STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155662	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NURSING CARE AT HARTSFIELD VILLAGE	503 OTIS R BOWEN DR MUNSTER, IN 46321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F000000	This visit was for the Investigation of Complaints IN00142011 and IN00142361. Complaint IN00142011-Substantiated. Federal/State deficiencies related to the allegations are cited at F157, F225, and F226. Complaint IN00142361-Substantiated. Federal/State deficiency related to the allegation is cited at F157. Survey dates: January 16 & 17, 2014 Facility number: 010758 Provider number: 155662 AIM number: 200229550 Survey team: Janet Adams, RN, TC Census bed type: SNF: 88 SNF/NF: 16 Total: 104 Census payor type: Medicare: 27 Medicaid: 12	F000000	Preparation and/or execution of the plan of correction in general, or these corrective actions in particular, does not constitute an admission or agreement of Nursing Care at Hartsfield Village of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal laws. It is the intention of this facility that this plan of correction serves as the facility's credible allegation of compliance with all regulatory guidelines.	

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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	Other: 65 Total: 104 Sample: 5 These deficiencies reflect State finding cited in accordance with 410 IAC 16.2. Quality review completed on January 25, 2014, by Janelyn Kulik, RN.			

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F000157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on record review and interview, the facility failed to ensure the resident's Physician was notified of a change in a pressure ulcer and a new onset of rectal/vaginal	F000157	F1571.Corrections from previous timeframes cannot be made. Resident #E was discharged to the hospital on 9-16-13 when the physician was notified of the residents change in condition.	02/07/2014

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	drainage for 1 of 3 resident's reviewed for change in condition in the sample of 5. (Resident #E). The facility also failed to notify the resident's family and/or responsible party of a change in a pressure ulcer, laboratory tests results and orders, and a medication change for 3 of 3 residents reviewed for condition changes in the sample of 5. (Residents #E, #F and #H) Findings include: 1. The closed record for Resident #E was reviewed on 1/16/14 at 11:45 a.m. The resident's diagnoses included, but were not limited to anxiety state, diabetes mellitus, anemia (low blood count), and acute kidney failure. A Skin Condition Report initiated on 8/24/13 indicated a Stage II (a partial thickness skin loss involving epidermis, dermis, or both) ulcer was observed to the resident's coccyx. The report indicated the ulcer measured 2.0 cm (centimeters) x 2.0 cm. and was red in color. An entry made on 8/26/13 indicated the ulcer remained a Stage II, measured 2.6 cm x 2.2 cm, and was red in color. An entry made on 9/2/13 indicated the ulcer remained a Stage		Resident #E did not return to the facility. Resident #H was discharged to the hospital on 12-16-13 when the physician was notified of the residents change in condition. Resident #H did not return to the facility. Resident #F remains a resident of the facility. Resident #F's family is aware of current treatment regimen.2.All residents could have been potentially been affected by this alleged deficient practice. A 100% audit of current residents was performed between the dates of 01-10-14 to 01-17-14 to ensure family/physician notification of change of condition was completed per policy. Notifications found non-compliant with the policy were completed as identified.3. Policies for Physician/Family Notification of Change in Condition and Accident/Incident were reviewed and revised to update the physician notification requirements. In-service education has been provided to all nurses from 1-21-14 through 2-7-14 to ensure understanding of policy. A new system was developed and instituted to document messages left or pages that were sent to physicians/families. The form entitled "Physician/Family Notification Needs" (attachment #1) will be kept hanging near the phones at all nurses stations to alert nurses and/or administration to follow up on messages left with	

