

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155490	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/28/2013
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NAME OF PROVIDER OR SUPPLIER  AMBASSADOR HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 705 E MAIN ST CENTERVILLE, IN 47330
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F000000	<p>This visit was for the Investigation of Complaint IN00124447.</p> <p>Complaint IN00124447 -- Substantiated. Federal/state deficiencies related to the allegations are cited at F223, F225 and F226.</p> <p>Unrelated deficiency is cited.</p> <p>Survey dates: February 27 and 28, 2013</p> <p>Facility number: 000456 Provider number: 155490 AIM number: 100288750</p> <p>Survey team: Penny Marlatt, RN</p> <p>Census bed type: SNF: 3 SNF/NF: 101 Total: 104</p> <p>Census payor type: Medicare: 13 Medicaid: 78 Other: 13 Total: 104</p> <p>Sample: 4</p>	F000000	By submitting the enclosed materials we ar not admitting the turth or accuracy of any specific findings or allegations as of any proceedings and submit these responses pursuant to our regulatory obligations.We are requesting a desk review for this survey.	

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

TITLE

(X6) DATE

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

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	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 3/06/13 by Suzanne Williams, RN</p>				

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F000223 SS=D	<p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>Based on interview and record review, the facility failed to ensure residents were not subjected to staff to resident physical and verbal abuse or resident to resident physical abuse, for 3 of 4 residents reviewed for abuse in a sample of 4. (Resident #A, #C and #D)</p> <p>Findings include:</p> <p>1. On 2-28-13 at 8:44 a.m., the Administrator provided a copy of an initial ISDH (Indiana State Department of Health) reportable incident. This document indicated on 2-16-13 at approximately 9:00 a.m., "[Name of Resident #A] was sitting at the nurse's station trying to get up frequently and would get combative, swinging at staff when they would try to have her sit down. [Name of Resident #A] started to become combative and [name of LPN #1] grabbed ahold of her by the wrists and pushed them down with force.</p>	F000223	<p>1. For Resident #A, the allegation of abuse was immediately reported to the police and ISBOH once the Administrator was notified. Family and physician were notified timely. LPN #1 was immediately suspended then terminated once investigation was complete. The Administrator and facility follow proper procedure once she was notified of the incident. Resident#A received some medication changes on 2/18/2013 that have calmed the resident down and has stopped her combative behavior. C.N.A. #1 and RT #1 was counceled on immediately reporting of any type of abuse/neglect. For resident's #C and #D, both residents were immediately separated. Resident #D was checked for injuries with none found. Families and physicians were immediately notified of occurance. Resident #C received medication changes and was immediately put on 15 minute checks. Resident#D psychosocial well-being was evaluated without any concerns or negative outcomes. The</p>	03/22/2013			

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	<p>Resident received a 5 cm [centimeter] by 3.5 cm bruise to top of left wrist, 2 cm by 1 cm bruise to 5th digit on left hand and a 1 cm by 1 cm bruise to inner left wrist." It indicated LPN #1 was suspended immediately and an investigation was initiated, with the physician, family and local police department informed of the incident. It indicated on 2-17-13, the resident could not recall how she received the bruises.</p> <p>A copy of the follow up report was also included which indicated, "Employee terminated. While one employee felt it was abuse, another did not feel it was intentional. The employee felt the staff member got frustrated and used a little too much force, but did not feel it was abuse. Police are still investigating."</p> <p>In interview with CNA #1 on 2-28-13 at 10:40 a.m., she indicated on that morning, 2-16-13, "[Name of Resident #A] was having an off day and kept trying to walk away from her vent. I tried to talk with her and calm her down. [Name of LPN #1] was behind the desk and came around to [name of Resident #A]. She told [name of Resident #A] she needed to sit down. I was standing off to the side and couldn't see what [name of Resident</p>		<p>Administrator was immediately notified of incident and proper notification to ISBOH occurred within the allowed reporting time. 2. Current residents residing at the facility with a history of combativeness on this LPN's unit were checked for any signs of bruising. No other residents on this unit are combative and no concerns of bruising were found. Current residents residing at the facility on the Alzheimer's Unit who were in the dining room with resident#C were interviewed to ensure no other residents were involved in any altercations with resident #C. None were found.3. All staff were educated on immediately reporting abuse on 3/15/2013. Attachment A. A copy of the inservice is included in the facility new hire packet.4. All areas of unknown source will be investigated by the DON and/or designee. This will be on-going. The results of these reviews will be discussed at the facilities quarterly Q.A. meeting.5. 3/22/2013</p>		

