

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155217	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 09/02/2016
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NAME OF PROVIDER OR SUPPLIER WATERS OF HUNTINGBURG, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1712 LELAND DR HUNTINGBURG, IN 47542
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaints IN00208924 and IN00207286.</p> <p>Complaint IN00208924 - Substantiated. Federal/State deficiencies related to the allegations are cited at F223, F225, F226.</p> <p>Complaint IN00207286-Substantiated. Federal/State deficiencies related to the allegation are cited at F 323.</p> <p>Survey dates: September 2, 2016</p> <p>Facility number: 000122 Provider number: 155217 AIM number: 100290560</p> <p>Census bed type: SNF/NF: 66 Total: 66</p> <p>Census payor type: Medicare: 8 Medicaid: 44 Other: 14 Total: 66</p> <p>Sample: 5</p> <p>This deficiencies reflects State findings</p>	F 0000	<p>Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal Laws. Facility's date of alleged compliance is: October 1, 2016.</p> <p>Facility is respectfully requesting paper compliance for all deficiencies in this POC.</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 0223 SS=G Bldg. 00	<p>cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by #20748 on September 9, 2016.</p> <p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION 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 observation, interview, and record review, the facility failed to ensure residents were free of mental and verbal abuse for 1 of 3 allegations reviewed. This deficient practice caused a feeling of humiliation for Resident F. (Resident F, Resident R)</p> <p>Findings include:</p>	F 0223	<p>F-223</p> <p>It is the policy to ensure the residents' rights to include freedom from verbal, sexual, physical and mental abuse, corporal punishment and involuntary seclusion.</p> <p>Resident F is being cared for</p>	10/01/2016

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	<p>During an interview with CNA #4 on 9/2/16 at 5:30 A.M., she indicated she had reported an allegation of abuse to the nurse last week. She indicated Resident F had indicated CNA #15 had refused to assist her with using the bedpan and instructed her to just go in her brief. She indicated Resident F was pretty upset by the occurrence and she had told the nurse as soon as she was told about it. CNA #4 indicated she was told the allegation had been taken care of.</p> <p>The facility reportable's were provided on 9/2/16 at 10:33 A.M., they included, but were not limited to, a "...INDIANA STATE DEPARTMENT OF HEALTH...SURVEY REPORT SYSTEM...Incident Number 39...Incident Date: 08/27/2016...Incident Time 07:15 AM [sic]...Residents Involved [Resident F]...[Resident R]...Staff Involved...[CNA #15]...Brief Description of Incident...8/26/2016...Two roommates allege staff member refused to provide care per resident's request. [Resident F] states she requested to be taken to the bathroom and had to wait for the CNA... [Resident R] states Staff member took her meal tray too soon and wasn't able to finish her meal. Both roommates were upset with the CNA...Type of Injury...No injury noted on either resident..."</p>		<p>and having her needs met in a professional and dignified manner.</p> <p>An apology has been extended to Resident F and her family. Resident R has had an apology extended to her and her family as well. CNA #15 has been terminated.</p> <p>Note: Resident F stated other than this isolated incident with CNA #15, Resident F has no other concerns at the facility.</p> <p>Based on facility wide interviews of interviewable residents, no residents in the facility feel like they are treated in an unprofessional or undignified manner by the facility care givers/staff.</p> <p>Residents who reside in the facility have the potential to be affected by this finding. The DON/Designee or the SSD Designee will make rounds on various shifts and various days</p>	

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	<p>The facility investigation was reviewed and included the following:</p> <p>An untimed statement dated 8/24/16 included, "...[Resident F] reported to me that she asked [CNA #15] for a bedpan...She sates that [CNA #15] told her 'You have a diaper on. Just go in it and I will change you after supper...' The statement was signed by Resident F. The page also contained a handwritten statement on 8/24/16 indicated the incident had been reported to LPN #10 at 7:00 P.M.</p> <p>An untimed typed statement dated 8/24/16 included, "...I was working on Unit 1. I walked down Unit 2 hall to drop off a chart to the nurse and [Resident R] walked out of her room and asked me 'Can I please have my potatoes back?' I said I wasn't sure what she was talking about, She said someone...had taken her potatoes and she wanted them back..."</p> <p>An untimed written statement dated 8/24/16 included but was not limited to, "...Suppertime bout [sic] 5:25 I went into [Resident R] to see if she was eating. She was doing bead work. I said let me move this plate out of the way...She said you're stupid. I said that's not nice to say at all she said well you are. So she told LPN</p>		<p>to include some weekend days. During the rounds, the CMS form 20050 will be used. During the rounds, at least 5 interviewable residents or families of residents will be interviewed 3 days weekly. Any concerns will be addressed immediately as found. This monitoring will continue until 4 consecutive weeks of zero negative findings are achieved. Afterwards, 5 residents/families will be interviewed weekly for a period of not less than 6 months to ensure ongoing compliance. After that, random monitoring will occur.</p> <p>Note: During the daily Guardian Angel Rounds, the residents will be offered an opportunity</p> <p>to share any concerns with the Guardian Angel representative.</p> <p>At an in-service given to the Administrator, DON and</p>	

