

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/27/2012
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NAME OF PROVIDER OR SUPPLIER SUGAR CREEK REHABILITATION AND CONVALESCENT CENT	STREET ADDRESS, CITY, STATE, ZIP CODE 5430 W US 40 GREENFIELD, IN 46140
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F0000	<p>This visit was for a Recertification and State Licensure Survey. This visit included Investigation of Complaint IN00110631.</p> <p>Complaint IN00110631-Unsubstantiated due to lack of evidence.</p> <p>Survey dates: July 23, 24, 25, 26, and 27, 2012</p> <p>Facility number: 000157 Provider number: 155254 AIM number: 100274720</p> <p>Survey team: Barbara Gray, RN-TC Sharon Lasher, RN Leslie Parrett, RN</p> <p>Census bed type: SNF/NF: 48 Total: 48</p> <p>Census payor type: Medicare: 2 Medicaid: 32 Other: 14 Total: 48</p> <p>These deficiencies reflect state findings cited in accordance with 410</p>	F0000	<p>This plan of correction is to serve as Sugar Creek Rehabilitation and Convalescent Center's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Sugar Creek Rehabilitation and Convalescent Center or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in the facility, nor does this submission constitute an agreement or admission of the survey allegations. We respectfully request a paper review of this plan of correction.</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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	IAC 16.2. Quality review completed on August 3, 2012 by Bev Faulkner, RN			

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F0225 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 observation, interview and record review the facility failed to</p>	F0225	I. R12's allegation has been fully investigated by the facility. R12 has been notified of the findings of the	08/22/2012			

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	<p>investigate a complaint of 1 resident being treated rude by a CNA and report or thoroughly investigate an injury for 1 resident with a injury of unknown origin for 2 of 16 residents interviewed. (Resident #12 and #44)</p> <p>Findings include:</p> <p>1.) The record of Resident #12 was reviewed on 7/25/12 at 11:00 a.m. Resident #12's diagnoses included but were not limited to, left side hemiplegia (total or partial paralyses of one side), stroke, morbid obesity, diabetes, chronic obstructive pulmonary disease, neuropathic pain, leaf extremity edema/chronic venous insufficiency and osteoarthritis.</p> <p>Resident #12 MDS (Minimum Data Set), assessment, dated 5/15/12, indicated the following:</p> <ul style="list-style-type: none"> - BIMS (Brief Interview for Mental Status) 10, with a score of 8-12 indicating cognition moderately impaired - transfer, total dependence full staff performance with 2 person+ assist - range of motion, upper, impairment on one side - range of motion, lower, impairment on both sides - urinary continence, always incontinent 		<p>investigation and actions taken to prevent recurrence. R12 has voiced satisfaction with the facility's actions in response to his allegation. R44's injury has been fully investigated by the facility with no evidence of mistreatment.</p> <p>II. All residents with the capacity to be interviewed were asked about care received with no allegations of mistreatment voiced. All non-interviewable residents were assessed for injuries of unknown origin with none found.</p> <p>III. The facility's Abuse Prohibition Policy was reviewed and found to be acceptable by QA committee. Administrator and Department Heads will be reeducated regarding investigatory and reporting requirements. All facility staff will receive reeducation on Abuse Prohibition including but not limited to; Definitions of Abuse, Abuse Investigation and Reporting Standards. This education will be validated through the use of Pre and Post testing as well as random unannounced auditing that will be conducted weekly for four weeks, monthly for two months and quarterly thereafter. Educational validation will be conducted by Administrator and/or designee.</p> <p>IV. The Social Services Director will conduct random unannounced audits with residents to identify any unreported allegations of mistreatment. These audits will</p>				

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	<p>Resident #12's care plan, dated 10/19/11 with an update of 4/20/12, indicated "Problem, has long history of making false accusations. Goal, Resident will allow staff to provide daily care without inappropriate behavior towards staff and wait own turn for care or assistance daily thru next review. Interventions, if inappropriate comments or gestures are made then tell residents this behavior is inappropriate, redirect any inappropriate behaviors, if behavior begins during care, stop and remind resident his behavior is not welcomed, try a different staff member, if needed and monitor for changes or increases in behavior and report to physician."</p> <p>A document titled "Behavior/Mood Reporting Sheet," dated 7/18/12 at 7:00 p.m., indicated "Describe what happened, "(Resident #12) put on his call light to go to bed and I told him to wait 30 minutes after dinner to lay down and he got mad and told me how would I feel if he kicked my a-- and called me a b----. He wanted to go to bed at dinner time I had to push the residents out of the dining room and toilet them. How long did the behavior last, about 30 to 45 minutes. General interventions, call resident by</p>		<p>be conducted weekly for four weeks and monthly thereafter. The Social Services Director will notify the Administrator immediately of any allegations of mistreatment. The Director of Nursing will monitor Accident/Incident reports for injuries of unknown origin. Upon identification of any injury of unknown origin the Director of Nursing will immediately notify the Administrator. The Administrator will initiate an investigation immediately upon the receipt of any allegation of mistreatment and/or evidence of an injury of unknown origin. All allegations and investigatory findings will be reported to the Indiana State Department of Health. All allegations and investigatory findings will be reviewed by the QA Committee weekly for four weeks and monthly thereafter. Educational validation will be reviewed by QA committee weekly for four weeks, monthly for two months and quarterly thereafter.</p>		

