

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155794	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/15/2014
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NAME OF PROVIDER OR SUPPLIER  STRATFORD RETIREMENT LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2460 GLEBE ST CARMEL, IN 46032
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R000000	<p>This visit was for the Investigation of Complaint IN00147279.</p> <p>Complaint IN00147279 Substantiated. State deficiencies related to the allegations are cited at R0036, R0051, R0052, R0090, R0214 and R240.</p> <p>Survey Dates: May 14, &amp; 15, 2014</p> <p>Facility number: 011151 Provider number: 155794 AIM number: NA</p> <p>Survey Team: Mary Jane G. Fischer RN</p> <p>Census bed type: SNF: 12 Residential: 26 Total: 38</p> <p>Census payor type: Medicare: 9 Other: 29 Total: 38</p> <p>Sample: 7</p> <p>These State findings are cited in accordance with 410 IAC 16.2-5.</p>	R000000		

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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R000036	<p>Quality Review was completed by Tammy Alley RN on May 19, 2014.</p> <p>410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on record review and interview the facility failed to ensure a concerned family member was notified in that when a cognitively impaired resident was subjected to sexual abuse, the facility failed to ensure the family member was notified of the occurrence. (Residents "B" and "C").</p> <p>Findings include:</p> <p>1. The record for Resident "B" was reviewed on 05-14-14 at 10:45 a.m. Diagnoses included, but were not limited to, severe dementia with periods of agitation, hypertension and depression.</p>	R000036	<p><b><u>What corrective action will be taken by the facility?</u></b></p> <p>Education will be provided to nurses, QMAs and Social Services by June 6th, 2014 regarding the notification of the resident's physician and resident's legal representative when the facility has noticed: 1) a significant decline in the resident's physical, mental, or psychosocial status; or 2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. All active</p>	06/06/2014	

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	<p>These diagnoses remained current at the time of the record review.</p> <p>A review of the "Interdisciplinary Progress Notes," dated 09-17-13 indicated the following documentation by the Social Service Director: "09-17-13 - New behavior - Staff reported to writer this resident was observed in a female resident's [Resident "C"] room &lt;sic&gt; stand close to her with his pants down. Resident female was in a recliner in front of him. When staff member knocked to enter room this resident pulled up his pants and turned to zip pants. Writer and Resident Coord. [coordinator] met with resident after being informed by staff. Resident was found relaxing in his room alone. Resident was able to talk about a lady in the room at the "T" [in reference to the unit layout] the short side of the "T" he said. When asked if he was in her room he said yes he was visiting her. He was encouraged not to go into her room. Writer and Resident Care Director left the room. Writer remained on the unit this resident came out his room and went to the same female resident's room again. Staff was instructed to monitor his whereabouts and 1:1 were put in place. Resident was observed talking to resident and was redirected to exit her room. Res. [Resident] did exit female residents</p>		<p>resident records have been audited for notification deficiencies.</p> <p><b><u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></b></p> <p>All residents on the Memory Care Unit have the potential to be affected by the alleged practice. Nurses, QMAs and Social Services will be educated on the notification process by June 6th, 2014.</p> <p><b><u>What measures will be put into place to ensure the practice does not recur?</u></b></p> <p>RCD or DON will conduct daily audits Monday thru Friday and the Charge Nurse will audit Saturday and Sunday for family and MD notification regarding incidents and change in condition. The RCD or DON will bring any identified issues to the next morning management interdisciplinary meeting for review and recommendations for follow-up. The 7 day audit process will occur for 3 months beginning June 9th, 2014. Following the completion of the 3 month period, the charts will be audited 5 times per week on an ongoing basis.</p> <p><b><u>How will the corrective action be monitored to ensure the deficient practice does not recur and what</u></b></p>	

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	<p>room."</p> <p>A review of the Nurses Notes, indicated following: "09-23-13 at 0645 [6:45 a.m.] - Received in report resident was found in female peer's [Resident "C"] room in bedroom. Female's shirt was unbuttoned and this resident was touching her breast. Staff was able to immediately redirect this resident out of her room and took him into his own room. Staff checked on resident '5 minutes later' and resident was again in the female peer's room. Shirt of female resident was again unbuttoned. This resident's pants were reported to be down with penis in hands of female peer. When approached by staff to redirect, this resident became agitated &lt;sic&gt; and pushed back staff. Two staff members were required to convince this resident to leave the situation. [Spouse] notified. M.D. [Medical Doctor] notified. Social Services notified. Staff performed one on one with this resident the rest of the day. These events transpired prior to this writer's arrival, but were recounted by CNA [certified nurses aide] nursing staff."</p> <p>A review of the "Interdisciplinary Progress Notes," dated 09-23-13 indicated the following documentation by the Social Service Director:</p>		<p><b><u>QA will be put into place?</u></b></p> <p>The RCD will bring the results of the reviews to the monthly QA Committee meeting for review and recommendations. Any recommendations made by the committee will be followed up by the RCD and the results will be brought to the next scheduled QA Committee meeting. The 7 day audit will be monitored for 3 months beginning June 9th, 2014 and then 5 times per week thereafter on an ongoing basis.</p>	

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	<p>"Notified by Resident Coord. Director of resident being found in female residents room with her shirt unbuttoned and he was observed touching the female residents breast. Resident was directed to exit room by the staff. Staff reports resident was found again in the same female residents room, just minutes after asking him to leave the room. Resident was observed by the staff to have his pants down and his penis was in the hand of the female. Staff immediately redirected resident and staff reported he became combative with the staff by pushing them. M.D. and [spouse of Resident "B"] notified. M.D. gave verbal order to DC [discharge] to psych. [psychiatric] hospital for eval. [evaluation]."</p> <p>The resident returned to the facility on 10-01-13 from the local area hospital.</p> <p>The resident was then followed by a local psychiatrist while at the facility.</p> <p>During an interview on 05-14-14 at 10:15 a.m. the Director of Nurses confirmed there occurred sexual behavior by Resident "B" towards another cognitively impaired resident. "It was consensual."</p> <p>The record for Resident "C" was reviewed on 05-14-14 at 12:00 p.m. The</p>			

