

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/11/2011
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NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN46342
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F0000	<p>This visit was for the Investigation of Complaint IN00097939 and IN00098009.</p> <p>This visit was in conjunction with the a post survey revisit (PSR) to Complaint IN00095435 investigated on 9/1/11.</p> <p>Complaint IN00097939 substantiated, Federal/State deficiencies related to the allegations are cited at F 224, F 225 and F 226.</p> <p>Complaint IN00098009 substantiated, Federal/State Deficiencies related to the allegations are cited at F 224, F 225 and F 226.</p> <p>Survey dates: October 6, 7, and 11, 2011</p> <p>Facility number: 000366 Provider number: 155469 AIM number: 100288900</p> <p>Survey team: Janelyn Kulik, RN, TC Kitty Vargas, RN (October 7, 2011)</p> <p>Census bed type: SNF/NF: 117 Total: 117</p>	F0000	<p>Preparation and / or execution of this plan of correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because the provisions of federal and state laws require it.</p> <p>This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation for substantial compliance. This provider also asks for a desk review of this 2567.</p>	

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

TITLE

(X6) DATE

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

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F0224 SS=D	<p>Census payor type: Medicare: 10 Medicaid: 89 Other: 18 Total: 117</p> <p>Sample: 8</p> <p>These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 10/17/11 Cathy Emswiller RN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to ensure every suspected allegation of abuse was reported promptly to the Administrator for 1 of 4 allegations of abuse reviewed in a sample of 8 related to a suspected allegation of abuse initially being report as a fall by two CNAs and then reporting the resident had not fall. (Resident #G, CNA #1 and CNA #2)</p> <p>Findings include:</p> <p>The record for Resident #G was reviewed on 10/7/11 at 11:54 a.m. The resident's diagnoses included, but were not limited</p>	F0224	<p>F 224</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>Resident #G was sent out for and evaluation at he time of the incident. The injury Resident G sustained has resolved. Resident G has been re-assessed and the care plan has been updated. CNA #1 is no longer employed at the facility. Investigator Greg Labis from the State of Indiana Office of Inspector General as well as the Hobart Police Department is conducting an investigation.</p>	10/31/2011	

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	<p>to, anemia, diabetes mellitus, aggressive behaviors, senile dementia, hypertension, and dementia with behavioral disturbances.</p> <p>A nursing note dated 9/24/11 at 10:35 p.m., indicated "called to hallway when resident was walking very fast behind CNA stating he was going to kill her. This writer tried (sic) calming the resident with a soft tone. This writer noticed resident (sic) had minimal blood coming from lower back of head near upper neck. This writer attempted to calm resident to check his injury and he was combative & (and) refused me (sic) to touch him as he continued to walk down the hallway very quickly yelling & (and) cursing at me. Paged (Physician's name) & (and) received orders to send resident to ER (emergency room). Called (name of ambulance company) to transport resident to hospital. CNA followed resident from a safe distance to assure his safety. Called Administrator & (and) reported incident. Called resident's sister. Unable to obtain vitals due to resident's combativeness." AT 10:55 p.m. ambulance attendants in building caring for resident. The hospital was called and report given. At 11:05 p.m. the resident was out of the building with two EMT's (Emergency Medical Technician). Staff unable to do neurological checks due to</p>		<p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken.</p> <p>All facility residents have the potential to be affected by the same alleged deficient practice. The facility has reviewed all allegations and grievances from the past 60 days to ensure that any allegation of abuse was reported.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</p> <p>The Administrator in serviced the Management Team regarding responsibilities and direct communication to the administrator in regards to allegations of abuse. This training occurred on 9/26/2011.</p> <p>All facility staff have been in-serviced by Stephanie Peterson RN Director of Clinical Services from Extended Care Consulting. This in-service included training on the Abuse Policy including definition of abuse, types of abuse,</p>	

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	<p>combativeness.</p> <p>A nursing note dated 9/25/11 at 5:00 a.m., indicated the resident returned to the facility at approximately 4:45 a.m. with 2 attendants and his sister. The resident had a diagnoses of head contusion, neck strain, and scalp laceration. There were three staples noted to the back of the resident's head with a small amount of red drainage. The resident was alert and talkative. The resident was assessed and no bruises or any other injuries were noted.</p> <p>Review of a Facility Incident Report Form on 10/7/11 at 12:00 p.m., indicated a reportable event occurred on 9/24/11 at 10:35 p.m. The event involved Resident #G.</p> <p>Description of occurrence: "Nurse was called to hallway to observe resident very agitated and following two Aides. The nurse noted a minimal amount of blood coming from the lower back of the resident's head. Both aides reported to the nurse that while changing his bed, resident urinated on floor and slipped and fell. Resident was sent to the ER and returned on 9/25/11 at 5:00 a.m. The ER records reflect resident received 3 staples to the back of head.</p> <p>At about 4:00 p.m. on 9/25/11, Aide #2 (CNA #2) informed the Nurse Manager</p>		<p>prevention, training, reporting, investigating, resident protection, and establishing a resident sensitive environment.</p> <p>Employees completed both a pre and post test. Employees that have not attended the in-serviced by the date of completion 10/31/2011 will not work until they have completed the required training.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</p> <p>The Administrator/designee will track all allegations of abuse including date and time of the allegation to ensure all allegations are reported timely.</p> <p>A summary of the audits will be presented to the Quality Assurance committee monthly by the Administrator /designee for a minimum of six months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.</p> <p>Date by which systemic corrections will be completed: October 31, 2011</p>	

