

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155104	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/14/2011
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NAME OF PROVIDER OR SUPPLIER HERITAGE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1201 W BUENA VISTA RD EVANSVILLE, IN47710
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F0000	<p>This visit was for the Investigation of Complaint IN00099638.</p> <p>Complaint IN00099638 Substantiated, Federal/State deficiencies are cited at F221, F223, F225, F226, F250, and F280.</p> <p>Survey dates: November 9, 10, and 14, 2011</p> <p>Facility number: 000043 Provider number: 155104 AIM number: 100290960</p> <p>Survey team: Anne Marie Crays RN</p> <p>Census bed type: SNF: 19 SNF/NF: 117 Total: 136</p> <p>Census payor type: Medicare: 30 Medicaid: 59 Other: 47 Total: 136</p> <p>Sample: 4</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p>	F0000		

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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F0221 SS=D	<p>Quality review completed 11/17/11 Cathy Emswiller RN</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. Based on interview and record review, the facility failed to ensure a resident was free from a physical restraint, in that a resident was restrained in a sheet or incontinence pad against her will during an incontinence check, for 1 of 4 residents reviewed for abuse, in a sample of 4. Resident A</p>	F0221	This Plan of Correction is submitted under Federal and State regulations and statues applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of the Plan does not constitute agreement by the	12/14/2011

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	<p>Findings include:</p> <p>On 11/9/11 at 2:15 P.M., during the initial tour of the Alzheimer's Unit, LPN # 1 indicated Resident A "could be resistive to care at times, especially when staff is trying to get her dressed."</p> <p>On 11/9/11 at 2:20 P.M., the clinical record of Resident A was reviewed. Diagnoses included, but were not limited to, Dementia.</p> <p>A Minimum Data Set [MDS] assessment, dated 9/6/11, indicated the resident had a short-term memory problem and was moderately impaired in cognitive skills for daily decision-making. The MDS assessment indicated the resident required extensive assistance of one person for toilet use.</p> <p>Nurse's Notes included the following notations:</p> <p>11/8/11 at 2:55 A.M.: "Received report of alleged abuse of resident per verbal report from [RN # 1]...."</p> <p>On 11/9/11 at 3:00 P.M., during interview with RN # 1, she indicated she was working on 11/8/11 with CNA # 1 and CNA # 2. RN # 1 indicated she went into</p>		<p>facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies cited are correctly applied. Furthermore, we request this 2567 (Plan of Correction) serve as our credible allegation of compliance.</p> <p>F 221 – (483.13a) Immediate Action – Right to be free from physical restraints Staff members were sent home pending investigation, Alleged Employee to Resident Abuse check list completed, Resident assessed, reported to Physician and continue to monitor/report any changes to Triage. CNA # 1 & 2 were in-serviced on: Choices: A Gift We Owe our Residents, Abuse and Neglect of the Elderly, Heritage Centers Policy on "Abuse Prohibition", Resident's Rights and Dignity, Behavioral Management, Combative Behavior and Steps to Understanding Challenging Behaviors; Responding to Persons With Alzheimer's Disease. RN # 1 was in-serviced on Heritage Centers Policy on "Abuse Prohibition".</p> <p>F 221 – Review of Residents Supervisor interviewed two other residents, with no complaints of care. No other residents were adversely affected by this action as it relates to being free from</p>		

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	<p>Resident A's room during "bed check" to put a cream on the resident. RN # 1 indicated she observed CNA # 1 and CNA # 2 wrap a draw sheet around the resident's arms and shoulders "like a mummy " to keep the resident from hitting at them. RN # 1 indicated, "It happened so quick." RN # 1 indicated she "had never seen anyone do anything like that before." RN # 1 indicated the CNAs wrapped the resident so quickly, that it "wasn't the first time they did that." RN # 1 indicated she reported the incident to her supervisor, LPN # 2, and demonstrated to the supervisor what she had observed.</p> <p>On 11/10/11 at 11:50 A.M., during interview with CNA # 3, she indicated that Resident A was "always combative and very fearful" during care. CNA # 3 indicated the resident "had to be wrapped like that every time or you couldn't change her." CNA # 3 indicated staff had attempted to hold her hands, but "once you turned her, she got very scared, and she hits very hard."</p> <p>On 11/10/11 at 12:35 P.M., during interview with LPN # 2, she indicated she was the night supervisor on 11/8/11. LPN # 2 indicated she was making her normal rounds on 11/8/11, and asked RN # 1 if she had any problems or concerns on her</p>		<p>physical restraints.</p> <p>F 221 - On Going Corrective Action Facility will in-service all staff by completion date of 12/14/2011 on "What Constitutes a Restraint", see attached in-service. Administrative Nursing Staff will be in-serviced on revised "A" List which includes "observed care provided to resident". This observation will be utilized on a resident that has a history of behaviors to ensure that the resident is free from a physical restraint.</p> <p>F 221 - On Going Monitoring Administrative Nursing Staff will utilize the revised "A" List which includes "observed care provided to resident" In order to monitor care provided by CNA to resident that exhibits behaviors. During the orientation process all staff will be instructed on "What Constitutes a Restraint" in-servicing. -----</p>		

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	<p>unit. RN # 1 indicated she told her there was "something she didn't like." LPN # 2 indicated RN # 1 showed her how CNA # 1 and CNA # 2 wrapped Resident A in a draw sheet. LPN # 2 indicated, "I always have my cell phone. She should have called me." LPN # 2 indicated RN # 1 told her she could not remember what time it happened.</p> <p>On 11/9/11 at 3:30 P.M., the Director of Nursing [DON] provided a "Fax/Unusual Occurrence Report," sent to the Indiana State Department of Health and dated 11/8/11. The report included: "...Brief Description of Incident, [RN # 1] was present during bed check and witnessed [CNA # 1] and [CNA # 2] wrap a draw sheet around resident's arms so she could not hit at them while they were doing bed check. Type of Injury/Injuries, 1 1/2 cm [centimeter] x 3 cm bruised area at posterior R [right] hip...."</p> <p>On 11/14/11 at 9:00 A.M., during interview with the Administrator and DON, they indicated the staff involved in the incident had been interviewed. The DON indicated a draw sheet was not on the bed, but perhaps an incontinence pad had been used. The DON indicated RN # 1 "couldn't remember a lot of things," but stayed with Resident A after the incident because the resident "seemed</p>				

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	<p>upset." The DON indicated RN # 1 told her that when she went to the desk, LPN # 2 was at the desk and that is when she informed her of the incident.</p> <p>This federal tag relates to Complaint IN00099638.</p> <p>3.1-3(w)</p>				

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F0223 SS=D	<p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on interview and record review, the facility failed to ensure a resident was free from physical abuse, in that a resident was wrapped in a sheet or incontinence pad against her will during an incontinence check, for 1 of 4 residents reviewed for abuse, in a sample of 4. Resident A</p> <p>Findings include:</p> <p>1. On 11/9/11 at 2:15 P.M., during the initial tour of the Alzheimer's Unit, LPN # 1 indicated Resident A "could be resistive to care at times, especially when staff is trying to get her dressed."</p> <p>On 11/9/11 at 2:20 P.M., the clinical record of Resident A was reviewed. Diagnoses included, but were not limited to, Dementia.</p> <p>A Minimum Data Set [MDS] assessment, dated 9/6/11, indicated the resident had a short-term memory problem and was moderately impaired in cognitive skills for daily decision-making. The MDS assessment indicated the resident required</p>	F0223	<p>F 223 – (483.13b) Immediate Action – Free From Abuse/Involuntary Seclusion Staff members were sent home pending investigation, Alleged Employee to Resident Abuse check list completed, Resident assessed, reported to Physician and continue to monitor/report any changes to Triage. CNA # 1 & 2 were in-serviced on: Choices: A Gift We Owe Our Residents, Abuse and Neglect of the Elderly, Heritage Centers Policy on "Abuse Prohibition", Resident's Rights and Dignity, Behavioral Management, Combative Behavior and Steps to Understanding Challenging Behaviors; Responding to Persons With Alzheimer's Disease. RN # 1 was in-serviced on Heritage Centers Policy on "Abuse Prohibition".</p> <p>F 223 – Review of Residents Supervisor interviewed two other residents, with no complaints of care. No other residents were adversely affected by this action as it relates to being free from abuse/involuntary seclusion.</p> <p>F 223 On Going Corrective Action</p>	12/14/2011

