

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155564	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/14/2011
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 259 W HARRISON ST MOORESVILLE, IN46158		
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F0000	<p>This visit was for the Investigation of Complaint IN00100653.</p> <p>Complaint IN00100653 substantiated, federal/state deficiencies related to the allegations are cited at F224, F225, and F226.</p> <p>Survey dates: December 13 & 14, 2011</p> <p>Facility number: 000398 Provider number: 155564 AIM number: 100291110</p> <p>Survey team: Joyce Hofmann, RN</p> <p>Census bed type: SNF: 23 SNF/NF: 57 Total: 80</p> <p>Census payor type: Medicare: 18 Medicaid: 46 Other: 16 Total: 80</p> <p>Sample: 4</p> <p>This deficiency also reflects state findings in accordance with 410 IAC 16.2.</p>	F0000	The Mooresville facility respectfully requests paper compliance. Please accept the following plan of correction for F-Tag 224, F-Tag 225, and F-Tag 226 as our credible allegation of compliance.		

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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F0224 SS=G	<p>Quality review completed 12/20/11 Cathy Emswiller RN</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on observation, interview, and record review, the facility failed to ensure residents were not neglected during changes in their conditions for 2 of 4 residents in a sample of 4 who were reviewed for neglect. [Resident #B and Resident #D]</p> <p>Findings include:</p> <p>1). Resident #B's closed clinical record was reviewed on 12/13/11 at 6:10 a.m. and indicated the resident was admitted to the facility on 07/20/11 and re-admitted on 09/08/11. The resident's diagnoses included, but were not limited to, congestive heart failure [CHF], cerebral artery occlusion with infarct, atrial fibrillation [A-fib], chronic obstructive pulmonary disease [COPD], coronary atherosclerosis, dysrhythmias, hypertension [HTN], cerebrovascular accident [CVA], acute kidney injury, anemia, coronary artery disease [CAD], cardiomegaly, insomnia, anxiety, chronic pain, depressive disorder, osteoarthritis, osteoporosis, history breast cancer, volume depletion, pneumonia, hypotension, gastroesophageal reflux</p>	F0224	<p>Miller's Merry Manor respectfully requests to informally dispute F-224, F-225 and F-226. Miller's Merry Manor has policies and procedures in place that prohibit mistreatment, neglect and abuse of residents and misappropriation of resident property. Miller's Merry Manor has abuse prevention, recognition, reporting and investigation training and education for all employees upon hire and routinely thereafter. In addition, informational postings related to each employee's responsibility to protect residents from abuse and reporting abuse are located in the employee break room. (Attachment 1) All employees referred to in the survey report (CMS 2567) have been trained as evidenced by inservice records (Attachment 2). The basis of all citations was the performance of LPN #3; however LPN #3 was not interviewed during the survey process about the events as</p>	12/29/2011	

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	<p>disorder, and clostridium difficile.</p> <p>Resident #B's care plan dated 07/25/11 with recent revision on 09/21/11 for Potential for exacerbation of : CHF, CAD, HTN, Atrial Fib and COPD indicated a goal of, "Will have s/s [signs/symptoms] of exacerbation recognized early." Interventions included, but were not limited to, "Notify MD as needed"; "Observe for changes in cardio/respiratory system and notify MD as needed"; and "Observe for s/s i.e. increased secretions, cough, SOB [shortness of breath] and notify MD for treatment."</p> <p>Electronic Nurse's Notes dated 12/01/11 at 2:30 a.m. by LPN #3 indicated the resident was alert and oriented to self, situation, place, and time, currently experiencing no pain, blood pressure 114/69, pulse 74, respirations 18, temperature 97.3 oxygen sats at 96%, shortness of breath when anxious, receives respiratory treatments, mucous membranes pink and moist, skin color pink, skin turgor good, and no cough present. The resident's lung sounds were absent or diminished.</p> <p>Electronic Nurse's Notes dated 12/02/11 at 9:05 a.m. indicated the medical doctor [MD] was notified and order received for transfer to hospital. The responsible party</p>		<p>they relate to Resident #B and Resident #D. The basis of the citations are comments and assessments made by nursing assistants that are neither educated or qualified to make. CNA#10 is quoted on page 5 of the CMS 2567 as stating Resident #B Has an oxygen saturation rate in the 90's and the breathing treatment done by LPN#3 "didn't help at all and actually made her worse". Assessments CNA#10 is not qualified to make. Additionally, the nursing assistants state LPN#3 did not attend to Resident #B and ignored her. This information is questionable as how could these employees know this as they were working and in and out of resident rooms throughout the shift. RN#5 is quoted in the survey report about LPN#3 even though she was not working on either shifts in question and her comments are hearsay and not first hand accounts of the events. CNA#1 was quoted as overhearing LPN#3 telling Resident #A he did not fill portable oxygen tanks until 4am. This is logical as Resident #A is on a concentrator until she gets up in the morning. Miller's Merry</p>		

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	<p>was notified of transfer, receiving facility was notified and given verbal report and the resident was transferred via ambulance. Vital signs at time of transfer were blood pressure 138/87, pulse 88, respirations 28, oxygen sats 92% and indicated in the notes was, "Res [Resident] having difficulty getting breath, warm to touch, sweaty."</p> <p>Interview with the Director of Nursing [DON] on 12/13/11 at 5:35 a.m. indicated the facility had terminated LPN #3 for sleeping on the job and for not checking on a resident [Resident #D] immediately after a fall. The DON was not aware of any other incidents with LPN #3.</p> <p>Interview with CNA #1 on 12/13/11 at 5:15 a.m. indicated LPN #3 works nights, sleeps during the shift, and plays on his phone. Employee #1 indicated LPN #3 told Resident #A he does not refill oxygen tanks until 4 a.m. Resident #A was observed at this time with 2 portable oxygen tanks on the back of her electric wheel chair.</p> <p>Interview with CNA #2 on 12/13/11 at 5:20 a.m. indicated she knew Resident #B and she was one of her favorite residents. CNA #2 indicated she got to work at 10 p.m. the night Resident #B went bad. CNA #2 indicated she was passing ice</p>		<p>Manor acted promptly once knowledge of the allegation of LPN#3 performance was brought to the attention of facility administration as evidenced by the termination of LPN#3. POC All residents had the potential to be affected by this deficient practice. The facility found that no other residents were affected by this practice through investigation conducted with staff and residents. The LPN responsible for not following our policy was terminated immediately. Mandatory Inservices held for all nursing staff on 12-7-2011 (attachment A & B) and on 12-22-2011 (attachment C & D). The following policies were covered in this inservice; Abuse Prohibition, Reporting and Investigation (attachment E), Physician & Family notification of condition change (attachment F), Charting Procedure (attachment G), and Residents Rights Handbook (attachment H). Monitoring of Abuse QA Tool (attachment I) will be completed by the DON or designee with at least 5 staff members weekly for 4 weeks then monthly for 5</p>				

