

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155815	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/25/2015
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NAME OF PROVIDER OR SUPPLIER CLEARVISTA LAKE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 8405 CLEARVISTA PLACE INDIANAPOLIS, IN 46256
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00175557.</p> <p>Complaint IN00175557- Substantiated. Deficiencies related to the allegations are cited at F224, F225, F226, F279, and F309</p> <p>Unrelated deficiency cited.</p> <p>Survey dates: June 22, 23, 24, and 25, 2015</p> <p>Facility number: 013019 Provider number: 155815 AIM number: 201251520</p> <p>Census bed type: SNF: 47 SNF/NF: 10 Total: 57</p> <p>Census payor type: Medicare: 27 Medicaid: 10 Other: 20 Total: 57</p> <p>Sample: 3</p> <p>These deficiencies reflect State findings</p>	F 0000	<p>Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during a Complaint (IN00175557) Survey on June 25, 2015. Please accept this plan of correction as the provider's credible allegation of compliance.</p> <p>The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</p>	

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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F 0164 SS=D Bldg. 00	<p>cited in accordance with 410 IAC 16.2-3.1.</p> <p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by law; third party payment contract; or the resident.</p> <p>Based on observation, the facility failed to ensure resident's confidential health care and personal information was protected from observation by and disclosure to unauthorized persons by</p>	F 0164	F 164 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: All residents have the potential to be affected by this alleged deficient practice.	07/25/2015

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	<p>leaving confidential documents in clear view in a public area with no staff supervision. 1 of 1 observation of confidential information.</p> <p>Findings include:</p> <p>During a tour and observation of the facility on 6/23/15 at 10:50 A.M., the nursing station on the Tinsley unit was noted to be unattended. A large work table attached to the nurse's station was noted to have numerous documents open and visible. There were no visual or physical barriers to keep anyone from walking up to, or rolling up to in a wheelchair, and observing the information on the table. 3 sides of the table were accessible.</p> <p>Documents clearly in view included, but were not limited to: Physician's orders, both on recapitulation of orders and hand written orders; Resident code status; Admission records, including personal and family information; Diagnoses lists; Photo copies of resident Social Security cards, Medicare/Medicaid cards, and driver's licenses; and Medication administration records.</p> <p>During an observation on 6/23/15 from</p>		<p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected by this alleged deficient practice. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the campus staff on the following guideline: HIPAA How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations of public areas will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Resident's confidential health care and personal information is protected from observation by and disclosure to unauthorized persons. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>	

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F 0224 SS=E Bldg. 00	<p>10:50 A.M., to 11:02 A.M., 7 people, including 3 residents, 3 visitors, and one dietary aide were observed in the immediate area of the table and documents. The information on the table was clearly visible and observable by anyone in the area.</p> <p>3.1-3(o)</p> <p>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATE</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.</p> <p>Based on record review and interview, the facility failed to ensure a resident (Resident #B) and 28 other residents on the same unit were protected from potential mistreatment, after a staff member (CNA #1) was accused of mistreatment including inappropriate verbal communication and incomplete care. 1 resident of 3 reviewed for mistreatment in a sample of 3.</p> <p>Findings include:</p> <p>The record of Resident #B was reviewed on 6/22/15 at 1:30 P.M. Diagnoses included, but were not limited to, partial quadriplegia, spondylosis with</p>	F 0224	<p>F 224 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #B - An investigation for the allegation of mistreatment was investigated and reported to the ISDH by the Executive Director.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected by the same alleged deficient practice. Measures put in place and systemic changes made to ensure the alleged deficient practice does</p>	07/25/2015

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	<p>myelopathy (degenerative back disease with nerve involvement), morbid obesity, hypertension, diabetes mellitus, and involuntary movements.</p> <p>An admission Minimum Data Set (M.D.S.) assessment dated 5/26/15 indicated Resident #B had no cognitive deficits, had no mood or behavior disorders, did not ambulate, required extensive assistance for bed mobility, required extensive assistance of 2 persons for transfers, and required extensive assistance for activities of daily living. He was noted to be frequently incontinent of bowel and bladder, and plans were to discharge him back to the community when clinically appropriate.</p> <p>Resident #B was interviewed in his room in private on 6/23/15 at 10:20 A.M. He was alert, oriented, cooperative, and communicated appropriately. He indicated that during morning care on Monday 6/22/15 the aide providing care, CNA #1, was "rude and had a bad attitude." Resident #B indicated that part of his morning care was the application of lotion to his legs, and that CNA #1 put lotion on his legs but did not rub it in. He indicated that he told the CNA that it wouldn't do any good unless it was rubbed in, and that this "made her mad." He indicated that she closed his room</p>		<p>not recur: DHS or designee will re-educate the campus staff on the following guidelines: 1). Abuse and Neglect 2). Accident and Incident Reporting How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 3 residents and 3 staff members will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Interview of residents and staff regarding any allegations of abuse / neglect / mistreatment. The campus will continue the process to screen employees prior to hire for history of abuse, train the new employees and on going for current employees on abuse prevention, including training on protection of the resident, investigation of the alleged abuse and reporting the suspected abuse. For any allegations identified, ED or designee will ensure the following occurs: Identification: appropriate MD/family notification, completion of accident / incident report, notification to the State Department of Health. Protection: suspension of suspected employee(s) pending outcome of investigation. Investigation: initiate and complete. The results of the audit observations will be</p>	