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	II, measured 2.4 cm x 2.0 cm, and was red in color. An entry made on 9/9/13 indicated the ulcer remained a Stage II, measured 2.4 cm x 2.0 cm, and was red in color. An entry made on 9/16/13 indicated the ulcer remained a Stage II, measured 2.0 cm x 1.6 cm, and the wound color was white/red in color. The 9/2013 Nursing Progress Notes were reviewed. An entry made on 9/14/13 at 7:00 a.m., indicated the Physician was paged related to the Stage II pressure ulcer to the resident's coccyx. The wound was open with whitish/yellow slough (necrotic or avascular tissue in the process of separating from viable tissue) in the center of the wound. The call was made to inquire whether the Physician wanted to change orders as the treatment appeared not to be causing improvement of the wound. The entry indicated staff were awaiting a call from the Physician. The next entry was made on 9/14/13 at 2:00 p.m. This entry indicated the Physician was paged about the coccyx wound and no call back received. The next entry was made on 9/14/13 at 8:00 p.m. There was no documentation related to the coccyx wound or any further calls		the physician/family and, further to call the alternate physician or Medical Director if there is no response or a lack of response from the attending physician. The Unit Manager/designee will monitor the clipboard throughout each shift to ensure timely follow up with the family/physician.4.DON/ADON/Designee will review 100% of current resident charts by 2-7-14 to ensure Family/Physician notification of change in the resident's condition has been made. Thereafter, the DON/ADON/Designee will review 20% of resident charts daily 5 X per week for 4 weeks to ensure compliance with Family/Physician notification of change of condition policy. DON/ADON/Designee will continue a daily audit with a 15% resident sample thereafter to ensure continued compliance with the facility policy. Results of the audits will be brought to the QA Nurse monthly for tracking, trending and follow up training needs. The tool entitled "Significant Condition-Quality Review Data Collection Form" (attachment #2) will be used to audit resident charts to confirm notifications of family/physician new orders. Results requiring attention and additional staff training will be brought to the QAPI Committee meeting quarterly for review and/or recommendations.5.DON responsible for compliance.	

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	made to the Physician. The next entry in the 9/2013 Progress Notes was made on 9/15/13 at 6:00 a.m. This entry indicated the coccyx area remained open with a scant amount of white slough noted. There was no documentation of any attempted calls to the Physician in this entry. Further entries made on 9/15/13 at 10:15 a..m., and on 9/15/13 at 7:00 p.m., indicated there was no documentation of the Physician being notified of the wound changes. There was no documentation of the resident's family or responsible party being notified of the wound changes. An entry made on 9/16/13 at 5:00 a.m. indicated Nurse #3 and the CNA #2 entered the resident's room to do a "brief change & dressing change" to the coccyx. The CNA turned the resident on her left side. The resident had a bowel movement. A new pad and brief were placed under the resident and "excrement" was seen "coming from vaginal area [sig]." Both the Nurse and the CNA visualized the rectum and "noted the rectum remained clean and free of excrement, however excrement continues to exude from vaginal area after being wiped away 2 more times." The Physician was paged at 6:15 a.m.			

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	and "has not returned call. Will pass on to day shift." There was no documentation of the resident's family and/or responsible party being notified of the above occurrence. The next entry was made on 9/16/13 at 10:50 a.m. This entry indicated the resident had some confusion. The entry also indicated the resident's temperature was 99.0 degrees Fahrenheit. There was no documentation of any further attempts to contact the Physician related to the excrement noted coming from the resident's vaginal area. There was no documentation of the resident's family and/or responsible party being notified of the vaginal discharge. The next entry was made on 9/16/13 at 12:00 p.m. This entry indicated the resident left the facility via ambulance transport to have a MRI test performed. There was no documentation of the any further attempts to contact the Physician related to the discharge noted coming from the resident's vaginal area. There was no documentation of the resident's family and/or responsible party being notified of the concern.			

