STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155156	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBORS AT MICHIGAN CITY	1101 E COOLSPRING AVE MICHIGAN CITY, IN 46360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaints IN00108317 and IN00109169. Complaint IN00108317-Substantiated. No deficiencies related to the allegations are cited. Complaint IN00109169-Substantiated. Federal/state deficiencies related to the allegation are cited at F225 and F226. Survey dates: June 5 & 6, 2012 Facility number: 000076 Provider number: 155156 AIM number: 100271060 Survey team: Janet Adams, RN Census bed type: SNF: 33 SNF/NF: 121 Total: 154 Census payor type: Medicare: 37 Medicaid: 100 Other: 17 Total: 154	F0000	In lieu of a revisit, please accept our plan of correction for a desk review.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	Sample: 9 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 6/7/12 Cathy Emswiller RN			

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F0225 SS=D	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. 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). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. 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. Based on observation, record review, and interview, the facility failed to ensure	F0225	F225 It is the intent of this facility to ensure injuries of unknown origin are throughly investigated	07/06/2012

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	injuries of unknown origins were thoroughly investigated related to not obtaining interviews from staff members providing resident care for 2 of 4 residents reviewed for injuries of unknown origin in the sample of 9. (Residents #F and #K) Findings include: 1. On 6/6/12 at 7:55 a.m. , Resident #K was observed sitting in a wheel chair at the Nurses Station on the 200 Hall. The resident had short sleeves on. An oval shaped echymotic area [bruise] was observed to the resident's left arm. The area was approximately 2 cm (centimeters) x 1 cm. The record for Resident #K was reviewed on 6/6/12 at 10:40 a.m. The resident's diagnoses included, but were not limited to, dementia, depression, and muscle spasms. The 4/20/12 MDS (Minimum Data Set) annual assessment indicated a BIMS (Brief Interview for Mental Status) was completed. The resident's score was (1), indicating she had sever impairment in her cognitive status. The assessment also indicated the resident required extensive assistance of two or more staff members for transferring and bed mobility. The assessment also indicated the resident required extensive assistance		and interviews are obtained from staff members who have provided care to the resident. 1. Resident K's care givers were reviewed and interviews obtained. No adverse findings were noted. Resident F: Upon further staff interviews it is unknown how skin tear occurred. The actions taken for prevention: Educated staff on resident's fragile skin; educated staff to report any changes to skin. Resident already has geri sleeves in place. Resident was screened by Therapy and changed to a two person hoyer transfer. 2. All residents have the potential to be affected by the same deficient practice. Investigations related to injuries of unknown orgin were reviewed for the past 30 days. No other residents were affected by this practice. 3. Nurse Managers were in-serviced on Thursday June 7, 2012 regarding the "Abuse and Neglect Procedural Guidelines" to include "Guidelines for Investigation" related to injuries of unknown orgin and completion of staff interviews. Incidents related to injuries of unknown orgin and completed interviews of staff that cared for resident will be reviewed by the IDT team in Clinical Meeting.. 4. The Director of Nursing/designee will conduct audits of incidents related to injuries of unknown orgin 5 times weekly using Audit Tool A to monitor compliance related to	

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	of one staff member for personal hygiene. The 6/2012 Physician Order Statement indicated the could be up as tolerated. Review of the 4/19/12 Nurses' Notes indicated an entry made at 2:30 p.m., indicated staff advised the nurse that the resident had raised area bruises on her left and right forehead. The entry also indicated the resident had a shower at 10:30 a.m. and the areas were not noted at that time. An "Incident/Accident Investigation" report was initiated on 4/19/12. The report indicated staff had advised the nurse of raised bruised areas on the left and right forehead and a treatment was implemented. The back page of the report had two sections titled "CNA Interview" and two sections titled "Nurse Interview." The CNA interview sections were completed. The first CNA indicated the CNA noted a bump and bruise on the resident's head and this was reported to the Nurse. The statement also indicated the resident had a shower at 10:30 a.m. and the mark was not there at that time. The second CNA interview indicated the staff noticed the bump on the resident's head and it was reported to the Nurse. The two "Nurse Interview" sections were blank		investigations are completed and include interviews of staff who cared for the resident. 5. Audits will be submitted to QA committee monthly times six. Then, after 3 months of no deficiency with audits, Committee will determine necessity of further monitoring. Date of Completion July 6, 2012.	