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	<p>name, approach in calm manner, allow residents to express feelings, provide residents expressed need. (offer foods, fluid, toileting etc) and toileting was underlined. Which interventions worked the best and what worked the least. Put in room to let him calm down. Signed by CNA #1 and date given Social Service, 7/19/12."</p> <p>Resident #12's Social Service notes, dated 7/19/12, "Received behavior sheet on resident for last night. Resident was in room after dinner and put his call light on to go to bed. Staff was still assisting other residents with their meals and they explained this to this resident. Resident became very upset and asked CNA how she would feel if he kicked her a--- and he called her a b---. Spoke with resident about staff's needs to finish assisting other residents with their meal. Also spoke about using more appropriate language and not using threatening language. Staff and resident spoke about resident realizing other residents need for assistance at the same time. Resident verbalized he understood this. Resident has not had behaviors lately. Will meet with resident and staff to determine appropriate schedule that resident</p>			

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	<p>feels meets his needs after meals."</p> <p>During an interview with Resident #12 on 7/25/12 at 3:56 p.m., he indicated about a week ago a CNA was rude to him. He stated "I explained to her I was real wet and my hip was hurting real bad and I needed to go to bed and she said I would have to wait for a while. She told me 'it will be alright'." Resident #12 also indicated he had to wait up in the wheelchair one-half hour to 45 minutes, but he did not need pain medication for his hip pain, he just needed to lay down and that would relieve his pain.</p> <p>During an interview with CNA #1 (that Resident #12 indicated was rude to him) on 7/25/12 at 12:07 p.m., indicated the evening Resident #12 wanted to go to bed and "he put his call light on around 6:30 p.m., and said he wanted to go to bed. He was in his room in his wheelchair and I needed another staff member to help me assist him to bed and the staff were still feeding residents in the dining room. I told him it would be one-half hour to 45 minutes before I could put him to bed and he got upset and called me a name so I gave him some time to cool down."</p> <p>During an interview with the</p>			

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	<p>Administrator on 7/25/12 at 2:49 p.m., she indicated Resident #12 came into her office and told her about a CNA that was rude to him. She told him 'he would have to wait' one-half hour to 45 minutes after he ate to be put back to bed. Resident #12 told her after supper he had returned to his room in his wheelchair and he wanted to lie down because his hip was hurting so he called for assistance by using his call light. He said he did not need pain medication but he just needed to lay down to stop the pain. The Administrator also indicated she didn't know if Resident #12 said he was wet or not or if he told the CNA he was wet or in pain. The Administrator stated "I told (Resident #12) I would talk with the CNA about telling him 'you will have to wait'." She did talk to the CNA about doing what the resident ask him to do. The Administrator indicated she had not reviewed the Social Service notes but she had reviewed the behavior report, dated 7/19/12, on Resident #12 and sent an E-Mail to the DON (Director of Nursing) or ADON (Assistant Director of Nursing) about the behavior report but she had not documented anything about the incident that Resident #12 reported to her and her conclusion was she needed to reeducate the CNA.</p>			

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	<p>The Administrator indicated she had not gotten back with Resident #12 since she talked to him in her office.</p> <p>During an interview on 7/25/12 at 4:57 p.m., RN #3 indicated she was Resident #12's nurse the evening he wanted to go back to bed and the CNA told her Resident #12 was upset. She indicated she went into Resident #12's room and talked to him and he said there was nothing wrong.</p> <p>During an interview on 7/27/12 at 11:06 a.m., the Social Service Director indicated she received a behavior report on 7/19/12 and she talked to Resident #12 and told him she was going to work on a schedule and see what they could work out that would be good for him and what would be good for the staff. "I have been off work since then (7/19/12) so I don't know if anyone checked back with Resident #12 about his problem as to how he is doing. "</p> <p>2.) On 7/25/12 at 11:06 A.M., Resident #44 was observed seated in the dining room in his wheelchair. Resident #44 had a purple bruised area on his left hand palm that went from the crease of his fingers, approximately 1/2 inch to 3/4 of an inch toward his wrist, and across the</p>			

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	<p>entire length of his palm. His left first finger was swollen.</p> <p>Resident #44's record was reviewed on 7/25/12 at 5:40 P.M. Diagnoses included but were not limited to Alzheimer's and dementia.</p> <p>A nurses note for Resident #44, dated 7/23/12 at 11:00 A.M., indicated the following: The nurse was notified by a CNA, Resident #44's fingers were swollen. When the writer assessed Resident #44's left hand, his left index finger was red, swollen, and he was unable to bend it. His left ring finger was red, swollen, and slightly bruised. His left middle finger was red, swollen, and slightly bruised on the inside crease. His fingers were warm to touch. An order was received to x-ray his left hand. When the nurse questioned him, he indicated that him and that girl that had been fighting everybody had got into a scuffle. Then he had indicated he did not know what happened.</p> <p>On 7/26/12 at 11:48 A.M., Resident #44 was observed seated in the dining room in his wheelchair. Resident #44's left palm remained bruised and his left first finger remained swollen. Resident #44 indicated "That waitress gripped my</p>			

