

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155720	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/04/2013
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NAME OF PROVIDER OR SUPPLIER  PROVIDENCE HOME HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 520 W 9TH ST JASPER, IN 47546
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F0000	<p>This visit was for the Investigation of Complaint IN00123384. This visit resulted in a partially extended survey - Immediate Jeopardy.</p> <p>Complaint IN00123384 - Substantiated. Federal/State deficiencies related to the allegations are cited at F223, F225, F226, and F490.</p> <p>Survey dates: January 30, 2013 Extended survey dates: January 31, February 1, 2, 3, and 4, 2013</p> <p>Facility number: 000315 Provider number: 155720 AIM number: 100289030</p> <p>Survey team: Anne Marie Crays, RN</p> <p>Census bed type: SNF/NF: 53 Total: 53</p> <p>Census payor type: Medicaid: 43 Other: 10 Total: 53</p>	F0000	<p>By submitting the enclosed material we are not admitting the truth or accuracy of any findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective 02/22/13 to the state findings of the Complaint Survey conducted on January 30, 31 and February 1, 2, 3 and 4, 2013.</p>	

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

TITLE

(X6) DATE

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

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	<p>Sample: 3 Extended sample: 4</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 2/06/13 by Suzanne Williams, RN</p>			

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F0223 SS=L	<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. Based on observation, interview, and record review, the facility failed to ensure a resident was free from ongoing physical and verbal abuse, after the failure of the facility to ensure abuse was immediately reported, investigated, and involved staff suspended during the investigation, for 1 of 3 residents reviewed for abuse in the sample of 3. [Resident A]. This deficient practice had the potential to affect 53 of 53 residents residing in the facility who were at risk of being abused by the three accused staff members [CNAs # 1, # 3, # 4].</p> <p>This deficient practice resulted in Immediate Jeopardy. The Immediate Jeopardy was identified on 1/31/13 and began on 9/17/12. The Director of Nursing and Assistant Director of Nursing were notified of the Immediate Jeopardy at 11:35 A.M. on 1/31/13. The Immediate Jeopardy was removed on 2/4/13, but the</p>	F0223	<p>The corrective action taken for those residents found to have been affected by the deficient practice is that the resident identified as Resident A has been physically and psychosocially assessed by the facility and is free from abuse. The CNAs identified as #1, #3 and #4 in the allegation of abuse are no longer employed by the facility. In addition nursing administration that were identified in the survey who allegedly failed to report, investigate and suspend the abusers are no longer employed by the facility. The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that all residents have the potential to be affected by the deficient practice. The CNAs identified as #1, #3 and #4 are no longer employed by the facility. In addition nursing administration who were identified in the survey are no longer employed by the facility. The measures that have been put into place to ensure that the deficient practice does not</p>	02/22/2013			

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	<p>facility remained out of compliance at the lower scope and severity level of widespread, no actual harm with potential for more than minimal harm that is not immediate jeopardy, because not all staff had been inserviced on the new policy of abuse reporting.</p> <p>Findings include:</p> <p>1. On 1/30/13 at 10:55 A.M., the clinical record of Resident A was reviewed. Diagnoses included, but were not limited to, dementia, Alzheimer's type, depression, and right below-the-knee amputation.</p> <p>A Minimum Data Set [MDS] assessment, dated 12/16/12, indicated the resident was unable to complete an interview regarding mental status, had a short-term and long-term memory problem, and was moderately impaired in cognitive skills for daily decision-making. The MDS assessment indicated the resident was totally dependent on two + staff for bed mobility, transfer, dressing, and personal hygiene.</p> <p>On 1/30/13 at 11:30 A.M., during interview with investigators from the Medicaid Fraud Control Unit of the Office of the Indiana Attorney General</p>		<p>recur is that the facility has revised their abuse policy to include that the Administrator is to be immediately notified of any and all allegations of abuse and that any and all alleged abusers will be removed from the work schedule immediately pending the outcome of the investigation. In addition the policy includes that failure to report any allegation of abuse immediately to the Administrator will be grounds for disciplinary action up to and including termination for failure to report. The revised policy also includes that an investigation into allegations of abuse will be immediately conducted by Administration. A mandatory all staff in-service was conducted on the revised abuse policy. The corrective action taken to monitor to assure compliance is that each investigation into all allegations of abuse will be reviewed by the Administrative team which shall consist of the Administrator, Nursing Administration and Social Services to ensure that all appropriate actions/measures have been taken into the investigation. This shall include appropriate notification of all appropriate agencies. Each member of the Administrative team will sign off upon completion of the review. The Administrator or designee will conduct random interviews of alert and oriented residents as well as staff members to ensure all allegations</p>		

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	<p>[AG], AG # 1 and AG # 2, AG # 2 indicated they had placed a surveillance camera in Resident A's room, with the permission of Resident A's family, since September 2012. AG # 2 indicated they entered the facility on 1/25/13 and informed the Administrator they had video evidence CNA # 1 was abusing Resident A. AG # 2 indicated the video was dated 1/19/13 from 11:55 A.M. to approximately 12:05 P.M. and provided the video at that time.</p> <p>The video included CNA # 1 rolling Resident A from side to side roughly, throwing a chux at his face, raising her arm at him in a threatening manner, and slapping at him. The video also included CNA # 1 appearing to place a chux or sheet on the resident's face and pushing down on the chux with her hands briefly.</p> <p>On 1/30/13 at 12:55 P.M., during interview with CNA # 2, she indicated she had witnessed abuse in the facility by CNA # 3 and CNA # 4. CNA # 2 indicated that in September 2012, she had witnessed CNA # 3 and CNA # 4 be abusive to Resident A, by rolling him over "as hard as they could," and holding his arms up over his head as he yelled. CNA # 2 indicated she had reported the abuse</p>		<p>of abuse have been reported to the Administrator in a timely manner. These interviews will be conducted weekly for four weeks, then monthly for three months and the quarterly for three quarters. These reviews and interviews will then be forwarded to the Quarterly Quality Assurance meeting for a final review to determine if any additional measures need to be taken.</p>				

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	<p>in the past and reported it to the Director of Nursing [DON] and Assistant Director of Nursing [ADON] but "nothing had been done." CNA # 2 indicated she "had even texted a board member, and he told me to follow the chain of command." CNA # 2 indicated she was no longer scheduled on the 2nd floor, where she had witnessed the abuse, after she complained in September. CNA # 2 indicated CNA # 4 was fired in December, but CNA # 3 still worked at the facility.</p> <p>On 1/30/13 at 2:45 P.M., during interview with CNA # 5, she indicated she had witnessed abuse in the facility. CNA # 5 indicated the abuse "was not that long ago; maybe November or December." CNA # 5 indicated she witnessed CNA # 3 clapping in Resident A's face, taunting him. CNA # 5 indicated CNA # 3 laid Resident A down in bed, and was "hateful," telling him "roll your big butt over." CNA # 5 indicated she informed CNA # 6 about the abuse, and CNA # 6 informed her, "It doesn't matter if you tell [the DON]; she won't do anything about it." CNA # 5 indicated she did not report the abuse to a nurse. CNA # 5 indicated she had previously put notes under the Administrator's door regarding</p>						