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	The next entry was made on 9/16/13 at 2:45 p.m. This entry indicated the resident returned to the facility from her appointment. The entry also indicated no new orders were received. There was no documentation of the any further attempts to contact the Physician related to the discharge noted coming from the resident's vaginal area. There was no documentation of the resident's family and/or responsible party being notified of the concern. The next entry was made on 9/16/13 at 4:00 p.m. This entry indicated the Nurse from the previous shift (the day shift) noted green watery discharge from the resident's vagina. The entry also indicated the Nurse had reported to the writer and the Physician was paged. The entry also indicated orders were obtained from the Physician to send the resident to the hospital and the resident was sent to the hospital via ambulance transport. The 4:00 p.m. entry was made by LPN #4. 2. The closed record for Resident #H was reviewed on 1/16/14 at 10:15 a.m. The resident's diagnoses			

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	included, but were not limited to, dementia, urinary tract infection, atrial fibrillation (an irregular heart beat), high blood pressure, and spine fracture. Review of the 12/2013 Physician orders indicated there was an order written on 12/1/13. The order was for a CBC (Complete Blood Count) laboratory test to be completed related to fatigue and malaise. The 12/2013 Nursing Progress Notes were reviewed. An entry made on 12/3/13 at 10:00 a.m. indicated laboratory results were called to the Physician and the Physician ordered a repeat CBC laboratory test to be completed in one month. There was no documentation in the Nursing Progress Notes of family and/or responsible party notification of the above. 3. The record for Resident #F was reviewed on 1/16/13 at 11:00 a.m. The resident's diagnoses included, but were not limited to, chronic kidney disease, congestive heart failure, and urinary retention. The 12/2013 Physician orders were			

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	reviewed. Two orders were written on 12/13/13 at 2:45 p.m. The first order was to discontinue Cipro (an antibiotic) 500 milligrams twice a day. The second order indicated the resident was to start receiving Bactrim (an antibiotic) single strength one tablet daily for 7 days. The 12/2013 Medication Administration Record was reviewed. Cipro 500 milligrams was discontinued on 12/13/13. Bactrim single strength was initiated on 12/14/13. Review of the 12/2013 Nursing Progress Notes indicated an entry was made on 12/13/13 at 2:50 p.m. This entry indicated staff had spoken with the resident's Physician and new orders were received. There was no documentation of the resident's family and/or responsible party being notified of the above medication changes from 12/13/13 through 12/14/13. When interviewed on 1/17/13 at 10:30 a.m., the Director of Nursing indicated the Nursing staff generally wait unit the Physician was notified of the change in condition and report the change and the orders to the family then. The Director of Nursing			

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	indicated the resident's Physician and family/responsible party were to be notified of changes in the resident's condition. The facility policy titled "Guidelines for Physician Notification for Change in Condition Overview" was reviewed on 1/16/14 at 9:35 a.m. The policy was dated with revised date of 4/20/2004. The Director of Nursing provided the policy and identified the policy as current. The policy indicated all significant changes in the resident's condition were to be thoroughly assessed and Physician notification was to be based on the assessment findings. The policy also indicated Physician notification was to be documented in the medical record. The policy indicated the Physician was to be notified of vaginal discharge. This Federal tag relates to Complaints IN00142011 and IN00142361. 3.1-5(a)(2) 3.1-5(a)(3)			

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F000225 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 record review and	F000225	1. Resident E is no longer at	01/17/2014

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	interview, the facility failed to ensure an allegation of possible abuse was thoroughly investigated and investigated in a timely manner for 1 of 1 allegations of possible abuse reviewed. The facility also failed to report the allegation to State survey agency as required for 1 of 1 allegations reviewed. (Resident #E) Findings include: A facility reported "Incident Report Form" dated 11/27/13 was reviewed on 1/16/14 at 12:40 p.m. The reported incident was marked as being the initial and follow -up report. The report indicated the incident date was listed as 9/16/13. The resident involved was identified as Resident #E. A description of the incident indicated a staff member and an RN were in the resident's room at 5:00 a.m. on 9/16/13 to perform rounds. The resident was turned on her left side to have her brief changed and the dressing to her coccyx changed. Staff cleaned the resident of bowel movement and when placing a new pad on the bed they noticed excrement coming out of the resident's vaginal area. The rectum remained clean and "green watery discharge continued to exude		the facility.2.All concerns and/or incident reports regarding potential abuse have been immediately investigated to determine cause and rule out any forms of alleged possible abuse. A report will be immediately made to the ISDH and the appropriate authorities if possible abuse is suspected as required by state and federal requirements. All residents could have been potentially affected by this alleged deficient practice however no other residents were identified as being affected. 3.Any and all allegations of alleged abuse will continue to be required to be reported immediately to the Supervisor and the Administrator for follow up investigation and reporting as required by state and federal requirements. Any condition changes unusual in nature will be immediately reported to the DON/ADON and carried to the Administrator for follow up investigation and reporting as required by state and federal requirements. Any staff member found to be involved in any form of abuse will be immediately disciplined per facility policy and reported to the appropriate licensing agency as well as local law enforcement. The facility entered into a contract with a Security Company and security has been placed in the facility 24 hours per day 7 days per week. Security rounds were implemented every 2 hours	