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	<p>water and noticed Resident #B did not look good at all and was not her normal self. CNA #2 indicated she told LPN #3 about Resident #B and LPN #3 said it was just her anxiety. CNA #2 indicated Resident #B was pushing on her call light and later wanted to go to the hospital. CNA #2 indicated she told LPN #3 that the resident wanted to go to the hospital and he said it was just her anxiety and never went to check on Resident #B. CNA #2 indicated another aide - CNA #10 came into work and she had her look at Resident #B and CNA #10 said she looked like she was dying. CNA #2 indicated the resident was still pushing her call light and was still asking to go to the hospital and at 3:30 a.m. CNA #2 approached LPN #3 again and told him he needed to check on Resident #B and he finally got up and gave her a breathing treatment.</p> <p>Interview with RN #5 on 12/13/11 at 5:40 a.m. indicated she knew LPN #3 and indicated he was a nice person, caught him sleeping one time and nodding off, had concerns about medications and thought he might have passed meds only to alert and oriented residents, because he would get done so fast, and indicated when she followed him one time he did not do his dressing change as the old dressing was still on when she came on</p>		<p>months then quarterly thereafter, rotating staff. Abuse & Neglect Review QA tool (attachment J) will be completed by SSD or designee with at least 6 residents weekly for 4 weeks then monthly for 5 months then quarterly thereafter, rotating residents.</p>		

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	<p>shift. RN #5 indicated she was not working the night Resident #B got bad, but heard about it from 3 different aides. RN #5 indicated one aide told her Resident #B was really different, not her normal self and employee #3 just ignored the situation. The other 2 aides had the same story that LPN #3 just ignored the resident and her condition.</p> <p>Interview with CNA #6 on 12/13/11 at 5:50 a.m. indicated she knew LPN #3, indicated he was very nice, corgal, took naps, and read a lot. CNA #6 indicated if she asked him for help, he would help her, but he would not answer call lights.</p> <p>Interview with CNA #10 on 12/13/11 at 9:27 a.m. indicated she came into work at 2 a.m. the night Resident #B went bad, and indicated Resident #B was unresponsive, very weak, very short of breath, clinching her chest, and wanted to go to the hospital. CNA #10 indicated Resident #B's stomach was trying to breathe, her respirations were 32 and her oxygen saturation was in the 90's, but she couldn't breath. CNA #10 indicated she informed LPN #3, three (3) times that Resident #B wanted to go to the hospital, but he ignored her. CNA #10 indicated LPN #3 finally got up from his nap at 3:30 a.m. and gave Resident #B a breathing treatment, but it didn't help at</p>				

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	<p>all and actually made her worse as it sometimes makes the resident more nervous and Resident #B's respirations went up to 36. CNA #10 indicated he still would not send Resident #B to the hospital, but day shift came in and finally sent her out that morning.</p> <p>Hospital records dated 12/02/11 indicated in emergency department notes the resident was awake, could follow commands, makes purposeful movements, does not verbalize answers, but makes sounds as what she wants. Right extremities contracted, positive for multiple discolored areas noted on bilateral upper extremities and right lower extremity. The resident's eyes open spontaneously, positive for labored breathing at rest noted. Positive for coarse crackles, rhonchi noted throughout. Skin hot to touch. Upon examination, the notes indicated the resident appeared cachactic and had a sickly appearance. Tachypnea was noted and notes indicated the resident was in respiratory distress. The resident had rhonchi and rales coarse throughout.</p> <p>Chest x-ray results from the hospital dated 12/02/11 indicated chronic upper lung interstitial infiltrates.</p> <p>Lab results indicated a blood Troponin T</p>				

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	<p>at 0.102 high [which is an indication of a heart attack], red blood cell 3.56 low, hemoglobin 11.0 low, and hematocrit 33.0 low [indicators of anemia or blood loss].</p> <p>The clinical impression was dyspnea, aspiration pneumonitis, and cardiac ischemia.</p> <p>Discharge Summary Notes dated 12/12/11 indicated date of death as 12/06/11. The notes indicated the resident was admitted with cough and congestion with increased need for oxygen, and most probably the patient aspirated and had aspiration pneumonia versus hospital-acquired pneumonia. The resident was on intravenous antibiotic, developed acute, on top of her chronic respiratory failure, and the family requested the resident to be on hospice and provide her with comfort measures only, secondary to her other comorbidities, including the stroke, which left her with chronic, right side hemiparesis. The resident was started on comfort measures and was comfortable with pain medications, other palliative and comfort measures, and she expired on the 6th.</p> <p>Interview with the DON on 12/13/11 at 5:35 a.m. indicated she was not aware of the incident with Resident #B.</p>				

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	<p>2). Resident #D's clinical record was reviewed on 12/13/11 at 12:35 p.m. and indicated the resident was admitted to the facility on 07/02/11 and re-admitted on 11/02/11 and had diagnoses which included, but were not limited to, congestive heart failure, hypertension, aphasia, cerebrovascular accident, anxiety, depression, and atrial fibrillation.</p> <p>Resident #D's care plan dated 07/08/11 and revision on 11/17/11 indicated a care plan for "Fall Risk Resident is at risk for falls due to resident has hx [history] of falls, poor positioning and poor trunk control d/t [due to] dx [diagnoses] of CVA [cerebrovascular accident] with right sided weakness and osteoporosis. Resident takes an anti-hypertensive med daily d/t dx of HTN [hypertension]. Resident also takes an antidepressant med daily for dx of depression. Above puts resident at risk for falls." Interventions included, reinforce need to call for assistance, encourage resident to use handrails or assistive devices properly, ensure environment is free of clutter, analyze previous resident falls to determine whether pattern/trend can be addressed, reassess fall risk factors at least quarterly, notify MD of changes in condition, notify therapy of changes in condition, monitor for changes in gait/positioning, call light in reach,</p>				

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	<p>explain use of it upon admission and reinforce as needed, encourage and assist with wearing non-skid foot-wear, low bed with mat, and lip mattress 12/5/11.</p> <p>Interview with the Director of Nursing [DON] on 12/13/11 at 5:35 a.m. indicated the facility had terminated LPN #3 for sleeping on the job and for not checking on a resident [Resident #D] immediately after a fall.</p> <p>Review of the electronic Occurrence Initial Assessment notes dated 12/05/11 which was put into the computer by LPN #3 indicated, "Called to room by CNA, resident found on floor next to bed. Resident lying on her right side. Resident turned over, resident has large hematoma on right side of forehead. No other open/bruised/swollen areas noted. Resident non-verbal, per yes/no questions does not know how she [sic] fell to floor. Room-mate reports hearing loud bump then turning on call light. Resident assisted to bed. Neuro checks started, wnl [within normal limits]. Denies pain. bed [sic] was in low postion [sic] with mat on floor. Also has bumpers on bed, bed has overlay on air mattress, bumper on side of bed, not on top of bed. Overlay repositioned and bumpers in place on top of mattress." Notes indicated the physician was notified.</p>				