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	<p>resident's record lacked documentation of the events with Resident "B," any interventions to protect the resident and lack of documentation Resident "C" family members were notified of the inappropriate sexual encounter.</p> <p>2. A review of the facility policy on 05-15-14 at 8:50 a.m., titled "Change of Condition; Resident," and dated 11-2011 indicated the following:</p> <p>"Policy Overview: It is the policy of Senior Living Communities to respond appropriately to resident changes in condition and update the resident's plan of care as needed."</p> <p>"Policy Detail: Change of Condition is defined as such: Any deviation from a resident's prior physical, emotional, behavioral or medical condition. This definition has no time period noted."</p> <p>"Staff members that notice a change in condition should immediately notify the Healthcare Administrator, Resident Care Director, Nurse or Supervisor in Charge. If the Resident's safety is in jeopardy, precautions to ensure they are safe should take precedence."</p> <p>"If upon evaluation it is noted that the resident's condition has changed, the staff</p>				

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R000051	<p>should notify the resident's physician, the resident's family and/or 911 if necessary.</p> <p>3. A review of the Facility Abuse Prohibition policy on 05-15-14 at 8:50 a.m., and dated 11-01-12 indicated the following: "Policy - Senior Living Communities will prohibit abuse, neglect, involuntary seclusion and misappropriation of property for all resident through the following: Prevention of occurrences; identification of possible incidents or allegations which need investigation; investigations of incidents and allegations, protection of residents during investigations; and reporting of incidents, investigations and Center response to the results of their investigations."</p> <p>"All reports of suspected abuse must also be reported to the resident's family and attending physician."</p> <p>This State finding relates to Complaint IN00147279.</p> <p>410 IAC 16.2-5-1.2(u) Residents' Rights - Offense (u) Residents have the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident ' s medical symptoms.</p>						

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	<p>Based on observation, record review and interview the facility failed to ensure residents were free from restraints, in that the facility nursing staff failed to ensure the resident's were not locked in their rooms, for protection from another cognitively impaired dementia resident, and staff convenience in regard to the supervision of Resident "B." This deficient practice affected 4 of 7 sampled resident's. (Resident's "A", "B", "C", and "F").</p> <p>Findings include:</p> <p>1. The record for Resident "B" was reviewed on 05-14-14 at 10:45 a.m. Diagnoses included, but were not limited to, severe dementia with periods of agitation, hypertension and depression. These diagnoses remained current at the time of the record review.</p> <p>A review of the "Interdisciplinary Progress Notes," dated 09-17-13 indicated the following documentation by the Social Service Director: "09-17-13 - New behavior - Staff reported to writer this resident was observed in a female resident's [Resident "C"] room &lt;sic&gt; stand close to her with his pants down. Resident female was in a recliner in front of him. When staff member knocked to enter room this</p>	R000051	<p><b><u>What corrective action will be taken by the facility?</u></b> The individual apartment locks on the Memory Care Unit have been removed. Both residents involved in the incident have been discharged. Staff will be educated on the removal of the locks by June 6th, 2014. The residents and family members were notified in writing of the lock removal on June 3rd, 2014. <b><u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></b> All residents on the Memory Care Unit have the potential to be affected by the alleged practice. All individual apartment locks on the Memory Care Unit have been removed and the staff will be educated by June 6th, 2014. <b><u>What measures will be put into place to ensure the practice does not recur?</u></b> Individual apartment locks on the Memory Care Unit have been removed. Daily rounds will be made by the RCD to ensure that locks have not been placed on active resident doors. The RCD or DON will bring any identified issues to the next morning management interdisciplinary meeting for review and recommendations for follow-up. Daily rounds will be conducted on an ongoing basis. <b><u>How will the corrective action be monitored to ensure the deficient practice does not</u></b></p>	06/06/2014			

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	<p>resident pulled up his pants and turned to zip pants. Writer and Resident Coord. [coordinator] met with resident after being informed by staff. Resident was found relaxing in his room alone. Resident was able to talk about a lady in the room at the "T" [in reference to the unit layout] the short side of the "T" he said. When asked if he was in her room he said yes he was visiting her. He was encouraged not to go into her room. Writer and Resident Care Director left the room. Writer remained on the unit this resident came out his room and went to the same female resident's room again. Staff was instructed to monitor his whereabouts and 1:1 were put in place. Resident was observed talking to resident and was redirected to exit her room. Res. [Resident] did exit female residents room."</p> <p>A review of the Nurses Notes, indicated following: "09-23-13 at 0645 [6:45 a.m.] - Received in report resident was found in female peer's room in bedroom. Female's shirt was unbuttoned and this resident was touching her breast. Staff was able to immediately redirect this resident out of her room and took him into his own room. Staff checked on resident '5 minutes later' and resident was again in the female peer's room. Shirt of female</p>		<p><b><u>recur and what QA will be put into place?</u></b> Locks have been permanently removed from the doors on the Memory Care Unit. This new protocol will be brought to the next scheduled QA Committee meeting in June 2014. Monitoring will occur on an ongoing basis and any discrepancies will be brought to the monthly QA meetings.</p>				

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	<p>resident was again unbuttoned. This resident's pants were reported to be down with penis in hands of female peer. When approached by staff to redirect, this resident became aggitated &lt;sic&gt; and pushed back staff. Two staff members were required to convince this resident to leave the situation. [Spouse] notified. M.D. [Medical Doctor] notified. Social Services notified. Staff performed one on one with this resident the rest of the day. These events transpired prior to this writer's arrival, but were recounted by CNA [certified nurses aide] nursing staff."</p> <p>A review of the "Interdisciplinary Progress Notes," dated 09-23-13 indicated the following documentation by the Social Service Director: "Notified by Resident Coord. Director of resident being found in female residents room with her shirt unbuttoned and he was observed touching the female residents breast. Resident was directed to exit room by the staff. Staff reports resident was found again in the same female residents room, just minutes after asking him to leave the room. Resident was observed by the staff to have his pants down and his penis was in the hand of the female. Staff immediately redirected resident and staff reported he became combative with the staff by</p>			