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	<p>hand. She had a grip like a man." Resident #44 was unable to elaborate any further and indicated again that she was a waitress.</p> <p>On 7/26/12 at 1:12 P.M., the Administrator indicated Resident #44's bruised palm and swollen fingers were first noted by two CNA's on 7/23/12 at 9:00 A.M. The Administrator indicated the two CNA's had reported the observation to their nurse. The Administrator indicated she reported the observation to ISDH on 7/25/12 at 11:40 A.M., after she was made aware of the incident. The Administrator indicated if an unusual incident was potentially abuse, neglect, or mistreatment, staff should report to her immediately, then she had 24 hours to report the incident to ISDH. The Administrator indicated the staff had not followed the correct procedure in notifying her of the incident immediately. The Administrator indicated Resident #44 was the only resident interviewed related to his left hand injuries. The Administrator indicated the only staff interviewed related to Resident #44's left hand injuries were the two CNA's who had first observed the injuries, and the LPN who had filled out the incident/accident report. The Administrator indicated she could not</p>			

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	<p>imagine an action by another person "that would cause that area of bruising."</p> <p>An Incident Report Form for Resident #44 provided by the Administrator on 7/26/12 at 1:27 P.M., indicated the following: " Incident Date: 7/23/12 at 9:00 A.M. Brief Description of Incident: CNA's noticed swelling and bruising to fingers of resident's left hand during transfer. LPN assessed resident upon CNA report. Resident has made multiple inconsistent statements about the origin of the bruise. Type of injury/injuries: Swelling and bruising to left hand. Immediate Action Taken: Physician and family contacted. X-ray ordered. Results were negative. No new orders".</p> <p>A Resident Abuse Investigation Report Form for Resident #44 provided by the Administrator on 7/26/12 at 1:27 P.M., indicated the following: Date of Incident: 7/23/12. Time: 9:00 A.M. Date Incident Reported: 7/25/12. Time: 11:40 A.M. Summary/Results of investigator's findings: The bruising on Resident #44's hand could not be attributed to anyone causing him harm due to Resident #44's varied and inconsistent reports. Resident</p>			

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	<p>#44's inconsistent reports were likely related to his diagnosis of Alzheimer's disease. Resident #44 had consistently reported the incident happened in the dining room. Resident #44's description of the person involved changed as Resident #44 spoke with different staff. Based on Resident #44's inconsistent descriptions and his bruise pattern being similar to gripping the stand-up-lift bar, the investigation was inconclusive. No abuse was substantiated.</p> <p>3.1-28(d)</p>				

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F0226 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 observation, interview and record review, the facility failed to, implement their policy for reporting, investigation and protecting residents related to allegations of rude treatment for 1 resident and reporting to the Administrator timely for 1 resident with an injury of unknown origin for 2 of 16 residents interviewed. (Resident #12 and #44)</p> <p>Findings include:</p> <p>1.) The record of Resident #12 was reviewed on 7/25/12 at 11:00 a.m. Resident #12's diagnoses included but were not limited to, left side hemiplegia (total or partial paralyses of one side), stroke, morbid obesity, diabetes, chronic obstructive pulmonary disease, neuropathic pain, leaf extremity edema/chronic venous insufficiency and osteoarthritis.</p> <p>Resident #12 MDS (Minimum Data Set), assessment, dated 5/15/12, indicated the following:</p>	F0226	<p>I. R12's allegation has been fully investigated by the facility. R12 has been notified of the findings of the investigation and actions taken to prevent recurrence. R12 has voiced satisfaction with the facility's actions in response to his allegation. R44's injury has been fully investigated by the facility with no evidence of mistreatment.</p> <p>II. All residents with the capacity to be interviewed were asked about care received with no allegations of mistreatment voiced. All non-interviewable residents were assessed for injuries of unknown origin with none found.</p> <p>III. The facility's Abuse Prohibition Policy was reviewed and found to be acceptable by QA committee. Administrator and Department Heads will be reeducated regarding investigatory and reporting requirements. All facility staff will receive reeducation on Abuse Prohibition including but not limited to; Definitions of Abuse, Abuse Investigations and Reporting Standards. This education will be validated through the use of Pre and Post testing as well as random unannounced auditing that will be</p>	08/22/2012			

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	<p>- BIMS (Brief Interview for Mental Status) 10, with a score of 8-12 indicating cognition moderately impaired</p> <p>- transfer, total dependence full staff performance with 2 person+ assist</p> <p>- range of motion, upper, impairment on one side</p> <p>- range of motion, lower, impairment on both sides</p> <p>- urinary continence, always incontinent</p> <p>Resident #12's care plan, dated 10/19/11 with an update of 4/20/12, indicated "Problem, has long history of making false accusations. Goal, Resident will allow staff to provide daily care without inappropriate behavior towards staff and wait own turn for care or assistance daily thru next review. Interventions, if inappropriate comments or gestures are made then tell residents this behavior is inappropriate, redirect any inappropriate behaviors, if behavior begins during care, stop and remind resident his behavior is not welcomed, try a different staff member, if needed and monitor for changes or increases in behavior and report to physician."</p> <p>A document titled "Behavior/Mood Reporting Sheet," dated 7/18/12 at</p>		<p>conducted weekly for four weeks, monthly for two months and quarterly thereafter . Educational validation will be conducted by Administrator and/or designee.</p> <p>IV. The Social Services Director will conduct random unannounced audits with residents to identify any unreported allegations of mistreatment. These audits will be conducted weekly for four weeks and monthly thereafter. The Social Services Director will notify the Administrator immediately of any allegations of mistreatment. The Director of Nursing will monitor Accident/Incident reports for injuries of unknown origin. Upon identification of any injury of unknown origin the Director of Nursing will immediately notify the Administrator. The Administrator will initiate an investigation immediately upon the receipt of any allegation of mistreatment and/or evidence of an injury of unknown origin. All allegations and investigatory findings will be reported to the Indiana State Department of Health. All allegations and investigatory findings will be reviewed by the QA Committee weekly for four weeks and monthly thereafter. Educational validation will be reviewed by QA committee weekly for four weeks, monthly for two months and quarterly thereafter.</p>				