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	<p>The Post Occurrence Assessment dated 12/05/11 at 9:11 a.m. indicated, Date and time of occurrence as 12/05/11 at 12:45 a.m.; summary of occurrence: "Resident on floor on right side"; type of injury: "Hematoma to forehead"; root cause: "Low air loss mattress provided by hospice, very sensitive to movement"; IDT [Interdisciplinary Team] recommendations: "Low air loss mattress removed, lip mattress placed."</p> <p>LPN #3 indicated on the "Investigation of reasons/causes of the incident: bed mattress has bumpers, pad of mattress overlay which was under over to side, allowing bumper to move to side of mattress." The "Action taken to prevent reoccurrence: Will notify unit manager about need to change bed overlay." Underneath the above documentation was written, "Low air loss mattress with bumper pads removed and resident given lip mattress. The facility's new intervention was to remove the low air loss mattress, and a lip mattress was placed." The Administrator and DON signed the sheet.</p> <p>Resident #D was observed on 12/14/11 at 10 a.m. and was observed asleep in low bed with mat on the floor beside the bed. Bruises were observed on the resident's</p>				

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	<p>right forehead area and right cheek.</p> <p>Interview with LPN #11 on 12/14/11 at 10:45 a.m. indicated the right forehead area was partially scabbed at the top of the hematoma.</p> <p>Interview with the Administrator and DON on 12/14/11 at 11:05 a.m. indicated Resident #D fell on 12/05/11 at 12:45 a.m.. The DON explained the Administrator and Assistant Director of Nursing [ADON] was made aware of the incident about LPN #3 not responding immediately the first time when told about the resident's fall during an in-service on 12/07/11. CNA #2 told LPN #4 that the nurse did not respond when told about the resident having fallen. The Administrator indicated LPN #4 was told by CNA #2 that she went once to get the nurse and then had to go a second time to get the nurse to come down and check on the resident. During termination of LPN #3, the nurse just said he assessed the resident, but did not say anything about the second time of the aide coming to get him. The Administrator indicated LPN #3 was pretty quiet that day of termination.</p> <p>Review of the facility's policy on Abuse Prohibition, Reporting, and Investigation dated 08/23/11 indicated, "... Abuse -</p>				

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	Physical, sexual, verbal and/or mental (known or alleged) abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. This includes deprivation of an individual, including caretaker, of goods or services that are necessary to attain or maintain physical, mental, or psychosocial well being. ... Neglect - means the failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness...." The policy indicated,"1. It is the policy of _____[name of health system] that all residents have the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion. 2. _____[name of health system] has policies and procedures in place that prohibit mistreatment, neglect and abuse of residents and misappropriation of resident property. These policies and procedures include but not limited to employment procedures: 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 will not be employed. 3. _____[name of health system] has policies and			

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	<p>procedures in place that ensures that all alleged violations involving mistreatment, neglect or abuse, including injuries of 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). 4. _____[name of health system] has policies and procedures in place that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress." The facility's policy and procedures also indicated, "It is the responsibility of every employee of _____[name of health system] to not only report abuse situations, but also suspicion of abuse and unusual observations and circumstances, to their immediate supervisor. ... All reports of alleged abuse/abuse and all unusual occurrences, must be reported to the Administrator immediately, and to the resident's representative (sponsor, responsible party), as soon as feasible possible, but no later than within 24 hours of the reporting or discovery of the incident. ... Violations of the aforementioned will be reported to the Long Term Care Division of the Indiana State Department of Health and other officials in accordance with state law through established procedures as outlined in the "Unusual Occurrence</p>			

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	<p>Reporting Policy and Procedure. ... The Administrator, or designee, shall initiate and direct the investigation immediately, and within 5 days a report of this investigation must be forwarded to the Long Term Care Division of the Indiana State Department of Health."</p> <p>Review of the Disciplinary Detail for LPN #3 dated 12/07/11 indicated, "Employee was witnessed sleeping while on duty for an uninterrupted period of 45 minutes. According to investigation, this has been a repeated violation of company policy. In addition, it was reported on this date a resident fell and a request had been made for this nurse to come quickly and assess (Nurse was not in middle of care with another resident.) Nurse had to be requested a second time to come assess resident. At which time this nurse did not assess above 2 violation demonstrate a lack of professional standard necessary for the protection of our resident's welfare."</p> <p>The Separation Form indicated, "I _____[name of LPN #3] certify that there are no incidences, that I am aware of, regarding "resident abuse" that are unresolved as of this date. I certify, further, that I have been trained in the recognition of resident abuse, both physical and mental, and ascertain no such violations of Resident's Rights are</p>				

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	<p>unresolved." This was initialed by LPN #3.</p> <p>This federal deficiency is related to Complaint IN00100653.</p> <p>3.1-27(a)(3)</p>				

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F0225 SS=G	<p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on observation, interview and record review, the facility failed to ensure all alleged violations of neglect/abuse were immediately reported to the Administrator and other officials in</p>	F0225	Miller's Merry Manor respectfully requests to informally dispute F-224, F-225 and F-226. Miller's Merry Manor has policies and	12/29/2011	

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	<p>accordance with State law through established procedures (including to the State survey and certification agency) for 2 of 2 incidents of abuse/neglect investigated. [LPN #3].</p> <p>Findings include:</p> <p>1). Resident #B's closed clinical record was reviewed on 12/13/11 at 6:10 a.m. and indicated the resident was admitted to the facility on 07/20/11 and re-admitted on 09/08/11. The resident's diagnoses included, but were not limited to, congestive heart failure [CHF], cerebral artery occlusion with infarct, atrial fibrillation [A-fib], chronic obstructive pulmonary disease [COPD], coronary atherosclerosis, dysrhythmias, hypertension [HTN], cerebrovascular accident [CVA], acute kidney injury, anemia, coronary artery disease [CAD], cardiomegaly, insomnia, anxiety, chronic pain, depressive disorder, osteoarthritis, osteoporosis, history breast cancer, volume depletion, pneumonia, hypotension, gastroesophageal reflux disorder, and clostridium difficile.</p> <p>Resident #B's care plan dated 07/25/11 with recent revision on 09/21/11 for Potential for exacerbation of : CHF, CAD, HTN, Atrial Fib and COPD indicated a goal of, "Will have s/s [signs/symptoms]</p>		<p>procedures in place that prohibit mistreatment, neglect and abuse of residents and misappropriation of resident property. Miller's Merry Manor has abuse prevention, recognition, reporting and investigation training and education for all employees upon hire and routinely thereafter. In addition, informational postings related to each employee's responsibility to protect residents from abuse and reporting abuse are located in the employee break room. (Attachment 1) All employees referred to in the survey report (CMS 2567) have been trained as evidenced by inservice records (Attachment 2). The basis of all citations was the performance of LPN #3; however LPN #3 was not interviewed during the survey process about the events as they relate to Resident #B and Resident #D. The basis of the citations are comments and assessments made by nursing assistants that are neither educated or qualified to make. CNA#10 is quoted on page 5 of the CMS 2567 as stating Resident #B Has an oxygen saturation rate in the 90's and the breathing treatment done</p>		

