

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 09/28/2015
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NAME OF PROVIDER OR SUPPLIER  CROWN SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 7960 SHADELAND AVENUE NORTH INDIANAPOLIS, IN 46250
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R 0000  Bldg. 00	<p>This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00182798 and IN00181026.</p> <p>Complaint IN00182798 - Substantiated. State deficiencies related to the allegations are cited at R0091.</p> <p>Complaint IN00181026 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: September 23, 24, 25 and 28, 2015</p> <p>Census bed type: Residential: 64 Total: 64</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed by 30576 on October 1, 2015</p>	R 0000		
R 0091  Bldg. 00	<p>410 IAC 16.2-5-1.3(h)(1-4) Administration and Management - Noncompliance (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>			

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>(1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request. Based on observation, interview and record review, the facility failed to establish a policy regarding resident transfers and implement its' abuse prevention policy regarding reporting of potential mistreatment for 1 of 3 residents whose incidents were reviewed. (Resident #B)</p> <p>Findings include:</p> <p>1. a) The clinical record for Resident #B was reviewed on 9/23/15 at 1:30 p.m. The diagnoses for Resident #B included, but were not limited to: osteoporosis, abnormal gait, neuropathy, and blindness.</p> <p>The 6/16/15 Service Plan for Resident #B indicated she required one person assistance with all transfers, required the use of a wheel chair, and required transport to and from meals and activities.</p> <p>The 7/8/15 physician notification form indicated Resident #B's foot gave out during a transfer from her wheel chair to the commode, and slid to the floor.</p>	R 0091	<p>The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion as set forth in the statement of deficiency or of any violation of regulation. <b>Identification of Corrective Action(s) for Residents Affected 1.</b> It has been cited that the facility did not have a transfer policy in place at the time of survey. It is of noteworthy mention that there is no ta state regulation, for licensed residential care facilities, that cites the requirement for a transfer policy. It is not customary to see Hoyer lifts, or other similar devices, within the residential care setting; and therefore, transfer policies are not generally put into place in this setting. Rather, transfer needs are individualized per each resident's personalized service plan. However, in an effort to comply with survey request, the facility has taken corrective action and has implemented a written transfer policy which states that the transfer needs of each resident will be reviewed and documented on the individualized service plan. The new policy also allows for more in-depth policy and procedure to be written, per</p>	10/09/2015

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	<p>The 7/15/15 physician notification form indicated Resident #B was lowered to the floor during a transfer from the commode to her wheel chair.</p> <p>The 9/15/15, 11:00 p.m., nurses note for Resident #B indicated she was lowered to the floor during a transfer from the commode to her wheel chair.</p> <p>The 9/21/15 Follow-Up Incident Report for Resident #B indicated CNA #1 and LPN #2 alleged LPN #3 treated Resident #B with unnecessary roughness during patient care, specifically during transfer. The report indicated the allegation was unsubstantiated, but revealed difficulty in transferring Resident #B.</p> <p>An interview was conducted with LPN #3 on 9/28/15 at 3:20 p.m. She indicated the incident referenced in the 9/21/15 Follow-Up Incident Report was not a smooth transfer. She indicated it would have been nice to have assistance with the transfer. She indicated in the times she'd transferred Resident #B, Resident #B did not bear weight.</p> <p>An observation of Resident #B being transferred from her wheel chair into her recliner was made on 9/25/15 at 8:42 a.m. One staff member was used for the transfer.</p>		<p>specific resident(s), when appropriate. 2. In the case of resident #B, as a corrective action, administration and family have worked with resident #B and the resident's private therapist, to ensure that staff members are properly trained on transfer techniques that are best suited for this resident. Additionally, administration requested that therapist provide written transfer instruction for resident #B. Any new staff members will receive training on the proper transfer techniques for resident #B. 3. It has also been documented that LPN #2 and CNA #1 failed to follow facility protocol and report to the administrator suspected mistreatment or abuse of a resident. The first corrective action on this matter occurred prior to survey, when administration filed a report with the ISDH upon receiving verbal notification of the allegation from LPN #4. An investigation was completed and the allegation was found to be unsubstantiated and it was determined that there was no mistreatment or abuse. A follow-up report was filed with ISDH. 4. It has been the policy of the facility that all new employees receive training and orientation on abuse, resident rights and reporting protocol. It has also been the policy of the facility that all employees receive quarterly abuse and report training, and more frequent training, if deemed</p>	