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	<p>door, and came back and "leaned into me" and said "Now listen: we're going to do it my way, or else." He indicated he said he wanted to talk to the Unit Manager or Executive Director. He indicated CNA #1 stated "(Name of unit manager) is not here and neither is (Name of Executive Director). You'll have to deal with me." Resident #B indicated that at that point he became angry, and he and CNA #1 "got into it." He indicated that CNA #1 then left the room and returned with the Unit Manager, who had CNA #1 leave the room. Resident #B stated "I told him what she said to me."</p> <p>Resident #B was again interviewed on 6/23/15 at 3:10 P.M. He recounted the incident with CNA #1 on 6/22/15 in the same detail. He indicated that at the time of the incident he felt "abused and helpless." At the time of the second interview he indicated "They don't treat me with respect. I'm still worried about what they're going to do to me. I'm pretty much helpless." He again indicated that he had told the Unit Manager about the details of the incident, including what CNA #1 had said to him.</p> <p>The Unit Manager was interviewed on 6/24/15 at 9:00A.M., with the Executive Director and Director of Health Services present. He indicated that CNA #1 came</p>		<p>reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>	

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	<p>to him on the morning of 6/22/15 and indicated she needed his assistance in dealing with Resident #B. He indicated he went to Resident #B's room, asked CNA #1 to leave to diffuse the situation, and talked to Resident #B. He indicated Resident #B expressed concern about quality of care, specifically not getting the lotion. rubbed into his legs. The Unit Manager indicated Resident #B did not tell him any specific information about what CNA #1 said that would indicate any abuse or mistreatment had occurred. He indicated that he went back later that morning to talk with Resident #B, he believed at approximately noon. He indicated that Resident #B was apologetic about the earlier incident, expressed no further concerns, and seemed satisfied with the resolution of the incident. The Unit Manager indicated other than the Employee Counseling Report for CNA #1 no other documentation of the incident had been created. He indicated Resident #B was the only resident interviewed, and that other residents had not been interviewed to determine if there were any concerns about CNA #1's treatment of residents.</p> <p>Facility staffing for all days of the survey was obtained, and indicated CNA #1 worked her complete shift on 6/22/15, and worked full shifts on 6/23/15 and</p>			

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	<p>6/24/15. She worked a partial shift on 6/25/15 and was sent home due to low census. This was confirmed by observation and interview with CNA #1.</p> <p>CNA #1 was issued an "Employee Counseling Record" on 6/22/15 related to the incident with Resident #B.</p> <p>CNA #1 was interviewed on 9/24/15 at 9:30 A.M. She indicated that during morning care of Resident #B on 6/22/15, he became angry while she was trying to complete care, and that he began cursing at her. She indicated at that point she got the Unit Manager, who intervened and talked to Resident #B. She denied any inappropriate behavior or language toward Resident #B, and indicated they "normally get along OK."</p> <p>During an interview on 6/24/15, both the Executive Director and the Director of Health Services indicated they had not spoken with Resident #B to obtain his account of events, and no other interview, such as by social services, had been done with Resident #B. Both indicated that based on the information provided by the Unit Manager they had not considered the possibility that the incident with Resident #B on 6/22/15 might constitute verbal abuse or mistreatment, and thus had not done any investigation, taken any</p>			

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	<p>action to protect residents, or reported the incident to the state agency.</p> <p>A facility policy dated 9/16/2011 received from the Director of Health Services on 6/25/15 titled "Abuse and Neglect Procedural Guidelines" indicated: "Purpose: (name of corporate entity) has developed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect. Procedure: 1. (corporate entity) has implemented processes in an effort to provide a comfortable and safe environment. 2. The Executive Director and Director of Health Services are responsible for the implementation and ongoing monitoring of abuse standards and procedures. 3. Definitions: a. Abuse means the willful infliction of injury...intimidation...or mental anguish (known and/or alleged). This includes deprivation by an individual, including a care giver, of goods or services that are necessary to maintain physical, mental, or psychosocial well-being...e. Mental/Emotional Abuse- includes, but is not limited to, humiliation, harassment, and threats of punishment or deprivation. 4...Implementation and monitoring consists of the following:...d. Identification v. The Executive Director or designee</p>			