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	<p>of exacerbation recognized early." Interventions included, but were not limited to, "Notify MD as needed"; "Observe for changes in cardio/respiratory system and notify MD as needed"; and "Observe for s/s i.e. increased secretions, cough, SOB [shortness of breath] and notify MD for treatment."</p> <p>Electronic Nurse's Notes dated 12/01/11 at 2:30 a.m. by LPN #3 indicated the resident was alert and oriented to self, situation, place, and time, currently experiencing no pain, blood pressure 114/69, pulse 74, respirations 18, temperature 97.3 oxygen sats at 96%, shortness of breath when anxious, receives respiratory treatments, mucous membranes pink and moist, skin color pink, skin turgor good, and no cough present. The resident's lung sounds were absent or diminished.</p> <p>Electronic Nurse's Notes dated 12/02/11 at 9:05 a.m. indicated the medical doctor [MD] was notified and order received for transfer to hospital. The responsible party was notified of transfer, receiving facility was notified and given verbal report and the resident was transferred via ambulance. Vital signs at time of transfer were blood pressure 138/87, pulse 88, respirations 28, oxygen sats 92% and indicated in the notes was, "Res</p>		<p>by LPN#3 "didn't help at all and actually made her worse". Assessments CNA#10 is not qualified to make. Additionally, the nursing assistants state LPN#3 did not attend to Resident #B and ignored her. This information is questionable as how could these employees know this as they were working and in and out of resident rooms throughout the shift. RN#5 is quoted in the survey report about LPN#3 even though she was not working on either shifts in question and her comments are hearsay and not first hand accounts of the events. CNA#1 was quoted as overhearing LPN#3 telling Resident #A he did not fill portable oxygen tanks until 4am. This is logical as Resident #A is on a concentrator until she gets up in the morning. Miller's Merry Manor acted promptly once knowledge of the allegation of LPN#3 performance was brought to the attention of facility administration as evidenced by the termination of LPN#3. POC All residents had the potential to be affected by this deficient practice. The facility found that no other residents were</p>		

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	<p>[Resident] having difficulty getting breath, warm to touch, sweaty."</p> <p>Interview with the Director of Nursing [DON] on 12/13/11 at 5:35 a.m. indicated the facility had terminated LPN #3 for sleeping on the job and for not checking on a resident [Resident #D] immediately after a fall. The DON was not aware of any other incidents with LPN #3.</p> <p>Interview with CNA #1 on 12/13/11 at 5:15 a.m. indicated LPN #3 works nights, sleeps during the shift, and plays on his phone. Employee #1 indicated LPN #3 told Resident #A he does not refill oxygen tanks until 4 a.m. Resident #A was observed at this time with 2 portable oxygen tanks on the back of her electric wheel chair.</p> <p>Interview with CNA #2 on 12/13/11 at 5:20 a.m. indicated she knew Resident #B and she was one of her favorite residents. CNA #2 indicated she got to work at 10 p.m. the night Resident #B went bad. CNA #2 indicated she was passing ice water and noticed Resident #B did not look good at all and was not her normal self. CNA #2 indicated she told LPN #3 about Resident #B and LPN #3 said it was just her anxiety. CNA #2 indicated Resident #B was pushing on her call light and later wanted to go to the hospital.</p>		<p>affected by this practice through investigation conducted with staff and residents. The LPN responsible for not following our policy was terminated immediately. Mandatory Inservices held for all nursing staff on 12-7-2011 (attachment A & B) and on 12-22-2011 (attachment C & D). The following policies were covered in this inservice; Abuse Prohibition, Reporting and Investigation (attachment E), Physician & Family notification of condition change (attachment F), Charting Procedure (attachment G), and Residents Rights Handbook (attachment H). Monitoring of Abuse QA Tool (attachment I) will be completed by the DON or designee with at least 5 staff members weekly for 4 weeks then monthly for 5 months then quarterly thereafter, rotating staff. Abuse & Neglect Review QA tool (attachment J) will be completed by SSD or designee with at least 6 residents weekly for 4 weeks then monthly for 5 months then quarterly thereafter, rotating residents.</p>		

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	<p>CNA #2 indicated she told LPN #3 that the resident wanted to go to the hospital and he said it was just her anxiety and never went to check on Resident #B. CNA #2 indicated another aide - CNA #10 came into work and she had her look at Resident #B and CNA #10 said she looked like she was dying. CNA #2 indicated the resident was still pushing her call light and was still asking to go to the hospital and at 3:30 a.m. CNA #2 approached LPN #3 again and told him he needed to check on Resident #B and he finally got up and gave her a breathing treatment.</p> <p>Interview with RN #5 on 12/13/11 at 5:40 a.m. indicated she knew LPN #3 and indicated he was a nice person, caught him sleeping one time and nodding off, had concerns about medications and thought he might have passed meds only to alert and oriented residents, because he would get done so fast, and indicated when she followed him one time he did not do his dressing change as the old dressing was still on when she came on shift. RN #5 indicated she was not working the night Resident #B got bad, but heard about it from 3 different aides. RN #5 indicated one aide told her Resident #B was really different, not her normal self and employee #3 just ignored the situation. The other 2 aides had the</p>				

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	<p>same story that LPN #3 just ignored the resident and her condition.</p> <p>Interview with CNA #6 on 12/13/11 at 5:50 a.m. indicated she knew LPN #3, indicated he was very nice, corgal, took naps, and read a lot. CNA #6 indicated if she asked him for help, he would help her, but he would not answer call lights.</p> <p>Interview with CNA #10 on 12/13/11 at 9:27 a.m. indicated she came into work at 2 a.m. the night Resident #B went bad, and indicated Resident #B was unresponsive, very weak, very short of breath, clinching her chest, and wanted to go to the hospital. CNA #10 indicated Resident #B's stomach was trying to breathe, her respirations were 32 and her oxygen saturation was in the 90's, but she couldn't breath. CNA #10 indicated she informed LPN #3, three (3) times that Resident #B wanted to go to the hospital, but he ignored her. CNA #10 indicated LPN #3 finally got up from his nap at 3:30 a.m. and gave Resident #B a breathing treatment, but it didn't help at all and actually made her worse as it sometimes makes the resident more nervous and Resident #B's respirations went up to 36. CNA #10 indicated he still would not send Resident #B to the hospital, but day shift came in and finally sent her out that morning.</p>				