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	<p>#A] was saying to [name of LPN #1]. Her trach cuff was inflated [which did not allow for her to speak audibly, just to mouth words]. Anyway [name of Resident #A] said something to [name of LPN #1], with her finger pointing at her [LPN #1]. [Name of LPN #1] raised her voice and said pretty hateful, 'You will not talk to me that way.' About that time [name of Resident #A] raised both of her arms up and [name of LPN #1] grabbed [name of Resident #A]'s wrists and shoved them down pretty hard. [Name of Resident #A] started rubbing her wrists and said to [name of LPN #1], 'Look what you did to me.' At that time, I thought to myself, 'Oh, my...' Within 5 or 10 minutes, I took [name of Resident #A] to the bathroom...while I was in there with her, I asked her how her wrists were and she saw they were bruised, but said they were fine and didn't hurt...Not long after this happened, one of the other aides, [name of CNA #4] walked by [name of Resident #A] and said, 'That's a fresh bruise...' I hadn't said a word to anybody [at this point in time]."</p> <p>In interview with Respiratory Therapist (RT) #1 on 2-28-13 at 3:01 p.m., she indicated on the morning of 2-16-13, she was standing near the</p>			

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	<p>cart near the Respiratory Manager's office. She indicated she had observed Resident #A getting up and down multiple times that morning, out of her wheelchair and trying to walk without assistance. She indicated, "I saw [name of LPN #1] grab [name of Resident #A]'s wrists and arms and tell her she couldn't hit staff, because [name of Resident #A] had been hitting at staff, too. In my opinion, she grabbed [name of Resident #A]'s wrist kind of rough and certainly rougher than I would have and she spoke to her harsher than I would have expected...I didn't know about the bruising until later in the week when [name of the Director of Nursing] talked to me. At that point, I felt it definitely needed reported. You also need to know [name of Resident #A] does have a history of bruising easily and very fragile skin."</p> <p>Resident #A's clinical record was reviewed on 2-28-13 at 9:05 a.m. Her diagnoses included, but were not limited to, respiratory failure due to end stage COPD (chronic obstructive pulmonary disease), ventilator dependency and depression. Her most recent Minimum Data Set (MDS) assessment, dated 1-13-13, indicated she is moderately cognitively impaired and requires</p>			

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	<p>extensive assistance of 2 or more persons for ambulation, transferring from surface to surface, personal hygiene and bathing needs and toileting. She uses a wheelchair for mobility.</p> <p>2. On 2-28-13 at 8:44 a.m., the Administrator provided a copy of an initial ISDH (Indiana State Department of Health) reportable incident. This document indicated on 2-14-13 at 5:45 p.m., "[Name of Resident #C] was in dining room. She was observed hitting [name of Resident #D] on the back of the head x1 [one time]. Residents were immediately separated. [Name of Resident #C] was questioned why she hit the other resident and she stated, 'Wasn't moving,' or 'Wouldn't move,' as she is a little hard to understand. Per staff, resident showed no precipitating behaviors prior to incident." This document indicated both residents' physicians and families were notified regarding the incident and of no apparent injuries. It indicated Resident #C was placed on every 15 minute checks/observation as her physician declined to send her for an evaluation at the geriatric psychiatric center, "just came from there and she needs to settle into the unit." It indicated</p>						