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	<p>#5...Time to pass out trays [Resident F] replied she had too [sic] go pee. I said well just turn on the light when you're done and Ill [sic] change your diaper..." The statement was signed by CNA #15.</p> <p>During an interview with the DON on 9/2/16 at 10:44 A.M., she indicated on 8/24/16 a staff member called her and reported an incident. She she had instructed to start the investigation, suspend the CNA and report the incident to the Administrator as she was on vacation at the time. She indicated when she returned to the facility on 8/29/16 and learned the allegation had been reported to the State late (2 days).</p> <p>The clinical record for Resident F was reviewed on 9/2/16 at 11:10 A.M., diagnoses included, but were not limited to, diabetes mellitus type 2, femur fracture, hypertension, major depressive disorder, anxiety disorder, and borderline personality disorder.</p> <p>An Minimum Data Set (MDS) assessment dated 8/29/16 indicated Resident F had a BIMS (Brief Interview Mental Status) score of 15 indicating she was cognitively intact with no behaviors. The MDS indicated Resident F required extensive assistance of two persons for bed mobility, and toileting and dressing.</p>		<p>ADON 1:1 on 9/26/2016, and at an all staff in-service held Sept 27,28,29, and 30, the following was reviewed:</p> <p>1.) Current and most recently revised Abuse Policy</p> <p style="padding-left: 40px;">a. Definition of "abuse" (Examples of including lack of timely toileting/professional language or removing food tray prior to resident finishing)</p> <p style="padding-left: 40px;">b. Definition of "demeaning" and "humiliation" (What does this mean? Examples of)</p> <p style="padding-left: 40px;">c. Immediate suspension of staff who are reported to having been suspected of abuse</p> <p>2.) Elder Abuse Act</p> <p>3.) Resident Rights—What are they?</p> <p>4.) Dignity—What does it</p>	

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	<p>The MDS further indicated Resident F required, total dependence of two people for transfers. The MDS indicated Resident F experienced occasional incontinence of urine and bowel.</p> <p>The care plans included, but were not limited to, the following:</p> <p>A care plan for anxiety, initiated 8/22/16. The interventions included, have resident voice feelings.</p> <p>A care plan for risk for decline in mood initiated 8/22/16. The interventions included, but were not limited to, antidepressant per order, encourage out of room activities, honor residents wishes, notify MD (medical doctor), family and IDT (interdisciplinary team) of any changes.</p> <p>The nursing notes from 8/24/16 lacked any documentation of the allegation or concern.</p> <p>Resident R was observed on 9/2/16 at 10:00 A.M., to be laying in bed with her eyes closed. Resident R appeared to be in no apparent distress. The clinical record for Resident R was reviewed on 9/2/16 at 12:00 P.M. The diagnoses included, but were not limited to, diabetes mellitus type 2, major depressive disorder.</p>		<p>really mean?</p> <p>5.) Abuse vs Customer Service (What is the difference?)</p> <p>6.) Reporting Abuse to appropriate agencies timely (ISDH and Ombudsman/APS/Police as indicated)</p> <p>7.) Responsibility of facility Administrative Staff to report timely and per policy</p> <p>Note: All newly hired staff are in-serviced on the Abuse Policy/Elder Justice Act upon hire.</p> <p>Any staff who fail to comply with the points of the in-service will be further educated and/or progressively disciplined as</p>	