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	<p>Hospital records dated 12/02/11 indicated in emergency department notes the resident was awake, could follow commands, makes purposeful movements, does not verbalize answers, but makes sounds as what she wants. Right extremities contracted, positive for multiple discolored areas noted on bilateral upper extremities and right lower extremity. The resident's eyes open spontaneously, positive for labored breathing at rest noted. Positive for coarse crackles, rhonchi noted throughout. Skin hot to touch. Upon examination, the notes indicated the resident appeared cachactic and had a sickly appearance. Tachypnea was noted and notes indicated the resident was in respiratory distress. The resident had rhonchi and rales coarse throughout.</p> <p>Chest x-ray results from the hospital dated 12/02/11 indicated chronic upper lung interstitial infiltrates.</p> <p>Lab results indicated a blood Troponin T at 0.102 high [which is an indication of a heart attack], red blood cell 3.56 low, hemoglobin 11.0 low, and hematocrit 33.0 low [indicators of anemia or blood loss].</p> <p>The clinical impression was dyspnea, aspiration pneumonitis, and cardiac</p>			

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	<p>ischemia.</p> <p>Hospital Discharge Summary Notes dated 12/12/11 indicated date of death as 12/06/11. The notes indicated the resident was admitted with cough and congestion with increased need for oxygen, and most probably the patient aspirated and had aspiration pneumonia versus hospital-acquired pneumonia. The resident was on intravenous antibiotic, developed acute, on top of her chronic respiratory failure, and the family requested the resident to be on hospice and provide her with comfort measures only, secondary to her other comorbidities, including the stroke, which left her with chronic, right side hemiparesis. The resident was started on comfort measures and was comfortable with pain medications, other palliative and comfort measures, and she expired on the 6th.</p> <p>Interview with the DON on 12/13/11 at 5:35 a.m. indicated she was not aware of the incident with Resident #B and LPN #3.</p> <p>2). Resident #D's clinical record was reviewed on 12/13/11 at 12:35 p.m. and indicated the resident was admitted to the facility on 07/02/11 and re-admitted on 11/02/11 and had diagnoses which</p>				

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	<p>included, but were not limited to, congestive heart failure, hypertension, aphasia, cerebrovascular accident, anxiety, depression, and atrial fibrillation.</p> <p>Resident #D's care plan dated 07/08/11 and revision on 11/17/11 indicated a care plan for "Fall Risk Resident is at risk for falls due to resident has hx [history] of falls, poor positioning and poor trunk control d/t [due to] dx [diagnoses] of CVA [cerebrovascular accident] with right sided weakness and osteoporosis. Resident takes an anti-hypertensive med daily d/t dx of HTN [hypertension]. Resident also takes an antidepressant med daily for dx of depression. Above puts resident at risk for falls." Interventions included, reinforce need to call for assistance, encourage resident to use handrails or assistive devices properly, ensure environment is free of clutter, analyze previous resident falls to determine whether pattern/trend can be addressed, reassess fall risk factors at least quarterly, notify MD of changes in condition, notify therapy of changes in condition, monitor for changes in gait/positioning, call light in reach, explain use of it upon admission and reinforce as needed, encourage and assist with wearing non-skid foot-wear, low bed with mat, and lip mattress 12/5/11.</p>				

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	<p>Interview with the Director of Nursing [DON] on 12/13/11 at 5:35 a.m. indicated the facility had terminated LPN #3 for sleeping on the job and for not checking on a resident [Resident #D] immediately after a fall.</p> <p>Review of the electronic Occurrence Initial Assessment notes dated 12/05/11 which was put into the computer by LPN #3 indicated, "Called to room by CNA, resident found on floor next to bed. Resident lying on her right side. Resident turned over, resident has large hematoma on right side of forehead. No other open/bruised/swollen areas noted. Resident non-verbal, per yes/no questions does not know how she [sic] fell to floor. Room-mate reports hearing loud bump then turning on call light. Resident assisted to bed. Neuro checks started, wnl [within normal limits]. Denies pain. bed [sic] was in low postion [sic] with mat on floor. Also has bumpers on bed, bed has overlay on air mattress, bumper on side of bed, not on top of bed. Overlay repositioned and bumpers in place on top of mattress." Notes indicated the physician was notified.</p> <p>The Post Occurrence Assessment dated 12/05/11 at 9:11 a.m. indicated, Date and time of occurrence as 12/05/11 at 12:45 a.m.; summary of occurrence: "Resident</p>				

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	<p>on floor on right side"; type of injury: "Hematoma to forehead"; root cause: "Low air loss mattress provided by hospice, very sensitive to movement"; IDT [Interdisciplinary Team] recommendations: "Low air loss mattress removed, lip mattress placed."</p> <p>LPN #3 indicated on the "Investigation of reasons/causes of the incident: bed mattress has bumpers, pad of mattress overlay which was under over to side, allowing bumper to move to side of mattress." The "Action taken to prevent reoccurrence: Will notify unit manager about need to change bed overlay." Underneath the above documentation was written, "Low air loss mattress with bumper pads removed and resident given lip mattress. The facility's new intervention was to remove the low air loss mattress, and a lip mattress was placed." The Administrator and DON signed the sheet.</p> <p>Resident #D was observed on 12/14/11 at 10 a.m. and was observed asleep in low bed with mat on the floor beside the bed. Bruises were observed on the resident's right forehead area and right cheek.</p> <p>Interview with LPN #11 on 12/14/11 at 10:45 a.m. indicated the right forehead area was partially scabbed at the top of the</p>				

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	<p>hematoma.</p> <p>Interview with the Administrator and DON on 12/14/11 at 11:05 a.m. indicated Resident #D fell on 12/05/11 at 12:45 a.m.. The DON explained the Administrator and Assistant Director of Nursing [ADON] was made aware of the incident about LPN #3 not responding immediately the first time when told about the resident's fall during an in-service on 12/07/11. CNA #2 told LPN #4 that the nurse did not respond when told about the resident having fallen. The Administrator indicated LPN #4 was told by CNA #2 that she went once to get the nurse and then had to go a second time to get the nurse to come down and check on the resident. During termination of LPN #3, the nurse just said he assessed the resident, but did not say anything about the second time of the aide coming to get him. The Administrator indicated LPN #3 was pretty quiet that day of termination.</p> <p>Review of the facility's policy on Abuse Prohibition, Reporting, and Investigation dated 08/23/11 indicated, "... Abuse - Physical, sexual, verbal and/or mental (known or alleged) abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or</p>				