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	<p>extensive assistance of one person for toilet use.</p> <p>Nurse's Notes included the following notations:</p> <p>11/8/11 at 2:55 A.M.: "Received report of alleged abuse of resident per verbal report from [RN # 1]...."</p> <p>On 11/9/11 at 3:00 P.M., during interview with RN # 1, she indicated she was working on 11/8/11 with CNA # 1 and CNA # 2. RN # 1 indicated she went into Resident A's room during "bed check" to put a cream on the resident. RN # 1 indicated she observed CNA # 1 and CNA # 2 wrap a draw sheet around the resident's arms and shoulders "like a mummy " to keep the resident from hitting at them. RN # 1 indicated, "It happened so quick." RN # 1 indicated she "had never seen anyone do anything like that before." RN # 1 indicated the CNAs wrapped the resident so quickly, that it "wasn't the first time they did that." RN # 1 indicated she reported the incident to her supervisor, LPN # 2, and demonstrated to the supervisor what she had observed.</p> <p>On 11/10/11 at 11:50 A.M., during interview with CNA # 3, she indicated that Resident A was "always combative</p>		<p>Facility will in-service all staff by completion date of 12/14/2011 on "What Constitutes a Restraint", see attached in-service. Administrative Nursing Staff will be in-serviced on revised "A" List which includes "observed care provided to resident". This observation will be utilized on a resident that has a history of behaviors to ensure that the resident is free from abuse/involuntary seclusion.</p> <p>F 223 On Going Monitoring Administrative Nursing Staff will utilize the revised "A" List which includes "observed care provided to resident" In order to monitor care provided by CNA to resident that exhibits behaviors. During the orientation process all staff are in-serviced on Abuse Prohibition Policy and Procedure.</p>		

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	<p>and very fearful" during care. CNA # 3 indicated the resident "had to be wrapped like that every time or you couldn't change her." CNA # 3 indicated staff had attempted to hold her hands, but "once you turned her, she got very scared, and she hits very hard."</p> <p>On 11/10/11 at 12:35 P.M., during interview with LPN # 2, she indicated she was the night supervisor on 11/8/11. LPN # 2 indicated she was making her normal rounds on 11/8/11, and asked RN # 1 if she had any problems or concerns on her unit. RN # 1 indicated she told her there was "something she didn't like." LPN # 2 indicated RN # 1 showed her how CNA # 1 and CNA # 2 wrapped Resident A in a draw sheet. LPN # 2 indicated, "I always have my cell phone. She should have called me." LPN # 2 indicated RN # 1 told her she could not remember what time it happened.</p> <p>On 11/9/11 at 3:30 P.M., the Director of Nursing [DON] provided a "Fax/Unusual Occurrence Report," sent to the Indiana State Department of Health and dated 11/8/11. The report included: "...Brief Description of Incident, [RN # 1] was present during bed check and witnessed [CNA # 1] and [CNA # 2] wrap a draw sheet around resident's arms so she could not hit at them while they were doing bed</p>				

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	<p>check. Type of Injury/Injuries, 1 1/2 cm [centimeter] x 3 cm bruised area at posterior R [right] hip...."</p> <p>On 11/14/11 at 9:00 A.M., during interview with the Administrator and DON, they indicated the staff involved in the incident had been interviewed. The DON indicated a draw sheet was not on the bed, but perhaps an incontinence pad had been used. The DON indicated RN # 1 "couldn't remember a lot of things," but stayed with Resident A after the incident because the resident "seemed upset." The DON indicated RN # 1 told her that when she went to the desk, LPN # 2 was at the desk and that is when she informed her of the incident.</p> <p>2. On 11/9/11 at 2:45 P.M., the DON provided the current facility policy on "Abuse Prohibition," revised 5/28/10. The policy included: "...'Abuse' means the willful infliction of injury, unreasonable confinement, intimidation or punishment with the resulting physical harm, pain or mental anguish...Prevention...Assignments, care planning and care instructions are accessible to team members to assure resident's needs are met, staff efficiency and decreased staff frustration...Consideration is given to CNA assignments that contain heavy care</p>				

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	<p>residents and residents who display aggressive/abusive behaviors...Residents in this category include cognitively impaired, physically dependent, behaviors...."</p> <p>This federal tag relates to Complaint IN00099638.</p> <p>3.1-27(a) 3.1-27(b)</p>				

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F0225 SS=D	<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 interview and record review, the facility failed to ensure a nurse immediately reported to her supervisor and/or Administrator an allegation of physical abuse, for 1 of 4 residents</p>	F0225	F 225 - (483.13c) Immediate Action – Investigate/Report Allegations/Individuals Staff members were sent home pending investigation, Alleged Employee to Resident Abuse	12/14/2011	

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	<p>reviewed for abuse, in a sample of 4. Resident A</p> <p>Findings include:</p> <p>1. On 11/9/11 at 2:15 P.M., during the initial tour of the Alzheimer's Unit, LPN # 1 indicated Resident A "could be resistive to care at times, especially when staff is trying to get her dressed."</p> <p>On 11/9/11 at 2:20 P.M., the clinical record of Resident A was reviewed. Diagnoses included, but were not limited to, Dementia.</p> <p>A Minimum Data Set [MDS] assessment, dated 9/6/11, indicated the resident had a short-term memory problem and was moderately impaired in cognitive skills for daily decision-making. The MDS assessment indicated the resident required extensive assistance of one person for toilet use.</p> <p>Nurse's Notes included the following notations:</p> <p>11/8/11 at 2:55 A.M.: "Received report of alleged abuse of resident per verbal report from [RN # 1]. Call placed to [name of Director of Nursing], [name] Administrative staff on call notified of alleged abuse."</p>		<p>check list completed, Resident assessed, reported to Physician and continue to monitor/report any changes to Triage.</p> <p>CNA # 1 & 2 were in-serviced on: Choices: A Gift We Owe Our Residents, Abuse and Neglect of the Elderly, Heritage Centers Policy on "Abuse Prohibition", Resident's Rights and Dignity, Behavioral Management, Combative Behavior and Steps to Understanding Challenging Behaviors; Responding to Persons With Alzheimer's Disease. RN # 1 was in-serviced on Heritage Centers Policy on "Abuse Prohibition" related to immediately reporting of suspicion of abuse to supervisor.</p> <p>F 225 – Review of Residents Supervisor interviewed two other residents, with no complaints of care. No other residents were adversely affected.</p> <p>F 225 – On Going Corrective Action By 12/14/2011 All staff will be in-serviced on Abuse Prohibition Policy & Procedure and acknowledge understanding it is the staff's responsibility to ensure that ALL allegations of abuse are IMMEDIATELY reported to appropriate supervisor to initiate a thorough investigation. Administrative Nursing staff will be in-serviced on revised "A" List which includes "any allegations of abuse? If yes, abuse checklist will</p>		

