

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155363	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/06/2016
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NAME OF PROVIDER OR SUPPLIER WILLOWDALE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 404 W WILLOW RD DALE, IN 47523
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaints IN00193682 and IN00193485.</p> <p>Complaint IN00193485- Substantiated. Federal/State deficiencies related to the allegations are cited at F225, F226, F 329.</p> <p>Complaint IN00193682 - Substantiated. Federal/State deficiencies related to the allegations are cited at F225, F 226, F329.</p> <p>Survey dates: May 6, 2016</p> <p>Facility number: 000254 Provider number: 155363 AIM number: 100266270</p> <p>Census bed type: SNF/NF: 36 Total: 36</p> <p>Census payor type: Medicare: 5 Medicaid: 23 Other: 8 Total: 36</p> <p>Sample: 4</p>	F 0000	<p>It is the practice of this provider to provide care, programs and services for the highest well-being of our residents in accordance with State and Federal law. The creation and submission of this <i>Plan of Correction (POC)</i> does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that this 2567 <i>Plan of Correction (POC)</i> be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review.</p>	
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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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F 0225 SS=D Bldg. 00	<p>These deficiencies reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by #02748 on May 12, 2016.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 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</p>			

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	<p>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, interview, and record review, the facility failed to immediately report allegations of abuse to the HFA [Health Facilities Administrator] and the ISDH [Indiana State Department of Health] for 2 of 3 abuse allegations reviewed. The facility failed to ensure allegations of abuse were thoroughly investigated for 1 of 2 allegations reviewed. (Resident F, Resident G)</p> <p>Findings include:</p> <p>1. On 5/6/16 at 8:20 A.M., Resident F was observed in his/her room lying in bed. Resident F was in no apparent distress. At that time during an interview the Director of Nursing Services (DNS) indicated Resident F was interviewable.</p>	F 0225	<p>1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> ·Family and MD of Resident F were notified of allegation of abuse with documentation placed in the medical record. ·Family and MD of Resident C were notified of allegation of abuse with documentation placed in the medical record. ·Family and MD of Resident G were notified of allegation of abuse with documentation placed in the medical record. ·Documentation of staff interviews regarding LPN#4 was obtained. ·Social Services Director and Housekeeping Supervisor completed abuse reporting policy in-servicing prior to returning from suspension on 02/09/2016. 	05/31/2016	

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	<p>On 5/6/16 at 11:00 A.M., the Administrator provided an incident reported to the Indiana State Board of Health (Incident # 33). The documentation included but was not limited to, "...1/11/2016 ABOM [assistant business office manager] was walking down hallway when she noticed light was on for resident [room # of Resident F] She went into the room and when she did...she stated that the nurse on night shift was rough when turning her towards the wall when performing care. ABOM told resident she would be back and when [sic] to get the BOM since this was one of her 'Customer Care Rooms' and knew the resident better than ABOM knew her...came to INT. ED to tell the issue...DNS contacted employee for his statement and he was suspended upon investigation of the incident...Resident expressed she would prefer not to be taken care of by the nurse in question anymore. Resident was reassured we would not let nurse provided care for her anymore... The facility provided a document titled "Incident Submission" that included "Incident Number 33....Date 1/12/2016 7:03 PM [sic]....Actual or Identified Date and Time of Incident: 1/11/2016 01:15 PM [sic]..."</p>		<p>·All staff was in-serviced on abuse prevention/immediatereporting, types of abuse, and protection of residents from further abuse wascompleted by ED/designee by 05/31/2016.</p> <p>2. How will you identify other residentshaving the potential to be affected by the same deficient practice and what correctiveaction will be taken?</p> <p>·Allresidents have the potential to be affected by alleged deficient practice.System in place to prevent abuse per policy.</p> <p>·Allresidents were interviewed by ED/designee using QIS with no furtherindications/allegations of abuse.</p> <p>·All staffmembers were interviewed by ED/designee with no further indications/allegationsof abuse noted.</p> <p>·Managementstaff were in-serviced by ED/designee on thorough investigation of allegationsof abuse.</p> <p>·All staffwere in-serviced by ED/designee by 05/31/2016 on reporting allegations of abuseimmediately to ED.</p> <p>3. What measures will be put into place orwhat systemic changes will you make to ensure that the deficient practice doesnot recur?</p> <p>·Interdisciplinary Team members in-serviced ondocumentation responsibilities following reported incident of</p>				

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	<p>The investigation for Incident #33 was reviewed, and included a "RESIDENT/FAMILY CONCERN/GRIEVANCE FORM" dated 1/11/16, the form included "...Time of Concern: midnight...Department Responsible for Concern Nursing...Section I: Nature of concern: ... [name of Resident F] call light was on, went in...and stated that [he/she] felt LPN #4...was rough when turning her towards the wall..."</p> <p>The investigation also included a typed note dated 1/13/16... it included "In regards to the alleged abuse complain, which I vehemently deny, that supposedly occurred on Sunday, January 10th 2016. I answered resident [room # for Resident F] call light and after using [his\her] communication board to determine [him\her] needing to have [his\her] brief changed. I then performed standard peri care...I performed [his\her] care by myself and had to use on hand to support [him\her] back while [he\she] was laying on [his\her] side...The above is my statement in regards to the alleged abuse complaint levied against me, and of which I was made aware of on January 12th, 2016 after working a full day in the facility..." the document was signed by LPN #4 and dated 1/13/16. A post it note attached to the bottom of the document</p>		<p>abuse and immediately reporting of allegations of abuse to ED.</p> <ul style="list-style-type: none"> ·Licensed Staff will be in-serviced on behavior flowsheet documentation by 05/31/2016. ·All staff in-serviced on abuse prevention/immediate reporting, types of abuse, and protection of residents from further abuse was completed by ED/designee by 05/31/2016. ·All allegations of abuse will be reported immediately by ED/designee with thorough investigation. ·All allegations of abuse will be reviewed by nurse consultant/designee to ensure thorough investigation. ·Staff will be interviewed by DNS/designee to ensure staff members are knowledgeable of reporting procedures. <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., quality assurance program will be put into place?</p> <ul style="list-style-type: none"> ·To ensure compliance the ED/designee is responsible for the completion of the Abuse Prohibition and Investigation CQI Tool weekly X 4 weeks, monthly X 6 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 100% is not achieved an action plan will be developed to ensure compliance. 		