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	<p>mental anguish. This includes deprivation of an individual, including caretaker, of goods or services that are necessary to attain or maintain physical, mental, or psychosocial well being. ... Neglect - means the failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness...." The policy indicated,"1. It is the policy of _____[name of health system] that all residents have the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion. 2. _____[name of health system] has policies and procedures in place that prohibit mistreatment, neglect and abuse of residents and misappropriation of resident property. These policies and procedures include but not limited to employment procedures: 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 will not be employed. 3. _____[name of health system] has policies and procedures in place that ensures that all alleged violations involving mistreatment, neglect or abuse, including injuries of immediately to the Administrator of the facility and to other officials in</p>				

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	accordance with State law through established procedures (including to the State survey and certification agency). 4. _____[name of health system] has policies and procedures in place that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress." The facility's policy and procedures also indicated, "It is the responsibility of every employee of _____[name of health system] to not only report abuse situations, but also suspicion of abuse and unusual observations and circumstances, to their immediate supervisor. ... All reports of alleged abuse/abuse and all unusual occurrences, must be reported to the Administrator immediately, and to the resident's representative (sponsor, responsible party), as soon as feasible possible, but no later than within 24 hours of the reporting or discovery of the incident. ... Violations of the aforementioned will be reported to the Long Term Care Division of the Indiana State Department of Health and other officials in accordance with state law through established procedures as outlined in the "Unusual Occurrence Reporting Policy and Procedure. ... The Administrator, or designee, shall initiate and direct the investigation immediately, and within 5 days a report of this investigation must be forwarded to the				

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	<p>Long Term Care Division of the Indiana State Department of Health."</p> <p>Review of the Disciplinary Detail for LPN #3 dated 12/07/11 indicated, "Employee was witnessed sleeping while on duty for an uninterrupted period of 45 minutes. According to investigation, this has been a repeated violation of company policy. In addition, it was reported on this date a resident fell and a request had been made for this nurse to come quickly and assess (Nurse was not in middle of care with another resident.) Nurse had to be requested a second time to come assess resident. At which time this nurse did not assess above 2 violation demonstrate a lack of professional standard necessary for the protection of our resident's welfare."</p> <p>The Separation Form indicated, "I _____[name of LPN #3] certify that there are no incidences, that I am aware of, regarding "resident abuse" that are unresolved as of this date. I certify, further, that I have been trained in the recognition of resident abuse, both physical and mental, and ascertain no such violations of Resident's Rights are unresolved." This was initialed by LPN #3.</p> <p>This federal deficiency is related to Complaint IN00100653.</p>				

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F0226 SS=G	<p>3.1-13(g)(1) 3.1-28(b)(2) 3.1-28(c) 3.1-28(d) 3.1-28(e)</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on observation, interview, and record review, the facility failed to implement their written policies and procedures that prohibit mistreatment, neglect, and abuse of residents for 2 of 2 alleged incidents of neglect/abuse investigated. [Resident #B and Resident #D]</p> <p>Findings include:</p> <p>1). Resident #B's closed clinical record was reviewed on 12/13/11 at 6:10 a.m. and indicated the resident was admitted to the facility on 07/20/11 and re-admitted on 09/08/11. The resident's diagnoses included, but were not limited to, congestive heart failure [CHF], cerebral artery occlusion with infarct, atrial fibrillation [A-fib], chronic obstructive pulmonary disease [COPD], coronary atherosclerosis, dysrhythmias, hypertension [HTN], cerebrovascular</p>	F0226	Miller's Merry Manor respectfully requests to informally dispute F-224, F-225 and F-226. Miller's Merry Manor has policies and procedures in place that prohibit mistreatment, neglect and abuse of residents and misappropriation of resident property. Miller's Merry Manor has abuse prevention, recognition, reporting and investigation training and education for all employees upon hire and routinely thereafter. In addition, informational postings related to each employee's responsibility to protect residents from abuse and reporting abuse are located in the employee break room. (Attachment 1) All employees referred to in the survey report (CMS 2567) have been trained as evidenced by	12/29/2011

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	<p>accident [CVA], acute kidney injury, anemia, coronary artery disease [CAD], cardiomegaly, insomnia, anxiety, chronic pain, depressive disorder, osteoarthritis, osteoporosis, history breast cancer, volume depletion, pneumonia, hypotension, gastroesophageal reflux disorder, and clostridium difficile.</p> <p>Resident #B's care plan dated 07/25/11 with recent revision on 09/21/11 for Potential for exacerbation of : CHF, CAD, HTN, Atrial Fib and COPD indicated a goal of, "Will have s/s [signs/symptoms] of exacerbation recognized early." Interventions included, but were not limited to, "Notify MD as needed"; "Observe for changes in cardio/respiratory system and notify MD as needed"; and "Observe for s/s i.e. increased secretions, cough, SOB [shortness of breath] and notify MD for treatment."</p> <p>Electronic Nurse's Notes dated 12/01/11 at 2:30 a.m. by LPN #3 indicated the resident was alert and oriented to self, situation, place, and time, currently experiencing no pain, blood pressure 114/69, pulse 74, respirations 18, temperature 97.3 oxygen sats at 96%, shortness of breath when anxious, receives respiratory treatments, mucous membranes pink and moist, skin color pink, skin turgor good, and no cough</p>		<p>inservice records (Attachment 2). The basis of all citations was the performance of LPN #3; however LPN #3 was not interviewed during the survey process about the events as they relate to Resident #B and Resident #D. The basis of the citations are comments and assessments made by nursing assistants that are neither educated or qualified to make. CNA#10 is quoted on page 5 of the CMS 2567 as stating Resident #B Has an oxygen saturation rate in the 90's and the breathing treatment done by LPN#3 "didn't help at all and actually made her worse". Assessments CNA#10 is not qualified to make. Additionally, the nursing assistants state LPN#3 did not attend to Resident #B and ignored her. This information is questionable as how could these employees know this as they were working and in and out of resident rooms throughout the shift. RN#5 is quoted in the survey report about LPN#3 even though she was not working on either shifts in question and her comments are hearsay and not first hand accounts of the events. CNA#1 was quoted as overhearing LPN#3 telling</p>		