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	<p>pushing them. M.D. [Medical Doctor] and [spouse] notified. M.D. gave verbal order to DC [discharge] to psych. [psychiatric] hospital for eval. [evaluation]."</p> <p>A review of the hospital "History and Physical," dictated 09-24-13 indicated the following:</p> <p>"[Resident] was admitted because of a one to two week history of increasing disinhibited behavior including inappropriate sexual behavior. Chief Complaint: Sexual aggression and disinhibited behavior. History of illness: He exposed himself to another resident on the locked unit. He tried to touch a staff member's bottom and another staff member's breast. Yesterday morning he gain &lt;sic&gt; exposed himself and tried to touch another peer inappropriately. He was combative with staff when they attempted to redirect him. Mental status: Thought processes are confused and he tries to cover for his deficits. Judgement and insight are both impaired. Memory is impaired. he is oriented only to person. He scored 13 out of 30 on the mini mental status exam consistent with a fairly significant level of cognitive impairment. Limitations include progressive memory loss."</p>			

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	<p>The resident returned to the facility on 10-01-13.</p> <p>2. During an interview on 05-15-14 at 10:30 a.m., a concerned family member indicated she went to visit her mother (Resident "A") one evening and could her her mother screaming. She immediately went to her mothers room where she found the door locked. She immediately summoned a CNA to open the door. The CNA did not have the key and had to summon another staff member for assistance. During this time the resident continued screaming. Upon opening the door, Resident "B" was found next to the resident who was seated in her recliner. "My mother was extremely afraid of him. I don't know how they didn't hear mother screaming and when she went to find out what was going on, she couldn't open the door and had to get someone to open it for her. She saw [name of Resident "B"] "in my mother's room again."</p> <p>A review of the family members Grievance Form on 05-14-14 at 10:00 a.m., and dated 03-02-14 indicated the following: When I arrived on Tuesday [02-25-14] evening I entered through side door. My mom was screaming in her room and I heard her as soon as I entered. The door was locked and as I was walking down hallway 2 staff members</p>			

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	<p>were approaching. They heard the door beep and were coming down as they thought a resident was escaping. (They did not come down because of screaming). The door was unlocked and a resident [Resident "B"] was inside my mom's room with the door locked. He terrorized my mom. There was a meeting about the doors and the behaviors of [Resident "B"]. The way they were going to fix the problem was to lock my mother in her room."</p> <p>3. During interview on 05-14-14 at 11:40 a.m. CNA # 6 indicated Resident "F" was "sick." During observation, the door to the resident's room was closed. When interviewed if we could enter the resident's room to check on her, the CNA agreed. As the CNA turned the door knob, it was noticed that the door to the resident's room was locked. The CNA took her key, and opened the resident's door. The resident was observed laying in bed and indicated she "didn't feel well today." The CNA indicated the resident had not gotten up for breakfast and told her that she was in pain. When interviewed about how the door got locked if the resident had not gotten out of bed, the CNA indicated she didn't know, but "sometimes if we don't make sure the button isn't pushed in - it will automatically lock."</p>			

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R000052	<p>During observation on 05-14-14 at 11:50 a.m., with CNA #6 in attendance, all resident rooms had latches which did have locks/buttons on the inside handle.</p> <p>During further interview on 05-14-14 at 1:30 p.m. CNA #6 indicated "When [name of Resident "B"] was here and after we got the ladies to bed I would lock their doors to make sure he didn't get in there at them."</p> <p>This State finding relates to Complaint IN00147279.</p> <p>410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion.</p> <p>Based on record review and interview the facility failed to ensure residents were not subjected to threats of physical abuse and actual sexual abuse, in that when residents were diagnosed with Alzheimer's dementia and had been assessed with targeted behaviors which included agitation, aggression, showing a fist in a threatening manner to another</p>	R000052	<p><b><u>What corrective action will be taken by the facility?</u></b></p> <p>All Memory Care Unit resident charts were audited for history of or potential for sexually inappropriate behavior. The resident initiating the sexual contact has been discharged. Our immediate intervention involved sending the sexually inappropriate resident to a</p>	06/06/2014

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	<p>residents with dementia, and entering other resident rooms, the nursing staff failed to ensure other residents were protected and not subjected to the aggression other Resident's. This deficient practice affected 7 of 7 sampled residents. (Residents "B", "C", "A", "G", "F", "D" and "E")</p> <p>Findings include:</p> <p>1. The record for Resident "B" was reviewed on 05-14-14 at 10:45 a.m. Diagnoses included, but were not limited to, severe dementia with periods of agitation, hypertension and depression. These diagnoses remained current at the time of the record review.</p> <p>A review of the "Interdisciplinary Progress Notes," dated 09-17-13 indicated the following documentation by the Social Service Director: "09-17-13 - New behavior - Staff reported to writer this resident was observed in a female resident's [Resident "C"] room &lt;sic&gt; stand close to her with his pants down. Resident female was in a recliner in front of him. When staff member knocked to enter room this resident pulled up his pants and turned to zip pants. Writer and Resident Coord. [coordinator] met with resident after being informed by staff. Resident was</p>		<p>psychiatric facility on 9/23/13 which was the day of the incident. All healthcare staff will be educated on the importance of noticing, preventing and reporting abuse including sexual interaction between residents on the Memory Care Unit by June 6th, 2014.</p> <p><b><u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></b></p> <p>All residents on the Memory Care Unit have the potential to be affected by the alleged practice. Current resident charts have been reviewed for history of or potential for sexually inappropriate behavior. None of these behaviors were identified in the resident records.</p> <p><b><u>What measures will be put into place to ensure the practice does not recur?</u></b></p> <p>RCD or DON will audit the 24 hour report daily Monday thru Friday and the Charge Nurse will audit Saturday and Sundays for reports of abuse between residents to ensure that residents are free from abuse. All new hires will be educated during general orientation and then annually thereafter. The RCD or DON will bring any identified issues to the next morning management interdisciplinary meeting for review and recommendations for follow-up. The 7 day audit will be monitored for 3 months and 5 times per week on an ongoing basis</p>				