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	from the vaginal area" after being wiped away twice. The resident was sent to the hospital on 9/16/13 due to "an apparent genitourinary condition where upon examination at the Hospital revealed the presence of a rectovaginal fistula. Etiology unknown." The resident was admitted to the hospital. The (name of the city) Police were called and are currently investigating this incident for "possible sexual abuse." The closed record for Resident #E was reviewed on 1/16/14 at 11:45 a.m. The resident's diagnoses included, but were not limited to anxiety state, diabetes mellitus, anemia (low blood count), and acute kidney failure. The 9/2013 Nursing Progress Notes were reviewed. An entry made on 9/16/13 at 5:00 a.m. indicated the Nurse and the CNA entered the resident's room to do a "brief change & dressing change" to the coccyx. The CNA turned the resident on her left side. The resident had a bowel movement. A new pad and brief were placed under the resident and "excrement" was seen "coming from vaginal area [sig]." Both the Nurse and the CNA visualized the rectum and "noted the rectum remained		around the clock by walking the entire building and each hallway watching for any unusual activity. Nurse rounds are done every 2 hours on opposite hours of security rounds. Mobile security guards monitor the campus grounds and parking areas in a marked vehicle 24 hours per day to display security presence. Every visitor and guest at the building is required to sign in upon arrival and sign out with security when leaving the facility. Every visitor and guest is provided a visitor pass to display at all times. Administrator met with the Resident Council and discussed safety and security with the group. The residents stated that they were “happy, comfortable and felt very secure and safe” in their home. All staff has been educated on the policies regarding investigation and reporting of suspected abuse on Abuse, Elder Justice Law, Resident Rights and HIPAA. The education and training is also given to all new employees during general orientation or as needed to all staff on an on-going basis. Criminal Background Checks continue to be required for all employees at Hartsfield Village and are completed prior to orientation as part of our hiring requirement.4.All concern forms regarding any form of possible abuse, nurse round reports, security reports and incident reports will be reviewed daily 5 X	

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	clean and free of excrement, however excrement continues to exude from vaginal area after being wiped away 2 more times." The Physician was paged at 6:15 a.m. and "has not returned call. Will pass on to day shift." The next entry was made on 9/16/13 at 10:50 a.m. This entry indicated the resident had some confusion. The entry also indicated the resident's temperature was 99.0 degrees Fahrenheit. The next entry was made on 9/16/13 at 12:00 p.m. This entry indicated the resident left the facility via ambulance transport to have a MRI test performed. The next entry was made on 9/16/13 at 2:45 p.m. This entry indicated the resident returned to the facility from her appointment. The entry also indicated no new orders were received. The next entry was made on 9/16/13 at 4:00 p.m. This entry indicated the Nurse from the previous shift (the day shift) noted green watery discharge from the resident's vagina. The entry also indicated the Nurse had reported to the writer and the		per week by the Administrator/Designee and actions taken as required. Unusual resident condition changes will be discussed in the morning meeting (or privately) as needed and investigations completed to ensure appropriate actions have been taken as required. Results of any unusual finding will be brought to the QAPI Committee meeting quarterly (on-going) for tracking, trending and/or recommendations. 5.Administrator responsible for compliance.	