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	<p>On 11/9/11 at 3:00 P.M., during interview with RN # 1, she indicated she was working on 11/8/11 with CNA # 1 and CNA # 2. RN # 1 indicated she went into Resident A's room during "bedcheck" to put a cream on the resident. RN # 1 indicated she observed CNA # 1 and CNA # 2 wrap a draw sheet around the resident's arms and shoulders "like a mummy" to keep the resident from hitting at them. RN # 1 indicated, "It happened so quick." RN # 1 indicated she "had never seen anyone do anything like that before." RN # 1 indicated the CNAs wrapped the resident so quickly, that it "wasn ' t the first time they did that." RN # 1 indicated she reported the incident to her supervisor, LPN # 2, and demonstrated to the supervisor what she had observed.</p> <p>On 11/10/11 at 11:50 A.M., during interview with CNA # 3, she indicated that Resident A was "always combative and very fearful" during care. CNA # 3 indicated the resident "had to be wrapped like that every time or you couldn ' t change her." CNA # 3 indicated staff had attempted to hold her hands, but "once you turned her, she got very scared, and she hits very hard."</p> <p>On 11/10/11 at 12:35 P.M., during</p>		<p>be completed appropriately".</p> <p>F 225 – On Going Monitoring House Supervisor contact number is programmed into the telephone on nurses stations for easy access. All staff will be in-serviced on additional method of supervisor contact. Administrative Nursing Staff will utilize the revised "A" List which includes "any allegations of abuse?". During the orientation process all staff are in-serviced on Abuse Prohibition Policy and Procedure.</p> <p>-----</p>		

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	<p>interview with LPN # 2, she indicated she was the night supervisor on 11/8/11. LPN # 2 indicated she was making her normal rounds on 11/8/11, and asked RN # 1 if she had any problems or concerns on her unit. RN # 1 indicated she told her there was "something she didn ' t like." LPN # 2 indicated RN # 1 showed her how CNA # 1 and CNA # 2 wrapped Resident A in a draw sheet. LPN # 2 indicated, "I always have my cell phone. She should have called me." LPN # 2 indicated RN # 1 told her she could not remember what time it happened.</p> <p>On 11/9/11 at 3:30 P.M., the Director of Nursing [DON] provided a "Fax/Unusual Occurrence Report," sent to the Indiana State Department of Health and dated 11/8/11. The report included: "...Brief Description of Incident, [RN # 1] was present during bed check and witnessed [CNA # 1] and [CNA # 2] wrap a draw sheet around resident's arms so she could not hit at them while they were doing bed check. Type of Injury/Injuries, 1 1/2 cm [centimeter] x 3 cm bruised area at posterior R [right] hip...."</p> <p>On 11/14/11 at 9:00 A.M., during interview with the Administrator and DON, they indicated the staff involved in the incident had been interviewed. The DON indicated a draw sheet was not on</p>				

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	<p>the bed, but perhaps an incontinence pad had been used. The DON indicated RN # 1 "couldn't remember a lot of things," but stayed with Resident A after the incident because the resident "seemed upset." The DON indicated RN # 1 told her that when she went to the desk, LPN # 2 was at the desk and that is when she informed her of the incident.</p> <p>2. On 11/9/11 at 2:45 P.M., the DON provided the current facility policy on "Abuse Prohibition," revised 5/28/10. The policy included: "...'Abuse' means the willful infliction of injury, unreasonable confinement, intimidation or punishment with the resulting physical harm, pain or mental anguish...Any team member with knowledge of an alleged abuse incident will report it immediately to the unit/charge nurse, supervisor, nursing administration, DON, or Administrator...."</p> <p>This federal tag relates to Complaint IN00099638.</p> <p>3.1-27(a)</p>				

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F0226 SS=D	<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 interview and record review, the facility failed to ensure implement their policy of immediately reporting to a supervisor and/or Administrator an allegation of physical abuse, for 1 of 4 residents reviewed for abuse, in a sample of 4. Resident A</p> <p>Findings include:</p> <p>1. On 11/9/11 at 2:15 P.M., during the initial tour of the Alzheimer's Unit, LPN # 1 indicated Resident A "could be resistive to care at times, especially when staff is</p>	F0226	<p>F 226 - (483.13c) Immediate Action – Develop/Implement Abuse/Neglect, Etc Policies Staff members were sent home pending investigation, Alleged Employee to Resident Abuse check list completed, Resident assessed, reported to Physician and continue to monitor/report any changes to Triage. CNA # 1 & 2 were in-serviced on: Choices: A Gift We Owe Our Residents, Abuse and Neglect of the Elderly, Heritage Centers Policy on "Abuse Prohibition", Resident's Rights and Dignity, Behavioral Management,</p>	12/14/2011

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	<p>trying to get her dressed."</p> <p>On 11/9/11 at 2:20 P.M., the clinical record of Resident A was reviewed. Diagnoses included, but were not limited to, Dementia.</p> <p>A Minimum Data Set [MDS] assessment, dated 9/6/11, indicated the resident had a short-term memory problem and was moderately impaired in cognitive skills for daily decision-making. The MDS assessment indicated the resident required extensive assistance of one person for toilet use.</p> <p>Nurse's Notes included the following notations:</p> <p>11/8/11 at 2:55 A.M.: "Received report of alleged abuse of resident per verbal report from [RN # 1]. Calls placed to [name of Director of Nursing], [name] Administrative staff on call notified of alleged abuse."</p> <p>On 11/9/11 at 3:00 P.M., during interview with RN # 1, she indicated she was working on 11/8/11 with CNA # 1 and CNA # 2. RN # 1 indicated she went into Resident A's room during "bed check" to put a cream on the resident. RN # 1 indicated she observed CNA # 1 and CNA # 2 wrap a draw sheet around the</p>		<p>Combative Behavior and Steps to Understanding Challenging Behaviors; Responding to Persons With Alzheimer's Disease. RN # 1 was in-serviced on Heritage Centers Policy on "Abuse Prohibition".</p> <p>F 226 – Review of Residents Supervisor interviewed two other residents, with no complaints of care. No other residents were adversely affected.</p> <p>F 226 – On Going Corrective Action By 12/14/2011 All staff will be in-serviced on Abuse Prohibition Policy & Procedure and acknowledge understanding it is the staff's responsibility to ensure that ALL allegations of abuse are IMMEDIATELY reported to appropriate supervisor to initiate a thorough investigation. Administrative Nursing staff will be in-serviced on revised "A" List which includes "any allegations of abuse? If yes, abuse checklist will be completed appropriately".</p> <p>F 226 – On Going Monitoring House Supervisor contact number is programmed into the telephone on nurses stations for easy access. All staff will be in-serviced on additional method of supervisor contact. Administrative Nursing Staff will utilize the revised "A" List which</p>		