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	<p>that the resident had not fallen as reported. She believed that when she and Aide #1 (CNA #1) were providing care to the resident, she heard a "smack sound." When she turned around, she noticed a small amount of blood to the back of the resident's head. The Nurse Manager has both of the aides removed from the floor. Both Aides were immediately suspended from their duties pending an investigation. (Name of Police Department) were notified of the alleged incident and responded to the facility. (Officer's name) with (Police Department name) was involved in the investigation. The resident's physician, family and the facility Medical Director were also notified.</p> <p>Interviews with staff were conducted. Aide #2 (CNA #2) stated that she heard a smack sound but never saw Aide #1 (CNA #1) do anything inappropriate or have anything in her hand. Aide #1 (CNA #1) denied any inappropriate behavior. Other staff reported that they never witnessed any inappropriate actions by Aide #1 (CNA #1). Interviews were conducted with other residents that Aide #1 (CNA #1) was assigned to and no concerns were voiced. The resident was unable to give any details.</p> <p>Resident returned from hospital with 3 staples to back of head. Assessments completed by nurse and plan of care</p>			

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	<p>updated. No pain noted and resident denies pain/discomfort. CT scan of cervical spine C 1 through C 7 shows no acute fracture, dislocation, or bony destruction. CT scan of head shows moderate atrophic changes, no midline shift, no acute infarction or intracranial bleeding. X-ray of cervical spine AP (anterior posterior) and LAT (lateral) show no acute fracture, dislocation, or bony destruction. Medication review with pharmacy completed with no recommendations for changes. Aggression risk assessment and risk for assessment for abuse and neglect were updated and plan of care updated. Wellness Checks conducted with no ill effects."</p> <p>Occurrence Resolution: "Inservicing on abuse and abuse prevention conducted with management and facility staff. Additional inservicing on abuse and abuse prevention was reinforced by VP of Clinical Services with management and facility staff. The resident's family and physician have been updated. Aide #1 (CNA #1) will no longer be working at this facility. The investigation with (Police Department name) continues."</p> <p>A Corrective Action Notice dated 10/5/11, was reviewed on 10/7/11 at 2:00 p.m. The form indicated CNA #1's name. The description of the problems was an</p>				

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	<p>investigation of allegation of abuse of a resident. The employee denied hitting the resident. The investigation continues with the Police Department, unable to provide proof that the employee did not hit resident. Under guidelines of Abuse and Neglect this does require termination.</p> <p>A written summary of events dated 9/25/11, indicated "I was notified by Nurse #1 on 9/24/11 that resident (Resident #G's name) was being very combative with them and that they could see a little bit of blood on the back of his head. She thought he had fallen, but it was not witnessed. i advised her that if it was an unwitnessed fall, he needed to go to the hospital for observation, to call his Dr., She replied that he had already been called and told her not to call him after 9:00, also stated that he had not responded to text messages. Resident was sent to ER with Dr's orders.</p> <p>Notified by (name of Nurse Manager #2 on call, that resident had returned from the hospital and she was going to review the chart, she thought at the time that he may have gotten sutures, but would let me know.</p> <p>9/25 Around 4:00 p.m., Unit Manager (Evening Supervisor's #1's name) called me at home and advised me that one of the aides who was attending to (Resident #G's name) yesterday had called her and</p>				

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	<p>said that he did not fall, but thought that the other aide may have struck him on the back of the head with a can of shaving cream. She advised she was on her way in, she had already told the nurse to send the aide home. I advised her that I was also on the way in.</p> <p>When I got to the facility at 4:30, (Evening Supervisor #1's name) met me with statements from both aides and the initial investigation report. (Evening Supervisor #1's name) had already sent (CNA #1's name) home, but brought (CNA #2's name) to my office. She also had a written statement stating that the resident had not fallen yesterday. She said she couldn't sleep last night and had to "come clean". I had (CNA #2's name) demonstrate to us how the event happened."</p> <p>9/27/11 at 4:40 p.m.</p> <p>Both aides were providing care and the resident was not combative until CNA #1 was pulling his brief. The resident started to urinate on the floor. The resident did not fall on the floor. CNA #2 had a hold of one hand and was trying to take his shirt off. CNA #1 had the other hand of the resident. CNA #2 heard a "smack". She turned around and saw some blood on the back of the resident's head and a can of shaving cream lying on the bed. CNA #2 asked CNA #1 "did you hit him with that?" She did not reply.</p>			