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	A "Skin Impairment Circumstance Investigation" form was initiated on 4/19/12. The report indicated purplish discolored raised areas were noted on the resident's forehead and the Physician was notified and a treatment was started for ice to be applied three times a day for 24 hours. The report indicated the resident did not have any recent fall, altercation, or any recent medical decline. The report also indicated the resident had no pain present. Two "Other Skin Impairment Assessment" forms were initiated on 4/19/12. The first form indicated a bruise raised area was present to the resident's left forehead. A second form indicated a bruised raised area was also noted to the right forehead. Review of the 4/30/12 Nurses' Notes indicated an entry was made at 8:00 p.m. This entry indicated the resident was noted to have two purplish discolorations to her left thigh and the resident did not complain of pain. The next entry in the Nurse's Notes was made on 5/2/12. An "Accident/Incident Report" was initiated on 4/30/12 at 8:00 p.m. The report indicated two purplish discolorations were noted to the resident's thigh. The areas measured 4.5 cm			

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	(Centimeters) x 2 cm and 2 cm x 2 cm. The Physician and the resident's family were notified. An "Incident/Accident Investigation" form was initiated on 4/30/12. The report indicated there was a section on the form titled "staff working in the last 24 hrs if applicable(attach interviews if possible)." The only staff documentation under this column read "attached." The back page of the report had two sections titled "CNA Interview" and two sections titled "Nurse Interview." The CNA Interview and the Nurse Interview sections were all blank. Under the "New Intervention" section of this form staff wrote "possibly occurred when res. (resident) involved in incident with (co resident name) on 4/28/12. A "Skin Impairment Circumstance, Assessment and Intervention" form was completed on 4/30/12. The form indicated a bruise was noted to the left thigh. The form also indicated the resident had no recent medical decline and no recent fall. Two "Other Skin Impairment Assessment" sheets were initiated on 4/30/12. The first indicated the resident had a bruise to the left thigh identified. The bruise measured 4.5 cm x 2.2 cm and was purple in color. The second			

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	sheet indicated another bruise was identified to the left thigh and the bruise measured 2 cm x 2 cm and was purple in color. The 5/2012 Nurses' Notes were reviewed. An entry made on 5/26/12 at 3:30 p.m.., indicated the resident was in the hallway and a purplish area of discoloration was noted to the top of her left hand. The area measured 3 cm x 2 cm. A "Accident/Incident Report" dated 5/26/12 indicated the resident was in the hallway and an area of purplish discoloration was noted to the resident's hand. An "Incident/Accident Investigation" form was completed on 5/26/12 at 3:30 p.m. The form indicated the resident was in the hallway and a 3 cm x 2 cm purplish discoloration was observed on the resident's hand. The report indicated there was a section on the form titled "staff working in the last 24 hrs if applicable(attach interviews if possible)." This section was blank. The back page of the report had two sections titled "CNA Interview" and two sections titled "Nurse Interview." The CNA Interview and the Nurse Interview sections were all blank. A "Skin Impairment Circumstance,			

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	Assessment and Intervention" form was completed on 4/30/12. The form indicated purplish discoloration was observed to the resident's left hand. The form also indicated the resident had no recent falls or medical decline. An "Other Skin Impairment Assessment" sheet was initiated on 5/26/12. This sheet indicated the resident had a bruise to the left hand measuring 3 cm x 2 cm and the resident had no complaints of pain. When interviewed on 6/6/12 at 12:05 p.m., the ADON indicated staff interviews of the staff that had provided care to the resident at the time of the above incidents should have been completed during the investigations as per the policies. When interviewed on 6/6/12 at 12:05 p.m., the Executive Director indicated staff interviews were not recorded from the employees caring for the residents. 2. The record for Resident #F was reviewed on 6/5/12 at 3:40 p.m. The resident's diagnoses included, but were not limited to, Alzheimer disease, insomnia, and depression. The 3/26/12			