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	Physician was paged. The entry also indicated orders were obtained from the Physician to send the resident to the hospital and the resident was sent to the hospital via ambulance transport. This entry was completed by LPN #4. Hospital records in Resident #E's closed record were reviewed. An Emergency Department note dated 9/16/13 at 5:03 p.m. indicated the resident was sent by EMS (Emergency Medical Services) for stool coming out of the resident's vaginal site since the a.m. A hospital Operative Note indicated a colostomy was placed on 9/18/13 for a preoperative diagnosis of "colovaginal fistula." The note indicated there was a large amount of stool present in the vagina and the rectum. The note also indicated "It appeared there were three lacerations posteriorly and there was no evidence of cancer. There were sharp torn edges and three separate points. It was felt that it would be unusual for all to occur at the same time naturally." Another hospital report indicated a diagnostic hysteroscopy was performed on 9/26/13. The report			

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	indicated three rectovaginal fistulas were noted and there was no evidence of a tumor. The report indicated "These appeared traumatic in nature." A hospital Progress Note, dated 9/27/13 at 2:32 p.m., was reviewed. The Progress Note was completed by a hospital Social Worker. The note indicated the Surgeon notified the Social Worker that he "suspects patient's vaginal fistulas could be from sexual abuse." The note indicated Resident #E was interviewed by the Social Worker and was asked if anyone had touched her vagina and the resident replied "...I don't remember anything." The note also indicated the Social Worker spoke to the facility and requested medical records from the facility including Nursing Notes, Progress Notes, and Medication sheets from the resident's stay. When interviewed on 1/16/14 at 2:05 p.m., the facility Administrator indicated staff noted excrement coming from the resident's vagina early in the morning on 9/16/13 and both CNA #2 and Nurse #3 observed the above at the time. Later in the day the resident went to			

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	the hospital for a scheduled MRI and returned to the facility. The resident was later sent to the hospital and was admitted. When interviewed on 1/16/14 at 2:32 p.m., the facility Administrator indicated Resident #E was admitted to the facility on 8/24/13 and was discharged on 9/16/13. The Administrator indicated their Admissions staff received a call from Social Worker #1 at the hospital on 9/27/13 stating the resident had surgery and they needed the resident's medical records from the facility. The hospital Social Worker requested the Administrator call hospital Social Worker #2. The Administrator indicated she called the hospital at approximately 12:00 p.m. on 9/27/13. The Administrator indicated hospital Social Worker #2 informed her they were "not accusing" the facility and they needed information regarding the residents orientation status, mental status, and visitors the resident had received at the facility. The Administrator indicated she informed hospital Social Worker #2 that Resident #E was alert and oriented but had periods of confusion, was known to have multiple visitors, and had been sent out for an MRI			

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	around noon on 9/16/13 and when she returned to the facility the Physician was called and the resident was sent to the hospital for an evaluation. The Administrator indicated hospital Social Worker #2 told her the resident's Surgeon indicated they felt the injury was "due to trauma." The hospital Social Worker also indicated it was her understanding it was "recent." The facility Administrator indicated the facility did not complete any staff or resident interviews on 9/27/13. The Administrator indicated they contacted an Attorney on 9/30/13 and was instructed to interview the Nursing staff caring for Resident #E on the Evening shift of 9/15/13 thru the night shift beginning on 9/15/13 and ending on 9/16/13 at 6:00 a.m. The facility Administrator indicated they then began conducting the staff interviews. Continued interview with the facility Administrator indicated one month later on 10/29/13, the facility received a phone call from the local Police Department. The Administrator indicated she spoke with the Police Officer and they requested a list of the names of the employees who worked with or had			

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	access to Resident #E. The Administrator indicated she contacted the above Attorney again and then emailed the list of employees to the Police Officer. The facility Administrator indicated there were no more contacts with the Police Department. Continued interview with the Administrator indicated there were no further issues related to Resident #E until 11/27/13. The facility Administrator indicated she was contacted by the facility Attorney on 11/27/13 and received copies of Resident #E's medical records from her hospitalization in September. The Administrator indicated the incident was not reported to the Indiana State Department of Health until 11/27/13. When interviewed on 1/17/14 at 10:45 a.m., the Administrator indicated the facility then started inservicing staff members on abuse, resident rights, neglect , and the Elder Justice Act on 11/27/13. The Administrator indicated they also implemented 24 hour Security service on 11/27/13. When interviewed on 1/17/14 at 11:50 a.m., the Administrator			