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	<p>concerns, and "nothing happened." CNA # 5 indicated staff was intimidated by CNA # 3 and CNA # 4, and would not report anything because "they are good friends with [the DON]."</p> <p>On 1/30/13 at 3:50 P.M., during interview with the ADON, she indicated in September 2012 she had been told by CNA # 2 that Resident A "had been abused awhile." The ADON indicated CNA # 2 mentioned CNA # 3 and CNA # 4 as the abusers. The ADON indicated she called the DON, who was out of the building, to report the allegation, and started her investigation. The ADON indicated she thought CNA # 3 and CNA # 4 were off that weekend, so they were not suspended.</p> <p>On 1/30/13 at 5:00 P.M., during interview with the Administrator, he indicated he was informed of the abuse by CNA # 1 against Resident A on 1/25/13 by AG # 1 and AG # 2. He indicated he had the DON immediately terminate CNA # 1. He indicated he did not begin an investigation, or re-inservice staff of the abuse policy. He indicated he was told he could not discuss the abuse investigation by the AG staff. The Administrator indicated after a</p>			

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	<p>September 2012 complaint survey, regarding a different allegation of abuse, the abuse policy was changed to notifying the charge nurse and the DON. The Administrator indicated he would probably change that policy to "notifying the Administrator immediately."</p> <p>On 1/31/13 at 9:40 A.M., during interview with the DON, she indicated she did receive an allegation of abuse on September 14, 2012. She indicated she was out of town, and the ADON called her, and told her CNA # 2 had said CNA # 3 and CNA # 4 had abused Resident A months and months previously. The DON indicated she spoke to the Administrator by phone, and asked if CNA # 3 and CNA # 4 should be suspended during the investigation. The DON indicated the Administrator informed her there would be no reason to "lay off" the employees, since the time frame was unclear. The DON indicated CNA #3 continued to work, including 9/15, 9/16, 9/17, and 9/18, and CNA # 4 continued to work, including 9/14, 9/15, and 9/16. The DON indicated they did an investigation, and could not substantiate the abuse. The DON indicated, "In hindsight, I should have suspended them." The DON indicated</p>			

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	<p>CNA # 4 was terminated in December 2012 for "failure to observe resident rights." The DON indicated CNA # 3 still worked at the facility.</p> <p>At that time, the DON provided an investigation into the allegation of abuse, undated. The report included: "... Alleged abuse of verbal and physical abuse of Resident [A] was reported at 3 pm on Friday 9/14/12. Statement received by CNA [# 2] was unable to mention the nurse she reported alleged abuse to nor dates and times, statement also didn't give names, all other staff deny per their written statements...." The investigation did not document the names of CNA # 3 or CNA # 4 as the alleged abusers. The investigation was signed by the DON, Administrator, and Social Services Director.</p> <p>The investigation documents included a hand-written statement by CNA # 9. The statement, undated, included: "I [CNA # 9] noticed that some of the 2nd shifts that I work that some are rude to [Resident A]. Roll him hard...She rolled him in anger, so I put my hand on the metal rail so his head would not bounce off of it. They make fun of him...I do not think its right to be rough with him...some</p>				

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	<p>CNAs lay on his bed to hold him down...he is treated like he is 2, he gets very rough treatment and a lot of times verbal abuse too...there is no reason to sit on him or cuse [sic] at him or be rough with him cause your [sic] mad or he is not happy...."</p> <p>On 1/31/13 at 2:15 P.M., during interview with CNA # 9, she indicated she worked at the facility for approximately one month around September 2012. She indicated, "They terminated me because I wouldn't work with those abusers." CNA # 9 mentioned CNA # 3 and CNA # 4 by name, and indicated, CNA # 3 "was the main one." She indicated CNA # 3 would "roll him so hard his face would hit the metal bar." She indicated CNA # 1 "was unstable," and preferred to work by herself. She indicated she witnessed CNA # 1 "throwing a resident in like a sack of potatoes," but she could not remember the resident's name. She indicated she did inform the DON, but that "I got written up instead of them." CNA # 9 indicated she did talk to the Administrator after she was terminated about the abuse, but he just told her the DON "was just doing her job."</p> <p>On 2/1/13 at 10:10 A.M., during</p>						

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	<p>interview with the Administrator, he indicated he would usually review investigations into abuse allegations. He indicated he never told the DON not to suspend CNA # 3 and CNA # 4 on September 14, 2012; that they should have been suspended during the investigation. The Administrator indicated he didn't recall speaking to any CNA regarding allegations of abuse, and he never received letters under his door regarding abuse.</p> <p>2. On 1/30/13 at 10:15 A.M., the Social Services Director provided the current policy and procedure on Abuse Reporting, dated 9/17/12. The policy included: "...If you have suspect [sic] or witnessed abuse, neglect or misuse of resident's property, follow the steps outlined below:...2. After the resident is safe notify the person in charge of the facility at the time of the occurrence and Director of Nursing. The person in charge or the Director of Nursing must immediately notify the Administrator and the Social Service Director...Measures to prevent further (potential) abuse will be immediately initiated and remain in effect to protect the residents. 7. If the alleged abuser is an employee, the staff member in charge of the facility at the time the incident occurred will</p>			
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	<p>immediately suspend the employee. The employee will be suspended until the investigation is completed...8. The charge nurse responsible for the resident alleged to have been abused will document in the resident's chart the events that occurred and will notify the resident's physician and family...."</p> <p>An Immediate Jeopardy was identified on 1/31/13. The Immediate Jeopardy began on 9/17/12 when staff accused of abuse were allowed to work during an abuse investigation. The Director of Nursing and Assistant Director of Nursing were notified at 11:35 A.M. on 1/31/13 of the Immediate Jeopardy related to failure to protect residents from abuse. The Immediate Jeopardy was removed on 2/4/13 when through observations, interviews and record reviews, it was determined the facility had implemented the plan of action to remove the Immediate Jeopardy and that the steps taken removed the immediacy of the problem. The facility suspended, then terminated CNA # 3, developed a new policy of abuse prohibition that specified notifying the Administrator immediately of allegations of abuse, and inserviced staff of the new policy. Nursing staff, CNAs and activity staff</p>						