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	<p>contained a handwritten note that stated, "As Medical Records -Nursing Director made sure there was not any contact w [with] /resident 1/13/16."</p> <p>The investigation lacked any documentation of the interviews conducted for other resident and staff members.</p> <p>The follow up to incident #33 was added on 1/15/16 at 6:20 P.M. It included "...1/15/2016 Resident [room # Resident F] has been observed for signs and symptoms of distress but none has been noted. Resident has expressed according to the direct nursing staff when resident feels depressed...Staff members involved has taken another position at one of our sister facilities since the incident, which was in the process before this incident was reported..."</p> <p>The clinical record for Resident F was reviewed on 5/6/16 at 9:40 A.M., the diagnoses included, but were not limited to depression, hypertension and anxiety.</p> <p>The Minimum Data Set assessment (MDS) dated 2/9/2016 indicated Resident F had a Brief Interview for Mental Status (BIMS) score of 15 indicating Resident F was cognitively intact. The MDS further indicated Resident F experienced no</p>		Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee.				

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	<p>behaviors.</p> <p>The Nursing notes for Resident F from 1/1/16 to 1/30/16 were reviewed and lacked any documentation of worsening depression and behaviors. The nursing notes lacked any documentation of the abuse allegation and that the residents family and physician were notified.</p> <p>The care plans included, but were not limited to, A care plan for risk of signs and symptoms of depression initiated 9/10/15. The interventions included, but were not limited to, "...Allow resident to express feelings and frustrations; offer validation and support, Emphasize and promote independence and feelings of control/choice, Encourage activities of interest, Encourage family support and involvement, Medications per order, Obtain psych [psychiatric] consult..."</p> <p>On 5/6/16 at 11:22 A.M., during an interview with the DNS (Director of Nursing Services) indicated the allegation of abuse of Resident F was reported to the interim ED on 1/11/16. She indicated Resident F had reported the allegation to the ABOM that day. She indicated herself and the interim ED had investigated the allegation immediately. She indicated LPN #4 was suspended and had transferred facilities. The DNS at that</p>			
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	<p>time provided proof of interviews for residents in the facility. No documentation that other staff members had been interviewed was provided. The DNS indicated at that time that LPN #4 had worked on the 1/12/16 while the investigation was still being completed. She indicated she ensured he had no contact with Resident F and had stayed in his office the entire day.</p> <p>The time card for LPN #4 was reviewed and indicated he had worked on 1/12/16 from 6:51 A.M. to 6:40 P.M.</p> <p>2. On 5/6/16 at 11:00 A.M., the Administrator provided an incident reported to the Indiana State Board of Health (Incident # 35). The documentation included but was not limited to, "... Incident Date: 02/04/2016 at 12:45 A.M...2/5/2016-- It was noted that Resident [Room # Resident C] reported to Housekeeping/Laundry /supervisor that she smacked Resident [Room # Resident G] and that she would do it again, there wasn't any witnesses to back up information, Resident's were immediately put at different dining room tables.</p> <p>The investigation for Incident #35 included, but was not limited to the following:</p>						

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	<p>A typed note dated 2/4/16 that included "Reported to Social Service at 12:45 pm [sic]. Housekeeping/Laundry Director came to my office and asked if SS could come and talk with two residents in the dining room because one was hollering at the other one for taking her dentures out and cleaning them in the dining room after every meal and it was making [Room # Resident C] very angry at [Room # Resident G]...Social Service spoke with both Ladies...[Resident C] explained [Resident G takes her dentures out and cleans them and this is very disgusting to have to watch...Social Service then spoke with [Resident G] and explained that it would probably be better to go to her room to clean her dentures because it is upsetting other diners...Spoke with [Resident C]...about moving to another table and both refused. Spoke with [Resident G] about moving tables and she states that she was there first here first and she has always sat at that table and "I'm not moving". It was told later in the evening at 4:15pm [sic] by LNDRY/HSKPG Mang. [Laundry/Housekeeping Manager] on the 4th that [Resident C] was witnessed walking down the hallway to her room stated that "I smacked [Resident G]'s hand and I will do it again!". The document was signed by the Social Service Director.</p>			

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	<p>Another typed note dated 2/4/16 included, "Around 12:45 pm [sic] I witnessed [Resident C] speaking loudly with [Resident G] saying 'Don't do that in the dining room'. [Resident G] was holding her dentures in her hand and cleaning them off in the dining room in front of table mates.</p> <p>Housekeeping/Laundry Dir. [Director] Walked [sic] over to the table and asked resident's what was wrong, why the raised voices? [Resident C] responded with 'She is cleaning her dentures at the table.' Came to SS [Social Service] office and reported the disturbance to her...Around 4:15pm [Resident C] came past HSKPG/LNDRY in west hallway and made a statement 'I smacked her and I'd do it again.' I asked her what she said and she said 'I was just joking'. I did not witness the smack so I did not go any further with that information I had..." The document was signed by HSK Supervisor on 2/5/16.</p> <p>Another typed note dated 2/5/16 included "Reported to ED [Executive Director] at morning meeting @ [at] 9:20am [sic] with SS that what was believed by Us [sic] [Unit Supervisor] to be change in behavior but after reporting was informed that the issue of resident to resident altercation was a reportable not a change</p>			

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	<p>in behavior as was thought.."</p> <p>Another typed note dated 2/5/16 included, "SS reported to Nursing DON [Director of Nursing] at 8:00am [sic] on 2/5/16 after receiving a new and worsening behavior...The incident of smacking was not witnessed...asked [Resident G] about this she did not answer only smiled...Both directors from SS and LNDRY/HSKPG brought this up in morning meeting as [sic] then told that even an allegation is to be turned into ED as a reportable occurrence. When [sic] spoke to [Resident C] again at lunch...asked her if she really smacked [Resident G]'s hand and [Resident C] stated 'yes I did she was picking her nose and I swatted her hand and told her to stop..' SS moved [Resident C] to another table...Also set [sic] with [Resident C] all through lunch service and dining because [Resident C] was speaking ill of [Resident G] in a loud voice for everyone in the DR [Dining Room] to be able to hear. Educated [Resident C] on proper tone and inappropriateness of verbal comments." The document was signed by the SSD.</p> <p>The follow up for Incident #35 was added on 2/9/16 at 8:52 A.M., it included, "...2/9/16 Resident [G] has been followed by Social Service and does not recall the</p>			