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	<p>"Demonstration: Resident was sitting on the edge of bed, he was wet and both aides were trying to change him. Resident was being real friendly until (CNA #1's name) pulled up his brief and he became combative.</p> <p>(CNA #2's name) was beside resident, facing the same way as him and had hold of that arm as she was trying to take his shirt off.</p> <p>(CNA #1's name) was beside resident on other side, facing towards resident's back and slightly behind him.</p> <p>(CNA #2's name) said she asked (CNA #1's name) "did you hit him with that?" but she did not reply. She said they went to get the nurse to report that he was bleeding and resident followed then hollering at them."</p> <p>At 5:15 p.m. the police were notified. The officers took pictures of the resident's room, they took a can of shaving cream from resident's bedside table and took pictures of the resident's head.</p> <p>Interview with CNA #2 on 10/11/11 at 12:35 p.m., indicated she had been asked to help CNA #1 with Resident #G. The resident became combative when CNA #1 pulled up his brief. She then indicated each aide took one of the resident's arms and sat him on the bed. She then indicated he had urinated on the floor but he never fell. She heard a "smack", saw</p>			

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	<p>the blood on the resident and saw the can of shaving cream, she indicated she just thought CNA #2 had hit the resident but she did not see CNA #2 hit the resident. She indicated she asked CNA #2 if she hit the resident and the CNA did not respond. She further indicated no one intimidated her into writing her first statement that the resident fell. She then indicated there were several employees standing around since it was the change of shift and CNA #1, so she just wrote in her statement what CNA #1 had written. She did not know her and did not know what she would do. She indicated when she came to work the next day she did not go on the floor but got the Evening Supervisor #1's phone number and called her and told her what had happened. She indicated she never went on the floor and worked. She indicated she feels very bad and should have said something as soon as the incident happened. This had been a learning experience and she now knows what to do and will not wait next time an incident happens to report the truth.</p> <p>Interview with the Administrator on 10/7/11 at 1:15 p.m., indicated the incident with Resident #G was first reported as a fall by CNA #1 and CNA #2. The investigation was started but the incident was being reviewed as a fall. On 9/25/11 CNA #2 called the Evening</p>			

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	<p>Supervision #1 and indicated Resident #G had not fallen. She had heard a smack. She did not see CNA #1 do anything to Resident #G. He further indicated CNA #1 continued to inform the facility that Resident #G fell and hit his head. CNA #2 indicated the resident never fell. The Administrator further indicated after listening to CNA #1 and CNA #2's details of event CNA #1's story was not plausible, however CNA #2's story was plausible. He also indicated the incident was still under investigation by the police. The shaving can was tested with negative results. He then indicated he cannot say CNA #1 hit the resident but the CNA was terminated. He also indicated CNA #2 had not reported the suspicion of abuse at the time of the incident and waited until the next day. He then indicated CNA #1 was working on 9/25/11 and was pulled from the floor after the allegation was made. He further indicated he could not substantiated CNA #2 abused Resident #G but CNA #1 had been terminated.</p> <p>Interview with the Nurse Consultant #1 on 10/11/11 at 11:10 a.m., indicated CNA #2 did change her story of the incident with Resident #G. She had suspected CNA #1 may have done something and CNA #2 did not report it at the time of the incident. The two CNAs were suspended the day after the incident when CNA #2</p>			

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	<p>informed the Evening Supervision #1 what had transpired in Resident #G's room.</p> <p>This Federal tag relates to complaint IN00097939 and IN00098009.</p> <p>3.1-28 (a)</p>				

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F0225 SS=D	<p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and interview, the facility failed to ensure every suspected allegation of abuse was reported promptly to the Administrator for 1 of 4 allegations of abuse reviewed in a sample of 8</p>	F0225	<p>F 225</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient</p>	10/31/2011			