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	<p>were interviewed on 2/04/13 and demonstrated knowledge of the new abuse prohibition policy, including immediately notifying the Administrator of allegations of abuse. Nursing staff, CNAs and activity staff were interviewed on 2/04/13 and demonstrated knowledge of the new abuse prohibition policy, including immediately notifying the Administrator of allegations of abuse. Even though the facility's corrective actions removed the Immediate Jeopardy, the facility remained out of compliance at a reduced scope and severity level of widespread, no actual harm with potential for more than minimal harm that is not immediate jeopardy.</p> <p>This federal tag relates to Complaint IN00123384.</p> <p>3.1-27(a)(1) 3.1-27(b)</p>				

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F0225 SS=L	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on observation, interview, and</p>	F0225	The corrective action taken for	02/22/2013			

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	<p>record review, the facility failed to ensure the Administrator was immediately notified of alleged abuse, all alleged violations were thoroughly investigated, and that staff accused of abuse were suspended during the abuse investigation, resulting in the ongoing physical and verbal abuse of 1 of 3 residents reviewed for abuse [Resident A] in the sample of 3. This deficient practice had the potential to affect 53 of 53 residents residing in the facility who were at risk being abused by the three accused staff members [CNAs # 1, # 3, # 4].</p> <p>This deficient practice resulted in Immediate Jeopardy. The Immediate Jeopardy was identified on 1/31/13 and began on 9/17/12. The Director of Nursing and Assistant Director of Nursing were notified of the Immediate Jeopardy at 11:35 A.M. on 1/31/13. The Immediate Jeopardy was removed on 2/4/13, but the facility remained out of compliance at the lower scope and severity level of widespread, no actual harm with potential for more than minimal harm that is not immediate jeopardy, because not all staff had been inserviced on the new policy of abuse reporting.</p> <p>Findings include:</p>		<p>those residents found to have been affected by the deficient practice is that the resident identified as Resident A is free from abuse in that CNAs identified as #1, #3 and #4 in the allegation of abuse are no longer employed by the facility. In addition nursing administration that were identified in the survey are no longer employed by the facility. In addition the administrator has conducted another housewide investigation into any and all abuse and has followed the revised abuse policy related to this completed investigation. The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that all residents have the potential to be affected by the same deficient practice. The CNAs identified as #1, #3 and #4 are no longer employed by the facility. In addition nursing administration who were identified in the survey are no longer employed by the facility. The measures that have been put into place to ensure that the deficient practice does not recur is that the facility has revised their abuse policy to include that the Administrator is to be immediately notified of any and all allegations of abuse and that any and all abusers will be removed from the work schedule immediately pending the outcome of the investigation. In addition the</p>				

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	<p>1. On 1/30/13 at 10:55 A.M., the clinical record of Resident A was reviewed. Diagnoses included, but were not limited to, dementia, Alzheimer's type, depression, and right below-the-knee amputation.</p> <p>A Minimum Data Set [MDS] assessment, dated 12/16/12, indicated the resident was unable to complete an interview regarding mental status, had a short-term and long-term memory problem, and was moderately impaired in cognitive skills for daily decision-making. The MDS assessment indicated the resident was totally dependent on two + staff for bed mobility, transfer, dressing, and personal hygiene.</p> <p>On 1/30/13 at 11:30 A.M., during interview with investigators from the Medicaid Fraud Control Unit of the Office of the Indiana Attorney General [AG], AG # 1 and AG # 2, AG # 2 indicated they had placed a surveillance camera in Resident A's room, with the permission of Resident A's family, since September 2012. AG # 2 indicated they entered the facility on 1/25/13 and informed the Administrator they had video evidence CNA # 1 was abusing Resident A. AG # 2 indicated the</p>		<p>policy includes that failure to report any allegation of abuse immediately to the Administrator will be grounds for disciplinary action up to and including termination for failure to report. The revised policy also includes that an investigation into all allegations of abuse will be immediately conducted by Administration. A mandatory all staff in-service was conducted on the revised abuse policy. The corrective action taken to monitor to assure compliance is that each investigation into all allegations of abuse will be reviewed by the Administrative team which shall consist of the Administrator, Nursing Administration and Social Services to ensure that all appropriate actions/measures have been taken into the investigation. This shall include appropriate notification of all appropriate agencies. Each member of the Administrative team will sign off upon completion of the review. The Administrator and/or designee will also conduct random interviews of alert and oriented residents as well as staff members to ensure all allegations of abuse have been reported to the Administrator in a timely manner. These interviews will be conducted weekly for four weeks, then monthly for three months and then quarterly for three quarters. These reviews and interviews will then be forwarded to the Quarterly Quality</p>	

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	<p>video was dated 1/19/13 from 11:55 A.M. to approximately 12:05 P.M. and provided the video at that time.</p> <p>The video included CNA # 1 rolling Resident A from side to side roughly, throwing a chux at his face, raising her arm at him in a threatening manner, and slapping at him. The video also included CNA # 1 appearing to place a chux or sheet on the resident's face and pushing down on the chux with her hands briefly.</p> <p>On 1/30/13 at 12:55 P.M., during interview with CNA # 2, she indicated she had witnessed abuse in the facility by CNA # 3 and CNA # 4. CNA # 2 indicated that in September 2012, she had witnessed CNA # 3 and CNA # 4 be abusive to Resident A, by rolling him over "as hard as they could," and holding his arms up over his head as he yelled. CNA # 2 indicated she had reported the abuse in the past and reported it to the Director of Nursing [DON] and Assistant Director of Nursing [ADON] but "nothing had been done." CNA # 2 indicated she "had even texted a board member, and he told me to follow the chain of command." CNA # 2 indicated she was no longer scheduled on the 2nd floor, where she had witnessed the abuse, after</p>		Assurance meeting for a final review to determine if any additional measures need to be taken.				

