

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E244	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/27/2012
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NAME OF PROVIDER OR SUPPLIER  RURAL HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1747 N RURAL ST INDIANAPOLIS, IN 46218
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F0000	<p>This visit was for the Investigation of Complaint IN00121028 and Complaint IN00121188.</p> <p>Complaint IN00121028 - Substantiated. Federal/State deficiencies related to the allegations are cited at F223, F225, and F226.</p> <p>Complaint IN00121188 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey Date: 12/27/2012</p> <p>Facility number: 000388 Provider number: 15E244 AIM number: 100454140</p> <p>Survey Team: Beth Walsh, RN-TC Gloria Bond, RN</p> <p>Census Bed Type: NF: 41 Total: 41</p> <p>Census Payor Type: Medicaid: 41 Total: 41</p> <p>Sample: 3</p>	F0000	<p><b>This plan of correction is to serve as Rural Health Care Centers' credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Rural Health Care Center or its' management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.</b></p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 1/04/13 by Suzanne Williams, RN</p>			

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F0223 SS=D	<p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>Based on interview and record review, the facility failed to keep a resident free from physical abuse. This affected 1 of 3 residents reviewed for abuse in a sample of 3. (Resident B)</p> <p>Findings include:</p> <p>During a review of a Resident Abuse Investigation Report Form, dated 11/3/12, received from the DoN (Director of Nursing) on 12/27/12 at 1:00 p.m., the form indicated, "On 11-2-12 (name of employee) CNA witnessed (name of employee) CNA hit (name of Resident B) in the [sic] 3 times while providing care. (Name of employee) reported the incident on 11-3-12. The allegation of abuse was substantiated and (name of employee) was terminated on 11-3-12 via phone. ISDH (Indiana State Department of Health), IMPD (Indianapolis Metro Police Department), MD (medical doctor),</p>	F0223	<p><b>F223 483.13(b) ABUSE</b> It is the practice of Rural Health Care Center to ensure the resident right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. I. Resident B was evaluated by the DON and showed no signs of physical or mental trauma CNA #1 removed from all resident contact and her employment was terminated. CNA #2 no longer works at the facility. A full investigation of mistreatment was initiated on 11/3/12. The Indiana State Department of Health and the IMPD was notified as required. II. All interviewable residents were identified and interviewed confidentially to determine if any other allegations of abuse existed. No resident verbalized any concern regarding their treatment by the identified offender or others. All non-interviewable residents were assessed for non-verbal signs/symptoms of abuse (abnormal bruising, fearful facial expressions, etc...). No resident</p>	01/11/2013	

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	<p>HFA (health facility administrator), DoN, and Resident's Guardian were notified of incident on 11-3-12. (Name of resident) was assessed for s/s (signs and symptoms) of injury resulting from the abuse."</p> <p>Review of a typed statement by CNA #2, dated 11/3/12, indicated, "On 11/2/12 at about 2pm [sic] I was outside of (name of Resident B's) room. I thought I heard (Resident B) say 'why are you doing that' so I stepped in the room. I saw (name of CNA #1) slapping (name of Resident B) in the face. I took out my phone and pretended that I stepped in the room to text someone and that I didn't want management to see me texting...After that she (CNA #1) stopped and left the room. By then it was time for (CNA #1) to leave for the day and (CNA #1) went home. (Name of Administrator) was out of the building doing an assessment. I wanted the mistreatment reported and asked a co-worker to report it to the Administrator for me. I knew (name of CNA #1) did not work again before Monday and wanted to make sure someone knew about it right away." The document had the signature of CNA #2 on it, with the date 11/3/12.</p>		<p>presented with any non-verbal signs or symptoms of mistreatment. Interviews and assessments were completed on 11/3/2012 at the time of the allegation III. The facility has an abuse prevention policy in place. The facilities 'Abuse Prevention Protection and Reporting Policy' was reviewed on 11/3/2012. Training for facility personnel was initiated on 11/3/2012. No personnel was permitted to work until he/she received education. This re-education was repeated again 01/11/2013. This re-education stressed the importance of reporting of any suspected abuse to the Administrator immediately. Social Service has reviewed all residents with behaviors that may increase their risk for mistreatment. All residents care plans were updated to include additional interventions as necessary to promote each resident's well-being and safety. This was completed on 11/3/2012..IV. The Social Service Director or Designee interviewed 2 random residents daily for 14 days, then 4 random residents weekly for 2 weeks, then 4 random residents monthly to identify any concerns regarding mistreatment. The results of these interviews were documented on the Resident Interview form and presented to Administrator for review. Department Managers will</p>				

