

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/10/2011
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NAME OF PROVIDER OR SUPPLIER HEARTH AT WINDERMERE	STREET ADDRESS, CITY, STATE, ZIP CODE 9745 OLYMPIA DR FISHERS, IN 46038
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R0000	<p>This visit was for the Investigation of Complaints number IN00098182 and IN00099589.</p> <p>Complaint number IN00098182 substantiated, state residential deficiencies related to the allegation are cited at R052 and R029.</p> <p>Complaint number IN00099589 substantiated, state residential deficiencies related to the allegations are cited at R052</p> <p>Survey Dates: November 09, 10 2011</p> <p>Facility number: 002999 Provider number: 002999 AIM number: NA</p> <p>Survey team: Chuck Stevenson RN</p> <p>Census bed type: Residential: 117 Total: 117</p> <p>Census payor type: Other: 117 Total: 117</p> <p>Sample: 8</p>	R0000	<p><u>DISCLAIMER:</u></p> <p><u>Preparation and implementation of this plan of correction does not constitute admission or agreement by Hearth at Windermere of the truth of the facts, findings, or other statements as alleged by the preparer of the survey/inspection dated 11/10/11. The Hearth at Windermere specifically reserves the right to move to strike or exclude this document as evidence in any civil, criminal or administrative action not related directly to the licensing and/or certification of this facility or provider. The facility reserves the right to challenge the findings by way of independent review procedures established by the agency.</u></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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	<p>These state residential findings are cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 11/16/11 Cathy Emswiller RN</p>						

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R0029	<p>(d) Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality.</p> <p>Based on record review and interview, the facility failed to protect residents from incidents of violation of personal dignity (Resident G, brought to the dining room in her night gown), and failure to be treated with respect and consideration (Resident I, refusing to assist the resident to his room after he had requested assistance) for 2 residents reviewed for resident's rights in a sample of 8.</p> <p>Findings include:</p> <p>1. The record of Resident I was reviewed on 11/10/11 at 3:00 p.m.</p> <p>Diagnoses included, but were not limited to dementia.</p> <p>A "Care or Concern Form" dated 10/27/11 (untimed) indicated "In DR (dining room)...(Resident I) got (symbol for "up") from eating...(CNA #2) told him Go to your room...I am not walking you to your room...(symbol for "and") did not help him back to his seat or to his room... chg (charge) nurse got him back to table and he ate another 1/2 of dinner..."</p> <p>A "Care or Concern Form" dated 10/27/11 (untimed) indicated "(CNA #2)...Brought</p>	R0029	<p>Plan of Correction: Facility wishes to preserve the right to contest the deficiency findings, however, the plan of correction for the deficiency is as follows:1. Describe what the facility did to correct the deficient practice...a. CNA #2 was individually trained by the Unit Manager concerning resident dignity and rights. In-service pertaining to dignity issues was placed in the communication book by the Unit Director and reviewed by Keepsake unit staff on 10/28/11.b. CNA #2 was progressively counseled/disciplined and resigned after his last counseling/disciplinary form. He is no longer employed at this facility as of 11/15/11.2. Describe how the facility reviewed all the clients in the facility that could be affected by the same deficient practice, and state, what action the facility took to correct the deficient practice for any client the facility identified as being affected.a. The residents and their care are monitored daily by the charge nurse who will counsel CNA's as part of the charge nurse's job responsibility. The charge nurse will continue to monitor resident care and dignity. b. Director of Nursing will monitor 24 hour report for unusual incidents. Executive Director is to monitor to</p>	01/06/2012			

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	<p>(Resident G) out to the DR in her night gown. chg nurse told him she cannot come out dressed like this he stated 'I don't care I do not want to dress her.'</p> <p>2. An undated facility policy titled "Residents Bill of Rights" received from the Executive Director on 11/10/11 at 5:00 p.m. indicated:</p> <p>"Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality.'</p>		<p>ensure this practice is in place by initialing the 24 hour reports. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur....a. Director of Nursing will train all charge nurses on policy and procedures related to disciplinary practices. b. Director of Nursing will review all nursing disciplinary actions within one week of the incident4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur....a. Executive Director will monitor all counseling/disciplinary forms on an ongoing basis to ensure the proper procedures are being followed. Information additional to the Plan of Correction:Facility respectfully requests this deficiency be removed from the Statement of Deficiencies. The reason for the request for removal is the facility did formally discipline CNA #2 at the time of the reported incidents and the documentation was in the employee's personnel file at the time of the survey. A Care or Concern Form was initiated by CNA#2's charge nurse as a result of CNA #2's conduct. The form was brought to the Unit Manager who counseled and trained CNA on the matter on 10/27/11. The Director of Nursing signed off on the form. The form was filed in the personnel file because it is a</p>				

