

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155650	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/30/2013
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NAME OF PROVIDER OR SUPPLIER LINCOLNSHIRE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8380 VIRGINIA ST MERRILLVILLE, IN 46410
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F000000	<p>This visit was for the Post Survey Revisit (PSR) to the Investigation of Complaint IN00125407 completed on May 21, 2013. This visit resulted in a partially extended survey-Substandard Quality of Care.</p> <p>This visit was in conjunction with the Post Survey Revisit (PSR) to the Investiigation of Complaint IN00130573 completed on June 13, 2013.</p> <p>This visit was in conjunction with the Investigation of Complaints IN00133030, IN00133794, IN00134446, and IN00134487.</p> <p>Complaint IN00125407- Corrected.</p> <p>Survey dates: August 26 & 27, 2013 Extended survey dates: August 28, 29, & 30, 2013.</p> <p>Facility number: 000577 Provider number: 155650 AIM number: 100266950</p> <p>Survey team: Janet Adams, RN, TC Heather Tuttle, RN</p>	F000000		

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>August 26 & 27, 2013</p> <p>Census bed type: SNF/NF: 79 Total: 79</p> <p>Census payor type: Medicare: 10 Medicaid: 59 Other: 10 Total: 79</p> <p>Sample: 15 Supplemental sample: 3</p> <p>Lincolnshire Health Care Center was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the Post Survey Revisit (PSR) to the Investigation of Complaint IN00125407.</p> <p>Quality review completed on September 10, 2013, by Janelyn Kulik, RN.</p>			

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F000225 SS=F	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and</p>	F000225	F225 Preparation and/or	09/25/2013			

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	<p>interview, the facility failed to ensure allegations of abuse were reported to the Administrator in a timely manner for 2 of 7 allegation of abuse reviewed resulting in the delay of initiating an investigation of the allegation of abuse. (Residents #F and #R)</p> <p>The facility also failed to ensure allegations of abuse were investigated at the time they were first reported for 1 of 7 allegations of abuse reviewed. (Resident #R)</p> <p>This deficient practice had the potential to affect 79 of 79 residents residing in the facility and resulted in Substandard Quality of Care.</p> <p>Findings include:</p> <p>1. The record for Resident #F was reviewed on 8/27/13 at 9:00 a.m. The resident's diagnoses included, but were not limited to, high blood pressure, chronic kidney disease, vascular dementia, insomnia, cognitive communication deficits, and cerebral vascular disease with hemiplegia (weakness in one side).</p> <p>The 6/17/13 Minimum Data Set (MDS) admission assessment indicated the resident's BIMS (Brief Interview for Cognitive Status) score was (5). This score indicated the</p>		<p>execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Immediate actions taken for those residents identified: The occurrence for Resident #F was reported to Indiana State Department of Health on 08/20/2013 when Administrator received notification of allegation. The occurrence for Resident #R was reported to Indiana State Department of Health on 07/10/2013 when Administrator received notification of allegation. How the facility identified other residents: All residents have the potential to be affected by this alleged deficiency. Measures put into place/ System changes: All facility personnel were provided direct and computer based re-education about facility procedures for identification and reporting of alleged violations. Completed in-servicing included post test(s) demonstrating retention and understanding of facility policy; specifically Administrator is the immediate contact for reporting alleged violations. Administrator, or designee, will continue ongoing educational abuse questionnaires with personnel; presenting</p>				

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	<p>resident's cognitive pattern were severely impaired. The MDS assessment also indicated the resident required extensive assistance of staff for bed mobility, transfers, dressing, eating, and hygiene. The assessment also indicated the resident had impairment of range of motion of the upper and lower extremities on one side.</p> <p>An Abuse Investigation Interdisciplinary Team Review report was reviewed. The report indicated an alleged abuse occurred on 8/17/13 related to Resident #F. The report indicated the above allegation was first reported to the Quality Assurance Consultant on 8/19/13.</p> <p>An Incident Report Form was completed on 8/20/13. This was an initial and follow up report. The report indicated the Quality Assurance Consultant received the report of an allegation of abuse on 8/19/13. the report indicated Resident #F alleged a staff member was rough during care provided on 8/17/13. There was no Incident Report Form completed on 8/17/13.</p> <p>Review of the facility investigation indicated a written statement was obtained from Activity Assistant #1 on</p>		<p>hypothetical situations to personnel, determining appropriate responses, and providing further re-education measures if needed. Abuse questionnaires will be completed with 5 randomly selected personnel 4x/week continuing for 4 weeks. Thereafter, conducted with 5 randomly selected personnel per week for QA monitoring as detailed in section #4 below. Administrator has amended departmental meeting head agenda to include specific questioning about any occurrences that potentially meet criteria for reporting under ISDH reporting requirements r/t abuse. This questioning will be conducted 5x/weekly. Administrator, or designee, will review all written witness statements (including staff and resident interviews) to determine if any further follow-up is needed related to statement. Administrator has posted direct contact number in designated areas throughout the facility; on-going educational abuse questionnaires include education about the location of these designated areas. Administrator or designee will be responsible for oversight of these audit(s). How the corrective actions will be monitored: The results of these questionnaire audits will be reviewed in monthly Quality Assurance meetings monthly x3 months, then quarterly</p>		