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	<p>resident's arms and shoulders "like a mummy" to keep the resident from hitting at them. RN # 1 indicated, "It happened so quick." RN # 1 indicated she "had never seen anyone do anything like that before." RN # 1 indicated the CNAs wrapped the resident so quickly, that it "wasn't the first time they did that." RN # 1 indicated she reported the incident to her supervisor, LPN # 2, and demonstrated to the supervisor what she had observed.</p> <p>On 11/10/11 at 11:50 A.M., during interview with CNA # 3, she indicated that Resident A was "always combative and very fearful " during care. CNA # 3 indicated the resident "had to be wrapped like that every time or you couldn't change her." CNA # 3 indicated staff had attempted to hold her hands, but "once you turned her, she got very scared, and she hits very hard."</p> <p>On 11/10/11 at 12:35 P.M., during interview with LPN # 2, she indicated she was the night supervisor on 11/8/11. LPN # 2 indicated she was making her normal rounds on 11/8/11, and asked RN # 1 if she had any problems or concerns on her unit. RN # 1 indicated she told her there was "something she didn't like." LPN # 2 indicated RN # 1 showed her how CNA # 1 and CNA # 2 wrapped Resident A in a</p>		<p>includes "any allegations of abuse?".</p> <p>During the orientation process all staff are in-serviced on Abuse Prohibition Policy and Procedure.</p> <p>-----</p>		

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	<p>draw sheet. LPN # 2 indicated, "I always have my cell phone. She should have called me." LPN # 2 indicated RN # 1 told her she could not remember what time it happened.</p> <p>On 11/9/11 at 3:30 P.M., the Director of Nursing [DON] provided a "Fax/Unusual Occurrence Report," sent to the Indiana State Department of Health and dated 11/8/11. The report included: "...Brief Description of Incident, [RN # 1] was present during bed check and witnessed [CNA # 1] and [CNA # 2] wrap a draw sheet around resident's arms so she could not hit at them while they were doing bed check. Type of Injury/Injuries, 1 1/2 cm [centimeter] x 3 cm bruised area at posterior R [right] hip...."</p> <p>On 11/14/11 at 9:00 A.M., during interview with the Administrator and DON, they indicated the staff involved in the incident had been interviewed. The DON indicated a draw sheet was not on the bed, but perhaps an incontinence pad had been used. The DON indicated RN # 1 "couldn't remember a lot of things," but stayed with Resident A after the incident because the resident "seemed upset." The DON indicated RN # 1 told her that when she went to the desk, LPN # 2 was at the desk and that is when she informed her of the incident.</p>				

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	<p>2. On 11/9/11 at 2:45 P.M., the DON provided the current facility policy on "Abuse Prohibition," revised 5/28/10. The policy included: "...'Abuse' means the willful infliction of injury, unreasonable confinement, intimidation or punishment with the resulting physical harm, pain or mental anguish...Any team member with knowledge of an alleged abuse incident will report it immediately to the unit/charge nurse, supervisor, nursing administration, DON, or Administrator...."</p> <p>This federal tag relates to Complaint IN00099638.</p> <p>3.1-28(a)</p>				

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F0250 SS=D	<p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on interview, observation, and record review, the facility failed to ensure residents had individualized and updated plans to manage their behaviors, for 2 of 3 residents reviewed for behaviors, in a sample of 4. Resident A, Resident B</p> <p>Findings include:</p> <p>1. On 11/9/11 at 2:15 P.M., during the initial tour of the Alzheimer's Unit, LPN # 1 indicated Resident A "could be resistive to care at times, especially when staff is trying to get her dressed."</p> <p>On 11/9/11 at 2:20 P.M., the clinical record of Resident A was reviewed. Diagnoses included, but were not limited to, Dementia.</p> <p>A Minimum Data Set [MDS] assessment, dated 9/6/11, indicated the resident had a</p>	F0250	<p>F 250 - (483.15g) Immediate Action – Provision of Medically Related Social Service The Social Worker updated behavior care plans for resident's A & B to provide more individualized interventions.</p> <p>F 250 – Review of Residents No other residents were adversely affected.</p> <p>F 250 – On Going Corrective Action An Admission Behavior Intervention Care Plan was created. Nursing and Social Service Staff will be in-serviced by 12/14/2011 on the new Admission Behavior Intervention Care Plan Form and Inderdisciplinary Care Plans. This care plan will be initiated within 24 hours of admission. The individualized care plan is completed within 7 days after the completion of the MDS. The care</p>	12/14/2011	

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	<p>short-term memory problem and was moderately impaired in cognitive skills for daily decision-making. The MDS assessment indicated the resident had behavior symptoms of "Physical behavioral symptoms directed toward others..." which occurred 1 to 3 days during the assessment period, and "significantly interfered with the resident's care." The resident also exhibited "Rejection of Care " 1 to 3 days. The MDS assessment indicated Resident A required limited assistance of one person for transfer, walking, dressing and personal hygiene.</p> <p>An "Interdisciplinary Communication Form," dated 9/13/11, indicated, "...Behaviors [and] resistance to care due to dementia. Recommendations: See hand-out for tips/techniques to [decrease] behaviors...add this sheet to CNA assignment sheet..." The attached hand-out included: "Tips for bathing, dressing, toileting with [Resident A], Usually, one person works much better than 2. With two people, she will feel trapped and overwhelmed and on the defensive...To get her out of bed or out of chair, Do not grab at her. She will get upset. Make friendly conversation, smile, joke around...Give her some seconds to process, and gently asked her to sit up or come with you again...Don't pull on her</p>		<p>plan is reviewed every 90 days or more frequently if the resident's condition changes.</p> <p>F 250 – On Going Monitoring Master degreed social worker will monitor monthly the behavior management binder to ensure there are individualized updated care plans for residents who have exhibited behaviors as part of the monthly Performance Improvement.</p> <p>-----</p>		

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	<p>arms or her back. "</p> <p>A Care Plan, dated 9/22/11, indicated, "Problem, [Resident A] can be very resistive to care: hitting, slapping, pinching, yelling at staff when they are attempting to assist with ADL [activities of daily living] care." The Interventions included: "Re-approach [Resident A] at a later time. Converse with [Resident A] before providing care. Build positive rapport before attempting care. She enjoys conversing about husband and family. Provide 1:1 as needed. Call [Resident A's] husband or daughter to talk or come in for a visit. Psychotropic medications as prescribed by Dr." An addendum, dated 10/6/11, indicated, "Husband states it can be worse if resident has not had enough sleep." Interventions dated after 10/6/11 were not observed in the clinical record.</p> <p>A Social Service Progress Note, dated 10/7/11, indicated, "Staff reports resident still resistive to care...Resident often incontinent, but hits, slaps, pinches, and yells at staff when they attempt to clean her. Staff has tried using families names...with little success...."</p> <p>Nurses Notes included the following notations:</p> <p>10/9/11 at 5:00 A.M.: "Pt [patient] awake</p>				

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	<p>resistive to care from CNAs trying to dress her for breakfast. Calmed down slightly after 5 mins of fighting [and] hitting the CNA's [sic]. "</p> <p>10/10/11 at 2:00 A.M.: "Asked pt is she would like to go to sleep she replied yes, CNA came to assist the nurse [with] changing brief [and] placing in bed. Pt was combative in spite of speaking politely [and] trying to reason [with] her. Hitting both CNA [and] nurse through-out care."</p> <p>10/10/11 at 10:15 A.M.: " Res [resident] has been resistive et [and] combative since start of shift..."</p> <p>10/12/11 at 11:00 P.M.: "While helping pt to bed, she slapped at CNA while we were trying to put on her depends."</p> <p>10/15/11 at 9:00 P.M.: "...Res combative [and] slapping this nurse on the [right] shoulder while assisting CNA [name] [with] Res to BR [bathroom]...Stated to Res not to slap this nurse. This nurse was just trying to help if needed. [No] help [with] discussion this nurse just left room...."</p> <p>10/19/11 at 9:00 P.M.: "Resident was swatting and cussing at staff...."</p>				