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F 0225 SS=D Bldg. 00	<p>must notify the resident's physician and family/responsible party. vi. Complete an Accident and Incident Report....vii. The Executive Director is responsible for: 1. Notification to the State Department of Health...and other agencies...e. Protection i. Upon identification of suspected abuse or neglect, immediately provide for the safety of the resident...This may include, but is not limited to, iv. Suspend suspected employee pending outcome of investigation..."</p> <p>This Federal tag relates to Complaint IN00175557.</p> <p>3.1-27(a)(3)</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or</p>			

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	<p>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 record review and interview, the facility failed to ensure an allegation of mistreatment and or neglect was thoroughly investigated after a resident (Resident #B) made an allegation of mistreatment by a staff member (CNA #1)alleging inappropriate verbal communication and incomplete care. 1 resident of 3 reviewed for mistreatment in a sample of 3.</p> <p>Findings include:</p> <p>The record of Resident #B was reviewed on 6/22/15 at 1:30 P.M. Diagnoses</p>	F 0225	<p>F 225 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #B - An investigation for the allegation of mistreatment was investigated and reported to the ISDH by the Executive Director.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected by the same alleged deficient practice. Measures put in place and systemic changes made to ensure the</p>	07/25/2015

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	<p>included, but were not limited to, partial quadriplegia, spondylosis with myelopathy (degenerative back disease with nerve involvement), morbid obesity, hypertension, diabetes mellitus, and involuntary movements.</p> <p>An admission Minimum Data Set (M.D.S.) assessment dated 5/26/15 indicated Resident #B had no cognitive deficits, had no mood or behavior disorders, did not ambulate, required extensive assistance for bed mobility, required extensive assistance of 2 persons for transfers, and required extensive assistance for activities of daily living. He was noted to be frequently incontinent of bowel and bladder, and plans were to discharge him back to the community when clinically appropriate.</p> <p>Resident #B was interviewed in his room in private on 6/23/15 at 10:20 A.M. He was alert, oriented, cooperative, and communicated appropriately. He indicated that during morning care on Monday 6/22/15 the aide providing care, CNA #1, was "rude and had a bad attitude." Resident #B indicated that part of his morning care was the application of lotion to his legs, and that CNA #1 put lotion on his legs but did not rub it in. He indicated that he told the CNA that it wouldn't do any good unless it was</p>		<p>alleged deficient practice does not recur: DHS or designee will re-educate the campus staff on the following guidelines: 1). Abuse and Neglect 2). Accident and Incident Reporting How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 3 residents and 3 staff members will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Interview of residents and staff regarding any allegations of abuse / neglect / mistreatment. The campus will continue the process to screen employees prior to hire for history of abuse, train the new employees and on going for current employees on abuse prevention, including training on protection of the resident, investigation of the alleged abuse and reporting the suspected abuse. For any allegations identified, ED or designee will ensure the following occurs: Identification: appropriate MD/family notification, completion of accident / incident report, notification to the State Department of Health. Protection: suspension of suspected employee(s) pending outcome of investigation. Investigation: initiate and complete. The results of the</p>	

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	<p>rubbed in, and that this "made her mad." He indicated that she closed his room door, and came back and "leaned into me" and said "Now listen: we're going to do it my way, or else." He indicated he said he wanted to talk to the Unit Manager or Executive Director. He indicated CNA #1 stated "(Name of unit manager) is not here and neither is (Name of Executive Director). You'll have to deal with me." Resident #B indicated that at that point he became angry, and he and CNA #1 "got into it." He indicated that CNA #1 then left the room and returned with the Unit Manager, who had CNA #1 leave the room. Resident #B stated "I told him what she said to me."</p> <p>Resident #B was again interviewed on 6/23/15 at 3:10 P.M. He recounted the incident with CNA #1 on 6/22/15 in the same detail. He indicated that at the time of the incident he felt "abused and helpless." At the time of the second interview he indicated "They don't treat me with respect. I'm still worried about what they're going to do to me. I'm pretty much helpless." He again indicated that he had told the Unit Manager about the details of the incident, including what CNA #1 had said to him.</p> <p>The Unit Manager was interviewed on 6/24/15 at 9:00 A.M. with the Executive</p>		<p>audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155815	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/25/2015
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NAME OF PROVIDER OR SUPPLIER CLEARVISTA LAKE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 8405 CLEARVISTA PLACE INDIANAPOLIS, IN 46256
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	<p>Director and Director of Health Services present. He indicated that CNA #1 came to him on the morning of 6/22/15 and indicated she needed his assistance in dealing with Resident #B. He indicated he went to Resident #B's room, asked CNA #1 to leave to diffuse the situation, and talked to Resident #B. He indicated Resident #B expressed concern about quality of care, specifically not getting the lotion. rubbed into his legs. The Unit Manager indicated Resident #B did not tell him any specific information about what CNA #1 said that would indicate any abuse or mistreatment had occurred. He indicated that he went back later that morning to talk with Resident #B, he believed at approximately noon. He indicated that Resident #B was apologetic about the earlier incident, expressed no further concerns, and seemed satisfied with the resolution of the incident. The Unit Manager indicated other than the Employee Counseling Report for CNA #1 no other documentation of the incident had been created. He indicated Resident #B was the only resident interviewed, and that other residents had not been interviewed to determine if there were any concerns about CNA #1's treatment of residents.</p> <p>CNA #1 was issued an "Employee Counseling Record" on 6/22/15 related to</p>			

