

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155524	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/30/2012
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NAME OF PROVIDER OR SUPPLIER GLENBURN HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 618 W GLENBURN ROAD LINTON, IN 47441
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F0000	<p>This visit was for the investigation of Complaint IN00106788.</p> <p>Complaint IN00106788 substantiated. Federal/State deficiencies related to the allegations are cited at F-225 and F-226.</p> <p>Survey date: 04/30/12</p> <p>Facility number: 000230 Provider number: 155524 AIM number: 100275000</p> <p>Survey team: Sharon Whiteman RN TC Susan Worsham RN</p> <p>Census bed type: SNF: 08 SNF/NF: 122 Total: 130</p> <p>Census payor type: Medicare: 19 Medicaid: 78 Other: 33 Total: 130</p> <p>Sample: 03</p> <p>These deficiencies also reflects state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 5/3/12 Cathy Emswiller RN</p>	F0000	<p>Submission of this plan of correction does not constitute an admission or agreement by the provider of the turth of facts alleged or corrections set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of the requirements under state and federal law.</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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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 interview and record review, the facility failed to report an unusual</p>	F0225	1.) What corrective actions will be accomplished for those residents found to have been affected by	05/30/2012			

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	<p>reportable occurrence to appropriate agencies regarding a licensed nurse quitting employment in the middle of a shift, without notice, resulting in a resident being late for an appointment and the appointment having to be delayed for 2 weeks, for 1 of 3 residents reviewed for care in a sample of 3. (Resident A)</p> <p>Findings Include:</p> <p>Review of Resident A's clinical record on 04/30/12 at 11:55 a.m. indicated the following:</p> <p>Resident A had diagnoses which included, but were not limited to, breast cancer metastatic (movement of cancer cells from one part of the body to another) to the brain.</p> <p>A nurse's note, dated 04/04/12 at 12:00 (p.m.), indicated, "...Res [Resident A] LOA (left facility) to MRI (magnetic resonance imaging) appt [appointment]...."</p> <p>A nurse's note, dated 04/04/12 at 4:30 p.m. indicated, "Res [Resident A] returned...from appt for MRI0 [No] distress noted. Hospital was unable to do MRI do to res late to appt. Need to re-schedule....and also call res [Resident A's] doctor...et [and] set up an appt.</p>		<p>the deficient practice; Resident A's appointment was rescheduled and completed on 4.19.12 prior to this survey. 2.) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken;All residents have the potential to be affected. After review of all residents, there have been no other such incidents. All scheduled appointments will be marked on a calendar that is kept on each unit. It will be the Unit Managers responsibility to make sure that the appointment is marked on a master schedule that is kept in a designated area for the whole building. The Director of Nursing will read the list of residents that will be sent out for an appointment on that particular day during morning meeting. The Unit Manager will supervise staff to make sure the resident is ready for each appointment prior to the scheduled leave time. The Unit Manager or designated person will make sure the resident is up, showered if desired by the resident, dressed, groomed, toileted, and fed (if allowable for the appointment scheduled) prior to the scheduled leave time. A letter will be sent to the receiving facility to note if the Resident was late. If so, we will ask them to call the Executive Director, Administrator, or the</p>				