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	<p>Resident #C's medications were adjusted by the physician with an increase in an antipsychotic medication. Documentation in Resident #C's and #D's clinical record reflected the same information with no further behaviors of physical aggression by Resident #C and no injury in the event by Resident #D.</p> <p>Resident #C's clinical record was reviewed on 2-28-13 at 10:10 a.m. Her diagnoses, included, but were not limited, to vascular dementia. It indicated she was admitted to this facility from an area geriatric psychiatric hospital and had been at another long term care facility prior to her hospitalization.</p> <p>Her admission MDS assessment, dated 2-2-13, indicated she did not walk, requires extensive assistance of 2 or more persons with transfers from one surface to another, with personal hygiene, bathing and toileting. It indicated she uses a wheelchair for mobility. It indicated she is moderately cognitively impaired.</p> <p>In interview with LPN #3 on 2-28-13 at 10:27 a.m., he indicated Resident #C is normally very pleasant. He indicated she can talk, but it is hard to understand her. He indicated she</p>				

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	<p>uses gestures to make her needs known, and, "swats at the air, especially if it's something she doesn't want." He indicated her behavior is "more calm with the increase in Seroquel [an antipsychotic medication]."</p> <p>Resident #D's clinical record was reviewed on 2-28-13 at 1:12 p.m. Her diagnoses included, but were not limited, to chronic pain, osteoporosis, history of traumatic brain injury and seizure disorder. Her most recent MDS assessment, dated 2-28-13, indicated she did not walk, requires extensive assistance of 2 or more persons with transfers from one surface to another, with personal hygiene, bathing and toileting. It indicated she uses a wheelchair for mobility. It indicated she is moderately cognitively impaired.</p> <p>Social service progress notes, dated 2-15-13, indicated Resident #D expressed she was not fearful of Resident #C, "she doesn't know what she is doing." It indicated she had no concerns related to this incident.</p> <p>On 2-27-13 at 3:40 p.m., the Director of Nursing provided a copy of a policy entitled, "Incident of Alleged Abuse," which had a copyright date of 2003.</p>						

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	<p>This policy indicated, "Residents residing in this facility will be treated with dignity and respect in accordance with their individual needs. They will not be subjected to physical, mental, verbal and sexual abuse, corporal punishment, mental and physical neglect, and involuntary seclusion."</p> <p>This Federal tag relates to Complaint IN00124447.</p> <p>3.1-27(a)(1) 3.1-27(b)</p>			

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F000225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record</p>	F000225	1. For resident #A, the allegation	03/22/2013

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	<p>review, the facility failed to ensure an allegation of staff to resident physical and verbal abuse was immediately reported to the Administrator and reported to the ISDH (Indiana State Department of Health) Long Term Care Division within 24 hours of occurrence, for 1 of 4 residents reviewed for abuse in a sample of 4. (Resident #A)</p> <p>Findings include:</p> <p>On 2-28-13 at 8:44 a.m., the Administrator provided a copy of an initial ISDH (Indiana State Department of Health) reportable incident. This document indicated on 2-16-13 at approximately 9:00 a.m., "[Name of Resident #A] was sitting at the nurse's station trying to get up frequently and would get combative, swinging at staff when they would try to have her sit down. [Name of Resident #A] started to become combative and [name of LPN #1] grabbed ahold of her by the wrists and pushed them down with force. Resident received a 5 cm [centimeter] by 3.5 cm bruise to top of left wrist, 2 cm by 1 cm bruise to 5th digit on left hand and a 1 cm by 1 cm bruise to inner left wrist." It indicated LPN #1 was suspended immediately and an investigation was initiated, with the</p>		<p>of abuse was immediately reported to the police and ISBOH once the Administrator was notified. Famikly and physician were notified timely. LPN #1 was immediaitely suspended and then terminated once the investigation was complete. The Administrator and faciltity followed proped procedures once she was notified of the incident. Resident#A rreceived some medication changes on 2/18/2013 that have calmed the resident down and stopped combative behavior. C.N.A. #1 and RT #1 was counseled on immediately reporting of any type of abuse/neglect.2. Current residents residing at the facility with a history of combativeness on this LPN's unit were checked for any signs of bruising. No other resident on this unit are combative and no concerns with bruising were found.3. All staff were educated on immediately reporting abuse on 3/15/2013. (Attachment A) A copy of in-service is included in the facility new hire packet.4. All areas of unknown source will be investigated by the DON and/ or designee. This will be on going. The results of these reviews will be discussed at the facilities quarterly Q.A. Meeting.5. 3/22/2013</p>				