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	<p>In an interview with the DoN and ADoN (Assistant Director of Nursing) at 2:58 p.m., on 12/27/12, the DoN indicated she was aware of the incident described above. The DoN indicated CNA #1 did slap Resident B a couple of times while providing care to the resident. She also indicated there were no issues involving CNA #1 prior to the above incident, related to providing proper care to residents, being respectful to residents, or harming residents. The ADoN agreed with the DoN on the description of the incident during the interview.</p> <p>On a list titled, Interviewable Residents, received from the DoN on 12/27/12 at 11:56 a.m., it indicated Resident B was not interviewable. CNA #2 was no longer employed by the facility and unavailable for interview.</p> <p>In a policy, titled Abuse Prevention and dated 7/2011, received from the ADoN on 12/27/12 at 1:26 p.m., it indicated, "It is the policy of this facility to provide each resident with an environment that is free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion." In a section titled, Preventing Resident Abuse, in the same document, it indicated,</p>		<p>conduct daily rounds Monday – Friday; the manager on duty will do rounds on the week-ends.. During these rounds, the managers will monitor residents for both verbal and non-verbal signs of abuse. Any sign/symptoms of potential abuse will be handled according to the facilities policies and procedures. The Administrator or Designee will randomly interview 6 staff members daily for 14 days, then 6 staff members weekly for 2 weeks, then 4 staff members monthly for 2 months to determine comprehension and compliance with the facility's Abuse Prevention, Protection, and Reporting Policy. The results of these audits will be recorded and reviewed by QA Committee weekly for 4 weeks, monthly for 2 months and then quarterly. The Quality Assurance Committee will review all audit findings weekly for four weeks and then monthly for two months and then quarterly.</p>	

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	<p>"Preventing resident abuse is a primary concern for this facility. It is our goal to achieve and maintain an abuse free environment."</p> <p>This federal tag relates to complaint IN00121028.</p> <p>3.1-27(a)(1)</p>						

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F0225 SS=D	<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 interview and record</p>	F0225	F225 483.13(c)(1)(ii)-(iii), (c)(2)-	01/11/2013			

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	<p>review, the facility failed to ensure an allegation of abuse was immediately reported to the Administrator. This affected 1 of 3 residents reviewed for abuse in a sample of 3. (Resident B)</p> <p>Findings include:</p> <p>During a review of a Resident Abuse Investigation Report Form, dated 11/3/12, received from the DoN (Director of Nursing) on 12/27/12 at 1:00 p.m., the form indicated, "On 11-2-12 (name of employee) CNA witnessed (name of employee) CNA hit (name of Resident B) in the [sic] 3 times while providing care. (Name of employee) reported the incident on 11-3-12. The allegation of abuse was substantiated and (name of employee) was terminated on 11-3-12 via phone. ISDH (Indiana State Department of Health), IMPD (Indianapolis Metro Police Department), MD (medical doctor), HFA (health facility administrator), DoN, and Resident's Guardian were notified of incident on 11-3-12. (Name of resident) was assessed for s/s (signs and symptoms) of injury resulting from the abuse."</p> <p>Review of a typed statement by CNA #2, dated 11/3/12, indicated, "On 11/2/12 at about 2pm [sic] I was</p>		<p><b>(4) INVESTIGATE/REPORT/ ALLEGATIONS/INDIVIDUALS</b></p> <p>It is the practice of Rural Health Care Center to 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. I. Resident B was evaluated by the DON and showed no signs of physical or mental trauma CNA #1 removed from all resident contact and her employment was terminated. CNA #2 no longer works at the facility. A full investigation of mistreatment was initiated on 11/3/12. The Indiana State Department of Health and the IMPD was notified as required. II. All interviewable residents were identified and interviewed confidentially to determine if any other allegations of abuse existed. No resident verbalized any concern regarding their treatment by the identified offender or others. All non-interviewable residents were assessed for non-verbal signs/symptoms of abuse (abnormal bruising, fearful facial expressions, etc...). No resident presented with any non-verbal signs or symptoms of mistreatment. Interviews and</p>				