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	<p>the incident with Resident #B.</p> <p>During an interview on 6/24/15, both the Executive Director and the Director of Health Services indicated they had not spoken with Resident #B to obtain his account of events, and no other interview, such as by social services, had been done with Resident #B. Both indicated that based on the information provided by the Unit Manager they had not considered the possibility that the incident with Resident #B on 6/22/15 might constitute verbal abuse or mistreatment, and thus had not done any investigation, taken any action to protect residents, or reported the incident to the state agency.</p> <p>A facility policy dated 9/16/2011 received from the Director of Health Services on 6/25/15 titled "Abuse and Neglect Procedural Guidelines" indicated: "Purpose: (name of corporate entity) has developed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect. Procedure: 2. The Executive Director and Director of Health Services are responsible for the implementation and ongoing monitoring of abuse standards and procedures. 3. Definitions: 4....Implementation and monitoring consists of the following:..d.</p>			

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	<p>Identification...vi. Complete an Accident and Incident Report...vii. The Executive Director is responsible for: 1. Notification to the State Department of Health...and other agencies...f. Investigation i. The executive Director is accountable for investigating and reporting. ii. Refer to the Incident and Accident Program for investigation procedures.</p> <p>A facility policy dated 11/20/10 and received from the Director of Health Services on 6/22/15 at 1:30 P.M. titled "Accident and Incident Reporting Guidelines" indicated: "Purpose: To ensure all accidents, and allegations of abuse involving residents, visitors, or employees are investigated and reported to the facility administration. Procedure: 1. All accidents, incidents, and allegations of abuse...shall be reported to the department supervisor as soon as it is discovered...2...An Accident and Incident Form shall be completed for known accidents, incidents and abuse allegations...8. Investigation action shall be initiated by the attending nurse and/or nursing supervisor by completing the appropriate 'Circumstance and Reassessment Form' and forwarding to the Director of Health Services...10. The administrative staff shall complete the investigation, by completion of the</p>			

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F 0226 SS=D Bldg. 00	<p>"Interdisciplinary Team" section of the Circumstances and Reassessment Form and/or State Agency form as required.</p> <p>11. The following data shall be included in either the Accident and Incident Form...and/or the Circumstance and Reassessment Form: g. The injured person's account of the occurrence if they are able to convey the information..."</p> <p>This Federal tag relates to Complaint IN00175557.</p> <p>3.1-27(a)(3)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</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.</p> <p>Based on record review and interview, the facility failed to ensure their policy and procedure was implemented to report an allegation of mistreatment and or neglect to the state agency, and other agencies as appropriate, after a resident (Resident #B) made an allegation of mistreatment by a staff member (CNA #1) alleging inappropriate verbal communication and incomplete care. 1 resident of 3 reviewed for mistreatment in a sample of 3.</p>	F 0226	<p>F 226 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #B - An investigation for the allegation of mistreatment was investigated and reported to the ISDH by the Executive Director.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be</p>	07/25/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155815	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/25/2015
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	<p>Findings include:</p> <p>The record of Resident #B was reviewed on 6/22/15 at 1:30 P.M. Diagnoses included, but were not limited to, partial quadriplegia, spondylosis with myelopathy (degenerative back disease with nerve involvement), morbid obesity, hypertension, diabetes mellitus, and involuntary movements.</p> <p>An admission Minimum Data Set (M.D.S.) assessment dated 5/26/15 indicated Resident #B had no cognitive deficits, had no mood or behavior disorders, did not ambulate, required extensive assistance for bed mobility, required extensive assistance of 2 persons for transfers, and required extensive assistance for activities of daily living. He was noted to be frequently incontinent of bowel and bladder, and plans were to discharge him back to the community when clinically appropriate.</p> <p>Resident #B was interviewed in his room in private on 6/23/15 at 10:20 A.M. He was alert, oriented, cooperative, and communicated appropriately. He indicated that during morning care on Monday 6/22/15 the aide providing care, CNA #1, was "rude and had a bad attitude." Resident B indicated that part of his morning care was the application</p>		<p>affected by the same alleged deficient practice. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the campus staff on the following guidelines: 1). Abuse and Neglect 2). Accident and Incident Reporting How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 3 residents and 3 staff members will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Interview of residents and staff regarding any allegations of abuse / neglect / mistreatment. The campus will continue the process to screen employees prior to hire for history of abuse, train the new employees and on going for current employees on abuse prevention, including training on protection of the resident, investigation of the alleged abuse and reporting the suspected abuse. For any allegations identified, ED or designee will ensure the following occurs: Identification: appropriate MD/family notification, completion of accident / incident report, notification to the State Department of Health. Protection: suspension of</p>	

