

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155251	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/03/2014
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 2901 W 37TH AVE HOBART, IN 46342
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F000000	<p>This visit was for the Investigation of Complaint IN00141722.</p> <p>Complaint IN00141722-Substantiated. Federal/State deficiencies related to the allegation are cited at F225 and F226.</p> <p>Survey date: February 3, 2014</p> <p>Facility number: 000154 Provider number: 155251 AIM number: 100289680</p> <p>Survey team: Janet Adams, RN, TC Regina Sanders, RN</p> <p>Census bed type: SNF: 20 SNF/NF: 69 Total: 89</p> <p>Census payor type: Medicare: 22 Medicaid: 61 Other: 6 Total: 89</p> <p>Sample: 3</p> <p>These deficiencies reflect State</p>	F000000		
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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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	findings cited in accordance with 410 IAC 16.2. Quality review completed on February 7, 2014, by Janelyn Kulik, RN.				

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F000225 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 observation, record</p>	F000225	It is the policy of Miller's Merry	02/21/2014			

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	<p>review, and interview, the facility failed to ensure an allegation of physical abuse was thoroughly investigated related to obtaining and documenting staff interviews in a timely manner, documenting the resident's physical and psychosocial condition at the time of the allegation, and completing ongoing documentation of the resident's status for 1 of 3 Abuse allegations reviewed. (Resident #C)</p> <p>Findings include:</p> <p>On 2/3/14 at 9:18 a.m., Resident #C was observed sitting in a wheelchair in the hallway across from the Nursing Station. The resident was talking to another resident seated next to her.</p> <p>Review of the facility "Incident Report Form" investigation completed on 12/20/13 indicated Resident #C reported to the Nurse "The girl hit me on my head and on my hand." The report indicated the above incident occurred on 12/20/13. The report indicted the facility Administrator, the resident's Physician, and the resident's family were informed. The report indicated the resident had no injuries and CNA #1 was suspended. The report</p>		<p>Manor Hobart to ensure abuse allegations are thoroughly investigated. The facility has policies in place to ensure that abuse allegations are thoroughly investigated and are reported to the ISDH. Resident #C: Any future allegations of abuse will be thoroughly investigated. Family and physician will be notified of allegation/investigation. Abuse allegations will be thoroughly investigated and reported per policy to the ISDH. All residents are at risk to be affected by the deficient practice. All staff are trained on the facility policy and procedures for "Abuse Prohibition, Reporting, and Investigation" upon hire and at least every 6 months. An all staff in-service will be provided to all staff regarding "Abuse Prohibition, Reporting, and Investigation" by 2/21/14. The facility staff will be educated to report all allegations of abuse, unusual occurrences, to the charge nurse and the charge nurse will immediately report to the administrator or other designee. An investigation will be immediately initiated and directed by the administrator or designee and a detailed report will be forwarded to the ISDH within 5 days. The investigation will be summarized, signed, and dated and kept as evidence of the facility's investigation by the administrator or other designee. The "Abuse Investigation</p>		

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	<p>indicated the resident was interviewed and indicated the CNA came into her room to answer her call light because she wanted a pain pill. The CNA then told the resident the Nurse had just given her a pain pill and said it would "kick in" shortly.</p> <p>The facility report also indicated the CNA had put her hand up to the resident's forehead to feel if she was hot and then rubbed the resident's hand. The report indicated at the time of the investigation and above interview the resident reported she felt safe. The report also indicated other alert an orientated residents on the hall were interviewed and other staff members were also interviewed.</p> <p>Written staff interviews were included in the investigation. An statement written by LPN #3 indicated the LPN spoke with Resident #C and the resident stated that someone had hit her on the head and on the hand. The LPN asked the resident if she knew the staff member's name and no name was given. The LPN's written statement indicated the resident stated "... she hit me hard." The LPN's statement also indicated the resident "balled" her fist, said "like</p>		Worksheet" (Attachment A) will be utilized by the administrator or other designee with each abuse allegation to ensure all components of a thorough investigation is completed per facility policy. The tool will be completed prior to submitting the final 5-day summary of investigation to the ISDH for the next 6 months. Any areas not completed per policy will be corrected/investigated and then logged on a QA tracking log. The QA tracking logs will be brought to the monthly QA meeting for review and to monitor for ongoing compliance.		