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			formal counseling and that is part of the facility disciplinary process. These forms were found by the surveyor while he was reviewing the personnel file. They are written evidence that discipline was administered. Counseling and disciplinary action are the same thing in our community. The Executive Director did not indicate that CNA #2 had been counseled but not formally disciplined for these incidents.		

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R0052	<p>(v) Residents have the right to be free from:</p> <p>(1) sexual abuse;</p> <p>(2) physical abuse;</p> <p>(3) mental abuse;</p> <p>(4) corporal punishment;</p> <p>(5) neglect; and</p> <p>(6) involuntary seclusion.</p> <p>A. Based on record review and interview, the facility failed to protect 2 residents from physical abuse including one resident being slapped on the hands (Resident B) and one resident being grabbed by the arms and sat on (Resident C). The facility also failed to ensure the safety of other residents by failing to ensure these incidents of abuse were promptly reported and acted on, allowing the CNA who abused the residents (CNA #1) to continue to work on the day of the incidents, and return to work in the facility the following day. The facility also failed to protect a resident (Resident F) from verbal abuse. This deficient practice affected 3 residents of 3 reviewed for abuse in a sample of 4 in a population of 26 on the facility's secured dementia unit.</p> <p>B. Based on record review, interview, and observation, the facility failed to ensure residents on the secured dementia unit were protected from harm from dog bites from a dog owned by and residing with a facility resident (Resident H) for 1 resident (Resident E) and one visitor, and</p>	R0052	<p>Defeciency ID: R _ 0052</p> <p>Completion Date: 1/6/12</p> <p>PLAN OF CORRECTION as related to allegation of physical and verbal abuse by 2 CNA's: Facility wishes to preserve the right to contest the deficiency and does not admit to any of the allegations, however, the plan of correction for the deficiency is as follows: 1. What was done to correct the deficient practice? The facility did all of the following in response to the abuse allegation: a. CNA #1 was reported by CNA #2 within the same shift to the charge nurse. Management immediately suspended CNA #1 upon being informed of the abuse allegation. The suspension of CNA #1 was within one hour of management learning of the allegation and less than 24 hours after the actual incident. b. Residents were assessed, family and physician notified. c. Pictures were taken of bruising on one resident's arm. No other injury noted on either resident. d. Unusual incident report to Indiana Department of Health was faxed. e. CNA #1 was suspended pending investigation and recommendation to terminate</p>	01/06/2012			

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	<p>failure to remove the dog from the facility following the documentation of 2 biting incidents.</p> <p>Findings include:</p> <p>A. 1. The record of Resident B was reviewed on 11/10/11 at 1:30 p.m.</p> <p>Diagnoses included, but were not limited to, dementia, hypertension, Alzheimer's Disease, atrial fibrillation, and diabetes mellitus.</p> <p>A facility document titled "Report of Abuse concerning (CNA #1)" prepared by the Executive Director and dated 11/09/11 was received on 11/10/11 at 9:30 a.m. The Executive Director indicated this document was a timeline of events related to the allegation of abuse of Residents B and C by CNA #1. The document included, but was not limited to:</p> <p>9/26/11 11:00 a.m. (CNA #2) calls (LPN #3) Unit Director and reported the incident with (CNA #1)...Also reported (CNA #1) smacked (Resident B) hands. (Resident B) was assessed, family notified and physician notified..."</p> <p>A facility "Incident/Accident Report" completed by LPN #3 on 9/28/11 at 12:00 noon indicated "Reported to writer</p>		<p>was made promptly. f. Residents were assessed by psychologist for recommendations. 2. Describe how the facility reviewed all clients in the facility that could be affected...and state what actions the facility took to correct the deficient practice for any client the facility identified as being affected. a. Interviewed staff to inquire as to whether they had witnessed any behavior from CNA #1 or CNA #2 that would be considered disrespectful or abusive. Completed on 10/3/11b. Interviewed residents on assisted living (where CNA #1 was primarily assigned) to determine if there were any other incidents observed or "heard about" as both residents were very social and observant. Interviewed resident with bruised arms. Completed on 9/30/11. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practices does not reoccur:a. On 9/25/11 all staff were in-serviced on Resident Abuse and provided copies of the facility procedures on reporting abuse and a handout on abuse prevention. In addition the staff received information on the definitions of abuse so they will be able to recognize abuse when it is witnessed. b. All staff were re-trained on Abuse and Neglect in the Upstairs Solution online training classes on 10/5/11. This is the second time this year staff</p>				