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	<p>7:00 p.m., indicated "Describe what happened: (Resident #12) put on his call light to go to bed and I told him to wait 30 minutes after dinner to lay down and he got mad and told me how would I feel if he kicked my a-- and called me a b----. He wanted to go to bed at dinner time I had to push the residents out of the dining room and toilet them. How long did the behavior last, about 30 to 45 minutes. General interventions, call resident by name, approach in calm manner, allow residents to express feelings, provide residents expressed need. (offer foods, fluid, toileting etc) and toileting was underlined. Which interventions worked the best and what worked the least. Put in room to let him calm down. Signed by CNA #1 and date given Social Service, 7/19/12."</p> <p>Resident #12's Social Service notes, dated 7/19/12, "Received behavior sheet on resident for last night. Resident was in room after dinner and put his call light on to go to bed. Staff was still assisting other residents with their meals and they explained this to this resident. Resident became very upset and asked CNA how she would feel if he kicked her a--- and he called her a b---. Spoke with resident about staff's</p>			

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	<p>needs to finish assisting other residents with their meal. Also spoke about using more appropriate language and not using threatening language. Staff and resident spoke about resident realizing other residents need for assistance at the same time. Resident verbalized he understood this. Resident has not had behaviors lately. Will meet with resident and staff to determine appropriate schedule that resident feels meets his needs after meals."</p> <p>During an interview with Resident #12 on 7/25/12 at 3:56 p.m., indicated about a week ago a CNA was rude to him. He stated "I explained to her I was real wet and my hip was hurting real bad and I needed to go to bed and she said I would have to wait for a while. She told me 'it will be alright'." Resident #12 also indicated he had to wait up in the wheelchair one-half hour to 45 minutes, but he did not need pain medication for his hip pain, he just needed to lay down and that would relieve his pain.</p> <p>During an interview with CNA #1 (that Resident #12 indicated was rude to him) on 7/25/12 at 12:07 p.m., indicated the evening Resident #12 wanted to go to bed and "he put his call light on around 6:30 p.m., and</p>			

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	<p>said he wanted to go to bed. He was in his room in his wheelchair and I needed another staff member to help me assist him to bed and the staff were still feeding residents in the dining room. I told him it would be one-half hour to 45 minutes before I could put him to bed and he got upset and called me a name so I gave him some time to cool down."</p> <p>During an interview with the Administrator on 7/25/12 at 2:49 p.m., indicated Resident #12 came into her office and told her about a CNA that was rude to him. She told him 'he would have to wait' one-half hour to 45 minutes after he ate to be put back to bed. Resident #12 told her after supper he had returned to his room in his wheelchair and he wanted to lie down because his hip was hurting so he called for assistance by using his call light. He said he did not need pain medication but he just needed to lay down to stop the pain. The Administrator also indicated she didn't know if Resident #12 said he was wet or not or if he told the CNA he was wet or in pain. The Administrator stated "I told (Resident #12) I would talk with the CNA about telling him 'you will have to wait'." She did talk to the CNA about doing what the resident ask him to do. The</p>			

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	<p>Administrator indicated she had not reviewed the Social Service notes but she had reviewed the behavior report, dated 7/19/12, on Resident #12 and sent an E-Mail to the DON (Director of Nursing) or ADON (Assistant Director of Nursing) about the behavior report but she had not documented anything about the incident that Resident #12 reported to her and her conclusion was she needed to reeducate the CNA. The Administrator indicated she had not got back with Resident #12 since she talked to him in her office.</p> <p>During an interview on 7/25/12 at 4:57 p.m., RN #3 indicated she was Resident #12's nurse the evening he wanted to go back to bed and the CNA told her Resident #12 was upset. She indicated she went into Resident #12's room and talked to him and he said there was nothing wrong.</p> <p>During an interview on 7/27/12 at 11:06 a.m., the Social Service Director indicated she received a behavior report on 7/19/12 and she talked to Resident #12 and told him she was going to work on a schedule and see what they could work out that would be good for him and what would be good for the staff. "I have</p>			

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	<p>been off work since then (7/19/12) so I don't know if anyone checked back with Resident #12 about his problem as to how he is doing."</p> <p>2.) On 7/25/12 at 11:06 A.M., Resident #44 was observed seated in the dining room in his wheelchair. Resident #44 had a purple bruised area on his left hand palm that went from the crease of his fingers, approximately 1/2 inch to 3/4 of an inch toward his wrist, and across the entire length of his palm. His left first finger was swollen.</p> <p>Resident #44's record was reviewed on 7/25/12 at 5:40 P.M. Diagnoses included but were not limited to Alzheimer's and dementia.</p> <p>A nurses note for Resident #44, dated 7/23/12 at 11:00 A.M., indicated the following: The nurse was notified by a CNA, Resident #44's fingers were swollen. When the writer assessed Resident #44's left hand, his left index finger was red, swollen, and he was unable to bend it. His left ring finger was red, swollen, and slightly bruised. His left middle finger was red, swollen, and slightly bruised on the inside crease. His fingers were warm to touch. An order was received to x-ray his left hand. When the nurse questioned him, he indicated that him</p>			