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	<p>of lotion to his legs, and that CNA #1 put lotion on his legs but did not rub it in. He indicated that he told the CNA that it wouldn't do any good unless it was rubbed in, and that this "made her mad." He indicated that she closed his room door, and came back and "leaned into me" and said "Now listen: we're going to do it my way, or else." He indicated he said he wanted to talk to the Unit Manager or Executive Director. He indicated CNA #1 stated "(Name of unit manager) is not here and neither is (Name of Executive Director). You'll have to deal with me." Resident #B indicated that at that point he became angry, and he and CNA #1 "got into it." He indicated that CNA #1 then left the room and returned with the Unit Manager, who had CNA #1 leave the room. Resident #B stated "I told him what she said to me."</p> <p>Resident #B was again interviewed on 6/23/15 at 3:10 P.M. He recounted the incident with CNA #1 on 6/22/15 in the same detail. He indicated that at the time of the incident he felt "abused and helpless." At the time of the second interview he indicated "They don't treat me with respect. I'm still worried about what they're going to do to me. I'm pretty much helpless." He again indicated that he had told the Unit Manager about the details of the incident, including what</p>		<p>suspected employee(s) pending outcome of investigation. Investigation: initiate and complete. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>	

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	<p>CNA #1 had said to him.</p> <p>The Unit Manager was interviewed on 6/24/15 at 9:00 A.M. with the Executive Director and Director of Health Services present. He indicated that CNA #1 came to him on the morning of 6/22/15 and indicated she needed his assistance in dealing with Resident #B. He indicated he went to Resident #B's room, asked CNA #1 to leave to diffuse the situation, and talked to Resident #B. He indicated Resident #B expressed concern about quality of care, specifically not getting the lotion. rubbed into his legs. The Unit Manager indicated Resident #B did not tell him any specific information about what CNA #1 said that would indicate any abuse or mistreatment had occurred. He indicated that he went back later that morning to talk with Resident #B, he believed at approximately noon. He indicated that Resident #B was apologetic about the earlier incident, expressed no further concerns, and seemed satisfied with the resolution of the incident. The Unit Manager indicated other than the Employee Counseling Report for CNA #1 no other documentation of the incident had been created. He indicated Resident #B was the only resident interviewed, and that other residents had not been interviewed to determine if there were any concerns</p>			

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	<p>about CNA #1's treatment of residents.</p> <p>CNA #1 was interviewed on 9/24/15 at 9:30 A.M. She indicated that during morning care of Resident #B on 6/22/15, he became angry while she was trying to complete care, and that he began cursing at her. She indicated at that point she got the Unit Manager, who intervened and talked to Resident #B. She denied any inappropriate behavior or language toward Resident #B, and indicated they "normally get along OK."</p> <p>During an interview on 6/24/15, both the Executive Director and the Director of Health Services indicated they had not spoken with Resident #B to obtain his account of events, and no other interview, such as by social services, had been done with Resident #B. Both indicated that based on the information provided by the Unit Manager they had not considered the possibility that the incident with Resident #B on 6/22/15 might constitute verbal abuse or mistreatment, and thus had not done any investigation, taken any action to protect residents, or reported the incident to the state agency.</p> <p>A facility policy dated 9/16/2011 received from the Director of Health Services on 6/25/15 titled "Abuse and Neglect Procedural Guidelines"</p>			

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	<p>indicated: "Purpose: (name of corporate entity) has developed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect.</p> <p>Procedure: 1. (corporate entity) has implemented processes in an effort to provide a comfortable and safe environment. 2. The Executive Director and Director of Health Services are responsible for the implementation and ongoing monitoring of abuse standards and procedures. 3. Definitions: a. Abuse means the willful infliction of injury...intimidation...or mental anguish (known and/or alleged). This includes deprivation by an individual, including a care giver, of goods or services that are necessary to maintain physical, mental, or psychosocial well-being...e. Mental/Emotional Abuse- includes, but is not limited to, humiliation, harassment, and threats of punishment or deprivation. 4....Implementation and monitoring consists of the following:...d. Identification v. The Executive Director or designee must notify the resident's physician and family/responsible party. vi. Complete an Accident and Incident Report....vii. The Executive Director is responsible for: 1. Notification to the State Department of Health...and other agencies...A facility policy dated</p>			

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F 0279 SS=D Bldg. 00	<p>11/20/10 and received from the Director of Health Services on 6/22/15 at 1:30 P.M. titled "Accident and Incident Reporting Guidelines" indicated: "Purpose: To ensure all accidents, and allegations of abuse involving residents, visitors, or employees are investigated and reported to the facility administration. Procedure: 1. All accidents, incidents, and allegations of abuse...shall be reported to the department supervisor as soon as it is discovered...2...An Accident and Incident Form shall be completed for known accidents, incidents and abuse allegations...5...Reporting of incidents, accidents and abuse shall be in compliance in accordance with agency guidelines..."</p> <p>This Federal tag relates to Complaint IN00175557.</p> <p>3.1-27(a)(3)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to</p>			