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	<p>this," and the resident then started shaking her fist.</p> <p>The clinical record for Resident #C was reviewed on 2/3/14 at at 9:50 a.m. The resident's diagnoses included, but were not limited to, anxiety state, depressive disorder, high blood pressure, and Alzheimer disease.</p> <p>The 11/21/13 Minimum Data Set (MDS) admission assessment was reviewed. The assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (12). A score of (12) indicted the resident's cognitive patterns were moderately impaired. The assessment indicated the resident displayed no behaviors, delusions, or hallucinations.</p> <p>An Initial Social Service Assessment was completed on 11/16/13. The assessment indicated the resident was interactive during the interview and did have some confusion when asked the day of the week and to recall a certain word. The assessment indicated the resident was alert to name and able to recall her birthday. The assessment also indicated the resident was able to</p>				

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	<p>hear when using a hearing device and her speech was clear.</p> <p>The 12/2013 Nursing Progress Notes were reviewed. There was only one entry made on 12/20/13. This entry was made at 1:16 p.m.. The entry indicated the resident was adjusting to her room change and had no signs or symptoms of distress. The next entry in the 12/2013 Nursing Progress Notes was made on 12/23/13 at 1:34 p.m. This entry indicated the Nurse spoke with the Physician related to the resident's pain medication and new orders were received to administer the pain medication every (6) hours.</p> <p>The 12/2013 Social Service Progress Notes were reviewed. There were no entries made on 12/20/13 related to assessing the resident after an allegation of physical abuse was made on 12/20/13. The first Social Service note after 12/20/13 was completed on 12/27/13 at 3:35 p.m. This entry was completed by Social Service Designee #2. The entry indicated the resident voiced no concerns, was in a really good mood, and thanked the writer for talking with her.</p>						

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	<p>When interviewed on 2/3/14 at 1:10 p.m., Resident #C stated "I had one Nurse Aide that hit me one time and that's been a long time ago." The resident also indicated she felt safe at the facility now.</p> <p>When interviewed on 2/3/14 at 11:10 a.m., the facility Administrator indicated Resident #C was excessive with putting her call light on and requesting pain medication. The Administrator indicated the 12/20/13 allegation was investigated. The Administrator indicated CNA #1 was caring for the resident that day and reported the resident complained of pain to her head, chest, and legs and the CNA reported she had put her hand on the resident's forehead to feel and patted her on the arm to reassure her. The Administrator indicated the resident then made an allegation to LPN #3. The Administrator stated she was walking down the hall at approximately 3:00 p.m. on 12/20/13 and LPN #3 approached her and told her Resident #C had reported that CNA #1 had slapped her in the head. The Administrator indicated CNA #1 had already left as her shift was over. The Administrator indicated she then spoke with CNA #1 on the phone as the CNA was</p>						

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	<p>not working over the weekend (the next few days). The Administrator indicated the CNA told her she did touch the resident's head as the resident had stated her head was hurting.</p> <p>Continued interview with the facility Administrator indicated she also interviewed other staff members on 12/20/13. The staff members who were interviewed were the Evening shift LPN and the two Evening shift CNA's on duty. The Administrator indicated on 12/20/13 she did not interview any other day staff who worked on 12/20/13 other then LPN #3 and CNA #1(over the phone). The Administrator indicated she had no documentation of what time LPN actually went into the resident's room when the allegation was made. The Administrator indicated the Unit Manager was interviewed but no other day staff that would have been present on the unit when CNA #1 was in Resident #C's room on the day shift were interviewed.</p> <p>Continued interview with the facility Administrator indicated the allegation was not substantiated. The Administrator indicated she determined the allegation was not substantiated at the time she had</p>				

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	<p>gone into Resident #C's room on 12/20/13 at approximately 3:00 p.m. after talking with CNA #1 on the telephone. The Administrator indicated when she was talking to the resident in her room on 12/20/13 she put her hand on the resident's forehead and patted the resident's hand and asked Resident #C if she felt what she (Administrator) was doing felt like she had just "slapped" her and the resident stated "yes." The Administrator indicated she did not document the above and it should have been documented in the investigation.</p> <p>When interviewed on 2/3/14 at 11:40 a.m., LPN #3 indicated she had taken care of Resident #C regularly on the Day shift. The LPN indicated she answered the resident's call light on 12/20/13 and the resident reported she got hit on the hand and hit on the head. The LPN indicated the resident did not recall the staff members name. The LPN indicated she informed the Administrator the resident reported the CNA had hit her on the head and hand. The LPN indicated she did not notice any bruising at that time. The LPN indicates she did not document an physical assessment of the resident at the above time.</p>						