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	<p>10/20/11 at 7:00 A.M.: "Res uncooperative [with] care. Swatting CNAs during bed checks [and] kicking. Res refused for the nurse to take CPAP [breathing machine] off 2 x's swatting [and] hateful verbally. Third x the nurse asked her again with a calm quiet voice [and] again the pt was visibly hateful [and] swatting @ this nurse. This nurse removed the CPAP w/o [without] pt's cooperation...."</p> <p>10/21/11 at 4:30 A.M.: "Resident has been resistant to care this shift, hitting, slapping [and] kicking @ all staff. Very combative this shift."</p> <p>10/21/11 at 10:30 A.M.: "CNA stated when attempting to get res ready, res grabbed her [right] pinky finger et bent it back. CNA had another CNA assist her [with bathing et clothing resident. "</p> <p>10/23/11 at 1:30 A.M.: "Resistive to care during bed check, hitting [and] kicking staff. "</p> <p>10/24/11 at 9:00 A.M.: "Pt resistive to care [with] staff during bed checks. Slapping [and] hitting staff when they are changing her wet briefs."</p> <p>10/25/11 at 7:50 A.M.: "Pt resistive to all ADL's, slapping [and] hitting the</p>				

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	<p>CNAs...."</p> <p>10/25/11 at 3:30 P.M.: "During High Risk discussed res [increased] behavior, hitting [and] slapping at staff not only during care but also when ambulating. Reviewed res. meds/labs. Also rept [sic] that staff has tried different approaches [with] care, seems to have [increased] in last 5-6 days...Req. [requested] TSH level x 1, routine stool softener, routine analgesic [and] routine Risperdal [anti-psychotic]...."</p> <p>A Social Service note, dated 10/25/11, indicated, "...Res. slapped CNA on her cheek. Res. had been resistive to care that morning as well...res. currently on Lexapro [anti-depressant], Ativan [anti-anxiety] PRN [as needed]...requested something for bowels and behaviors...."</p> <p>Nurses notes continued:</p> <p>10/26/11 at 2:30 P.M.: "Res resistive [with] ADL care this am, hitting at staff...."</p> <p>10/27/11 at 1:30 P.M.: "Res continues to be resistive [with] AM care, hit CNA several x's on head...."</p> <p>10/28/11 at 10:30 A.M.: "Res extremely</p>			

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NAME OF PROVIDER OR SUPPLIER HERITAGE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 W BUENA VISTA RD EVANSVILLE, IN47710		
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	<p>combative et resistive [with] ADL care. Hit CNA several x 's during bath...."</p> <p>A Social Service note, dated 10/28/11, indicated, "Resident con't to be resistive to care daily, hitting et slapping at staff... [Nurse practitioner] did not want Risperdal ordered at this time."</p> <p>Nurses notes included:</p> <p>10/30/11 at 7:00 A.M.: "Pt resistive to care anytime CNAs tried to change her wet briefs she would slap them [and] kick. Pt hit the nurse several times as she was trying to remove the CPAP and give her 630 AM meds."</p> <p>11/1/11 [untimed]: "Pt resistive to care, slapping hitting CNA during routine care..."</p> <p>11/3/11 at 4:00 A.M.: "Pt resistive to routine care slapping [and] hitting CNAs."</p> <p>11/7/11 at 8:00 A.M.: "Pt hitting CNAs during routine care on this shift (11-7). "</p> <p>11/8/11 at 2:55 A.M.: "Received report of alleged abuse of resident per verbal report from nurse [RN# 1]...."</p> <p>On 11/10/11 at 9:55 A.M., CNA # 4 was observed toileting Resident A. Resident A</p>				

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NAME OF PROVIDER OR SUPPLIER HERITAGE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 W BUENA VISTA RD EVANSVILLE, IN47710		
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	<p>was cooperative with the care. CNA # 4 indicated, "If she gets real frustrated, she'll swing her arms." CNA # 4 indicated, "You just have to talk real soft and gentle to her."</p> <p>On 11/10/11 at 10:00 A.M., during interview with LPN # 1 regarding Resident A's behaviors, she indicated, "The Dr. wanted to order Risperdal, but the husband didn't want her to take it, but we just got a call from triage and she can start taking it now." When interviewed regarding letting the resident sleep before attempting to remove the CPAP machine, LPN # 1 indicated, "The CPAP is ordered for night shift." LPN # 1 referred to the hand-out, dated 9/22/11, when reviewing what staff does to manage the resident's behaviors.</p> <p>On 11/10/11 at 10:45 A.M., during interview with the Social Services Director [SSD], she indicated Resident A was "different day to day" regarding her behavior. The SSD indicated she participated in behavior meetings monthly, in which behaviors and medications were discussed. The SSD indicated the pharmacist was the person who suggested the Risperdal for Resident A. The SSD indicated she had only been at the facility 4 months, and was in the process of changing and developing</p>				

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NAME OF PROVIDER OR SUPPLIER HERITAGE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 W BUENA VISTA RD EVANSVILLE, IN47710		
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	<p>different behavior care plans.</p> <p>On 11/10/11 at 11:50 A.M., during interview with CNA # 3, she indicated that Resident A was "always combative and very fearful" during care. CNA # 3 indicated the resident "had to be wrapped like that every time or you couldn't change her." CNA # 3 indicated staff had attempted to hold her hands, but "once you turned her, she got very scared, and she hits very hard." CNA # 3 indicated, "We tried with 1 person, but it never worked." CNA # 3 indicated, "I guess we didn't know how to care for her." CNA # 3 indicated the nurses were aware of the resident's combative behavior.</p> <p>On 11/14/11 at 12:30 P.M., the SSD provided Behavior Monitoring/Intervention Records, dated October and November 2011. The SSD indicated the records were kept in the resident's chart, and she checked them periodically. Interventions listed included: "Redirect a. Bed, Change caregiver, Toilet, Activity, Talk in slow low voice. Re-approach later." The SSD indicated the nursing staff completed them "pretty well."</p> <p>2. On 11/9/11 at 2:15 P.M., during initial tour of the Alzheimer's Unit, LPN # 1 indicated Resident B was resistive to care</p>				

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NAME OF PROVIDER OR SUPPLIER HERITAGE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1201 W BUENA VISTA RD EVANSVILLE, IN47710
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	<p>at times.</p> <p>The clinical record of Resident B was reviewed on 11/10/11 at 10:15 A.M. Diagnoses included, but were not limited to Alzheimer's Disease.</p> <p>A Minimum Data Set [MDS] assessment, dated 10/17/11, indicated Resident B had a short-term memory problem, was moderately impaired in cognitive skills for daily decision-making, and had behavioral symptoms of physical, verbal, and rejection of care.</p> <p>Social Service Progress Notes, dated 9/20/11, indicated, "CNA reported to SW [social worker] that res has been resistive to care almost daily aeb [as evidenced by]: hitting, slapping, and yelling at staff during care. Nurse advised CNA to use two staff members during care for safety."</p> <p>Nurses Notes included the following notations:</p> <p>10/12/11 at 9:20 A.M.: "Res pinching CNA [with] ADL care, makes false accusations against staff et yelling...."</p> <p>10/13/11 at 10:50 P.M.: "Resident was cursing at residents [and] staff. Tried to push staff. Accused staff of stealing her shoes...very delusional [and] hard to</p>			