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	<p>9/26/11 at 11:30 a.m. by CNA via phone, concerns R/T (related to) 9/25/11 prior to dinner another CNA slapped this resident's hands."</p> <p>A typed statement from CNA #2 dated September 26, 2011 and noted as received by the Executive Director on 9/27/11 included, but was not limited to:</p> <p>"...I then went into (Resident B's) room, and asked her (CNA #1) to help me with...due to her having a bowel movement in her brief. The 3 of us entered (Resident B's) bathroom, and I was having difficulty getting (Resident B) to sit on the commode. (CNA #1) tried pushing down on top of (Resident B's) shoulder, and when she did (Resident B) said, 'No, stop that.' (Resident B) then went to slap her as I tried to stop her. When (Resident B) made the attempt, (CNA #1) slapped her hand and said, 'Don't do that.'"</p> <p>A typed report by LPN #3 dated 9/26/11 at 11:30 indicated "...Same nursing assistant (CNA #2) also reported...(CNA #1) went to room (Resident B's room number) and tried to force resident onto toilet and resident became upset and tried to smack nursing assistant (CNA #1), nursing assistant then smacked resident's hands."</p>		<p>were assigned a training class on Abuse and Neglect. c. In-serviced staff on the policy and procedures related to resident abuse and reporting requirements to ensure all staff are aware of proper reporting requirements. Completed on October 5, 2011.d. All staff have background checks prior to hire.e. All staff have reference checks prior to hire. f. All staff have at least 6 hours of dementia training prior having any resident contact. g. All staff are drug tested prior to hire. h. All licensed and certified staff have their licenses and certifications checked for validity with the licensing/certification board prior to hire. i. All staff are trained on resident abuse, resident dignity, resident rights and proper reporting of resident abuse prior to resident contact. j. Supervisors were assigned a training class on Abuse and Neglect Investigation in May of 2011. k. The local ombudsman provides staff training for issues related to resident right and dignity yearly.l. Staff training on resident rights, resident abuse and reporting requirements is mandatory for each staff member yearly. m. Staff who fail to report resident abuse timely will be counseled by their appropriate department head concerning proper procedures. 4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur: a.</p>				