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	<p>present. The resident's lung sounds were absent or diminished.</p> <p>Electronic Nurse's Notes dated 12/02/11 at 9:05 a.m. indicated the medical doctor [MD] was notified and order received for transfer to hospital. The responsible party was notified of transfer, receiving facility was notified and given verbal report and the resident was transferred via ambulance. Vital signs at time of transfer were blood pressure 138/87, pulse 88, respirations 28, oxygen sats 92% and indicated in the notes was, "Res [Resident] having difficulty getting breath, warm to touch, sweaty."</p> <p>Interview with the Director of Nursing [DON] on 12/13/11 at 5:35 a.m. indicated the facility had terminated LPN #3 for sleeping on the job and for not checking on a resident [Resident #D] immediately after a fall. The DON was not aware of any other incidents with LPN #3.</p> <p>Interview with CNA #1 on 12/13/11 at 5:15 a.m. indicated LPN #3 works nights, sleeps during the shift, and plays on his phone. Employee #1 indicated LPN #3 told Resident #A he does not refill oxygen tanks until 4 a.m. Resident #A was observed at this time with 2 portable oxygen tanks on the back of her electric wheel chair.</p>		<p>Resident #A he did not fill portable oxygen tanks until 4am. This is logical as Resident #A is on a concentrator until she gets up in the morning. Miller's Merry Manor acted promptly once knowledge of the allegation of LPN#3 performance was brought to the attention of facility administration as evidenced by the termination of LPN#3. POC All residents had the potential to be affected by this deficient practice. The facility found that no other residents were affected by this practice through investigation conducted with staff and residents. The LPN responsible for not following our policy was terminated immediately. Mandatory Inservices held for all nursing staff on 12-7-2011 (attachment A & B) and on 12-22-2011 (attachment C& D). The following policies were covered in this inservice; Abuse Prohibition, Reporting and Investigation (attachment E), Physician & Family notification of condition change (attachment F), Charting Procedure (attachment G), and Residents Rights Handbook</p>		

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	<p>Interview with CNA #2 on 12/13/11 at 5:20 a.m. indicated she knew Resident #B and she was one of her favorite residents. CNA #2 indicated she got to work at 10 p.m. the night Resident #B went bad. CNA #2 indicated she was passing ice water and noticed Resident #B did not look good at all and was not her normal self. CNA #2 indicated she told LPN #3 about Resident #B and LPN #3 said it was just her anxiety. CNA #2 indicated Resident #B was pushing on her call light and later wanted to go to the hospital. CNA #2 indicated she told LPN #3 that the resident wanted to go to the hospital and he said it was just her anxiety and never went to check on Resident #B. CNA #2 indicated another aide - CNA #10 came into work and she had her look at Resident #B and CNA #10 said she looked like she was dying. CNA #2 indicated the resident was still pushing her call light and was still asking to go to the hospital and at 3:30 a.m. CNA #2 approached LPN #3 again and told him he needed to check on Resident #B and he finally got up and gave her a breathing treatment.</p> <p>Interview with RN #5 on 12/13/11 at 5:40 a.m. indicated she knew LPN #3 and indicated he was a nice person, caught him sleeping one time and nodding off,</p>		(attachment H). Monitoring of Abuse QA Tool (attachment I) will be completed by the DON or designee with at least 5 staff members weekly for 4 weeks then monthly for 5 months then quarterly thereafter, rotating staff. Abuse & Neglect Review QA tool (attachment J) will be completed by SSD or designee with at least 6 residents weekly for 4 weeks then monthly for 5 months then quarterly thereafter, rotating residents.		

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	<p>had concerns about medications and thought he might have passed meds only to alert and oriented residents, because he would get done so fast, and indicated when she followed him one time he did not do his dressing change as the old dressing was still on when she came on shift. RN #5 indicated she was not working the night Resident #B got bad, but heard about it from 3 different aides. RN #5 indicated one aide told her Resident #B was really different, not her normal self and employee #3 just ignored the situation. The other 2 aides had the same story that LPN #3 just ignored the resident and her condition.</p> <p>Interview with CNA #6 on 12/13/11 at 5:50 a.m. indicated she knew LPN #3, indicated he was very nice, corgal, took naps, and read a lot. CNA #6 indicated if she asked him for help, he would help her, but he would not answer call lights.</p> <p>Interview with CNA #10 on 12/13/11 at 9:27 a.m. indicated she came into work at 2 a.m. the night Resident #B went bad, and indicated Resident #B was unresponsive, very weak, very short of breath, clinching her chest, and wanted to go to the hospital. CNA #10 indicated Resident #B's stomach was trying to breathe, her respirations were 32 and her oxygen saturation was in the 90's, but she</p>				

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	<p>couldn't breath. CNA #10 indicated she informed LPN #3, three (3) times that Resident #B wanted to go to the hospital, but he ignored her. CNA #10 indicated LPN #3 finally got up from his nap at 3:30 a.m. and gave Resident #B a breathing treatment, but it didn't help at all and actually made her worse as it sometimes makes the resident more nervous and Resident #B's respirations went up to 36. CNA #10 indicated he still would not send Resident #B to the hospital, but day shift came in and finally sent her out that morning.</p> <p>Hospital records dated 12/02/11 indicated in emergency department notes the resident was awake, could follow commands, makes purposeful movements, does not verbalize answers, but makes sounds as what she wants. Right extremities contracted, positive for multiple discolored areas noted on bilateral upper extremities and right lower extremity. The resident's eyes open spontaneously, positive for labored breathing at rest noted. Positive for coarse crackles, rhonchi noted throughout. Skin hot to touch. Upon examination, the notes indicated the resident appeared cachactic and had a sickly appearance. Tachypnea was noted and notes indicated the resident was in respiratory distress. The resident had</p>			

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	<p>rhonchi and rales coarse throughout.</p> <p>Chest x-ray results from the hospital dated 12/02/11 indicated chronic upper lung interstitial infiltrates.</p> <p>Lab results indicated a blood Troponin T at 0.102 high [which is an indication of a heart attack], red blood cell 3.56 low, hemoglobin 11.0 low, and hematocrit 33.0 low [indicators of anemia or blood loss].</p> <p>The clinical impression was dyspnea, aspiration pneumonitis, and cardiac ischemia.</p> <p>Hospital Discharge Summary Notes dated 12/12/11 indicated date of death as 12/06/11. The notes indicated the resident was admitted with cough and congestion with increased need for oxygen, and most probably the patient aspirated and had aspiration pneumonia versus hospital-acquired pneumonia. The resident was on intravenous antibiotic, developed acute, on top of her chronic respiratory failure, and the family requested the resident to be on hospice and provide her with comfort measures only, secondary to her other comorbidities, including the stroke, which left her with chronic, right side hemiparesis. The resident was started on comfort measures and was comfortable</p>			