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	<p>An anonymous interview was conducted with a staff member. The staff member indicated Resident #B was "dead weight" during transfers, and her ankle "bended" sometimes during transfers.</p> <p>An interview was conducted with the Administrator on 9/25/15 at 2:40 p.m. She indicated there was no facility policy on resident transfers, as it was individualized and should be in their care plan.</p> <p>b) The clinical record for Resident #B was reviewed on 9/23/15 at 1:30 p.m. The diagnoses for Resident #B included, but were not limited to: osteoporosis, abnormal gait, neuropathy, and blindness.</p> <p>The 9/21/15 Follow-Up Incident Report for Resident #B indicated CNA #1 and LPN #2 alleged LPN #3 was rough when witnessing her transfer Resident #B into bed, was sarcastic with Resident #B, and referred to her as "Princess", to which the CNA #1 and LPN #2 felt was inappropriate. Both CNA #1 and LPN #2 denied any injury or physical abuse to Resident #B, but reported that LPN #3 could have been more empathetic and gentle when working with Resident #B.</p> <p>On 9/25/15 at 10:50 a.m., an interview</p>		<p>appropriate. These policies will remain in place. As a corrective action, employees were again in-serviced on abuse, resident rights and the protocol to report suspected mistreatment or abuse of a resident. <b>5.</b> Regarding the failure of LPN #2 and CNA #1 to follow facility protocol and report the possible allegation of mistreatment or abuse to administrator, corrective action has been taken, and LPN #2 and CNA#1 are no longer employed at the facility. <b>Identification of Corrective Action for Other Residents with Potential to be Affected</b> 1. At this time, there are no other residents to be affected by the transfer policy. However, the policy is now in place, and will be consulted, should another resident require the need for such policy at a later time. 2. As an additional corrective action, the facility has performed quality assurance, which included the interview of all residents, as well as the interview of family members that wished to participate. The quality assurance survey was unremarkable, as it relates to potential mistreatment or abuse. <b>Measures and Systemic Changes by Facility</b> 1. As noted above, a transfer policy has been put into place and the facility's ongoing in-service and training programs will continue, as well as the quality assurance program. <b>Monitoring</b></p>				

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	<p>was conducted with the Administrator, who investigated the above incident. She indicated LPN #2 did not follow protocol in regards to reporting the incident with Resident #B. She indicated she was notified by LPN #4, not LPN #2, twelve hours after the alleged incident occurred.</p> <p>A telephone interview was conducted with LPN #2 on 9/28/15 at 3:05 p.m. She indicated she received training on reporting suspected mistreatment and abuse, but did not report the incident involving Resident #B, because she was intimidated, due to LPN #3 being her immediate supervisor.</p> <p>The Abuse Prevention Policy, revised November, 2014, was provided by the Administrator on 9/24/15 at 8:45 a.m. It indicated, "Employees are required to report any (sic) all occurrences of potential mistreatment, abuse or neglect they observe, hear about, or suspect to a supervisor or the Administrator.</p> <p>This state tag relates to Complaint #IN00182798.</p>		<p><b>of Corrective Action 1.</b> The corrective action will be ongoing, as noted above, and will include in-service training and quality assurance. These items will be monitored by both the Business Office Manager and the Director of Nursing. The Administrator is ultimately responsible for ensuring the corrective action remains in place and is ongoing. The Administrator is involved in all in-services, training and quality assurance. <b>Completion Date of Systemic Changes 1.</b> All corrective action has already been implemented.</p>				