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	<p>outside of (name of Resident B's) room. I thought I heard (Resident B) say 'why are you doing that' so I stepped in the room. I saw (name of CNA #1) slapping (name of Resident B) in the face. I took out my phone and pretended that I stepped in the room to text someone and that I didn't want management to see me texting...After that she (CNA #1) stopped and left the room. By then it was time for (CNA #1) to leave for the day and (CNA#1) went home. (Name of Administrator) was out of the building doing an assessment. I wanted the mistreatment reported and asked a co-worker to report it to the Administrator for me. I knew (name of CNA #1) did not work again before Monday and wanted to make sure someone knew about it right away." The document had the signature of CNA #2 on it, with the date 11/3/12.</p> <p>In an interview with the DoN, ADoN (Assistant Director of Nursing), and Administrator at 2:58 p.m., on 12/27/12, the DoN indicated she was aware of the incident described above. The DoN indicated she was notified the following day (11-3-12) after the incident occurred, by LPN #4. LPN #4 was notified on 11-3-12, about the incident on 11-2-12, from</p>		<p>assessments were completed on 11/3/2012 at the time of the allegation III. The facility has an abuse prevention policy in place. The facilities 'Abuse Prevention Protection and Reporting Policy' was reviewed on 11/3/2012. Training for facility personnel was initiated on 11/3/2012. No personnel was permitted to work until he/she received education. This re-education was repeated again 01/11/2013. This re-education stressed the importance of reporting of any suspected abuse to the Administrator immediately. Social Service has reviewed all residents with behaviors that may increase their risk for mistreatment. All residents care plans were updated to include additional interventions as necessary to promote each resident's well-being and safety. This was completed on 11/3/2012. . IV. The Social Service Director or Designee interviewed 2 random residents daily for 14 days, then 4 random residents weekly for 2 weeks, then 4 random residents monthly to identify any concerns regarding mistreatment. The results of these interviews were documented on the Resident Interview form and presented to Administrator for review. Department Managers will conduct daily rounds Monday – Friday; the manager on duty will do rounds on the week-ends..</p>		

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	<p>CNA #2. The DoN notified the Administrator, after the incident was reported to her by LPN #4. The Administrator indicated, during the interview, he was called the day of the incident by another employee (CNA#3), and the employee just indicated that he (the Administrator) needed to talk to CNA #2 about something. The Administrator also indicated CNA #3 did not further elaborate or give any details about why he needed to talk to CNA #2, and he was unclear on why he needed to talk to CNA #2. The DoN indicated she felt that CNA #2 was scared of CNA #1 and did not want to report CNA #1 directly, so CNA #2 told CNA #3 to tell the Administrator about the incident. The DoN also indicated CNA #2 "felt she had time to notify" the Administrator/DoN, because CNA #1 was not scheduled to work the next couple of days and the incident happened right before CNA #1 left for the day, so she was not going to be around the residents for awhile. The Administrator indicated the policy of the facility was for staff to notify the Administrator immediately with any abuse allegations.</p> <p>This federal tag relates to complaint IN00121028.</p>		<p>During these rounds, the managers will monitor residents for both verbal and non-verbal signs of abuse. Any sign/symptoms of potential abuse will be handled according to the facilities policies and procedures. The Administrator or Designee will randomly interview 6 staff members daily for 14 days, then 6 staff members weekly for 2 weeks, then 4 staff members monthly for 2 months to determine comprehension and compliance with the facility's Abuse Prevention, Protection, and Reporting Policy. The results of these audits will be recorded and reviewed by QA Committee weekly for 4 weeks, monthly for 2 months and then quarterly. The Quality Assurance Committee will review all audit findings weekly for four weeks and then monthly for two months and then quarterly.</p>				

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F0226 SS=D	<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 interview and record review, the facility failed to follow policy and procedures for abuse prevention by not immediately notifying the Administrator about an abuse allegation. This affected 1 of 3 residents reviewed for abuse in the sample of 3. (Resident B)</p> <p>Findings include:</p> <p>During a review of a Resident Abuse Investigation Report Form, dated 11/3/12, received from the DoN (Director of Nursing) on 12/27/12 at 1:00 p.m., the form indicated, "On 11-2-12 (name of employee) CNA witnessed (name of employee) CNA hit (name of Resident B) in the [sic] 3 times while providing care. (Name of employee) reported the incident on 11-3-12. The allegation of abuse was substantiated and (name of employee) was terminated on 11-3-12 via phone. ISDH (Indiana State Department of Health), IMPD (Indianapolis Metro Police Department), MD (medical doctor),</p>	F0226	<p><b>F226 483.13(c) DEVELOP/IMPLEMENT ABUSE/NEGLECT POLICIES!</b> It is the practice of Rural Health Care Center to develop and implement policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of property. I. Resident B was evaluated by the DON and showed no signs of physical or mental trauma CNA #1 removed from all resident contact and her employment was terminated. CNA #2 no longer works at the facility. A full investigation of mistreatment was initiated on 11/3/12. The Indiana State Department of Health and the IMPD was notified as required. II. All interviewable residents were identified and interviewed confidentially to determine if any other allegations of abuse existed. No resident verbalized any concern regarding their treatment by the identified offender or others. All non-interviewable residents were assessed for non-verbal signs/symptoms of abuse (abnormal bruising, fearful facial expressions, etc...). No resident</p>	01/11/2013	