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	indicated the facility policy was to report any incidents or unusual occurrences within 24 hours to the Indiana State Department of Health. The Administrator indicated they felt they did not have an incident in September as the information they had was "hearsay." The facility policy titled "Abuse Prevention" was reviewed on 1/16/14 at 9:10 a.m. The policy had a revised date of 10/2011. The facility Administrator provided the policy and indicated the policy was current. The policy indicated the facility was to comply with state and federal regulations for reporting suspected or actual acts. The policy indicated the Administrator was responsible to supervise the investigative process. Methods of investigation could include obtaining written statements from supervising and direct care staff members, interviewing individuals including other residents, staff, and visitors. The policy also indicated the results of all the internal investigations were to be finalized and reported to all regulatory bodies within five working days of the incident. A copy of the investigative record and a written report were to be made to the Indiana State Department of Health.			

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	The facility policy titled "Accident/Incident and Unusual Occurrence" policy was reviewed on 1/17/14 at 12:15 p.m. The policy had a revised date of 6/30/11. The facility Administrator provided the policy and indicated the policy was current. The policy indicated any injury was to be classified as an injury of unknown source when both of the following conditions were met: 1. "The Source of the injury was not observed by any persons or the source of the injury could not be explained by the resident; AND 2. The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally not vulnerable to trauma) or the number of injuries observed at one particular point in time or the incident of injuries over time." This Federal tag relates to Complaint IN00142011. 3.1-28(c) 3.1-28(d)			

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F000226 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 record review and interview, the facility failed to follow their Abuse Prevention and Accident/Incident and Unusual Occurrence Policies related to completing a thorough and timely investigation of possible abuse and reporting the incident to the required agencies in a timely manner for 1 of 1 investigations reviewed. (Resident #E) Findings include: A facility reported "Incident Report Form" dated 11/27/13 was reviewed on 1/16/14 at 12:40 p.m. The reported incident was marked as being the initial and follow -up report. The report indicated the incident date was listed as 9/16/13. The resident involved was identified as Resident #E. A description of the incident indicated a staff member and an RN were in the resident's room at 5:00 a.m. on 9/16/13 to	F000226	1. Resident E is no longer at the facility.2.All concerns and/or incident reports regarding potential abuse have been immediately investigated to determine cause and rule out any forms of alleged possible abuse. A report will be immediately made to the ISDH and the appropriate authorities if possible abuse is suspected as required by state and federal requirements. All residents could have been potentially affected by this alleged deficient practice however no other residents were identified as being affected. 3.Any and all allegations of alleged abuse will continue to be required to be reported immediately to the Supervisor and the Administrator for follow up investigation and reporting as required by state and federal requirements. Any condition changes unusual in nature will be immediately reported to the DON/ADON and carried to the Administrator for follow up investigation and reporting as required by state and federal requirements. Any staff member found to be involved in	01/17/2014