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	<p>physician, family and local police department informed of the incident. It indicated on 2-17-13, the resident could not recall how she received the bruises. This document indicated it had been faxed from the facility to ISDH on 2-18-13 at 8:25 a.m., approximately 47 hours after the occurrence of the abuse allegation.</p> <p>In interview with CNA #1 on 2-28-13 at 10:40 a.m., she indicated she did not immediately report the abuse allegation to anyone at the facility, "I was a little uncertain as to who to talk to." She indicated, "I decided to report it the next morning when I came in at 2:00 a.m. It had been weighing on me all night. I told the [charge] nurse everything when I came in and she called the Administrator...After I talked to the Director of Nursing, I now know that I could've gone to any other nurse or called [the name of the Administrator] or [the name of the Director of Nursing]."</p> <p>On 2-27-13 at 3:40 p.m., the Director of Nursing provided a copy of a policy entitled, "Accident/Incident and Unusual Occurrence Policy," which was indicated as the current policy in effect. This policy indicated, "All staff members are responsible for promptly</p>			

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	<p>reporting to the nurse in charge, their immediate supervisor or other department head, any occurrence which has or could have resulted in injury to residents...verbal, physical, mental or sexual abuse...The Administrator, Director of Nursing or Designee are responsible for informing the Division of Long Term Care..by telephone or fax within 24 hours of determining a situation exists or existed that is reportable under state guidelines..."</p> <p>This Federal tag relates to Complaint IN00124447.</p> <p>3.1-28(c)</p>			

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F000226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review, the facility failed to implement their policies regarding abuse for 3 of 4 residents reviewed for abuse in a sample of 4 (Residents #A, B, C), specifically related to not allowing abuse to occur, protection of the resident following a staff to resident allegation of verbal and physical abuse, lack of prompt reporting of an allegation of abuse to the Administrator, untimely initial reporting of a staff to resident allegation of verbal and physical abuse to ISDH (Indiana State Department of Health) Long Term Care Division, and lack of annual training for abuse/abuse prevention for 1 of 2 employees reviewed for annual inservice education (LPN #1).</p> <p>Findings include:</p> <p>1. On 2-28-13 at 8:44 a.m., the Administrator provided a copy of an initial ISDH (Indiana State Department of Health) reportable incident. This document indicated on</p>	F000226	<p>1. For resident #A, the allegation of abuse was immediately reported to the police and ISBOH once the Administrator was notified. Family and physician were notied timely. LPN #1 was immediately suspended and then terminated once the investigation was complete. The Administrator and facility followed proper procedure once she was notified of the incident. Resident #A rerreived some medication changes on 2/18/2013 that have calmed the resident down and stopped her combative behavior. C.N.A. #1 and RT #1 were counseled on immediately reporting of any type of abuse/neglect.For resident's #C and #D, both residents were immediately separated. Resident #D was checked for injuries with none found. Families and physicians were immediately notified of occurance. Resident #C received medication changes and was immediately put on 15 minute checks. Resident # D psychosocial well- being was evaluated without any concerns or negative outcomes. The Administrator was immediately notified of the incident and proper</p>	03/22/2013	

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	<p>2-16-13 at approximately 9:00 a.m., "[Name of Resident #A] was sitting at the nurse's station trying to get up frequently and would get combative, swinging at staff when they would try to have her sit down. [Name of Resident #A] started to become combative and [name of LPN #1] grabbed ahold of her by the wrists and pushed them down with force. Resident received a 5 cm [centimeter] by 3.5 cm bruise to top of left wrist, 2 cm by 1 cm bruise to 5th digit on left hand and a 1 cm by 1 cm bruise to inner left wrist." It indicated LPN #1 was suspended immediately and an investigation was initiated, with the physician, family and local police department informed of the incident. It indicated on 2-17-13, the resident could not recall how she received the bruises.</p> <p>A copy of the follow up report was also included which indicated, "Employee terminated. While one employee felt it was abuse, another did not feel it was intentional. The employee felt the staff member got frustrated and used a little too much force, but did not feel it was abuse. Police are still investigating."</p> <p>In interview with CNA #1 on 2-28-13 at 10:40 a.m., she indicated on that</p>		<p>notification to ISBOH occurred within the allowing reporting time.2. Current residents residing at the facility with a history of combativeness on this LPN's unit were checked for any signs of bruising. No other resident's on this unit are combative and no concerns with bruising were found.Current residents residing at the facility on the Alzheimer's Unit who were in the dining room with resident #C were interviewed to ensure no other resident were involved in any altercations with Resident #C. Non was found.3. All staff was educated on immediately reporting abuse on 3/15/2013 (attachment A). A copy of in-service is included in the facility new hire packet. The systemic change includes that the facility will have a printout of all employees and each employee will sign by their name to ensure every employee has received education on the in-service.4. All areas of unkown source will be investigated by the DON and/ or designee. This weill be on-going. The results of these reviews will be discussed at the facilities quarterly Q.A. Meeting.5. 3 22/2013</p>		