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	<p>with pain medications, other palliative and comfort measures, and she expired on the 6th.</p> <p>Interview with the DON on 12/13/11 at 5:35 a.m. indicated she was not aware of the incident with Resident #B and LPN #3.</p> <p>2). Resident #D's clinical record was reviewed on 12/13/11 at 12:35 p.m. and indicated the resident was admitted to the facility on 07/02/11 and re-admitted on 11/02/11 and had diagnoses which included, but were not limited to, congestive heart failure, hypertension, aphasia, cerebrovascular accident, anxiety, depression, and atrial fibrillation.</p> <p>Resident #D's care plan dated 07/08/11 and revision on 11/17/11 indicated a care plan for "Fall Risk Resident is at risk for falls due to resident has hx [history] of falls, poor positioning and poor trunk control d/t [due to] dx [diagnoses] of CVA [cerebrovascular accident] with right sided weakness and osteoporosis. Resident takes an anti-hypertensive med daily d/t dx of HTN [hypertension]. Resident also takes an antidepressant med daily for dx of depression. Above puts resident at risk for falls." Interventions included, reinforce need to call for assistance, encourage resident to use</p>				

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	<p>handrails or assistive devices properly, ensure environment is free of clutter, analyze previous resident falls to determine whether pattern/trend can be addressed, reassess fall risk factors at least quarterly, notify MD of changes in condition, notify therapy of changes in condition, monitor for changes in gait/positioning, call light in reach, explain use of it upon admission and reinforce as needed, encourage and assist with wearing non-skid foot-wear, low bed with mat, and lip mattress 12/5/11.</p> <p>Interview with the Director of Nursing [DON] on 12/13/11 at 5:35 a.m. indicated the facility had terminated LPN #3 for sleeping on the job and for not checking on a resident [Resident #D] immediately after a fall.</p> <p>Review of the electronic Occurrence Initial Assessment notes dated 12/05/11 which was put into the computer by LPN #3 indicated, "Called to room by CNA, resident found on floor next to bed. Resident lying on her right side. Resident turned over, resident has large hematoma on right side of forehead. No other open/bruised/swollen areas noted. Resident non-verbal, per yes/no questions does not know how she [sic] fell to floor. Room-mate reports hearing loud bump then turning on call light. Resident</p>				

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	<p>assisted to bed. Neuro checks started, wnl [within normal limits]. Denies pain. bed [sic] was in low postion [sic] with mat on floor. Also has bumpers on bed, bed has overlay on air mattress, bumper on side of bed, not on top of bed. Overlay repositioned and bumpers in place on top of mattress." Notes indicated the physician was notified.</p> <p>The Post Occurrence Assessment dated 12/05/11 at 9:11 a.m. indicated, Date and time of occurrence as 12/05/11 at 12:45 a.m.; summary of occurrence: "Resident on floor on right side"; type of injury: "Hematoma to forehead"; root cause: "Low air loss mattress provided by hospice, very sensitive to movement"; IDT [Interdisciplinary Team] recommendations: "Low air loss mattress removed, lip mattress placed."</p> <p>LPN #3 indicated on the "Investigation of reasons/causes of the incident: bed mattress has bumpers, pad of mattress overlay which was under over to side, allowing bumper to move to side of mattress." The "Action taken to prevent reoccurrence: Will notify unit manager about need to change bed overlay." Underneath the above documentation was written, "Low air loss mattress with bumper pads removed and resident given lip mattress. The facility's new</p>				

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	<p>intervention was to remove the low air loss mattress, and a lip mattress was placed." The Administrator and DON signed the sheet.</p> <p>Resident #D was observed on 12/14/11 at 10 a.m. and was observed asleep in low bed with mat on the floor beside the bed. Bruises were observed on the resident's right forehead area and right cheek.</p> <p>Interview with LPN #11 on 12/14/11 at 10:45 a.m. indicated the right forehead area was partially scabbed at the top of the hematoma.</p> <p>Interview with the Administrator and DON on 12/14/11 at 11:05 a.m. indicated Resident #D fell on 12/05/11 at 12:45 a.m.. The DON explained the Administrator and Assistant Director of Nursing [ADON] was made aware of the incident about LPN #3 not responding immediately the first time when told about the resident's fall during an in-service on 12/07/11. CNA #2 told LPN #4 that the nurse did not respond when told about the resident having fallen. The Administrator indicated LPN #4 was told by CNA #2 that she went once to get the nurse and then had to go a second time to get the nurse to come down and check on the resident. During termination of LPN #3, the nurse just said</p>			

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	<p>he assessed the resident, but did not say anything about the second time of the aide coming to get him. The Administrator indicated LPN #3 was pretty quiet that day of termination.</p> <p>Review of the facility's policy on Abuse Prohibition, Reporting, and Investigation dated 08/23/11 indicated, "... Abuse - Physical, sexual, verbal and/or mental (known or alleged) abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. This includes deprivation of an individual, including caretaker, of goods or services that are necessary to attain or maintain physical, mental, or psychosocial well being. ... Neglect - means the failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness...." The policy indicated,"1. It is the policy of _____[name of health system] that all residents have the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion. 2. _____[name of health system] has policies and procedures in place that prohibit mistreatment, neglect and abuse of residents and misappropriation of resident property. These policies and procedures include but not limited to employment procedures:</p>			

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	<p>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 will not be employed. 3. _____ [name of health system] has policies and procedures in place that ensures that all alleged violations involving mistreatment, neglect or abuse, including injuries of 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). 4. _____ [name of health system] has policies and procedures in place that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress." The facility's policy and procedures also indicated, "It is the responsibility of every employee of _____ [name of health system] to not only report abuse situations, but also suspicion of abuse and unusual observations and circumstances, to their immediate supervisor. ... All reports of alleged abuse/abuse and all unusual occurrences, must be reported to the Administrator immediately, and to the resident's representative (sponsor, responsible</p>				

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	<p>party), as soon as feasible possible, but no later than within 24 hours of the reporting or discovery of the incident. ... Violations of the aforementioned will be reported to the Long Term Care Division of the Indiana State Department of Health and other officials in accordance with state law through established procedures as outlined in the "Unusual Occurrence Reporting Policy and Procedure. ... The Administrator, or designee, shall initiate and direct the investigation immediately, and within 5 days a report of this investigation must be forwarded to the Long Term Care Division of the Indiana State Department of Health."</p> <p>Review of the Disciplinary Detail for LPN #3 dated 12/07/11 indicated, "Employee was witnessed sleeping while on duty for an uninterrupted period of 45 minutes. According to investigation, this has been a repeated violation of company policy. In addition, it was reported on this date a resident fell and a request had been made for this nurse to come quickly and assess (Nurse was not in middle of care with another resident.) Nurse had to be requested a second time to come assess resident. At which time this nurse did not assess above 2 violation demonstrate a lack of professional standard necessary for the protection of our resident's welfare."</p>				

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	<p>The Separation Form indicated, "I _____[name of LPN #3] certify that there are no incidences, that I am aware of, regarding "resident abuse" that are unresolved as of this date. I certify, further, that I have been trained in the recognition of resident abuse, both physical and mental, and ascertain no such violations of Resident's Rights are unresolved." This was initialed by LPN #3.</p> <p>This federal deficiency is related to Complaint IN00100653.</p> <p>3.1-28(a)</p>				