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	<p>8/19/13. The statement indicated the resident stated his left arm hurt because someone was rough with him on Saturday when a girl in a colored, flowered top grabbed him by the arm.</p> <p>An interview with the SSD (Social Service Director) on 8/28/13 at 8:10 a.m., indicated she was working on Saturday 8/17/13 when Activity Aide #1 reported to her that Resident #F said someone had been rough with his care and the resident did not know who the staff member was but indicated it was someone wearing a flowered top. The SSD indicated the resident was in a Church activity at the time and was seated near the front row of the activity. The SSD indicated she asked the Activity Aide how much longer the Church Activity was going to last and was told it would be about 15 minutes longer. The SSD indicated she did not assess the resident then as he was seated near the front of the activity. The SSD indicated she did not report the allegation to Nursing staff or the Administrator at the time. The SSD indicated she became involved in other events occurring in the facility and forgot to follow up with or report the allegation to the Administrator as required by the facility Abuse Policy.</p>		x1 for a total of 6 months. Date of compliance: September 25th, 2013	

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	<p>The SSD indicated she was aware it was her responsibility to immediately report any allegations to the Administrator and ensure an investigation was initiated at that time to ensure the resident's safety. The SSD indicated it was on Monday afternoon on 8/19/13 when the Nurse Consultant approached her about Resident #F's allegation which occurred on 8/17/13 that she remembered she had forgotten to follow through on the allegation reported by the Activity Aide on Saturday.</p> <p>An interview 8/27/13 at 4:30 p.m., with the Nurse Consultant indicated APS (Adult Protective Services) called the facility Administrator on 8/19/13 in the afternoon regarding reports of abuse allegations in the facility. The Nurse Consultant indicated they immediately began conducting staff interviews related to the phone call the Administrator received. The Nurse Consultant indicated during the interview process Activity Aide #1 was one of the several staff members interviewed related to Abuse. During the interview Activity Aide #1 reported she had received an allegation from Resident #F on Saturday 8/17/13 and reported it to the SSD who was the Weekend Manager present at the</p>						

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	<p>time. The Activity Aide reported Resident #F had informed her someone had twisted his arm and she then informed the Social Worker. The Nurse Consultant indicated the above allegation made on 8/17/13 had not been conveyed to anyone else in management prior to 8/19/13. The Nurse Consultant indicated the SSD was interviewed on 8/19/13 and now realized she had become distracted with events on 8/17/13 and forgot to follow through with the allegation the Activity Aide reported to her on Saturday 8/17/13.</p> <p>Continued interview with the Nurse Consultant, indicated the Nurses were instructed to assess Resident #F on 8/19/13. The Nurse Consultant indicated the resident was not interviewed until 8/20/13.</p> <p>2. When interviewed on 8/27/13 at 3:50 p.m. the facility Activity Director indicated Activity Aide #1 came to her one day and reported that she heard Activity Aide #2 yelling at residents in an activity event. The Activity Director indicated she intervened and Activity Aide #2 reported that she told the residents "you all are getting on my nerves." The Activity Director indicated she then went and asked</p>				