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	<p>related to a suspected allegation of abuse initially being report as a fall by two CNAs and then reporting the resident did not fall. (Resident #G, CNA #1 and CNA #2)</p> <p>Findings include:</p> <p>The record for Resident #G was reviewed on 10/7/11 at 11:54 a.m. The resident's diagnoses included, but were not limited to, anemia, diabetes mellitus, aggressive behaviors, senile dementia, hypertension, and dementia with behavioral disturbances.</p> <p>A nursing note dated 9/24/11 at 10:35 p.m., indicated "called to hallway when resident was walking very fast behind CNA stating he was going to kill her. This writer tried (sic) calming the resident with a soft tone. This writer noticed resident (sic) had minimal blood coming from lower back of head near upper neck. This writer attempted to calm resident to check his injury and he was combative & (and) refused me (sic) to touch him as he continued to walk down the hallway very quickly yelling & (and) cursing at me. Paged (Physician's name) & (and) received orders to send resident to ER (emergency room). Called (name of ambulance company) to transport resident to hospital. CNA followed resident from</p>		<p>practice;</p> <p>Resident #G was sent out for and evaluation at he time of the incident. The injury Resident G sustained has resolved. Resident G has been re-assessed and the care plan has been updated. CNA #1 is no longer employed at the facility. Investigator Greg Labis from the State of Indiana Office of Inspector General as well as the Hobart Police Department is conducting an investigation.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken.</p> <p>All facility residents have the potential to be affected by the same alleged deficient practice. The facility has reviewed all allegations and grievances from the past 60 days to ensure that any allegation of abuse was reported.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</p> <p>The Administrator in serviced the Management Team regarding</p>		

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	<p>a safe distance to assure his safety. Called Administrator & (and) reported incident. Called resident's sister. Unable to obtain vitals due to resident's combativeness." AT 10:55 p.m. ambulance attendants in building caring for resident. The hospital was called and report given. At 11:05 p.m. the resident was out of the building with two EMT's (Emergency Medical Technician). Staff unable to do neurological checks due to combativeness.</p> <p>A nursing note dated 9/25/11 at 5:00 a.m., indicated the resident returned to the facility at approximately 4:45 a.m. with 2 attendants and his sister. The resident had a diagnoses of head contusion, neck strain, and scalp laceration. There were three staples noted to the back of the resident's head with a small amount of red drainage. The resident was alert and talkative. The resident was assessed and no bruises or any other injuries were noted.</p> <p>Review of a Facility Incident Report Form on 10/7/11 at 12:00 p.m., indicated a reportable event occurred on 9/24/11 at 10:35 p.m. The event involved Resident #G.</p> <p>Description of occurrence: "Nurse was called to hallway to observe resident very agitated and following two Aides. The</p>		<p>responsibilities and direct communication to the administrator in regards to allegations of abuse. This training occurred on 9/26/2011.</p> <p>All facility staff have been in-serviced by Stephanie Peterson RN Director of Clinical Services from Extended Care Consulting. This in-service included training on the Abuse Policy including definition of abuse, types of abuse, prevention, training, reporting, investigating, resident protection, and establishing a resident sensitive environment. Employees completed both a pre and post test. Employees that have not attended the in-serviced by the date of completion 10/31/2011 will not work until they have completed the required training.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</p> <p>The Administrator/designee will track all allegations of abuse including date and time of the allegation to ensure all allegations are reported timely.</p> <p>A summary of the audits will be presented to the Quality Assurance committee monthly by</p>				

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	<p>nurse noted a minimal amount of blood coming from the lower back of the resident's head. Both aides reported to the nurse that while changing his bed, resident urinated on floor and slipped and fell. Resident was sent to the ER and returned on 9/25/11 at 5:00 a.m. The ER records reflect resident received 3 staples to the back of head.</p> <p>At about 4:00 p.m. on 9/25/11, Aide #2 (CNA #2) informed the Nurse Manager that the resident had not fallen as reported. She believed that when she and Aide #1 (CNA #1) were providing care to the resident, she heard a "smack sound." When she turned around, she noticed a small amount of blood to the back of the resident's head. The Nurse Manager has both of the aides removed from the floor. Both Aides were immediately suspended from their duties pending an investigation. (Name of Police Department) were notified of the alleged incident and responded to the facility. (Officer's name) with (Police Department name) was involved in the investigation. The resident's physician, family and the facility Medical Director were also notified.</p> <p>Interviews with staff were conducted. Aide #2 (CNA #2) stated that she heard a smack sound but never saw Aide #1 (CNA #1) do anything inappropriate or have anything in her hand. Aide #1 (CNA</p>		<p>the Administrator /designee for a minimum of six months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.</p> <p>Date by which systemic corrections will be completed: October 31, 2011</p>		

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	<p>#1) denied any inappropriate behavior. Other staff reported that they never witnessed any inappropriate actions by Aide #1 (CNA #1). Interviews were conducted with other residents that Aide #1 (CNA #1) was assigned to and no concerns were voiced. The resident was unable to give any details.</p> <p>Resident returned from hospital with 3 staples to back of head. Assessments completed by nurse and plan of care updated. No pain noted and resident denies pain/discomfort. CT scan of cervical spine C 1 through C 7 shows no acute fracture, dislocation, or bony destruction. CT scan of head shows moderate atrophic changes, no midline shift, no acute infarction or intracranial bleeding. X-ray of cervical spine AP (anterior posterior) and LAT (lateral) show no acute fracture, dislocation, or bony destruction. Medication review with pharmacy completed with no recommendations for changes.</p> <p>Aggression risk assessment and risk for assessment for abuse and neglect were updated and plan of care updated.</p> <p>Wellness Checks conducted with no ill effects."</p> <p>Occurrence Resolution: "Inservicing on abuse and abuse prevention conducted with management and facility staff. Additional inservicing on abuse and abuse prevention was reinforced by VP of</p>			