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	<p>2. The record of Resident C was reviewed on 11/10/11 at 2:00 p.m.</p> <p>Diagnoses included, but were not limited to, dementia, a history of prostate cancer, hypertension, hyperlipidemia, and occasional tachycardia.</p> <p>A facility document titled "Report of Abuse concerning (CNA #1)" prepared by the Executive Director and dated 11/09/11 was received on 11/10/11 at 9:30 a.m. The Executive Director indicated this document was a timeline of events related to the allegation of abuse of Residents B and C by CNA #1. The document included, but was not limited to:</p> <p>"9/25/11 4:00 p.m. (CNA #2) witnesses incident between (CNA #1) and (Resident C). (CNA #2) stated he is not sure about how (CNA #1) handled the situation and felt he needed to think it over to make sure he did the right thing.</p> <p>9/25/11 10:00 p.m. (CNA #2) reports to (LPN #4) that (Resident C) bumped (CNA #1) with his walker in the lunch room and (CNA #1) responded by grabbing (Resident B's) arm. He stated (Resident B) was afraid of (CNA #1).</p> <p>9/26/11 11:00 a.m. (CNA #2) calls (LPN</p>		<p>Department heads will ensure all staff prior to hire have reference checks, background checks, have required certifications/license and background checks. b. Business office manager will coordinate times for new hires to receive training on resident abuse and reporting during orientation and will monitor each personnel file to ensure all new hire items are completed. c. A new hire Abuse Questionnaire will be used in all new hire files that is designed to emphasize the importance of reporting abuse timely, letting new hires know how and where to report abuse, inform new employees that reporting will not result in retaliation and inquire about the past and present practices and intentions of each new employee as related to temper control and abuse issues. d. Executive Director to spot check new hire files to ensure all new hire practices are being completed appropriately. All items will be completed by January 6, 2012. PLAN OF CORRECTION FOR DOG ISSUE Facility wishes to preserve the right to contest the deficiency and does not admit to any of the allegations, however, if the deficiency should be found valid the plan of correction for the deficiency would be as follows: 1. What was done to correct the deficient practice? a. Dog was removed from contact with all residents</p>				

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	<p>#3) Unit Director and reported the incident with (CNA #1). (LPN #3) reports the incident to (Name of Director of Nursing) and (Name of Executive Director. (CNA #1) was called into the office and interviewed. She was asked to write a statement on the events of the incident with (Resident C) and was suspended pending investigation. Also reported (CNA #1) smacked (Resident B) hands...(LPN #3) assessed (Resident C) and did a body check. She noted small bruises on left and right arm which were blue and red in color...</p> <p>9/26/11 (Untimed) Spoke with (CNA #2) and requested he submit a written statement.</p> <p>9/28/11 1:00 p.m. Received written statement from (CNA #2). Was in my email from DON (Director of Nursing) forwarded on 9/27/11 at 12:45 p.m.</p> <p>9/28/11 (Untimed) Bruises reported to me on (Resident C), took pictures of the bruising. (LPN #3) reported it has gotten worse over time.</p> <p>9/28/11 (Untimed) After preliminary investigation, statements, it appears there is a reportable incident, so at 9:12 p.m. Faxed in unusual incident to ISBOH (sic).</p>		<p>except the owner immediately upon learning there was an allegation of nipping/biting. Dog was permanently removed from the facility as of 11/15/11. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice...:a. Inquired from Unit Manager if there were any reports of nipping/biting. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practices do not reoccur:a. Facility acknowledges a resident's right to have pets in our facility. The only way to ensure that an animal will not ever nip or bite is to prohibit animals on the property. Community did protect residents after the first report of potential aggression. In the future, if there is a any report of aggression from an animal living or visiting the facility, the facility will ask the animal be removed from the facility. b. Facility policy will state that it does not allow dangerous animals of any type and all pets must not be a threat to other residents or staff. 4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur: a. All new residents who wish to have a pet will have the pet evaluated by staff prior to the pet coming into the building. Staff will observe the animal for any obvious signs of aggression when first meeting the animal.b.</p>				

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	<p>9/28/11 (Untimed) (CNA #5) reports allegations of abuse against (CNA #2)...due to behaviors she witnessed in May, June, and July...Decision was made not to immediately suspend (CNA #2)...Weighed the value of suspension and any danger to resident's (sic) vs (versus) the effect it would have on staff that would be afraid to report abuse to retaliation against them...</p> <p>9/28/11 1:40 p.m. Interviewed (LPN #3) concerning allegations of abuse against (CNA #2). She counseled him a while ago for calling a resident a yeast infection...</p> <p>10/07/11 (Untimed) Spoke with (Area Ombudsman) as she was in for an in-service and explained the situation of abuse...</p> <p>10/07/11 (Untimed) (CNA #2) suspended.</p> <p>10/10/11 (Untimed) Interview with (CNA #2). Discussed allegations of abuse and results of investigation...asked (CNA #2) to provide a written statement...</p> <p>10/11/11 (CNA #2) provides statement... (CNA #2) brought back to work."</p> <p>A written statement from CNA #5, signed and dated 9/28/11 and given to the Executive Director on that date, included,</p>		<p>Residents will be asked to fill out a short questionnaire about their pet that will include inquires about the pet's temperament. This will be part of the admission packet for all residents effective immediately. c. Any animal who shows any sign of aggression will be asked to leave the building and may not return to the building unless a licensed veterinarian will provide a written statement stating that it is his belief the aggression was transient and due to a temporary condition (ie medical, medication, pain...) that has been resolved and a behavioral specialist, who has credential that are approved by the facility, evaluates the animal and deems him safe to live in a community setting . The rest of following information is respectfully included in the POC to provide some clarification of the information presented in the survey and some further explanations. The first section is related to the staff issues and the last section covers the issues revolving around the dog. We appreciate the opportunity to present this information and would like it included on the final plan of correction. Facility Respectfully would like to submit the following information as clarification concerning the physical abuse allegation.At the suggestion of the Surveyor, the Executive Director prepared a summary</p>				