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	<p>found relaxing in his room alone. Resident was able to talk about a lady in the room at the "T" [in reference to the unit layout] the short side of the "T" he said. When asked if he was in her room he said yes he was visiting her. He was encouraged not to go into her room. Writer and Resident Care Director left the room. Writer remained on the unit this resident came out his room and went to the same female resident's room again. Staff was instructed to monitor his whereabouts and 1:1 were put in place. Resident was observed talking to resident and was redirected to exit her room. Res. [Resident] did exit female residents room."</p> <p>A review of the Nurses Notes, indicated following: "09-23-13 at 0645 [6:45 a.m.] - Received in report resident was found in female peer's room in bedroom. Female's shirt was unbuttoned and this resident was touching her breast. Staff was able to immediately redirect this resident out of her room and took him into his own room. Staff checked on resident '5 minutes later' and resident was again in the female peer's room. Shirt of female resident was again unbuttoned. This resident's pants were reported to be down with penis in hands of female peer. When approached by staff to redirect, this</p>		<p>beginning June 9th, 2014. <b><u>How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></b> The RCD will bring the results of the reviews to the monthly QA Committee meeting for review and recommendations. Any recommendations made by the committee will be followed up by the RCD and the results will be brought to the next scheduled QA Committee meeting. The 7 day audit will be monitored for 3 months and then 5 times per week on an ongoing basis beginning June 9th, 2014. Monitoring will occur on an ongoing basis and any discrepancies will be brought to the monthly QA meetings.</p>				

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	<p>resident became aggitated &lt;sic&gt; and pushed back staff. Two staff members were required to convince this resident to leave the situation. [Spouse] notified. M.D. [Medical Doctor] notified. Social Services notified. Staff performed one on one with this resident the rest of the day. These events transpired prior to this writer's arrival, but were recounted by CNA [certified nurses aide] nursing staff."</p> <p>A review of the "Interdisciplinary Progress Notes," dated 09-23-13 indicated the following documentation by the Social Service Director: "Notified by Resident Coord. Director of resident being found in female residents room with her shirt unbuttoned and he was observed touching the female residents breast. Resident was directed to exit room by the staff. Staff reports resident was found again in the same female residents room, just minutes after asking him to leave the room. Resident was observed by the staff to have his pants down and his penis was in the hand of the female. Staff immediately redirected resident and staff reported he became combative with the staff by pushing them. M.D. and [spouse] notified. M.D. gave verbal order to DC [discharge] to psych. [psychiatric] hospital for eval. [evaluation]."</p>			

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	<p>A review of the hospital "History and Physical," dictated 09-24-13 indicated the following:</p> <p>"[Resident] was admitted because of a one to two week history of increasing disinhibited behavior including inappropriate sexual behavior. Chief Complaint: Sexual aggression and disinhibited behavior. History of illness: He exposed himself to another resident on the locked unit. He tried to touch a staff member's bottom and another staff member's breast. Yesterday morning he gain &lt;sic&gt; exposed himself and tried to touch another peer inappropriately. He was combative with staff when they attempted to redirect him. Mental status: Thought processes are confused and he tries to cover for his deficits. Judgement and insight are both impaired. Memory is impaired. he is oriented only to person. He scored 13 out of 30 on the mini mental status exam consistent with a fairly significant level of cognitive impairment. Limitations include progressive memory loss."</p> <p>The resident returned to the facility on 10-01-13.</p> <p>The resident was then followed by a local psychiatrist while at the facility.</p>			
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	<p>During an interview on 05-14-14 at 10:15 a.m. the Director of Nurses confirmed there occurred sexual behavior by Resident "B" towards another cognitively impaired resident. "It was consensual."</p> <p>A review of the 11-21-13 psychiatric notation indicated the following: "SSD [Social Service Director] reports the following recent behavior issues with resident: He hit a resident on the head with newspaper and was easily redirected, he tried to pull a wheelchair bound resident out of her wheelchair to try to get her to stand up, he had picked up a walker that a female peer had kicked over and he was shaking the walker but did not hit resident, he was again redirectable for these behaviors. SSD reports resident fixates on his roommates wife and will pick her up off the floor when ever he sees her, causing anxiety in roommate's wife. SSD reports resident patted a female CNA on the bottom last night."</p> <p>A subsequent notation by the psychiatrist, dated 12-23-13 indicated "Staff report at times resident becomes easily agitated, one episode last week when he raised his fist toward staff but did not hit. Staff report he had become upset when he was separated from pushing a wheelchair</p>			

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	<p>bound female resident around."</p> <p>A review of the most recent "Resident Assessment Form," dated 12-16-13 lacked any updated interventions under the section of "Cognitive Capabilities" which indicated the resident continued to wander "frequently and indiscriminately. May wander at night, in addition to severe impairment most of the time with "Time/Place Orientation," demonstrating "poor judgement and required behavioral management with potentially disruptive and dangerous to self and/or others."</p> <p>During an interview on 05-15-14 at 10:30 a.m., a concerned family member indicated she went to visit her mother (Resident "A") one evening and could her her mother screaming. She immediately went to her mothers room where she found the door locked. She immediately summoned a CNA to open the door. The CNA did not have the key and had to summon another staff member for assistance. During this time the resident continued screaming. Upon opening the door, Resident "B" was found next to the resident who was seated in her recliner. "My mother was extremely afraid of him. I don't know how they could have allowed him to get in there at her. Where were they ? Another family member told me that when she was visiting one</p>				