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	Minimum Data Set (MDS) quarterly assessment indicated the resident's cognitive skills for decision making were severely impaired and the resident never/rarely made decisions. The assessment also indicated the resident required extensive assistance of two staff members for transfers and extensive assistance of one staff person for bed mobility, personal hygiene, and dressing. Review of the 4/16/12 Nurses' Notes indicated an entry was made on 4/16/12 at 4:00 p.m. The entry indicated the resident's son notified the Nurse the resident had a skin tear to the left elbow. It was unknown how the injury occurred. The skin tear measured 1.0 cm x 0.8 cm. and the resident had no expressions of pain. The next entry was made on 4/16/12 at 8:30 p.m. This entry indicated the Physician was notified and orders were obtained to apply Bacitracin (an antibiotic) ointment and cover the area. An "Accident/Incident Report" was completed on 4/16/12. The report indicated the resident's skin noted a skin tear to the resident's left elbow and it was unknown how it occurred. The Physician was notified at 8:30 p.m. An "Incident/Accident Investigation" report was initiated on 4/16/12. The			

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	report indicated there was a section on the form titled "Staff working in the last 24 hrs if applicable(attach interviews if possible)." This section was blank. The back page of the report had two sections titled "CNA Interview" and two sections titled "Nurse Interview." The CNA Interview and the Nurse Interview sections were all blank. A "Skin Impairment Circumstance Investigation" form was initiated on 4/16/12. The form indicated the resident had a skin tear to the left elbow and the resident had no recent falls. The form also indicated the resident did not have the ability to change positions and had a history of skin impairments. An "Other Skin Impairment Assessment" sheet was initiated on 4/16/12. The sheet indicated the resident had a skin tear to the left elbow measuring 1.0 cm x 0.8 cm and the treatment was to apply Bacitracin and cover the area. The 4/18/12 Nurses' Notes were reviewed. There was only one entry made on 4/18/12. This entry was made at 9:00 p.m. The entry indicated a purplish discoloration was noted to the right side of the resident's neck and the resident did not voice any complaints of pain or discomfort.			

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	An "Accident/Incident Report" was initiated on 4/18/12. The report noted a purplish discoloration was noted to the right side of the resident's neck. The Physician was notified and no new orders were given. An "Incident/Accident Investigation" was initiated on 4/18/12. The report indicated the CNA called the writer to the resident's room and the resident had a skin tear to the right elbow. The report indicated there was a section on the form titled "Staff working in the last 24 hrs if applicable(attach interviews if possible)." The words "see attached" was written in this section. The back page of the report had two sections titled "CNA Interview" and two sections titled "Nurse Interview." The CNA Interview and the Nurse Interview sections were all blank. There were no attachments with the investigation. A "Skin Impairment Circumstance, Assessment and Intervention" form was completed on 4/18/12. This form indicated the resident had no recent fall or medical decline and the resident was receiving Hospice care. An "Other Skin Impairment Assessment" sheet was initiated on 4/18/12. This sheet			

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	indicated a bruise was noted to the right side of the neck. The 5/12 Nurses' Notes were reviewed. An entry made on 5/7/12 at 3:00 p.m. indicated staff were advised a skin tear was noted to the resident's right elbow during care. An "Accident/Incident Investigation" report was initiated on 5/7/12 at 3:00 p.m. The report indicated a CNA called the Nurse to the resident's room and a .5 cm x .5 cm skin tear was observed on the resident's right elbow. The Physician was notified on 5/7/12 at 5:00 p.m. The report indicated there was a section on the form titled "Staff working in the last 24 hrs if applicable(attach interviews if possible)." The words "see attached" was written in this section. The back page of the report had two sections titled "CNA Interview" and two sections titled "Nurse Interview." On the back page there was one CNA interview completed. This interview was obtained from the CNA who found the skin tear. The interview indicated while the CNA was getting the resident up from the bed and she noticed a small skin tear on the resident's right elbow and notified the Nurse. A "Skin Impairment Circumstance, Assessment and Intervention" was			