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	<p>she complained in September. CNA # 2 indicated CNA # 4 was fired in December, but CNA # 3 still worked at the facility.</p> <p>On 1/30/13 at 2:45 P.M., during interview with CNA # 5, she indicated she had witnessed abuse in the facility. CNA # 5 indicated the abuse "was not that long ago; maybe November or December." CNA # 5 indicated she witnessed CNA # 3 clapping in Resident A's face, taunting him. CNA # 5 indicated CNA # 3 laid Resident A down in bed, and was "hateful," telling him "roll your big butt over." CNA # 5 indicated she informed CNA # 6 about the abuse, and CNA # 6 informed her, "It doesn't matter if you tell [the DON]; she won't do anything about it." CNA # 5 indicated she did not report the abuse to a nurse. CNA # 5 indicated she had previously put notes under the Administrator's door regarding concerns, and "nothing happened." CNA # 5 indicated staff was intimidated by CNA # 3 and CNA # 4, and would not report anything because "they are good friends with [the DON]."</p> <p>On 1/30/13 at 3:50 P.M., during interview with the ADON, she indicated in September 2012 she had</p>			

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	<p>been told by CNA # 2 that Resident A "had been abused awhile." The ADON indicated CNA # 2 mentioned CNA # 3 and CNA # 4 as the abusers. The ADON indicated she called the DON, who was out of the building, to report the allegation, and started her investigation. The ADON indicated she thought CNA # 3 and CNA # 4 were off that weekend, so they were not suspended.</p> <p>On 1/30/13 at 5:00 P.M., during interview with the Administrator, he indicated he was informed of the abuse by CNA # 1 against Resident A on 1/25/13 by AG # 1 and AG # 2. He indicated he had the DON immediately terminate CNA # 1. He indicated he did not begin an investigation, or re-inservice staff of the abuse policy. He indicated he was told he could not discuss the abuse investigation by the AG staff. The Administrator indicated after a September 2012 complaint survey, regarding a different allegation of abuse, the abuse policy was changed to notifying the charge nurse and the DON. The Administrator indicated he would probably change that policy to "notifying the Administrator immediately."</p> <p>On 1/31/13 at 9:40 A.M., during</p>				

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	<p>interview with the DON, she indicated she did receive an allegation of abuse on September 14, 2012. She indicated she was out of town, and the ADON called her, and told her CNA # 2 had said CNA # 3 and CNA # 4 had abused Resident A months and months previously. The DON indicated she spoke to the Administrator by phone, and asked if CNA # 3 and CNA # 4 should be suspended during the investigation. The DON indicated the Administrator informed her there would be no reason to "lay off" the employees, since the time frame was unclear. The DON indicated CNA #3 continued to work, including 9/15, 9/16, 9/17, and 9/18, and CNA # 4 continued to work, including 9/14, 9/15, and 9/16. The DON indicated they did an investigation, and could not substantiate the abuse. The DON indicated, "In hindsight, I should have suspended them." The DON indicated CNA # 4 was terminated in December 2012 for "failure to observe resident rights." The DON indicated CNA # 3 still worked at the facility.</p> <p>At that time, the DON provided an investigation into the allegation of abuse, undated. The report included: "... Alleged abuse of verbal and physical abuse of Resident [A] was</p>				

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	<p>reported at 3 pm on Friday 9/14/12. Statement received by CNA [# 2] was unable to mention the nurse she reported alleged abuse to nor dates and times, statement also didn't give names, all other staff deny per their written statements...." The investigation did not document the names of CNA # 3 or CNA # 4 as the alleged abusers. The investigation was signed by the DON, Administrator, and Social Services Director.</p> <p>The investigation documents included a hand-written statement by CNA # 9. The statement, undated, included: "I [CNA # 9] noticed that some of the 2nd shifts that I work that some are rude to [Resident A]. Roll him hard...She rolled him in anger, so I put my hand on the metal rail so his head would not bounce off of it. They make fun of him...I do not think its right to be rough with him...some CNAs lay on his bed to hold him down...he is treated like he is 2, he gets very rough treatment and a lot of times verbal abuse too...there is no reason to sit on him or cuse [sic] at him or be rough with him cause your [sic] mad or he is not happy...."</p> <p>On 1/31/13 at 2:15 P.M., during interview with CNA # 9, she indicated</p>						

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	<p>she worked at the facility for approximately one month around September 2012. She indicated, "They terminated me because I wouldn't work with those abusers." CNA # 9 mentioned CNA # 3 and CNA # 4 by name, and indicated, CNA # 3 "was the main one." She indicated CNA # 3 would "roll him so hard his face would hit the metal bar." She indicated CNA # 1 "was unstable," and preferred to work by herself. She indicated she witnessed CNA # 1 "throwing a resident in like a sack of potatoes," but she could not remember the resident's name. She indicated she did inform the DON, but that "I got written up instead of them." CNA # 9 indicated she did talk to the Administrator after she was terminated about the abuse, but he just told her the DON "was just doing her job."</p> <p>On 2/1/13 at 10:10 A.M., during interview with the Administrator, he indicated he would usually review investigations into abuse allegations. He indicated he never told the DON not to suspend CNA # 3 and CNA # 4 on September 14, 2012; that they should have been suspended during the investigation. The Administrator indicated he didn't recall speaking to any CNA regarding allegations of</p>						

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	<p>abuse, and he never received letters under his door regarding abuse.</p> <p>2. On 1/30/13 at 10:15 A.M., the Social Services Director provided the current policy and procedure on Abuse Reporting, dated 9/17/12. The policy included: "...If you have suspect [sic] or witnessed abuse, neglect or misuse of resident's property, follow the steps outlined below:...2. After the resident is safe notify the person in charge of the facility at the time of the occurrence and Director of Nursing. The person in charge or the Director of Nursing must immediately notify the Administrator and the Social Service Director...Measures to prevent further (potential) abuse will be immediately initiated and remain in effect to protect the residents. 7. If the alleged abuser is an employee, the staff member in charge of the facility at the time the incident occurred will immediately suspend the employee. The employee will be suspended until the investigation is completed...8. The charge nurse responsible for the resident alleged to have been abused will document in the resident's chart the events that occurred and will notify the resident's physician and family...."</p>				

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	An Immediate Jeopardy was identified on 1/31/13. The Immediate Jeopardy began on 9/17/12 when staff accused of abuse were allowed to work during an abuse investigation. The Director of Nursing and Assistant Director of Nursing were notified at 11:35 A.M. on 1/31/13 of the Immediate Jeopardy related to failure to protect residents from abuse. The Immediate Jeopardy was removed on 2/4/13 when through observations, interviews and record reviews, it was determined the facility had implemented the plan of action to remove the Immediate Jeopardy and that the steps taken removed the immediacy of the problem. The facility suspended, then terminated CNA # 3, developed a new policy of abuse prohibition that specified notifying the Administrator immediately of allegations of abuse, and inserviced staff of the new policy. Nursing staff, CNAs and activity staff were interviewed on 2/04/13 and demonstrated knowledge of the new abuse prohibition policy, including immediately notifying the Administrator of allegations of abuse. Even though the facility's corrective actions removed the Immediate Jeopardy, the facility remained out of compliance at a reduced scope and severity level of widespread, no actual						