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	<p>but was not limited to: "I (name of CNA #5) is (sic) writing this statement because I feel that (name of CNA #2) has (sic) physically and verbally abuse (sic) residents on Keepsake (the facility's dementia unit). He have called (sic) (Name of Resident F) 'tea cup tittys". He calls us (co-works) (sic) and (residents) sexual transmitted names...Last Wed. (Wednesday) 21 2011 (CNA #2) was tapping on (Resident B's) glasses it was making her mad. He was forceful with (Resident G) Sept. (September) 7, 2011 and made her cry..."</p> <p>A typed statement from CNA #2 dated September 26, 2011 and noted as received by the Executive Director on 9/27/11 included, but was not limited to:</p> <p>"Around 4:00 pm on Sunday I went to the Activity Room to ask (Resident C) to come to dinner. He got agitated and refused. I went and asked (CNA #1) to help me...(CBA #1) asked (Resident C) to come to dinner, with him refusing...he was getting angry, so I told her to forget it...when she turned to walk away (Resident C) pushed his walker into (CNA #1's) legs. (CNA #1) got very aggressive and voicetrous (sic) with him. She fought to get his walker away from him...I told her to stop and lets just leave him alone. She said, "He isn't going to do</p>		<p>timeline of the events in recognition of the volume of information involved in the investigation. The summary timeline was quoted in the survey with much information omitted as indicated by ellipses (lots of ...). It presents a different view than if the timeline is read in total. The three events below are summarized and at the end of this document the missing parts are added back in and parts of the survey language is clarified to present a more complete picture of the incidents in question. Summary of the facts concerning the allegation of resident physical abuse: Most of this information is based on a report from CNA #2 and the resulting investigation. On 9/25/11 at around 4pm, CNA#2 observed an incident between a resident and CNA #1. The Facility did an extensive investigation and concluded CNA #1 acted inappropriately. CNA #1 is no longer employed at the facility. CNA #2 reported both incidents about 6 hours after they occurred (at about 10 p.m. on 9/25/2011) to his charge nurse. When questioned as to why he waited until 10 p.m. to report the incident he said he "wasn't sure about what he saw" and he wanted time to think about the incident and what to do. He wanted to make sure he did the right thing. Management immediately suspended CNA #1 upon learning of the abuse</p>				