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	completed on 5/7/12. The report indicated a skin tear was noted to the resident's right elbow and the resident had no recent fall or a medical decline. The facility policy titled "Abuse and Neglect Procedural Guidelines" was received from the ADON on 6/5/12 at 4:15 p.m. The policy had a revised date of 9/16/2011. The ADON identified the policy as current. The policy indicated that an injury of unknown source was an injury of which the source is not observed by any person or the source could not be explained by the resident and the nature of the injury is suspicious because of the extent of the injury or the number of injuries observed at one particular point in time. The facility policy titled "Guidelines for Investigation Folder" was reviewed on 6/6/12 at 2:30 p.m. The policy had a date of 11/2010. The policy was received from the ADON and identified as current. The policy indicated accidents and incidents should be thoroughly investigated to determine the cause and to implement interventions. The Investigation should include interviews of witnesses. If no witness, all persons that came into contact with the resident within three days prior the incident should be interviewed.			

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	When interviewed on 6/6/12 at 12:05 p.m., the ADON indicated staff interviews of the staff that had provided care to the resident at the time of the above incidents should have been completed during the investigations as per the policies. When interviewed on 6/6/12 at 12:05 p.m., the Executive Director indicated staff interviews were not recorded from the employees caring for the residents. This Federal tag relates to Complaint IN000109169. 3.1-28(c)			

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F0226 SS=D	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, record review, and interview, the facility failed to follow their policy for investigating injuries of unknown origin related to obtaining interviews from staff members caring for or having contact with the injures for 2 of 4 resident's with injuries of unknown origin review in the sample of 9. (Residents # F and #K) Findings include: 1. On 6/6/12 at 7:55 a.m. , Resident #K was observed sitting in a wheel chair at the Nurses Station on the 200 Hall. The resident had short sleeves on. An oval shaped echymotic area [bruise]was observed to the resident's left arm. The area was approximately 2 cm (centimeters) x 1 cm. The record for Resident #K was reviewed on 6/6/12 at 10:40 a.m. The resident's diagnoses included, but were not limited to, dementia, depression, and muscle spasms. The 4/20/12 MDS (Minimum Data Set) annual assessment indicated a	F0226	F226 It is the intent of this facility to ensure injuries of unknown origin are throughly investigated and interviews are obtained from staff members who have provided care to the resident. 1. Resident K's care givers were reviewed and interviews obtained. No adverse findings were noted. Resident F;: Upon further staff interviews it is unknown how skin tear occurred. The actions taken for prevention: Educated staff on resident's fragile skin; educated staff to report any changes to skin. Resident already has geri sleeves in place. Resident was screened by Therapy and changed to a two person hoyer transfer. 2. All residents have the potential to be affected by the same deficient practice. Investigations related to injuries of unknown orgin were reviewed for the past 30 days. No other residents were affected by this practice. 3. Nurse Managers were in-serviced on Thursday June 7, 2012 regarding the "Abuse and Neglect Procedural Guidelines" to include "Guidelines for Investigation" related to injuries of unknown orgin and completion of staff	07/06/2012