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	<p>harm with potential for more than minimal harm that is not immediate jeopardy.</p> <p>This federal tag relates to Complaint IN00123384.</p> <p>3.1-27(a)(1) 3.1-27(b) 3.1-28(c) 3.1-28(d) 3.1-28(e)</p>						

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F0226 SS=L	<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 observation, interview, and record review, the facility failed to develop and implement policies to prohibit abuse in that staff accused of abuse were not suspended during the abuse investigation, staff failed to report allegations of abuse, and Administration failed to immediately begin an investigation into an abuse allegation resulting in the ongoing physical and verbal abuse of 1 of 3 residents reviewed for abuse [Resident A] in the sample of 3. This deficient practice had the potential to affect 53 of 53 residents residing in the facility who were at risk being abused by the three accused staff members [CNAs # 1, # 3, # 4].</p> <p>This deficient practice resulted in Immediate Jeopardy. The Immediate Jeopardy was identified on 1/31/13 and began on 9/17/12. The Director of Nursing and Assistant Director of Nursing were notified of the Immediate Jeopardy at 11:35 A.M. on 1/31/13. The Immediate Jeopardy was removed on 2/4/13, but the</p>	F0226	<p>The corrective action taken for those residents found to have been affected by the deficient practice is that the facility has reviewed and revised their policy and procedure on abuse. The policy includes that any staff member accused of abuse will be immediately removed from the work schedule pending the outcome of the investigation. All facility staff have been directed through a mandatory in-service that all allegations of abuse must be immediately reported to the facility Administrator and failure to do so will result in a disciplinary action up to and including termination of employment. The Administrator through the revised policy has been directed to begin immediately an investigation into all allegations of abuse per facility policy. The Administrator has conducted a new investigation into the allegation of abuse concerning the resident identified as Resident A and all appropriate actions have been taken based on the outcome of that investigation. The corrective action taken for the other residents having the potential to be affected by the same deficient</p>	02/22/2013	

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	<p>facility remained out of compliance at the lower scope and severity level of widespread, no actual harm with potential for more than minimal harm that is not immediate jeopardy, because not all staff had been inserviced on the new policy of abuse reporting.</p> <p>Findings include:</p> <p>1. On 1/30/13 at 10:55 A.M., the clinical record of Resident A was reviewed. Diagnoses included, but were not limited to, dementia, Alzheimer's type, depression, and right below-the-knee amputation.</p> <p>A Minimum Data Set [MDS] assessment, dated 12/16/12, indicated the resident was unable to complete an interview regarding mental status, had a short-term and long-term memory problem, and was moderately impaired in cognitive skills for daily decision-making. The MDS assessment indicated the resident was totally dependent on two + staff for bed mobility, transfer, dressing, and personal hygiene.</p> <p>On 1/30/13 at 11:30 A.M., during interview with investigators from the Medicaid Fraud Control Unit of the Office of the Indiana Attorney General</p>		<p>practice is taht all residents have the potential to be affected by the same deficient practice. Through implementation of the revised abuse policy the administrator will be immediately notified of any allegation of abuse. If the allegation of abuse involves a staff member the alleged abuser will be immediately removed from the work schedule and an immediate investigation will be conducted. Any employee who fails to immediately report an allegation of abuse to the Administrator will be disciplined in accordance with the facility abuse policy. The measures that have been put into place to ensure that the deficient practice does not recur is that the facility has revised their abuse policy to include that the Administrator is to be immediately notified of any allegations of abuse and that any and all alleged abusers will be removed from the schedule immediately pending the outcome of the investigation. In addition the policy includes that failure to report ant allegation of abuse immediately to the Administrator will br grounds for disciplinary action up to and including termination for failure to report. The revised policy also includes that an investigation into allegations of abuse will be immediately conducted by Administration. A mandatory in-service for all staff members was conducted on the revised</p>				

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	<p>[AG], AG # 1 and AG # 2, AG # 2 indicated they had placed a surveillance camera in Resident A's room, with the permission of Resident A's family, since September 2012. AG # 2 indicated they entered the facility on 1/25/13 and informed the Administrator they had video evidence CNA # 1 was abusing Resident A. AG # 2 indicated the video was dated 1/19/13 from 11:55 A.M. to approximately 12:05 P.M. and provided the video at that time.</p> <p>The video included CNA # 1 rolling Resident A from side to side roughly, throwing a chux at his face, raising her arm at him in a threatening manner, and slapping at him. The video also included CNA # 1 appearing to place a chux or sheet on the resident's face and pushing down on the chux with her hands briefly.</p> <p>On 1/30/13 at 12:55 P.M., during interview with CNA # 2, she indicated she had witnessed abuse in the facility by CNA # 3 and CNA # 4. CNA # 2 indicated that in September 2012, she had witnessed CNA # 3 and CNA # 4 be abusive to Resident A, by rolling him over "as hard as they could," and holding his arms up over his head as he yelled. CNA # 2 indicated she had reported the abuse</p>		Abuse Policy. The corrective action taken to monitor to assure compliance is that each investigation into all allegations of abuse will be reviewed by the Administrative team which shall consist of the Administrator, Nursing Administration and Social Services to ensure that all appropriate actions/measures have been taken into the investigation. This shall include appropriate notification of all appropriate agencies. Each member of the Administrative team will sign off upon completion of the review. The Administrator and/or designee will also conduct random interviews of alert and oriented residents as well as staff members to ensure all allegations of abuse have been reported to the Administrator in a timely manner. These interviews will be conducted weekly for four weeks, then monthly for three months and then quarterly for three quarters. These reviews and interviews will then be forwarded to the Quarterly Quality Assurance meeting for a final review to determine if any additional measures need to be taken.				

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	<p>in the past and reported it to the Director of Nursing [DON] and Assistant Director of Nursing [ADON] but "nothing had been done." CNA # 2 indicated she "had even texted a board member, and he told me to follow the chain of command." CNA # 2 indicated she was no longer scheduled on the 2nd floor, where she had witnessed the abuse, after she complained in September. CNA # 2 indicated CNA # 4 was fired in December, but CNA # 3 still worked at the facility.</p> <p>On 1/30/13 at 2:45 P.M., during interview with CNA # 5, she indicated she had witnessed abuse in the facility. CNA # 5 indicated the abuse "was not that long ago; maybe November or December." CNA # 5 indicated she witnessed CNA # 3 clapping in Resident A's face, taunting him. CNA # 5 indicated CNA # 3 laid Resident A down in bed, and was "hateful," telling him "roll your big butt over." CNA # 5 indicated she informed CNA # 6 about the abuse, and CNA # 6 informed her, "It doesn't matter if you tell [the DON]; she won't do anything about it." CNA # 5 indicated she did not report the abuse to a nurse. CNA # 5 indicated she had previously put notes under the Administrator's door regarding</p>				