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NAME OF PROVIDER OR SUPPLIER HERITAGE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1201 W BUENA VISTA RD EVANSVILLE, IN47710
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	<p>reason with."</p> <p>10/14/11 at 1:00 P.M.: "Res hit at CNA x [one] [with] ADL care...Upsets easily when staff attempting to assist resident [with] eating, transferring...."</p> <p>10/16/11 at 10:30 P.M.: "Resident verbally abusive to staff [with] routine care. Complained loudly about dinner. Refuses to go to activities...."</p> <p>10/17/11 at 2:50 P.M.: "Res quite argumentative this shift. Attempted to get [up] x 1 unassisted. Had several episodes of yelling at staff."</p> <p>10/26/11 at 11:45 A.M.: "Res yelling at staff et other residents at lunch table in day room...attempting to redirect res, but res yelling...."</p> <p>Social Service Notes, dated 10/26/11, indicated, "(Late entry for 10/25/11) ..Res has hx [history] of being resistive to care and hitting at staff...."</p> <p>Nurses Notes continued:</p> <p>10/28/11 at 9:15 A.M.: "Res resistive [with] AM care, hitting/yelling at staff...."</p> <p>10/29/11 at 11:30 A.M.: "...Combative at times [with] care this AM.</p>			

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NAME OF PROVIDER OR SUPPLIER HERITAGE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 W BUENA VISTA RD EVANSVILLE, IN47710		
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	<p>Non-cooperative [with] CNAs...."</p> <p>10/30/11 [untimed]: "Resident very argumentative [with] staff. Verbally abusive, Resistive to routine care...Slapped [and] kicked at staff."</p> <p>11/1/11 at 2:30 P.M.: "Res resistive et combative [with] ADL care et transfers...."</p> <p>Social Service notes, dated 11/1/11, indicated: " Resident continues to be combative with care and yell at staff, even when staff not providing care...SW had to keep res at arms length b/c [because] res would hit at SW for [no] reason.... "</p> <p>Nurses Notes continued:</p> <p>11/2/11 at 2:00 P.M.: "Res resistive [with] ADL care. Argumentative [with] staff et other residents...."</p> <p>11/8/11 at 11:30 P.M.: "Resident yelled at CNA when she was toileting [and] putting resident to bed...."</p> <p>A Care Plan, dated 1/31/11 and updated 4/14/11, indicated a problem of "Urinating trash can (sic); Resistive to care; Verbally Abusive...R/T [related to] Alzheimer's disease, Cognitive status problem, Dementia, Mood problem AEB</p>				

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NAME OF PROVIDER OR SUPPLIER HERITAGE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 W BUENA VISTA RD EVANSVILLE, IN47710		
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	<p>[as evidenced by] Socially inappropriate...Verbally abusive behavior, Resistive to care, Anger at staff." The Interventions included: "Monitor behavior to aid in determining cause...Cognitive level allowing, help resident understand why such behavior cannot be allowed...Help resident develop coping strategies...." Revisions to the care plan since 4/11 were not documented in the clinical record.</p> <p>On 11/10/11 at 10:45 A.M., during interview with the SSD regarding Resident B's behaviors, she indicated, "The doctor was hesitant about changing the resident's meds." The SSD indicated Resident B would yell out and upset other residents. The SSD indicated the resident is awaiting a visit from a psychiatrist. The SSD indicated she did not know why an updated care plan was not in the chart, but that she had one in her computer.</p> <p>At that time, the SSD provided a care plan for Resident B. The care plan, dated 10/21/11, indicated a problem of "[Resident B] is frequently resistive and combative with care...." Interventions included: "Change caregivers, Two caregivers providing care...Psychotropic medications as prescribed by MD. Call daughters - they often come in to visit [Resident B] when she is in a negative</p>				

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NAME OF PROVIDER OR SUPPLIER HERITAGE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 W BUENA VISTA RD EVANSVILLE, IN47710		
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	<p>mood...."</p> <p>On 11/14/11 at 12:30 P.M., the SSD provided "Behavior Monitoring/Intervention Records" for Resident B, dated October 2011 and November 2011. The Interventions listed were: "Redirect a. food/snack. Change caregiver Toilet. Activity. Reassure resident, Take to room." The SSD indicated the records were kept in the chart. The SSD indicated she checked the records periodically.</p> <p>3. On 11/14/11 at 10:00 A.M., the DON provided the current facility policy on "Behavior Management," dated 2/06. The policy included: "Purpose: To provide a procedure for monitoring residents who exhibit inappropriate behavior. This policy will be used as a tool to evaluate the need for interventions, as well as the effectiveness of current interventions...Nursing will assess every shift until no longer required...A care conference may be held with family and other appropriate parties. Social Service/Nursing will evaluate behavior and determine a short term plan...."</p> <p>At that time, the DON provided an additional policy, dated 5/09, which indicated: "Policy and Procedure for Social Service to Address</p>				

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NAME OF PROVIDER OR SUPPLIER HERITAGE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 W BUENA VISTA RD EVANSVILLE, IN47710		
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	<p>Behaviors...When the action of a resident is identified as something which has the potential to cause harm to the residents involved, other residents, or staff, a mood and behavior monitoring sheet will be initiated by nursing...Behavior Care Plan(s) will be initiated/revised...."</p> <p>This federal tag relates to Complaint IN00099638.</p> <p>3.1-34(a)</p>				

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NAME OF PROVIDER OR SUPPLIER HERITAGE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 W BUENA VISTA RD EVANSVILLE, IN47710		
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F0280 SS=D	<p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on interview, observation, and record review, the facility failed to ensure care plans regarding behavior management were revised for 2 of 3 residents reviewed for behavior symptoms, in sample of 4. Resident A, Resident B</p> <p>Findings include:</p> <p>1. On 11/9/11 at 2:15 P.M., during the initial tour of the Alzheimer's Unit, LPN # 1 indicated Resident A "could be resistive to care at times, especially when staff is trying to get her dressed."</p> <p>On 11/9/11 at 2:20 P.M., the clinical</p>	F0280	<p>F 280 - (483.20d) Immediate Action - Right to Participate Planning Care – Revise CP Social Worker updated behavior care plans for resident's A & B.</p> <p>F 280 – Review of Residents No other residents were adversely affected.</p> <p>F 280 – On Going Corrective Action Nursing and social service staff members will be in-serviced on revised Behavior Management and Behavior Monitoring Policies by 12/14/2011. Each resident will have a behavior monitoring form which will be placed in the behavior management binder on each unit. Binders will be accessible to all staff to view</p>	12/14/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155104		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/14/2011	
NAME OF PROVIDER OR SUPPLIER HERITAGE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1201 W BUENA VISTA RD EVANSVILLE, IN47710			
(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			
	<p>record of Resident A was reviewed. Diagnoses included, but were not limited to, Dementia.</p> <p>A Minimum Data Set [MDS] assessment, dated 9/6/11, indicated the resident had a short-term memory problem and was moderately impaired in cognitive skills for daily decision-making. The MDS assessment indicated the resident had behavior symptoms of "Physical behavioral symptoms directed toward others..." which occurred 1 to 3 days during the assessment period, and "significantly interfered with the resident's care." The resident also exhibited "Rejection of Care " 1 to 3 days. The MDS assessment indicated Resident A required limited assistance of one person for transfer, walking, dressing and personal hygiene.</p> <p>An "Interdisciplinary Communication Form," dated 9/13/11, indicated, "...Behaviors [and] resistance to care due to dementia. Recommendations: See hand-out for tips/techniques to [decrease] behaviors...add this sheet to CNA assignment sheet..." The attached hand-out included: "Tips for bathing, dressing, toileting with [Resident A], Usually, one person works much better than 2. With two people, she will feel trapped and overwhelmed and on the</p>		<p>behavior care plans for each resident. When a resident exhibits a behavior, nursing or social service staff will complete behavior monitoring form. Each week, social service will bring behavior monitoring forms and care plans to interdisciplinary high risk meetings to discuss behaviors as well as make changes and additions to the care plan. Copies of behavior care plans will be placed in the behavior management binder on each unit, original will be placed in the blue care plan folder in the resident's chart, and the CNA assignment sheets will be updated as warranted.</p> <p>F 280 – On Going Monitoring Master degreed social worker will monitor monthly the behavior management binder to ensure there are updated care plans for residents who have exhibited behaviors as part of the monthly Performance Improvement.</p> <p>Listed above are the actions we implemented to comply with Survey Event ID C4IT11: To complete our correction process we have provided comprehensive in-servicing to staff, revised policies and created forms. We respectfully request</p>				