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	<p>When interviewed on 2/3/14 at 1:40 P.M., Social Service Designee (SSD) #1 indicated she recalled an incident reported involving Resident #C where the resident had accused a staff member of hitting her in the head. SSD #1 indicated she recalled there was an investigation and it was noted the CNA had put her hand on the resident's head. SSD #1 indicated there should have been documentation by Social Services in the resident's record. SSD #1 indicated the protocol was usually for one of the Social Service staff to meet with the resident at the time and follow up with the resident to assess the resident's psychosocial status and ensure they are comfortable. SSD #1 indicated she did not have any contact with Resident #C related to the 12/20/13 incident. SSD #1 indicated the first Social Service Note completed after the 12/20/13 allegation was entered on 12/27/13 by Social Service Designee #2.</p> <p>When interviewed on 2/3/14 at 1:43 p.m., Social Service Designee (SSD) #2 indicated she did not recall if she had any contact with Resident #C related to the resident alleged being hit in the head. The SSD #2</p>			
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	<p>indicated she did complete the Social Service Note in the resident's record dated 12/27/13.</p> <p>When interviewed on 2/3/14 at 2:00 p.m., the facility Administrator indicated Social Service was to assess the resident and document the resident's status at the time of the allegation. The Administrator also indicated a physical assessment of the resident should have been completed and documented at the time of the allegation on 12/20/13. The Administrator also indicated she should have documented her telephone interview with CNA #1. The Administrator also indicated Nursing staff did not complete and document ongoing assessments of the resident every shift as per the policy.</p> <p>The facility policy titled "Abuse Prohibition, Reporting, and Investigation" was reviewed on 2/3/14 at 11:30 a.m. The policy start date was 2/22/13. The policy indicated the facility policies and procedures were in place that alleged violations were to be thoroughly investigated. The policy indicated a comprehensive investigation was to be completed</p>						

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	<p>and the Administrator was to summarize the investigation, sign and date the document, and keep as evidence of the facility's investigation. The policy also indicated the investigation was to be completed to assure other residents had not been affected by the incident and this could involve interviewing staff members when appropriate. The investigation summary was to be compiled by the Administrator or designee and may include but was not limited to:</p> <p>"Facts and observation from the involved resident or residents." "Facts and observation from the involved employee or employees." "Facts and observations from witnessing employees or those that intervened in the incident." "Facts and observations from visitors or other who might have pertinent information that is relevant to the investigation." "Injuries or lack thereof based upon the nursing assessment following the incident."</p> <p>The policy also indicated follow up assessments were to completed/documentd during every shift until the resident was stable and safety was maintained. The policy also indicated the</p>			
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F000226 SS=D	<p>Resident was to be examined and assessed immediately by the Nurse to determine if any injuries had occurred and their extent. The policy also indicated a thorough investigation was to be initiated and a summary of the investigation was to be signed and dated by the Administrator or designee and kept by the facility.</p> <p>This Federal tag relates to Complaint IN00141722.</p> <p>3.1-28(d)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p>						

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	<p>Based on record review and interview, the facility failed to follow their Abuse Prohibition, Reporting, and Investigation policy related to obtaining interviews from staff members who were working at the time of an alleged physical abuse allegation, completing documentation of the resident's physical status, and documentation of all completed interviews for 1 of 3 abuse allegations reviewed. (Resident #C)</p> <p>Findings include:</p> <p>Review of the facility "Incident Report Form" investigation completed on 12/20/13 indicated Resident #C reported to the Nurse that "The girl hit me on my head and on my hand." The report indicted the facility Administrator, the resident's Physician, and the resident's family were informed. The report indicated the resident had no injuries and CNA #1 was suspended. The report indicated the resident was interviewed and indicated the CNA came into her room to answer her call light because she wanted a pain pill. The CNA then told the resident the Nurse had just given her a pain pill and said it would "kick in " shortly.</p>	F000226	<p>It is the policy of Miller's Merry Manor Hobart to ensure abuse allegations are thoroughly investigated. The facility has policies in place to ensure that abuse allegations are thoroughly investigated and are reported to the ISDH. Resident #C: Any future allegations of abuse will be thoroughly investigated. Family and physician will be notified of allegation/investigation. Abuse allegations will be thoroughly investigated and reported per policy to the ISDH. All residents are at risk to be affected by the deficient practice. All staff are trained on the facility policy and procedures for "Abuse Prohibition, Reporting, and Investigation" upon hire and at least every 6 months. An all staff in-service will be provided to all staff regarding "Abuse Prohibition, Reporting, and Investigation" by 2/21/14. The facility staff will be educated to report all allegations of abuse, unusual occurrences, to the charge nurse and the charge nurse will immediately report to the administrator or other designee. An investigation will be immediately initiated and directed by the administrator or designee and a detailed report will be forwarded to the ISDH within 5 days. The investigation will be summarized, signed, and dated and kept as evidence of the facility's investigation by the administrator or other designee.</p>	02/21/2014	

