

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155777	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/17/2016
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NAME OF PROVIDER OR SUPPLIER CREASY SPRINGS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1750 S CREASY LN LAFAYETTE, IN 47905
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R 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00192876.</p> <p>Complaint IN00192876 Substantiated. State deficiency related to the allegation is cited at R0091.</p> <p>Survey dates: February 15, 17, 2016</p> <p>Facility Number: 012285 Provider Number: 155777 Aim Number: NA</p> <p>Census Bed Type: Residential: 49 Total: 49</p> <p>Sample: 3</p> <p>This Residential finding is cited in accordance with 410 IAC 16.2-5.</p> <p>Quality Review was completed by 21662 on Februaty 18, 2016.</p>	R 0000	<p>Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the Provider of the accuracy or validity of the findings as alleged or conclusion set forth in the statement of deficiencies. This Plan of Correction is prepared and/or executed solely because it is required by the provision of federal and state law. Please accept this Plan of Correction as Creasy Springs Health Campus' Credible Allegation of Compliance. Creasy Springs Health Campus respectfully requests Desk Review/Paper Compliance.</p>	
R 0091 Bldg. 00	<p>410 IAC 16.2-5-1.3(h)(1-4) Administration and Management - Noncompliance</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>(h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following:</p> <p>(1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations.</p> <p>The policies shall be made available to residents upon request.</p> <p>Based on record review and interview the facility failed to ensure the implementation of the facility abuse policy, in regard to reporting and the protection of residents from suspected abuse by a staff member (Certified Nurse Aide #2) for 1 of 3 sampled cognitively impaired residents. (Resident "B").</p> <p>This deficient practice had the potential to effect 20 of 20 cognitively impaired residents who resided on the Legacy unit. (Dementia Care Unit)</p> <p>Findings include:</p> <p>The record for Resident "B" was reviewed on 02-15-17 at 11:00 a.m. Diagnoses included, but were not limited to, Alzheimer's dementia, depression, frontal skull lesion and anxiety. These diagnoses remained current at the time of the record review.</p> <p>The record indicated the resident received the services of a local Geriatric physician.</p>	R 0091	<p>1. Resident B was assessed upon notification of incident. No physical trauma or emotional distress was identified. Certified Nurse Aide #2 was suspended pending investigation of incident.</p> <p>2. All other residents of the Legacy Unit were assessed. No other residents were affected. Certified Nurse Aide #2 was suspended pending investigation of incident.</p> <p>3. Staff were initially educated on the Abuse and Neglect Procedural Guidelines on the following dates: CNA #2 on 12/16/15. CNA #3 on 1/23/15; CNA #9 on 11/17/15. All were re-educated on the procedural guidelines and protocol that "all suspected or observed abuse must be reported immediately to your supervisor and/or facility administration." The Campus Executive Director or Designee will educate all new staff upon hire of the Abuse and Neglect Procedural Guidelines and hold quarterly inservicing with all staff to ensure continued understanding.</p> <p>4. The results of the initial and quarterly education inservicing will be presented by</p>	03/10/2016

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	<p>A review of the Progress Note, dated 12-28-15 indicated, "asked to recheck [recheck]. Staff report she is very combative toward them during care. At times takes 4 staff members to provide care. She also gets aggressive toward [family member], stating 'I want to kill you.' She spends most of the time lying in her bed staring at the ceiling. She no longer participates in activities or interacts with peers. Orientation to person only, with memory poor with short term memory and long term recall. Thought process: so confused. Behavioral Recommendations: Cautious on approach, she probably misperceives and then can become more aggressive. Dementia is progressive now."</p> <p>A review of the facility investigation on 02-15-16 at 10:00 a.m., indicated CNA #2 was suspended pending investigation of alleged abuse which involved Resident "B" on 02-04-16 at 8:30 p.m..</p> <p>During an interview on 02-15-16 at 10:30 a.m., the Director of the Legacy unit verified an incident of alleged abuse "on the evening shift," and involved (name Resident "B") and 3 CNA's. "[Name CNA] #3, reported to the nurse, approximately 15 minutes before the end of her shift that [name of CNA #2] used profanity and held a washcloth to [name</p>		<p>the Executive Director or Designee at the Campus Quality Assurance and Assessment committee meeting monthly. The QAA committee will monitor monthly for six months and determine at that time if the monitoring shall be ongoing or revised. 5. 3/10/16.</p>				

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	<p>of Resident "B"] mouth. The nurse immediately went to assess [name of Resident "B"] and found no distress or injuries. The nurse called the Director to inform of the allegation and the safety of the resident. The nurse was instructed to send [name of CNA #2] home, but she had already clocked out and went home."</p> <p>During an interview on 02-15-16 at 1:35 p.m., CNA #2 denied anything had happened on the evening shift 02-04-16. CNA #2 further indicated the resident had "become erratic, grabbing, pinching and scratching. Then she started to spit." When interviewed if she held a towel to the resident's mouth, CNA #2 indicated "no." When further interviewed CNA #2 indicated, "[Names of CNA #3 and CNA #9] do not like me and I don't know why." When further interviewed if a resident became combative, what had she been instructed, CNA #2 indicated "walk away and reapproach later when the resident is calm." When further interviewed if that occurred with Resident "B" on the evening of 02-04-16, CNA #2 indicated, "no." When interviewed if she witnessed abuse would she immediately inform the nurse, CNA #2 indicated, "No, but it depends on who was the nurse."</p> <p>During an interview on 02-15-16 at 2:05</p>			