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	<p>evening she could again hear my mother screaming and when she when to find out what was going on, she couldn't open the door and had to get someone to open it for her. She saw [name of Resident "B"] in my mother's room again."</p> <p>A review of the family members Grievance form on 05-14-14 at 10:00 a.m., and dated 03-02-14 indicated the following: When I arrived on Tuesday [02-25-14] evening I entered through side door. My mom was screaming in her room and I heard her as soon as I entered. The door was locked and as I was walking down hallway 2 staff members were approaching. They heard the door beep and were coming down as they thought a resident was escaping. (They did not come down because of screaming). The door was unlocked and a resident [Resident "B"] was inside my mom's room with the door locked. My mom was terrified."</p> <p>2. The record for Resident "G" was reviewed on 05-15-14 at 11:20 a.m. Diagnoses included, but were not limited to, Alzheimer's dementia, memory lapse and osteoporosis. These diagnoses remained current at the time of the record review.</p> <p>A review of the Nurse's notes, dated</p>						

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	<p>04-19-14 indicated "Resident punched [Resident "F"] in the face. Right side at about 3:00 p.m." Resident "F" record indicated the resident "did not provoke the other one [Resident "G"] involved."</p> <p>A review of the facility reportable to the Indiana State Department of Health, dated 04-19-14 as the follow up report, indicated the following: [Resident "G"] and [Resident "F"] were participating in an activity together with a staff member, when [Resident "G"] got up from the table and tried to push [Resident "F"] wheelchair from the table. Staff member intervened, but was not able to separate the residents prior to [Resident "G"] striking [Resident "F"] on the right side of the face."</p> <p>3. The record for Resident "D" was reviewed on 05-04-14 at 2:15 p.m. Diagnosis included, but were not limited to, Alzheimer's disease. This diagnosis remained current at the time of the record review.</p> <p>The Nurses Notes dated, 01-24-14 at 3:30 p.m. indicated "Writer notified that CNA [certified nurses aide] attempted to push in res. [resident] chair at lunch to table. Res. became upset got up from chair et [and] started swinging at staff. Male peer [Resident "E"] got up from table and</p>						

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R000090	<p>walked towards res. Resident hit male peer [Resident "E"] in stomach twice." The Nurses Notes for Resident "E", reviewed on 05-14-14 at 2:40 p.m., indicated the resident stated, "He got me twice."</p> <p>4. A review of the Facility Abuse Prohibition policy on 05-15-14 at 8:50 a.m., and dated 11-01-12 indicated the following: "Policy - Senior Living Communities will prohibit abuse, neglect, involuntary seclusion and misappropriation of property for all resident through the following: Prevention of occurrences; identification of possible incidents or allegations which need investigation; investigations of incidents and allegations, protection of residents during investigations; and reporting of incidents, investigations and Center response to the results of their investigations."</p> <p>This State finding relates to Complaint IN00147279.</p> <p>410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following:</p>						

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	<p>(1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to:</p> <p>(A) epidemic outbreaks; (B) poisonings; (C) fires; or (D) major accidents.</p> <p>If the division cannot be reached, a call shall be made to the emergency telephone number published by the division.</p> <p>(2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative.</p> <p>(3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility.</p> <p>(4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the:</p> <p>(A) employee's full name; and (B) dates and hours worked during the past twelve (12) months.</p> <p>(5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability.</p> <p>(6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports</p>			

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	<p>available for inspection to any member of the public upon request</p> <p>Based on record review and interview the facility failed to inform the Indiana State Department of Health of an unusual occurrence, in that when a cognitively impaired resident displayed sexual behaviors to another resident with impaired cognition, the Administrator did not report the occurrence for 1 of 1 sampled residents who displayed sexual behaviors to another resident. This deficient practice had the potential to affect all female residents who resided on the secured dementia unit. (Resident "B").</p> <p>Findings include:</p> <p>The record for Resident "B" was reviewed on 05-14-14 at 10:45 a.m. Diagnoses included, but were not limited to, severe dementia with periods of agitation, hypertension and depression. These diagnoses remained current at the time of the record review.</p> <p>A review of the "Interdisciplinary Progress Notes," dated 09-17-13 indicated the following documentation by the Social Service Director: "09-17-13 - New behavior - Staff reported to writer this resident was observed in a female resident's room</p>	R000090	<p><b><u>What corrective action will be taken by the facility?</u></b> All charts will be audited to ensure that no further reportable incidents have occurred without being reported to the State. All Healthcare staff will be educated to notify the Administrator of any reportable incident as defined in the ISDH regulations by June 6th, 2014. All future incidents identified as reportable will be reported to the ISDH within the documented time guidelines. <b><u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></b> All residents on the Memory Care Unit have the potential to be affected by the alleged practice. All healthcare staff will be educated to notify the administrator of any reportable incident as defined in the ISDH regulations by June 6th, 2014. <b><u>What measures will be put into place to ensure the practice does not recur?</u></b> RCD or DON will audit the 24 hour report daily Monday thru Friday and the Charge Nurse will audit Saturday and Sunday to ensure all reportable events have been reported to the Administrator. All new hires will be educated during general orientation and then annually thereafter. The RCD or DON will bring any identified issues to the next morning</p>	06/06/2014