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	<p>meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to ensure a resident who demonstrated behaviors of refusal of care and verbal and physical aggression towards staff had care plans for these behaviors, and whose's transfer status was not accurately represented in his care plan. 1 resident of 3 reviewed for care plans in a sample of 3. (Resident #B)</p> <p>Findings include:</p> <p>The record of Resident #B was reviewed on 6/22/15 at 1:30 P.M. Diagnoses included, but were not limited to, partial quadriplegia, spondylosis with myelopathy (degenerative back disease with nerve involvement), morbid obesity, hypertension, diabetes mellitus, and involuntary movements.</p> <p>An admission Minimum Data Set (M.D.S.) assessment dated 5/26/15</p>	F 0279	<p>F 279</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #B - care plan was reviewed and revised related to behaviors of refusal of care and verbal and physical aggression towards staff and accurate transfer status.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: DHS or designee will review all residents with behaviors of refusal of care and verbal and physical aggression towards staff and accurate transfer status to</p>	07/25/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155815		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/25/2015	
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	<p>indicated Resident #B had no cognitive deficits, had no mood or behavior disorders, did not ambulate, required extensive assistance for bed mobility, required extensive assistance of 2 persons for transfers, and required extensive assistance for activities of daily living. He was noted to be frequently incontinent of bowel and bladder, and plans were to discharge him back to the community when clinically appropriate.</p> <p>A "Resident Lift Assessment Profile" dated 5/19/15 indicated Resident #B was assessed to require a mechanical "sling" type lift, such as a "***** (Brand name of mechanical transfer assistive device)" or "***** (Brand name #2 of mechanical transfer assistive device)" and was not appropriate for a "***** (brand name #3 of mechanical transfer assistive device)" type standing lift.</p> <p>A Resident Preferences sheet dated 6/23/15 indicated Resident #B was a "(Brand name of mechanical transfer assistive device)".</p> <p>Resident #B's care plan dated 5/25/15 indicated "At present I require assistance of 2 people with transfers. I am currently non-ambulatory."</p> <p>Resident #B's care plan did not reflect his</p>		<p>ensure a care plan is in place for each.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Interdisciplinary Team on the following campus guidelines: Care Plans.</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits will be conducted by the DHS or designee on 5 residents 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: review to ensure a care plan is in place for identified behaviors of refusal of care and verbal and physical aggression towards staff and accurate transfer status.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for</p>				

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	<p>status as being assessed as appropriate for a mechanical sling lift.</p> <p>A nurse's progress note dated 5/20/15 at 6:00A.M., indicated "Resident refused A.M., lab (laboratory) draw stating 'and don't come back here' to phlebotomist."</p> <p>An OT (Occupational Therapy) Daily Treatment Note for Resident #B dated 6/15/15 indicated: "...Once seated in w/c (wheelchair) this OT attempted to help Pt (patient) reposition self in w/c however Pt forcefully pushed away this OT's arm and used extremely inappropriate language...the patient continued to use extremely inappropriate language and made no attempts at appropriate communication, rather persistently made accusatory remarks such as, 'You sayin' I lie all the time...'"</p> <p>The following interviews were focused on Resident #B's behavior when interacting with staff.</p> <p>CNA #7 was interviewed on 9/24/15 at 9:45 A.M. She indicated "He cusses every other word. He'll throw the word "n...r" at you."</p> <p>CNA #8 was interviewed on 6/24/15 at 9:55 A.M. She indicated "He's "hood." He curses all the time. He'll curse you</p>		a minimum of 6 months then randomly thereafter for further recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155815	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/25/2015
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NAME OF PROVIDER OR SUPPLIER CLEARVISTA LAKE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 8405 CLEARVISTA PLACE INDIANAPOLIS, IN 46256
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F 0309 SS=G Bldg. 00	<p>out."</p> <p>LPN #2 was interviewed on 6/24/15 at 10:05 A.M. She indicated "He has good days and bad days, but more bad days. He refuses therapy all the time. Friday ot was "F...this and M.....F...that." I saw him smack the therapist's hand away."</p> <p>Speech Therapist #5 was interviewed on 6/24/15 at 10:15 A.M. She indicated "I took him on because he was difficult and would end sessions early because of the therapist's 'attitude.' He would cuss at them, say 'get out of the f...n room.' (Because of his attitude) some of his needs were not getting met. He would be left in his wheelchair and not laid down."</p> <p>Resident #B's care plan contained no stated problem, goals, or interventions for the behaviors noted above.</p> <p>This Federal tag relates to complaint IN00175557</p> <p>3.1-35(a)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and</p>			