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	<p>the Medical Records staff member and the front desk staff member if they heard anything and they did not. The Activity Director indicated she did not recall the date this occurred on.</p> <p>When interviewed on 8/27/13 at 4:30 p.m., the Nurse Consultant indicated the Activity Director did not report the above incident to the facility Administrator on the day it occurred. The Nurse consultant indicated the Activity Director reported it at a later date when she was being interviewed by the Corporate Administrator during the investigation of an unrelated allegation of abuse filed on 8/9/13. The Nurse Consultant indicated the Activity Director had been suspended on 8/9/13 when the unrelated allegations occurred.</p> <p>When interviewed on 8/28/13 at 9:06 a.m., the Corporate Administrator indicated during the investigation of an unrelated allegation of abuse on 8/12/13 she interviewed Activity Aide #1 and the aide informed her about an occurrence that had occurred once where Activity Aide #2 raised her voice at the resident's telling them to be quiet and they were getting on her nerves. Activity Aide #1 indicated she told her Activity Director about the above on the day it occurred. The</p>				

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	<p>Administrator indicated she suspended Activity Aide #2 on 8/12/13 after the above interview with Activity Aide #1. The Administrator indicated Activity Aide #1 did not remember the day the above occurred. The Corporate Administrator indicated during her 8/12/13 interview with the Activity Director, the Activity Director informed her about Activity Aide #2 raising her voice at the residents during an activity but did not recall the date. The Administrator indicated the Activity Director should have reported the statement made by Activity Aide #2 to the Administrator on the day they occurred.</p> <p>3. An Abuse Investigation Interdisciplinary Team Review form was reviewed on 8/28/13. The form indicated an allegation of staff to resident verbal abuse was reported on 7/9/13 by Resident #R. The form also indicated the resident indicated the alleged abuse occurred on Sunday (7/7/13). The Facility Incident Reporting Form related to the above incident indicated an incident occurred on 7/9/13 on the evening shift. The form indicated the resident reported on 7/9/13 that a CNA on the Sunday evening shift was rude and refused to put her to bed. The</p>				

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	<p>Director of Nursing and the Administrator were notified at the time and the CNA was immediately suspended. The investigation included interviews from staff members. An interview written(no date noted) by LPN #1 indicated she was on her way to lunch and Resident #R asked her to put her to bed as she did not like (CNA #3's name). LPN #1's statement also indicated she rendered care to the resident and put her to bed. The statement also indicated the next day Resident #R asked her if she had told RN #5 about her having to put the resident to bed and LPN #1 stated yes she had. The resident tried to tell her something else but she could not understand her so she told the resident she would have RN #5 come and talk to her. LPN #1's statement also indicated RN #5 came and talked to the resident and RN #5 came back stating the resident stated CNA #3 was being mean to her. There was no interview with RN #5 included in the investigation.</p> <p>The record for Resident #R was reviewed on 8/28/13 at 10:55 a.m. The resident's diagnoses included, but were not limited to, dementia, joint contractors, anxiety state, and depressive disorder. The 7/19/13</p>						

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	<p>Minimum Data Set (MDS) quarterly assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (15). A score of (15) indicated the resident's cognitive patterns were intact. A Social Service Progress Notes completed on 7/10/13 at 10:04 a.m. indicated the Social worker met with the resident and the resident told her about the incident. The progress note also indicated the resident indicated she did not want the staff member to provide care to her because she "gets in her face and is rude."</p> <p>When interviewed on 8/28/13 at 1:25 p.m., RN #5 indicated she works as both a shift supervisor and also as a staff nurse. RN #5 indicated on Monday 7/8/13 Resident #R told me that LPN #1 had put her to bed yesterday and the resident also stated she did not like CNA #3's voice. RN #5 indicated she spoke with LPN #1 that same night.</p> <p>When interviewed on 8/28/13 at 1:35 p.m., LPN #1 indicated Resident #R was sitting in doorway of her room and asked her to lay her down. The LPN indicated she put the resident into bed. The LPN then indicated the next day while she was in the Dining Room, Resident #R asked her if she</p>				

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	<p>had told RN #5 that she put her into bed last night and then could not really understand what else the resident was saying and told the resident she would get RN #5 to try and understand what the resident was saying. LPN #1 indicated RN #5 came and talked with the resident and then the RN came back and indicted Resident #R had said the CNA mean. The LPN indicated this is what she thought she heard.</p> <p>When interviewed on 8/28/13 at 11:30 a.m., the Director of Nursing indicated she did not recall who first reported Resident #R's allegation to her on 7/9/13. The Director of Nursing indicated staff interviews were conducted on 7/9/13. The Director of Nursing indicated she did not interview RN #5.</p> <p>When interviewed on 8/29/13 at 8:00 a.m., the facility Nurse Consultant indicated written interviews were obtained from the Nurses involved as part of the investigation. The Nurse Consultant indicated the resident reported the allegation on 7/9/13. The Nurse Consultant indicated LPN #1's written statement did note that on 7/8/13 RN #5 said the resident told her CNA #3 had been mean to her. The Nurse Consultant indicated the</p>			