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	<p>incident. Resident [C] was redirected at the time of the issue on 2/5, the table that resident normally sits at has been adjusted to a different area...It has been discovered Resident [C] received a GDR for Celexa [an antidepressant] 40 mil [mg] [milligrams] on 1/29/16 after a discussion with the family and physician. It was decided to put the resident back to the original dosage of medicine. Social Service will continue to provide assistance to both resident and monitor for any other signs or symptoms of psychosocial distress."</p> <p>The investigation contained an electronic mail (E mail) dated 2/5/16 at 11:58 A.M. from the facility Social Service Consultant (SSC). It included but was not limited to, "I have attached the [company name] abuse policy and our guidelines for reporting any allegation or suspicion of abuse. Remember that we never get to make the call on if we think the allegation or suspicion of abuse is legit. We must first always ensure the resident is safe and then immediately report to the ED who then decides if the situation needs to be reported to the ISDH. Any suspicion or report of any type of abuse (verbal, physical, mental, neglect, misappropriation of funds, sexual, involuntary seclusion or injuries of unknown origin) all must be reported to</p>			

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	<p>the ED...It does not matter if the resident who reports is demented or has a mental illness is a frequent reported of allegation; we always immediately let the ED know...".</p> <p>Another E mail dated 2/5/16 at 7:54 P. M. was sent by the interim HFA, it included, but was not limited to, "Here is the initial reportable [DNS] and I have worked up for the issue we were made aware of late...If it is okay to put the initial through tonight, we will..."</p> <p>An "Employee Communication Form" dated 2/5/16 indicated the SSD was suspended on 2/5/16 to 2/8/16 for failure to report resident to resident abuse.</p> <p>An "Employee Communication Form" dated 2/5/16 indicated the HSK Supervisor was suspended on 2/5/16 to 2/8/16 for failure to report resident to resident abuse.</p> <p>A typed note dated 2/9/16 included, but was not limited to, "...It was brought to SS attention at 1:30pm [sic] from LPN #7 on first shift working on East hall that a resident [room # Resident H] stated that another resident [Resident C] said '[Resident C] was out to get [Resident G] for lying about her and saying she smacked her'...[Resident R] states she is</p>			

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	<p>very worried about [Resident C] because she has known her for several years and she has always been a very sweet loving person and has never acted this way before...".</p> <p>Resident G was observed on 5/6/16 at 10:55 A.M., in bed with eyes closed, Resident G appeared to be in no apparent distress.</p> <p>The clinical record for Resident G was reviewed on 5/6/16 at 1:56 P.M., the diagnoses included, but were not limited to edema, diabetes, dementia without behavioral disturbances and hypertension.</p> <p>The Nurses notes lacked any documentation of family and physician notification of the incident.</p> <p>The care plans included, but were not limited to, a care plan for risk of psychological distress related to alleged negative interaction with another resident initiated 2/10/16. The interventions included, encourage resident to participate in activities of choice, observe for and report any changes in moods or behaviors, offer comfort, support and reassurance as needed.</p> <p>On 5/6/16 at 2:20 P.M., Resident C was</p>				

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	<p>observed lying in her bed. Resident C did not recall the incident and appeared to be in no apparent distress.</p> <p>The clinical record for Resident C was reviewed on 5/6/16 at 1:56 P.M., the diagnoses included, but were not limited to, depression, anxiety, Alzheimer's disease and a history of breast cancer.</p> <p>The Nurses Notes from 1/29/16 to 2/28/16 were reviewed and lacked any documentation of behaviors.</p> <p>An timed Social Service note dated 2/5/16 included "Reported to SS from Laundry/Housekeeping dire. that [Resident name] was dancing down the hall after afternoon [sic] and was saying that she hit another resident on her hand because she wouldn't stop taking her dentures out and cleaning them in DR [dining room]..."</p> <p>During an interview with the Administrator on 5/6/16 at 2:00 P.M., he indicated he was aware of the concerns with the investigation and reporting of incident #33. The HFA further indicated all incidents of abuse should be thoroughly investigated, prior to the staff member returning to work and all allegations of abuse should immediately</p>			

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	<p>reported to the HFA and the ISDH as soon as the residents involved are safe.</p> <p>A policy titled "ABUSE PROHAVITION, REPORTING, AND INVESTIGATION" dated July 2015 was provided by the HFA on 5/6/16 at 2:20 P.M. The policy included, but was not limited to "...It is the policy of American Senior Communities to protect residents from abuse including physical abuse...verbal abuse, mental abuse...Abuse is the willful infliction of injury...intimidation or punishment with resulting physical harm or pain, or mental anguish...This presumes that instances of abuse of all residents, even those in a coma, cause physical harm, or pain, or mental anguish...Physical Abuse-a willful act against a resident by another resident...Examples: hitting...slapping...striking...Verbal Abuse-oral, written or gestured language that includes disparaging and derogatory terms to residents or their families, or within their hearing, regardless of their age, ability to comprehend, or disability...Examples would include, but are not limited to: threats of harm, saying things to frighten a resident..1. Resident to resident verbal threats of harm...Mental Abuse-Verbal or nonverbal infliction or anguish, pain or distress that results in physiological or</p>			