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	<p>psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to provide adequate supervision and training to ensure a resident was protected from harm, including a fall from bed during care resulting in a hospital visit with identified injuries, and 2 instances of the use of an inappropriate lifting device resulting in injury and psychosocial distress. 1 resident of 3 reviewed for harm in a sample of 3. (Resident #B)</p> <p>Findings include:</p> <p>The record of Resident #B was reviewed on 6/22/15 at 1:30 P.M. Diagnoses included, but were not limited to, partial quadriplegia, spondylosis with myelopathy (degenerative back disease with nerve involvement), morbid obesity, hypertension, diabetes mellitus, and involuntary movements.</p> <p>An admission Minimum Data Set (M.D.S.) assessment dated 5/26/15 indicated Resident #B had no cognitive deficits, had no mood or behavior disorders, did not ambulate, required extensive assistance for bed mobility, required extensive assistance of 2 persons for transfers, and required extensive</p>	F 0309	<p>F 309</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #B was observed for turning/repositioning in bed and transfers to ensure staff provided adequate assistance/supervision and the appropriate lifting device was in use. Resident #B was re-assessed and is being transferred with the appropriate lift.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: DHS or designee will observe all residents requiring assist with turning/repositioning/transfer to ensure staff provides adequate assistance/supervision and the appropriate lifting device is in use and is used correctly.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient</p>	07/25/2015

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NAME OF PROVIDER OR SUPPLIER CLEARVISTA LAKE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 8405 CLEARVISTA PLACE INDIANAPOLIS, IN 46256
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	<p>assistance for activities of daily living. He was noted to be frequently incontinent of bowel and bladder, and plans were to discharge him back to the community when clinically appropriate.</p> <p>A nurse's progress note dated 6/01/15 at 11:00A.M., indicated: "Resident was being transferred to wheel chair (sic) when his leg brushed against the lift. (Symbol for "no") pain (Symbol for "no") bleeding. Skin tear is 2cm (centimeters) by 1.5cm..."</p> <p>A nurse's progress note dated 6/02/15 at 9:00A.M., indicated: "Clarification: Skin tear is on top of (Symbol for "right") foot."</p> <p>A "Skin Impairment Circumstance, Assessment and Intervention" form dated 6/01/15 indicated: "Date of Impairment Discovery: 6/01/15. Location of Impairment: Top of (Symbol for "right") foot. Type of Impairment: Skin tear, full thickness. MD notified? Yes. Prevention Update: Reinforce safety with ***** (Brand name of mechanical transfer assistive device) lift (symbol for "with") caregivers."</p> <p>During an interview with Resident #B on 6/23/15 at 3:10P.M., he indicated that the above incident "Hurt like crazy. They had</p>		<p>practice does not recur: DHS or designee will re-educate the nursing staff on the following guideline: 1). SWAT - We've Got Your Back Program 2). Lift re-training 3). Positioning the Resident</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 5 residents on all shifts will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Observe residents requiring assist with turning/repositioning/transfer to ensure staff provides adequate assistance/supervision and the appropriate lifting device is in use and is used correctly.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>	

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NAME OF PROVIDER OR SUPPLIER CLEARVISTA LAKE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 8405 CLEARVISTA PLACE INDIANAPOLIS, IN 46256
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	<p>my foot trapped under the machine (a "****[Brand name]" stand up lift). My trainer (therapist) told me they used the wrong kind of lift and they should never have done that." He rated the pain at the time of the incident as a 10 on a scale of 1 to 10.</p> <p>During an interview on 6/23/15 at 3:10P.M., Resident #B indicated he had a second occurrence of injury involving the use of the "****(Brand name)" stand up lift on 6/15/15. He stated "They got me up in it and couldn't get me out. They forgot to strap my legs in again. I was just hanging there for 15 or 20 minutes while a bunch of people tried to get me out. I felt like I was choking and couldn't breath. I hung there so long my arms got bruised. I kept telling them just put me back to bed but they wouldn't do it."</p> <p>An OT (Occupational Therapy) Treatment Note" dated 6/15/15 indicated: "Upon entering the patient's room this morning, CRCA (C.N.A.) and Nsing (sic; nursing) attempting to complete bed...w/c (wheelchair) transfer using stand lift. This OT informed Nsing staff that this is not the appropriate lift to use 2/2 (secondary to) Pt's (patient's) BLE (bilateral lower extremity) hemiparesis (weakness), as previously explained at earlier date by PT (physical</p>			

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	<p>therapist)...This OT educated Nsging and patient on importance of using ***** (brand name) lift (mechanical sling lift) at this time...Nsging verbalized understanding..."</p> <p>CNA #3 was interviewed on 6/25/15 at 11:40A.M. She indicated she initiated the transfer of resident #B, and that Resident #B told her he preferred the stand up lift to the ***** (brand name) lift, and that is what she used. She indicated she "forgot" to put the strap around the resident's lower legs and that when she initiated the transfer his "legs came off" and she could not complete the transfer. She called for help, and ultimately 3 additional staff assisted her and they were able to physically move Resident #B from the lift to his wheelchair. She estimated that Resident #B had been in the lift for approximately 10 minutes.</p> <p>LPN #2 was interviewed on 6/25/15 at 11:30 A.M. She indicated she responded to CNA #3's call for assistance. She indicated Resident #B's legs were not strapped in and they "wouldn't bend." She indicated that 2 people lifted his upper body and 2 lifted his legs and placed him in his wheelchair. She indicated she was aware the Resident #B's assessment called for use of a ***** (brand name) lift.</p>			