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	<p>morning, 2-16-13, "[Name of Resident #A] was having an off day and kept trying to walk away from her vent. I tried to talk with her and calm her down. [Name of LPN #1] was behind the desk and came around to [name of Resident #A]. She told [name of Resident #A] she needed to sit down. I was standing off to the side and couldn't see what [name of Resident #A] was saying to [name of LPN #1]. Her trach cuff was inflated [which did not allow for her to speak audibly, just to mouth words] Anyway [name of Resident #A] said something to [name of LPN #1], with her finger pointing at her [LPN #1]. [Name of LPN #1] raised her voice and said pretty hateful, 'You will not talk to me that way.' About that time [name of Resident #A] raised both of her arms up and [name of LPN #1] grabbed [name of Resident #A]'s wrists and shoved them down pretty hard. [Name of Resident #A] started rubbing her wrists and said to [name of LPN #1], 'Look what you did to me.' At that time, I thought to myself, 'Oh, my...' Within 5 or 10 minutes, I took [name of Resident #A] to the bathroom...while I was in there with her, I asked her how her wrists were and she saw they were bruised, but said they were fine and didn't hurt...Not long after this happened,</p>			
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	<p>one of the other aides, [name of CNA #4] walked by [name of Resident #A] and said, 'That's a fresh bruise...' I hadn't said a word to anybody [at this point in time]." CNA #1 indicated she did not immediately report the abuse allegation to anyone at the facility, "I was a little uncertain as to who to talk to." She indicated, "I decided to report it the next morning when I came in at 2:00 a.m. It had been weighing on me all night. I told the [charge] nurse everything when I came in and she called the Administrator...[Name of LPN #1] wasn't supposed to come in on [2-17-13] until 10:00 a.m., so by that time [by the Administrator], she had been called and didn't come in."</p> <p>In interview with Respiratory Therapist (RT) #1 on 2-28-13 at 3:01 p.m., she indicated on the morning of 2-16-13, she was standing near the cart near the Respiratory Manager's office. She indicated she had observed Resident #A getting up and down multiple times that morning, out of her wheelchair and trying to walk without assistance. She indicated, "I saw [name of LPN #1] grab [name of Resident #A]'s wrists and arms and tell her she couldn't hit staff, because [name of Resident #A] had been hitting at staff, too. In my opinion, she</p>			

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	<p>grabbed [name of Resident #A]'s wrist kind of rough and certainly rougher than I would have and she spoke to her harsher than I would have expected...I didn't know about the bruising until later in the week when [name of the Director of Nursing] talked to me. At that point, I felt it definitely needed reported. You also need to know [name of Resident #A] does have a history of bruising easily and very fragile skin."</p> <p>Review of the time card for LPN #1 indicated on 2-16-13 she worked from 6:00 a.m. until 6:27 p.m. This indicated she was working on the same unit with Resident #A for approximately 9 hours after the allegation of physical and verbal abuse occurred.</p> <p>Resident #A's clinical record was reviewed on 2-28-13 at 9:05 a.m. Her diagnoses included, but were not limited to, respiratory failure due to end stage COPD (chronic obstructive pulmonary disease), ventilator dependency and depression. Her most recent Minimum Data Set (MDS) assessment, dated 1-13-13, indicated she is moderately cognitively impaired and requires extensive assistance of 2 or more persons for ambulation, transferring</p>				