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	<p>emotional suffering...2. Resident to resident, if it appears to be willfully directed toward a specific resident. Examples: humiliation, harassment...bullying....American Senior Communities will not permit residents to be subjected to abuse by anyone, including...other residents...or other individuals.....Employees weather direct care, contract staff, ancillary department...receive instruction/training on abuse during orientation and periodically during ongoing inservice education. The training will include: a. What constitutes abuse...To whom to report abuse, and when...His/her role in an investigation...RESIDENT-TO-RESIDENT ABUSE: Policy: It is the policy of [name of company] to assure appropriate interventions are in place and followed to assure safety of the resident (s) is maintained if abuse is identified or suspected...If resident-to-resident abuse is identified, or there is suspicion of resident-to-resident abuse, the following guidelines will be followed...Any individual who witnesses...will immediately separate the residents involves...The individual who witnessed the abuse will report the situation immediately to his/her supervisor and Executive Director...The staff member in charge will initiate the investigation</p>			

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F 0226 SS=D	<p>immediately...The attending physician will be notified...The family of the resident (s) and/or responsible party will be notified...The Behavior Management team will assess the situation and make recommendations for further integrations..It is the responsibility of the Administrator/Director of Nursing to report abuse, or allegations of abuse, immediately to the Indiana State Department of Health...RESIDENT ABUSE-staff member...Any staff member implicated in the alleged abuse will be removed from the facility at one and will remain suspended until an investigation is completed...The investigation will include: Facts and observation by involved employee...witnessed employees...witnessing non-employees...others who might have pertinent information...supervisor or individual whom the initial report was made..."</p> <p>This Federal tag relates to Complaint IN00193485 and IN00193682.</p> <p>3.1-28 (c)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT,</p>				

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Bldg. 00	<p>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 observation, interview, and record review, the facility failed follow their policy for abuse prohibition by failing to identify, report, and thoroughly investigate residents allegations of abuse for 2 of 3 allegations reviewed. (Resident F, Resident G, Resident R, Resident H)</p> <p>Findings include:</p> <p>1. On 5/6/16 at 8:20 A.M., Resident F was observed in his/her room lying in bed. Resident F was in no apparent distress. At that time during an interview the Director of Nursing Services (DNS) indicated Resident F was interviewable.</p> <p>On 5/6/16 at 11:00 A.M., the Administrator provided an incident reported to the Indiana State Board of Health (Incident # 33). The documentation included but was not limited to, "...1/11/2016 ABOM [assistant business office manager] was walking down hallway when she noticed light was on for resident [room # of Resident F] She went into the room and when she did...she stated that the nurse on night shift was rough when turning</p>	F 0226	<p>1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> ·Family and MD of Resident F were notified of allegation of abuse with documentation placed in the medical record. ·Family and MD of Resident C were notified of allegation of abuse with documentation placed in the medical record. ·Family and MD of Resident G were notified of allegation of abuse with documentation placed in the medical record. ·Documentation of staff interviews regarding LPN#4 was obtained. ·Social Services Director and Housekeeping Supervisor completed abuse reporting policy in-servicing prior to returning from suspension on 02/09/2016. ·All staff was in-serviced by DNS/designee on abuse prevention/immediate reporting, types of abuse, and protection of residents from further abuse was completed by ED/designee by 05/31/2016. <p>2. How will you identify other residents having the potential to be affected by the same deficient practice and</p>	05/31/2016	

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	<p>her towards the wall when performing care. ABOM told resident she would be back and when [sic] to get the BOM since this was one of her 'Customer Care Rooms' and knew the resident better than ABOM knew her...came to INT. ED to tell the issue...DNS contacted employee for his statement and he was suspended upon investigation of the incident...Resident expressed she would prefer not to be taken care of by the nurse in question anymore. Resident was reassured we would not let nurse provided care for her anymore... The facility provided a document titled "Incident Submission" that included "Incident Number 33....Date 1/12/2016 7:03 PM [sic]....Actual or Identified Date and Time of Incident: 1/11/2016 01:15 PM [sic]..."</p> <p>The investigation for Incident #33 was reviewed, and included a "RESIDENT/FAMILY CONCERN/GRIEVANCE FORM" dated 1/11/16, the form included "...Time of Concern: midnight...Department Responsible for Concern Nursing...Section I: Nature of concern: ... [name of Resident F] call light was on, went in...and stated that [he/she] felt LPN #4...was rough when turning her towards the wall..."</p>		<p>whatcorrective action will be taken?</p> <ul style="list-style-type: none"> ·Allresidents have the potential to be affected by alleged deficient practice.System in place to prevent abuse per policy. ·Allresidents were interviewed by ED/designee using QIS with no furtherindications/allegations of abuse. ·All staffmembers were interviewed by ED/designee with no further indications/allegationsof abuse noted and interviewed to ensure staff were knowledgeable of who toreport abuse to for appropriate follow-up. <p>3. What measures will be put into place orwhat systemic changes will you make to ensure that the deficient practice doesnot recur?</p> <ul style="list-style-type: none"> ·Interdisciplinary Team members in-serviced byED/designee on documentation responsibilities following reported incident ofabuse. ·Licensed Staff will be in-serviced byDNS/designee on behavior flowsheet documentation by 05/31/2016. ·All staff in-serviced by DNS/designee on abuseprevention/immediate reporting, types of abuse, and protection of residentsfrom further abuse was completed by ED/designee by 05/31/2016. ·Allallegations of abuse will be reported immediately by ED/designee with 				

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	<p>The investigation also included a typed note dated 1/13/16... it included "In regards to the alleged abuse complain, which I vehemently deny, that supposedly occurred on Sunday, January 10th 2016. I answered resident [room # for Resident F] call light and after using [his\her] communication board to determine [him\her] needing to have [his\her] brief changed. I then performed standard peri care...I performed [his\her] care by myself and had to use on hand to support [him\her] back while [he\she] was laying on [his\her] side...The above is my statement in regards to the alleged abuse complaint levied against me, and of which I was made aware of on January 12th, 2016 after working a full day in the facility..." the document was signed by LPN #4 and dated 1/13/16. A post it note attached to the bottom of the document contained a handwritten note that stated, "As Medical Records -Nursing Director made sure there was not any contact w [with] /resident 1/13/16."</p> <p>The investigation lacked any documentation of the interviews conducted for other resident and staff members.</p> <p>The follow up to incident #33 was added on 1/15/16 at 6:20 P.M. It included "...1/15/2016 Resident [room # Resident</p>		<p>thoroughinvestigation. 4. How the corrective action(s) will bemonitored to ensure the deficient practice will not recur, i.e., qualityassurance program will be put into place To ensure compliance the ED/designee is responsible for the completion of the Abuse Prohibition and Investigation CQITool weekly X 4 weeks, monthly X 6 and then quarterly until continued compliance is maintained for2 consecutive quarters. The results ofthese audits will be reviewed be the CQI committee overseen by the ED. Ifthreshold of 100% is not achieved an action plan will be developed to ensurecompliance. Deficiency in this practicewill result in disciplinary action up to and including termination ofresponsible employee.</p>	