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	BIMS (Brief Interview for Mental Status) was completed. The resident's score was (1), indicating she had sever impairment in her cognitive status. The assessment also indicated the resident required extensive assistance of two or more staff members for transferring and bed mobility. The assessment also indicated the resident required extensive assistance of one staff member for personal hygiene. The 6/2012 Physician Order Statement indicated the could be up as tolerated. Review of the 4/19/12 Nurses' Notes indicated an entry made at 2:30 p.m., indicated staff advised the nurse that the resident had raised area bruises on her left and right forehead. The entry also indicated the resident had a shower at 10:30 a.m. and the areas were not noted at that time. An "Incident/Accident Investigation" report was initiated on 4/19/12. The report indicated staff had advised the nurse of raised bruised areas on the left and right forehead and a treatment was implemented. The back page of the report had two sections titled "CNA Interview" and two sections titled "Nurse Interview." The CNA interview sections were completed. The first CNA indicated the CNA noted a bump and bruise on the resident's head and this was reported to		interviews. Incidents related to injuries of unknown orgin and completed interviews of staff that cared for resident will be reviewed by the IDT team in Clinical Meeting.. 4. The Director of Nursing/designee will conduct audits of incidents related to injuries of unknown orgin 5 times weekly using Audit Tool A to monitor compliance related to investigations are completed and include interviews of staff who cared for the resident. 5. Audits will be submitted to QA committee monthly times six. Then, after 3 months of no deficiency with audits, Committee will determine necessity of further monitoring. Date of Completion July 6, 2012.	

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	the Nurse. The statement also indicated the resident had a shower at 10:30 a.m. and the mark was not there at that time. The second CNA interview indicated the staff noticed the bump on the resident's head and it was reported to the Nurse. The two "Nurse Interview" sections were blank Review of the 4/30/12 Nurses' Notes indicated an entry was made at 8:00 p.m. This entry indicated the resident was noted to have two purplish discolorations to her left thigh and the resident did not complain of pain. The next entry in the Nurse's Notes was made on 5/2/12. An "Accident/Incident Report" was initiated on 4/30/12 at 8:00 p.m. The report indicated two purplish discolorations were noted to the resident's thigh. The areas measured 4.5 cm (Centimeters) x 2 cm and 2 cm x 2 cm. The Physician and the resident's family were notified. An "Incident/Accident Investigation" form was initiated on 4/30/12. The report indicated there was a section on the form titled "staff working in the last 24 hrs if applicable(attach interviews if possible)." The only staff documentation under this			

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	column read "attached." The back page of the report had two sections titled "CNA Interview" and two sections titled "Nurse Interview." The CNA Interview and the Nurse Interview sections were all blank. Under the "New Intervention" section of this form staff wrote "possibly occurred when res. (resident) involved in incident with (co resident name) on 4/28/12. The 5/2012 Nurses' Notes were reviewed. An entry made on 5/26/12 at 3:30 p.m.., indicated the resident was in the hallway and a purplish area of discoloration was noted to the top of her left hand. The area measured 3 cm x 2 cm. A "Accident/Incident Report" dated 5/26/12 indicated the resident was in the hallway and an area of purplish discoloration was noted to the resident's hand. An "Incident/Accident Investigation" form was completed on 5/26/12 at 3:30 p.m. The form indicated the resident was in the hallway and a 3 cm x 2 cm purplish discoloration was observed on the resident's hand. The report indicated there was a section on the form titled "staff working in the last 24 hrs if applicable(attach interviews if possible)."			

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	This section was blank. The back page of the report had two sections titled "CNA Interview" and two sections titled "Nurse Interview." The CNA Interview and the Nurse Interview sections were all blank. When interviewed on 6/6/12 at 12:05 p.m., the ADON indicated staff interviews of the staff that had provided care to the resident at the time of the above incidents should have been completed during the investigations as per the policies. When interviewed on 6/6/12 at 12:05 p.m., the Executive Director indicated staff interviews were not recorded from the employees caring for the residents. 2. The record for Resident #F was reviewed on 6/5/12 at 3:40 p.m. The resident's diagnoses included, but were not limited to, Alzheimer disease, insomnia, and depression. The 3/26/12 Minimum Data Set (MDS) quarterly assessment indicated the resident's cognitive skills for decision making were severely impaired and the resident never/rarely made decisions. The assessment also indicated the resident required extensive assistance of two staff members for transfers and extensive assistance of one staff person for bed			