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	<p>RN #4 was interviewed on 6/25/15 at 11:55 A.M. She indicated she came to help get Resident #B out of the Sara lift. She indicated Resident B had told CNA #3 he wanted to use the "****(Brand name)" lift, but that the CNA "should have checked the book" to determine Resident #B's appropriate transfer status. She indicated the lower leg strap had not been fastened, and his legs had fallen off the lift, making it impossible to complete the transfer. She indicated they could not put him back to bed because of the positioning of his legs. She stated "we could have broken his legs."</p> <p>A "Resident Lift Assessment Profile" dated 5/19/15 Resident #B was assessed to require a mechanical "sling" type lift, such as a "****(Brand name #1 of mechanical transfer assistive device)" or "***** (brand name #2 mechanical transfer assistive device)" and was not appropriate for a "****(Brand name #3 transfer assistive device)" type standing lift.</p> <p>A Resident Preferences sheet dated 6/23/15 indicated Resident #B was a "****(Brand name mechanical transfer assistive device) lift."</p> <p>A manufacturer's instruction book for the</p>			

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	<p>***** (Brand name #3 Mechanical transfer assistive device) stand up lift received from the Director of Health Services indicated: "Warning: An assessment must be made for each individual resident being raised by the ***** (Brand name #3 mechanical transfer assistive device)-by a medically qualified person-as to whether the resident requires the lower leg straps when using the standing sling. Use if necessary..with residents with spasms...that were assessed as suitable to be raised with the ***** (Brand name).</p> <p>An untimed physician's progress note dated 6/03/15 "Reportedly pt (patient) rolled OOB (out of bed) early this AM. Now at ER (emergency room).</p> <p>A "Fall Circumstance, Assessment and Intervention" form dated 6/03/15 indicated: "Time of fall: 12:45 A.M. Witnessed: Yes. Injury: None. Treatment required: No. C/O Pain: 5 on a scale of 1 to 10. Location: Knees aching. Activity at time of fall: Turning in bed. Fall Risk Re-Assessment included, but was not limited to, that Resident B required assistance to transfer and ambulate safely, was unable to maintain balance without assistance, required the use of an assistive device, and was unable to maintain postural</p>			

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	<p>positioning in bed or chair."</p> <p>A "Change in Condition Form" dated 6/03/15 indicated: "Condition change that prompted request for physician order: Fall or other injury. Describe signs and symptoms of condition change: Resident rolled off side of bed during care. Did not use side rails. Has requested a larger bed and overhead trapeze. (symbol for "no") injuries or open areas noted.</p> <p>A hospital discharge note for Resident #B dated 6/03/15 indicated "You have a contusion to your lower extremity (leg, knee, ankle, foot or toes). This causes local pain, swelling and sometimes bruising. There are no broken bones. This injury may take from a few days to a few weeks to heal."</p> <p>A nurse's progress note dated 6/03/15 at 1:00 P.M. indicated: "Resident returned to facility by (name of ambulance company). (Symbol for "no") new orders....Resident still c/o (complaining of) pain upon return."</p> <p>Resident #B was interviewed on 6/23/15 at 10:20 A.M. He indicated there were 2 staff members in the room when he fell from bed, and they were on the same side of the bed. He stated "I just did what they</p>			

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	<p>told me to do. They said turn to the other side of the bed, and when I did my leg flopped over and pulled me out of bed. I can't control my legs. They should have known that was going to happen. It hurt and I asked to go to the hospital and they said no. I kept complaining and finally the next morning they sent me to the hospital."</p> <p>An undated facility policy titled "Guidelines for SWAT-We've Got Your Back Program" received from the Director of Health Services on 6/24/15 at 8:55A.M., indicated: "Purpose: To ensure the safety of residents and staff when performing mobility/transfer tasks. Procedure: Upon admission the admitting nurse shall determine the type of transfer device required to assist with safe mobility...4. The type of equipment to be used for the resident should be reflected on the individual care plan and on the nursing assistant assignment sheet. 7. As a general guideline: The Dependant Mechanical Lift shall be used for individuals who cannot bear weight, have poor trunk stability and require extensive assistance or total dependence with transfers."</p> <p>This Federal tag relates to Complaint IN00175557.</p>			

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NAME OF PROVIDER OR SUPPLIER CLEARVISTA LAKE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 8405 CLEARVISTA PLACE INDIANAPOLIS, IN 46256		
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