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	<p>Clinical Services with management and facility staff. The resident's family and physician have been updated. Aide #1 (CNA #1) will no longer be working at this facility. The investigation with (Police Department name) continues."</p> <p>A Corrective Action Notice dated 10/5/11, was reviewed on 10/7/11 at 2:00 p.m. The form indicated CNA #1's name. The description of the problems was an investigation of allegation of abuse of a resident. The employee denied hitting the resident. The investigation continues with the Police Department, unable to provide proof that the employee did not hit resident. Under guidelines of Abuse and Neglect this does require termination.</p> <p>A written summary of events dated 9/25/11, indicated "I was notified by Nurse #1 on 9/24/11 that resident (Resident #G's name) was being very combative with them and that they could see a little bit of blood on the back of his head. She thought he had fallen, but it was not witnessed. i advised her that if it was an unwitnessed fall, he needed to go to the hospital for observation, to call his Dr., She replied that he had already been called and told her not to call him after 9:00, also stated that he had not responded to text messages. Resident was sent to ER with Dr's orders.</p>			

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	<p>Notified by (name of Nurse Manager #2 on call, that resident had returned from the hospital and she was going to review the chart, she thought at the time that he may have gotten sutures, but would let me know.</p> <p>9/25 Around 4:00 p.m., Unit Manager (Evening Supervisor's #1's name) called me at home and advised me that one of the aides who was attending to (Resident #G's name) yesterday had called her and said that he did not fall, but thought that the other aide may have struck him on the back of the head with a can of shaving cream. She advised she was on her way in, she had already told the nurse to send the aide home. I advised her that I was also on the way in.</p> <p>When I got to the facility at 4:30, (Evening Supervisor #1's name) met me with statements from both aides and the initial investigation report. (Evening Supervisor #1's name) had already sent (CNA #1's name) home, but brought (CNA #2's name) to my office. She also had a written statement stating that the resident had not fallen yesterday. She said she couldn't sleep last night and had to "come clean". I had (CNA #2's name) demonstrate to us how the event happened."</p> <p>9/27/11 at 4:40 p.m.</p> <p>Both aides were providing care and the resident was not combative until CNA #1</p>				

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	<p>was pulling his brief. The resident started to urinate on the floor. The resident did not fall on the floor. CNA #2 had a hold of one hand and was trying to take his shirt off. CNA #1 had the other hand of the resident. CNA #2 heard a "smack". She turned around and saw some blood on the back of the resident's head and a can of shaving cream lying on the bed. CNA #2 asked CNA #1 "did you hit him with that?" She did not reply.</p> <p>"Demonstration: Resident was sitting on the edge of bed, he was wet and both aides were trying to change him. Resident was being real friendly until (CNA #1's name) pulled up his brief and he became combative.</p> <p>(CNA #2's name) was beside resident, facing the same way as him and had hold of that arm as she was trying to take his shirt off.</p> <p>(CNA #1's name) was beside resident on other side, facing towards resident's back and slightly behind him.</p> <p>(CNA #2's name) said she asked (CNA #1's name) "did you hit him with that?" but she did not reply. She said they went to get the nurse to report that he was bleeding and resident followed then hollering at them."</p> <p>At 5:15 p.m. the police were notified. The officers took pictures of the resident's room, they took a can of shaving cream from resident's bedside table and took</p>						

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	<p>pictures of the resident's head.</p> <p>Interview with CNA #2 on 10/11/11 at 12:35 p.m., indicated she had been asked to help CNA #1 with Resident #G. The resident became combative when CNA #1 pulled up his brief. She then indicated each aide took one of the resident's arms and sat him on the bed. She then indicated he had urinated on the floor but he never fell. She heard a "smack", saw the blood on the resident and saw the can of shaving cream, she indicated she just thought CNA #2 had hit the resident but she did not see CNA #2 hit the resident. She indicated she asked CNA #2 if she hit the resident and the CNA did not respond. She further indicated no one intimidated her into writing her first statement that the resident fell. She then indicated there were several employees standing around since it was the change of shift and CNA #1, so she just wrote in her statement what CNA #1 had written. She did not know her and did not know what she would do. She indicated when she came to work the next day she did not go on the floor but got the Evening Supervisor #1's phone number and called her and told her what had happened. She indicated she never went on the floor and worked. She indicated she feels very bad and should have said something as soon as the incident happened. This had been a</p>				