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	<p>LPN did not report on 7/8/13 when the resident indicated a staff member was mean.</p> <p>The facility policy titled "Abuse, Neglect, and Misappropriation of Resident Property" was reviewed on 8/28/13 at 11:30 a.m. The policy had a current version date of 01/2012. The policy indicated all allegations of mistreatment, neglect, or abuse were to be reported immediately to the Administrator of the facility. The policy also indicated all alleged violations were to be thoroughly investigated.</p> <p>This federal tag was cited on May 21, 2103. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>This federal tag relates to Complaints IN00133030, IN00133794, IN00134446, and IN00134487.</p> <p>3.1-28(d)</p>				

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F000226 SS=F	<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 the facility Abuse Policy was followed related to reporting of abuse allegations at the time of occurrence for 3 of 7 completed abuse investigations reviewed. (Residents #F and #R) (Activity Aide #2) (Activity Director)</p> <p>The facility also failed to follow their policy related to completing a thorough investigation related to not addressing a written statement which indicated staff were informed of the allegation prior to it being reported to the Administrator or an investigation being initiated. (Resident #R) (RN #5) (LPN #1)</p> <p>Findings include:</p> <p>1. The record for Resident #F was reviewed on 8/27/13 at 9:00 a.m. The resident's diagnoses included, but</p>	F000226	<p>F226 Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Immediate actions taken for those residents identified: The occurrence for Resident #F was reported to Indiana State Department of Health on 08/20/2013 when Administrator received notification of allegation. The occurrence for Resident #R was reported to Indiana State Department of Health on 07/10/2013 when Administrator received notification of allegation. How the facility identified other residents: All residents have the potential to be affected by this alleged deficiency. Measures put into place/ System changes: All facility personnel were provided direct and computer based re-education about facility procedures for identification and reporting of alleged violations. Completed in-servicing included</p>	09/25/2013	

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	<p>were not limited to, high blood pressure, chronic kidney disease, vascular dementia, insomnia, cognitive communication deficits, and cerebral vascular disease with hemiplegia (weakness in one side).</p> <p>An Abuse Investigation Interdisciplinary Team Review report was reviewed. The report indicated an alleged abuse occurred on 8/17/13 related to Resident #F. The report indicated the above allegation was first reported to the Quality Assurance Consultant on 8/19/13.</p> <p>An Incident Report Form was completed on 8/20/13. This was an initial and follow up report. The report indicated the Quality Assurance Consultant received the report of an allegation of abuse on 8/19/13. the report indicated Resident #F alleged a staff member was rough during care provided on 8/17/13. There was no Incident Report Form completed on 8/17/13.</p> <p>Review of the facility investigation indicated a written statement was obtained from Activity Assistant #1 on 8/19/13. The statement indicated the resident stated his left arm hurt because someone was rough with him on Saturday when girl in a</p>		<p>post test(s) demonstrating retention and understanding of facility policy; specifically Administrator is the immediate contact for reporting alleged violations. Administrator, or designee, will continue ongoing educational abuse questionnaires with personnel; presenting hypothetical situations to personnel, determining appropriate responses, and providing further re-education measures if needed. Abuse questionnaires will be completed with 5 randomly selected personnel 4x/week continuing for 4 weeks. Thereafter, conducted with 5 randomly selected personnel per week for QA monitoring as detailed in section #4 below. Administrator has amended departmental meeting head agenda to include specific questioning about any occurrences that potentially meet criteria for reporting under ISDH reporting requirements r/t abuse. This questioning will be conducted 5x/weekly.</p> <p>Administrator, or designee, will review all written witness statements (including staff and resident interviews) to determine if any further follow-up is needed related to statement. Administrator has posted direct contact number in designated areas throughout the facility; on-going educational abuse questionnaires include education about the location of these</p>	