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	<p>F] has been observed for signs and symptoms of distress but none has been noted. Resident has expressed according to the direct nursing staff when resident feels depressed...Staff members involved has taken another position at one of our sister facilities since the incident, which was in the process before this incident was reported..."</p> <p>The clinical record for Resident F was reviewed on 5/6/16 at 9:40 A.M., the diagnoses included, but were not limited to depression, hypertension and anxiety.</p> <p>The Minimum Data Set assessment (MDS) dated 2/9/2016 indicated Resident F had a Brief Interview for Mental Status (BIMS) score of 15 indicating Resident F was cognitively intact. The MDS further indicated Resident F experienced no behaviors.</p> <p>The Nursing notes for Resident F from 1/1/16 to 1/30/16 were reviewed and lacked any documentation of worsening depression and behaviors. The nursing notes lacked any documentation of the abuse allegation and that the residents family and physician were notified.</p> <p>The care plans included, but were not limited to, A care plan for risk of signs and symptoms of depression initiated</p>			

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	<p>9/10/15. The interventions included, but were not limited to, "...Allow resident to express feelings and frustrations; offer validation and support, Emphasize and promote independence and feelings of control/choice, Encourage activities of interest, Encourage family support and involvement, Medications per order, Obtain psych [psychiatric] consult..."</p> <p>On 5/6/16 at 11:22 A.M., during an interview with the DNS (Director of Nursing Services) indicated the allegation of abuse of Resident F was reported to the interim ED on 1/11/16. She indicated Resident F had reported the allegation to the ABOM that day. She indicated herself and the interim ED had investigated the allegation immediately. She indicated LPN #4 was suspend and then transferred facilities. The DNS at that time provided proof of interviews for residents in the facility. No documentation that other staff members had been interviewed was provided. The DNS indicated at that time that LPN #4 had worked on the 1/12/16 while the investigation was still being completed. She indicated she ensured he had no contact with Resident F and had stayed in his office the entire day.</p> <p>The time care for LPN #4 was reviewed and indicated he had worked on 1/12/16 from 6:51 A.M. to 6:40 P.M.</p>			

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	<p>2. On 5/6/16 at 11:00 A.M., the Administrator provided an incident reported to the Indiana State Board of Health (Incident # 35). The documentation included but was not limited to, "... Incident Date: 02/04/2016 at 12:45 A.M...2/5/2016-- It was noted that Resident [Room # Resident C] reported to Housekeeping/Laundry /supervisor that she smacked Resident [Room # Resident G] and that she would do it again, there wasn't any witnesses to back up information, Resident's were immediately put at different dining room tables.</p> <p>The investigation for Incident #35 included, but was not limited to the following: A typed note dated 2/4/16 that included "Reported to Social Service at 12:45 pm [sic]. Housekeeping/Laundry Director came to my office and asked if SS could come and talk with two residents in the dining room because one was hollering at the other one for taking her dentures out and cleaning them in the dining room after every meal and it was making [Room # Resident C] very angry at [Room # Resident G]...Social Service spoke with both Ladies...[Resident C] explained [Resident G takes her dentures out and cleans them and this is very</p>			

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	<p>disgusting to have to watch...Social Service then spoke with [Resident G] and explained that it would probably be better to go to her room to clean her dentures because it is upsetting other diners...Spoke with [Resident C]...about moving to another table and both refused. Spoke with [Resident G] about moving tables and she states that she was the first here first and she has always sat at that table and "I'm not moving". It was told later in the evening at 4:15pm [sic] by LNDRY/HSKPG Mang. [Laundry/Housekeeping Manager] on the 4th that [Resident C] was witnessed walking down the hallway to her room stated that "I smacked [Resident G]'s hand and I will do it again!" The document was signed by the Social Service Director.</p> <p>Another typed note dated 2/4/16 included, "Around 12:45 pm [sic] I witnessed [Resident C] speaking loudly with [Resident G] saying 'Don't do that in the dining room'. [Resident G] was holding her dentures in her hand and cleaning them off in the dining room in front of table mates. Housekeeping/Laundry Dir. [Director] Walked [sic] over to the table and asked resident's what was wrong, why the raised voices? [Resident C] responded with 'She is cleaning her dentures at the</p>			

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	<p>table.' Came to SS [Social Service] office and reported the disturbance to her...Around 4:15pm [Resident C] came past HSKPG/LNDRY in west hallway and made a statement 'I smacked her and I'd do it again.' I asked her what she said and she said 'I was just joking'. I did not witness the smack so I did not go any further with that information I had..." The document was signed by HSK Supervisor on 2/5/16.</p> <p>Another typed note dated 2/5/16 included "Reported to ED [Executive Director] at morning meeting @ [at] 9:20am [sic] with SS that what was believed by Us [sic] [Unit Supervisor] to be change in behavior but after reporting was informed that the issue of resident to resident altercation was a reportable not a change in behavior as was thought.."</p> <p>Another typed note dated 2/5/16 included, "SS reported to Nursing DON [Director of Nursing] at 8:00am [sic] on 2/5/16 after receiving a new and worsening behavior...The incident of smacking was not witnessed...asked [Resident G] about this she did not answer only smiled...Both directors from SS and LNDRY/HSKPG brought this up in morning meeting as [sic] then told that even an allegation is to be turned into ED as a reportable occurrence. When</p>			