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	<p>and that girl that had been fighting everybody had got into a scuffle. Then he had indicated he did not know what happened.</p> <p>On 7/26/12 at 11:48 A.M., Resident #44 was observed seated in the dining room in his wheelchair. Resident #44's left palm remained bruised and his left first finger remained swollen. Resident #44 indicated "That waitress gripped my hand. She had a grip like a man." Resident #44 was unable to elaborate any further and indicated again that she was a waitress.</p> <p>On 7/26/12 at 1:12 P.M., the Administrator indicated Resident #44's bruised palm and swollen fingers were first noted by two CNA's on 7/23/12 at 9:00 A.M. The Administrator indicated the two CNA's had reported the observation to their nurse. The Administrator indicated she reported the observation to ISDH on 7/25/12 at 11:40 A.M., after she was made aware of the incident. The Administrator indicated if an unusual incident was potentially abuse, neglect, or mistreatment, staff should report to her immediately, then she had 24 hours to report the incident to ISDH. The Administrator indicated the staff had not followed the correct</p>			

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	<p>procedure in notifying her of the incident immediately. The Administrator indicated Resident #44 was the only resident interviewed related to his left hand injuries. The Administrator indicated the only staff interviewed related to Resident #44's left hand injuries were the two CNA's who had first observed the injuries, and the LPN who had filled out the incident/accident report. The Administrator indicated she could not imagine an action by another person "that would cause that area of bruising."</p> <p>An Incident Report Form for Resident #44 provided by the Administrator on 7/26/12 at 1:27 P.M., indicated the following: " Incident Date: 7/23/12 at 9:00 A.M. Brief Description of Incident: CNA's noticed swelling and bruising to fingers of resident's left hand during transfer. LPN assessed resident upon CNA report. Resident has made multiple inconsistent statements about the origin of the bruise. Type of injury/injuries: Swelling and bruising to left hand. Immediate Action Taken: Physician and family contacted. X-ray ordered. Results were negative. No new orders."</p> <p>A Resident Abuse Investigation</p>			

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	<p>Report Form for Resident #44 provided by the Administrator on 7/26/12 at 1:27 P.M., indicated the following: "Date of Incident: 7/23/12. Time: 9:00 A.M. Date Incident Reported: 7/25/12. Time: 11:40 A.M. Summary/Results of investigator's findings: The bruising on Resident #44's hand could not be attributed to anyone causing him harm due to Resident #44's varied and inconsistent reports. Resident #44's inconsistent reports were likely related to his diagnosis of Alzheimer's disease. Resident #44 had consistently reported the incident happened in the dining room. Resident #44's description of the person involved changed as Resident #44 spoke with different staff. Based on Resident #44's inconsistent descriptions and his bruise pattern being similar to gripping the stand-up-lift bar, the investigation was inconclusive. No abuse was substantiated."</p> <p>The Abuse Policy was provided by the Administrator on 7/25/12 at 8:52 A.M. The Abuse Policy indicated the following: "IV. IDENTIFYING & RECOGNIZING SIGNS AND SYMPTOMS OF ABUSE. Policy Statement: Our facility will not</p>			

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	<p>condone any form of resident abuse or neglect. To aid in abuse prevention, all personnel are to report any signs and symptoms of abuse/neglect to their supervisor or to the director of nursing services. The Administrator should then be notified immediately. Policy Interpretation and Implementation: 1. The following are some examples of actual abuse/neglect and signs and symptoms of abuse/neglect that should be promptly reported. However, this listing is not all-inclusive. Other signs and symptoms of actual abuse/neglect may be apparent. When in doubt, report it. a. Welts or bruises; abrasions or lacerations; fractures, dislocations or sprains of questionable origin...</p> <p>V. ABUSE INVESTIGATION. Policy Statement: All reports of resident abuse, neglect and injuries of an unknown source shall be promptly and thoroughly investigated by facility management. Policy Interpretation and Implementation: 1. Should an incident or suspected incident of resident abuse, neglect or injury of an unknown source be reported, the administrator, or his/her designee, will appoint a member of management to investigate the alleged incident. 2. the individual conducting the</p>			

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	<p>investigation will, at a minimum: a. Review the resident's medical record to determine events leading up to the incident; b. Interview the person(s) reporting the incident; c. Interview any witnesses to the incident; d. Interview the resident (as medically appropriate); f. Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; g. Interview the resident's roommate, family members, and visitors; h. Interview other residents to whom the accused employee provides care or services; and i. Review all events leading up to the alleged incident...</p> <p>VII. REPORTING ABUSE TO: A. FACILITY MANAGEMENT, ISDH, LAW ENFORCEMENT AGENCIES. Policy Statement: It is the responsibility of our employees, facility consultants, attending physicians, family members, visitors etc., to promptly report any incident, suspected incident, or allegation of neglect or resident abuse, including injuries of an unknown source, and theft or misappropriation of resident property to facility management. Policy Interpretation and Implementation: 1. Our facility will not condone resident abuse by anyone, including staff members, physicians, consultants, volunteers, staff of other</p>			