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	<p>The facility report also indicated the CNA had put her hand up to the resident's forehead to feel if she was hot and then rubbed the resident's hand. The report indicated at the time of the investigation and above interview the resident reported she felt safe. The report also indicated other alert an orientated residents on the hall were interviewed and other staff members were also interviewed.</p> <p>Written staff interviews were included in the investigation. An statement written by LPN #3 indicated the LPN spoke with Resident #C and the resident stated someone had hit her on the head and on the hand. The LPN asked the resident if she knew the staff member's name and no name was given. The LPN's written statement indicated the resident stated "... she hit me hard." The LPN's statement also indicated the resident "balled" her fist said "like this," and the resident then started shaking her fist.</p> <p>The clinical record for Resident #C was reviewed on 2/3/14 at at 9:50 a.m. The resident's diagnoses included, but were not limited to,</p>		<p>The "Abuse Investigation Worksheet" (Attachment A) will be utilized by the administrator or other designee with each abuse allegation to ensure all components of a thorough investigation is completed per facility policy. The tool will be completed prior to submitting the final 5-day summary of investigation to the ISDH for the next 6 months. Any areas not completed per policy will be corrected/investigated and then logged on a QA tracking log. The QA tracking logs will be brought to the monthly QA meeting for review and to monitor for ongoing compliance.</p>				

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	<p>anxiety state, depressive disorder, high blood pressure, and Alzheimer disease.</p> <p>The 12/2013 Nursing Progress Notes were reviewed. There was only one entry made on 12/20/13. This entry was made at 1:16 p.m.. The entry indicated the resident was adjusting to her room change and had no signs or symptoms of distress. The next entry in the 12/2013 Nursing Progress Notes was made on 12/23/13 at 1:34 p.m. This entry indicated the Nurse spoke with the Physician related to the resident's pain medication and new orders were received to administer the pain medication every (6) hours.</p> <p>The 12/2013 Social Service Progress Notes were reviewed. There were no entries made on 12/20/13 related to assessing the resident after an allegation of physical abuse was made on 12/20/13. The first Social Service note after 12/20/13 was completed on 12/27/13 at 3:35 p.m. This entry was completed by Social Service Designee #2. The entry indicated the resident voiced no concerns, was in a really good mood, and thanked the writer for talking with her.</p>				

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	<p>When interviewed on 2/3/14 at 1:10 p.m., Resident #C stated "I had one Nurse Aide that hit me one time and that's been a long time ago." The resident also indicated she felt safe at the facility now.</p> <p>When interviewed on 2/3/14 at 11:10 a.m., the facility Administrator indicated Resident #C was excessive with putting her call light on and requesting pain medication. The Administrator indicated the 12/20/13 allegation was investigated. The Administrator indicated CNA #1 was caring for the resident that day and reported the resident complained of pain to her head, chest, and legs and the CNA reported she had put her hand on the resident's forehead to feel and patted her on the arm to reassure her. The Administrator indicated the resident then made an allegation to LPN #3. The Administrator stated she was walking down the hall at approximately 3:00 p.m. on 12/2013 and LPN #3 approached her and told her Resident #C had reported that CNA #1 had slapped her in the head. The Administrator indicated CNA #1 had already left as her shift was finished. The Administrator indicated she then spoke with CNA</p>			