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	<p>[sic] spoke to [Resident C] again at lunch...asked her if she really smacked [Resident G]'s hand and [Resident C] stated 'yes I did she was picking her nose and I swatted her hand and told her to stop..' SS moved [Resident C] to another table...Also set [sic] with [Resident C] all through lunch service and dining because [Resident C] was speaking ill of [Resident G] in a loud voice for everyone in the DR [Dining Room] to be able to hear. Educated [Resident C] on proper tone and inappropriateness of verbal comments." The document was signed by the SSD.</p> <p>The follow up for Incident #35 was added on 2/9/16 at 8:52 A.M., it included, "...2/9/16 Resident [G] has been followed by Social Service and does not recall the incident. Resident [C] was redirected at the time of the issue on 2/5, the table that resident normally sits at has been adjusted to a different area...It has been discovered Resident [C] received a GDR for Celexa [an antidepressant] 40 mil [mg] [milligrams] on 1/29/16 after a discussion with the family and physician. It was decided to put the resident back to the original dosage of medicine. Social Service will continue to provide assistance to both resident and monitor for any other signs or symptoms of psychosocial distress."</p>			

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	<p>The investigation contained an electronic mail (E mail) dated 2/5/16 at 11:58 A.M. from the facility Social Service Consultant (SSC). It included but was not limited to, "I have attached the [company name] abuse policy and our guidelines for reporting any allegation or suspicion of abuse. Remember that we never get to make the call on if we think the allegation or suspicion of abuse is legit. We must first always ensure the resident is safe and then immediately report to the ED who then decides if the situation needs to be reported to the ISDH. Any suspicion or report of any type of abuse (verbal, physical, mental, neglect, misappropriation of funds, sexual, involuntary seclusion or injuries of unknown origin) all must be reported to the ED...It does not matter if the resident who reports is demented or has a mental illness is a frequent reported of allegation; we always immediately let the ED know..."</p> <p>Another E mail dated 2/5/16 at 7:54 P. M. was sent by the interim HFA, it included, but was not limited to, "Here is the initial reportable [DNS] and I have worked up for the issue we were made aware of late...If it is okay to put the initial through tonight, we will..."</p>			

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	<p>An "Employee Communication Form" dated 2/5/16 indicated the SSD was suspended on 2/5/16 to 2/8/16 for failure to report resident to resident abuse.</p> <p>An "Employee Communication Form" dated 2/5/16 indicated the HSK Supervisor was suspended on 2/5/16 to 2/8/16 for failure to report resident to resident abuse.</p> <p>A typed note dated 2/9/16 included, but was not limited to, "...It was brought to SS attention at 1:30pm [sic] from LPN #7 on first shift working on East hall that a resident [room # Resident H] stated that another resident [Resident C] said '[Resident C] was out to get [Resident G] for lying about her and saying she smacked her'...[Resident R] states she is very worried about [Resident C] because she has known her for several years and she has always been a very sweet loving person and has never acted this way before...".</p> <p>Resident G was observed on 5/6/16 at 10:55 A.M., in bed with eyes closed, Resident G appeared to be in no apparent distress.</p> <p>The clinical record for Resident G was reviewed on 5/6/16 at 1:56 P.M., the diagnoses included, but were not limited</p>			

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	<p>to edema, diabetes, dementia without behavioral disturbances and hypertension.</p> <p>The Nurses notes lacked any documentation of family and physician notification of the incident.</p> <p>The care plans included, but were not limited to, a care plan for risk of psychological distress related to alleged negative interaction with another resident initiated 2/10/16. The interventions included, encourage resident to participate in activities of choice, observe for and report any changes in moods or behaviors, offer comfort, support and reassurance as needed.</p> <p>On 5/6/16 at 2:20 P.M., Resident C was observed lying in her bed. Resident C did not recall the incident and appeared to be in no apparent distress.</p> <p>The clinical record for Resident C was reviewed on 5/6/16 at 1:56 P.M., the diagnoses included, but were not limited to, depression, anxiety, Alzheimer's disease and a history of breast cancer.</p> <p>The Nurses Notes from 1/29/16 to 2/28/16 were reviewed and lacked any documentation of behaviors.</p>			

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	<p>An timed Social Service note dated 2/5/16 included "Reported to SS from Laundry/Housekeeping dire. that [Resident name] was dancing down the hall after afternoon [sic] and was saying that she hit another resident on her hand because she wouldn't stop taking her dentures out and cleaning them in DR [dining room]..."</p> <p>During an interview with the Administrator on 5/6/16 at 2:00 P.M., he indicated he was aware of the concerns with the investigation and reporting of incident #33. The HFA further indicated all incidents of abuse should be thoroughly investigated, prior to the staff member returning to work and all allegations of abuse should immediately reported to the HFA and the ISDH as soon as the residents involved are safe.</p> <p>A policy titled "ABUSE PROHAVITION, REPORTING, AND INVESTIGATION" dated July 2015 was provided by the HFA on 5/6/16 at 2:20 P.M. The policy included, but was not limited to "...It is the policy of American Senior Communities to protect residents from abuse including physical abuse...verbal abuse, mental abuse...Abuse is the willful infliction of injury...intimidation or punishment with</p>			

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	<p>resulting physical harm or pain, or mental anguish...This presumes that instances of abuse of all residents, even those in a coma, cause physical harm, or pain, or mental anguish...Physical Abuse-a willful act against a resident by another resident...Examples: hitting...slapping...striking...Verbal Abuse-oral, written or gestured language that includes disparaging and derogatory terms to residents or their families, or within their hearing, regardless of their age, ability to comprehend, or disability...Examples would include, but are not limited to: threats of harm, saying things to frighten a resident..1. Resident to resident verbal threats of harm...Mental Abuse-Verbal or nonverbal infliction or anguish, pain or distress that results in physiological or emotional suffering...2. Resident to resident, if it appears to be willfully directed toward a specific resident. Examples: humiliation, harassment...bullying....American Senior Communities will not permit residents to be subjected to abuse by anyone, including...other residents...or other individuals.....Employees weather direct care, contract staff, ancillary department...receive instruction/training on abuse during orientation and periodically during ongoing inservice education. The training will include: a.</p>			