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	<p>HFA (health facility administrator), DoN, and Resident's Guardian were notified of incident on 11-3-12. (Name of resident) was assessed for s/s (signs and symptoms) of injury resulting from the abuse."</p> <p>Review of a typed statement by CNA #2, dated 11/3/12, indicated, "On 11/2/12 at about 2pm [sic] I was outside of (name of Resident B's) room. I thought I heard (Resident B) say 'why are you doing that' so I stepped in the room. I saw (name of CNA #1) slapping (name of Resident B) in the face. I took out my phone and pretended that I stepped in the room to text someone and that I didn't want management to see me texting...After that she (CNA #1) stopped and left the room. By then it was time for (CNA #1) to leave for the day and (CNA #1) went home. (Name of Administrator) was out of the building doing an assessment. I wanted the mistreatment reported and asked a co-worker to report it to the Administrator for me. I knew (name of CNA #1) did not work again before Monday and wanted to make sure someone knew about it right away." The document had the signature of CNA #2 on it, with the date 11/3/12.</p>		<p>presented with any non-verbal signs or symptoms of mistreatment. Interviews and assessments were completed on 11/3/2012 at the time of the allegation III. The facility has an abuse prevention policy in place. The facilities 'Abuse Prevention Protection and Reporting Policy' was reviewed on 11/3/2012. Training for facility personnel was initiated on 11/3/2012. No personnel was permitted to work until he/she received education. This re-education was repeated again 01/11/2013. This re-education stressed the importance of reporting of any suspected abuse to the Administrator immediately. Social Service has reviewed all residents with behaviors that may increase their risk for mistreatment. All residents care plans were updated to include additional interventions as necessary to promote each resident's well-being and safety. This was completed on 11/3/2012. . IV. The Social Service Director or Designee interviewed 2 random residents daily for 14 days, then 4 random residents weekly for 2 weeks, then 4 random residents monthly to identify any concerns regarding mistreatment. The results of these interviews were documented on the Resident Interview form and presented to Administrator for review. Department Managers will</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E244	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/27/2012
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	In an interview with the DoN, ADoN (Assistant Director of Nursing), and Administrator at 2:58 p.m., on 12/27/12, the DoN indicated she was aware of the incident described above. The DoN indicated she was notified the following day (11-3-12) after the incident occurred, by LPN #4. LPN #4 was notified on 11-3-12, about the incident on 11-2-12, from CNA #2. The DoN notified the Administrator, after the incident was reported to her by LPN #4. The Administrator indicated, during the interview, he was called the day of the incident by another employee (CNA#3), and the employee just indicated that he (the Administrator) needed to talk to CNA #2 about something. The Administrator also indicated CNA #3 did not further elaborate or give any details about why he needed to talk to CNA #2, and he was unclear on why he needed to talk to CNA #2. The DoN indicated she felt that CNA #2 was scared of CNA #1 and did not want to report CNA #1 directly, so CNA #2 told CNA #3 to tell the Administrator about the incident. The DoN also indicated CNA #2 "felt she had time to notify" the Administrator/DoN, because CNA #1 was not scheduled to work the next couple of days, the incident happened right before CNA #1 left for		conduct daily rounds Monday – Friday; the manager on duty will do rounds on the week-ends.. During these rounds, the managers will monitor residents for both verbal and non-verbal signs of abuse. Any sign/symptoms of potential abuse will be handled according to the facilities policies and procedures. The Administrator or Designee will randomly interview 6 staff members daily for 14 days, then 6 staff members weekly for 2 weeks, then 4 staff members monthly for 2 months to determine comprehension and compliance with the facility's Abuse Prevention, Protection, and Reporting Policy. The results of these audits will be recorded and reviewed by QA Committee weekly for 4 weeks, monthly for 2 months and then quarterly. The Quality Assurance Committee will review all audit findings weekly for four weeks and then monthly for two months and then quarterly.	

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	<p>the day, so she was not going to be around the residents for awhile. The Administrator indicated the policy of the facility was for staff to notify the Administrator immediately with any abuse allegations.</p> <p>In a policy, titled Abuse Prevention and dated 7/2011, received from the ADoN on 12/27/12 at 1:26 p.m., it indicated, "2. Employees, facility consultants and/or attending physicians must report any suspected abuse, allegations of abuse, or incidents of abuse to the Administrator immediately...3. The Administrator must be immediately notified of suspected abuse, allegations of abuse, or incidents of abuse. If such incidents occur or are discovered after hours, the Administrator must be called at home or must be paged and informed of such incident."</p> <p>This federal tag relates to complaint IN00121028.</p> <p>3.1-28(a)</p>						