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	<p>concerns, and "nothing happened." CNA # 5 indicated staff was intimidated by CNA # 3 and CNA # 4, and would not report anything because "they are good friends with [the DON]."</p> <p>On 1/30/13 at 3:50 P.M., during interview with the ADON, she indicated in September 2012 she had been told by CNA # 2 that Resident A "had been abused awhile." The ADON indicated CNA # 2 mentioned CNA # 3 and CNA # 4 as the abusers. The ADON indicated she called the DON, who was out of the building, to report the allegation, and started her investigation. The ADON indicated she thought CNA # 3 and CNA # 4 were off that weekend, so they were not suspended.</p> <p>On 1/30/13 at 5:00 P.M., during interview with the Administrator, he indicated he was informed of the abuse by CNA # 1 against Resident A on 1/25/13 by AG # 1 and AG # 2. He indicated he had the DON immediately terminate CNA # 1. He indicated he did not begin an investigation, or re-inservice staff of the abuse policy. He indicated he was told he could not discuss the abuse investigation by the AG staff. The Administrator indicated after a</p>				

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	<p>September 2012 complaint survey, regarding a different allegation of abuse, the abuse policy was changed to notifying the charge nurse and the DON. The Administrator indicated he would probably change that policy to "notifying the Administrator immediately."</p> <p>On 1/31/13 at 9:40 A.M., during interview with the DON, she indicated she did receive an allegation of abuse on September 14, 2012. She indicated she was out of town, and the ADON called her, and told her CNA # 2 had said CNA # 3 and CNA # 4 had abused Resident A months and months previously. The DON indicated she spoke to the Administrator by phone, and asked if CNA # 3 and CNA # 4 should be suspended during the investigation. The DON indicated the Administrator informed her there would be no reason to "lay off" the employees, since the time frame was unclear. The DON indicated CNA #3 continued to work, including 9/15, 9/16, 9/17, and 9/18, and CNA # 4 continued to work, including 9/14, 9/15, and 9/16. The DON indicated they did an investigation, and could not substantiate the abuse. The DON indicated, "In hindsight, I should have suspended them." The DON indicated</p>			

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	<p>CNA # 4 was terminated in December 2012 for "failure to observe resident rights." The DON indicated CNA # 3 still worked at the facility.</p> <p>At that time, the DON provided an investigation into the allegation of abuse, undated. The report included: "... Alleged abuse of verbal and physical abuse of Resident [A] was reported at 3 pm on Friday 9/14/12. Statement received by CNA [# 2] was unable to mention the nurse she reported alleged abuse to nor dates and times, statement also didn't give names, all other staff deny per their written statements...." The investigation did not document the names of CNA # 3 or CNA # 4 as the alleged abusers. The investigation was signed by the DON, Administrator, and Social Services Director.</p> <p>The investigation documents included a hand-written statement by CNA # 9. The statement, undated, included: "I [CNA # 9] noticed that some of the 2nd shifts that I work that some are rude to [Resident A]. Roll him hard...She rolled him in anger, so I put my hand on the metal rail so his head would not bounce off of it. They make fun of him...I do not think its right to be rough with him...some</p>						

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	<p>CNAs lay on his bed to hold him down...he is treated like he is 2, he gets very rough treatment and a lot of times verbal abuse too...there is no reason to sit on him or cuse [sic] at him or be rough with him cause your [sic] mad or he is not happy...."</p> <p>On 1/31/13 at 2:15 P.M., during interview with CNA # 9, she indicated she worked at the facility for approximately one month around September 2012. She indicated, "They terminated me because I wouldn't work with those abusers." CNA # 9 mentioned CNA # 3 and CNA # 4 by name, and indicated, CNA # 3 "was the main one." She indicated CNA # 3 would "roll him so hard his face would hit the metal bar." She indicated CNA # 1 "was unstable," and preferred to work by herself. She indicated she witnessed CNA # 1 "throwing a resident in like a sack of potatoes," but she could not remember the resident's name. She indicated she did inform the DON, but that "I got written up instead of them." CNA # 9 indicated she did talk to the Administrator after she was terminated about the abuse, but he just told her the DON "was just doing her job."</p> <p>On 2/1/13 at 10:10 A.M., during</p>						

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	<p>interview with the Administrator, he indicated he would usually review investigations into abuse allegations. He indicated he never told the DON not to suspend CNA # 3 and CNA # 4 on September 14, 2012; that they should have been suspended during the investigation. The Administrator indicated he didn't recall speaking to any CNA regarding allegations of abuse, and he never received letters under his door regarding abuse.</p> <p>2. On 1/30/13 at 10:15 A.M., the Social Services Director provided the current policy and procedure on Abuse Reporting, dated 9/17/12. The policy included: "...If you have suspect [sic] or witnessed abuse, neglect or misuse of resident's property, follow the steps outlined below:...2. After the resident is safe notify the person in charge of the facility at the time of the occurrence and Director of Nursing. The person in charge or the Director of Nursing must immediately notify the Administrator and the Social Service Director...Measures to prevent further (potential) abuse will be immediately initiated and remain in effect to protect the residents. 7. If the alleged abuser is an employee, the staff member in charge of the facility at the time the incident occurred will</p>			

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	<p>immediately suspend the employee. The employee will be suspended until the investigation is completed...8. The charge nurse responsible for the resident alleged to have been abused will document in the resident's chart the events that occurred and will notify the resident's physician and family...."</p> <p>An Immediate Jeopardy was identified on 1/31/13. The Immediate Jeopardy began on 9/17/12 when staff accused of abuse were allowed to work during an abuse investigation. The Director of Nursing and Assistant Director of Nursing were notified at 11:35 A.M. on 1/31/13 of the Immediate Jeopardy related to failure to protect residents from abuse. The Immediate Jeopardy was removed on 2/4/13 when through observations, interviews and record reviews, it was determined the facility had implemented the plan of action to remove the Immediate Jeopardy and that the steps taken removed the immediacy of the problem. The facility suspended, then terminated CNA # 3, developed a new policy of abuse prohibition that specified notifying the Administrator immediately of allegations of abuse, and inserviced staff of the new policy. Nursing staff, CNAs and activity staff</p>				

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	<p>were interviewed on 2/04/13 and demonstrated knowledge of the new abuse prohibition policy, including immediately notifying the Administrator of allegations of abuse. Even though the facility's corrective actions removed the Immediate Jeopardy, the facility remained out of compliance at a reduced scope and severity level of widespread, no actual harm with potential for more than minimal harm that is not immediate jeopardy.</p> <p>This federal tag relates to Complaint IN00123384.</p> <p>3.1-27(a)(1) 3.1-27(b) 3.1-28(a)</p>			