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	<p>me like that." She proceeded to grab his arms...They argued and were physical to the point of (CNA #1) pulling (Resident C) out of his chair to the arm of the couch...(CNA #1) the straddles (Resident C) holding his hands in a crisscross positioning his lap all the while telling (Resident C) 'You're not going to do me like that.' (Resident C) backed down and said 'Okay. Okay.' (CNA #1) got off him...I finished getting (Resident B) changed, and then I headed back into the Activity Room, for (Resident C). (Resident C) asked me, 'Will you protect me?'...I said absolutely!"</p> <p>A review of documentation and time card punches for CNA #1 indicate that following the incident of abuse of Resident C on 9/25/11 at 4:00 p.m. CNA #1 completed her shift and left the building at 8:00 p.m. She returned to the building on 9/26/11 at 6:05 a.m., and left at 12:11.</p> <p>During an interview with the Executive Director on 11/10/11 at 9:25 a.m., she indicated that CNA #2 should have reported his observation of abuse against Resident C immediately, as opposed to waiting 6 hours to report it. She also indicated that she was aware CNA #1 had worked at least part of 2 shifts following the incident of abuse. She indicated that</p>		<p>allegation. By 12:30 p.m. CNA #1 was called back from lunch, interviewed, requested to write a statement, suspended pending investigation and out of the building. The incident was reported to the Indiana State Board of Health, an extensive investigation was completed which resulted in the recommendation to terminate CNA #1. Clarification Concerning CNA #2's reporting the abuse at 10 p.m. rather than earlier in the shift: CNA #2 was questioned as to why he did not report the abuse immediately after the incident and was told he needed to report abuse more timely. CNA #2 was crying when he was interviewed by management. He was afraid. He wanted to do the right thing and said he needed time to "process and think about what he saw to make sure it really was what he was thinking it was..." Management trained and discussed this with the CNA to re-enforce the correct procedure in the event of abuse but did not formally discipline CNA #2 because CNA #2 did do the right thing by reporting the abuse despite his fears. Executive Director did tell surveyor that reporting procedures and timeliness were discussed with CNA #2 but he was not formally disciplined. This is the only context in which the Executive Director said a CNA was not formally counseled Facility</p>				

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	<p>CNA #2 had been counseled but not disciplined for his failure to report abuse in a timely fashion.</p> <p>B. 1. The record of Resident E was reviewed on 11/10/11 at 1:00 p.m.</p> <p>Diagnoses included, but were not limited to, dementia, hypertension, a history of a hip fracture, and osteoporosis.</p> <p>Nurse's notes dated 10/06/11 at 11:00 a.m. indicated "Reported to writer per Activity Director resident was bit by dog yesterday on unit...area on right arm hardly visible... (Name of physician) office notified..."</p> <p>During an interview with Resident E on 11/10/11 2:45 p.m. she indicated the dog "liked to jump up and bite her fingers" and had done this "several times" and had broken the skin twice. She indicated she had not reported these incidents as the dog belonged to her good friend, Resident H. Resident H was present for this interview, and indicated "Yes, she does like to nip."</p> <p>A Safety Committee Minute Form dated 11/02/11 indicated "(Name of dog) is a safety issue...will talk to family-her owner's visitor who was bit...(Name of dog) will be separated from all residents...only in owners room for visitors on a leash..."</p>		<p>Respectfully would like to submit the following information as clarification concerning the verbal abuse allegation. Facility respectfully denies the validity of this deficiency and requests this deficiency be removed from the Statement of Deficiencies. The reason for the denial and request for removal is there is no credible evidence to show verbal abuse took place. Summary of the facts: CNA #2 reported CNA #1 for abuse on 9/25/11. On 9/28/11 CNA #5 reported CNA #2 for verbal abuse. During the initial interview with CNA #5, she appeared angry at CNA #2 for reporting CNA #1 for abuse when she felt he was guilty of the same conduct. It was reported to management that CNA #5 and CNA #1 were friends by several staff. On 9/1/11 CNA #2 was counseled for various issues related to the allegation of verbal abuse reported by CNA #5 on 9/25/11 and an investigation with statements from staff was obtained during that investigation. Due to confidentiality the disciplinary action was not disclosed so CNA #5 was not aware that any discipline was administered. Often this means staff think "nothing was done." During the 9/1/11 investigation, a written statement from CNA #2's supervisor reported offensive comments were said to another</p>				