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	<p>A Minimum Data Set (MDS) assessment dated 7/15/16 included a BIMS score 12 of 15 indicating Resident R had slight cognitive loss, with no behaviors.</p> <p>The care plans included, but were not limited to, the following:</p> <p>A care plan for decline is psychosocial wellbeing, dated 5/3/16. The interventions included, but were not limited to, encourage out of room activities, encourage to vent feelings.</p> <p>A care plan for assistance with ADL's chronic pain indicated 5/3/16. The interventions included, but were not limited to, Assist as needed so resident is clean and dry, encourage resident to complete as much as they are able, keep call light in reach,</p> <p>A care plan for risk for decline in mood initiated 5/3/16. The interventions included, but were not limited to, medications as ordered, encourage family involvement, encourage out of room activities, encourage to vent feelings, honor residents wishes, notify MD, family and IDT of any changes, offer choices, psych services per order.</p> <p>The nursing notes dated 8/24/16 lacked</p>		<p>indicated.</p> <p>At the monthly QA meetings the results of the monitoring (interviews) by the DON/Designee and/or SSD Designee will be reviewed. However, any concerns will be addressed immediately as found to include any necessary education and/or disciplinary action.</p>	

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	<p>any documentation of the allegation.</p> <p>During an interview with the DON on 9/2/16 at 12:34 P.M., she indicated the allegation against CNA #15 had been substantiated because it occurred. She indicated the residents had been provided assistance by other staff members and CNA #15 was suspended pending an investigation and terminated for "poor customer service".</p> <p>During an interview with CNA #55 on 9/2/16 at 12:50 P.M. she indicated refusing to assist residents to the restroom could be considered abuse.</p> <p>During an interview with Resident F on 9/2/16 at 1:00 P.M., she was observed to be sitting up in her wheel chair on the facility front porch. Resident F appeared to be in no apparent distress. she indicated she had reported the incident on 8/24/16. She indicated she had requested assistance to use the bedpan from CNA #15 and the CNA had gotten upset and told her "No, just use your brief, I'll change you when you are done". Resident F continued and indicated CNA #15 was constantly stating how overworked she was and how she was going to quit. Resident F indicated she felt the remark was verbally abusive, they made her feel</p>			

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	<p>bad and being instructed to use her "diaper" was humiliating. She indicated she had experienced incontinence as a result of CNA #15 not assisting her to the restroom. She stated "It's bad enough I can't get on the toilet anymore but to be told to pee on myself it humiliating, you can't do that to people". Resident F indicated other than that incident she had no other concerns at the facility.</p> <p>The time card for CNA #15 was provided by the facility on 9/2/16. It indicated CNA #15 had worked on 8/24/16 from 1:59 P.M., to 10:15 P.M., (3 hours after the allegation had been reported to LPN #10). The time card indicated CNA #15 had been suspended on 8/25/16 and terminated on 8/26/26.</p> <p>During an interview with the Administrator on 9/2/16 at 1:15 P.M., she indicated she indicated the allegation was substantiated and she had reported the allegation to the State department of health on 8/26/16 because she was unable to access the portal. She indicated she had sent the incident to the facility corporate office for review but had not contacted the Indiana State Department of Health for any recommendations on how to send in the allegation of abuse. She indicated the CNA #15 had been suspended effective 8/24/16 at 10:00</p>			

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	<p>P.M., (3 hours after the allegation was reported) and the allegation was sent to the State on 8/26/16 (2 days) after it was reported to her.</p> <p>A policy dated 1/2007 titled "ABUSE REPORTING" included but was not limited to, "It is the polity of the facility to encourage and support all residents, staff, and family members to feel free to report any suspected acts of abuse, neglect,...The facility will take all measures possible to assure that residents, staff and families are free from reprisal, when reports or incidents are reported to the facility...Any persons witnessing or having knowledge of potential or actual abuse must contact and report the incident to the Administrator and/or designee immediately...The Incident Documentation and Investigation Tool form is to be submitted to the Administrator or designee as soon as possible within 24 hours for further investigation. The Administrator (or designee) will report Abuse/Neglect to the Department of Health within 24 hours per the Indiana Department of Health reporting guidelines...Any Individual who is accused of resident abuse whether physical or verbal will be suspended until further investigation has been completed...The Director of Nursing or</p>			

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	<p>Charge Nurse will complete the investigation form with a writing, dated, and signed statement from all persons involved...If abuse is suspected or substantiated, the employee will be immediately sent home."</p> <p>A undated policy titled, "ABUSE PROHAVITION POLICY AND PROCEDURE", included, but was not limited to... "It is the policy of this facility to maintain an environment free of abuse and neglect. The resident as the right to be free from verbal..and mental abuse...Residents will not be subjected to such events by anyone...This facility shall comply with all federal and state requirements to ...train, prevent, identify, Investigate, protect, and report...Abuse: willful infliction of injury...or punishment with resulting physical harm, pain or mental anguish. This includes the deprivation by an individual, including a caretaker of goods or services that are necessary to attain or maintain physical, mental and psychosocial well being...Mental Abuse: This includes, but is not limited to humiliation...Neglect: A failure to provide goods and services necessary to avoid physical harm, mental anguish..."</p> <p>This Federal tag relates to Complaint #IN00208924</p>			