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	<p>&lt;sic&gt; stand close to her with his pants down. Resident female was in a recliner in front of him. When staff member knocked to enter room this resident pulled up his pants and turned to zip pants. Writer and Resident Coord. [coordinator] met with resident after being informed by staff. Resident was found relaxing in his room alone. Resident was able to talk about a lady in the room at the "T" [in reference to the unit layout] the short side of the "T" he said. When asked if he was in her room he said yes he was visiting her. He was encouraged not to go into her room. Writer and Resident Care Director left the room. Writer remained on the unit this resident came out his room and went to the same female resident's room again. Staff was instructed to monitor his whereabouts and 1:1 were put in place. Resident was observed talking to resident and was redirected to exit her room. Res. [Resident] did exit female residents room."</p> <p>A review of the Nurses Notes, indicated following: "09-23-13 at 0645 [6:45 a.m.] - Received in report resident was found in female peer's room in bedroom. Female's shirt was unbuttoned and this resident was touching her breast. Staff was able to immediately redirect this resident out of</p>		<p>management interdisciplinary meeting for review and recommendations for follow-up. The 7 day audit will be monitored for 3 months beginning June 9th, 2014. Following the completion of the 3 month period, the charts will be audited 5 times per week on an ongoing basis. <u>How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The RCD will bring the results of the reviews to the monthly QA Committee meeting for review and recommendations. Any recommendations made by the committee will be followed up by the RCD and the results will be brought to the next scheduled QA Committee meeting. Monitoring will occur on an ongoing basis and any discrepancies will be brought to the monthly QA meetings.</p>				

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	<p>her room and took him into his own room. Staff checked on resident '5 minutes later' and resident was again in the female peer's room. Shirt of female resident was again unbuttoned. This resident's pants were reported to be down with penis in hands of female peer. When approached by staff to redirect, this resident became aggitated &lt;sic&gt; and pushed back staff. Two staff members were required to convince this resident to leave the situation. [Spouse] notified. M.D. [Medical Doctor] notified. Social Services notified. Staff performed one on one with this resident the rest of the day. These events transpired prior to this writer's arrival, but were recounted by CNA [certified nurses aide] nursing staff."</p> <p>A review of the "Interdisciplinary Progress Notes," dated 09-23-13 indicated the following documentation by the Social Service Director: "Notified by Resident Coord. Director of resident being found in female residents room with her shirt unbuttoned and he was observed touching the female residents breast. Resident was directed to exit room by the staff. Staff reports resident was found again in the same female residents room, just minutes after asking him to leave the room. Resident was observed by the staff to have his</p>						

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	<p>pants down and his penis was in the hand of the female. Staff immediately redirected resident and staff reported he became combative with the staff by pushing them. M.D. and [spouse] notified. M.D. gave verbal order to DC [discharge] to psych. [psychiatric] hospital for eval. [evaluation]."</p> <p>During an interview on 05-14-14 at 10:15 a.m. the Director of Nurses confirmed there occurred sexual behavior by Resident "A" towards another cognitively impaired resident. "It was consensual."</p> <p>When interviewed on 05-14-14 at 3:00 p.m., the Administrator indicated the incident was not investigated nor did she report the incident to the Indiana State Department of Health.</p> <p>A review of the facility policy on 05-15-14 at 8:50 a.m., titled "Abuse Prohibition," and dated 11-01-12, indicated the following:</p> <p>"Policy - Senior Living Communities will prohibit abuse, neglect, involuntary seclusion and misappropriation of property for all resident through the following: Prevention of occurrences; identification of possible incidents or allegations which need investigation; investigations of incidents and</p>						

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R000214	<p>allegations, protection of residents during investigations; and reporting of incidents, investigations and Center response to the results of their investigations."</p> <p>"Process - 6. Upon receiving information concerning a report of suspected or alleged abuse, neglect, or misappropriation of Member/Resident property, the Administrator or designee will: Report via fax [facsimile] or e-mail to the appropriate state specific regulatory department as the 24 hour report. 8. The Administrator or designee will ensure report findings are printed or typed and postmarked to the state specific regulatory department within five working days of the submission of the Initial 24 hour report and take all necessary, corrective action depending on the results of the investigation."</p> <p>This State finding relates to Complaint IN00147279.</p> <p>410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to</p>						

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	<p>admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident.</p> <p>Based on record review and interview the facility failed to ensure a resident's evaluation was updated, in that when residents who had sexual behaviors and aggressive behaviors, the facility staff failed to update the residents assessment and individual care plan evaluation to reflect the resident's current needs and interventions and recommendation by the psychiatrist for 2 of 3 resident's with behaviors in a sample of 7. (Resident "B" and "G").</p> <p>Findings include:</p> <p>1. The record for Resident "B" was reviewed on 05-14-14 at 10:45 a.m. Diagnoses included, but were not limited to, severe dementia with periods of agitation, hypertension and depression. These diagnoses remained current at the time of the record review.</p> <p>A review of the "Interdisciplinary Progress Notes," dated 09-17-13 indicated the following documentation by the Social Service Director: "09-17-13 - New behavior - Staff reported to writer this resident was</p>	R000214	<p><b><u>What corrective action will be taken by the facility?</u></b></p> <p>All charts will be reviewed to ensure that the care plan includes behaviors. All identified behaviors will be added to the care plans and the staff assignment sheets will be updated to reflect these behaviors. Nursing staff and Social Services will be educated to update care plans to include all behaviors by June 6th, 2014.</p> <p><b><u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></b></p> <p>All residents on the Memory Care Unit have the potential to be affected by the alleged practice. Education will be provided to Nursing and Social Services to update care plans with any reported behaviors by June 6th, 2014.</p> <p><b><u>What measures will be put into place to ensure the practice does not recur?</u></b></p> <p>All care plans were audited by</p>	06/06/2014