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	<p>learning experience and she now knows what to do and will not wait next time an incident happens to report the truth.</p> <p>Interview with the Administrator on 10/7/11 at 1:15 p.m., indicated the incident with Resident #G was first reported as a fall by CNA #1 and CNA #2. The investigation was started but the incident was being reviewed as a fall. On 9/25/11 CNA #2 called the Evening Supervision #1 and indicated Resident #G had not fallen. She had heard a smack. She did not see CNA #1 do anything to Resident #G. He further indicated CNA #1 continued to inform the facility that Resident #G fell and hit his head. CNA #2 indicated the resident never fell. The Administrator further indicated after listening to CNA #1 and CNA #2's details of event CNA #1's story was not plausible, however CNA #2's story was plausible. He also indicated the incident was still under investigation by the police. The shaving can was tested with negative results. He then indicated he cannot say CNA #1 hit the resident but the CNA was terminated. He also indicated CNA #2 had not reported the suspicion of abuse at the time of the incident and waited until the next day. He then indicated CNA #1 was working on 9/25/11 and was pulled from the floor after the allegation was made. He further indicated he could not</p>			

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F0226 SS=D	<p>substantiated CNA #2 abused Resident #G but CNA #1 had been terminated.</p> <p>Interview with the Nurse Consultant #1 on 10/11/11 at 11:10 a.m., indicated CNA #2 did change her story of the incident with Resident #G. She had suspected CNA #1 may have done something and CNA #2 did not report it at the time of the incident. The two CNAs were suspended the day after the incident when CNA #2 informed the Evening Supervision #1 what had transpired in Resident #G's room.</p> <p>This Federal tag relates to complaint IN00097939 and IN00098009.</p> <p>3.1-28(c)</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. Based on record review and interview, the facility failed to ensure the facility followed its abuse policy regarding reporting all allegations of abuse immediately to the Administrator or Director of Nursing for 1 of 4 allegations of abuse reviewed in a sample of 8 related to two CNAs reporting an incident as a fall and later indicating the resident had</p>	F0226	<p>F 226</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>Resident #G was sent out for and evaluation at he time of the incident. The injury Resident G</p>	10/31/2011

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	<p>not fallen. (Resident #G, CNA #1, and CNA #2)</p> <p>Findings include:</p> <p>The record for Resident #G was reviewed on 10/7/11 at 11:54 a.m. The resident's diagnoses included, but were not limited to, anemia, diabetes mellitus, aggressive behaviors, senile dementia, hypertension, and dementia with behavioral disturbances.</p> <p>A nursing note dated 9/24/11 at 10:35 p.m., indicated "called to hallway when resident was walking very fast behind CNA stating he was going to kill her. This writer tried (sic) calming the resident with a soft tone. This writer noticed resident (sic) had minimal blood coming from lower back of head near upper neck. This writer attempted to calm resident to check his injury and he was combative & (and) refused me (sic) to touch him as he continued to walk down the hallway very quickly yelling & (and) cursing at me. Paged (Physician's name) & (and) received orders to send resident to ER (emergency room). Called (name of ambulance company) to transport resident to hospital. CNA followed resident from a safe distance to assure his safety. Called Administrator & (and) reported incident. Called resident's sister. Unable to obtain</p>		<p>sustained has resolved. Resident G has been re-assessed and the care plan has been updated. CNA #1 is no longer employed at the facility. Investigator Greg Labis from the State of Indiana Office of Inspector General as well as the Hobart Police Department is conducting an investigation.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken.</p> <p>All facility residents have the potential to be affected by the same alleged deficient practice. The facility has reviewed all allegations and grievances from the past 60 days to ensure that any allegation of abuse was reported.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</p> <p>The Administrator in serviced the Management Team regarding responsibilities and direct communication to the administrator in regards to allegations of abuse. This training occurred on 9/26/2011.</p>				

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	<p>vitals due to resident's combativeness." AT 10:55 p.m. ambulance attendants in building caring for resident. The hospital was called and report given. At 11:05 p.m. the resident was out of the building with two EMT's (Emergency Medical Technician). Staff unable to do neurological checks due to combativeness.</p> <p>A nursing note dated 9/25/11 at 5:00 a.m., indicated the resident returned to the facility at approximately 4:45 a.m. with 2 attendants and his sister. The resident had a diagnoses of head contusion, neck strain, and scalp laceration. There were three staples noted to the back of the resident's head with a small amount of red drainage. The resident was alert and talkative. The resident was assessed and no bruises or any other injuries were noted.</p> <p>Review of a Facility Incident Report Form on 10/7/11 at 12:00 p.m., indicated a reportable event occurred on 9/24/11 at 10:35 p.m. The event involved Resident #G.</p> <p>Description of occurrence: "Nurse was called to hallway to observe resident very agitated and following two Aides. The nurse noted a minimal amount of blood coming from the lower back of the resident's head. Both aides reported to the</p>		<p>All facility staff have been in-serviced by Stephanie Peterson RN Director of Clinical Services from Extended Care Consulting. This in-service included training on the Abuse Policy including definition of abuse, types of abuse, prevention, training, reporting, investigating, resident protection, and establishing a resident sensitive environment. Employees completed both a pre and post test. Employees that have not attended the in-serviced by the date of completion 10/31/2011 will not work until they have completed the required training.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</p> <p>The Administrator/designee will track all allegations of abuse including date and time of the allegation to ensure all allegations are reported timely.</p> <p>A summary of the audits will be presented to the Quality Assurance committee monthly by the Administrator /designee for a minimum of six months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be</p>	