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F 0225 SS=D Bldg. 00	<p>3.1-27(b)</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 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</p>			
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	<p>officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on observation, interview, and record review, the facility failed to follow their policy for abuse prohibition and ensure their Administrator was immediately notified of an allegation of abuse, failure to report the allegation immediately to the Indiana State Department of Health, failed to immediately suspend the staff following an allegation of abuse, and to report the certification for a CNA after substantiating abuse for 1 of 3 allegations reviewed. (Resident F, Resident R)</p> <p>Findings include:</p> <p>1. During an interview with CNA #4 on 9/2/16 at 5:30 A.M., she indicated she had reported an allegation of abuse to the nurse last week. She indicated Resident F had indicated CNA #15 had refused to assist her with using the bedpan and instructed her to just go in her brief. She indicated Resident F was pretty upset by the occurrence and she had told the nurse as soon as she was told about it. CNA #4 indicated she was told the allegation had been taken care of.</p>	F 0225	<p>F-225</p> <p>It is the policy of the facility to follow the Abuse Policy and to see that it is implemented appropriately and timely as indicated. Included in the policy is the mandate to provide immediate safety for the resident. Also, included in the policy is the requirement to immediately notify the Administrator of any kind of abuse or alleged abuse. The Administrator then reports the allegation to the ISDH timely as per policy and regulatory requirement. Any staff involved or thought to have the possibility (suspicion) of being involved in an abuse allegation is immediately suspended pending results of an in-depth investigation which is initiated immediately. There is always someone available and trained to report an abuse</p>	10/01/2016

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NAME OF PROVIDER OR SUPPLIER WATERS OF HUNTINGBURG, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1712 LELAND DR HUNTINGBURG, IN 47542
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	<p>The facility reportable's were provided on 9/2/16 at 10:33 A.M., they included, but were not limited to, a "...INDIANA STATE DEPARTMENT OF HEALTH...SURVEY REPORT SYSTEM...Incident Number 39...Incident Date: 08/27/2016...Incident Time 07:15 AM [sic]...Residents Involved [Resident F]...[Resident R]...Staff Involved...[CNA #15]...Brief Description of Incident...8/26/2016...Two roommates allege staff member refused to provide care per resident's request. [Resident F] states she requested to be taken to the bathroom and had to wait for he CNA... [Resident R] states Staff member took her meal tray too soon and wasn't able to finish her meal. Both roommates were upset with the CNA...Type of Injury...No injury noted on either resident..."</p> <p>The facility investigation was reviewed and included the following:</p> <p>An untimed statement dated 8/24/16 included, "...[Resident F] reported to me that she asked [CNA #15] for a bedpan...She sates that [CNA #15] told her 'You have a diaper on. Just go in it and I will change you after supper...' The statement was signed by Resident F. The page also contained a handwritten statement on 8/24/16 indicated the</p>		<p>allegation into the Gateway system (ISDH reporting system).</p> <p>Any resident who resides in the facility has the potential to be affected by this finding. Going forward, the staff will immediately notify their supervisor of any abuse or alleged abuse. The supervisor will immediately notify the Administrator who will give guidance and direction as to how to proceed including initiation of all steps of the policy (including initiation of the investigation) in a timely manner. The Administrator will be responsible for timely notifications and reporting to all appropriate parties. The Administrator will notify the appropriate corporate team member(s) of any reportable incidents.</p> <p>As part of the daily CQI meeting agenda, any event that appears on the 24 Hour</p>	