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	<p>What constitutes abuse...To whom to report abuse, and when...His/her role in an investigation...RESIDENT-TO-RESIDENT ABUSE: Policy: It is the policy of [name of company] to assure appropriate interventions are in place and followed to assure safety of the resident (s) is maintained if abuse is identified or suspected...If resident-to-resident abuse is identified, or there is suspicion of resident-to-resident abuse, the following guidelines will be followed...Any individual who witnesses...will immediately separate the residents involves...The individual who witnessed the abuse will report the situation immediately to his/her supervisor and Executive Director...The staff member in charge will initiate the investigation immediately...The attending physician will be notified...The family of the resident (s) and/or responsible party will be notified...The Behavior Management team will assess the situation and make recommendations for further integrations..It is the responsibility of the Administrator/Director of Nursing to report abuse, or allegations of abuse, immediately to the Indiana State Department of Health...RESIDENT ABUSE-staff member...Any staff member implicated in the alleged abuse will be removed from the facility at one</p>			

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F 0329 SS=D Bldg. 00	<p>and will remain suspended until an investigation is completed...The investigation will include: Facts and observation by involved employee...witnessed employees...witnessing non-employees...others who might have pertinent information...supervisor or individual whom the initial report was made..."</p> <p>This Federal tag relates to Complaint IN00193485 and IN00193682.</p> <p>3.1-28 (a)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and</p>			

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	<p>residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, interview, and record review, the facility failed to ensure adequate behavior monitoring was in place for a resident receiving a gradual dose reduction for 1 of 1 residents reviewed for medication errors. (Resident C)</p> <p>Findings include:</p> <p>On 5/6/16 at 2:20 P.M., Resident C was observed lying in her bed. Resident C was able to answer questions appropriately and appeared to be in no apparent distress.</p> <p>The clinical record for Resident C was reviewed on 5/6/16 at 1:56 P.M., the diagnoses included, but were not limited to, depression, anxiety, Alzheimer's disease and a history of breast cancer.</p> <p>A typed Gradual Dose Reeducation (GDR) request form dated 1/21/16 indicated Resident C had been taking Celexa 40 mg every day for depression and experienced no behaviors. The form indicated the last attempt at a GDR had been attempted on 8/15. The form continued and included, "...REDUCE this</p>	F 0329	<p>1. What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?</p> <ul style="list-style-type: none"> · Resident Cis receiving the correct dosage of psychoactive medication per MD order. <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken</p> <ul style="list-style-type: none"> · All residents receiving orders for gradual drug reductions for psychoactive medications have the potential to be affected by the alleged deficient practice. · An audit will be completed by DNS/designee to determine all residents receiving psychoactive medications and potential need of GDR by 06/05/2016. <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <ul style="list-style-type: none"> · DNS/designee will provide in servicing for transcription of medications to the medication administration record by 06/05/2016. · SSD/designee will in service licensed staff on behavior tracking flow sheets for all residents by 06/05/2016. 	06/05/2016

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	<p>medication by 10 mg [milligrams] [to 30 mg]..." signed on 1/29/16 by the physician.</p> <p>The Physician Telephone Orders dated 1/29/16 included, "...D/C [discontinue] Celexa 40 mg Start Celexa 10 mg q [every] day (depression).</p> <p>On 5/6/16 at 2:00 P.M., during an interview with the Director of Nursing Services (DNS) she indicated a medication and transcription error had been made following a request for a GDR for Resident C. She indicated the nurse wrote for Resident C to receive 10 mg of Celexa instead of decreasing the 40 mg to 30 as the form instructed. During the interview the DNS provided an internal form titled "MEDICATION/TREATMENT ERROR REPORT" the document included, "...2/3/16...Transcription error...Description of error : Celexa dosage written...Effect of error on resident: 'None'...Measure taken to prevent reoccurrence:...DNS to check orders to ensure accuracy, DNS will look at GDR's before orders written...Actions taken: one on one teaching..." At that time an interview with the Social Service Director was requested however she was unavailable for an interview.</p>		<p>All residents receiving orders for gradual drug reductions for psychoactive medications will be reviewed by DNS/designee daily to ensure appropriate behavior monitoring.</p> <p>All orders for gradual drug reductions for psychoactive medication will be checked by DNS/designee against the medication administration record for transcription accuracy and the original gradual drug reduction request.</p> <p>4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place</p> <p>a) To ensure compliance the DNS/designee is responsible for the completion of the Unnecessary Medication CQI Tool weekly X4 weeks, monthly X 6 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 100% is not achieved an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee.</p> <p>b) To ensure compliance the DNS/designee is responsible for the completion of the Medication Error CQI Tool weekly X 4 weeks,</p>	

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	<p>The Nurses Notes from 1/1/16 to 2/28/16 were reviewed and lacked any documentation of behaviors.</p> <p>An untimed Social Service note dated 1/4/16 include, "...No s/s [signs or symptoms] of anxiety or depression noted. Family is very involved [with] care choices...[Resident C] is always smiling, has made lots of friends... Will follow through next review not [sic] changes on this date."</p> <p>A Physicians Telephone Order dated 2/3/16 included, "Celexa 30 mg 1 po [by mouth] daily...clarification of previous Celexa order..."</p> <p>No behaviors were documented in the social service notes from 1/5/16 to 2/5/16.</p> <p>An timed Social Service note dated 2/5/16 included "Reported to SS from Laundry/Housekeeping dire. that [Resident name] was dancing down the hall after afternoon [sic] and was saying that she hit another resident on her hand because she wouldn't stop taking her dentures out and cleaning them in DR [dining room]..."</p> <p>On 5/6/16 at 11:00 A.M., the Administrator provided an incident</p>		<p>monthly X 6 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 100% is not achieved an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee.</p>	