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	<p>observed in a female resident's [Resident "C"] room &lt;sic&gt; stand close to her with his pants down. Resident female was in a recliner in front of him. When staff member knocked to enter room this resident pulled up his pants and turned to zip pants. Writer and Resident Coord. [coordinator] met with resident after being informed by staff. Resident was found relaxing in his room alone. Resident was able to talk about a lady in the room at the "T" [in reference to the unit layout] the short side of the "T" he said. When asked if he was in her room he said yes he was visiting her. He was encouraged not to go into her room. Writer and Resident Care Director left the room. Writer remained on the unit this resident came out his room and went to the same female resident's room again. Staff was instructed to monitor his where abouts and 1:1 were put in place. Resident was observed talking to resident and was redirected to exit her room. Res. [Resident] did exit female residents room."</p> <p>A review of the Nurses Notes, indicated following: "09-23-13 at 0645 [6:45 a.m.] - Received in report resident was found in female peer's room in bedroom. Female's shirt was unbuttoned and this resident was touching her breast. Staff was able to</p>		<p>5/27/14 to ensure that all behaviors have been added to the Care Plans and assignment sheets. The 24 hour report will be audited daily Monday thru Friday by the RCD or DON to ensure new behaviors are added to care plans and assignment sheet. The Charge Nurse will audit Saturdays and Sundays. The RCD will bring any identified issues to the next morning management interdisciplinary meeting for review and recommendations for follow-up. The 7 day audit will be monitored for 3 months and a pattern of compliance is established beginning June 9th, 2014.</p> <p><b><u>How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></b></p> <p>The RCD will bring the results of the audits to the monthly QA Committee meeting for review and recommendations. Any recommendations made by the committee will be followed up by the RCD and the results will be brought to the next scheduled QA Committee meeting. This will be monitored for 3 months and a pattern of compliance is established beginning June 9th, 2014.</p>				

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	<p>immediately redirect this resident out of her room and took him into his own room. Staff checked on resident '5 minutes later' and resident was again in the female peer's room. Shirt of female resident was again unbuttoned. This resident's pants were reported to be down with penis in hands of female peer. When approached by staff to redirect, this resident became aggitated &lt;sic&gt; and pushed back staff. Two staff members were required to convince this resident to leave the situation. [Spouse] notified. M.D. [Medical Doctor] notified. Social Services notified. Staff performed one on one with this resident the rest of the day. These events transpired prior to this writer's arrival, but were recounted by CNA [certified nurses aide] nursing staff."</p> <p>A review of the "Interdisciplinary Progress Notes," dated 09-23-13 indicated the following documentation by the Social Service Director: "Notified by Resident Coord. Director of resident being found in female residents room with her shirt unbuttoned and he was observed touching the female residents breast. Resident was directed to exit room by the staff. Staff reports resident was found again in the same female residents room, just minutes after asking him to leave the room. Resident</p>						

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	<p>was observed by the staff to have his pants down and his penis was in the hand of the female. Staff immediately redirected resident and staff reported he became combative with the staff by pushing them. M.D. and [spouse] notified. M.D. gave verbal order to DC [discharge] to psych. [psychiatric] hospital for eval. [evaluation]."</p> <p>A review of the hospital "History and Physical," dictated 09-24-13 indicated the following:</p> <p>"[Resident] was admitted because of a one to two week history of increasing disinhibited behavior including inappropriate sexual behavior. Chief Complaint: Sexual aggression and disinhibited behavior. History of illness: He exposed himself to another resident on the locked unit. He tried to touch a staff member's bottom and another staff member's breast. Yesterday morning he gain &lt;sic&gt; exposed himself and tried to touch another peer inappropriately. He was combative with staff when they attempted to redirect him. Mental status: Thought processes are confused and he tries to cover for his deficits. Judgement and insight are both impaired. Memory is impaired. he is oriented only to person. He scored 13 out of 30 on the mini mental status exam consistent with a</p>			

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	<p>fairly significant level of cognitive impairment. Limitations include progressive memory loss."</p> <p>The resident returned to the facility on 10-01-13.</p> <p>The Hospital Discharge Summary, dated 10-01-13, indicated the following: "Summary of Hospital Course: The patient was a fairly active participant in froup &lt;sic&gt; and individual therapies. He seems to do well when participating in activities. We will encourage that at the facility as well. Follow-Up Recommendations: 3. Would recommend keeping the patient as busy as possible. He tends to do best in activities and not when he is left idle."</p> <p>A review of the resident's record lacked any Activity note updated interests or interventions since the resident was discharge from the hospital. The most recent Activity note was dated 09-05-13, which was prior to the resident's hospitalization.</p> <p>A review of the most recent "Resident Assessment Form," dated 12-16-13 lacked any updated interventions under the section of "Cognitive Capabilities" which indicated the resident continued to wander "frequently and indiscriminately.</p>				

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	<p>May wander at night, in addition to severe impairment most of the time with "Time/Place Orientation," demonstrating "poor judgement and required behavioral management with potentially disruptive and dangerous to self and/or others."</p> <p>The Resident's "Individual Care Plan (ICP) also dated 12-16-13 also lacked any indication the resident had been to the psychiatric hospital for evaluation and physician intervention, or any recommendations as noted by the psychiatrist.</p> <p>2. The record for Resident "G" was reviewed on 05-15-14 at 11:20 a.m. Diagnoses included, but were not limited to, Alzheimer's dementia, memory lapse and osteoporosis. These diagnoses remained current at the time of the record review.</p> <p>The resident displayed behaviors which included striking another cognitively impaired resident in the face.</p> <p>The clinical record lacked a current Individual Care Plan (ICP) or Resident Assessment. The most recent evaluation dated 07-30-13 indicated the resident's was "alert with no impairment" in regard to Cognitive Capabilities or Level of Awareness.</p>						

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R000240	<p>This State finding relates to Complaint IN00147279.</p> <p>410 IAC 16.2-5-4(d) Health Services - Deficiency (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences.</p> <p>Based on record review the facility failed to ensure a resident's personal care needs were met, in that when a resident became ill, the facility nursing staff failed to provide basic hygiene and nutritional needs to the resident. This deficient practice affected 1 of 7 sampled residents. (Resident "D").</p> <p>Findings include:</p> <p>The record for Resident "D" was reviewed on 05-14-14 at 2:15 p.m. Diagnoses included, but were not limited to, Alzheimer's disease diverticulosis and cataracts. These diagnoses remained current at the time of the record review.</p> <p>The resident's Individual Care Plan (ICP) dated 11-13-14, indicated the resident needed reminder/cues with dressing, supervise and cues with bathing, needed reminders and cues with toileting and nutrition, and had confusion.</p>	R000240	<p><u>What corrective action will be taken by the facility?</u></p> <p>All charts have been reviewed for potential changes in condition that were not properly managed by nursing staff. All nursing staff will be educated on adjusting care provided based on resident need and updating the care plan during a change in condition by June 6th, 2014.</p> <p><u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></p> <p>All residents on the Memory Care Unit have the potential to be affected by the alleged practice. Education will be provided to all nursing staff regarding adjusting care provided based on resident need during a change in condition and updating the care plan during a change in condition by June 6th,</p>	06/06/2014			