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F0490 SS=L	<p>483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING</p> <p>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, interview, and record review, the facility failed to ensure Administration was actively aware of abuse allegations and investigations, in that staff accused of abuse were not suspended during an abuse investigation, staff failed to report allegations of abuse, and Administration failed to immediately begin an investigation into an abuse allegation resulting in the ongoing physical and verbal abuse of 1 of 3 residents reviewed for abuse [Resident A] in the sample of 3. This deficient practice had the potential to affect 53 of 53 residents residing in the facility who were at risk being abused by the three accused staff members [CNAs # 1, # 3, # 4].</p> <p>This deficient practice resulted in Immediate Jeopardy. The Immediate Jeopardy was identified on 1/31/13 and began on 9/17/12. The Director of Nursing and Assistant Director of Nursing were notified of the Immediate Jeopardy at 11:35 A.M. on</p>	F0490	<p>The corrective action taken for those residents found to have been affected by the deficient practice is that the facility has revised their abuse policy to include that the Administrator is to be immediately notified of any allegation of abuse. The policy also includes that any staff member who fails to report any allegation immediately to the Administrator will receive a disciplinary action up to and including termination of employment. If the alleged abuser is a staff member the revised policy directs that the individual will immediately be removed from the work schedule pending the outcome of the investigation. The revised policy includes that the Administrator will begin investigation immediately per the revised facility policy. The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that all residents have the potential to be affected by the deficient practice. Through the implementation of the revised abuse policy the Administrator will</p>	02/22/2013			

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	<p>1/31/13. The Immediate Jeopardy was removed on 2/4/13, but the facility remained out of compliance at the lower scope and severity level of widespread, no actual harm with potential for more than minimal harm that is not immediate jeopardy, because not all staff had been inserviced on the new policy of abuse reporting.</p> <p>Findings include:</p> <p>1. On 1/30/13 at 10:55 A.M., the clinical record of Resident A was reviewed. Diagnoses included, but were not limited to, dementia, Alzheimer's type, depression, and right below-the-knee amputation.</p> <p>A Minimum Data Set [MDS] assessment, dated 12/16/12, indicated the resident was unable to complete an interview regarding mental status, had a short-term and long-term memory problem, and was moderately impaired in cognitive skills for daily decision-making. The MDS assessment indicated the resident was totally dependent on two + staff for bed mobility, transfer, dressing, and personal hygiene.</p> <p>On 1/30/13 at 11:30 A.M., during interview with investigators from the</p>		<p>be immediately notified of any allegation of abuse. If the allegation of abuse involves a staff member the alleged abuser will be immediately removed from the work schedule and an immediate investigation will be conducted. Any employee who fails to immediately report an allegation of abuse to the Administrator will be disciplined in accordance with the facility abuse policy. The measures that have been put into place to ensure that the deficient practice does not recur is that the facility has revised their abuse policy to include that the Administrator is to be immediately notified of any and all allegations of abuse and that any and all abusers wwill be removed from the work schedule immediately pending the outcome of the investigation. In addition the policy includes that failure to report any allegation of abuse immediately to the Administrator will be grounds for disciplinary action up to and including termination for failure to report. The revised policy also includes that an investigation into all allegations of abuse will be immediately conducted by Administration. A mandatory in-service for all staff members was conducted on the revised Abuse Policy. The corrective action taken to monitor to assure compliance is that each</p>				

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	<p>Medicaid Fraud Control Unit of the Office of the Indiana Attorney General [AG], AG # 1 and AG # 2, AG # 2 indicated they had placed a surveillance camera in Resident A's room, with the permission of Resident A's family, since September 2012. AG # 2 indicated they entered the facility on 1/25/13 and informed the Administrator they had video evidence CNA # 1 was abusing Resident A. AG # 2 indicated the video was dated 1/19/13 from 11:55 A.M. to approximately 12:05 P.M. and provided the video at that time.</p> <p>The video included CNA # 1 rolling Resident A from side to side roughly, throwing a chux at his face, raising her arm at him in a threatening manner, and slapping at him. The video also included CNA # 1 appearing to place a chux or sheet on the resident's face and pushing down on the chux with her hands briefly.</p> <p>On 1/30/13 at 12:55 P.M., during interview with CNA # 2, she indicated she had witnessed abuse in the facility by CNA # 3 and CNA # 4. CNA # 2 indicated that in September 2012, she had witnessed CNA # 3 and CNA # 4 be abusive to Resident A, by rolling him over "as hard as they could," and holding his arms up over</p>		<p>investigation into all allegations of abuse will be reviewed bt the Administrative team which shall consist of the Administrator, Nursing Administration and Social Services to ensure that all appropriate actions/measures have been taken into the investigation. This shall include appropriate notification of all appropriate agencies. Each member of the Administrative team will sign off upon completion of the review. The Administrator and/or designee will also conduct random interviews of alert and oriented residents and staff members to ensure all allegations of abuse have been reported to the Administrator in a timely manner. These interviews will be conducted weekly for four weeks, then monthly for three months and then quarterly for three quarters. These reviews and interviews will then be forwarded to the Quarterly Quality Assurance meeting for a final review to determine if any additional measures need to be taken.</p>		

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	<p>his head as he yelled. CNA # 2 indicated she had reported the abuse in the past and reported it to the Director of Nursing [DON] and Assistant Director of Nursing [ADON] but "nothing had been done." CNA # 2 indicated she "had even texted a board member, and he told me to follow the chain of command." CNA # 2 indicated she was no longer scheduled on the 2nd floor, where she had witnessed the abuse, after she complained in September. CNA # 2 indicated CNA # 4 was fired in December, but CNA # 3 still worked at the facility.</p> <p>On 1/30/13 at 2:45 P.M., during interview with CNA # 5, she indicated she had witnessed abuse in the facility. CNA # 5 indicated the abuse "was not that long ago; maybe November or December." CNA # 5 indicated she witnessed CNA # 3 clapping in Resident A's face, taunting him. CNA # 5 indicated CNA # 3 laid Resident A down in bed, and was "hateful," telling him "roll your big butt over." CNA # 5 indicated she informed CNA # 6 about the abuse, and CNA # 6 informed her, "It doesn't matter if you tell [the DON]; she won't do anything about it." CNA # 5 indicated she did not report the abuse to a nurse. CNA # 5 indicated she</p>			