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	<p>from surface to surface, personal hygiene and bathing needs and toileting. She uses a wheelchair for mobility.</p> <p>2. On 2-28-13 at 8:44 a.m., the Administrator provided a copy of an initial ISDH (Indiana State Department of Health) reportable incident. This document indicated on 2-14-13 at 5:45 p.m., "[Name of Resident #C] was in dining room. She was observed hitting [name of Resident #D] on the back of the head x1 [one time]. Residents were immediately separated. [Name of Resident #C] was questioned why she hit the other resident and she stated, 'Wasn't moving,' or 'Wouldn't move,' as she is a little hard to understand. Per staff, resident showed no precipitating behaviors prior to incident." This document indicated both residents' physicians and families were notified regarding the incident and of no apparent injuries. It indicated Resident #C was placed on every 15 minute checks/observation as her physician declined to send her for an evaluation at the geriatric psychiatric center, "just came from there and she needs to settle into the unit." It indicated Resident #C's medications were adjusted by the physician with an</p>						

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	<p>increase in an antipsychotic medication. Documentation in Resident #C's and #D's clinical record reflected the same information with no further behaviors of physical aggression by Resident #C and no injury in the event by Resident #D.</p> <p>Resident #C's clinical record was reviewed on 2-28-13 at 10:10 a.m. Her diagnoses, included, but were not limited, to vascular dementia. It indicated she was admitted to this facility from an area geriatric psychiatric hospital and had been at another long term care facility prior to her hospitalization.</p> <p>Her admission MDS assessment, dated 2-2-13, indicated she did not walk, requires extensive assistance of 2 or more persons with transfers from one surface to another, with personal hygiene, bathing and toileting. It indicated she uses a wheelchair for mobility. It indicated she is moderately cognitively impaired.</p> <p>In interview with LPN #3 on 2-28-13 at 10:27 a.m., he indicated Resident #C is normally very pleasant. He indicated she can talk, but it is hard to understand her. He indicated she uses gestures to make her needs known, and, "swats at the air,</p>						

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	<p>especially if it's something she doesn't want." He indicated her behavior is "more calm with the increase in Seroquel [an antipsychotic medication]."</p> <p>Resident #D's clinical record was reviewed on 2-28-13 at 1:12 p.m. Her diagnoses included, but were not limited, to chronic pain, osteoporosis, history of traumatic brain injury and seizure disorder. Her most recent MDS assessment, dated 2-28-13, indicated she did not walk, requires extensive assistance of 2 or more persons with transfers from one surface to another, with personal hygiene, bathing and toileting. It indicated she uses a wheelchair for mobility. It indicated she is moderately cognitively impaired.</p> <p>Social service progress notes, dated 2-15-13, indicated Resident #D expressed she was not fearful of Resident #C, "she doesn't know what she is doing." It indicated she had no concerns related to this incident.</p> <p>3. In review of LPN #1's employee record on 2-28-13 between 11:32 a.m. and 11:55 a.m., it indicated she was employed on 11-11-09. There was no record of annual abuse training for the 2012 to 2013 year.</p>				

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	<p>In interview with the Director of Nursing on 2-28-13 at 2:45 p.m., she indicated the facility was unable to locate any inservice education documentation on abuse training for LPN #1 for the 2012 to 2013.</p> <p>4. On 2-27-13 at 3:40 p.m., the Director of Nursing provided a copy of a policy entitled, "Incident of Alleged Abuse," which had a copyright date of 2003. This policy indicated, "Residents residing in this facility will be treated with dignity and respect in accordance with their individual needs. They will not be subjected to physical, mental, verbal and sexual abuse, corporal punishment, mental and physical neglect, and involuntary seclusion...Any suspicion of abuse must be reported immediately to the Administrator or his/her designee. The Administrator or his/her designee will be responsible to coordinate the abuse investigation process. Should any type of abuse or alleged abuse occur, the following procedure is to be followed: Any staff member witnessing an incident of physical, verbal, mental or sexual abuse, must intervene immediately on behalf of the resident. After the resident's immediate safety is ensured, the staff member must then report the incident</p>			