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	nurse that while changing his bed, resident urinated on floor and slipped and fell. Resident was sent to the ER and returned on 9/25/11 at 5:00 a.m. The ER records reflect resident received 3 staples to the back of head. At about 4:00 p.m. on 9/25/11, Aide #2 (CNA #2) informed the Nurse Manager that the resident had not fallen as reported. She believed that when she and Aide #1 (CNA #1) were providing care to the resident, she heard a "smack sound." When she turned around, she noticed a small amount of blood to the back of the resident's head. The Nurse Manager has both of the aides removed from the floor. Both Aides were immediately suspended from their duties pending an investigation. (Name of Police Department) were notified of the alleged incident and responded to the facility. (Officer's name) with (Police Department name) was involved in the investigation. The resident's physician, family and the facility Medical Director were also notified. Interviews with staff were conducted. Aide #2 (CNA #2) stated that she heard a smack sound but never saw Aide #1 (CNA #1) do anything inappropriate or have anything in her hand. Aide #1 (CNA #1) denied any inappropriate behavior. Other staff reported that they never witnessed any inappropriate actions by		done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed: October 31, 2011		

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	<p>Aide #1 (CNA #1). Interviews were conducted with other residents that Aide #1 (CNA #1) was assigned to and no concerns were voiced. The resident was unable to give any details.</p> <p>Resident returned from hospital with 3 staples to back of head. Assessments completed by nurse and plan of care updated. No pain noted and resident denies pain/discomfort. CT scan of cervical spine C 1 through C 7 shows no acute fracture, dislocation, or bony destruction. CT scan of head shows moderate atrophic changes, no midline shift, no acute infarction or intracranial bleeding. X-ray of cervical spine AP (anterior posterior) and LAT (lateral) show no acute fracture, dislocation, or bony destruction. Medication review with pharmacy completed with no recommendations for changes.</p> <p>Aggression risk assessment and risk for assessment for abuse and neglect were updated and plan of care updated.</p> <p>Wellness Checks conducted with no ill effects."</p> <p>Occurrence Resolution: "Inservicing on abuse and abuse prevention conducted with management and facility staff. Additional inservicing on abuse and abuse prevention was reinforced by VP of Clinical Services with management and facility staff. The resident's family and physician have been updated. Aide #1</p>				

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	<p>(CNA #1) will no longer be working at this facility. The investigation with (Police Department name) continues."</p> <p>A Corrective Action Notice dated 10/5/11, was reviewed on 10/7/11 at 2:00 p.m. The form indicated CNA #1's name. The description of the problems was an investigation of allegation of abuse of a resident. The employee denied hitting the resident. The investigation continues with the Police Department, unable to provide proof that the employee did not hit resident. Under guidelines of Abuse and Neglect this does require termination.</p> <p>A written summary of events dated 9/25/11, indicated "I was notified by Nurse #1 on 9/24/11 that resident (Resident #G's name) was being very combative with them and that they could see a little bit of blood on the back of his head. She thought he had fallen, but it was not witnessed. i advised her that if it was an unwitnessed fall, he needed to go to the hospital for observation, to call his Dr., She replied that he had already been called and told her not to call him after 9:00, also stated that he had not responded to text messages. Resident was sent to ER with Dr's orders.</p> <p>Notified by (name of Nurse Manager #2 on call, that resident had returned from the hospital and she was going to review</p>			

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	<p>the chart, she thought at the time that he may have gotten sutures, but would let me know.</p> <p>9/25 Around 4:00 p.m., Unit Manager (Evening Supervisor's #1's name) called me at home and advised me that one of the aides who was attending to (Resident #G's name) yesterday had called her and said that he did not fall, but thought that the other aide may have struck him on the back of the head with a can of shaving cream. She advised she was on her way in, she had already told the nurse to send the aide home. I advised her that I was also on the way in.</p> <p>When I got to the facility at 4:30, (Evening Supervisor #1's name) met me with statements from both aides and the initial investigation report. (Evening Supervisor #1's name) had already sent (CNA #1's name) home, but brought (CNA #2's name) to my office. She also had a written statement stating that the resident had not fallen yesterday. She said she couldn't sleep last night and had to "come clean". I had (CNA #2's name) demonstrate to us how the event happened."</p> <p>9/27/11 at 4:40 p.m.</p> <p>Both aides were providing care and the resident was not combative until CNA #1 was pulling his brief. The resident started to urinate on the floor. The resident did not fall on the floor. CNA #2 had a hold</p>			