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	<p>agencies serving the resident, family members, legal guardians, sponsors, other residents, friends, or of the individuals. 2. Employees, facility consultants and/or attending physicians must report any suspected abuse, allegations of abuse, or incidents of abuse to the Administrator immediately. If the Administrator is the suspected perpetrator the Director of Nursing services should be notified who will notify the Regional Director of Operations. 3. The Administrator (or Director of Nursing as indicated in #2) must be immediately notified of suspected abuse, allegations of abuse, or incidents of abuse. If such incidents occur or are discovered after hours, the Administrator (or the Director of Nursing as indicated in #2) must be called at home or must be paged and informed of such incident"....</p> <p>3.1-28(a)</p>			

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F0241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on interview and record review, the facility failed to ensure staff responded in a timely manner to a resident's request to be transferred to bed from his wheelchair after he complained of hip pain and needed to return to bed to relieve his pain. (Resident #12)</p> <p>Findings include:</p> <p>The record of Resident #12 was reviewed on 7/25/12 at 11:00 a.m. Resident #12's diagnoses included but were not limited to, left side hemiplegia (total or partial paralyses of one side), stroke, morbid obesity, diabetes, chronic obstructive pulmonary disease, neuropathic pain, leaf extremity edema/chronic venous insufficiency and osteoarthritis.</p> <p>Resident #12 MDS (Minimum Data Set), assessment, dated 5/15/12, indicated the following: - BIMS (Brief Interview for Mental Status) 10, with a score of 8-12 indicating cognition moderately</p>	F0241	<p>I. R12's allegation has been fully investigated by the facility. R12 has been notified of the findings of the investigation and actions taken to prevent recurrence. R12 has voiced satisfaction with the facility's actions in response to his allegation. R12 is assisted into bed upon request and has had no further complaints or concerns.</p> <p>II. All residents with the capacity to be interviewed were asked about care requests and staff response time with no concerns voiced.</p> <p>III. The facility's Resident's Rights Policy was reviewed and found to be acceptable by QA committee. All staff will be reeducated on each resident's right to dignity and respect with focus on timely response to care requests. This education will be validated through the use of Pre and Post testing as well as random unannounced auditing that will be conducted weekly for four weeks, monthly for two months and quarterly thereafter. Educational validation will be conducted by Administrator and/or designee.</p> <p>IV. The Social Services Director will conduct random unannounced</p>	08/22/2012

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	<p>impaired</p> <ul style="list-style-type: none"> - transfer, total dependence full staff performance with 2 person+ assist - range of motion, upper, impairment on one side - range of motion, lower, impairment on both sides - urinary continence, always incontinent <p>During an interview with Resident #12 on 7/25/12 at 3:56 p.m., he indicated about a week ago a CNA was rude to him. He stated "I explained to her I was real wet and my hip was hurting real bad and I needed to go to bed and she said I would have to wait for a while. She told me 'it will be alright'." Resident #12 also indicated he had to wait up in the wheelchair one-half hour to 45 minutes, but he did not need pain medication for his hip pain, he just needed to lay down and that would relieve his pain.</p> <p>During an interview with CNA #1 (that Resident #12 indicated was rude to him) on 7/25/12 at 12:07 p.m., indicated the evening Resident #12 wanted to go to bed and he put his call light on around 6:30 p.m., and said he wanted to go to bed. He was in his room in his wheelchair and I needed another staff member to help me assist him to bed and the staff</p>		<p>audits with residents to identify any concerns regarding staff response to care requests. These audits will be conducted weekly for four weeks and monthly thereafter. The Social Services Director will notify the Administrator immediately of any allegations of mistreatment. Audit findings will be reviewed by QA Committee weekly for four weeks, monthly for two months and quarterly thereafter.</p>		

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	<p>were still feeding residents in the dining room. I told him it would be one-half hour to 45 minutes before I could put him to bed and he got upset and called me a name so I gave him some time to cool down.</p> <p>During an interview with the Administrator on 7/25/12 at 2:49 p.m., she indicated Resident #12 came into her office and told her about a CNA that was rude to him. She told him 'he would have to wait' one-half hour to 45 minutes after he ate to be put back to bed. Resident #12 told her after supper he had returned to his room in his wheelchair and he wanted to lie down because his hip was hurting so he called for assistance by using his call light. He said he did not need pain medication but he just needed to lay down to stop the pain. The Administrator also indicated she didn't know if Resident #12 said he was wet or not or if he told the CNA he was wet or in pain. The Administrator stated "I told (Resident #12) I would talk with the CNA about telling him 'you will have to wait'." She did talk to the CNA about doing what the resident ask him to do. The Administrator indicated she had not reviewed the Social Service notes but she had reviewed the behavior report, dated 7/19/12, on Resident #12 and</p>			

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	<p>sent an E-Mail to the DON (Director of Nursing) or ADON (Assistant Director of Nursing) about the behavior report but she had not documented anything about the incident that Resident #12 reported to her and her conclusion was she needed to reeducate the CNA.</p> <p>During an interview on 7/25/12 at 4:57 p.m., RN #3 indicated she was Resident #12's nurse the evening he wanted to go back to bed and the CNA told her Resident #12 was upset. She indicated she went into Resident #12's room and talked to him and he said there was nothing wrong.</p> <p>During an interview on 7/27/12 at 11:06 a.m., the Social Service Director indicated she received a behavior report on 7/19/12 and she talked to Resident #12 and told him she was going to work on a schedule and see what they could work out that would be good for him and what would be good for the staff.</p> <p>3.1-3(t)</p>			