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	<p>colored, flowered top grabbed him by the arm.</p> <p>An interview with the SSD (Social Service Director) on 8/28/13 at 8:10 a.m., indicated she was working on Saturday 8/17/13 when Activity Aide #1 reported to her that Resident #F said someone had been rough with his care and the resident did not know who the staff member was but indicated it was someone wearing a flowered top. The SSD indicated the resident was in a Church activity at the time and was seated near the front row of the activity. The SSD indicated she asked the Activity Aide how much longer the Church Activity was going to last and was told it would be about 15 minutes longer. The SSD indicated she did not assess the resident then as he was seated near the front of the activity. The SSD indicated she did not report the allegation to Nursing staff or the Administrator at the time. The SSD indicated she became involved in other events occurring in the facility and forgot to follow up with or report the allegation to the Administrator as required by the facility Abuse Policy. The SSD indicated she was aware it was her responsibility to immediately report any allegations to the Administrator and ensure an</p>		<p>designated areas. Administrator or designee will be responsible for oversight of these audit(s). How the corrective actions will be monitored: The results of these questionnaire audits will be reviewed in monthly Quality Assurance meetings monthly x3 months, then quarterly x1 for a total of 6 months. Date of compliance: September 25th, 2013</p>	

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	<p>investigation was initiated at that time to ensure the resident's safety. The SSD indicated it was on Monday afternoon on 8/19/13 when the Nurse Consultant approached her about Resident #F's allegation which occurred on 8/17/13 that she remembered she had forgotten to follow through on the allegation reported by the Activity Aide on Saturday.</p> <p>An interview 8/27/13 at 4:30 p.m., with the Nurse Consultant indicated APS (Adult Protective Services) called the facility Administrator on 8/19/13 in the afternoon regarding reports of abuse allegations in the facility. The Nurse Consultant indicated they immediately began conducting staff interviews related to the phone call the Administrator received. The Nurse Consultant indicated during the interview process Activity Aide #1 was one of the several staff members interviewed related to Abuse. During the interview Activity Aide #1 reported she had received an allegation from Resident #F on Saturday 8/17/13 and reported it to the SSD who was the Weekend Manager present at the time. The Activity Aide reported Resident #F had informed her someone had twisted his arm and she then informed the Social Worker.</p>			

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	<p>The Nurse Consultant indicated the above allegation made on 8/17/13 had not been conveyed to anyone else in management prior to 8/19/13. The Nurse Consultant indicated the SSD was interviewed on 8/19/13 and now realized she had become distracted with events on 8/17/13 and forgot to follow through with the allegation the Activity Aide reported to her on Saturday 8/17/13.</p> <p>Continued interview with the Nurse Consultant indicated the Nurses were instructed to assess Resident #F on 8/19/13. The Nurse Consultant indicated the resident was not interviewed until 8/20/13.</p> <p>2. When interviewed on 8/27/13 at 3:50 p.m. the facility Activity Director indicated Activity Aide #1 came to her one day and reported that she heard Activity Aide #2 yelling at residents in an activity event. The Activity Director indicated she intervened and Activity Aide #2 reported that she told the residents "you all are getting on my nerves." The Activity Director indicated she then went and asked the Medical Records staff member and the front desk staff member if they heard anything and they did not. The Activity Director indicated she did not recall the date this occurred on.</p>				

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	<p>When interviewed on 8/27/13 at 4:30 p.m., the Nurse Consultant indicated the Activity Director did not report the above incident to the facility Administrator on the day it occurred. The Nurse consultant indicated the Activity Director reported it at a later date when she was being interviewed by the Corporate Administrator during the investigation of an unrelated allegation of abuse filed on 8/9/13. The Nurse Consultant indicated the Activity Director had been suspended on 8/9/13 when the unrelated allegations occurred.</p> <p>When interviewed on 8/28/13 at 9:06 a.m., the Corporate Administrator indicated during the investigation of an unrelated allegation of abuse on 8/12/13 she interviewed Activity Aide #1 and the aide informed her about an occurrence that had occurred once where Activity Aide #2 raised her voice at the resident's telling them to be quiet and they were getting on her nerves. Activity Aide #1 indicated she told her Activity Director about the above on the day it occurred. The Administrator indicated she suspended Activity Aide #2 on 8/12/13 after the above interview with Activity Aide #1. The Administrator indicated Activity Aide #1 did not</p>			
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	<p>remember the day the above occurred. The Corporate Administrator indicated during her 8/12/13 interview with the Activity Director, the Activity Director informed her about Activity Aide #2 raising her voice at the residents during an activity but did not recall the date. The Administrator indicated the Activity Director should have reported the statement made by Activity Aide #2 to the Administrator on the day they occurred.</p> <p>3. An Abuse Investigation Interdisciplinary Team Review form was reviewed on 8/28/13. The form indicated an allegation of staff to resident verbal abuse was reported on 7/9/13 by Resident #R. The form also indicated the resident indicated the alleged abuse occurred on Sunday (7/7/13). The Facility Incident Reporting Form related to the above incident indicated an incident occurred on 7/9/13 on the evening shift. The form indicated the resident reported on 7/9/13 that a CNA on the Sunday evening shift was rude and refused to put her to bed. The Director of Nursing and the Administrator were notified at the time and the CNA was immediately suspended. The investigation included interviews from staff</p>			