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	<p>reported to the Indiana State Board of Health (Incident # 35). The documentation included but was not limited to, "... Incident Date: 02/04/2016 at 12:45 A.M...2/5/2016-- It was noted that Resident [Room # Resident C] reported to Housekeeping/Laundry /supervisor that she smacked Resident [Room # Resident G] and that she would do it again, there wasn't any witnesses to back up information, Resident's were immediately put at different dining room tables.</p> <p>The investigation for Incident #35 included, but was not limited to the following: A typed note dated 2/4/16 that included "Reported to Social Service at 12:45 pm [sic]. Housekeeping/Laundry Director came to my office and asked if SS could come and talk with two residents in the dining room because one was hollering at the other one for taking her dentures out and cleaning them in the dining room after every meal and it was making [Room # Resident C] very angry at [Room # Resident G]...Social Service spoke with both Ladies...[Resident C] explained [Resident G takes her dentures out and cleans them and this is very disgusting to have to watch...Social Service then spoke with [Resident G] and explained that it would probably be better</p>			

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	<p>to go to her room to clean her dentures because it is upsetting other diners...Spoke with [Resident C]...about moving to another table and both refused. Spoke with [Resident G] about moving tables and she states that she was the first here first and she has always sat at that table and "I'm not moving". It was told later in the evening At 4:15pm [sic] by LNDRY/HSKPG Mang. [Laundry/Housekeeping Manager] on the 4th that [Resident C] was witnessed walking down the hallway to her room stated that "I smacked [Resident G]'s hand and I will do it again!" The document was signed by the Social Service Director.</p> <p>Another typed note dated 2/4/16 included, "Around 12:45 pm [sic] I witnessed [Resident C] speaking loudly with [Resident G] saying 'Don't do that in the dining room'. [Resident G] was holding her dentures in her hand and cleaning them off in the dining room in front of table mates. Housekeeping/Laundry Dir. [Director] Walked [sic] over to the table and asked resident's what was wrong, why the raised voices? [Resident C] responded with 'She is cleaning her dentures at the table.' Came to SS [Social Service] office and reported the disturbance to her...Around 4:15pm [Resident C] came</p>			

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	<p>past HSKPG/LNDRY in west hallway and made a statement 'I smacked her and I'd do it again.' I asked her what she said and she said 'I was just joking'. I did not witness the smack so I did not go any further with that information I had..." The document was signed by HSK Supervisor on 2/5/16.</p> <p>Another typed note dated 2/5/16 included "Reported to ED [Executive Director] at morning meeting @ [at] 9:20am [sic] with SS that what was believed by Us [sic] [Unit Supervisor] to be change in behavior but after reporting was informed that the issue of resident to resident altercation was a reportable not a change in behavior as was thought.."</p> <p>Another typed note dated 2/5/16 included, "SS reported to Nursing DON [Director of Nursing] at 8:00am [sic] on 2/5/16 after receiving a new and worsening behavior...The incident of smacking was not witnessed...asked [Resident G] about this she did not answer only smiled...Both directors from SS and LNDRY/HSKPG brought this up in morning meeting as [sic] then told that even an allegation is to be turned into ED as a reportable occurrence. When [sic] spoke to [Resident C] again at lunch...asked her if she really smacked [Resident G]'s hand and [Resident C]</p>			

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	<p>stated 'yes I did she was picking her nose and I swatted her hand and told her to stop..' SS moved [Resident C] to another table...Also set [sic] with [Resident C] all through lunch service and dining because [Resident C] was speaking ill of [Resident G] in a loud voice for everyone in the DR [Dining Room] to be able to hear. Educated [Resident C] on proper tone and inappropriateness of verbal comments." The document was signed by the SSD.</p> <p>The follow up for Incident #35 was added on 2/9/16 at 8:52 A.M., it included, "...2/9/16 Resident [G] has been followed by Social Service and does not recall the incident. Resident [C] was redirected at the time of the issue on 2/5, the table that resident normally sits at has been adjusted to a different area...It has been discovered Resident [C] received a GDR for Celexa [an antidepressant] 40 mil [mg] [milligrams] on 1/29/16 after a discussion with the family and physician. It was decided to put the resident back to the original dosage of medicine. Social Service will continue to provide assistance to both resident and monitor for any other signs or symptoms of psychosocial distress."</p> <p>A typed note dated 2/9/16 included, but was not limited to, "...It was brought to</p>			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>SS attention at 1:30pm [sic] from LPN #7 on first shift working on East hall that a resident [room # Resident H] stated that another resident [Resident C] said '[Resident C] was out to get [Resident G] for lying about her and saying she smacked her'...[Resident R] states she is very worried about [Resident C] because she has known her for several years and she has always been a very sweet loving person and has never acted this way before...".</p> <p>A Physicians Telephone Order dated 2/9/16 included, "D/C previous order for Celexa...Celexa 40mg Po daily for Reactive Depression..."</p> <p>The manufacturers instructions for citalopram (Celexa) included, but was not limited to "...Precautions...Discontinuation of Treatment with Celexa During marketing of Celexa and other SSRIs and SNRIs (serotonin and norepinephrine reuptake inhibitors), there have been spontaneous reports of adverse events occurring upon discontinuation of these drugs, particularly when abrupt, including the following: dysphoric mood, irritability, agitation, dizziness, sensory disturbances (e.g., paresthesias such as electric shock sensations), anxiety, confusion, headache, lethargy,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155363	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/06/2016
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	<p>insomnia, and hypomania. While these events are generally self...limiting, there have been reports of serious iscontinuation symptoms. Patients should be monitored for these symptoms when discontinuing treatment with Celexa. A gradual reduction in the dose rather than abrupt cessation is recommended whenever possible. If intolerable symptoms occur following a decrease in the dose or upon discontinuation of treatment, then resuming the previously prescribed dose may be considered. Subsequently, the physician may continue decreasing the dose but at a more gradual rate..."</p> <p>During an interview with the DNS she was informed of the concern with the transcription error and the subsequent behaviors of Resident C. She indicated she was aware the error had occurred and it was consistent with the time frame of the medication error. She indicated following the behaviors the medication was increased when she had noted the errors and to ensure it does not reoccur she now personally checks each order after it is written. She further indicated Resident C had no behaviors prior to the medication error and has experienced no further behaviors since being back on the correct dose of the medications.</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/27/2016

FORM APPROVED

OMB NO. 0938-0391

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	This Federal tag relates to Complaint IN00193485 and IN00193682. 3.1-37(a)				