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	<p>incident had been reported to LPN #10 at 7:00 P.M.</p> <p>An untimed typed statement dated 8/24/16 included, "...I was working on Unit 1. I walked down Unit 2 hall to drop off a chart to the nurse and [Resident R] walked out of her room and asked me 'Can I please have my potatoes back?' I said I wasn't sure what she was talking about, She said someone...had taken her potatoes and she wanted them back..."</p> <p>An untimed written statement dated 8/24/16 included but was not limited to, "...Supertime bout [sic] 5:25 I went into [Resident R] to see if she was eating. She was doing bead work. I said let me move this plate out of the way...She said you're stupid. I said that's not nice to say at all she said well you are. So she told LPN #5...Time to pass out trays [Resident F] replied she had too [sic] go pee. I said well just turn on the light when you're done and Ill [sic] change your diaper..." The statement was signed by CNA #15.</p> <p>2. During an interview with the DON on 9/2/16 at 10:44 A.M., she indicated on 8/24/16 a staff member called her and reported an incident. She she had instructed to start the investigation, suspend the CNA and report the incident to the Administrator as she was on</p>		<p>Report review or any event that has been reported to the Administrator since the last daily CQI meeting that meets criteria for abuse will be reviewed to see that all protocol was followed including timely reporting to the ISDH. Any concerns will be immediately acted upon.</p> <p>Note: (See agenda for all staff in-service for F-223 as education for F-225 is included.)</p> <p>At the monthly QA meeting all Reportable Incidents since the previous monthly QA meeting will be reviewed for timeliness of reporting to the Administrator, timeliness of suspensions and timeliness of reporting to ISDH. Any necessary action/education and/or progressive discipline will take place or will have taken place as indicated.</p>	

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	<p>vacation at the time. She indicated when she returned to the facility on 8/29/16 and learned the allegation had been reported to the State late (2 days).</p> <p>During an interview with the DON on 9/2/16 at 12:34 P.M., she indicated the allegation against CNA #15 had been substantiated because it occurred. She indicated the residents had been provided assistance by other staff members and CNA #15 was suspended pending an investigation and terminated for "poor customer service".</p> <p>During an interview with CNA #55 on 9/2/16 at 12:50 P.M. she indicated refusing to assist residents to the restroom could be considered abuse.</p> <p>3. During an interview with Resident F on 9/2/16 at 1:00 P.M., she was observed to be sitting up in her wheel chair on the facility front porch. Resident F appeared to be in no apparent distress. she indicated she had reported the incident on 8/24/16. She indicated she had requested assistance to use the bedpan from CNA #15 and the CNA had gotten upset and told her "No, just use your brief, I'll change you when you are done". Resident F continued and indicated CNA #15 was constantly stating how overworked she was and how she was going to quit. Resident F indicated she felt the remark</p>			

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	<p>was verbally abusive, they made her feel bad and being instructed to use her "diaper" was humiliating. She indicated she had experienced incontinence as a result of CNA #15 not assisting her to the restroom. She stated "It's bad enough I can't get on the toilet anymore but to be told to pee on myself it humiliating, you can't do that to people". Resident F indicated other than that incident she had no other concerns at the facility.</p> <p>4. The time card for CNA #15 was provided by the facility on 9/2/16. It indicated CNA #15 had worked on 8/24/16 from 1:59 P.M., to 10:15 P.M., (3 hours after the allegation had been reported to LPN #10). The time card indicated CNA #15 had been suspended on 8/25/16 and terminated on 8/26/26.</p> <p>5. During an interview with the Administrator on 9/2/16 at 1:15 P.M., she indicated she indicated the allegation was substantiated and she had reported the allegation to the State department of heath on 8/26/16 because she was unable to access the portal. She indicated she had sent the incident to the facility corporate office for review but had not contacted the Indiana State Department of Health for any recommendations on how to send in the allegation of abuse. She indicated the CNA #15 had been</p>			

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	<p>suspended effective 8/24/16 at 10:00 P.M., (3 hours after the allegation was reported) and the allegation was sent to the State on 8/26/16 (2 days) after it was reported to her.</p> <p>A policy dated 1/2007 titled "ABUSE REPORTING" included but was not limited to, "It is the polity of the facility to encourage and support all residents, staff, and family members to feel free to report any suspected acts of abuse, neglect,...The facility will take all measures possible to assure that residents, staff and families are free from reprisal, when reports or incidents are reported to the facility...Any persons witnessing or having knowledge of potential or actual abuse must contact and report the incident to the Administrator and/or designee immediately...The Incident Documentation and Investigation Tool form is to be submitted to the Administrator or designee as soon as possible within 24 hours for further investigation. The Administrator (or designee) will report Abuse/Neglect to the Department of Health within 24 hours per the Indiana Department of Health reporting guidelines...Any Individual who is accused of resident abuse whether physical or verbal will be suspended until further investigation has been</p>			