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	<p>p.m., CNA #3 indicated CNA #2 went to get the resident up from the chair, and the resident immediately became combative. "The nurse told her [CNA #2] she needed to get help in taking care of [name of Resident "B"] so me and [name of CNA #9] went to help. The whole time [name of Resident "B"] was hitting and resistant. Then she started spitting at [name of CNA #2]. Once we got [name of Resident "B"] into the bathroom, we sat her on the toilet. [Name of Resident "B"] kept spitting, especially at [name of CNA #2]. That's when [name of CNA #2] got a wet wash cloth and held it to [name of Resident "B"] mouth. We got [name of Resident "B"] completed and cleaned up and then we left the room. When I got hired I was told if a resident became combative that we were suppose to walk away and remove yourself from the situation." The CNA further indicated she had not removed herself from the situation in regard to Resident "B" and she had not reported anything to the nurse until the end of the shift. "I wasn't sure, but I should have gone to the nurse earlier."</p> <p>During an interview on 02-17-16 at 9:30 a.m., CNA #9 indicated the resident was "combative that night." [Name of Resident "B"] kept spitting, but she was scared and confused. When we were told</p>			

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	<p>to take [name of Resident "B"] to the bathroom, you could tell she didn't want to go, but [name of CNA #2] kept saying 'come on, let's go.' You could see that [name of Resident "B"] got more combative when [name of CNA #2] kept trying to help. [Name of Resident "B"] was spitting and that's when [name of CNA #2] got the towel and put it in front of her [Resident "B"] mouth. We told [name of CNA #2] to leave and that we could 'handle it,' but she wouldn't leave. The more I thought about it it was something thing that could have been considered abusive. I know [name of CNA #3] reported everything to the nurse, but that was towards the end of our shift."</p> <p>A review of the facility "Abuse and Neglect Procedural Guidelines," on 02-15-16 at 11:00 a.m. and dated 11/2010, indicated the following:</p> <p>"Purpose: Trilogy Health Services has developed and implemented processes, which strive to ensure the prevention and reporting of suspected alleged resident abuse and neglect."</p> <p>"Procedure: 1. THS [Trilogy Health Services] has implemented processes in an effort to provide a comfortable and safe environment. 2. The Executive</p>			

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	<p>Director and Director of Health Services are responsible for the implementation and ongoing monitoring of abuse standards and procedures. ... 4. Implementation and monitoring consists of the following components. ... b. Training - Provide training for new employees through orientation and with ongoing training programs. Training will include, but is not limited to:</p> <p>"1. Definitions of abuse or neglect."</p> <p>"2. Identification of abuse or neglect."</p> <p>"3. Appropriate interventions to deal with aggressive or catastrophic reactions of residents."</p> <p>"4. How to provide protection for residents. ... d. Identification - ... Any person with knowledge or suspicion of suspected violations shall report immediately, without fear of reprisal. ... e. Protection - Upon identification of suspected abuse or neglect, immediately provide for the safety of the resident and the person reporting to maintain anonymity as reasonable and necessary... . g. Reporting - Any staff member, resident, visitor or responsible party may report known or suspected abuse, neglect, misappropriation to local or state agencies."</p>			

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	<p>A review of the Employee file for CNA #2 in regard to the facility guidelines for Abuse and Neglect was signed on 12-16-15. In addition the Employee file for CNA #3 signed the guidelines on 01-23-15, and CNA #9 signed the guidelines on 11-17-15.</p> <p>A notation on the Procedural Guidelines indicated the CNA's "read the Abuse and Neglect Procedure Guidelines and agree to abide by the terms therein."</p> <p>A review of the "Abuse Training/Education Acknowledgement," on 02-15-16 at 1:30 p.m., indicated "All suspected or observed abuse must be reported IMMEDIATELY to your supervisor and/or facility administration. Failure to do so will result in disciplinary action up to and including termination. Also note that engaging in type of abuse and/or failing to report observed or suspected abuse to your supervisor is reportable to the Nurse Aide Registry, Health Professions Bureau, and State/Federal Regulatory Agencies."</p> <p>This Education Acknowledgement was signed by CNA #3 on 01-23-15.</p> <p>A review of the timecard on 02-15-16 at 1:15 p.m., CNA #2 "clocked out," and</p>			

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	<p>left the facility at 10:11 p.m. The CNA was allowed to continue to work with the cognitively impaired residents on the Legacy unit for approximately 1 1/5 hours after the incident which involved Resident "B" and observed by CNA's #3 and #9.</p> <p>During an interview with the Director of Nurses on 02-15-16 at 10:50 a.m., she indicated the allegation of abuse was not verified and CNA #2 was allowed to return to work on 02-08-16.</p> <p>This State finding relates to Complaint IN00192876.</p>			