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	<p>#1 on the phone as the CNA was not working over the weekend (the next few days). The Administrator indicated the CNA told her she did touch the resident's head as the resident had stated her head was hurting.</p> <p>Continued interview with the facility Administrator indicated she also interviewed other staff members on 12/20/13. The staff members who were interviewed were the Evening shift LPN and the two Evening shift CNA's on duty. The Administrator indicated on 12/20/13 she did not interview any other day staff who worked on 12/20/13 other then LPN #3 and CNA #1(over the phone). The Administrator indicated she had no documentation of what time the LPN actually went into the resident's room when the allegation was made. The Administrator indicated the Unit Manager was interviewed but no other day staff that would have been present on the unit when CNA #1 was in Resident #C's room on the day shift were interviewed.</p> <p>Continued interview with the facility Administrator indicated the allegation was not substantiated. The Administrator indicated she determined the allegation was not</p>				

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	<p>substantiated at the time she had gone into Resident #C's room on 12/20/13 at approximately 3:00 p.m. after talking with CNA #1 on the telephone. The Administrator indicated when she was talking to the resident in her room on 12/20/13 she put her hand on the resident's forehead and patted the resident's hand and asked Resident #C if she felt what she (Administrator) had just done had felt like she had just "slapped" her and the resident stated "yes."</p> <p>When interviewed on 2/3/14 at 11:40 a.m., LPN #3 indicated she had taken care of Resident #C regularly on the Day shift. The LPN indicated she answered the resident's call light on 12/20/13 and the resident reported she got hit on the hand and hit on the head. The LPN indicated the resident did not recall the staff members name. The LPN indicated she informed the Administrator the resident reported the CNA had hit her on the head and hand. The LPN indicated she did not notice any bruising at that time.</p> <p>When interviewed on 2/3/14 at 1:40 P.M., Social Service Designee (SSD) #1 indicated she recalled an incident reported involving Resident</p>				

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	<p>#C where the resident had accused a staff member of hitting her in the head. SSD #1 indicated she recalled there was an investigation and it was noted the CNA had put her hand on the resident's head. SSD #1 indicated there should have been documentation by Social Services in the resident's record. SSD #1 indicated the protocol was usually for one of the Social Service staff to meet with the resident at the time and follow up with the resident to assess the resident's psychosocial status and ensure they are comfortable. SSD #1 indicated she did not have any contact with Resident #C related to the 12/20/13 incident. SSD #1 indicated the first Social Service Note completed after the 12/20/13 allegation was entered on 12/27/13 by Social Service Designee #2.</p> <p>When interviewed on 2/3/14 at 1:43 p.m., Social Service Designee (SSD) #2 indicated she did not recall if she had contacted Resident #C related to the resident alleged being hit in the head. SSD #2 indicated she did complete the Social Service Note in the resident record dated 12/27/13.</p> <p>When interviewed on 2/3/14 at 2:00 p.m., the facility Administrator</p>						

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	<p>indicated Social Service was to assess the resident and document the resident's status at the time of the allegation. The Administrator also indicated a physical assessment of the resident should have completed and documented at the time of the allegation on 12/20/13. The Administrator indicated she should have documented her telephone interview with CNA #1. The Administrator also indicated Nursing staff did not complete and document ongoing assessments of the resident every shift as per the policy.</p> <p>The facility policy titled "Abuse Prohibition, Reporting, and Investigation" was reviewed on 2/3/14 at 11:30 a.m. The policy start date was 2/22/13. The policy indicated the facility policies and procedures were in place that alleged violations were to be thoroughly investigated. The policy indicated a comprehensive investigation was to be completed and the Administrator was to summarize the investigation, sign and date the document, and keep as evidence of the facility's investigation. The policy also indicated the investigation was to be completed to assure other residents</p>				

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	<p>had not been affected by the incident and this could involve interviewing staff members when appropriate. The investigation summary was to be compiled by the Administrator or designee and may include but was not limited to:</p> <p>"Facts and observation from the involved resident or residents." "Facts and observation from the involved employee or employees." "Facts and observations from witnessing employees or those that witnessed in the incident." "Facts and observations from visitors or other who might have pertinent information that is relevant to the investigation." "Injuries or lack thereof based upon the nursing assessment following the incident."</p> <p>The policy also indicated follow up assessments were to be completed/documented during every shift until the resident was stable and safety was maintained. The policy also indicated the Resident was to be examined and assessed immediately by the Nurse to determine if any injuries had occurred and their extent. The policy also indicated a thorough investigation was to be initiated and a summary of the investigation was</p>						

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	<p>to be signed and dated by the Administrator or designee and kept by the facility.</p> <p>This Federal tag relates to Complaint IN00141722.</p> <p>3.1-28(d)</p>			