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	<p>The clinical record lacked documentation indicating the time Resident A left the facility.</p> <p>Interview of Unit Manager #1 on 04/30/12 at 2:00 p.m. indicated the ambulance arrived on time on 04/04/12 to pick up Resident A for transport to an Indianapolis hospital for a MRI. Unit Manager #1 indicated she remembered because "it was a big deal that morning." Unit Manager #1 indicated Resident A's nurse walked off the floor and other nursing staff did not know "where they were at in getting her [Resident A] ready. Unit Manager #1 indicated the ambulance service had to wait while nursing staff got the resident ready and when they arrived in Indianapolis they were late and the resident did not get her MRI. Unit Manager #1 indicated the ambulance service had to wait about 30 minutes.</p> <p>Interview of Resident A on 04/04/12 at 3:30 p.m.. indicated the facility did not get her ready on time and she missed an appointment for a MRI test and she had to return to the hospital later on for the MRI. Resident A indicated she was not very happy about it.</p> <p>A nurse's note, dated 04/19/12 at 4:50 a.m., indicated, "Res went LOA to (an</p>		<p>Director of nursing immediately. Glenburn Home will then investigate the reason the Resident was late for the appointment. If it is determined that a Resident was late due to an employee quitting in the middle of their shift, then the incident will be reported to the Indiana State Department of Health. All staff will be educated on reporting anyone who quits their job in the middle of their shift to the Executive Director, Administrator, and or the Director of Nursing. The Executive Director, Administrator, Director of Nursing and the Risk Manager will determine the severity of the incident and if it is reportable to the Indiana State Department of Health. According to the Indiana Sate Department of Health, Division of Long Term Care list of "Reportable Unusual Occurrences" Abandonment is defined as "employee(s) that walks off the job leaving residents unattended which results in the facility being unable to adequately care for the residents needs and the resident(s) are in jeopardy".</p> <p>3.) What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. All scheduled appointments will be marked on a calendar that is kept on each unit. It will be the Unit Managers responsibility to make sure that the appointment is marked on a master schedule</p>		

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	<p>Indianapolis hospital) for MRI & Doc [doctor] appt.</p> <p>On 05/02/12 at 1:25 p.m. ADON #1 (Assistant Director of Nursing #1) was interviewed. The ADON indicated sometime between 11:00 a.m. and 11:30 a.m. on 4/4/12, RN #1 turned her keys in to her. The ADON indicated she tried to get RN #1 to stay but RN #1 said, "No, I'm done" and walked off. ADON #1 indicated she went right to the Unit where RN #1 had been working to make sure the nurse working that Unit could take care of everything. ADON #1 indicated she saw "EMS" (Emergency Medical Services) waiting. ADON #1 indicated she did not know anything about Resident A's appointment for an MRI. ADON #1 indicated she went to the kitchen and brought Resident A her lunch tray and the EMS waited while the resident ate her lunch.</p> <p>Interview of the Executive Director (ED) on 05/02/12 at 1:00 p.m. indicated the facility did not report the incident of RN #1 walking off the floor before her shift was finished to ISDH.</p> <p>This Federal tag relates to Complaint IN00106788.</p> <p>3.1-28(c)</p>		<p>that is kept in a designated area for the whole building. The Director of Nursing will read the list of residents that will be sent out for an appointment on that particular day during morning meeting. The Unit Manager will supervise staff to make sure the resident is ready for each appointment prior to the scheduled leave time. The Unit Manager or designated person will make sure the resident is up, showered if desired by the resident, dressed, groomed, toileted, and fed (if allowable for the appointment scheduled) prior to the scheduled leave time. A letter will be sent to the appointments that will ask the receiving facility to note if the Resident was late. If so, we will ask them to call the Executive Director, Administrator, or the Director of nursing immediately. Glenburn Home will then investigate the reason the Resident was late for the appointment. If it is determined that a Resident was late due to an employee quitting in the middle of their shift, then the incident will be reported to the Indiana State Department of Health. All staff will be educated on reporting anyone who quits their job in the middle of their shift to the Executive Director, Administrator, and or the Director of Nursing. The Executive Director, Administrator, Director of Nursing and the Risk Manager</p>				