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	<p>During an interview on 11/09/11 at 11:30 a.m. the Executive Director indicated she was aware a dog belonging to Resident H had bitten one of her owner's visitors. She indicated that the bite had been treated by a nurse, and that she didn't feel it was a reportable incident as it didn't involve a resident. She also indicated that she was personally observing the dog to determine if it could safely remain in the facility, and that as experienced dog trainer, she felt she could determine if the dog was safe to be in the building. She indicated she personally took the dog to the dementia unit for visits on a leash. She also indicated that the dog was not to be loose in the facility, but that in the early morning of 11/09/11 the dog had been loose in the dementia unit.</p> <p>On 11/09/11 at 11:00 a.m. the dog was observed to exit the open door to the management offices, run briefly in a common area corridor, then return to the office area.</p> <p>At survey exit on 11/10/11 at 5:50 p.m. the dog remained in the facility.</p> <p>3. An undated facility document titled "Resident's Bill of Rights" provided by the Executive Director on 11/10/11 at 5:00 p.m. indicated:</p>		<p>CNA but NOT to the resident. This statement and subsequent investigation lead management to the conclusion CNA #2 spoke to another CNA and not to the resident or within her hearing. CNA #2 was given a final written warning and told, in the disciplinary form, that failure to improve would result in termination. Had the inappropriate and unprofessional comment been said to a resident it would have warranted termination. Our Resident Abuse Policy specifically states; "An employer may not discharge, demote, transfer, prepare a negative evaluation or reduce benefits, pay or work privileges or take any other action to retaliate against an employee who in good faith files a report." CNA #2 filed his report of abuse in good faith. The subsequent allegations against him by CNA #5 were previously investigated and handled. Per the Resident Abuse Policy if abuse is observed or reported; "Suspend the staff member without pay pending the outcome of an investigation. This procedure may be modified only with the consent of Director of Nurses' (sic) Executive Director."The decision not to suspend was based on the facts at hand, the policy, the fact the allegations had already been investigated and discipline administered. In addition, there was no new evidence of abuse</p>				

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	"Residents have the right to be free from sexual abuse, physical abuse, mental abuse, corporal punishment, neglect and involuntary seclusion."		alleged and the suspension could be construed as retaliation for reporting the abuse by either the employer or CNA #5. All of this information made the decision to not suspend compelling at the time of the determination. On 10/7/11 the issues surrounding the allegation of abuse were discussed with the Ombudsman who felt any allegation of abuse warranted immediate suspension of the employee. Consequently, CNA #2 was suspended and the old issue was reinvestigated and it was determined to bring CNA #2 back to work. The results of this second investigation and the reason for the determination to bring CNA #2 back to work were outlined in a written memo dated 10/10/11 which is part of the employee's file and available for inspection. Facility Respectfully would like to submit the following information as clarification concerning the abuse allegation related to the dog: Daisy (the dog) was owned by a resident in the dementia care unit of the facility. She was 3 ½ years old, had no prior history of aggression and in the 1 ½ months prior to the alleged "bite" she was loved by all the residents, families and staff in the dementia unit. After one of the dementia resident reported the dog bit her, the dog was removed from resident contact and only allowed back to the unit to see her owner. The dog was diagnosed with a				

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			urinary tract infection by a veterinarian. Often the first indication of an underlying medical issue is exhibited by behavioral issues. Once the medical issue is resolved the behavioral issues can also be resolved. It was this rational that prompted the removal of the dog from resident contact and evaluation prior to permanent removal of the dog from the facility and thus the resident. The dog was instrumental in helping the resident adjust to moving to a new home and was very loved by the resident. It was important to try all avenues possible to protect the resident's right to have her pet. CLARIFICATION IN SURVEY: Survey states: "Nurse's notes dated 10/06/11 at 11:00 a.m. indicated 'Reported to writer per Activity Director resident was bit by dog yesterday on unit...area on right arm hardly visible..." This report was from the resident mentioned in the above letter who is on a dementia unit. The resident's physician has written a statement: "Mrs. (name omitted) should not be considered a reliable witness." The nurses are trained to report the facts and the fact that was written is "reported to writer" not observed or confirmed or even that the "area on right arm hardly visible.." was a bite mark. There were substantial inquiries concerning this incident. Dog had no history of aggression. Resident said dog	

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			<p>slept in her room and never did so resident's self-report of a bite without any independent observation was highly suspect. Despite the questionable accuracy of the report, the report was taken seriously and the dog was removed from the resident population, no longer allowed to roam and remained under the direct control of the Executive Director or was ONLY in the owner's room with the owner present for limited visits. The dog was removed from the facility most night, left in a cage in administrative offices or on a few occasions, in the owner's room with the door shut. It was also out of the building on weekends. During the day, the dog was under the director control of the Executive Director or another responsible staff member. The dog was allowed to run in the area of the administrative offices because only staff were in the offices and the offices were separated from the facility by a self-closing door so there was never a danger of the door being accidentally left open and allowing the dog to go into the resident part of the building. The dog has not been exposed to any resident other than her owner after that incident. Executive Director personally made sure the residents were protected while at the same time balancing the resident dog owner's right to have a pet. CLARIFICATION IN</p>	