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	<p>The concerned family member submitted a Grievance to the Administrator on 03-04-14 which described the following events:</p> <p>"Wednesday February 26, 2014 I received a phone message from Health Care Director that [Resident "D"] had been ill during the night. She said he vomited and had diarrhea and they were able to get him cleaned up and back in bed. He did not have an elevated temperature. I returned the call and ask that [name of resident] be put on a bland diet and they try to get him to drink fluids as much as possible. I specifically asked that he be given chicken soup, jell-o and cranberry juice. She assured me that was no problem they would take care of it."</p> <p>"My caregiver arrived at approximately 4:30. [Name of resident] was a mess. She got him cleaned up and down to the dining room for dinner. She asked that they warm up chicken soup for him. She was told there was no chicken soup. Then she asked that they give him some jell-o, they said sorry, there was no jell-o." The document indicated the caregiver was able to find some applesauce and asked that someone help him eat that while she went to the store and got chicken soup. "When she</p>		<p>2014.</p> <p><b><u>What measures will be put into place to ensure the practice does not recur?</u></b></p> <p>RCD or DON will audit the 24 hour report daily Monday thru Friday and the Charge Nurse will audit Saturday and Sunday to ensure that all residents with a change in condition are being provided care as needed along with the updates to the care plan. The RCD or DON will bring any identified issues to the next morning management interdisciplinary meeting for review and recommendations for follow-up. The 7 day audit will be monitored for 3 months beginning June 9th, 2014. Following the completion of the 3 month period, the charts will be audited 5 times per week on an ongoing basis.</p> <p><b><u>How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></b></p> <p>The RCD will bring the results of the reviews to the monthly QA Committee meeting for review and recommendations. Any recommendations made by the committee will be followed up by the RCD and the results will be brought to the next scheduled QA Committee meeting. This will be monitored for 3 months beginning</p>		

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	<p>returned she fed him some soup and took him back to the room and got him ready for bed. He immediately went to sleep."</p> <p>"Thursday February 27, 2014. I called the Health Care Director from my work place and asked how [resident] was doing. She said, no more vomiting and just slightly loose bowels. I told her to please call me if [resident] seems to be any worse or if he needed anything. I did not hear anything from anyone at Trude's [the secured dementia unit] the entire day. Immediately after work (approximately 4:45 p.m.) I arrived at Trude's. When I entered I asked the aides how [resident] was doing. They informed me that he had not eaten or drank anything today. Also that he was in his apartment and that they were unable to get him to come to the dining room for dinner. I said that's fine I'll go down and help him. When I went into [resident's] room he was sitting on he couch. By his demeanor it was obvious that he was not well. He's &lt;sic&gt; eyes were not focused and he was having trouble understanding what I was saying. He had a thin cotton shirt on with no undershirt and was cold. I placed a blanket on him to warm him up. I then had to go back down the hall and ask that they warm up soup for his dinner and bring jell-o, 7 Up and cranberry juice.</p>		<p>June 9th, 2014 and 5 times per week thereafter.</p> <p>-</p>	

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	<p>There was no evidence that any fluids had been brought to his apartment to encourage him to drink. I fed him a bowl of soup, some crackers and 2 full glasses of fluid. It was apparent that he was hungry and very dehydrated. He was very weak, I managed to get him cleaned up and into bed. I asked what his temperature was and was told at 10:00 a.m. when they last took his temperature it was normal. This was 6:00 p.m. and not one had checked his vitals since the a.m."</p> <p>"Friday February 28, 2014 I called Trude's at approximately 9:00 a.m. and asked how [resident ] was this morning. The Health Care Director said that they were unable to get him up or to clean him up. She also said that [resident] had injured his hand but she was unable to get a good look at it. It appeared to her to be about a 2 cm [centimeter] scratch. Actually he had a huge area gouged out from the back of his hand (covering most of the center of the back of his hand and several skin layers deep). She also said that he had not eaten or drank anything that day so far. I immediately proceeded to Trude's. When I arrived they said he had knocked the cranberry just out of their hands when they tried to give him a drink (even though I had said on the phone please wait until I get there and I</p>			

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	<p>will help him). They had tried to get him to drink while he was lying in bed. [Resident] has some swallowing difficulty and would never want to drink lying down. After caring for him for over 1 1/2 years it was hard for me to believe that they were not aware of this. I was appalled when I went into [resident's] bedroom. He was curled up in a fetal position, with just his T-shirt and underwear on. There was cranberry juice, blood, and urine on his sheets and mattress. He was cold, wet and smelled terrible. I got him him into the shower, bathed him, washed his hair. He was able to sit on the shower stool. I dressed him and fed him some jell-o and juice. I asked that they have 2 eggs and toast prepared for him. I took him to the dining room and he ate everything and drank a glass of orange juice and 7 Up. He also had about 1/2 cup of coffee. I feel that [ resident] did not receive even basic care while he was ill. No one was checking on him, no one was trying to give him fluids. I have made it abundantly clear that if they have any trouble caring for [resident] they should call me. So the very least that should have been done was to let me know that they couldn't or weren't giving him care."</p> <p>The "action taken and date taken" 03-07-14 indicated the dietary manager</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155794	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/15/2014
NAME OF PROVIDER OR SUPPLIER  STRATFORD RETIREMENT LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2460 GLEBE ST CARMEL, IN 46032		
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	<p>and health care director will assure that chicken soup and jello is always in stock. Staff education to be completed in regards to feeding and having a resident drinking while in bed."</p> <p>This State finding relates to Complaint IN00147279.</p>				