-0391

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