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	mobility, personal hygiene, and dressing. Review of the 4/16/12 Nurses' Notes indicated an entry was made on 4/16/12 at 4:00 p.m. The entry indicated the resident's son notified the Nurse the resident had a skin tear to the left elbow. It was unknown how the injury occurred. The skin tear measured 1.0 cm x 0.8 cm. and the resident had no expressions of pain. The next entry was made on 4/16/12 at 8:30 p.m. This entry indicated the Physician was notified and orders were obtained to apply Bacitracin (an antibiotic) ointment and cover the area. An "Accident/Incident Report" was completed on 4/16/12. The report indicated the resident's skin noted a skin tear to the resident's left elbow and it was unknown how it occurred. The Physician was notified at 8:30 p.m. An "Incident/Accident Investigation" report was initiated on 4/16/12. The report indicated there was a section on the form titled "Staff working in the last 24 hrs if applicable(attach interviews if possible)." This section was blank. The back page of the report had two sections titled "CNA Interview" and two sections titled "Nurse Interview." The CNA Interview and the Nurse Interview sections were all blank.			

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	The 4/18/12 Nurses' Notes were reviewed. There was only one entry made on 4/18/12. This entry was made at 9:00 p.m. The entry indicated a purplish discoloration was noted to the right side of the resident's neck and the resident did not voice any complaints of pain or discomfort. An "Accident/Incident Report" was initiated on 4/18/12. The report noted a purplish discoloration was noted to the right side of the resident's neck. The Physician was notified and no new orders were given. An "Incident/Accident Investigation" was initiated on 4/18/12. The report indicated the CNA called the writer to the resident's room and the resident had a skin tear to the right elbow. The report indicated there was a section on the form titled "Staff working in the last 24 hrs if applicable(attach interviews if possible)." The words "see attached" was written in this section. The back page of the report had two sections titled "CNA Interview" and two sections titled "Nurse Interview." The CNA Interview and the Nurse Interview sections were all blank. There were no attachments with the investigation.			

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	The 5/12 Nurses' Notes were reviewed. An entry made on 5/7/12 at 3:00 p.m. indicated staff were advised a skin tear was noted to the resident's right elbow during care. An "Accident/Incident Investigation" report was initiated on 5/7/12 at 3:00 p.m. The report indicated a CNA called the Nurse to the resident's room and a .5 cm x .5 cm skin tear was observed on the resident's right elbow. The Physician was notified on 5/7/12 at 5:00 p.m. The report indicated there was a section on the form titled "Staff working in the last 24 hrs if applicable(attach interviews if possible)." The words "see attached" was written in this section. The back page of the report had two sections titled "CNA Interview" and two sections titled "Nurse Interview." On the back page there was one CNA interview completed. This interview was obtained from the CNA who found the skin tear. The interview indicated while the CNA was getting the resident up from the bed and she noticed a small skin tear on the resident's right elbow and notified the Nurse. A "Skin Impairment Circumstance, Assessment and Intervention" was completed on 5/7/12. The report			

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	indicated a skin tear was noted to the resident's right elbow and the resident had no recent fall or a medical decline. The facility policy titled "Abuse and Neglect Procedural Guidelines" was received from the ADON on 6/5/12 at 4:15 p.m. The policy had a revised date of 9/16/2011. The ADON identified the policy as current. The policy indicated that an injury of unknown source was an injury of which the source is not observed by any person or the source could not be explained by the resident and the nature of the injury is suspicious because of the extent of the injury or the number of injuries observed at one particular point in time. The facility policy titled "Guidelines for Investigation Folder" was reviewed on 6/6/12 at 2:30 p.m. The policy had a date of 11/2010. The policy was received from the ADON and identified as current. The policy indicated accidents and incidents should be thoroughly investigated to determine the cause and to implement interventions. The Investigation should include interviews of witnesses. If no witness, all persons that came into contact with the resident within three days prior the incident should be interviewed.			

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	When interviewed on 6/6/12 at 12:05 p.m., the ADON indicated staff interviews of the staff that had provided care to the resident at the time of the above incidents should have been completed during the investigations as per the policies. When interviewed on 6/6/12 at 12:05 p.m., the Executive Director indicated staff interviews were not recorded from the employees caring for the residents. This Federal tag relates to Complaint IN000109169. 3.1-28(a)			