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F0309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to provide interventions to prevent skin tears and to follow their plan of care for a resident to wear bilateral lower extremity geriatric sleeves, for 1 of 3 residents reviewed from 6 who met the criteria for non-pressure related skin conditions. (Resident #44)</p> <p>Findings include:</p> <p>On 7/23/12 at 4:03 P.M., Resident #44 was observed with a band-aid on top of his left hand and a band-aid on the top of his right arm. He had scattered purple areas of discoloration on his bilateral arms and hands. When questioned about the band-aids, Resident #44 stated "Oh, there were some things that come up."</p> <p>On 7/25/12 at 11:06 A.M., Resident #44 was observed with a small skin tear in the shape of a V on his right</p>	F0309	<p>I. R44's orders have been reviewed and interventions are in place based on physician's orders. C.N.A. assignment sheet for R44 has been updated to reflect prescribed skin tear prevention interventions.II. All residents' physician orders were reviewed to identify prescribed skin tear prevention interventions. All C.N.A. assignment sheets and care plans were reviewed and revised as necessary to assure current prescribed skin tear prevention interventions were documented and fully communicated to front line staff.III. The facility's Wound Prevention Policy was reviewed and found to be acceptable by QA committee. All nursing staff will be reeducated on adhering to prescribed skin tear prevention interventions. This education will be validated through the use of Pre and Post testing.IV. All new orders will be reviewed by IDT Committee daily to assure proper transcription of skin tear prevention orders occurs on C.N.A. assignment sheets and care plan. The Director of</p>	08/22/2012			

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	<p>forearm, with scant blood visible. Both tears were approximately 1/4 inch long. Resident #44 had a small scabbed area on the top of his middle finger on his left hand and on the top of his left hand.</p> <p>Resident #44's record was reviewed on 7/25/12 at 5:40 P.M. Diagnoses included but were not limited to Alzheimer's, dementia, and vitamin B12 deficiency.</p> <p>A Quarterly Nursing Assessment for Resident #44, dated 5/3/12, indicated the following: Resident #44 had skin tears and abrasions. He had left lower extremity scratches and open areas related to scratching.</p> <p>A care plan for Resident #44 initiated 11/4/11, and updated 5/4/12, indicated the following: Problem: Resident #44 was at risk for impaired skin integrity related to incontinence and decreased mobility secondary to a diagnosis of dementia. Resident #44 easily got skin tears. Goal: Resident #44's blisters would be identified and treated promptly and show no signs and symptoms of infection through his next review. Interventions: Resident #44 would have a skin assessment at least weekly. Resident #44 would be kept</p>		<p>Nursing or designee will conduct random unannounced audits of skin tear prevention interventions weekly for four weeks and monthly thereafter. These audits will occur on all three shifts. C.N.A. assignment sheets will be reviewed during Care Plan Conferences to assure assignment sheets accurately reflect care plan and care plan interventions are communicated to front line staff. Audit findings will be presented to QA committee weekly for four weeks, monthly for two months and quarterly thereafter.</p>		

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	<p>well hydrated. Resident #44 would wear geriatric sleeves to his bilateral lower extremities as he would allow.</p> <p>A nurses note for Resident #44, dated 7/23/12 at 11:00 A.M., indicated the following: The nurse was notified by a CNA, Resident #44's fingers were swollen. When the writer assessed Resident #44's left hand, his left index finger was red, swollen, and he was unable to bend it. His left ring finger was red, swollen, and slightly bruised. His left middle finger was red, swollen, and slightly bruised on the inside crease. His fingers were warm to touch. No open areas were noted except a skin tear.</p> <p>A Skin Assessment for Resident #44, dated 7/25/12, indicated the following: "Left hand bruised. Skin O.K".</p> <p>On 7/26/12 at 2:17 P.M., Resident #44's arms and legs were observed with the Director of Nursing (DoN). Resident #44 had 3 small scabbed areas on his left leg and 1 small scabbed area on his right leg. Resident #44's fingernails were jagged. The DoN indicated Resident #44 usually had scratches on his legs due to scratching his legs with his fingernails or rubbing his shoes up and down his legs. The DoN</p>			

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	<p>indicated Resident #44 did not have any geriatric sleeves for his upper or lower extremities and she was not aware he had been getting skin tears on his upper extremities. The DoN indicated she would order geriatric sleeves for his arms. The DoN indicated Resident #44's fingernails were jagged. CNA #2 was also present in the room at this time and she indicated she had never seen Resident #44 wear geriatric sleeves on his upper or lower extremities.</p> <p>On 7/26/12 at 3:02 P.M., the DoN indicated one of the interventions on Resident #44's care plan was for him to wear geriatric sleeves on his lower extremities as he would allow. The DoN indicated she would provide Resident #44 with geriatric sleeves for his legs if he would allow them. The DoN indicated she also planned to address Resident #44's fingernails. The DoN indicated Resident #44's care plan did not address to keep his fingernails trimmed.</p> <p>3.1-37(a)</p>			