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	perform rounds. The resident was turned on her left side to have her brief changed and the dressing to her coccyx changed. Staff cleaned the resident of bowel movement and when placing a new pad on the bed they noticed excrement coming out of the resident's vaginal area. The rectum remained clean and "green watery discharge continued to exude from the vaginal area" after being wiped away twice. The resident was sent to the hospital on 9/16/13 due to "an apparent genitourinary condition where upon examination at the Hospital revealed the presence of a rectovaginal fistula. Etiology unknown." The resident was admitted to the hospital. The (name of the city) Police were called and are currently investigating this incident for "possible sexual abuse." The closed record for Resident #E was reviewed on 1/16/14 at 11:45 a.m. The resident's diagnoses included, but were not limited to anxiety state, diabetes mellitus, anemia (low blood count), and acute kidney failure. The 9/2013 Nursing Progress Notes were reviewed. An entry made on 9/16/13 at 5:00 a.m. indicated the Nurse and the CNA entered the		any form of abuse will be immediately disciplined per facility policy and reported to the appropriate licensing agency as well as local law enforcement. The facility entered into a contract with a Security Company and security has been placed in the facility 24 hours per day 7 days per week. Security rounds were implemented every 2 hours around the clock by walking the entire building and each hallway watching for any unusual activity. Nurse rounds are done every 2 hours on opposite hours of security rounds. Mobile security guards monitor the campus grounds and parking areas in a marked vehicle 24 hours per day to display security presence. Every visitor and guest at the building is required to sign in upon arrival and sign out with security when leaving the facility. Every visitor and guest is provided a visitor pass to display at all times. Administrator met with the Resident Council and discussed safety and security with the group. The residents stated that they were “happy, comfortable and felt very secure and safe” in their home. All staff has been educated on the policies regarding investigation and reporting of suspected abuse on Abuse, Elder Justice Law, Resident Rights and HIPAA. The education and training is also given to all new employees during general orientation or as needed	

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	resident's room to do a "brief change & dressing change" to the coccyx. The CNA turned the resident on her left side. The resident had a bowel movement. A new pad and brief were placed under the resident and "excrement" was seen "coming from vaginal area [sig]." Both the Nurse and the CNA visualized the rectum and "noted the rectum remained clean and free of excrement, however excrement continues to exude from vaginal area after being wiped away 2 more times." The Physician was paged at 6:15 a.m. and "has not returned call. Will pass on to day shift." The next entry was made on 9/16/13 at 10:50 a.m. This entry indicated the resident had some confusion. The entry also indicated the resident's temperature was 99.0 degrees Fahrenheit. The next entry was made on 9/16/13 at 12:00 p.m. This entry indicated the resident left the facility via ambulance transport to have a MRI test performed. The next entry was made on 9/16/13 at 2:45 p.m. This entry indicated the resident returned to the facility from her appointment. The entry also		to all staff on an on-going basis. Criminal Background Checks continue to be required for all employees at Hartsfield Village and are completed prior to orientation as part of our hiring requirement.4.All concern forms regarding any form of possible abuse, nurse round reports, security reports and incident reports will be reviewed daily 5 X per week by the Administrator/Designee and actions taken as required. Unusual resident condition changes will be discussed in the morning meeting (or privately) as needed and investigations completed to ensure appropriate actions have been taken as required. Results of any unusual finding will be brought to the QAPI Committee meeting quarterly (on-going) for tracking, trending and/or recommendations. 5.Administrator responsible for compliance.	

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	indicated no new orders were received. The next entry was made on 9/16/13 at 4:00 p.m. This entry indicated the Nurse from the previous shift (the day shift) noted green watery discharge from the resident's vagina. The entry also indicated the Nurse had reported to the writer and the Physician was paged. The entry also indicated orders were obtained from the Physician to send the resident to the hospital and the resident was sent to the hospital via ambulance transport. This entry was completed by LPN #4. Hospital records in Resident #E's closed record were reviewed. An Emergency Department note dated 9/16/13 at 5:03 p.m. indicated the resident was sent by EMS (Emergency Medical Services) for stool coming out of the resident's vaginal site since the a.m. A hospital Operative Note indicated a colostomy was placed on 9/18/13 for a preoperative diagnosis of "colovaginal fistula." The note indicated there was a large amount of stool present in the vagina and the rectum. The note also indicated "It appeared there were three			

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	lacerations posteriorly and there was no evidence of cancer. There were sharp torn edges and three separate points. It was felt that it would be unusual for all to occur at the same time naturally." Another hospital report indicated a diagnostic hysteroscopy was performed on 9/26/13. The report indicated three rectovaginal fistulas were noted and there was no evidence of a tumor. The report indicated "These appeared traumatic in nature." A hospital Progress Note, dated 9/27/13 at 2:32 p.m., was reviewed. The Progress Note was completed by a hospital Social Worker. The note indicated the Surgeon notified the Social Worker that he "suspects patient's vaginal fistulas could be from sexual abuse." The note indicated Resident #E was interviewed by the Social Worker and was asked if anyone had touched her vagina and the resident replied "...I don't remember anything." The note also indicated the Social Worker spoke to the facility and requested medical records from the facility including Nursing Notes, Progress Notes, and Medication sheets from the			