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	<p>of one hand and was trying to take his shirt off. CNA #1 had the other hand of the resident. CNA #2 heard a "smack". She turned around and saw some blood on the back of the resident's head and a can of shaving cream lying on the bed. CNA #2 asked CNA #1 "did you hit him with that?" She did not reply.</p> <p>"Demonstration: Resident was sitting on the edge of bed, he was wet and both aides were trying to change him. Resident was being real friendly until (CNA #1's name) pulled up his brief and he became combative.</p> <p>(CNA #2's name) was beside resident, facing the same way as him and had hold of that arm as she was trying to take his shirt off.</p> <p>(CNA #1's name) was beside resident on other side, facing towards resident's back and slightly behind him.</p> <p>(CNA #2's name) said she asked (CNA #1's name) "did you hit him with that?" but she did not reply. She said they went to get the nurse to report that he was bleeding and resident followed then hollering at them."</p> <p>At 5:15 p.m. the police were notified. The officers took pictures of the resident's room, they took a can of shaving cream from resident's bedside table and took pictures of the resident's head.</p> <p>The Reporting Abuse to Facility</p>				

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	<p>Management was provided by the Administrator reviewed on 10/7/11 at 12:30 p.m. The policy statement: "It is the responsibility of our employees, facility consultants, Attending Physicians, family members, visitors ect., to promptly report any incident or suspected incident of neglect or resident abuse, including injuries of unknown source, and theft or misappropriation of resident property to facility management."</p> <p>Responsibility of person(s) observing incidents of abuse: "Any individual observing an incident of resident abuse or suspecting resident abuse must immediately report such incident to the Administrator or Director of nursing."</p> <p>Failure to report abuse: "Any staff member or person affiliated with this facility who has witnessed or who believes that a resident has been a victim of mistreatment, abuse, neglect, or any other criminal offense shall immediately report, or cause a report to be made of, the mistreatment or offense. Failure to report such an incident may result in legal/criminal action being filed against the individual(s) withholding such information.</p> <p>Interview with CNA #2 on 10/11/11 at 12:35 p.m., indicated she had been asked to help CNA #1 with Resident #G. The</p>				

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	<p>resident became combative when CNA #1 pulled up his brief. She then indicated each aide took one of the resident's arms and sat him on the bed. She then indicated he had urinated on the floor but he never fell. She heard a "smack", saw the blood on the resident and saw the can of shaving cream, she indicated she just thought CNA #2 had hit the resident but she did not see CNA #2 hit the resident. She indicated she asked CNA #2 if she hit the resident and the CNA did not respond. She further indicated no one intimidated her into writing her first statement that the resident fell. She then indicated there were several employees standing around since it was the change of shift and CNA #1, so she just wrote in her statement what CNA #1 had written. She did not know her and did not know what she would do. She indicated when she came to work the next day she did not go on the floor but got the Evening Supervisor #1's phone number and called her and told her what had happened. She indicated she never went on the floor and worked. She indicated she feels very bad and should have said something as soon as the incident happened. This had been a learning experience and she knows and will not wait next time an incident happens.</p> <p>Interview with the Administrator on</p>				

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	<p>10/7/11 at 1:15 p.m., indicated the incident with Resident #G was first reported as a fall by CNA #1 and CNA #2. The investigation was started but the incident was being reviewed as a fall. On 9/25/11 CNA #2 called the Evening Supervision #1 and indicated Resident #G had not fallen. She had heard a smack. She did not see CNA #1 do anything to Resident #G. He further indicated CNA #1 continued to inform the facility that Resident #G fell and hit his head. CNA #2 indicated the resident never fell. The Administrator further indicated after listening to CNA #1 and CNA #2's details of event CNA #1's story was not plausible, however CNA #2's story was plausible. He also indicated the incident was still under investigation by the police. The shaving can was tested with negative results. He then indicated he cannot say CNA #1 hit the resident but the CNA was terminated. He also indicated CNA #2 had not reported the suspicion of abuse at the time of the incident and waited until the next day. He then indicated CNA #1 was working on 9/25/11 and was pulled from the floor after the allegation was made. He further indicated he could not substantiated CNA #2 abused Resident #G but CNA #1 had been terminated.</p> <p>Interview with the Nurse Consultant #1 on 10/11/11 at 11:10 a.m., indicated CNA</p>			

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	<p>#2 did change her story of the incident with Resident #G. She had suspected CNA #1 may have done something and CNA #2 did not report it at the time of the incident. The two CNAs were suspended the day after the incident when CNA #2 informed the Evening Supervision #1 what had transpired in Resident #G's room.</p> <p>This Federal tag relates to complaint IN00097939 and IN00098009.</p> <p>3.1-28(a)</p>				