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	<p>completed...The Director of Nursing or Charge Nurse will complete the investigation form with a writing, dated, and signed statement from all persons involved...If abuse is suspected or substantiated, the employee will be immediately sent home."</p> <p>A undated policy titled, "ABUSE PROHIBITION POLICY AND PROCEDURE", included, but was not limited to... "It is the policy of this facility to maintain an environment free of abuse and neglect. The resident as the right to be free from verbal..and mental abuse...Residents will not be subjected to such events by anyone...This facility shall comply with all federal and state requirements to ...train, prevent, identify, Investigate, protect, and report...Abuse: willful infliction of injury...or punishment with resulting physical harm, pain or mental anguish. This includes the deprivation by an individual, including a caretaker of goods or services that are necessary to attain or maintain physical, mental and psychosocial well being...Mental Abuse: This includes, but is not limited to humiliation...Neglect: A failure to provide goods and services necessary to avoid physical harm, mental anguish..."</p> <p>This Federal tag relates to Complaint</p>			

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F 0226 SS=D Bldg. 00	<p>#IN00208924</p> <p>3.1-28(a)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on observation, interview, and record review, the facility failed to ensure an allegation of abuse policy was followed for 1 of 3 allegations reviewed. (Resident F, Resident R)</p> <p>Findings include:</p> <p>1. During an interview with CNA #4 on 9/2/16 at 5:30 A.M., she indicated she had reported an allegation of abuse to the nurse last week. She indicated Resident F had indicated CNA #15 had refused to assist her with using the bedpan and instructed her to just go in her brief. She indicated Resident F was pretty upset by the occurrence and she had told the nurse as soon as she was told about it. CNA #4 indicated she was told the allegation had been taken care of.</p>	F 0226	<p>F-226</p> <p>It is the policy of the facility to follow the policies in place including the current and most recently revised Abuse Policy. And, to ensure that the policy is implemented appropriately and timely as indicated.</p> <p>Note: (See responses to F-223 and F-225 as responses to F-226 are included in the response for those F-tags).</p>	10/01/2016	

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	<p>2. The facility reportable's were provided on 9/2/16 at 10:33 A.M., they included, but were not limited to, a "...INDIANA STATE DEPARTMENT OF HEALTH...SURVEY REPORT SYSTEM...Incident Number 39...Incident Date: 08/27/2016...Incident Time 07:15 AM [sic]...Residents Involved [Resident F]...[Resident R]...Staff Involved...[CNA #15]...Brief Description of Incident...8/26/2016...Two roommates allege staff member refused to provide care per resident's request. [Resident F] states she requested to be taken to the bathroom and had to wait for he CNA... [Resident R] states Staff member took her meal tray too soon and wasn't able to finish her meal. Both roommates were upset with the CNA...Type of Injury...No injury noted on either resident..."</p> <p>The facility investigation was reviewed and included the following:</p> <p>An untimed statement dated 8/24/16 included, "...[Resident F] reported to me that she asked [CNA #15] for a bedpan...She sates that [CNA #15] told her 'You have a diaper on. Just go in it and I will change you after supper...' The statement was signed by Resident F. The page also contained a handwritten statement on 8/24/16 indicated the incident had been reported to LPN #10 at</p>			
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	<p>7:00 P.M.</p> <p>An untimed typed statement dated 8/24/16 included, "...I was working on Unit 1. I walked down Unit 2 hall to drop off a chart to the nurse and [Resident R] walked out of her room and asked me 'Can I please have my potatoes back?' I said I wasn't sure what she was talking about, She said someone...had taken her potatoes and she wanted them back..."</p> <p>An untimed written statement dated 8/24/16 included but was not limited to, "...Supertime bout [sic] 5:25 I went into [Resident R] to see if she was eating. She was doing bead work. I said let me move this plate out of the way...She said you're stupid. I said that's not nice to say at all she said well you are. So she told LPN #5...Time to pass out trays [Resident F] replied she had too [sic] go pee. I said well just turn on the light when you're done and Ill [sic] change your diaper..." The statement was signed by CNA #15.</p> <p>3. During an interview with the DON on 9/2/16 at 10:44 A.M., she indicated on 8/24/16 a staff member called her and reported an incident. She she had instructed to start the investigation, suspend the CNA and report the incident to the Administrator as she was on vacation at the time. She indicated when</p>				