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F0323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident was supervised and the pull tab alarm was in place as planned for 1 of 3 residents reviewed with a history of falls. (Resident #42)</p> <p>Findings include:</p> <p>Resident #42's record was reviewed on 7/26/12 at 9:00 a.m. Resident # 42's diagnoses included but were not limited to, Alzheimer's disease and stroke.</p> <p>Resident #42's MDS (Minimum Data Set), assessment, dated 5/15/12, indicated the following:</p> <ul style="list-style-type: none"> - BIMS (Brief Interview for Mental Status), 8, with a score of 8-12 indicating cognition moderately impaired - transfer, extensive assistance, one person physical assist - walk in room and hall, limited assistance, one person physical 	F0323	<p>I. R42's orders have been reviewed and pull tab alarm is secured according to physician's orders.</p> <p>II. All residents' orders have been reviewed for alarm orders. C.N.A. assignment sheets were reviewed and updated as needed to assure proper communication of alarm placement to front line staff.</p> <p>III. The facility's Fall Prevention Policy was reviewed and found to be acceptable by QA committee. All nursing staff will receive reeducation on alarm placement according to physician's orders. This education will be validated through the use of Pre and Post testing.</p> <p>IV. The Director of Nursing or designee will conduct random unannounced audits of alarm placement weekly for four weeks and monthly thereafter. These audits will occur on all three shifts. All new orders will be reviewed by IDT Committee daily to assure proper transcription of alarm orders occurs on C.N.A. assignment sheets and care plan. C.N.A. assignment sheets will be reviewed during Care Plan Conferences to assure assignment sheets accurately reflect care plan and care plan</p>	08/22/2012	

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	<p>assist</p> <p>- number of falls since admission or prior assessment, which ever is more recent, 2 or more</p> <p>Resident #42's care plan, dated 5/21/12 and updated 7/25/12, indicated "Problem, resident is at risk for falls and injury related to impaired cognition and impaired safety awareness secondary to diagnoses of dementia and use of psychotropic medications, anti-hypertensive and incontinence. Goal, resident will have no fall related injuries through next review. Interventions, dated 8/20/11, encourage resident to wear shoes with non-skid soles, fall risk assessment quarterly and with each new fall, physical therapy/occupational therapy per physician orders for balance and safety, 10/20/11, bed alarm, non-skid strips on floor in front of bed and chair, 12/12/11, keep walker at bedside, 1/19/12, recliner chair to be replaced with straight backed chair, 2/29/12, hipsters on for safety, 3/26/12, encourage resident to take frequent breaks while ambulating, remove improper fitting shoes and provide shoes that fit properly. Supply non-skid socks, 4/20/12, will change blood pressure medication to night time dose, 5/3/12, restorative for</p>		<p>interventions are communicated to front line staff. Audit findings will be presented to QA committee weekly for four weeks, monthly for two months and quarterly thereafter.</p>				

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	<p>walk to dine, toileting schedule upon rise, before and after meals and at bedtime, lay resident down after meals, 5/24/12, pull tab alarm while in chair.</p> <p>Resident #42's "Fall Risk Assessment" indicated the following scores with a score of 10 or more representing high risk for falls, 3/23/12, score 15, 4/19/12, score 16, 5/2/12, score 16, 5/18/12, score 16, 5/24/12, score 15 and 7/1/12, score 18.</p> <p>Resident #42's nursing notes indicated the following:</p> <ul style="list-style-type: none"> - 4/19/12 at 1:15 p.m., stood up from dining room table, pushed chair back, walked around chair to walker, stumbled and fell over backwards pulling chair down on top of her - 5/2/12 at 12:00 p.m., heard "grunt", saw resident lying on floor with head under table, per tablemate "she went to push her chair back to stand up and lost her balance" - 5/18/12 at 1:40 p.m., this writer informed by other nurse and occupational therapy that resident was just found on floor sitting on buttocks between bathroom and dresser - 5/24/12 at 12:00 p.m. this writer called to resident's room per 			

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	<p>roommate. Upon arrival, resident laying on right side on floor outside of bathroom. At time of assessment resident noted to have quarter sized bruise to left side of forehead over brow</p> <p>- 7/1/12 at 4:30 p.m., resident sitting in dining room with fellow resident, stood up and fell, hitting her head on side of the table and aid from the kitchen prevented her from falling on the floor</p> <p>On 7/26/12 at 12:57 p.m., Resident #42 was observed up in the dining room. Resident #42 and 3 other residents were the only residents left in the dining room. There was no staff in attendance and Resident #42 was in a dining room chair and started to stand but about the time she got her buttocks off the chair approximately 3 seconds she sat back down in her chair. There was no alarm on Resident #42 or her chair.</p> <p>On 7/27/12 at 12:00 p.m., Resident #42 was observed in the dining room in a dining room chair with no alarm on and no alarm in the chair.</p> <p>During an interview with CNA #2 on 7/27/12 at 12:09 p.m., she indicated Resident #42 did not have an alarm</p>			

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	<p>on. She stated "we put one on her when she is in her wheelchair but not in the dining room chair."</p> <p>During an interview with the DON (Director of Nursing) on 7/27/12 at 12:30 p.m., indicated Resident #42 should have an alarm on any chair she is in, the one in her room, in the hall or in the dining room.</p> <p>Review of the CNA assignment sheet on 7/27/12 at 4:00 p.m., indicated Resident #42 was a "high fall risk" but did not include an alarm for her bed or her chair.</p> <p>3.1-45(a)(2)</p>			