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NAME OF PROVIDER OR SUPPLIER HERITAGE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 W BUENA VISTA RD EVANSVILLE, IN47710		
(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	
	<p>defensive...To get her out of bed or out of chair, Do not grab at her. She will get upset. Make friendly conversation, smile, joke around...Give her some seconds to process, and gently asked her to sit up or come with you again...Don't pull on her arms or her back. "</p> <p>A Care Plan, dated 9/22/11, indicated, "Problem, [Resident A] can be very resistive to care: hitting, slapping, pinching, yelling at staff when they are attempting to assist with ADL [activities of daily living] care." The Interventions included: "Re-approach [Resident A] at a later time. Converse with [Resident A] before providing care. Build positive rapport before attempting care. She enjoys conversing about husband and family. Provide 1:1 as needed. Call [Resident A's] husband or daughter to talk or come in for a visit. Psychotropic medications as prescribed by Dr." An addendum, dated 10/6/11, indicated, "Husband states it can be worse if resident has not had enough sleep." Interventions dated after 10/6/11 were not observed in the clinical record.</p> <p>A Social Service Progress Note, dated 10/7/11, indicated, "Staff reports resident still resistive to care...Resident often incontinent, but hits, slaps, pinches, and yells at staff when they attempt to clean her. Staff has tried using families</p>		paper compliance for this survey event, attached is the supportive documentation.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155104	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/14/2011
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NAME OF PROVIDER OR SUPPLIER HERITAGE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1201 W BUENA VISTA RD EVANSVILLE, IN47710
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>names...with little success...."</p> <p>Nurses Notes included the following notations:</p> <p>10/9/11 at 5:00 A.M.: "Pt [patient] awake resistive to care from CNAs trying to dress her for breakfast. Calmed down slightly after 5 mins of fighting [and] hitting the CNA's [sic]. "</p> <p>10/10/11 at 2:00 A.M.: "Asked pt is she would like to go to sleep she replied yes, CNA came to assist the nurse [with] changing brief [and] placing in bed. Pt was combative in spite of speaking politely [and] trying to reason [with] her. Hitting both CNA [and] nurse through-out care."</p> <p>10/10/11 at 10:15 A.M.: " Res [resident] has been resistive et [and] combative since start of shift...."</p> <p>10/12/11 at 11:00 P.M.: "While helping pt to bed, she slapped at CNA while we were trying to put on her depends."</p> <p>10/15/11 at 9:00 P.M.: "...Res combative [and] slapping this nurse on the [right] shoulder while assisting CNA [name] [with] Res to BR [bathroom]...Stated to Res not to slap this nurse. This nurse was just trying to help if needed. [No] help</p>			

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NAME OF PROVIDER OR SUPPLIER HERITAGE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 W BUENA VISTA RD EVANSVILLE, IN47710		
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	<p>[with] discussion this nurse just left room...."</p> <p>10/19/11 at 9:00 P.M.: "Resident was swatting and cussing at staff...."</p> <p>10/20/11 at 7:00 A.M.: "Res uncooperative [with] care. Swatting CNAs during bed checks [and] kicking. Res refused for the nurse to take CPAP [breathing machine] off 2 x's swatting [and] hateful verbally. Third x the nurse asked her again with a calm quiet voice [and] again the pt was visibly hateful [and] swatting @ this nurse. This nurse removed the CPAP w/o [without] pt's cooperation...."</p> <p>10/21/11 at 4:30 A.M.: "Resident has been resistant to care this shift, hitting, slapping [and] kicking @ all staff. Very combative this shift."</p> <p>10/21/11 at 10:30 A.M.: "CNA stated when attempting to get res ready, res grabbed her [right] pinky finger et bent it back. CNA had another CNA assist her [with bathing et clothing resident. "</p> <p>10/23/11 at 1:30 A.M.: "Resistive to care during bed check, hitting [and] kicking staff. "</p> <p>10/24/11 at 9:00 A.M.: "Pt resistive to</p>				

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	<p>care [with] staff during bed checks. Slapping [and] hitting staff when they are changing her wet briefs."</p> <p>10/25/11 at 7:50 A.M.: "Pt resistive to all ADL's, slapping [and] hitting the CNAs...."</p> <p>10/25/11 at 3:30 P.M.: "During High Risk discussed res [increased] behavior, hitting [and] slapping at staff not only during care but also when ambulating. Reviewed res. meds/labs. Also rept [sic] that staff has tried different approaches [with] care, seems to have [increased] in last 5-6 days...Req. [requested] TSH level x 1, routine stool softener, routine analgesic [and] routine Risperdal [anti-psychotic]...."</p> <p>A Social Service note, dated 10/25/11, indicated, "..Res. slapped CNA on her cheek. Res. had been resistive to care that morning as well...res. currently on Lexapro [anti-depressant], Ativan [anti-anxiety] PRN [as needed]...requested something for bowels and behaviors...."</p> <p>Nurses notes continued:</p> <p>10/26/11 at 2:30 P.M.: "Res resistive [with] ADL care this am, hitting at staff...."</p>			

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	<p>10/27/11 at 1:30 P.M.: "Res continues to be resistive [with] AM care, hit CNA several x's on head...."</p> <p>10/28/11 at 10:30 A.M.: "Res extremely combative et resistive [with] ADL care. Hit CNA several x 's during bath...."</p> <p>A Social Service note, dated 10/28/11, indicated, "Resident con't to be resistive to care daily, hitting et slapping at staff... [Nurse practitioner] did not want Risperdal ordered at this time."</p> <p>Nurses notes included:</p> <p>10/30/11 at 7:00 A.M.: "Pt resistive to care anytime CNAs tried to change her wet briefs she would slap them [and] kick. Pt hit the nurse several times as she was trying to remove the CPAP and give her 630 AM meds."</p> <p>11/1/11 [untimed]: "Pt resistive to care, slapping hitting CNA during routine care..."</p> <p>11/3/11 at 4:00 A.M.: "Pt resistive to routine care slapping [and] hitting CNAs."</p> <p>11/7/11 at 8:00 A.M.: "Pt hitting CNAs during routine care on this shift (11-7). "</p>			

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	<p>11/8/11 at 2:55 A.M.: "Received report of alleged abuse of resident per verbal report from nurse [RN# 1]...."</p> <p>On 11/10/11 at 9:55 A.M., CNA # 4 was observed toileting Resident A. Resident A was cooperative with the care. CNA # 4 indicated, "If she gets real frustrated, she'll swing her arms." CNA # 4 indicated, "You just have to talk real soft and gentle to her."</p> <p>On 11/10/11 at 10:00 A.M., during interview with LPN # 1 regarding Resident A's behaviors, she indicated, "The Dr. wanted to order Risperdal, but the husband didn't want her to take it, but we just got a call from triage and she can start taking it now." When interviewed regarding letting the resident sleep before attempting to remove the CPAP machine, LPN # 1 indicated, "The CPAP is ordered for night shift." LPN # 1 referred to the hand-out, dated 9/22/11, when reviewing what staff does to manage the resident's behaviors.</p> <p>On 11/10/11 at 10:45 A.M., during interview with the Social Services Director [SSD], she indicated Resident A was "different day to day" regarding her behavior. The SSD indicated she participated in behavior meetings monthly, in which behaviors and</p>				