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	<p>members. An interview written(no date noted) by LPN #1 indicated she was on her way to lunch and Resident #R asked her to put her to bed as she did not like (CNA #3's name). LPN #1's statement also indicated she rendered care to the resident and put her to bed. The statement also indicated the next day Resident #R asked her if she had told RN #5 about her having to put the resident to bed and LPN #1 stated yes she had. The resident tried to tell her something else but she could not understand her so she told the resident she would have RN #5 come and talk to her. LPN #1's statement also indicated RN #5 came and talked to the resident and RN #5 came back stating the resident stated CNA #3 was being mean to her. There was no interview with RN #5 included in the investigation.</p> <p>The record for Resident #R was reviewed on 8/28/13 at 10:55 a.m. The resident's diagnoses included, but were not limited to, dementia, joint contractors, anxiety state, and depressive disorder. The 7/19/13 Minimum Data Set (MDS) quarterly assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (15). A score of (15) indicated the resident's cognitive</p>						

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	<p>patterns were intact. A Social Service Progress Notes completed on 7/10/13 at 10:04 a.m. indicated the Social worker met with the resident and the resident told her about the incident. The progress note also indicated the resident indicated she did not want the staff member to provide care to her because she "gets in her face and is rude."</p> <p>When interviewed on 8/28/13 at 1:25 p.m., RN #5 indicated she works as both a shift supervisor and also as a staff nurse. RN #5 indicated on Monday 7/8/13 Resident #R told me that LPN #1 had put her to bed yesterday and the resident also stated she did not like CNA #3's voice. RN #5 indicated she spoke with LPN #1 that same night.</p> <p>When interviewed on 8/28/13 at 1:35 p.m., LPN #1 indicated Resident #R was sitting in doorway of her room and asked her to lay her down. The LPN indicated she put the resident into bed. The LPN then indicated the next day while she was in the Dining Room, Resident #R asked her if she had told RN #5 that she put her into bed last night and then could not really understand what else the resident was saying and told the resident she would get RN #5 to try</p>			

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	<p>and understand what the resident was saying. LPN #1 indicated RN #5 came and talked with the resident and then the RN came back and indicted Resident #R had said the CNA mean. The LPN indicated this is what she thought she heard.</p> <p>When interviewed on 8/28/13 at 11:30 a.m., the Director of Nursing indicated she did not recall who first reported Resident #R's allegation to her on 7/9/13. The Director of Nursing indicated staff interviews were conducted on 7/9/13. The Director of Nursing indicated she did not interview RN #5.</p> <p>When interviewed on 82/9/13 at 8:00 a.m., the facility Nurse Consultant indicated written interviews were obtained from the Nurses involved as part of the investigation. The Nurse Consultant indicated the resident reported the allegation on 7/9/13. The Nurse Consultant indicated LPN #1's written statement did note that on 7/8/13 RN #5 said the resident told her CNA #3 had been mean to her. The Nurse Consultant indicated the LPN did not report on 7/8/13 when the resident indicated a staff member was mean.</p> <p>The facility policy titled "Abuse,</p>						

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	<p>Neglect, and Misappropriation of Resident Property" was reviewed on 8/28/13 at 11:30 a.m. The policy had a current version date of 01/2012. The policy indicated all allegations of mistreatment, neglect, or abuse were to be reported immediately to the Administrator of the facility. The policy also indicated all alleged violations were to be thoroughly investigated.</p> <p>This federal tag was cited on May 21, 2103. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>This federal tag relates to Complaints IN00133030, IN00133794, IN00134446, and IN00134487.</p> <p>3.1-28(d)</p>			

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