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	<p>she returned to the facility on 8/29/16 and learned the allegation had been reported to the State late (2 days).</p> <p>During an interview with the DON on 9/2/16 at 12:34 P.M., she indicated the allegation against CNA #15 had been substantiated because it occurred. She indicated the residents had been provided assistance by other staff members and CNA #15 was suspended pending an investigation and terminated for "poor customer service".</p> <p>During an interview with CNA #55 on 9/2/16 at 12:50 P.M. she indicated refusing to assist residents to the restroom could be considered abuse.</p> <p>4. During an interview with Resident F on 9/2/16 at 1:00 P.M., she was observed to be sitting up in her wheel chair on the facility front porch. Resident F appeared to be in no apparent distress. she indicated she had reported the incident on 8/24/16. She indicated she had requested assistance to use the bedpan from CNA #15 and the CNA had gotten upset and told her "No, just use your brief, I'll change you when you are done". Resident F continued and indicated CNA #15 was constantly stating how overworked she was and how she was going to quit. Resident F indicated she felt the remark was verbally abusive, they made her feel</p>			

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	<p>bad and being instructed to use her "diaper" was humiliating. She indicated she had experienced incontinence as a result of CNA #15 not assisting her to the restroom. She stated "It's bad enough I can't get on the toilet anymore but to be told to pee on myself it humiliating, you can't do that to people". Resident F indicated other than that incident she had no other concerns at the facility.</p> <p>5. The time card for CNA #15 was provided by the facility on 9/2/16. It indicated CNA #15 had worked on 8/24/16 from 1:59 P.M., to 10:15 P.M., (3 hours after the allegation had been reported to LPN #10). The time card indicated CNA #15 had been suspended on 8/25/16 and terminated on 8/26/26.</p> <p>6. During an interview with the Administrator on 9/2/16 at 1:15 P.M., she indicated she indicated the allegation was substantiated and she had reported the allegation to the State department of health on 8/26/16 because she was unable to access the portal. She indicated she had sent the incident to the facility corporate office for review but had not contacted the Indiana State Department of Health for any recommendations on how to send in the allegation of abuse. She indicated the CNA #15 had been suspended effective 8/24/16 at 10:00</p>			

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	<p>P.M., (3 hours after the allegation was reported) and the allegation was sent to the State on 8/26/16 (2 days) after it was reported to her.</p> <p>A policy dated 1/2007 titled "ABUSE REPORTING" included but was not limited to, "It is the polity of the facility to encourage and support all residents, staff, and family members to feel free to report any suspected acts of abuse, neglect,...The facility will take all measures possible to assure that residents, staff and families are free from reprisal, when reports or incidents are reported to the facility...Any persons witnessing or having knowledge of potential or actual abuse must contact and report the incident to the Administrator and/or designee immediately...The Incident Documentation and Investigation Tool form is to be submitted to the Administrator or designee as soon as possible within 24 hours for further investigation. The Administrator (or designee) will report Abuse/Neglect to the Department of Health within 24 hours per the Indiana Department of Health reporting guidelines...Any Individual who is accused of resident abuse whether physical or verbal will be suspended until further investigation has been completed...The Director of Nursing or</p>			

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	<p>Charge Nurse will complete the investigation form with a writing, dated, and signed statement from all persons involved...If abuse is suspected or substantiated, the employee will be immediately sent home."</p> <p>A undated policy titled, "ABUSE PROHIBITION POLICY AND PROCEDURE", included, but was not limited to... "It is the policy of this facility to maintain an environment free of abuse and neglect. The resident as the right to be free from verbal..and mental abuse...Residents will not be subjected to such events by anyone...This facility shall comply with all federal and state requirements to ...train, prevent, identify, Investigate, protect, and report...Abuse: willful infliction of injury...or punishment with resulting physical harm, pain or mental anguish. This includes the deprivation by an individual, including a caretaker of goods or services that are necessary to attain or maintain physical, mental and psychosocial well being...Mental Abuse: This includes, but is not limited to humiliation...Neglect: A failure to provide goods and services necessary to avoid physical harm, mental anguish..."</p> <p>This Federal tag relates to Complaint #IN00208924</p>			

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F 0323 SS=D Bldg. 00	<p>3.1-28(c)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure interventions were applied correctly and supervision was in place to prevent falls for 1 of 3 residents who met the criteria for the review of accidents. (Resident E)</p> <p>Findings include:</p> <p>On 9/2/16 at 5:45 A.M., Resident E was observed to be sitting in a recliner with her eyes closed. Resident E was observed to be in no apparent distress.</p> <p>During an interview with LPN #4 on 9/2/16 at 6:15 A.M. She indicated Resident E had a fall on 9/1/16 after scooting out of her recliner and onto the floor. LPN #5 indicated Resident E had experienced no injuries and the new</p>	F 0323	<p>F-323</p> <p>It is the policy of the facility to ensure that interventions are applied correctly and supervision is in place to prevent falls. Resident E has had no further falls. Resident E has the chair alarm box</p> <p>and cord attached to the appropriate place on the resident's person and her chair. The cord has been shortened. Her call light is placed within reach as well.</p> <p>Residents who reside in the facility and who have an alarmed device as a fall</p>	10/01/2016