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	<p>had previously put notes under the Administrator's door regarding concerns, and "nothing happened." CNA # 5 indicated staff was intimidated by CNA # 3 and CNA # 4, and would not report anything because "they are good friends with [the DON]."</p> <p>On 1/30/13 at 3:50 P.M., during interview with the ADON, she indicated in September 2012 she had been told by CNA # 2 that Resident A "had been abused awhile." The ADON indicated CNA # 2 mentioned CNA # 3 and CNA # 4 as the abusers. The ADON indicated she called the DON, who was out of the building, to report the allegation, and started her investigation. The ADON indicated she thought CNA # 3 and CNA # 4 were off that weekend, so they were not suspended.</p> <p>On 1/30/13 at 5:00 P.M., during interview with the Administrator, he indicated he was informed of the abuse by CNA # 1 against Resident A on 1/25/13 by AG # 1 and AG # 2. He indicated he had the DON immediately terminate CNA # 1. He indicated he did not begin an investigation, or re-inservice staff of the abuse policy. He indicated he was told he could not discuss the abuse</p>						

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	<p>investigation by the AG staff. The Administrator indicated after a September 2012 complaint survey, regarding a different allegation of abuse, the abuse policy was changed to notifying the charge nurse and the DON. The Administrator indicated he would probably change that policy to "notifying the Administrator immediately."</p> <p>On 1/31/13 at 9:40 A.M., during interview with the DON, she indicated she did receive an allegation of abuse on September 14, 2012. She indicated she was out of town, and the ADON called her, and told her CNA # 2 had said CNA # 3 and CNA # 4 had abused Resident A months and months previously. The DON indicated she spoke to the Administrator by phone, and asked if CNA # 3 and CNA # 4 should be suspended during the investigation. The DON indicated the Administrator informed her there would be no reason to "lay off" the employees, since the time frame was unclear. The DON indicated CNA #3 continued to work, including 9/15, 9/16, 9/17, and 9/18, and CNA # 4 continued to work, including 9/14, 9/15, and 9/16. The DON indicated they did an investigation, and could not substantiate the abuse. The DON</p>			

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	<p>indicated, "In hindsight, I should have suspended them." The DON indicated CNA # 4 was terminated in December 2012 for "failure to observe resident rights." The DON indicated CNA # 3 still worked at the facility.</p> <p>At that time, the DON provided an investigation into the allegation of abuse, undated. The report included: "... Alleged abuse of verbal and physical abuse of Resident [A] was reported at 3 pm on Friday 9/14/12. Statement received by CNA [# 2] was unable to mention the nurse she reported alleged abuse to nor dates and times, statement also didn't give names, all other staff deny per their written statements..." The investigation did not document the names of CNA # 3 or CNA # 4 as the alleged abusers. The investigation was signed by the DON, Administrator, and Social Services Director.</p> <p>The investigation documents included a hand-written statement by CNA # 9. The statement, undated, included: "I [CNA # 9] noticed that some of the 2nd shifts that I work that some are rude to [Resident A]. Roll him hard...She rolled him in anger, so I put my hand on the metal rail so his head would not bounce off of it. They</p>						

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	<p>make fun of him...I do not think its right to be rough with him...some CNAs lay on his bed to hold him down...he is treated like he is 2, he gets very rough treatment and a lot of times verbal abuse too...there is no reason to sit on him or cuse [sic] at him or be rough with him cause your [sic] mad or he is not happy...."</p> <p>On 1/31/13 at 2:15 P.M., during interview with CNA # 9, she indicated she worked at the facility for approximately one month around September 2012. She indicated, "They terminated me because I wouldn't work with those abusers." CNA # 9 mentioned CNA # 3 and CNA # 4 by name, and indicated, CNA # 3 "was the main one." She indicated CNA # 3 would "roll him so hard his face would hit the metal bar." She indicated CNA # 1 "was unstable," and preferred to work by herself. She indicated she witnessed CNA # 1 "throwing a resident in like a sack of potatoes," but she could not remember the resident's name. She indicated she did inform the DON, but that "I got written up instead of them." CNA # 9 indicated she did talk to the Administrator after she was terminated about the abuse, but he just told her the DON "was just doing her job."</p>			

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	<p>On 2/1/13 at 10:10 A.M., during interview with the Administrator, he indicated he would usually review investigations into abuse allegations. He indicated he never told the DON not to suspend CNA # 3 and CNA # 4 on September 14, 2012; that they should have been suspended during the investigation. The Administrator indicated he didn't recall speaking to any CNA regarding allegations of abuse, and he never received letters under his door regarding abuse.</p> <p>2. On 1/30/13 at 10:15 A.M., the Social Services Director provided the current policy and procedure on Abuse Reporting, dated 9/17/12. The policy included: "...If you have suspect [sic] or witnessed abuse, neglect or misuse of resident's property, follow the steps outlined below:...2. After the resident is safe notify the person in charge of the facility at the time of the occurrence and Director of Nursing. The person in charge or the Director of Nursing must immediately notify the Administrator and the Social Service Director...Measures to prevent further (potential) abuse will be immediately initiated and remain in effect to protect the residents. 7. If the alleged abuser is an employee, the staff</p>				

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	<p>member in charge of the facility at the time the incident occurred will immediately suspend the employee. The employee will be suspended until the investigation is completed...8. The charge nurse responsible for the resident alleged to have been abused will document in the resident's chart the events that occurred and will notify the resident's physician and family...."</p> <p>An Immediate Jeopardy was identified on 1/31/13. The Immediate Jeopardy began on 9/17/12 when staff accused of abuse were allowed to work during an abuse investigation. The Director of Nursing and Assistant Director of Nursing were notified at 11:35 A.M. on 1/31/13 of the Immediate Jeopardy related to failure to protect residents from abuse. The Immediate Jeopardy was removed on 2/4/13 when through observations, interviews and record reviews, it was determined the facility had implemented the plan of action to remove the Immediate Jeopardy and that the steps taken removed the immediacy of the problem. The facility suspended, then terminated CNA # 3, developed a new policy of abuse prohibition that specified notifying the Administrator immediately of allegations of abuse,</p>			

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	<p>and inserviced staff of the new policy. Nursing staff, CNAs and activity staff were interviewed on 2/04/13 and demonstrated knowledge of the new abuse prohibition policy, including immediately notifying the Administrator of allegations of abuse. Even though the facility's corrective actions removed the Immediate Jeopardy, the facility remained out of compliance at a reduced scope and severity level of widespread, no actual harm with potential for more than minimal harm that is not immediate jeopardy.</p> <p>This federal tag relates to Complaint IN00123384.</p> <p>3.1-13(a) 3.1-13(g) 3.1-13(q) 3.1-13(r) 3.1-27(a)(1) 3.1-27(b) 3.1-28(a) 3.1-28(c) 3.1-28(d) 3.1-28(e)</p>			