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			<p>will determine the severity of the incident and if it is reportable to the Indiana State Department of Health. According to the Indiana Sate Department of Health, Division of Long Term Care list of "Reportable Unusual Occurrences" Abandonment is defined as "employee(s) that walks off the job leaving residents unattended which results in the facility being unable to adequately care for the residents needs and the resident(s) are in jeopardy".</p> <p>4.) How the corrective actions will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place;All scheduled trips will be audited for timeliness with the results being reported to the QA committee Quarterly for 1 year. If those results are conclusive the problem is resolved then the committe will decide at that time what percentage needs to be audited from that point forward.</p> <p>5.) What date the systemic changes will be completed;5.30.12</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 interview and record review, the facility failed to implement their policy and procedure by not reporting an unusual reportable occurrence to appropriate agencies regarding a licensed nurse quitting employment in the middle of a shift, without notice, resulting in a resident being late for an appointment and the appointment having to be delayed for 2 weeks, for 1 of 3 residents reviewed for care in a sample of 3. (Resident A)</p> <p>Findings Include:</p> <p>Review of Resident A's clinical record on 04/30/12 at 11:55 a.m. indicated the following:</p> <p>Resident A had diagnoses which included, but were not limited to, breast cancer metastatic (movement of cancer cells from one part of the body to another) to the brain.</p> <p>A nurse's note, dated 04/04/12 at 12:00 (p.m.), indicated, "...Res [Resident A] LOA (left facility) to MRI (magnetic</p>	F0226	<p>1.) What corrective actions will be accomplished for those residents found to have been affected by the deficient practice; Resident A's appointment was reshceduled and completed on 4.19.12 prior to this survey. 2.) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken;All residents have the potential to be affected. After review of all residents, there have been no other such incidents. All scheduled appointments will be marked on a calendar that is kept on each unit. It will be the Unit Managers responsibility to make sure that the appointment is marked on a master schedule that is kept in a designated area for the whole building. The Director of Nursing will read the list of residents that will be sent out for an appointment on that particular day during morning meeting. The Unit Manager will supervise staff to make sure the resident is ready for each appontment prior to the scheduled leave time. The Unit Manager or designated person will make sure the resident is up,</p>	05/30/2012			

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	<p>resonance imaging) appt [appointment]...."</p> <p>A nurse's note, dated 04/04/12 at 4:30 p.m. indicated, "Res [Resident A] returned...from appt for MRI0 [No] distress noted. Hospital was unable to do MRI do to res late to appt. Need to re-schedule....and also call res [Resident A's] doctor...et [and] set up an appt.</p> <p>The clinical record lacked documentation indicating the time Resident A left the facility.</p> <p>Interview of Unit Manager #1 on 04/30/12 at 2:00 p.m. indicated the ambulance arrived on time on 04/04/12 to pick up Resident A for transport to an Indianapolis hospital for a MRI. Unit Manager #1 indicated she remembered because "it was a big deal that morning." Unit Manager #1 indicated Resident A's nurse walked off the floor and other nursing staff did not know "where they were at in getting her [Resident A] ready. Unit Manager #1 indicated the ambulance service had to wait while nursing staff got the resident ready and when they arrived in Indianapolis they were late and the resident did not get her MRI. Unit Manager #1 indicated the ambulance service had to wait about 30 minutes.</p>		<p>showered if desired by the resident, dressed, groomed, toileted, and fed (if allowable for the appointment scheduled) prior to the scheduled leave time. A letter will be sent to the appointments that will ask the receiving facility to note if the Resident was late. If so, we will ask them to call the Executive Director, Administrator, or the Director of nursing immediately. Glenburn Home will then investigate the reason the Resident was late for the appointment. If it is determined that a Resident was late due to an employee quitting in the middle of their shift, then the incident will be reported to the Indiana State Department of Health. All staff will be educated on reporting anyone who quits their job in the middle of their shift to the Executive Director, Administrator, and or the Director of Nursing. The Executive Director, Administrator, Director of Nursing and the Risk Manager will determine the severity of the incident and if it is reportable to the Indiana State Department of Health. According to the Indiana Sate Department of Health, Division of Long Term Care list of "Reportable Unusual Occurrences" Abandonment is defined as "employee(s) that walks off the job leaving residents unattended which results in the facility being unable to adequately care for the residents needs and</p>		