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	<p>interventions were to shorten the string on Resident E's personal alarm and to place the box on the back of the chair rather than the trash can since it moved with her.</p> <p>The clinical record for Resident E was reviewed on 9/2/16 at 10:15 A.M. The diagnoses included, but were not limited to diabetes mellitus type 2, heart failure, pain, major depressive disorder.</p> <p>A Quarterly Minimum Data Set (MDS) assessment, dated 6/29/16 indicated Resident E had a BIMS (Brief Interview for Mental Status) score of 8 indicating she had moderate cognitive impairment. The MDS indicated Resident E required extensive assist of two persons for transfers, bed mobility, ambulation, dressing and toileting.</p> <p>The Nurses notes indicated on 9/1/16 at 9:38 P.M., "...Res. [Resident] slid off end of recliner with no injuries. Res. denies any pain. Nero checks started due to no witnesses. Res. was sitting with back against recliner. Call light was not on. Tab alarm attached to res., but alarm box attached to trash can which slid forward with her. Also noted that tab alarm string was to long. Readjusted tab alarm string and attached alarm box to back of recliner. Reminded res. use call light for</p>		<p>intervention have the potential to be affected by this finding. A facility wide audit was conducted at which time a targeted list of residents was compiled. All of these residents were reassessed to ensure that the current alarming device was still appropriate. If found to be appropriate, the following was verified: 1.)Order</p> <p>2.)Checked for function/working order and appropriate cord length (if cord present)</p> <p>3.)Care Planned</p> <p>4.)CNA information sheets (include daily check for function "sounding")</p> <p>5.)Observed for proper placement practice</p> <p>At the daily CQI meetings any new orders for alarms will be reviewed to see that they are proper as per assessment results and that all</p>	

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	<p>assistance..."</p> <p>The care plans included, but were not limited to, the following:</p> <p>A care plan for falls initiated 1/1/15 indicated resident experienced unsteady gait, poor balance, diabetes, and osteoporosis. The interventions included, but were not limited to Pull Tab Alarm on Recliner dated 12/15/15, skid strips by recliner, therapy screen as indicated, toilet every 2 hours and PRN.</p> <p>The DON was interviewed on 9/2/16 at 12:55 P.M., she indicated at that time the fall that occurred on 9/1/16 had not been reviewed by the IDT (Interdisciplinary Team) yet. She indicated alarms should be applied correctly to ensure they alarm correctly. She further indicated it was the policy of the facility to ensure that adequate supervision and appropriate interventions were properly applied to assist with prevention of falls.</p> <p>This Federal tag relates to Complaint #IN00207286</p> <p>3.1-45(a)(2)</p>		<p>appropriate protocol for alarms is implemented.</p> <p>The DON/Designee will monitor 5 alarms 3 days weekly on various shifts and to include some week end days. The monitoring will occur checking for: 1.) Ordered device in use 2.) Proper placement 3.) Cord Length proper (if it has a cord) Any concerns will be addressed as found.</p> <p>This monitoring will continue until 4 consecutive weeks of zero negative findings is achieved. Afterwards, 5 alarms will be monitored weekly for at least 6 months to ensure ongoing compliance. After that, random monitoring will occur.</p> <p>At an in-service held for all staff Sept 27,28,29, and 30, the following was reviewed:</p>	

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			<p>1.) Alarms as a fall prevention intervention—Pros and Cons</p> <p>2.) Proper placement of alarms (Who can physically place them?--- Nursing/Therapy)</p> <p>3.) What to do if you see an alarm “detached” from a resident or not working? (Whom to notify? When?)</p> <p>4.) Alarm- -Assessment/Order/Care Plan/CNA Assignment/Check Function Daily</p> <p>5.) Questions/Answers</p> <p>Any staff who fail to comply with the points of the in-service will be further educated and/or progressively disciplined as indicated. However, any concerns will have been addressed as discovered. If necessary, an Action Plan written by the committee will be monitored</p>	

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			weekly by the Administrator until resolution.	

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