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			<p>SURVEY: The survey states: "...She (Executive Director) indicated that the bite had been treated by a nurse, and that she didn't feel it was a reportable incident as it didn't involve a resident." The incident was reportable within our facility and recorded on our intrafacility forms and it needed to be reported by staff per policy but per Indiana State Department of Health Reportable Unusual Occurrences Policy Rev. 1/25/2006 the incident was clearly NOT a reportable incident that was required to be reported to the Indiana State Department of Health.</p> <p>CLARIFICATION IN SURVEY Survey states: "She (Executive Director) indicated that she was personally observing the dog to determine if it could safely remain in the facility and that as an experienced dog trainer, she felt she could determine if the dog was safe to be in the building."Executive Director was personally observing the dog for safety and if any further aggression was noted after there was no medical reason for the aggression, then it would clearly indicate dog was not appropriate to be returned to the owner in the dementia unit. Executive Director is not a behavioral expert and had no intention of returning the dog to the unit or to contact with residents without evaluation by an expert. Executive Director did indicate she had prior experience</p>		

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			training dogs as an owner/handler in relation to commands such as come, sit, down and cage training to ensure the dog was housebroken. CLARIFICATION OF SURVEY Survey states: "She (Executive Director) indicated she personally took the dog to the dementia unit for visits on a leash." Executive Director took dog to visit the owner who lived on the dementia unit but the dog was not allowed to visit anyone other than the owner in the dementia unit and the visits were targeted specifically for the owner's benefit and not "to the dementia unit for visits." CLARIFICATION OF SURVEY Survey states: "She (Executive Director) also indicated the the dog was not to be loose in the facility, but that in the early morning of 11/09/11 the dog had been loose in the dementia unit." The dog's owner missed the dog and staff, along with the Executive Director, helped coordinate visits with the dog by allowing the owner to spend some nights with the dog in her room with the door closed. It was brought to the owner at bedtime and it slept in the room with the owner. A staff member let the dog outside to eliminate shortly before 5 am and brought it back to the owner's room and shut the door. It was reported to the Executive Director the dog was found outside the room a few minutes after 5am in the hallway		

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			<p>and returned to the owners room. This event occurred the morning of the second day of the survey. In discussing the dog and where it was kept, Executive Director explained the dog was in the owner's room sometimes at night alone with the owner and the door shut. However, Executive Director stated this will no longer be allowed because the owner, unknown to staff, let the dog out of the room. Since that happened the owner can no longer keep the dog in the room at night. No residents were exposed to the dog and it was not allowed to be loose, the owner's actions simply put us on notice that the system in place needed to be changed. The owner typically kept the dog in the room all night and did not let the dog out of the room.</p> <p>CLARIFICATION OF SURVEY Survey states: "On 11/19/11 at 11:00 a.m. the dog was observed to exit the open door to the management offices, run briefly in a common area corridor, then return to the office area."Surveyor went to the receptionist window and found no one behind the window. He did mention later he observed the dog in the administrative office area. Surveyor went around a corner to the door of the administrative offices and knocked. Executive Director opened the door, which always remains closed because there is an automatic closure device on the door. The dog ran</p>	

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			<p>out happily greeting the surveyor who was standing about one foot or less away from the door. Executive Director called the dog back into the office and dog immediately returned upon command. The dog was not more than 1-2 feet out of the door and always under the control of the Executive Director. No residents were at the door and the Executive Director knew the surveyor was at the door as he was observed heading that way from the receptionist window. The Executive Director took a personal interest in the dog because there was some discussion on the part of the owner's family and staff that if the owner was unable to care for the dog, the residents and staff wanted to adopt the dog as a facility dog. By bringing the dog home, the Executive Director would be able to closely observe the dog for unwanted behaviors, help to make sure the dog was housebroken and not an infection control issue and allow the owner to still enjoy her dog. Residents were, at all times protected from the dog once there was an allegation of a bite/nip.</p>		