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	<p>Interview of Resident A on 04/04/12 at 3:30 p.m.. indicated the facility did not get her ready on time and she missed an appointment for a MRI test and she had to return to the hospital later on for the MRI. Resident A indicated she was not very happy about it.</p> <p>A nurse's note, dated 04/19/12 at 4:50 a.m., indicated, "Res went LOA to (an Indianapolis hospital) for MRI & Doc [doctor] appt.</p> <p>During return trip to the facility on 05/02/12 at 1:00 p.m. for additional information ADON #1 (Assistant Director of Nursing #1) was interviewed at 1:25 p.m. The ADON indicated sometime between 11:00 a.m. and 11:30 a.m. RN #1 turned her keys in to her. The ADON indicated she tried to get RN #1 to stay but RN #1 said, "No, I'm done" and walked off. ADON #1 indicated she went right to the Unit where RN #1 had been working to make sure the nurse working that Unit could take care of everything. ADON #1 indicated she saw "EMS" (Emergency Medical Services) waiting. ADON #1 indicated she did not know anything about Resident A's appointment for an MRI. ADON #1 indicated she went to the kitchen and brought Resident A her lunch tray and the EMS waited while the resident ate her lunch.</p>		<p>the resident(s) are in jeopardy".</p> <p>3.) What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. All scheduled appointments will be marked on a calendar that is kept on each unit. It will be the Unit Managers responsibility to make sure that the appointment is marked on a master schedule that is kept in a designated area for the whole building. The Director of Nursing will read the list of residents that will be sent out for an appointment on that particular day during morning meeting. The Unit Manager will supervise staff to make sure the resident is ready for each appointment prior to the scheduled leave time. The Unit Manager or designated person will make sure the resident is up, showered if desired by the resident, dressed, groomed, toileted, and fed (if allowable for the appointment scheduled) prior to the scheduled leave time. A letter will be sent to the appointments that will ask the receiving facility to note if the Resident was late. If so, we will ask them to call the Executive Director, Administrator, or the Director of nursing immediately. Glenburn Home will then investigate the reason the Resident was late for the appointment. If it is determined that a Resident was late due to an employee quitting in the</p>				

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	<p>Interview of the Executive Director (ED) on 05/02/12 at 1:00 p.m. indicated the facility did not report the incident of RN #1 walking off the floor before her shift was finished to ISDH.</p> <p>A policy titled "Reportable Unusual Occurrences" was provided by the Executive Director on 05/02/12 at 1:40 p.m. The policy indicated, "Purpose: To ensure that reportable occurrences are recorded and monitored to facilitate compliance with state and federal laws. Policy: All unusual occurrences reported to the Indiana State Department of Health will be recorded and tracked or monitored to insure residents are receiving appropriate care and services. Procedure: Occurrences to be reported: Facilities are required by law to report unusual occurrences within 24 hours of occurrence to the Long Term Care Division....The following are examples of occurrences that the Long Term Care Division considers reportable under both State Rule and Federal Regulation. These occurrences will be reported by facility and will be tracked and monitored....Abandonment...Employee(s) that walks off the job leaving residents unattended which results in the facility being unable to adequately care for the residents needs...."</p>		<p>middle of their shift, then the incident will be reported to the Indiana State Department of Health. All staff will be educated on reporting anyone who quits their job in the middle of their shift to the Executive Director, Administrator, and or the Director of Nursing. The Executive Director, Administrator, Director of Nursing and the Risk Manager will determine the severity of the incident and if it is reportable to the Indiana State Department of Health. According to the Indiana Sate Department of Health, Division of Long Term Care list of "Reportable Unusual Occurrences" Abandonment is defined as "employee(s) that walks off the job leaving residents unattended which results in the facility being unable to adequately care for the residents needs and the resident(s) are in jeopardy".</p> <p>4.) How the corrective actions will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place; All scheduled trips will be audited for timeliness with the results being reported to the QA committee Quarterly for 1 year. If those results are conclusive the problem is resolved then the committe will decide at that time what percentage needs to be audited from that point forward.</p> <p>5.) What date the systemic changes will be completed; 5.30.12</p>		

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