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	<p>to the supervisor in charge of the facility at the time of the incident...there must be steps taken to prevent further (potential) abuse while the investigation is in progress. If the suspected abusive individual is an employee, it is the responsibility of the supervisor at the time of the incident, if other than the Administrator, to suspend the abusive employee until the incident can be fully investigated...All incidents of resident abuse will be reported to the Indiana State Department of Health and any other necessary agencies, as required by the Unusual Occurrence Reporting Policy...Thoroughly orient new staff (and current staff) on their understanding of the abuse policy and procedure...Place an emphasis on staff's ability to identify abuse as well as knowing to whom they are to report abuse concerns. Ongoing education on abuse should be provided at a minimum of annually."</p> <p>On 2-27-13 at 3:40 p.m., the Director of Nursing provided a copy of a policy entitled, "Accident/Incident and Unusual Occurrence Policy," which was indicated as the current policy in effect. This policy indicated, "All staff members are responsible for promptly reporting to the nurse in charge, their immediate supervisor or other</p>				

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	<p>department head, any occurrence which has or could have resulted in injury to residents...verbal, physical, mental or sexual abuse...The Administrator, Director of Nursing or Designee are responsible for informing the Division of Long Term Care..by telephone or fax within 24 hours of determining a situation exists or existed that is reportable under state guidelines..."</p> <p>This Federal tag relates to Complaint IN00124447.</p> <p>3.1-27(a)(1) 3.1-27(b) 3.1-28(a) 3.1-28(c) 3.1-14(k)(1) 3.1-14(l) 3.1-14(m)</p>				

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F009999	<p>3.1-14 PERSONNEL</p> <p>(t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to ensure pre-employment physicals were conducted and signed by the physician prior to the employee's start date for 5 of 5 employees who had begun employment in the last 120 days reviewed for timeliness of pre-employment physicals. (RN #1, LPN #2, CNA #2, CNA #3, Activities Staff #1)</p> <p>Findings include:</p> <p>During the review of employee records on 2-28-13, between 11:32 a.m. and 11:55 a.m., 5 of 5 employee records indicated the date the physician signed the "Employee Health Examination Record," was after each employee's start date. In interview with the Human Resources Manager on 2-28-13 at 12:10 p.m.,</p>	F009999	<p>1. No resident has been affected by physicals being signed late.2. The Administrator met with all Department Heads and explained that no employee can be allowed to be on the floor working until they have a completed physical.3. Each Department will be responsible for ensuring that each new employee has in their department has a physical before the employee is allowed to go to the floor to work. H.R. will check all new hire packets to ensure that a completed physical is in place before allowing a new employee to go to the floor to work. H.R. will report to the Administrator of any employee that is allowed to work before physical has been completed. That employee will be removed from the schedule until physical has been completed. This will be on-going.4. H.R. will report to the quarterly Q.A. Meeting of any re-occurring issues with physicals not being completed before employees are allowed to go to the floor to work.5. 3/22/2013</p>	03/22/2013	

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	<p>she indicated, "The doctor isn't here everyday in order to get the physicals signed."</p> <p>Review of RN #1's employee file indicated her start date of employment was 1-21-13. Her physical form was signed by the physician on 1-25-13.</p> <p>Review of LPN #2's employee file indicated her start date of employment was 1-03-13. Her physical form was signed by the physician on 1-8-13.</p> <p>Review of CNA #2's employee file indicated her start date of employment was 2-1-13. Her physical form was signed by the physician on 2-18-13.</p> <p>Review of CNA #3's employee file indicated her start date of employment was 1-3-13. Her physical form was signed by the physician on 1-8-13.</p> <p>Review of Activities Staff #1's employee file indicated her start date of employment was 12-30-12. Her physical form was signed by the physician on 1-8-13.</p> <p>In interview with the Administrator on</p>				

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	<p>2-28-13 at 4:15 p.m., she indicated the facility does not have a policy which indicates when the pre-employment physicals are to be conducted and signed by the physician.</p> <p>3.1-14(t)</p>						