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	<p>medications were discussed. The SSD indicated the pharmacist was the person who suggested the Risperdal for Resident A. The SSD indicated she had only been at the facility 4 months, and was in the process of changing and developing different behavior care plans.</p> <p>On 11/10/11 at 11:50 A.M., during interview with CNA # 3, she indicated that Resident A was "always combative and very fearful" during care. CNA # 3 indicated the resident "had to be wrapped like that every time or you couldn't change her." CNA # 3 indicated staff had attempted to hold her hands, but "once you turned her, she got very scared, and she hits very hard." CNA # 3 indicated, "We tried with 1 person, but it never worked." CNA # 3 indicated, " I guess we didn't know how to care for her." CNA # 3 indicated the nurses were aware of the resident's combative behavior.</p> <p>On 11/14/11 at 12:30 P.M., the SSD provided Behavior Monitoring/Intervention Records, dated October and November 2011. The SSD indicated the records were kept in the resident's chart, and she checked them periodically. Interventions listed included: "Redirect a. Bed, Change caregiver, Toilet, Activity, Talk in slow low voice. Re-approach later." The SSD indicated</p>				

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	<p>the nursing staff completed them "pretty well."</p> <p>2. On 11/9/11 at 2:15 P.M., during initial tour of the Alzheimer's Unit, LPN # 1 indicated Resident B was resistive to care at times.</p> <p>The clinical record of Resident B was reviewed on 11/10/11 at 10:15 A.M. Diagnoses included, but were not limited to Alzheimer's Disease.</p> <p>A Minimum Data Set [MDS] assessment, dated 10/17/11, indicated Resident B had a short-term memory problem, was moderately impaired in cognitive skills for daily decision-making, and had behavioral symptoms of physical, verbal, and rejection of care.</p> <p>Social Service Progress Notes, dated 9/20/11, indicated, "CNA reported to SW [social worker] that res has been resistive to care almost daily aeb [as evidenced by]: hitting, slapping, and yelling at staff during care. Nurse advised CNA to use two staff members during care for safety."</p> <p>Nurses Notes included the following notations:</p> <p>10/12/11 at 9:20 A.M.: "Res pinching CNA [with] ADL care, makes false</p>			

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	<p>accusations against staff et yelling...."</p> <p>10/13/11 at 10:50 P.M.: "Resident was cursing at residents [and] staff. Tried to push staff. Accused staff of stealing her shoes...very delusional [and] hard to reason with."</p> <p>10/14/11 at 1:00 P.M.: "Res hit at CNA x [one] [with] ADL care...Upsets easily when staff attempting to assist resident [with] eating, transferring...."</p> <p>10/16/11 at 10:30 P.M.: "Resident verbally abusive to staff [with] routine care. Complained loudly about dinner. Refuses to go to activities...."</p> <p>10/17/11 at 2:50 P.M.: "Res quite argumentative this shift. Attempted to get [up] x 1 unassisted. Had several episodes of yelling at staff."</p> <p>10/26/11 at 11:45 A.M.: "Res yelling at staff et other residents at lunch table in day room...attempting to redirect res, but res yelling...."</p> <p>Social Service Notes, dated 10/26/11, indicated, "(Late entry for 10/25/11) ..Res has hx [history] of being resistive to care and hitting at staff...."</p> <p>Nurses Notes continued:</p>			

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	<p>10/28/11 at 9:15 A.M.: "Res resistive [with] AM care, hitting/yelling at staff...."</p> <p>10/29/11 at 11:30 A.M.: "...Combative at times [with] care this AM. Non-cooperative [with] CNAs...."</p> <p>10/30/11 [untimed]: "Resident very argumentative [with] staff. Verbally abusive, Resistive to routine care...Slapped [and] kicked at staff."</p> <p>11/1/11 at 2:30 P.M.: "Res resistive et combative [with] ADL care et transfers...."</p> <p>Social Service notes, dated 11/1/11, indicated: " Resident continues to be combative with care and yell at staff, even when staff not providing care...SW had to keep res at arms length b/c [because] res would hit at SW for [no] reason.... "</p> <p>Nurses Notes continued:</p> <p>11/2/11 at 2:00 P.M.: "Res resistive [with] ADL care. Argumentative [with] staff et other residents...."</p> <p>11/8/11 at 11:30 P.M.: "Resident yelled at CNA when she was toileting [and] putting resident to bed...."</p>			

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	<p>A Care Plan, dated 1/31/11 and updated 4/14/11, indicated a problem of "Urinating trash can (sic); Resistive to care; Verbally Abusive...R/T [related to] Alzheimer's disease, Cognitive status problem, Dementia, Mood problem AEB [as evidenced by] Socially inappropriate...Verbally abusive behavior, Resistive to care, Anger at staff." The Interventions included: "Monitor behavior to aid in determining cause...Cognitive level allowing, help resident understand why such behavior cannot be allowed...Help resident develop coping strategies...." Revisions to the care plan since 4/11 were not documented in the clinical record.</p> <p>On 11/10/11 at 10:45 A.M., during interview with the SSD regarding Resident B's behaviors, she indicated, "The doctor was hesitant about changing the resident's meds." The SSD indicated Resident B would yell out and upset other residents. The SSD indicated the resident is awaiting a visit from a psychiatrist. The SSD indicated she did not know why an updated care plan was not in the chart, but that she had one in her computer.</p> <p>At that time, the SSD provided a care plan for Resident B. The care plan, dated 10/21/11, indicated a problem of "[Resident B] is frequently resistive and</p>				

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	<p>combative with care...." Interventions included: "Change caregivers, Two caregivers providing care...Psychotropic medications as prescribed by MD. Call daughters - they often come in to visit [Resident B] when she is in a negative mood...."</p> <p>On 11/14/11 at 12:30 P.M., the SSD provided "Behavior Monitoring/Intervention Records" for Resident B, dated October 2011 and November 2011. The Interventions listed were: "Redirect a. food/snack. Change caregiver Toilet. Activity. Reassure resident, Take to room." The SSD indicated the records were kept in the chart. The SSD indicated she checked the records periodically.</p> <p>3. On 11/14/11 at 10:00 A.M., the DON provided the current facility policy on "Behavior Management," dated 2/06. The policy included: "Purpose: To provide a procedure for monitoring residents who exhibit inappropriate behavior. This policy will be used as a tool to evaluate the need for interventions, as well as the effectiveness of current interventions...Nursing will assess every shift until no longer required...A care conference may be held with family and other appropriate parties. Social Service/Nursing will evaluate behavior</p>				

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	<p>and determine a short term plan...."</p> <p>At that time, the DON provided an additional policy, dated 5/09, which indicated: "Policy and Procedure for Social Service to Address Behaviors...When the action of a resident is identified as something which has the potential to cause harm to the residents involved, other residents, or staff, a mood and behavior monitoring sheet will be initiated by nursing...Behavior Care Plan(s) will be initiated/revised...."</p> <p>This federal tag relates to Complaint IN00099638.</p> <p>3.1-35(d)(2)(B)</p>				

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

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FORM APPROVED

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