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	resident's stay. When interviewed on 1/16/14 at 2:32 p.m., the facility Administrator indicated Resident #E was admitted to the facility on 8/24/13 and was discharged on 9/16/13. The Administrator indicated their Admissions staff received a call from Social Worker #1 at the hospital on 9/27/13 stating the resident had surgery and they needed the resident's medical records from the facility. The hospital Social Worker requested the Administrator call hospital Social Worker #2. The Administrator indicated she called the hospital at approximately 12:00 p.m. on 9/27/13. The Administrator indicated hospital Social Worker #2 informed her they were "not accusing" the facility and they needed information regarding the residents orientation status, mental status, and visitors the resident had received at the facility. The Administrator indicated she informed hospital Social Worker #2 that Resident #E was alert and oriented but had periods of confusion, was known to have multiple visitors, and had been sent out for an MRI around noon on 9/16/13 and when she returned to the facility the Physician was called and the			

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	resident was sent to the hospital for an evaluation. The Administrator indicated hospital Social Worker #2 told her the resident's Surgeon indicated they felt the injury was "due to trauma." The hospital Social Worker also indicated it was her understanding it was "recent." The facility Administrator indicated the facility did not complete any staff or resident interviews on 9/27/13. The Administrator indicated they contacted an Attorney on 9/30/13 and were instructed to interview the Nursing staff caring for Resident #E on the Evening shift of 9/15/13 thru the night shift beginning on 9/15/13 and ending on 9/16/13 at 6:00 a.m. The facility Administrator indicated they then began conducting the staff interviews. Continued interview with the Administrator indicated there were no further issues related to Resident #E until 11/27/13. The facility Administrator indicated she was contacted by the facility Attorney on 11/27/13 and received copies of Resident #E's medical records from her hospitalization in September. The Administrator indicated the incident was not reported to the Indiana State Department of Health			

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	until 11/27/13. When interviewed on 1/17/14 at 10:45 a.m., the Administrator indicated the facility then started inservicing staff members on abuse, resident rights, neglect , and the Elder Justice Act on 11/27/13. The Administrator indicated they also implemented 24 hour Security service on 11/27/13. When interviewed on 1/17/14 at 11:50 a.m., the Administrator indicated the facility policy was to report any incidents or unusual occurrences within 24 hours to the Indiana State Department of Health. The Administrator indicated they felt they did not have an incident in September as the information they had was "hearsay." The facility policy titled "Abuse Prevention" was reviewed on 1/16/14 at 9:10 a.m. The policy had a revised date of 10/2011. The facility Administrator provided the policy and indicated the policy was current. The policy indicated the facility was to comply with state and federal regulations for reporting suspected or actual acts. The policy indicated the Administrator was responsible to supervise the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155662	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/17/2014
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	investigative process. Methods of investigation could include obtaining written statements from supervising and direct care staff members, interviewing individuals including other residents, staff, and visitors. The policy also indicated the results of all the internal investigations were to be finalized and reported to all regulatory bodies within five working days of the incident. A copy of the investigative record and a written report were to be made to the Indiana State Department of Health. The facility policy titled "Accident/Incident and Unusual Occurrence" policy was reviewed on 1/17/14 at 12:15 p.m. The policy had a revised date of 6/30/11. The facility Administrator provided the policy and indicated the policy was current. The policy indicated any injury was to be classified as an injury of unknown source when both of the following conditions were met: 1. "The Source of the injury was not observed by any persons or the source of the injury could not be explained by the resident; AND 2. The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally not vulnerable to trauma) or the			

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	number of injuries observed at one particular point in time or the incident of injuries over time." This Federal tag relates to Complaint IN00142011. 3.1-28(c) 3.1-28(d)			